

**Forensic Services Patient Information Form (PIF)**

**Defendant Name:**

**Date of Birth:**

**SSN:**

**Race/Sex:**

**Marital Status:**

**County of Commitment:**

**County of Residence:**

Pending Charge(s)/Case Number(s):

Extent of contact with defendant:

Date of Last contact:

Observations/Information regarding the need for clinical evaluation, including specific difficulties in

communicating with the defendant:

If applicable, what circumstances surrounding the alleged offense led you to believe the defendant's mental

state is an issue: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous convictions/legal contacts information:



Previous psychiatric treatment location(s):

Previous psychiatric diagnoses:

Education level:

Any other relevant information: \_\_\_\_\_

**NEXT OF KIN:**

Name/Relationship:

Phone Number: \_

If possible, please provide the name and number of two family members/friends who are willing and able to provide additional information regarding the patient’s history of mental illness or disability.

Name/Relationship:

Phone Number:

Name/Relationship:

Phone Number:

Defendant’s current location (Circle One) **Detention Center On Bond**

Please return this form and pertinent records/previous evaluations you have by secure email to Forensic

Services at: [forensic.orders@msh.ms.gov](mailto:forensic.orders@msh.ms.gov) or by fax to 601-351-8570.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_