



Family Treatment Court Program Coordinator

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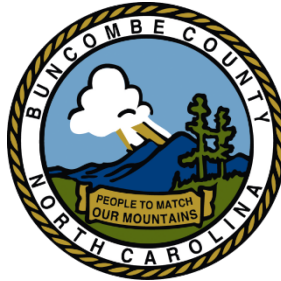
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SOAR FAMILY TREATMENT COURT REFERRAL FORM

Date:

Referring Person:

- checkbox Judge
checkbox Social Worker
checkbox Parent/Guardian
checkbox Guardian Ad Litem
checkbox Other



Next Court Date: \_\_\_\_\_

Juvenile Case No: \_\_\_\_\_

Referring Agency's Phone Numbers: \_\_\_\_\_

Cell: \_\_\_\_\_

Name of Referring Person: \_\_\_\_\_

Agency: \_\_\_\_\_

Open Case in Juvenile Court? \_\_\_\_\_ File number? \_\_\_\_\_

Parent/Guardian Information:

Name:

Last:

Middle:

First:

Date of Birth:

SS#: \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Age \_\_\_\_\_

Buncombe County Resident? \_\_\_ Yes \_\_\_ No

Address:

Phone Numbers: (H) \_\_\_\_\_ (C) \_\_\_\_\_

Higher Level of Education? \_\_\_\_\_

**Parent/Guardian Information:**

**Name:**

**Last:**

**Middle:**

**First:**

**Date of Birth:**

**Address:**

**Phone Numbers: (H) \_\_\_\_\_ (C) \_\_\_\_\_**

**Child Name: \_\_\_\_\_**

**DOB \_\_\_\_\_ Where is the child? \_\_\_\_\_**

**Child Name: \_\_\_\_\_**

**DOB \_\_\_\_\_ Where is the child? \_\_\_\_\_**

**Child Name: \_\_\_\_\_**

**DOB \_\_\_\_\_ Where is the child? \_\_\_\_\_**

**Is client receiving other services?  
(Probation, Substance Use Treatment) \_\_\_\_\_**

**Parent Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_**

**DSS Social Worker: \_\_\_\_\_ Phone: \_\_\_\_\_**

**Court Ordered:  Yes  No Date: \_\_\_\_\_**

**Criminal Charges?  Yes  No If yes, what are the criminal charges? \_\_\_\_\_**

**Criminal Defense Attorney? \_\_\_\_\_**

**Reason for Referral: (Presenting issues, why is client being referred)**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- **Reporting Needs:** (follow up action)

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- **Service Requested:**

- |  |  |
|--|--|
| <input type="checkbox"/> Case Management/Supportive Services | <input type="checkbox"/> Housing                               |
| <input type="checkbox"/> Employment                          | <input type="checkbox"/> Public Benefit Applications           |
| <input type="checkbox"/> Education                           | <input type="checkbox"/> Life Skills/Psycho Educational Groups |
| <input type="checkbox"/> Expunction                          | <input type="checkbox"/> Other _____                           |

**-FOR SOAR COURT COORDINATOR USE ONLY-**

Substance use? \_\_\_\_\_

When was the last time the client used? \_\_\_\_\_

What type of substance? \_\_\_\_\_

Mental Health conditions? \_\_\_\_\_

Medication? \_\_\_\_\_

Do you have a support system? \_\_\_\_\_