



**The Justice Program  
 Referral Form**

<b>Referral Information (omit this information if self-referral)</b>	
Name of referral source:	Date of referral:
Agency/Organization/Department:	Telephone/Email:

<b>Applicant Information</b>	
Surname:	First Name:
Address (prior to incarceration):	Postal Code:
Date of Birth: (Year/Month/Day)	Telephone:
Social Insurance Number :	Email:
MCP:	MCP Expiry:
Remaining in the St. John's area : Yes / No	If no, where:

<b>Psychiatric History</b>
Mental Illness Diagnosis:

<b>Legal Involvement</b>	
Current/Past Criminal Charges:	
Continued:	
Sentenced: Yes / No	Release Date:
Outstanding Charges: Yes / No	Nature of outstanding charge(s):
Continued:	

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 Toll Free: 1-877.753.8550  
 Fax: (709) 745.0022  
[hedgar@cmhanl.ca](mailto:hedgar@cmhanl.ca)  
[www.cmhanl.ca](http://www.cmhanl.ca)

<b>Risk Behavior</b>	
Is there a history of verbally/physically aggressive behavior in the past: Yes / No	
Is the person currently aggressive: Yes / No	
If yes, to the above, please provide details (ie. anger, violence):	
Continued:	
Does the person have a history of substance abuse: Yes / No	
If yes to the above, please provide details (ie. Substance type, duration, frequency, etc.)	
Continued:	
Has the person attempted suicide in the past: Yes / No	
Is the person currently suicidal or having suicidal thoughts: Yes / No	
If yes to the above, please provide details (ie. Frequency, hospitalization, etc):	
Does the person have a current or prior history of self harm: Yes / No	

Is the client aware of the referral: Yes / No	
Client Signature :	Referee Signature:

<b>Office Use Only:</b>	
Action Date:	
Accepted: Yes / No	If no, please specify reason:
Referral Source Notified: Yes / No	Date Notified:
Signature:	