PRE-SCREENING FORM

MERRIMACK COUNTY / 6TH CIRCUIT-DISTRICT DIVISION – CONCORD
MENTAL HEALTH COURT
32 Clinton Street, Office #203, Concord, NH 03301
Telephone: (603) 219-3037 * Fax: (603) 271-6413

_____
Defendant Name—Last, First, Middle Initial

_____ _____
DOB Referral Date

_____
Current Location (Inmate, Address, etc)

_____
Phone Number

Hearing:
- ☐ Pre-Trial
- ☐ Arraignment
- ☐ Show Cause
- ☐ Other: _____

Check if DV

Case 1_____ ☐
Charge_____

Case 2_____ ☐
Charge_____

Case 3_____ ☐
Charge_____

Case 4_____ ☐
Charge_____

Reason(s) for the Referral: (Check all that apply)
- ☐ Possible suicide risk/danger to others
- ☐ Possible inability to care for self in or outside of the jail setting
- ☐ Possible evidence of mental disorder (e.g. psychosis, depression)---
- ☐ Other:_____

Brief summary of the presenting problem (**Required**): _____

_____

_____

Referred by:

☐ Mental Health Court Judge	☐ Police/Law Enforcement	☐ Defense Attorney
☐ Other Judge/Magistrate	☐ Treatment Provider	☐ Public Defender's Office
☐ Judicial Officer	☐ Jail	☐ Probation
☐ Court Clerk	☐ Court Officials	☐ Community Mental Health
☐ Private Citizen/Family	☐ Treatment Provider	☐ Self-Referral
☐ Other: Specify_____		

_____ _____
Referring Party—Please Print Name Judge

_____ _____
Referring Party's Firm/Agency Prosecuting Attorney

_____ _____
Referring Party's Telephone Number Defense Attorney (If no referring party)

REQUIRED

*****PLEASE ATTACH A FULLY COMPLETED AND SIGNED RELEASE OF INFORMATON*****

Please note: An incomplete prescreen form may result in a rejection to Mental Health Court.