

CPCS Public Defender Division SSA Referral Form

Attached is:	Opening Booklet <input type="checkbox"/>	CORI <input type="checkbox"/>	Police Reports <input type="checkbox"/>	HIPAA <input type="checkbox"/>	Medical Records/ reports <input type="checkbox"/>
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CASE INFORMATION

Client Name:	Due Date: <small>Click here to enter a date.</small>	Flexible?: Choose an item.
Next Court Date: <small>Click here to enter a date.</small>	Purpose of Next Court Date: Choose an item.	
Court:	Pending Charge(s):	
Attorney Name:	Attorney Telephone:	
Attorney Office: <small>Choose an item.</small>	Casey Number:	

CLIENT INFORMATION

DOB:	SSN:	Gender:	Health Insurance?:
Address:		Primary #:	Secondary #:
Emergency Contact:		Relationship:	Primary #:

CLIENT HISTORY:	Substance Abuse	<input type="checkbox"/>	type:
	Mental Illness	<input type="checkbox"/>	type:
	Physical Disability	<input type="checkbox"/>	type:
	Traumatic Brain Injury	<input type="checkbox"/>	type:
	Developmental Disability	<input type="checkbox"/>	type:
	Chronic Illness	<input type="checkbox"/>	type:
	Other:	<input type="checkbox"/>	type:

REASON FOR SERVICE REQUEST (i.e. reports, placement requests etc., and why):	
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SUMMARY OF CASE/THEORY:	
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