Community Based Correctional Facility
Field Referral Form

DATE OF REFERRAL:	HEARING DATE:
REFERRING OFFICER/CONTACT:	HEARING OFFICER:
OFFENDER'S CURRENT LOCATION: Is offender scheduled to move from this location? ☐ YES ☐ NO If yes, what date is offender scheduled to move and to what location?	PHONE NUMBER: EMAIL:
REQUESTED PLACEMENT DATE:	

REFERRALS MUST PROVIDE A PSI AND VIOLATION REPORT

☐ PSI IS LOCATED IN THE GATEWAY PORTAL ☐ PSI IS ATTACHED	☐ VIOLATION REPORT IS LOCATED IN THE GATEWAY PORTAL ☐ VIOLATION REPORT IS ATTACHED

OFFENDER NAME (*Last Name, First Name, M.I*):		ODRC INSTITUTION NUMBER	SENTENCING COUNTY:	RESIDENT COUNTY:
DOB:	SEX: ☐ M ☐ F	Check Type of Supervision: ☐ PRC ☐ PAR ☐ COMPACT ☐ ILC ☐ PT ☐ CC ☐ JR		

SECURITY THREAT GROUP AFFILIATION? ☐ YES ☐ NO	IF YES FOR SECURITY THREAT GROUP, IDENTIFY AFFILIATION/S:
PENDING CRIMINAL CHARGES? ☐ YES ☐ NO	IF PENDING CHARGES, LIST CHARGES AND COUNTY/COURT/DOC #
ANY "NO CONTACT" ORDERS OR PROTECTION ORDERS? ☐ YES ☐ NO	DOES THE OFFENDER HAVE A CURRENT OR PREVIOUS CONVICTION OF ARSON? ☐ YES ☐ NO

Offense Type: Select One: Attempted, Conspiracy, Complicity, None of the Above	ORC Code Number:	ORC Description:	Docket Number:	Offense Level: Select One: Agg Murder, Murder, F1-F5,Unclassified Felony, Misd, Other	Charge/Arrest Date First date of contact with law enforcement regarding charge. If this is unavailable use court date.

ADDITIONAL INFORMATION REGARDING CRIMINAL RECORD:

DOES THE OFFENDER HAVE A CURRENT OR PREVIOUS CONVICTION/S FOR A VIOLENT OFFENSE AS DEFINED BY ORC OR A SEX OFFENSE?

☐ YES OFFENDER HAS CURRENT OR PREVIOUS CONVICTIONS FOR VIOLENT OFFENSE

☐ YES OFFENDER HAS CURRENT OR PREVIOUS CONVICTIONS FOR SEX OFFENSE SEX OFFENDER CLASSIFICATION:________________________

☐ NO

DATE OF LAST ORAS:	ORAS TOOL:	ORAS SCORE:	ORAS RISK LEVEL:

PHYSICAL HEALTH CONCERNS: ☐ YES ☐ NO If yes, list:	CURRENT MEDICATIONS:	IS OFFENDER MEDICATION COMPLIANT? ☐ YES ☐ NO (If no describe compliance concerns)
MENTAL HEALTH CONCERNS? ☐ YES ☐ NO If yes, list:	CURRENT MEDICATIONS:	IS OFFENDER MEDICATION COMPLIANT? ☐ YES ☐ NO (If no describe compliance concerns)

IF THE OFFENDER HAS MEDICAL OR MENTAL HEALTH ISSUES, DESCRIBE TREATMENT HISTORY, CURRENT NEEDS, AND IF THE OFFENDER IS CURRENTLY STABLE:

DOES THE OFFENDER NEED ANY SPECIAL ACCOMODATIONS?

CURRENT ALLEGED VIOLATIONS:

As part of consideration for placement in a CBCF, I hereby authorize ODRC or ___________County Jail and the custodian of my medical and mental health records to release my ____(initial) medical and/or ____(initial) mental health records to both agents of ODRC and agents of CBCF in the violation process, to be utilized solely for the purpose of making and considering any recommendation for CBCF placement. This authorization is subject to revocation at any time except to the extent that the agents which are to make the disclosure have already acted in reliance on it. If not previously revoked, I acknowledge that this authorization will terminate upon rejection of placement into the CBCF or at the conclusion of the CBCF Programming.

Witness: ____Date: ________________________

Offender signature: ____________________________________Date: ________________________

Revised 10/19

CBCF STAFF TO COMPLETE AND RETURN FORM TO REFERING OFFICER WITHIN 10 CALANDAR DAYS OF REFERRAL DATE

OFFENDER NAME: ____

ODRC INSTITUTION NUMBER: _________________________________

DATE FORM RETURNED TO THE APA: __________________________

OFFENDER ACCEPTED IN PROGRAM:

☐ YES

AVAILABLE BED DATE: _______________________________________

MIN NUMBER OF DAYS OFFENDER MUST BE SANCTIONED TO CBCF IN ORDER TO BE ACCEPTED:

REPORTING INSTRUCTIONS & COMMENTS:

☐ NO

☐ NO, BED NOT AVAILABLE WITHIN 60 DAYS OF REFERAL DATE

CBCF FACILITY: ____

NAME OF CBCF EMPLOYEE COMPLETING FORM: ____

REVISED 10/19

PO SCREENING QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY IN ORDER TO ASSIST IN MAKING A RECOMMENDATION FOR PLACEMENT.

1. DOES THE DEFENDANT HAVE ANY CURRENT MEDICAL/DENTAL CONDITIONS (I.E. DIABETES, HEART DISEASE, SEIZURES, HIGH BLOOD PRESSURE, ASTHMA, TUBERCULOSIS, EPILEPSY, HEPATITIS, OTHER)?

2. IS THE DEFENDANT CURRENTLY TAKING ANY MEDICATION, INCLUDING MAT DRUGS?

3. REGARDING THE DEFENDANT'S OVERALL HEALTH, DO THEY HAVE A NEED FOR ANY TYPE OF SURGERY OR THE NEED TO SEE A SPECIALIST, INCLUDING DENTAL, WITHIN THE NEXT 6 MONTHS?

4. HAS THE DEFENDANT BEEN DIAGNOSED WITH A MENTAL HEALTH DISORDER, AND DO THEY FEEL THAT THEY ARE CURRENTLY STABLE AT THIS PRESENT TIME?

5. IS THE DEFENDANT ABLE, AND WILLING, TO FULLY PARTICIPATE IN THE FRANKLIN COUNTY CBCF PROGRAM?