FELONY & MISDEMEANOR
MENTAL HEALTH DIVISION REFERRAL SHEET

Date of Referral:_____ Arrest Date:_____ Book In #:_____

Client Name:_____ DOB:____/____/____ Client Phone: _____

Referring Attorney:_____Atty. Phone: _____

Attorney's email address: _____

Case Number:_____Charge_____ Court:_____

Case Number:_____Charge_____ Court:_____

Why do you think this defendant is a good candidate for the mental health unit?

_____

Does your client receive social security disability? YES NO
Is your client currently employed? YES NO
List any mental health provider the client has/is seeing?_____
List any pysch medications your client has/is taking:

_____

_____

DO YOU HAVE ANY INFORMATION ON ANY OF THE FOLLOWING?
Behavioral Clues:_____

Diagnosis: ___Schizophrenia ____ Bipolar Disorder ____ Major Depressive Disorder
____Schizoaffective Disorder ____ Anxiety Disorder ____ None of the Above

Does your client have a chronic or terminal health condition? YES NO

_____

REQUIRED INFORMATION
How many times has the case been reset?_____

What is the current State's recommendation?_____

Is the case set for Trial?_____

Court DA signature acknowledging they:
- **have made contact with the CW and**
- **are aware of referral request to mental health:**

_____ _____
Signature **Printed Name**

PLEASE NOTE: A **Mental Health Diagnosis** must accompany the referral to be considered for the division.
Please return this referral to the M.H. Division, 6th Floor, Room A19, or email to: **gia.slayton@dallascounty.org**

FELONY & MISDEMEANOR
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ACKNOWLEDGEMENTS

By making this referral to the Mental Health Division I acknowledge the following by my signature below:

1. **This Referral Sheet DOES NOT constitute a "Pass Slip." Continue to pass this case with the court it is currently in until you are contacted by a Representative of the Mental Health Division via email.**

2. **Acceptance of your case into the Mental Health Division DOES NOT GUARANTEE that the case will be placed in a program that results in a dismissal or that will alter the current recommendation on the case.**

3. **This form DOES NOT automatically get your case onto a Mental Health case load. The case must still be accepted by the division.**

4. **Upon acceptance into the Mental Health Division, the case will be sent to the program deemed appropriate by the Chief of the Mental Health Division. Refusal to participate will result in the case being sent back to the trial court.**

5. **I hereby give permission for my client to be evaluated by Care Coordinators from the North Texas Behavioral Health Authority. I understand and authorize those Care Coordinators to both review and release any mental health information about my client to the Restorative Justice Division of the District Attorney's Office for the purpose of making an intake decision and I further authorize the Care Coordinators to do an assessment of my client to assist in providing treatment alternatives and provide a copy of that assessment to the Restorative Justice Division of the District Attorney's Office. I further understand that the Care Coordinators will be presenting a Release of Information to my client for signature that allows them to provide information to the Restorative Justice Division of the District Attorney's Office and do not have any objection to them doing so.**
6. **I understand that the mental health division may review the case once it has been dismissed to track recidivism statistics.**

Signed on the _____ day of _____, 20____

_____

Attorney for the defendant.

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CAUSE NO. _____

THE STATE OF TEXAS	§	IN THE JUDICIAL/CRIMINAL
	§	
VS.	§	DISTRICT COURT #_____
	§	
_____	§	DALLAS COUNTY, TEXAS

GENERAL OR MENTAL HEALTH PRE-TRIAL DIVERSION

DISCOVERY PAUSE ACKNOWLEDGEMENT

When a defendant requests a referral to be considered for General or Mental Health Pre-Trial Diversion (PTD), the defendant agrees to pause the State's obligation to produce case information (called discovery). Any discovery already uploaded under digital media evidence (DME) on the DallasCounty.Prosecutor system (DCP) at the time of referral will be made discoverable to defense. No additional discovery will be sought out by our office after the PTD referral or while the defendant is in a PTD program. Any unsolicited discovery added to the DCP after a PTD referral or while a defendant is in the PTD program will be disclosed as it is received. If the defendant chooses not to join, is rejected from, or is removed from PTD, then normal discovery will resume with the assistant district attorney assigned to prosecute the case.

