UNITED STATES PROBATION DEPARTMENT
DISTRICT OF MASSACHUSETTS

COURT ASSISTED RECOVERY EFFORT (C.A.R.E.)

Referral Form

Name: _____	Date: _____
Address: _____ Home ___ or Treatment ___	Sex: Male _____ Female_____
Treatment contact: _____	DOB: _____
Telephone: _____	SSN #: _____
If homeless how long: _____	Marital status: _____
Primary language: _____ Secondary language: _____	Childcare responsibilities: _____ _____
TCU Score: _____	Referring officer: _____

COURT INVOLVEMENT INFORMATION			
Federal Court Status:	Probation: _____	Supervised Release: _____	Parole: _____
	Other: _____	Please explain: _____	
Case #:	Beginning Supervision Date: ___/___/___	Termination Date: ___/___/___	
Please attach copy of Supervision Conditions			
Prior substance abuse related violations: _____ _____			
Other court involvement and contact(s): _____ _____			
History of violent offenses: _____ _____			
Previous convictions for arson: Yes ___ No ___ If yes, explain: _____ _____			
Previous convictions for rape or other sex crimes: Yes ___ No ___ If yes, explain: _____ _____			
Active restraining orders: Yes _____ No _____ If yes, explain: _____ _____			

SUSTANCE ABUSE TREATMENT INFORMATION			
Current substance abuse treatment: _____			
Provider contact: _____		Telephone #: _____	
Prior detoxes: _____ Prior holdings: _____		Prior residential treatment: _____ Prior sober house residency: _____	
Prior outpatient treatment: _____			
Drugs of choice:	First:	Second:	Third:
Last Use: _____		I.V. drug use HX: _____	

Name: _____ Date: _____

Longest period of recovery: _____
When: _____ How: _____
Please attach copy of TCU Drug Screen

MENTAL HEALTH/MEDICAL/INSURANCE INFORMATION	
Mental health issues: Yes _____ No _____ _____	Diagnosis: _____ _____
Provider contact: _____	Telephone: _____
Current mental health status: _____	
HX suicidal/homicidal ideation/attempts: Yes _____ No _____ If yes, explain _____ _____	
Medical issues: Yes ___ No ___ If yes, explain: _____ _____	
Any physical limitations: _____	
Medications: _____	
Prescribing physician: _____ Telephone #: _____	Primary care physician: _____ Telephone #: _____
Client's employment status: _____ Employer: _____	Monthly income: _____
Health Insurance: Yes _____ No _____	Insurance Provider: _____ ID Number: _____
Veteran: Yes _____ No _____	ID Number: _____

OTHER

Cultural & family issues: _____ _____ _____
Client's motivation for recovery: _____ _____ _____
Officer's comments: _____ _____ _____