

OUTAGAMIE COUNTY TREATMENT COURTS REFERRAL

Treatment Court Applying For:

- Drug and Alcohol Treatment Court
- Branch 2 Treatment Court
- Mental Health Court
- Veterans Treatment Court

Form Completed by: _____

Phone Number: _____

Referral Date: _____

Outagamie County Resident: Yes No

Applicant Name:	Telephone #:	DOB:	Address:
Employment Status:	Last 4 digits of SSN:	Race/Ethnicity:	Referral Source:
Gender Identity:	Language:	COMPAS Score:	Number of Children:
Level of Education:	Insurance/VA Healthcare:	Marital Status:	Housing Type:

Current/Pending Charges and Case Number:	For ATRs- Current Conviction:
Next Scheduled Court Date: Branch:	Type of Hearing (pre-trial, trial, sentencing, etc.):
Current AODA/Mental Health Treatment:	Diagnosis AODA and/or Mental Health:
Previous Participation in Treatment/Diversion Court: <input type="checkbox"/> Yes <input type="checkbox"/> No Location:	Supervision Status: Agent:
Previous AODA Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed: Agency:	Served in the US Armed Forces, National Guard, or Reserves: <input type="checkbox"/> Yes <input type="checkbox"/> No Dates Served: Branch: Discharge:

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Criminal History

DATE	OFFENSE	LOCATION	DISPOSITION

Reason for Referral (pending charges, term of probation, ATR) and explanation of how and why criminal behavior is related to diagnosis:

Observable Characteristics of Mental Illness/Distress/AODA:

Previous Drug or Alcohol Treatment (i.e. detox, residential, outpatient, etc.):

Previous Mental Health Treatment (i.e. hospitalization, residential, outpatient, etc.):

General Health Issues/Concerns or Service Connected Disability:

