

Columbia County Adult Drug Treatment Court Participant Referral Form

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Referral Date: _____ Referral Source: _____

Participant name: _____ Participant date of birth: _____

Participant phone number: _____ Participant address: _____

New Charges Alternative to Revocation

Case #: _____ Charges Pending: _____

Attorney name: _____ Attorney phone: _____

Probation agent: _____ Agent phone: _____

Does the client have any criminal record involving use of a weapon or violence towards others? YES NO

(If yes, explain) _____

Treatment History:

Insurance: (for treatment purposes) _____

Has the participant had a previous drug and alcohol assessment? YES NO

If so, what was the diagnosis? _____

Has the participant been in AODA treatment previously? YES NO Drug of Choice: _____

Are there mental health concerns? YES NO

Have there been any mental health assessments? YES NO

If yes, what is the diagnosis? _____

Family/Social History:

Is the participant: Single Married Divorced

Children: YES NO If yes, how many? _____ Participant primary care-taker? YES NO

Health and Human Services involved: YES NO If yes, social worker name: _____

Current living situation: _____

Resided in Columbia County for 6 months or more? YES NO

(If no, explain) _____

Employment: _____

Driver's license: YES NO Is reliable transportation available? YES NO

USE THE BACK OF THE SHEET TO INCLUDE ANY OTHER INFORMATION YOU WOULD LIKE THE TEAM TO KNOW

It is the applicant's responsibility to inform his or her legal counsel of any wish to participate in the Columbia County Adult Drug Treatment Court Program and of any efforts taken to facilitate that participation. The Adult Drug Treatment Court's confidentiality policy will apply to all requests for information to be disclosed to third parties.