

MENTAL HEALTH COURT REFERRAL FORM

CLIENT & COURT INVOLVEMENT INFORMATION

Client's Name:	Date: / /
Date of Birth: / /	SS#: - -
Has client ever served in the U.S. Military/Armed Forces <input type="checkbox"/> Yes <input type="checkbox"/> No Currently in Chester County Prison? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of admittance: / /	
Client's Home Address:	Home Phone: - - Cell Phone: - -
OTN:	CR#:
Current Criminal Charges:	Is the client currently on probation/parole? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Any other outstanding charges/detainers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes,	

MENTAL HEALTH INFORMATION

Mental Health Diagnosis:	Current Medications:
Current Treatment Provider:	IOC : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, expiration:
Drug &/or Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Current Treatment Provider:	
Insurance: <input type="checkbox"/> None <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private,	

REFERRAL INFORMATION

Referral Source: <small>(Name & Agency if applicable)</small>	Relationship to Client:
Referral Source Phone #:	Is client aware of referral: <input type="checkbox"/> Yes <input type="checkbox"/> No

Some indicators of severe mental illness (check those observed or reported):

- | | | |
|---|--|--|
| <input type="checkbox"/> Auditory and/or visual hallucinations | <input type="checkbox"/> Irrational/bizarre behavior | <input type="checkbox"/> Delusional thoughts |
| <input type="checkbox"/> History of psychiatric hospitalization | <input type="checkbox"/> Suicidal behavior | <input type="checkbox"/> Severe depression |
| <input type="checkbox"/> Manic behavior/speech, racing thoughts | <input type="checkbox"/> Self-injurious behavior | |

REFERRAL FORM SHOULD BE FORWARDED TO THE TREATMENT COURT COORDINATOR

FAX: 610-344-4332

PHONE: 610-344-6290

201 WEST MARKET STREET, SUITE 2100 WEST CHESTER, PA 19380

FOR ADMINISTRATIVE USE ONLY

RECEIVED BY APO: / /	REFERRED FOR ASSESSMENT: / / AGENCY:
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