**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**