

**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 \_\_\_\_\_

Probation \_\_\_\_\_  
Felony \_\_\_\_\_ Misdemeanor \_\_\_\_\_

Prosecutor \_\_\_\_\_

Judge \_\_\_\_\_ Name of Judge \_\_\_\_\_

Defense Attorney \_\_\_\_\_

Law Enforcement \_\_\_\_\_

Name and phone number of person completing referral \_\_\_\_\_

**Section III – Charge Information**

Date of Arrest \_\_\_\_\_ Indictment/Case Number \_\_\_\_\_

Current Pending Charges (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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_