



Treatment Services
Accountability Courts Referral Form

Please fax referral form to 706-265-8426.

Dawson Co. Treatment Court (Drug/DUI) Office: 706-265-8425
 Dawson Co. H.E.L.P. Program (Mental Health Court) Office: 706-531-2799

Date of referral: _____

Referral Information:

Name: _____

DOB: _____ SSN: _____

Address: _____

City _____ Zip: _____

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

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

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

Current legal charge(s):

Currently incarcerated: Yes No If yes, where? _____

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

Phone: _____ Fax: _____ Email: _____

Referring agency/point of contact:

Phone: _____ Fax: _____ Email: _____



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Treatment Services use only

Date referral received: _____

<u>Prosecution Initial Review</u>	<u>Defense Attorney Review</u>
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: _____

LSI-R Score _____ TCUDS Result _____ TCU-CTS Result _____

AUDIT Result _____ ASI Result _____ NEEDS Result _____

SASSI Result _____

Additional assessments: _____

Team Review

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

Enrollment date: _____ ____ Pre-adjudication ____ Post-adjudication ____ Sentenced

Comments: _____
