**MONROE COUNTY**

**MENTAL HEALTH COURT**

**REFERRAL**

*Top section is to be filled out by the individual making the referral. If the referral is being made by the Prosecutor, please also fill out the bottom section.*

Defendant’s name DOB: \_\_\_\_\_\_

Cause Number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Defendant currently in the Monroe County Jail? [ ]  **YES** **[ ]  NO**

If marked NO, provide contact information for the Defendant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name of person making the referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deputy Prosecutor assigned to the case: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Defense Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for referral:

**PLEASE FORWARD THIS REFERRAL TO BECCA STREIT, PROBATION OFFICE**

*This section to be completed by the Prosecuting Attorney. Please return completed form to Becca Streit, Probation Office within two business days of receiving the referral form.*

**Is the Prosecuting Attorney agreeing to make the Defendant eligible for consideration for participation in the Mental Health Court?**  [ ]  **YES** [ ]  **NO**

If not being made eligible, a justification must be provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Deputy Prosecutor: Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 1/13/15 (BS)