EIGHTH JUDICIAL DISTRICT COURT
SPECIALTY COURTS DIVISION
Regional Justice Center
200 Lewis Avenue
Las Vegas, Nevada 89155
(702) 671-3291

Mental Health Court Referral Pre-Screening

Defendant's Name: _____ DOB:_____

Have you ever been diagnosed with a mental illness? ☐ YES ☐ NO

If so which;

- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Bipolar Disorder
- ☐ Major Depressive Disorder
- ☐ Posttraumatic Stress Disorder
- ☐ Other: _____

Have you ever been hospitalized (for psychiatric- not medical- needs)? ☐ YES ☐ NO

Hospital	Dates of Admission	Discharged on Medication?
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

Have you ever received mental health treatment in the community? ☐ YES ☐ NO

Are you currently or have you ever taken psychiatric medication? ☐ YES ☐ NO

If your client has answered YES to <u>3 or more</u> the above questions they may be eligible for mental health court.

Please be sure to request records from prior treatment facilities to include in referral packet to:
specialtycourts@clarkcountycourts.us
Complete applications should include medical records from previous treating sources. This will enable the Mental Health Court team to assess the client's appropriateness promptly.

Please note: Program participants must reside in Clark County during the program. Under limited circumstances cases may be transferred to other parts of Nevada. Interstate compact is not available for Specialty Court participants.

Mental Health Court Application

Please return to SpecialtyCourts@clarkcountycourts.us

Date: _____ Ltd. Juris. Ct. Case #: _____ Dist Ct. Case#: _____

Attorney: _____ phone#: _____email: _____

Legal Social Worker: _____ phone#: _____email: _____

Defendant's Name: _____ DOB: _____

ID#: _____ Social Security#: _____Male ☐Female ☐

Race: _____ Primary Language: _____ Interpreter Needed? Yes ☐ No ☐

Address: _____ phone#: _____

Emergency Contact: _____ phone#: _____

In-Custody? Yes ☐ No ☐ Location: _____

Charges: _____

Next Court Date: _____ Hearing Type:_____

Please attach the following, if available **(please note- medical records showing mental health treatment and diagnosis are mandatory):**

☐ Charging Document
☐ Arrest Report
☐ Court Minutes
☐ PSI
☐ Substance Abuse History
☐ **MH records of treatment and diagnosis**

Arresting Agency: _____ Arrest Date/Time: _____

Does the Defendant appear to be aware of his/her charges and able to talk rationally about them?

Yes ☐ No ☐ Comments: _____

Has the defendant previously received services for mental illness: Yes ☐ No ☐

Name of Agency: _____ Diagnosis: _____

Please indicate type of services received: _____

Was medication prescribed? Yes ☐ No ☐ Medications: _____

Does the defendant have a criminal history containing any of the following:

Violence ☐ Gang Affiliation ☐ Drug Trafficking ☐ Sex Crime ☐

SUBSTANCE USE HISTORY

Which substance have you used? Please check all that apply.			
☐ Alcohol	☐ Amphetamine	☐ Barbiturates	☐ Bath Salts
☐ Benzodiazepines	☐ Caffeine/Energy Drinks	☐ Cannabis/Marijuana	☐ Cocaine
☐ Ecstasy	☐ Herbal Supplements	☐ Heroin	☐ Inhalants
☐ LSD	☐ Methadone	☐ Methamphetamine	☐ Mushrooms
☐ Nicotine/Tobacco	☐ Opiates (pain pills)	☐ PCP	☐ Spice
☐ Other_____			

History of IV Use: ☐ YES ☐ NO	History of Substance Use Treatment: ☐ YES ☐ NO

Identify #1 substance used:	
Method of use:	Frequency of use:
Age at first use:	Date last used:

Was the substance prescribed to you? ☐ Yes ☐ No

Did you use this substance intravenously? ☐ Yes ☐ No

Identify #2 substance used:	
Method of use:	Frequency of use:
Age at first use:	Date last used:

Was the substance prescribed to you? ☐ Yes ☐ No

Did you use this substance intravenously? ☐ Yes ☐ No

Identify #3 substance used:	
Method of use:	Frequency of use:
Age at first use:	Date last used:

Was the substance prescribed to you? ☐ Yes ☐ No

Did you use this substance intravenously? ☐ Yes ☐ No

Identify #4 substance used:	
Method of use:	Frequency of use:
Age at first use:	Date last used:

Was the substance prescribed to you? ☐ Yes ☐ No

Did you use this substance intravenously? ☐ Yes ☐ No

LEGAL HISTORY

Applicants may not have out-of-state extraditable warrants, immigration detainers or other holds. Applicants serving a jail or prison sentence expiring more than sixty days after referral to the program will not be accepted.

Current Charges:		
Did you plead guilty?	☐ YES	☐ NO
Does your plea allow a deferral or reduction?	☐ YES	☐ NO
Have you been sentenced?	☐ YES	☐ NO
Are you in custody?	☐ YES	☐ NO
What facility?		
When is your release date?		

