50th JUDICIAL DISTRICT – COURT OF COMMON PLEAS
DRUG TREATMENT COURT

Butler County

124 W. Diamond Street -:- PO Box 1208 -:- Butler, PA 16003-1208
724-284-5265 TDD Users 724-284-5473

The Honorable Kelley T.D. Streib, Judge

DRUG TREATMENT COURT REFERRAL INFORMATION

Referral Source/Attorney:	**Phone number:**	**Date of Referral:**
E-Mail:		

CLIENT & COURT INVOLVEMENT INFORMATION

Client's name:		Date of Birth:	Gender:	Race:
Home Address:		Social Security #:		
DL#:	Possess a driver's license: ☐ Yes ☐ No	Status: ☐ Valid ☐ Suspended ☐ Expired		
Home Phone #: Cell Phone #:		Email:		
Currently incarcerated in Butler County Prison: ☐ Yes ☐ No		If yes, admittance date:		
Has client ever served in the U.S. Military/Armed Forces? ☐ Yes ☐ No Branch of Military:_____ Dates of Service: _____to _____ Discharge Status (Honorable, General, etc.):_____ List Service in a Combat Theater & Location, If known: _____				
Is the client currently on probation/parole? ☐ Yes ☐ No If yes, who is the probation/parole officer : _____				

MENTAL HEALTH/ DRUG & ALCOHOL INFORMATION

Attach recent Mental Health/Psychological Evaluation if applicable*	Treatment Provider(s):
Mental Health Diagnosis:	If none, when last in service(s):
Drug & Alcohol Use: ☐ Yes ☐ No Drug(s) of Choice: _____	If yes, current treatment provider(s):

SOME INDICTATORS OF SEVERE MENTAL ILLNESS (check those observed or reported):

☐ Auditory/Visual Hallucinations	☐ Irrational/Bizarre Behavioral	☐ Delusional Thoughts
☐ Hx of psychiatric hospitalization	☐ Suicidal Behavior	☐ Severe Depression
☐ Manic Behavior/speech, racing thoughts	☐ Self-injurious Behavior	

***In order to fully process this referral, please attach a psychiatric or psychological evaluation that has been completed within the last two years. If one has not been completed please have one completed prior to submitting the Drug Treatment Court Referral.**

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BUTLER COUNTY SPECIALTY COURTS REFERRAL

I am filing this Referral to be considered for a Specialty Court Program.

This Referral is being made with regard to the following case(s):

Case Number(s)	OTN(s)	Offense(s)	Crimes Code(s)	Grade(s)	Count(s)

Signify your acknowledgement and acceptance to the following statements by initialing in the spaces provided.

_____ 1. I understand, and acknowledge, that if my Referral is accepted, I will be required to enter a plea of guilty in the above matter(s), or stipulate to the parole/probation violation before a Specialty Court Judge.

_____ 2. I understand, and accept, that by applying to a Specialty Court, I am waiving all of my speedy trial rights pursuant to Rule 600 of the Pennsylvania Rules of Criminal Procedure as well as my right to be sentenced subsequent to my plea of guilty, within ninety (90) days, pursuant to Rule 704 of the Pennsylvania Rules of Criminal Procedure.

_____ 3. I understand and agree to execute all Consents to Release Confidential Information to a Specialty Court Team regarding any present or past Substance Abuse Treatment Programs, Medical Treatment, Prescribed Medication, and/or any other information a Specialty Court Team may require to design a proper treatment program for me and to monitor the same.

_____ 4. I understand and acknowledge that upon submitting this Referral, I will not need to attend any further hearings on the cases involved with this Referral pending a notification of acceptance or rejection into a Specialty Court Program.

_____ 5. However, I also understand and acknowledge if this Referral is for Reconsideration for admission into a Specialty Court, until I receive notice of acceptance or rejection into a Specialty Court, I will continue to appear at all proceedings in my case(s).

_____ 6. I understand and acknowledge that upon acceptance into a Specialty Court, this case will be continued generally pending the successful completion or termination of my Specialty Court Program.

_____ 7. I understand and acknowledge should my Referral be rejected, my case(s) shall continue through the normal criminal procedure process.

_____ 8. I understand that upon Acceptance I will comply with all the requirements of the Butler County Court of Common Pleas Specialty Court Program I am accepted into.

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The facts set forth in the Referral are true and correct to the best of my knowledge, information, and belief. I understand that false statements made herein are subject to the penalties of 18 Pa.C.S.A. § 4904 relating to Unsworn Falsification to Authorities.

