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):_______________________

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

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Return this Form to:

Sarah J. Littlebear, Coordinator
Treatment Accountability Court
90 North Street
Suite 370
Canton, GA 30114