Recovery Alberta
MENTAL HEALTH AND ADDICTION SERVICES

Provincial Mental Health Diversion Program Referral

Client Information

Last Name	First Name	Middle Name

Personal Health Number	Date of Birth *(yyyy-Mon-dd)*	Gender

Address *(Apt/House # and Street Name)*	City	Province	Postal Code

Contact Phone Number ☐ Home ☐ Cell
Can Diversion staff leave a message or text? ☐ Yes ☐ No

Alternate Contact Phone Number ☐ Home ☐ Cell
Can Diversion staff leave a message or text? ☐ Yes ☐ No

Email Address

Preferred Method of Contact
☐ Phone Call ☐ Text Message ☐ Email

Consent
By signing below, I agree to having my legal file forwarded to the nearest Mental Health Diversion Service Site to facilitate my referral.

Client, Legal Guardian, or Counsel Signature _____ Date *(yyyy-Mon-dd)* _____

Referral Information - (To be completed by Crown Prosecutor's Office)

Date of Referral *(yyyy-Mon-dd)*	Name of Defence Counsel

Docket Number	Section Number	Offence Date	Referred Charge(s)
			Other Current Charge(s) Not Referred

Next Court Date *(yyyy-Mon-dd)*	Time *(hh:mm)*	Courtroom

Crown Prosecutor Approval

Name of Crown Prosecutor *(Print)*	Signature	Date *(yyyy-Mon-dd)*

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