Mental Health Court Referral Form

Referral Name

Date of Birth

Male Female Transgender

Social Security Number

Emergency Contact

Phone Number

County of Residence

Phone Number

Relationship

Address

Address

City, State ZIP Code

City, State ZIP Code

Date Referral Form Completed

Name/Office/Phone Number of person completing this form

Demographic Information

Primary Language

Race/Ethnicity

Transportation?

Cigarette Smoker?

Children?

Ages of Children

Marital Status

Who has custody of children?

Name of Significant Other and Date of Birth

Address where children live

Criminal Information

In custody?

Arrest Date

SID #

County of Jail

On probation?

Probation Supervision County

Probation Officer

ADA

Defense Attorney

Pending charges/revocations in other counties?

Current Charges

Mental Health/Medical Information

Mental Health Diagnosis

Doctor/Facility that provided diagnosis

Insurance Company/Medicaid/Medicare/Uninsured

Other medical conditions

Previous Mental Health Providers (Highland Rivers, Georgia Hope, etc.)

Administrative Office • 214 W. King St. • Dalton, Georgia 30720
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I, _____ (defendant) certify that my attorney has reviewed the following characteristics of the Accountability and Resource Court program with me, and I am interested in moving forward in the referral process.

1. This is an 18-24 month program.
2. If accepted into this program, I will be required to attend court weekly, attend treatment several days a week, and will be subject to curfew and random drug screens.
3. Additional specific program requirements will be individualized based upon my mental health and addiction history, as well as my other needs and capabilities.

Defendant Signature _____ Date _____

OFFICE USE ONLY

DA Received Date _____ Legal Approval Date _____ ADA Signature _____ Coordinator Received Date _____