Problem Solving Courts

# DISTRICT COURT OF MARYLAND

**District Six**

191 E. Jefferson Street
Rockville, MD 20850

## MENTAL HEALTH COURT REFERRAL AND PRE-SCREENING FORM

**Please email form to maxine.curtis@mdcourts.gov. If you have any questions, please call 301-563-8890.**

Date: _____

Defendant's Name: _____ DOB: _____ SID #: _____

Montgomery County Resident: □ Yes □ No

Case Number(s) and Charge(s): _____

_____

Location of Defendant: □ MCCF □ MCDC □ Other (Please specify) _____

Referral Made By (Include name and contact information):_____

_____

Defense Counsel (Include name and contact information): _____

_____

Please answer the following to the best of your ability regarding the defendant for whom you are making the referral:

Mental health diagnosis: □ Yes □ No Please specify: _____

Current/Past medications: □ Yes □ No Please specify: _____

Prior mental health treatment: □ Yes □ No Please specify: _____

Prior mental health hospitalizations: □ Yes □ No Please specify: _____

History of substance abuse: □ Yes □ No Please specify: _____

Please provide any additional information that may assist with the screening and assessment of this defendant for eligibility and acceptance into District Court Mental Health Court

_____

_____

_____