**8507 COURT ORDEREED COMMITMENT**

**ADMISSION VERIFICATION**

*This form is due, 7 days following Defendant’s admission BHA Justice Services at mdh.bhajstxproviders@maryland.gov.*

**CONSUMER INFORMATION**

|  |  |  |
| --- | --- | --- |
| NAME: | DOB: | AGE: |
| RACE: | GENDER: | SID #: |

**CARE COORDINATOR INFORMATION**

|  |  |
| --- | --- |
| NAME: | E-MAIL: |
| PHONE: | FAX: |

**COURT INFORMATION**

|  |  |  |
| --- | --- | --- |
| COURT: | JUDGE: | NEXT HEARING DATE: |
| CASE #: | CASE #: | CASE #: |
| LEGAL STATUS: | | |

**SOMATIC HEALTH INFORMATION**

|  |  |
| --- | --- |
| CONDITION(S): | MEDICATION(S): |
| ALLERGIES: | |

**MEDICATION-ASSISTED TREATMENT INFORMATION**

|  |  |
| --- | --- |
| MEDICATION: | PROVIDER: |

**RESIDENTIAL PROVIDER INFORMATION**

|  |  |
| --- | --- |
| PROGRAM NAME: | |
| ADDRESS: | PHONE: |
| ASAM LEVEL OF CARE: | ADMISSION DATE: |

|  |
| --- |
| ***TO BE COMPLETED BY PROVIDER*** |

**ADMISSION ASSESSMENTS**

Intake Interview Date:

Urinalysis Submitted Results:

Person/Belongings Searched Results:

**ASSIGNED CLINICIANS**

Counselor Name:       Initial Session Date:       Ongoing Session Schedule:

Therapist Name:       Initial Session Date:       Ongoing Session Schedule:

Psychiatrist Name:       Initial Session Date:       Ongoing Session Schedule:

**ASSIGNED RESIDENCE**

Address:       House Manager Name:       Phone:

**All applicable fields must be completed prior to form submission.**

**Attach an additional sheet – if necessary**