

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 _____
