

Police Mental Health Detention Information Sheet

Form 3.18.1

THIS IS NOT A PICK UP ORDER - DO NOT FAX TO POLICE

Law Enforcement Agency

(check appropriate box)

- Apache Junction
 Avondale
 Buckeye
 Chandler
 El Mirage
 Gilbert
 Glendale
 Goodyear
 Maricopa County Sheriff
 Mesa
 Peoria
 Phoenix
 Queen Creek
 Scottsdale
 Surprise
 Tempe
 Youngtown

Magellan Health Service of Arizona

COT MH #	Amendment Submittal Date:	COT Expiration Date:
Clinic Name:	Telephone # (including area code)	
Case Manager:	Telephone # (including area code)	
Psychiatrist Name:	Telephone # (including area code)	
Relative:	Telephone # (including area code)	
Clinical Director or Site Administrator:	Telephone # (including area code)	
Email: (Clinical Director or Site Administrator)		

Behavioral Health Recipient Information (ALL FIELDS REQUIRED)

Last Name:		First Name:			MI:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Wt:	Ht:	Eyes:	Hair:	Race:
SSN: - -			DOB: (mm/dd/yyyy)		

Residential Information

(check appropriate box)

- Homeless
 House
 Apartment
 Group/Care Home
 Other:

Current Pick-Up Address/Location:		Apt Number (if Applicable):	
City:	State: Arizona	Zip code:	Telephone # (including area code)
Major Cross Roads:			
Has this recipient been contacted at this address? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, provide details:			
Does this recipient live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, with whom?		Relationship:	
Recipient's current physical condition?			
Number and ages of children/dependents needing Foster Care (if applicable):		Is Rabies/Animal Control required for any pets: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, number and type(s) of pet(s):	
Does the recipient possess any known weapons? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list type(s) of weapon(s) and location if known:			
Shown to have a history of violence toward police? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, provide detailed information:			
Type of transportation recommended: <input type="checkbox"/> Ambulance <input type="checkbox"/> Police Unit <input type="checkbox"/> Special Transportation: (provide details)			
Please list any additional information that would assist police in locating the recipient: (additional addresses, arrest booking number, current arrest location, etc.)			

Note: This confidential information WILL NOT be acted upon until the receipt of a Court Order (ARS 36-529, 36-540) or authorization by the Medical Director of the evaluating agency (ARS 36-540.1, ARS 36-544)

Please complete this form online, print and fax to Magellan Court Advocacy at 1-800-424-4280