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 / MHClinician Phone: | |
| Medical / MHClinician Name: |  |
| Medical / MHClinician Signature: |  | Date: |  |