

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

Sex at Birth \_\_\_\_\_

Race \_\_\_\_\_

Phone Number and Email Address \_\_\_\_\_

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, phone number, and email of person completing referral \_\_\_\_\_

**Section III – Charge Information**

Date of Arrest \_\_\_\_\_

Indictment/Case Number \_\_\_\_\_

Current Pending Charges in **ANY JURISDICTION** (indicate if felony or misdemeanor): \_\_\_\_\_

Name, phone number and office of Prosecutor \_\_\_\_\_

Name, phone number, and email of Defense Attorney (if any) \_\_\_\_\_

Name, phone number, and email 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 \_\_\_\_\_

\_\_\_\_\_

For cases where there is no documented mental health diagnosis please provide explanation regarding the reason for the referral:

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

**Return this Form to:**

Treatment Accountability Court  
154 North Street  
Canton, GA 30114  
[eachilders@cherokeecountyga.gov](mailto:eachilders@cherokeecountyga.gov)

**CHEROKEE COUNTY TREATMENT ACCOUNTABILITY COURT**

**CONSENT FOR ASSESSMENT AND INTAKE INTERVIEW**

By signing below, I hereby acknowledge that I have been informed about the Cherokee County Treatment Accountability Court and consent to my attorney sharing my information with the Treatment Accountability Court Team. I further agree that I will submit to any assessment determined to be necessary to determine my suitability to participate in the Treatment Accountability Court program and any interview with the Treatment Accountability Court Coordinator. I understand that my attorney will not be present for any assessment and may not be present for the interview with the Court Coordinator.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Attorney's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Attorney's Name

**CHEROKEE COUNTY TREATMENT ACCOUNTABILITY COURT**

**CRIMINAL HISTORY CONSENT FORM**

I hereby authorize the Cherokee County Treatment Accountability Court and its representatives to process my criminal history record information which may be in the files of any criminal justice agency of any state or local criminal justice agency in the State of Georgia, to include the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC). This consent shall remain in effect for seven (7) years from the date this form is executed.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Sex/Race/Date of Birth

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Driver's License/ID Number/State