

## **Forensic Psycholegal Clinic: External Referral and Registration Form**

The Forensic Psycholegal Clinic (FPLC) at the 455 Spadina Avenue Site of the Centre for Addiction and Mental Health is a Forensic Psychiatry third-party referral clinic.

The Forensic Psycholegal Clinic accepts third party psycholegal criminal and civil assessment requests. Third parties include, but are not limited to: the Court, legal counsel (defence and crown), professional bodies (e.g., CPSO, CMPA, Law Society of Upper Canada), law enforcement (RCMP, OPP), and employment assistance programs. The clinic cannot accept self-referrals, referrals from family members / friends, or from physicians (internally or externally). Please note that the third party requesting the assessment is fully responsible for all payment. Payment will not be collected from the evaluatee (the individual being assessed). Please note that the assessments are not funded by the Ministry of Health (OHIP).

The assessments may involve psychologists and social workers as part of a multidisciplinary team.

Psychiatrists take on a case as their workload, interest, and expertise allows. In some cases, a psychiatrist will not be available to take on a case. The clinic reserves the right **not** to accept a case. If a psychiatrist is available, the time frame for reports will generally be 45-60 days from when all information is available, and depending on the complexity of the matter.

The assessor will contact you to discuss details, time frame, and fees. File information (such as court order, CPIC, police/legal records, psychiatric/medical records, etc., as applicable) is to be forwarded to the assessor.

### **Referral Information** *Please print clearly or type*

#### **Evaluee Information**

**Evaluee Name:** \_\_\_\_\_  
(individual to be assessed)

**Date of Birth:** Day / Month / Year

**Charges/Convictions (as applicable):** \_\_\_\_\_

**Does the evaluatee speak English? Yes [ ] No [ ]**

**If not, do they require an interpreter\*? Yes [ ] No [ ]**

**Language/dialect:** \_\_\_\_\_

**\*Please note: The referral source will be responsible for paying for the services of an interpreter.**

**Has your client ever been seen at CAMH before? Yes [ ] No [ ]**

**Referral Source Information**

Referral date: Day / Month / Year

Referral name: \_\_\_\_\_

Referral organization: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**Reason for Referral:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Funding for Referral**

*Please choose from the following and provide details if relevant/possible*

**Legal Aide**

Hours approved for psychiatrist: \_\_\_\_\_

Hours approved for other (e.g. psychology, social work, interpreter): \_\_\_\_\_

Legal Aide Certificate Number: \_\_\_\_\_

**Crown Attorney**

**Private Retainer (Referral source is fully responsible for all payment)**

Please note: The individual psychiatrist may request that a retainer letter be signed. The hourly rate and fees are to be confirmed with the individual psychiatrist.

**Civil Case**

**Plaintiff: Yes [ ] No [ ]**

**Defence: Yes [ ] No [ ]**

**Regulatory Body: Yes [ ] No [ ]**

*Please note: This assessment is NOT covered by OHIP.*

**Type of Assessment Requested**

*Please check box*

**Violence Risk Assessment**

- General
- Sexual
- Domestic
- Stalking
- Threat
- Workplace

**Psychopathy Assessment**

- Malingering Assessment
- Criminal Responsibility Assessment
- Pre-sentence/Disposition Assessment
- Dangerous Offender/Long-Term Offender Assessment
- Capacity Assessments (e.g. Professional Misconduct, Carry Firearm, etc.)
- Civil Assessments (e.g. Fitness for Duty, Disability Evaluations)
- Other (please specify) \_\_\_\_\_

**Thank you for your referral. You will be contacted to confirm receipt.**

**All attempts will be made to meet your request to have this assessment completed. However, the ability to meet this request is subject to availability and the clinic reserves the right not to accept a referral.**

**Signature of individual making the referral to the FPLC:  
By signing this form, you acknowledge that you will be responsible for payment to the individual psychiatrist who performs the assessment.**

\_\_\_\_\_

***Please forward this completed form to:***

**Iliana Hernandez**  
**Administrative Assistant of FPLC**  
 Tel: 416-535-8501 Ext 77360  
 Fax: 416-971-7172  
[iliana.hernandez@camh.ca](mailto:iliana.hernandez@camh.ca)

**FOR INTERNAL USE ONLY**

**Referral accepted by:** \_\_\_\_\_ **(Name of Psychiatrist)**

**Date of Appointment:** \_\_\_\_\_

**Location of Appointment:** \_\_\_\_\_

**Category of Assessment:**

- Legal Aide
- Crown Attorney
- Other Criminal Issue (Private Retainer)
- Civil Case (circle Plaintiff, Defence, or Regulatory Body)