

Marion County Drug Court

Referral Form

SECTION I: REFERRAL

I, _____, nominate the following person as a candidate for the above program:

Name: _____ Sex: Male Female Race: W B H A O _____

Address: _____ How long at this residence? _____

_____ Phone: _____

Case #: _____ Pending Offense: _____

Case # _____ Pending Offense: _____

Does the Defendant have any other pending cases? No Yes Explain: _____

Defendant Date Defendant's Attorney/Referral Source Date

SECTION II: PRESCREEN FOR REVIEW BY DRUG COURT TEAM & STATES ATTORNEY

Yes No Over the age of 18
Yes No Resident of Marion County & will maintain residency in county throughout the program
Yes No Admission of addiction to or dependence on alcohol or illicit drugs
Yes No Defendant is willing to participate in the program
Yes No Defendant has no disqualifying offenses

OBJECTION

OBJECTION TO SCREENING

Marion County States Attorney Date Printed Name

SECTION III: FINAL TEAM STAFFING – SCREENING & ASSESSMENT RESULTS

Suitable for the Program

Not Suitable for the Program

PSC Judge Date