# MENTAL HEALTH COURT REFERRAL

**Please Send Referrals To:**
Mental Health Court Coordinator
Boone County Circuit Court
705 East Walnut, Columbia, MO 65201
Phone: (573)886-4082 Fax: (573)886-4247

**Please Indicate Referral Source Information:**
Name: _____
Agency: _____
Phone: _____ Fax: _____
Date of Referral: _____

**SECTION A**
**To be completed by the referral source (please provide information as known)**

Defendant Name: _____ SSN: _____
Date of Birth: _____ Gender: _____ Race: _____
Current Address: _____ Phone: _____
_____
Criminal Case #: _____ Arrest Date: _____ In Custody:
☐ No
☐ Yes
Charges: _____ Where?
_____
_____

Does the defendant have a diagnosed mental illness? ☐ No ☐ Yes (please provide details)
Primary Diagnosis: _____ Source of Information: _____
Is the defendant currently receiving Mental health Services? ☐ No ☐ Yes
☐ alcohol ☐ drugs Source of Information
Does the defendant have Medicaid? ☐ No ☐ Yes

**SECTION B**
**To be completed by the Mental Health Coordinator**

Does this person meet basic eligibility requirements for mental health court?
☐ No-Reason(s) _____
☐ Yes-The defendant's first Mental Health Court appearance is scheduled for:
Date: _____ Time: _____ Division: _____
The defendant has a hearing scheduled in division _____ on _____
for: _____
Additional Comments from Intake: _____