

MENTAL HEALTH COURT REFERRAL FORM

Name:	Date:
Case #:	DOB:
Address:	City/State/Zip:
Home Phone:	Cell/Message Phone:
Current Charges:	
Observed Behaviors/Reported Mental Health Symptoms:	
Substance Abuse Issues:	
Current Providers:	
Referred By:	
Contact Information of Referral Source:	
*** <u>Release of Information must be included with referral</u>***	

**Send Completed Form to:
D.A.'s office, Fax: 541-330-4691
DCBH, Lisa Rosen, Phone: 541-322-7513 / Fax: 541-322-7565**