Date of referral: _____

Treatment Services
Accountability Court Referral Form

Referral Information

Name: _____

DOB: _____ SSN: _____

Address: _____

City: _____ Zip: _____

County of residence: _____

Phone: (H) _____ (W) _____ (C) _____

Translation services required: _____ Yes _____ No If yes, what type of services? _____

Race/ethnicity/origin: _____ Sex at birth:_____ Gender identity: _____

Reason for referral (e.g., substance use issues, mental health symptoms or history, DFCS involvement, delinquent child support):

_____

_____

_____

Current legal charge(s): _____

Currently incarcerated: _____ Yes _____ No If yes, where? _____

Arrest date: _____

Probation officer assigned: _____ Probation charge(s): _____

Phone: _____ Fax: _____ Email: _____

Referring agency/point of contact:

_____

Phone: _____ Fax: _____ Email: _____

TREATMENT SERVICES USE ONLY

Treatment Services
Accountability Court Referral Form

Date referral received: _____

Prosecution Initial Review	Defense Attorney Review
SID: _____	Consultation date: _____
GCIC review date: _____	Interested in program: _____ Yes _____ No
Eligible: ____ Yes ____ No	Comments: _____
Comments: _____	_____
_____	_____
_____	_____

Clinical Assessment

Date: _____ Meets clinical eligibility: _____ Yes _____ No

Comments: _____

_____

_____

_____

LS/CMI Score _____ ASAM Score _____ TCUDS Result _____

AUDIT Result _____ ASI Result _____ NEEDS Result _____ SASSI Result _____

START Result _____

Additional assessments: _____

_____

Team Review

Referral review date: _____ Approved for program entry: _____ Yes _____ No

Enrollment date: _____ ____ Pre-adjudication ___ Post-adjudication ___ Probation Revocation

Comments: _____

_____

_____

Referral Outcome

TREATMENT SERVICES USE ONLY

Participant Decline Date: _____
Participant Decline Reason (check one - required):

- ☐ Requirements too strict
- ☐ Program length
- ☐ Prefers other program
- ☐ Not interested
- ☐ Other

Denial Date: _____
Eligibility Denial Source (check one - required):

- ☐ Team Member Objection – Prosecutor
- ☐ Team Member Objection – Defense Attorney
- ☐ Team Member Objection – Treatment
- ☐ Team Member Objection – Other
- ☐ Program-related
- ☐ Case-related

Eligibility Denial Reason (check one - required):

- ☐ Legal – Length of criminal history
- ☐ Legal – Violent crime in present offense
- ☐ Legal – Sex offender
- ☐ Legal – Gang affiliation
- ☐ Legal – Drug dealer/trafficker – past and/or present
- ☐ Legal – Legal issues in other courts/circuits
- ☐ Treatment – Alternative program more appropriate
- ☐ Treatment – Lower level of care needed
- ☐ Treatment – Higher level of care needed
- ☐ Legal – Other
- ☐ Treatment – Other
- ☐ Program-related – Housing
- ☐ Program-related – Transportation
- ☐ Program-related – At capacity
- ☐ Program-related – Out of Jurisdiction
- ☐ Program-related – Other
- ☐ Case-related – Sentence not long enough
- ☐ Case-related – New crime/violation arrest
- ☐ Case-related – Codefendant
- ☐ Case-related – Other

Acceptance date: _____