WAKE COUNTY DRUG TREATMENT COURT REFERRAL FORM

Client's Name _____ **Date of Birth** _____ **Referral Date** _____
First Middle Last

Complete Address _____

Phone (Home)_____ (Work) _____ (Cell)_____

OPUS Number (if applicable) _____ **Social Security #**_____

Race _____ **Gender**: ____Male ____Female Hispanic Descent ___yes ___no

Client in jail: ___Yes ___No **If yes, location:** ___Public Safety Center ___Annex

Jail Credit: ___Yes ___No **If yes, how many days**: _____

Referring Person _____ **Agency** _____ **Phone Number** _____
Email Address _____

Client's Attorney_____ **Phone Number**_____

Probation Officer Name _____ **Phone Number**_____

CHARGE INFORMATION

New Charge:___Yes___No **Probation Violation/Revocation**:___Yes ___No **If yes, hearing date**: _____

Has client received a probation risk and needs assessment?: ___Yes ___ No **If yes, risk level:** _____

Does the client have pending charges? _____

CHARGE (S)	DOCKET #	DATE OF ARREST	FELONY/ MISD.	STRUCT. SENT. OFFENSE CLASS	RECORD LEVEL

Probation referrals must include a copy of judgment and drug screen results

Reason for Referral:

_____
_____
_____
_____

Submit completed form to the Drug Treatment Court Office
Wake County Courthouse Room 230 or in the
Drug Treatment Court mailbox in the District Court Judge's Office

Phone: (919)856-2773/856-6441/856-6414 Fax: (919) 743-4895