MONMOUTH COUNTY PROSECUTOR'S OFFICE

reStart DIVERSION PROGRAM

REFERRAL FORM

This is a fillable form. Please provide as much information as possible, save as a pdf and email to AP Lindsay Ashwal at lashwal@mcponj.org

DATE:		**PROSECUTOR'S FILE NO:**
DEFENDANT'S NAME:	**DATE OF BIRTH:**	**EMAIL ADDRESS:**
ADDRESS:	**PHONE NUMBER:** **CELL:** **HOME:**	
DEFENSE ATTORNEY'S NAME:	**PHONE:**	**EMAIL ADDRESS:**
CHARGES AGAINST THE DEFENDANT:		
LIVING ARRANGEMENTS: ☐ OWN HOME/APT ☐ WITH FAMILY ☐ SECTION 8 ☐ BOARDING HOME ☐ TEMPORARY SHELTER ☐ HOMELESS ☐ OTHER		
DEFENDANT'S EMERGENCY CONTACT:	**PHONE:**	**RELATIONSHIP:**
SUSPECTED MENTAL HEALTH ISSUES:		
SUSPECTED SUBSTANCE USE ISSUES:		
HAS DEFENDANT EVER BEEN <u>DIAGNOSED</u> BY A MEDICAL/MENTAL HEALTH PROFESSIONAL ☐ YES ☐ NO		
DIAGNOSES:	**DATES:**	
DOCTOR'S NAME:	**PHONE NUMBER:**	
IS DEFENDANT CURRENTLY TAKING OR EVER BEEN PRESCRIBED MEDICATIONS FOR MENTAL HEALTH ISSUES ☐ YES ☐ NO		

MEDICATIONS:	DATES:
PRESCRIBING DOCTOR:	PHONE NUMBER:
PREVIOUS PSYCHIATRIC EMERGENCY/CRISIS SCREENING: ☐ YES ☐ NO	
WHERE:	DATES:
DISCHARGE RECOMMENDATIONS:	
HAS DEFENDANT EVER BEEN LINKED WITH A CASE MANAGEMENT SERVICE: ☐ YES ☐ NO	
DATES:	PROGRAM & COUNTY:

LIST OF ALL PAST AND PRESENT PSYCHIATRIC / SUBSTANCE USE TREATMENT (include inpatient, day programs, therapy, etc)

NAME	CONTACT INFORMATION	DATES OF SERVICE

ADDITIONAL INFORMATION:

RESTART DIVERSION PROGRAM USE ONLY	
DATE REFERRAL RECEIVED:	LEGALLY ELIGIBLE: ☐ YES ☐ NO
CLINICALLY ELIGIBLE: ☐ YES ☐ NO	AP REVIEWING DECISION: