RSA

Regional Support Associates

Dual Diagnosis Justice Case Management

Referral Form

Name of Person Being Referred: _____ DOB: _____

Preferred Name:_____ Pronouns: He, Him

Address: _____
Street City Postal Code

Phone #: _____ Email:_____

Preferred language: Other: Interpreter required?

Primary Contact (if Not the Person Being Referred): _____

Address: _____
Street City Postal Code

Phone #: _____ Email:_____

Substitute Decision Maker Name (if necessary): _____

Address: _____
Street City Postal Code

Phone #: _____ Email:_____

What do they consent for? ☐ Financial ☐ Health

Has a Capacity Assessment been completed? No

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Regional
Support
Associates

LIVING SITUATION AT TIME OF REFERRAL

☐ Independent	☐ Group Home	☐ Hospital
☐ With Family	☐ Shelter	☐ Homeless
☐ Supported Housing	☐ Correctional Facility	☐ Safe Bed
Other:		

REFERRAL SOURCE

☐ Community Agency	☐ Court Diversion	☐ Court System
☐ Jail	☐ Family/Friend	☐ Hospital
☐ Probation & Parole	☐ Network Partner	☐ Police Referral
☐ Short Term Crisis Support Bed	☐ School	☐ Self
☐ Other:		

Name: _____ Phone Number: _____

Address: _____
Street City Postal Code

REASON FOR REFERRAL

☐ Court support	☐ Need counsel/legal aid

Next Court Date: _____ Lawyer/Duty Counsel: _____

Phone Number: _____ Email: _____

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Current Criminal Charges	Date Charged	Current Status

Past Criminal Charges	Date Charged	Current Status

☐ Verbal Consent Received Date:_____

Has eligibility for Developmental Services been confirmed? ☐ Yes ☐ No

_____ _____

Signature of Person Completing *Date*

Please forward the complete referral package RSA Admin:

Fax: 519-421-4249
or
Email: rsaadmin@woodstockhospital.ca