If the defendant is removed/closed from PTD, is later charged in a new case, or becomes a victim or witness in another case, then upon a proper request under article 39.14 of the Code of Criminal Procedure, the State must produce and permit the defense to inspect any documents given to the State during the PTD program.

By signing below, I acknowledge my understanding and agreement.

_____
Defense Attorney Name (printed)

_____ _____
Defense Attorney's Signature Date

_____ _____
Defendant's Signature Date

metrocare.

OFFICE USE ONLY: MRN_____

☐ Photo ID ☐ Signature Verified ☐ Other _____

Staff Name:_____

Staff Signature:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Disclosure: This authorization is intended to allow METROCARE to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. I reserve the right to remove this authorization at any time by providing written notice of removal to Metrocare for the named individual/facility. The removal will be effective as of the date it is received except to the extent Metrocare has already relied upon my authorization to use or disclose my health information as described in the Notice of Privacy Practices. Metrocare is prohibited from releasing psychotherapy notes without specific authorization for disclosure of psychotherapy notes. I understand the information released in response to this authorization may be re-disclosed to other parties.

Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

SECTION I - CLIENT DATA

1. NAME: *(First, Middle, Last Name)*	2. DATE OF BIRTH: *(MM/DD/YY)*	3. SOCIAL SECURITY NUMBER:

4. PHONE NUMBER: *(999)999-9999*

SECTION II - DISCLOSURE

5. I hereby authorize Metrocare to disclose/use/receive the specified protected health information below from the medical record of the above-named individual. **The designated staff may ☐ disclose to *OR* ☐ receive from, the following organization or person:**

a. NAME OF FACILITY *OR* PERSON:	b. ADDRESS *OR* EMAIL:
c. PHONE NUMBER: *(999)999-9999*	**d. FAX:** *(999)999-9999*
6. TYPE OF INFORMATION: ☐ Mental Health Records ☐ Primary Care Records ☐ Cohen Records ☐ Intellectual & Developmental Disability Records	***7. PERIOD OF TREATMENT:*** *(MM/DD/YY)* FROM: TO:

8. PURPOSE OF DISCLOSURE:

☐ Personal Use ☐ Treatment/Continuing Care ☐ Attorney/Legal ☐ Educational Use
☐ Discuss with Family ☐ Disability ☐ Housing ☐ Other (*specify*):_____

9. INFORMATION TO BE RELEASED: ☐ ALL RECORDS (excluding psychotherapy notes) **OR select below:**

☑ Psychiatric Evaluation ☑ Medication List ☑ Treatment Plans ☐ HIV/AIDS Results
☑ Psychological Evaluation ☑ Diagnosis Letter ☑ Labs ☐ Sexual Transmitted Infection (STI) Results
☑ Provider Notes ☑ Progress Notes ☐ Other (*specify*):_____

10. ☐ I authorize the release of the selected information **including** all records that include any substance use disorder and/or substance use disorder treatment records, **or**

☐ I authorize the release of the selected information **excluding** all records that include any substance use disorder and/or substance use disorder treatment records.

SECTION III - EFFECTIVE TIME PERIOD

11. This authorization is valid until _____. If no date is specified, this authorization will expire one (1) year from the date the authorization is signed.

SECTION IV - SIGNATURES

12. INDIVIDUAL SERVED: (Print)	13. SIGNATURE:	*DATE: (MM/DD/YY)*
14. LEGALLY AUTHORIZED REPRESENATIVE: (Print) RELATIONSHIP:	**15. SIGNATURE:**	***DATE:*** *(MM/DD/YY)*