



# JACKSON COUNTY

Health & Human Services



## Jackson County Mental Health Court

### REFERRAL FORM

Please complete all fields and email to the Mental Health Court Coordinator at [MHCOURT@jacksoncounty.org](mailto:MHCOURT@jacksoncounty.org)  
 For questions, please contact the Mental Health Court Coordinator at 541-776-7171 ext. 215

Date of Referral:	
Defendant's Name:	Defendant's Contact Information
	Phone:
Defendant's Address:	Email:
	Other:
DOB:	

Referred by (name):	Contact Information
	Phone:
Referring Agency/Relationship:	Email:
	Other:

Court Case Number:	Incident Date:
Current Charges:	
Are any of these Measure 11 charges?	If yes, do any exceptions/opt out apply?
Defense attorney/agency:	Prosecuting Attorney:
Phone:	Phone:

Mental Health Diagnosis:	Date of diagnosis:
Who provided the diagnosis/assessment?	

Any Substance Abuse Issues? (If yes, please briefly describe):	Onset date:

Why do you think this defendant is a good referral for Mental Health Court?

(Observed behaviors, reported mental health symptoms, connection between mental health/substance abuse issues and incident, interested in treatment?) \_\_\_\_\_

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**\*\*\*MENTAL HEALTH COURT USE ONLY\*\*\***

Staffing date: \_\_\_\_\_ In Custody?  Yes  No

JCMH case manager: \_\_\_\_\_

Staffing decision: \_\_\_\_\_

Next Step: \_\_\_\_\_

Court date: \_\_\_\_\_