Use

Washington State Department of Social & Health Services
Transforming lives

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 ☐ No

Language:

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) 464-2225

For 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