OFFICE OF THE ESSEX COUNTY PROSECUTOR
Mental Health Diversion Program
Referral Form

PROSECUTOR FILE NO.:

Name of Defendant Being Referred:	Address:	DOB:
Name of Person Making Referral:	**Phone No. of Person Making Referral:**	**Relationship to Defendant:**

Charges Against Defendant:

Defense Attorney Name:	Defense Attorney Phone No.:

Health Insurance:

☐ Yes ☐ No *If Yes, specify:* ☐ Medicaid ☐ Medicare ☐ Private ☐

Living Arrangement:

☐ Own House/Apt. ☐ With Family ☐ Section 8 ☐ Boarding Home ☐ Temporary Shelter ☐ Homeless ☐ Other:

1. Suspected Mental Illness:

2. Suspected Substance Abuse Issues:

3. Has defendant ever been DIAGNOSED* by a medical/mental health professional?

☐ Yes ☐ No Diagnoses:	Dates:
Doctor's Name:	Doctor's Phone No.:

Applicants must provide proof of an **Axis I severe and persistent mental health diagnosis to be accepted into this Program.*

4. Has defendant ever been prescribed MEDICATION for mental illness?

☐ Yes ☐ No Dates:

What Medications:

Prescribing Doctor's Name:	Prescribing Doctor's Phone No.:

5. EMERGENCY CRISIS Screenings:

☐ Yes ☐ No Where:

Dates:

Discharge Recommendations:

Mental Health Diversion Program
Referral Form Continued

6. Hospitalizations:
☐ Yes ☐ No Where:
Dates:
Discharge Recommendations:
7. Has defendant ever been linked with a case management service?
☐ Yes ☐ No Dates:
County: ☐ CJS ☐ ICMS ☐ PATH ☐ PACT ☐ VA ☐ Other:
8. List all Past and Present Psychiatric/Substance Abuse TREATMENT *(Include Inpatient, Day programs, Therapy, etc.)*:
Names, Contact Information, and Dates of Service:
9. Present Problems / Reasons for Referral: *REQUIRED*

MENTAL HEALTH INITIATIVE USE ONLY	
DATE REFERRAL RECEIVED:	LEGALLY APPROPRIATE: ☐ Yes ☐ No
FINAL DECISION DATE:	DATE SENT TO DEFENSE COUNSEL:
A/P REVIEWING:	