PREA Medical / Mental Health Referral

### Inmate Information

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| --- | --- | --- | --- |
|  Offender Name: |   |  Offender #: |   |
|  Release Date: |  |  Location: |   |

I am referring this offender to be screened by DOC Medical / Mental Health due to the offender admitting or this staff member’s prior knowledge of the offender being a victim or perpetrator of sexual victimization. Therefore, the offender has requested a referral, as the result of the PREA risk assessment. Please sign below and return to the referral source once this has been completed.

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| --- | --- | --- | --- |
|  Referrer Name: |   |  Referrer Phone: |   |
|  Referrer Signature: |  |  Date: |   |

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*Medical / Mental Health Only\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

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| --- | --- | --- |
|  Date of Screening: |   |  Medical / MH  Clinician Phone:    |
|  Medical / MH  Clinician Name: |  |
|  Medical / MH  Clinician Signature: |  |  Date: |  |