DISTRICT ATTORNEY TREATMENT ALTERNATIVE PROGRAM (DATA) CLIENT REFERRAL FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY AND FORWARD IT TO JESSICA SPENCER VIA DROPPING OFF AT THE DISTRICT ATTORNEY'S OFFICE IN HER BOX OR EMAILING TO JESSICA.L.SPENCER@NCCOURTS.ORG

PLEASE ALSO SEND A COPY TO BRENDA FRENCH AT BFRENCH@INSIGHTNC.ORG AND HUGH MCGUINNESS AT HMCGUINNESS@INSIGHTNC.ORG

IMPORTANT!!! YOU AND YOUR CLIENT MUST APPEAR IN COURT UNTIL YOUR CLIENT HAS BEEN OFFICIALLY ACCEPTED INTO THIS PROGRAM.

Date of Referral ______________________________ Court Date ________________________________

Clients Name ____ DOB ____________________ Sex ____ Race ____

Address ____

County of Residence: ______________________________Phone Numbers: (H) ___________ (W) __________ (C) ___________

Attorney's Name _____________________________ Attorney's Phone Number(s) ________________________________

Is client currently in custody? YES or NO

Please list what your client is charged with (all charges). YOU MUST INCLUDE ANY CHARGES YOUR CLIENT MAY HAVE PENDING IN OTHER COUNTIES AND STATES. *If there is not enough room provided, please attach additional charges to this form. Please include case number(s).*

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I give my approval for this client to be screened for the DATA Program. ____________________ ___________

Jessica Spencer, ADA **Date**

Does your client report a history of substance abuse? YES or NO

Does your client currently receive any type of substance abuse treatment? YES or NO
If yes, where does your client currently receive services? ____

Has your client received substance abuse treatment in the past? YES or NO (if Yes, please list where and when)

For Office Use Only **Date Referral Received** _______________ **Date Client Screened** _____________ **Court Date** _____________

Updated 6/2015