



**STATE OF FLORIDA
FIFTH JUDICIAL CIRCUIT
ADMINISTRATIVE OFFICE OF THE COURTS
CITRUS, HERNANDO, LAKE, MARION, AND SUMTER
COUNTIES**



REQUEST FOR SCREENING FOR MENTAL HEALTH COURT

Date of Request: _____ Attorney: _____

Defendant's Name: _____ Defendant in Custody: _____

DOB: _____ Age at Screening: _____ Last 4 of SSN: _____

Defendant's Email Address: _____

Defendant's Phone Number: _____

HERNANDO County address: _____

Name of Adult Contact at residence: _____

Phone Number(s) of Adult Contact: _____

Names and ages of other people defendant will reside with: _____

Telephone/Cell Phone Numbers of people listed above: _____

Scoresheet Points (if available): _____ Judge/Docket: _____ Next Court Date: _____

Case Number(s): _____ Charges: _____

Any Pending OPEN charges in other counties? _____

If "YES" please list charge(s) AND county: _____

Does Defendant have health insurance? Yes, Private Yes, Medicaid Yes, Medicare No, Uninsured

AXIS I DIAGNOSIS: _____ Current Medications: _____

**Is there a history of Substance Dependence/Use: _____ If "Yes" which substance(s): _____

NOTES:

Copy sent to: State Attorney Drug Court Coordinator

Check if Received: Application Dispo \$250

Application Fee Received within 90 days of arrest? Choose an item.

****If substance dependence/abuse becomes PRIMARY diagnosis, defendant will be offered Drug Court.**