MIDDLESEX COUNTY

Mental Health Diversion Program Referral Form

Email completed form to mcpomhdp@co.middlesex.nj.us

Please provide as much information as possible

DATE:		**PROSECUTOR FILE NO:**
NAME OF DEFENDANT BEING REFERRED:	**DATE OF BIRTH:**	**EMAIL ADDRESS:**
ADDRESS:		**PHONE:** ☐ **Cell** ☐ **Home**
NAME OF PERSON MAKING REFERRAL:	**PHONE NUMBER:**	**RELATIONSHIP TO DEFENDANT:**
CHARGES AGAINST DEFENDANT:		
LIVING ARRANGEMENTS: ☐ Own house/apt ☐ With family ☐ Section 8 ☐ Boarding home ☐ Temporary shelter ☐ Homeless ☐ Other ______________		
DEFENDANT'S EMERGENCY CONTACT:	**PHONE NUMBER:**	**RELATIONSHIP TO DEFENDANT:**
SUSPECTED MENTAL HEALTH ISSUES:		
SUSPECTED SUBSTANCE USE ISSUES:		
HAS DEFENDANT EVER BEEN *DIAGNOSED* BY A MEDICAL /MENTAL HEALTH PROFESSIONAL: ☐ YES ☐ NO		
DIAGNOSES:		**DATES:**
DOCTOR'S NAME:		**PHONE NUMBER:**
IS DEFENDANT CURRENTLY TAKING, OR EVER BEEN PRESCRIBED, MEDICATIONS FOR MENTAL HEALTH ISSUES: ☐ YES ☐ NO		
MEDICATIONS:		**DATES:**
PRESCRIBING DOCTOR:		**PHONE NUMBER:**
PREVIOUS PSYCHIATRIC EMERGENCY / CRISIS SCREENING: ☐ Yes ☐ No		
WHERE:		**DATES:**

DISCHARGE RECOMMENDATIONS:

HISTORY OF ANY MENTAL/PSYCHIATRIC HOSPITALIZATIONS: ☐ Yes ☐ No

WHERE:	**DATES:**

DISCHARGE RECOMMENDATIONS:

HAS DEFENDANT EVER BEEN LINKED WITH A CASE MANAGEMENT SERVICE? ☐ Yes ☐ No

DATES:	**PROGRAM & COUNTY:**

LIST ALL PAST AND PRESENT PSYCHIATRIC / SUBSTANCE USE *TREATMENT* (include inpatient, day programs, therapy, etc.)

NAME	CONTACT INFORMATION	DATES OF SERVICE

ADDITIONAL INFORMATION:

MENTAL HEALTH DIVERSION PROGRAM INITIATIVE USE ONLY	
DATE REFERRAL RECEIVED:	**LEGALLY APPROPRIATE:** ☐ **Yes** ☐ **No**
FINAL DECISION DATE:	**AP REVIEWING:**