McHenry County
AOT Program
Phone 815/334-4502 Fax 815/334-4691
REFERRAL FORM

*Referral Name: ____ *DOB: __________________________

Address: ____ Phone Number: ___________________________

E-Mail: ____

***Referral from**: **(Include Contact Information) Name, address, phone number, email address**

☐Agency: ____

____

☐Other: ____

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*Does the referral have a Mental Health Diagnosis? YES NO

*If YES, what is the diagnosis? ____

*Is the referral currently in the hospital? YES NO If YES, is there a discharge date: _______________

*If YES, which hospital? ____

*Why is the referral hospitalized? ____

*Was this hospitalization voluntary or involuntary? ____

*How many times has the referral been hospitalized in the past 6 months? _____________________

*Does the referral have a pending criminal charge? YES NO UNKNOWN

*If YES, what is the case number and county the charge is in? ______________________________

Signed: ____ Date: ____________________

PLEASE FORWARD THIS REFERRAL TO: specialtycourtreferrals@22ndcircuitil.gov

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Original to – Specialty Courts Director – Kelly Scimeca
Copies to – SAO, ATTY
REV 5/2026
*Must Be Answered