

MSMHS Forensic Mental Health Referral Form

Forensic MH Coordinator

Phone: (410) 770-4665

Fax: (410) 770-4467

Date of Referral: _____ County: _____ District or Circuit

Client's Name: _____

DOB: ____/____/____ Gender: _____ Race: _____

Social Security Number: _____ - _____ - _____

Incarcerated? Yes No If so Where? _____

Address: _____

Phone Number: _____

Criminal Charges: _____

Case Numbers: _____

Trial Status: _____

Probation Officer: _____

Mental Health Diagnosis (if known): _____

Drugs/Alcohol: Yes No

Referral Source: _____ Relationship to client: _____

Referral Source Phone Number: _____

Reason for referral: _____

Please fax to Forensic MH Coordinator at the fax number listed above.

Please attach a Case History report.
