Treatment Court Referral Form

Referral Source: _____ **Referral Date:** _____

Name of Defendant: _____ **Date of Birth:** _____

Address: _____ **Phone Number:** _____

_____

County of Residence: _____ **Requesting Transfer?:** Y / N

Incarcerated?: Y / N ***If yes, place of incarceration:*** _____

Docket Number(s): _____

Charges: _____ _____

_____ _____

Sentencing Guidelines: _____

_____

Plea Agreement: _____

Sentencing Date: _____

Drug of Choice: _____

Mental Health Diagnosis: _____

_____

Evaluating Agency: _____

Signatures:

_____ _____

District Attorney/Assistant District Attorney **Defense Attorney**

*Referral forms should be submitted to Kristine Shaffer, Deputy Director of Probation kshaffer@co.clarion.pa.us