

Justice Services

Specialty Court Referral Form



GENERAL INFORMATION

Referral Date: _____ In Jail: Yes No

Referral From: _____

Case Number: _____

<input type="checkbox"/> Family Drug Court	<input type="checkbox"/> Veterans Court
<input type="checkbox"/> DWI Court	<input type="checkbox"/> Mental Health Court
<input type="checkbox"/> W.O.R.T.H Court	<input type="checkbox"/> Adult Drug Treatment Court

THE COURT MONITORS PARTICIPANTS FOR A MINIMUM 12 TO 18 MONTH PERIOD

CLIENT PROFILE

Name: _____ DOB: _____ Age: _____ Ethnicity: _____ Gender: _____

Physical Address: _____

Primary Phone: _____ Secondary Phone: _____

CHARGE INFORMATION

Pending Charge(s): Yes No

If So, Where: _____

Violent Crime Conviction? Yes No

Is this Person Employed? Yes No

If So, Where? _____

Does this Person have Suitable Housing?

Yes No

Does this Person have Transportation?

Yes No

Does this Person have Medical Needs? Yes No

Is this Person a Human Trafficking Victim?

Yes No

Is this Person Susceptible to being Trafficked?

Yes No

Any Mental Health Issues? Yes No Not Sure

Is this Person in Treatment for Substance Abuse?

Yes No

If so, Where? _____

List All Drugs the Person is Known to Use:

Is this Person in the Military or a Veteran?

Yes No

If so, Which Branch? _____

Dates Served: _____

MOS: _____

Discharge Status: _____

Does this Person receive Services through the VA?

Yes No

Can you access your DD214? Yes No

Submitted By

Contact Information