pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES

Revision: March 2022

Outpatient Competency Evaluation Program Referral Form

Name of Defendant: _____
LAST FIRST MI (MAIDEN)

Address: _____

Male ☐ / Female ☐ (Select): Marital Status: _____

U.S. Citizen (Select): YES ☐ / NO ☐ Race: _____ Date of Birth: _____

Veteran (Select): YES ☐ / NO ☐ Branch: _____

Occupation: _____

Primary Language (If other than English): _____

County of Residence: _____ Committing County: _____

402 Commitment Date: _____

List All Pending Charges Including Any Probation/Parole Violations:

Date of Arrest: _____

Upcoming Hearing(s)? (Select): YES ☐ / NO ☐

Date of Upcoming Hearing(s): _____

Office of Mental Health and Substance Abuse Services | Outpatient Competency Evaluation Program
P.O. Box 2675 I Harrisburg, Pennsylvania 17105 I E-mail: RA-OMHSASAssess@pa.gov

List of contacts to receive the completed competency evaluation report **including those listed in the court order:** (**Name, Email, Phone Number are **REQUIRED**):

Name of Referring Agency or Jail: _____

Referring Agency Point of Contact: _____

Email:_____Phone: _____

PRESIDING JUDGE: _____

Email:_____Phone: _____

DEFENSE COUNSEL/PUBLIC DEFENDER:

Name: _____

Email:_____Phone: _____

DISTRICT ATTORNEY:

Name: _____

Email:_____Phone: _____

COUNTY MH/ID POINT OF CONTACT:

Name: _____

Email:_____Phone: _____

COUNTY JAIL/PRISON or SCI POINT OF CONTACT:

Name: _____

Email:_____Phone: _____

OTHER:

Name: _____

Email:_____Phone: _____

Office of Mental Health and Substance Abuse Services | Outpatient Competency Evaluation Program
P.O. Box 2675 I Harrisburg, Pennsylvania 17105 I E-mail: RA-OMHSASAssess@pa.gov

Psychiatric/Medical Diagnoses (and Dates of Diagnoses, if available):_____

High Risk Behavior: (Past/Present)

☐ Suicide Attempt(s); Date(s); Method(s)_____

☐ AWOL History ☐ Self-Mutilative ☐ Homicidal

☐ Anorexic ☐ Self-Abusive ☐ History of Fire Setting

☐ Polydipsia ☐ Assaultive/Destructive ☐ Sexually Aberrant Behavior

☐ PICA OTHER_____

Current Medications: (Psychiatric and non-Psychiatric)

Name of Medication	*Dosage and Frequency*	*Medication Compliant Yes/No*	*Start Date*

List All Over the Counter Herbal Supplements: _____

Office of Mental Health and Substance Abuse Services | Outpatient Competency Evaluation Program
P.O. Box 2675 I Harrisburg, Pennsylvania 17105 I E-mail: RA-OMHSASAssess@pa.gov

Drug Allergies (Specify Reaction):

_____

Behavioral Issues While Incarcerated (Be Specific):_____

Physical Problems (Including recent injury(ies), chronic pain, or otherwise):_____

Recent Psychological Tests (Select): YES ☐ / NO ☐

If Yes, Please List Tests Administered: _____

Prior Hospitalizations and Dates of Admission:_____

_____

Drug, Alcohol and Nicotine History: _____

Treatment History (Please include if the person was involved in any mental health, intellectual disability or drug and alcohol services prior to incarceration): _____

Office of Mental Health and Substance Abuse Services | Outpatient Competency Evaluation Program
P.O. Box 2675 I Harrisburg, Pennsylvania 17105 I E-mail: RA-OMHSASAssess@pa.gov

pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES

Revision: March 2022

THE FOLLOWING DOCUMENTATION IS REQUIRED FOR ALL REFERRAL PACKETS:

- Please Use the Checklist Below to Ensure That You're Submitting a Complete Referral Packet to: RA-OMHSASAssess@pa.gov.
- Ensure that you Sign and Date the Bottom of this Page and Include Your E-mail Address and Phone Number or the Referral Packet Will Be Returned as Incomplete. *(Typing your Signature in the Signature Box is the preferred method of signing this document; no need to print, sign, and scan.)*
- Incomplete Referral Packets Will Be Returned with the Missing Documentation Highlighted.
- Review of **ALL** Requested Records is an **ESSENTIAL** part of any Competency Evaluation. If you are having issues obtaining any of the required records, we suggest that you contact the Presiding Judge who issued the court order for an evaluation and request their assistance in obtaining the required records.

1. ☐ Completed, Signed and Dated Referral Form (This Document)
2. ☐ Court Order for a **Competency Evaluation**
3. ☐ **Criminal Complaint** and **Affidavit of Probable Cause** for All Pending Charges
4. Copies of Attached Assessments (Check All That Apply):
   - ☐ Psychiatric
   - ☐ Nursing
   - ☐ Social
   - ☐ Psycho-social
   - ☐ Medical
   - ☐ Competency Evaluation
   - ☐ Psychological testing
   - ☐ Other disciplines involved in patient's care
5. Copies of Reports (Check All That Apply):
   - ☐ Consultations
   - ☐ Laboratory Reports and/or other medical studies performed including:
   - ☐ Chest X-Ray; EKG; EEG; HIV; Hepatitis; CBC; SMAC; WBC; PPD
   - ☐ Medication related blood levels
6. ☐ Copies of Progress Notes and Physician's Orders for at least the last three (3) months.
7. ☐ Copy of Current Treatment Plan and any Notes from the Jail/Prison/SCI.

Signature:_____Date:_____

Email:_____Phone Number:_____Ext:_____

****Note:** You do not need to physically sign this form, typing your name in the signature box is acceptable. After completing this form, save and e-mail it, with all documentation, to RA-OMHSASAssess@pa.gov.