**WINCHESTER-FREDERICK COUNTY**

**BEHAVIORAL HEALTH DOCKET**

**REFERRAL FORM**

Applicant Name

Date of Birth

Age

Race

Social Security Number

Marital Status (circle one): Married Single Divorced Separated

Children: Yes No If yes, ages:

Education Completed

Does this applicant have health insurance? (circle one) Yes No

Residence Address(es) for Three (3) Months prior to most recent incarceration:

Cell Phone Number(s)

Court (please circle) Winchester Frederick

Charge(s) (Include VCC):

Date of Arrest

Next Court Date

Defense Attorney

Name Date

Email Address/Telephone Number/Fax Number

**Instructions**: The Defense Attorney must complete Section A in full, then have the Commonwealth’s Attorney complete Section B. The form must then be sent to: Lesli Bosse, Mental Health Docket Program Coordinator @ [lbosse@valleyhealthlink.com](mailto:lbosse@valleyhealthlink.com) . The Defense Attorney must also review the Participant Handbook with the client prior to submitting this form to the Commonwealth Attorney.

|  |  |  |  |
| --- | --- | --- | --- |
| Section A (to be completed by Defense Counsel) | | | |
| Question | Yes | No | Comments |
| 1) Is the Defendant charged with a misdemeanor offense in the Winchester or Frederick County General District Court? |  |  |  |
| 2) Is the Defendant a resident of the City of Winchester or Frederick County, or homeless within the City of Winchester or Frederick County? |  |  |  |
| 3) Did mental illness contribute to the behavior underlying the criminal charge(s)? |  |  |  |
| 4) Does the Defendant have any charges pending outside the City of Winchester or Frederick? If yes, when will the charge(s) be resolved? (Please indicate in comments section). |  |  |  |
| 5) Has the defendant been terminated from the Behavioral Health Docket within the last 12 months? |  |  |  |
| 6) Does the Defendant want to participate in the Behavioral Health Docket program? |  |  |  |
| 7) Has Defense Counsel has reviewed the Participant Handbook in full with the Defendant and believes the Defendant understands all of the program requirements? |  |  |  |

**NOTE: NO STATEMENT, OR ANY INFORMATION PROCURED THEREFORE, MADE BY THE DEFENDNAT TO ANY ASSESSMENT TEAM MEMBER DURING THE COURSE OF THE ASSESSMENT SHALL BE ADMISSIBLE IN ANY ACTION OR PROCEEDING AGAINST THE DEFENDANT.**

|  |  |  |  |
| --- | --- | --- | --- |
| Section B (to be completed by Commonwealth’s Attorney) | | | |
| Question | Yes | No | Comments |
| 1) Is the Defendant charged with a violent felony as defined by Va. Code  §19.2‐297.1? |  |  |  |
| 2) Do you agree to the Defendant being evaluated for participation in the WFCBHD Program? |  |  |  |

Commonwealth’s Attorney

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Date

Email Address

|  |  |  |  |
| --- | --- | --- | --- |
| Section C (to be completed by the Division of Court Services) | | | |
| Question | Yes | No | Comments |
| 1) Does the Defendant’s score on the OST recommend Medium to High Supervision? |  |  |  |

# Division of Court Services

Name Date

Email Address

|  |  |  |  |
| --- | --- | --- | --- |
| Section D (to be completed by Clinical Evaluator) | | | |
| Question | Yes | No | Comments |
| 1) Following your evaluation, does the Defendant have a diagnosis for a serious mental illness recognized under the DSV-V? |  |  |  |

# Clinical Evaluator

Name Date

Email Address