Referral Form for Inpatient Forensic Evaluation

Receiving Facility: _____

Referring Facility: _____

Date of Referral: _____ Date of Outpatient Evaluation: _____

Name of Service Recipient: _____

Social Security Number: _____ Date of Birth: _____

Charge(s): _____ Docket #: _____

_____ DCS Custody (if juvenile): Yes _____ No _____

Date(s) of Alleged Crime: _____ Current Location/Placement: _____

County: _____ Prosecutor: _____

Judge: _____ Defense Atty: _____

Clinical Information: _____

_____

List All Interventions Used to Prevent Referral: ____ Malingering Exam ____ Medication Intro/Adjust

____ Contacted Judge or Attorney(s) ____ Competency Training ____ Psychological Testing (specify):_____

____ Other (specify): _____

Reason for Referral to Inpatient Facility: (Specify Clinical Rationale - Do Not State "For Forensic Evaluation") _____

_____

_____

Reason for Referral to FSP [ADULT ONLY] (Specify Clinical Rationale)**:** _____

_____

Current Medications: _____

_____

Current Medical Concerns: _____

_____

Current and/or Previous Mental Health Treatment: Yes _____ No _____

Facility: _____

Past Forensic Evaluation (Where and When): _____

_____

Date of Phone Contact with the Receiving Forensic Coordinator: _____

Name of CMHC Person Making Referral: _____

Phone Number of CMHC Person Making Referral: _____

Information Included:

_____ C/4N6 Evaluation	_____ Military Records	_____ Witness Reports
_____ Jail/Court Records	_____ School/Employment Records	_____ Risk Assessment
_____ Attorney Records	_____ Past Treatment Records	_____ Other: _____
_____ Medical Records	_____ A & D Records	_____
		_____