Mental Health Court Program
Referral Form

Attorney must put <u>completed</u> form in basket at STEP Office in Room 4351

Referral Date:_____Next Court Date: _____

Referral By: ☐ Judge _____ (Name) ☐ Attorney _____ (Name)

☐ DA _____ (Name) ☐ Other _____ (Name)

Consented to By: _____, Prosecuting, A.D.A
Signature of ADA Prosecuting Case

Client in Jail: ☐ Yes ☐ No Location: _____

Client's Name: _____
First Middle Last Date of Birth

Address: _____

Telephone: _____
Home Work Cell

Attorney's Name: _____
First Middle Last

Address: _____

Telephone: _____ Fax: _____

Mental Health Case Coordinator: (If known) _____
Name Phone#

CHARGE INFORMATION

Charge	CR Number	Class	Level	Complaint Number

ATTORNEY MUST PUT COMPLETED FORM IN BASKET AT STEP OFFICE IN ROOM 4351