



**20<sup>TH</sup> JUDICIAL CIRCUIT  
ADULT DRUG TREATMENT COURT**  
414 Washington Street, Suite 300  
Grand Haven, Michigan 49417  
Phone: 616-846-8340  
Fax: 616-846-8179

# REFERRAL FORM

**INSTRUCTIONS:** Mail, fax or drop off the completed form to the above address or fax number.

**REFERRAL SOURCE INFORMATION**

Referred By: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Next Hearing Date: \_\_\_\_\_  Hearing  Sentence

**CLIENT INFORMATION**

Name:		Contact Phone:	
Address:		Alternate Phone:	
City / State / ZIP:		County:	
D.O.B.:	Gender:	Race/Ethnicity:	
SS#:		D.L.#:	

**PLEASE ANSWER THE QUESTIONS BELOW:**

- |          |          |   |
|----------|----------|---|
| <u>Y</u> | <u>N</u> |   |
| ___      | ___      | 1. Is the client a current Ottawa County, MI resident?  |
| ___      | ___      | 2. Is the client on adult probation in Ottawa County? If so, Officer's name _____   |
| ___      | ___      | 3. Does the current case or any prior convictions involve death or serious bodily injury or intent to cause death or serious bodily injury? |
| ___      | ___      | 4. Does the client have any prior convictions for criminal sexual conduct?  |
| ___      | ___      | 5. Does the client have any other pending felony charges?   |
| ___      | ___      | 6. Does the client have an alcohol and/or drug addiction or show a serious pattern of substance abuse?                                      |
| ___      | ___      | 7. Is the client currently receiving chemical treatment for substance abuse withdrawal?   |
| ___      | ___      | 8. Are there obvious signs of diminished mental capacity (mental impairment)?   |
| ___      | ___      | 9. Does the client have an open case or owe money in any other jurisdiction? If so, what county? _____                                      |

Additional Information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_