Jackson County Medication Assisted Treatment Diversion Program

Courthouse, 307 Main Street Black River Falls, WI 54615

This project is supported by Award No. 2019-TD-06-14841 Wisconsin Department of Justice

REFERRAL FORM

Received:

Referring Agency

☐ Law Enforcement ☐ Prosecutor ☐ Defense Attorney ☐ Jail ☐ Judge ☐ Other: _____

Person Making Referral: _____ Date: _____

Defendant Details

Name: _____ Date of Birth: _____
First Last MI

Address: _____ Telephone: _____

Pending charges: _____

Currently on Probation: ☐ YES ☐ NO Agent: _____

Details of Presenting Issues

Observed Behaviors; Reported mental health symptoms; substance abuse issues:

_____

_____

_____

_____

_____

_____

_____

Previous AODA treatment: _____

Previous mental health treatment: _____

For Office Use Only

☐ BH Screen Completed _____ (date) CSP Y /N
☐ Medical Screen Completed _____ (date) Cleared Y / N Pharmacy Notified Y / N
☐ BH Assessment Completed _____ (date) ES notified Y / N
☐ Risk/Need Assessment Completed _____ (date) Medicaid app. Y / N
☐ Defense Counsel meeting _____ (date) Clinic notified and Appt. made Y /N
☐ DA/DPA Supportive Y / N ROI shared Y / N