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 INFORMAITON
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 your 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, RoomA19, or email to: **gia.slayton@dallascounty.org**

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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 and Case Managers from the North Texas Behavioral Health Authority and Metrocare. 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 a 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

DEFENSE'S CCP ART. 39.14 & HEATH WAIVER FOR PRE-TRIAL DIVERSION/MENTAL HEALTH REFERRAL

1. When referring to diversion, the Defendant waives the right to additional discovery beyond materials already provided, acknowledging receipt of all necessary information to enter into the pretrial diversion agreement.
2. The State retains control over a database containing potentially exculpatory or mitigating information related to personnel involved in the case.
3. Although disclosure of this information might be required under *Brady v. Maryland* and CCP Article 39.14, the defendant voluntarily waives the right to request an inquiry of the database for personnel involved.
4. This waiver is executed without coercion and is independent of the pretrial diversion agreement.
5. Upon diversion failure, the waiver is voided, and discovery resumes under normal prosecutorial protocols.
6. The defense agrees that the pause in discovery requests and inquiries, absent new evidence received during diversion, will not be held against the assigned court prosecutor should the case be returned to the court for disposition.
7. Upon successful completion of diversion, defense attorney will notify and recommend that defendant apply for immediate expunction.
8. Pursuant to State of Texas v. Dwayne Robert Heath, as decided by the Texas Court of Criminal Appeals, the attorney acknowledges that any documents submitted to the State for any reason must be disclosed to the defense attorney in the event the defendant fails to complete the diversionary process, and the case(s) are returned to the original court or division.
9. Furthermore, any documents submitted to the Restorative Justice/Mental Health Division may be disclosed to the defense attorney if the defendant is ever charged with a new case in the future or becomes a complaining witness in a future case.
10. Finally, the attorney acknowledges that the above examples are not exhaustive; other situations not explicitly outlined here may also fall under the Heath ruling and require disclosure.

I consent to the above waiver, have read CCP Art. 39.14 and the Heath disclosure, and understand that any document submitted to the State is subject to the discovery requirements outlined in Heath. By signing below, I acknowledge my understanding and agreement with these terms:

_____
Defense Attorney Name (printed)

_____ _____
Defense Attorney's Signature Date

_____ _____
Defendant's Signature Date

metrocare.

OFFICE USE ONLY:

☐ Photo ID ☐ Signature Verified ☐ Other: _____

Staff Name: _____

Staff Signature: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Disclosure: Metrocare will not condition treatment, payment, enrollment, or eligibility for benefits based on the completion of this form.

This authorization is intended to allow METROCARE SERVICES 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.

SECTION I - CLIENT DATA

1. NAME: *(First, Middle, Last Name)*	2. DATE OF BIRTH: *(MM/DD/YY)*	3. SOCIAL SECURITY NUMBER:
4. EMAIL:	5. PHONE NUMBER: *(XXX) XXX-XXXX*	6. MRN: *(Medical Record Number)*

SECTION II - DISCLOSURE

7. 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 *(Street, City, State and ZIP Code)* or Email:
c. TELEPHONE: (Include Area Code)	d. FAX: (Include Area Code)

8. TYPE OF INFORMATION:

☐ Mental Health Records ☐ Primary Care Records ☐ Cohen Records

9. PERIOD OF TREATMENT: *(MM/DD/YY)*

FROM: TO: OR ☐ ***ALL RECORDS***

10. PURPOSE OF DISCLOSURE:

☐ Personal Use ☐ Treatment/Continuing Care ☐ Attorney/Legal ☐ Educational Use

☐ Discuss w/ Family ☐ Disability ☐ Housing ☐ Other (*specify*): _____

11. INFORMATION TO BE RELEASED

☐ Psychiatric Evaluation ☐ HIV/AIDS Results ☐ Provider Notes ☐ Sexual Transmitted Disease (STD) Results

☐ Psychological Evaluation ☐ Medication List ☐ Labs ☐ Other (*specify*): _____

☐ Progress Notes ☐ Diagnosis Letter ☐ Treatment Plans

12. ☐ 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

13. This authorization is valid for 1 year from the date it is signed, or on _____. If no date is specified, this authorization will expire one (1) year from the date of signature.

SECTION IV - SIGNATURES

14. INDIVIDUAL SERVED: (Print)	15. SIGNATURE:	*DATE: (MM/DD/YY)*
16. LEGALLY AUTHORIZED REPRESENATIVE: (Print) RELATIONSHIP:	17. SIGNATURE:	*DATE: (MM/DD/YY)*