

10th Judicial District Treatment Court Referral Form

Client Name:		Date:	
Current Location/Address:		Phone:	
Gender:	Last 4 SSN:	DOB:	
Case #:	Current Offense(s):		
Current Supervision Status:			
<input type="checkbox"/> Jail <input type="checkbox"/> Pre-Trial <input type="checkbox"/> Adult Court Services <input type="checkbox"/> Community Corrections			
Referral type:			
<input type="checkbox"/> Adult Drug Court <input type="checkbox"/> Behavioral Health Court <input type="checkbox"/> Veterans Treatment Court			
Rationale or reasoning for referral (symptoms/behavior/history):			
Referring person/agency:			
Email:		Phone:	



10th Judicial District
Johnson County



JOHNSON COUNTY
KANSAS
Mental Health

Substance Abuse/Mental Health Status

Does the client have a history of alcohol/drug use? Yes No Unknown

If yes, is the client currently receiving substance abuse treatment? Yes No Unknown

Is the client a SB123 case? Yes No Unknown

Does the client have a history of mental health issues? Yes No Unknown

If yes, is the client currently under the care of a mental health clinician? Yes No Unknown

Does the client have a history of current or past head injuries? Yes No Unknown

If yes, was the client diagnosed with at traumatic brain injury (TBI)? Yes No Unknown

Other Information:

The Treatment Court Release of Information Form.

The Referral Form and Release of Information should be emailed to: treatmentcourts@jocogov.org

For Official Use:

JCMHC Number:



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