DeKalb Misdemeanor Mental Health Court (MMHC) Program 556 N McDonough St. #1200, Decatur, GA 30030 404-371-2241 (office); 404-371-2683 (fax)

CONFIDENTIAL
MISDEMEANOR MENTAL HEALTH COURT PROGRAM REFERRAL

I._____ _____
Defendant's Name **Social Security No.**

_____ _____ _____
DOB **Race** **Sex**

_____ _____
DOA **SPN**

_____
Jail cell location or (local address)

_____ _____
Indictment/Case Number **Citation/Warrant**

_____
Charge(s)

Referral/Evaluation Results: (To be completed after eval has been completed)

____Provisionally Appropriate for MMHC Program

____Not Appropriate for MMHC Program due to:

- ☐ declined service
- ☐ consent denied
- ☐ no mental illness
- ☐ substance abuse only
- ☐ too violent
- ☐ already sentenced
- ☐ no housing
- ☐ other_____
- ☐ released prior to evaluation _____ date

_____ _____
Evaluator's signature date

_____ _____
Signature date

•**Reason for referra**l (i.e. basis for determination that defendant may have mental illness related to crime or benefit from treatment services, observations; please be specific):

_____

_____

_____ _____ _____ _____
Name/title of person completing form **Telephone No.** **Fax number/email** **Date**
[please print]

II. •**Previous Contact w/Diversion Treatment Court?:** ____ yes _____no

_____

_____

•**Previous Treatment Services? ____yes ____no _____(where?)**

Previous DCSB __yes__no : (e.g. Kirkwood, DAC , Peer Support, CST, ACT, Winn Way, Clifton Springs)

_____

•**Does Defendant have a place to live**? __yes __ no.
•**If no**, does Def have funds/benefits for housing? __yes __ no.
Comments: _____

Next scheduled court date: _____ Time: ___ Courtroom _____

Date referral received: _____