



DELIVER THIS FORM TO:
Mr. Javier Gonzalez
Mental Health Coordinator
1110 Victoria Street, Ste. 301
Laredo, Texas 78040
Tel. (956) 523-4796
Fax (956) 523-5088

111th MENTAL HEALTH COURT REFERRAL

Date: _____

Defendant's Name: _____ Gender: _____ Race: _____ DOB: _____

Cause No. _____ Court: _____

*****NOTE: the above-mentioned defendant will be considered for the mental health court program solely on the case/cause number mentioned above unless otherwise notified, in writing by the District Attorney's Office.*****

Charge(s): Felony _____ Misdemeanor _____

Specify: _____

ADA Assigned: _____ Defense Attorney: _____

Phone No.: _____ Phone No.: _____

Referral Made by: _____
Name Phone No.

Defendant's physical/ mailing address

Street City State Zip Code Phone No.

Is the Defendant currently incarcerated? Yes No Is the Defendant released on bond? Yes No

OFFICE USE ONLY:

Accepted Not Accepted Reason _____

Defendant: Agrees Does NOT Agree Reason _____

Defendant's Signature _____

Office Notes: _____