

EARLY DIVERSION COURT REFERRAL FORM



Demographics			
Full Name		DOB	Date
SS#	Gender	Race	
Home Address		Home Phone	Cell Phone
Has individual ever served in the armed forces?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Court Involvement Information			
CF#		CM#	
# Current Felony Charges:		# Current Felony Charges:	
Is individual currently incarcerated?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes where:		Date of incarceration	
Total # Prior Arrests?	Total # Felony <u>Sentences</u> ?	Total # <u>Prior</u> Misdemeanor Charges:	
Any other outstanding charges /detainers? OSW		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes explain:			
Is individual currently on probation?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Wellness Information			
Wellness Diagnosis:			
Current Medications:			
Drug and/or Alcohol use?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Unknown <input type="checkbox"/>	
Currently in treatment? Yes <input type="checkbox"/>		Treatment Provider: No <input type="checkbox"/>	
Insurance: <input type="checkbox"/> None <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private			
Referral Information			
Referral Source:		Referral Source Phone:	
Relationship to individual:			
Is individual aware of referral?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Some indicators of severe mental illness (check those observed or reported):			
<input type="checkbox"/> Auditory and/or visual hallucinations		<input type="checkbox"/> Irrational/bizarre behavior	
<input type="checkbox"/> History of psychiatric hospitalization		<input type="checkbox"/> Suicidal behavior	
<input type="checkbox"/> Severe depression		<input type="checkbox"/> Manic behavior/speech, racing thoughts	
<input type="checkbox"/> Delusional thoughts		<input type="checkbox"/> Self-injurious behavior	

Referral Form Should Be Forwarded To The Alternative Court Coordinator

20TH District Division II Treatment Court, Inc. P.O. Box 719 Madill, OK 73446

OFFICE PHONE: (580) 257-2002

EMAIL: 20thearlydc@gmail.com

FOR ADMINISTRATIVE USE ONLY	
DATE RECEIVED BY COORDINATOR:	REFERRED FOR ASSESSMENT:
	AGENCY:

Type of Risk Assessment Used:

Score:

What was the risk level?

High Low Moderate Moderate High Very High

Is the Individual Eligible? Yes No

If yes, was the individual accepted into the program? Yes No

If accepted:

Treatment provider:

Is the individual AWOL? Yes No

X _____
Alternative Court Coordinator Date

FOR DISTRICT ATTORNEY USE ONLY

Form received by: Assistant District Attorney _____

Participation in the Alternative Court Program is:

Approved Denied

If denied, reason for denial.

DA Refused

Ineligible Charge

Judge Refused

Low Risk Assessment

Low Treatment Need Results

Other Team Member Refused