Mental Health Jail Diversion Program

REFERRAL FORM

Please complete the form below where applicable and return by fax, (713)-755-4020 or by email, mhjd@cjo.hctx.net.

CLIENT INFORMATION

Client's Name: ______________________ MHMRA #: ______________

DOB: ______________ SPN: ______________

Address: ______________________ Phone #: ______________

Alternative Address: ______________________

Male ☐ Female ☐ In Jail? ☐ Yes ☐ No Homeless? ☐ Yes ☐ No

REFERRAL DETAILS

Diagnosis: ______________________

Open to MHMRA Clinic: ☐ Yes ☐ No List clinic: ______________

Reason for Referral:

Special Concerns: (violent, physical limitations, etc.)

REFERRAL SOURCE INFORMATION

Name: ______________________ Relationship to Client: ______________

Organization/Agency: ______________________

☐ Misdemeanor Court ☐ Felony Court ☐ Felony Mental Health Court ☐ Other Specialty Court

Phone #: ______________ Permission to contact if further info is needed? ☐ Yes ☐ No

Email: ______________________

FOR OFFICE USE ONLY					
Date Received (CJO):		Received by (CJO):		Date Submitted (CJO):	
Date Received (MHMRA):		Received by (MHMRA):		Assigned To (MHMRA):	

Harris County Mental Health Jail Diversion Program

Instructions for Referral Form

Purpose: To ensure referrals to the Program are processed in an efficient and timely manner. Potential clients will be identified in three ways: 1) in jail by jail staff, 2) MHMRA staff, while receiving MHMRA services within the clinics or other programs, or 3) in the community by other agencies, private providers, and family/friends.

Completed by: The Mental Health Jail Diversion Program staff will receive the completed referral form directly from the referral source or from MHMRA staff via fax or email; or will take necessary information by phone to complete the form, including referral source contact information in case further information is needed.

INSTRUCTIONS:

1. CLIENT INFORMATION: Referral source will complete the Referral Form to the best of his/her knowledge. Client's Name in addition to the Date of Birth (DOB) and/or SPN is required in order to identify the client in the Harris County database.
2. DIAGNOSIS: When listing the diagnosis, a reference to which facility or practitioner who provided the diagnosis is appreciated if known. Please note that only clients who have a Big 3 diagnosis (Bipolar Disorder, Major Depression, Schizophrenia/Schizoaffective) or PTSD will be considered for the Mental Health Jail Diversion Program.
3. REASON FOR REFERRAL: A comment is appreciated and any reason for urgency is welcomed.
4. SPECIAL CONCERNS: Any information provided is appreciated and will be taken into consideration during the screening and assessment processes.
5. REFERRAL SOURCE INFORMATION: The referral source information is optional; however, contact information is appreciated in order to follow up with additional questions. An alternate contact can be provided if needed.

Any field not completed or needs clarification will be followed up by a phone call from the Mental Health Jail Diversion Program staff.

Every attempt will be made to respond to the referral source in a timely fashion regarding the status of the referral. Please allow 1-2 weeks for a response to be generated.