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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  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](mailto: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 | | | | | |