Signature of Referral	**Date**
Signature of Defense Attorney	**Date**

FILING INSTRUCTIONS

REFERRAL FORMS SHOULD BE FORWARDED TO THE SPECIALTY COURTS COORDINATOR
Holly Hines: PHONE: 724-284-5265, FAX: 724-285-8762, 124 West Diamond Street, P.O. Box 1208, Butler, PA 16003
The original Referral must be filed with the Specialty Court Coordinator within 72 hours (3 business days) upon signing.

DO NOT COMPLETE THIS SECTION – PROBATION USE ONLY	
Date Received:	*Received By:*
Date Fwd. to PO:	*Forwarded By:*
Date Fwd. to CM:	*Forwarded By:*

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Release of Information

Candidate's Name: _____

Date of Birth: _____

Social Security Number: _____-_____-_____

Address: _____

_____

I consent to Butler County Drug Treatment Court Team to obtain complete health records (hospital records – including records relating to mental healthcare, verification of diagnoses, treatment providers, dates of counseling, level of participation in counseling, test results, evaluation, assessment of problems, date and nature of further assessments, progress reports).

The records are required for the specific purpose of: referral to other services, coordination of care, consultation with doctors, consultation with other mental health providers, and/or transfer of care.

This authorization is intended as a voluntary waiver of the privileged communication rule of law and is in compliance with Federal regulations (42 CRF, Section 2.39) and Pennsylvania statues. I have had this form read and explained to me and I understand its content.

I agree to unrestricted communication between providers and the Butler County Drug Treatment Court Team, and I understand that I cannot revoke this consent until there has been a formal and effective termination or revocation of such release from confinement, probation or parole, pursuant with Federal regulation (CRF, Section 2.39, Paragraph c).

_____
Signature of Candidate

_____ _____
Witness **Date**

CENTER FOR COMMUNITY RESOURCES, INC.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION: Criminal Justice & Governmental Agencies

Client Name: _____ Date of Birth: _____/_____/_____

I authorize Center for Community Resources to: □ request information from □ release information to
Name of Facility: Butler County Drug Treatment Court
Address: 124 W Diamond St., Butler, PA 16001
Phone: (724)285-4731
These records are requested for the purpose of:

□ Collaboration and coordination of services □ Assessment and/or Service Planning □ All of the above
□ Recommendations □ Other: _____

Please include approximate dates of service for information being requested: _____

The records to be released (identify all that apply) are:

□ Individual Education Plan/CER	□ Psychiatric Evaluation	□ Psychological Evaluation
□ CYS Records, & Summary Reports	□ Medication Evaluation & History	□ Social History
□ Treatment History & Recommendations	□ Medical History	□ Lab Reports
□ Intake/Assessment	□ Follow-up Reports/SC Updates	□ Presence in Tx. (Admit/Discharge Dates)
□ Brief Description of Progress	□ Synopsis of Prognosis/Diagnosis	□ Presence in BSU (Enrollment/Disenrollment)
□ Statement re: Relapse	□ Verbal Communications	□ Previous Housing Assistance

□ Other (Specify): _____

*** HIV-related information and drug and alcohol information contained in the parts of the record indicated above will be disclosed through this authorization unless otherwise indicated. Do not Release: ☐ HIV ☐ Drug & Alcohol**

The Authorization shall be in effect for a period of **1 year** from the date of signature, unless another timeframe/event is documented _____.
(extended date/event, if applicable)

I understand the following:

- I have the right to revoke this Authorization at any time in writing, except to the extent that action has already been taken.

  Center for Community Resources, Inc. has forms for you to use if you wish to revoke this Authorization at any time before it expires.
- The information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to the privacy protections provided to me by law.
- In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials shall be restricted to the following: (1) Whether the client is or is not in treatment (2) The prognosis of the client (3) The nature of the program (4) A brief description of the progress of the client (5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- Center for Community Resources, Inc. may not require that I sign this Authorization in order to obtain treatment.
- I am entitled to a copy of this completed Authorization form: □ **ACCEPTED** □ **DECLINED** **Client Initials: _____**

I have read this Authorization, or had it explained to me, and I understand its contents.

Signature: _____ Date: _____/_____/_____
Client/Legal Representative Signature

If you are the legal representative of the person listed above, please check off the basis for your authority:

□ Parent of Minor □ Power of Attorney (copy must be in chart)
□ Guardianship Order (copy must be in chart) □ Other: _____

Staff/Witness Signature: _____ Date: _____/_____/_____

Witness Signature: _____ Date: _____/_____/_____
(Two witnesses are required for oral authorizations or when the client is physically unable to sign)

**This information has been disclosed to you from records whose confidentiality is protected by state statute. State regulations limit your right to make further disclosures of this information without prior written consent of the person to whom it pertains.