Are you on **probation or parole** in this or any other case?	☐ YES	☐ NO
Officer:	Officer's Phone Number:	

Do you have any other cases pending?	☐ YES	☐ NO
What are the charges and case numbers?		
When is your next court date?		

Do you have any previous charges or convictions?	☐ **YES**	☐ **NO**
Please list priors:		
# of Felonies?	# of Misdemeanors?	

Have you been convicted of arson, a sex offense or a violent crime?	☐ **YES**	☐ **NO**
If yes; please explain:		

Have you participated in any specialty court program before?	☐ **YES**	☐ **NO**
What program?	When?	
What was the outcome?		

THE STATE OF NEVADA
EIGHTH JUDICAL DISTRICT COURT
SPECIALTY COURTS APPLICATION

Applicant Consent

I am applying to participate in a Specialty Court program. I authorize an employee of the Eighth Judicial District Court Specialty Court to speak with, request and obtain information from me and/or my attorney about my application for a Specialty Court program.

I also consent for a Specialty Court employee to contact people listed in this application to verify residence, employment and other information regarding my application. I agree to sign all necessary releases to provide information in support of my application, including medical or mental health records. I understand that a background check will be completed. Also, if I am transferring from a specialty court program in another jurisdiction in the State of Nevada, I consent for the originating court to provide all information relating to my treatment and progress in that program.

I understand that all information provided and gathered will be considered in the decision whether I am accepted into a Specialty Court program. I understand that if I do not submit the required mental health records, police reports, PSI or probation violation reports, that a Specialty Court employee will review all records and documentation available in Odyssey to consider my acceptance. I also understand that the information submitted with and included in this application will be shared with the members of the Specialty Court team; including probation, the prosecuting attorney, case manager and any treatment provider I may work with.

This consent takes effect immediately and expires upon denial of my application, termination from the program or completion of the program. I understand providing false information in this application is grounds for disqualification or termination from the Specialty Court program.

_____ _____

Applicant Signature Date

How to Request Medical Records

1. Have your client complete and sign the release of information (attached) for each treatment provider.
2. Contact prior treatment facility to obtain contact person, telephone number and fax number of the medical records department.
3. Submit signed ROI to applicable medical records departments with information of where the records should be sent to.

Please Note: Some facilities may require their own release form to be completed and signed by your client.

Common Treatment Facilities & Medical Records Contact Info:

1. **Southern Nevada Adult Mental Health Services (SNAMHS)/Rawson-Neal Hospital**
   Phone: 702-486-6045
   Fax: 702-486-7152

2. **Seven Hills Hospital**
   Phone: 866-331-5541
   Fax: 702-614-2086

3. **Montevista Hospital/Red Rock Behavioral Health**
   Phone: 702-364-1111
   Fax: 702-251-1214

4. **Desert Parkway Hospital**
   Phone: 702-776-3508
   Fax: 702-776-3595

5. **Community Counseling Center**
   Phone: 702-369-8700
   Fax: 702-369-489

6. **Spring Mountain Treatment Center**
   Phone: 702-873-2400
   Fax: 702-873-1859

7. **Valley Behavioral Health**
   Phone: 702-388-4000
   Fax: 702-388-4585

THE STATE OF NEVADA
EIGHTH JUDICAL DISTRICT COURT
SPECIALTY COURTS APPLICATION

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF CONFIDENTIAL RECORDS AND/OR PROTECTED HEALTH INFORMATION

Name: _____ Case#: _____

Address: _____ Phone: _____

Social Security: _____ DOB: _____

I _____ hereby authorize _____
to have unrestricted communication with **a representative of the Eighth Judicial District Court Mental Health Court**.

This release includes phone calls, visitations, release of confidential information and protected health information to/from the above named agencies. The purpose of this release is allow access to information the Court will use to determine whether or not I am an appropriate for Mental Health Court . I hereby release the holder of such information from liability if any; arising from the disclosure of otherwise confidential information. You are specifically authorized to photocopy the following records and to release copies to the above mentioned representative. Records may include but are not limited to:

_____ Medical History and Treatment _____ Correctional Records
_____ Judicial Records (including juvenile)
_____ Other _____

USE AND REDISCLOSURE: I understand that I may revoke this authorization at any time, by written request, except to the extent that action has been taken in reliance to it. I understand that the information used and disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. This consent, if not withdrawn, will automatically expire according to the following specification of date, event, or condition: one year or disposition of current case. A reproduced copy of this authorization shall be as valid as the original. This information may also be provided to any subsequent attorney who represents me for the previously outlined purposes or to facilitate an appeal.

Note: The confidentiality of psychiatric, drug and/or alcohol abuse and HIV records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Federal Regulation 42 CFR 2. Regulations prohibit any further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose. I give consent to the release of any or all records containing the following diagnoses for the intended purposes and conditions as stated above:

_____ Psychiatric/Psychological Records
_____ Drug/Alcohol Treatment Records
_____ Other: _____

_____ _____
Client Signature Date

_____ _____
Witness Date