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: ______________________