

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
INSTITUTIONAL DIVISION
Chronic Mentally Ill Treatment Program
(CMI-TP)

TRANSFER REFERRAL

***Scan into "CMI TREATMENT PROGRAM ADMISSION"
folder, notify via EMR Email to Group:
"CMI TREATMENT PROGRAM REFERRALS"***

Offender's Name: _____ TDCJ#: _____

Referral Date: _____ Referring Unit: _____ Age: _____

Custody Level (circle one): Ad Seg Level: 1A 2A 3A GP Level: G4 G5 Other: _____

Current Mental Health Diagnosis: (Completed by the Provider): _____

Current Treatment: (Please use section below for additional comments)

Medications: _____

Last Mental Health Inpatient admission date: _____

Is the offender participating in any chronic clinics? _____ YES _____ NO

List Medical devices (cast, catheter, etc):

Does the offender consent to treatment: YES _____ NO _____

Brief Clinical Summary:

Please PRINT Referring Providers: Name _____ Credentials _____

Phone# _____ EMR email address _____

Disposition (this section is for administrative use only):

Referral was **approved / disapproved** for CMI Inpatient Services: Date: _____

Initials _____

Reason (if not approved):

If Referral Cancelled: Date of Cancellation: _____

Cancelling clinician: _____

Reason for Cancellation: _____