

Veterans Treatment Court Referral Form

_____		_____		Male	Female
Last Name		Frist Name		Transgender	
- - / /		_____			
Social Security Number		Date of Birth		Emergency Contact	
_____		_____		_____	
Phone Number	County of Residence	Phone Number	Relationship		
_____	_____	_____	_____		
Address		Address			
_____		_____			
City, State, ZIP Code		City, State, ZIP Code			

Veterans Status

Did you ever serve in the U.S. Armed Forces, including the National Guard or Reserves? Yes No

Army (including Army National Guard or Reserve) Navy (including Reserve) Marine Corps (including Reserve)

Air Force (including Air National Guard and Reserve) Coast Guard (including Reserve) Other (Specify)

When did you first enter the Armed Forces? Month Year How long did you serve in the Armed Forces?

During this time did you see combat? Yes No When were you last discharged? Month Year

Type of discharge received:

Honorable General (Honorable Conditions) General (Without Honorable Conditions)

Other Than Honorable Bad Conduct Dishonorable Don't Know Other (Specify)

Criminal Information

_____	_____	_____	_____
In custody?	Arrest Date	SID #	On probation?

Current Charges			

Mental Health/Medical Information

_____	_____
Mental Health Diagnosis	Doctor/Facility that provided diagnosis
_____	_____
Insurance Company/Medicaid/Medicare/Uninsured	Other Medical Conditions

Previous Mental Health Providers (View Point Health (GRN), New Rock, Advantage, Georgia Regional, Augusta Regional, etc.)	

OFFICE USE ONLY

_____	_____	_____	_____
DA Received Date	Legal Approval Date	Assessment Date	Referral Close Date