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| Use |  BEHAVIORAL HEALTH ADMINISTRATION (BHA) **21-Day Competency Check Request** |
| **Defendant Information** |
| LAST NAME | FIRST NAME | MIDDLE INITIAL | BIRTH DATE | CAUSE NUMBER |
| **ATTORNEY ASSIGNED** |
| NAME | EMAIL |
| **REFERRING PARTY** |
| NAME | EMAIL | PHONE |
| **Referral Information** |
| INTERPRETER REQUIRED[ ]  Yes [ ]  NoLanguage:  | CURRENT MEDICATION STATUS, IF KNOWN[ ]  Taking prescribed medications regularly[ ]  Defendant not following regular administration of prescribed medications.[ ]  No medications currently prescribed.  |
| Statement or description of how the defendant’s condition has improved so that a re-evaluation may be warranted: |
| **Referral Completion** |
| This completed form should be emailed to: BHA21daycheck@dshs.wa.gov or faxed to (360) 464-2225For the most precise review, please include the following in your referral, if available:[ ]  A completed copy of this 21-Day Check Request[ ]  Facility mental health contact or psychiatric records from the jail[ ]  Medication records from the past two weeks |