SUPERIOR COURT OF CALIFORNIA

COUNTY OF SANTA CRUZ
COLLABORATIVE COURTS OFFICE
701 OCEAN STREET
SANTA CRUZ, CA 95060
(831) 420-2498
www.santacruzcourt.org

Mental Health Diversion
Contact Information Form

Client Name:_____ Date of Referral:_____

DOB: _____ Phone number: _____

Referral Source Name: _____ Referral Source Phone Number: _____

Hispanic: ☐ Yes ☐ No Ethnicity: _____ Sex: _____

Case Number(s) _____

Offense(s) _____

Charge Level: Felony ☐ Misdemeanor ☐ Violation of Supervision ☐ Other ☐

In Custody: ☐ Main Jail ☐ Rountree ☐ Blaine St. Women's Facility ☐ R&R ☐ Out of Custody

Military Service: ☐ Yes ☐ No ☐ Unknown

Has been declared PC 1368: ☐ Current ☐ Past ☐ No ☐ Unknown

Healthcare insurance: ☐ Yes ☐ No Insurance Provider: _____ County: _____

Mental Health Diagnosis:

1) _____ 2) _____

☐ Current ☐ Past ☐ Documented ☐ Self-Report ☐ Current ☐ Past ☐ Documented ☐ Self-Report

Psychiatric Medications:

1) _____ 2) _____

☐ Current ☐ Past ☐ Documented ☐ Self-Report ☐ Current ☐ Past ☐ Documented ☐ Self-Report

By signing below, you acknowledge that you have received information about mental health diversion, you are open to being assessed, and you are interested in receiving mental health services. This includes participating in mental health programming as recommended, taking all medication as prescribed, sustaining from illegal substances, submit to testing and follow directives of mental health provider.

_____ _____

Participant Signature Date