RECOVERY WITH JUSTICE PROGRAM
SPRINGFIELD SPECIALTY COURT: MENTAL HEALTH SESSION
REFERRAL FORM

Please submit completed form to:
MISSION CREST
110 Maple Street
Springfield, MA 01105
413 310-3306 (phone)
413 781-1059 (fax)
Olga.Orbe@bhninc.org or Jennifer.corbett@bhninc.org (EMAIL)

Referral Source:_____
Phone:_____
Email:_____
Date of Referral: _____

CLIENT INFORMATION

Full legal name:_____A/K/A_____
Client in Custody? ☐Y ☐N
DOB:_____Age:_____Race:_____Gender:_____SS#_____
Primary Language, Languages Spoken: _____
Current Situation (in custody, incarcerated, on pretrial probation, etc):_____
_____
_____
Telephone:_____Cell#_____
Emergency Contact and Telephone:_____
Address: _____
Lives with:_____
Can individual return to this address, if no reason why?_____
_____
History of chronic homelessness?☐Y ☐N
Does individual have a guardian? If yes, Name and phone #_____
Does individual have Social Security Benefits? If yes, $_____
Does individual have a Representative Payee? If yes, please give contact information.
_____
Does individual receive Veteran's Benefits: if yes, $_____
Does Individual have Medicare, Medicaid, or private insurance?_____
What insurance Company are they covered by?_____

LEGAL INFORMATION

Attorney:_____Phone #_____
ADA: _____Phone #_____
Current Charge(s):_____Docket No._____
_____Docket No._____
_____Docket No._____
_____Docket No._____
*Prior Charge(s) please attach CORI, and Police Report. Next Court Date?_____
Has client ever been arrested for a violent felony and/or sex crime?
☐Y☐N If yes, Charge(s): _____Docket No._____
Is client subject to a protective order? ☐Y ☐N Docket No._____
Is client currently on Probation or Parole? ☐Y ☐N
If yes, Probation/Parole Officer's Name: _____
Phone: _____
Does client have pretrial conditions of probation☐Y ☐N. If yes, what are the conditions? __
_____

When is client's next court date?_____

Please provide narrative concerning specifics of case and reason why client is appropriate for Springfield Specialty Court: Mental Health Session.

_____
_____
_____
_____

MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT AND HISTORY

Mental Health Diagnosis:_____

Some indicators of severe mental illness, (check those observed or reported)

☐ Auditory and/or visual hallucinations ☐ Irrational/bizarre behavior
☐ Delusional thoughts ☐ History of psychiatric hospitalization
☐ Suicidal behavior ☐ Severe depression
☐ Manic behavior/speech, ☐ Racing thoughts ☐ Self-injurious behavior

Currently taking medications? ☐Y ☐N

If yes, list medications

1._____ 4. _____
2._____ 5._____
3._____ 6._____

Currently engaged in Mental Health Treatment ☐Y ☐N If yes, agency_____

Prior Psychiatric Hospitalizations? Dates, hospitals?_____

_____

Prior Mental Health Treatment Providers:_____

_____

Previously prescribed psychiatric medications ☐Y ☐N If yes, list

1._____ 4. _____
2._____ 5._____
3._____ 6._____

Does client have a history of drug or alcohol use? ☐Y ☐N

If yes, substance(s) of choice?_____

Has client used drugs or alcohol in past two weeks ☐Y ☐N

If yes, substance(s) used?_____

Currently engaged in Substance Abuse Treatment? ☐Y ☐N If yes, agency_____

Prior Substance Abuse Treatment? ☐Y ☐N If yes, agency_____

MEDICAL INFORMATION

Primary Care Physician: Name:_____

Address:_____

Medical Conditions:_____

Current Medications:_____

_____

I wish to apply to the Springfield District Court: Mental Health Session
I have signed the required consent forms.

_____ _____
Client/Defendant Date

_____ _____
Defense Attorney Date

****PLEASE ATTACH A FULLY COMPLETED AND SIGNED RELEASE OF INFORMATION, CORI & DISCOVERY****

RECOVERY WITH JUSTICE
SPRINGFIELD SPECIALTY COURT: MENTAL HEALTH SESSION

The Adult Court Clinic
Hampden Hall of Justice
50 State St. Springfield, MA 01103
413 748-7701 (phone)
413 737-7157 (fax)

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION— FOR ELIGIBILITY SCREENING

When you complete this form, you are authorizing the disclosure and/or use of your protected health information, as described below, consistent with state and federal laws concerning the privacy of such information. This authorization will be kept on file to allow future contact with Agencies/Persons listed below.

Client Name: _____
Social Security #: _____-____-_____
Date of Birth: ___/___/___

I,_____ , hereby authorize the **Springfield Specialty Court: Mental Health Session Case Manager; the Behavioral Health Network, Inc. Forensic Mental Health Services; my defense attorney,** and the following mental health and substance abuse programs to communicate with and disclose to one another below initialed information:

1. _____
   name address phone fax
2. _____
   name address phone fax
3. _____
   name address phone fax
4. _____
   name address phone fax
5. _____
   name address phone fax
6. _____
   name address phone fax

PURPOSE OF REQUESTED USE OR DISCLOSURE

The purpose of this Authorization is to determine eligibility for the Springfield Specialty Court: Mental Health Session.

This authorization expires automatically upon the final disposition of my case or six months from the date below, whichever is first.

INFORMATION TO WHICH THIS AUTHORIZATION APPLIES

☐ All health information pertaining to any medical history, mental or physical condition, and

treatment received

☐ All health information pertaining to any medical history, mental or physical condition, and treatment received, except:

_____

Only the following records or types of health information (including any dates):

_____

☐ I specifically authorize the release of personal health information relating to drug and/or alcohol abuse. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information.

Signature:_____

☐ I specifically authorize the release of information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)

Signature:_____

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my providing or refusing to provide this Authorization. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically upon the disposition of my Mental Health Court case or two years from the date below, whichever is first?

I consent that information about my **Springfield Specialty Court: Mental Health Session** application and participation may be used in outcome studies to assess the impact of this program on participants. I further understand that my confidentiality will be maintained and any results will be disseminated in a manner to protect individual participant's identities.

Except as described above with respect to drug and alcohol abuse records, information disclosed as a result of this Authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality laws.

I may inspect or obtain a copy of the health information to be used or disclosed under federal or state law. In addition, I have been provided with a copy of the form.

_____ _____

Signature of client or legal representative Date

_____

Print name of client or legal representative