

Fifth Judicial District Veterans Court – Referral Form

All fields with an asterisk (*) must be completed.

Referral Date (MM/DD/YYYY)* ____/____/____ Referral Submitted by*: _____

Title/Organization*: _____ Phone No.*: _____ E-mail Address: _____

Participant's Name*: _____ Sex*: Male Female

Date of Birth*: ____/____/____ (MM/DD/YYYY) Age of Participant: ____ MN State ID No.: _____

Current Address*: _____ Current Phone No.*: _____

What county does the participant live in?* _____

Does the participant have children?* Yes No

If Yes, list the age of children: _____

Is the prosecutor's office aware of this referral?* Yes No

Has PSI already been requested?* Yes No Unknown (If No, Coordinator will submit request)

Has participant ever served in the armed services*? Yes No

If Yes, what is the participant's current status? _____

If Yes, is the applicant willing to participate in any court other than Vets Court? Yes No

Does the participant have pending charges*? Yes No

If Yes, list the County, State _____

and Case No. of pending charge. _____

Is the participant currently on probation? Yes No

If Yes, list the County(ies), State(s) _____

and Case No(s). _____

Participant's PO/DOC Agent: _____ Phone No.: _____ E-mail Address: _____

Does the participant have past felony convictions Yes No

If Yes, list the court file no(s) _____

Is the participant a registered predatory offender? Yes No

Mental Health:

Does the candidate have a diagnosis of a serious mental illness? Yes No

(e.g., schizophrenia, bipolar mood disorder, psychotic disorder, or other major affective disorder?)

If yes, are they currently receiving treatment? Yes No

If yes, please name the provider if known : _____

Please list any prior MH treatment ((if known, list treatment type/facility/dates)

Alcohol and Other Drug (AOD) Use:

Does the candidate have a substance abuse diagnosis? Yes No

If yes, what is the diagnosis (abusive or dependent) and date of determination if known. _____

If yes, are they currently receiving treatment? Yes No

If yes, please name the provider if known _____

Please list prior any AOD treatment (if known including type/facility/dates)

Please submit form or:

Questions? Contact: Kevin Mettler Veterans Court Coordinator

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