COMMUNITY INTEGRATED Health Services

Trueblood Mental Health Diversion Program

Participant Referral Form

Referral Guidelines

1. To refer a potential participant, please complete this form and return it by e-mail or fax.

   Fax: (360) 356-1832 or (844) 810-6422
   or
   E-mail: TrueBlood@cihealthservices.com

2. Potential participant (PP) must be 18 years or older and consent to services.

3. Must be currently charged with criminal offense that contains a nexus (causal relationship) to PP's diagnosed chronic mental illness **AND** meet the requirements of **RCW 2.30.030.**

Referring Party

Name: _____ Date: _____

Position: _____ Department: _____

Email: _____ Telephone: _____

Referral Information

Potential Participant Initials: _____

PP's Current County/Facility: _____

Referring Party's Signature _____

Has screening under RCW 2.30.030(3) been completed? _____

Has consent to services been established? _____

For Program Use Only

Date Received: _____ Accepted? _____

Do not add to form or fax cover sheet ANY identifying information that may compromise PHI considerations.