Cherokee County Family Treatment Court

90 North Street, Suite 350, Canton, Georgia 30114

Referral Form

Please send the completed form to Shannon Kirby
Email: slkirby@cherokeecountyga.gov
Phone: (470)302-0723

Referral Source (check one):

- ☐ DFCS: Case Manager Name and Contact: _____
- ☐ Juvenile Court Name and Contact: _____
- ☐ Other (please specify) _____

County: _____ Date of referral: _____

Client's name: _____

Address: _____

City: _____ Zip _____

Phone: _____ Email: _____

Social Security No: _____ (required) DOB: _____

Gender: ☐Male ☐ Female Race: _____

Medicaid/Peachcare: ☐Yes ☐ No M/P number: _____

(If the family does not have Medicaid number, please indicate source of payment for services)

Child(ren) names:

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Date(s) children were removed: _____

_____

Petition/Complaint Date: _____ Shines ID: _____

Date Last in Court: _____ Next Court Date: _____

Children placed with (if applicable): ☐ Mother ☐ Father ☐ Both Parents

☐Maternal Grandparents ☐Paternal Grandparents ☐Foster Care

☐ Legal Guardian: _____ ☐Other: _____

Is the client on medications?

☐No ☐Yes If yes, please list_____

_____

Is the client currently receiving any mental health or substance abuse services?

☐No ☐Yes If yes please list: _____

_____

Criminal History/Pending Charges and County: _____

_____

Is there a history of violence/domestic violence? ☐No ☐Yes

Explain: _____

_____

Results of Alcohol/Drug Screens: _____

_____

Drug of Choice (do not leave blank):_____

Additional Information: _____

_____

_____

_____

Date Received: _____

Appointment Date and Time: _____

Disposition: _____