Mental Health and Justice - Toronto Region
Short – term Residential Beds
Referral Form

Registry Phone # - (416) 248 - 4174
Registry Fax # - (416) 248 – 2784

To provide short-term Residential Beds for individuals living with mental illness who have been involved with the criminal justice system.

Basic Eligibility Criteria

1. **Homeless** or **potentially homeless** individuals.
2. Individuals with **serious mental illness**
3. Current **involvement with the criminal justice system**
4. Individuals who are **likely to be safely supported in the community.**

The safe bed network is a voluntary service any reporting or probation requirements remain between the individual and the criminal justice system.

Staff Making Referral

Name: ____

Agency: ____

Sector: ____

Phone#: ____

Fax#: ____

Release of information for the purposes of this referral have been agreed to by the client

Yes No

Person in Crisis

Name: ____

D.O. B.: Day ___________ Month ______________ Year ____________

Male Female Transgender

Current Location: ____

Address: ____

Phone#: ____

Housing/Living Situation: ____

Income Source: ____

Identification: Yes No

Drug Card: Yes No

O.H.I.P.#: ______________________________________

Languages spoken: ____

Presenting Problem/Reason for Referral

Y/N	Presenting Issue	Description/Details
	Threat to others/attempted suicide	
	Specific symptoms of SMI	
	Physical/Sexual Abuse	
	Educational	
	Occupational/employment/vocational	
	Housing	
	Financial	
	Legal	
	Problems with relationships	
	Substance abuse	
	ADL	
	Other/Specify___________________	

Supports		
Relationship	Name	Phone #
G.P.		
Psychiatrist		
Therapist		
Case Manager		
Probation Officer		
Lawyer		
Court Support		
G.P.		
Other		

Current Involvement with the Criminal Justice System: Y N

Description of involvement

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____
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Current Mandatory Supervision		
Name of Supervising Body:	**Status**	
		On restraining order/peace bond
		On bail/undertaking
Name of Supervisor/Phone #:		On probation
		Under ORB
		On restraining order/peace bond

Safety Risks				
Y/N	Risks	Current	History	Description/Details/Dates
	Suicide			
	Violence			
	Substance Use			
	Self Harm			
	Verbal Aggression			
	Weapons			
	Arson			

Current prescribed medications (please include all medications)		
Medication	Dosage	Prescribing Physician

Does client have a prescription and/or medication? Yes No

Describe: ____

History of Hospitalization for Mental Heath reasons: Yes No

Most recent hospitalizations			
Date	Hospital	Length of stay	Reason

Mental Health Diagnosis: Yes No ______________________

Follow Up? Yes No

By Whom? Name: ______________________ Phone #: ______________________

Where: ______________________ When: ______________________

Physical Health Concerns / Special Needs
(dietary, mobility, physical care, etc.)

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Allergies: ____

Has the client received service from the Mental Heath and Justice Short-term Residential Beds in the past?

Yes No Unknown

Date of last stay: ____