

Referral Form for Inpatient Forensic Evaluation

Receiving Facility: _____

Referring Agency: _____

Date of Referral: _____ Date of Outpatient Evaluation: _____

Name of Service Recipient: _____

Social Security Number: _____ Date of Birth: _____

Gender: _____ Ethnicity: _____ Primary Language: _____

Docket #: _____

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

County: _____ Prosecutor: _____

Judge: _____ Defense Atty: _____

Charge(s): Felony: _____

Misdemeanor: _____

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):

PATIENT IDENTIFICATION (Label)		Dept. of Mental Health and Substance Abuse Services
MH-5253 (Rev. 8/17) TDMHSAS, DPRF, Forensics		Referral Form for Inpatient Forensic Evaluation
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