

Behavioral Health Court Referral Form

Referral Source: _____

Referral Date: _____

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

County of Residence: _____

Requesting Transfer?: Y / N

Incarcerated?: Y / N *If yes, place of incarceration:* _____

Docket Number(s): _____

Charges: _____

Plea Offer: _____

Sentencing Guidelines: _____

Date to enter Plea: _____

Drug of Choice: _____

Mental Health Diagnosis: _____

Did mental health diagnosis contribute to the commission of the crime?: Y / N

Evaluating Agency: _____

Signatures:

District Attorney/Assistant District Attorney

Defense Attorney

*Referral forms should be submitted to Kristine Shaffer, Deputy Director of Probation kshaffer@co.clarion.pa.us