MENTAL HEALTH COURT REFERRAL FORM

Name:	Date:
Case #:	DOB:
Address:	City/State/Zip:
Cell/home:	Additional phone:
Current Charges:	
Observed Behaviors/Reported Mental Health Symptoms:	
Substance Abuse Issues:	
Current treatment providers:	
Referred by:	
Contact Information of Referral Source:	
*** Release of Information must be included with referral***	

Send Completed Form to:
D.A.'s office, Fax: 541-330-4691
DCBH, Stephanie Koutsopoulos, Phone: 541-322-7520 / Fax: 541-322-7565
Stephanie.Koutsopoulos@deschutes.org