Cherokee County Treatment Accountability Court
Referral Information Sheet

(Please provide as much information as you have available)

Section I – General Information

DATE OF REFERRAL_____

Defendant's FULL Name_____ Date of Birth_____

Social Security No._____ Gender_____ Race_____

Current Residence Address_____

Is this address?: With a family member_____ Group home_____ Independent_____ Other_____

If other, please describe_____

Is Defendant currently incarcerated? Yes_____ No_____

If yes, give location and cell number_____

Section II – Referring Party

Jail_____

Prosecutor_____

Defense Attorney_____

Probation_____
Felony_____ Misdemeanor_____

Judge_____ Name of Judge_____

Law Enforcement_____

Name and phone number of person completing referral_____

Section III – Charge Information

Date of Arrest_____ Indictment/Case Number_____

Current Pending Charges in **ANY JURISDICTION** (indicate if felony or misdemeanor):_____
_____
_____

Name, phone number and office of Prosecutor_____

Name and phone number of Defense Attorney (if any)_____

Name and phone number of Probation Officer (if any)_____

Status of Case:

Preliminary Hearing_____ Arraigned/Indicted_____ Plea Entered_____ Revocation_____ Status_____

Next Court Date_____

Has the Defendant been referred for a competency evaluation? Yes_____ No_____

If yes, indicate when, where and by whom (attach report, if available)_____

Section IV – Reason for Referral

Major Mental Illness? Yes_____ No_____ Unknown_____

If yes, what was the Primary Diagnosis (if known): _____

When was the diagnosis made? _____

Who made the diagnosis? _____

Any other diagnosis? _____

Any Previous Treatment History? Yes_____ No_____ Unknown_____

If yes, name and location of provider_____

Any History of Substance Abuse? Yes_____ No_____ Unknown_____

List all known substances_____

Any Previous Treatment for Substance Abuse? Yes_____ No_____ Unknown_____

If yes, name and location of provider_____

Any known medical issues? Yes_____ No_____ Unknown_____

If yes, what is the medical issue(s)? _____

Is the Defendant currently on any medications? Yes_____ No_____ Unknown_____

If yes, list all known medications_____
_____
_____

Please provide any other information regarding the reason for the referral:

_____
_____
_____
_____
_____

Return this Form to:

Treatment Accountability Court
154 North Street
Canton, GA 30114