

**MARION COUNTY JUVENILE DEPENDENCY DRUG COURT**  
**REFERRAL FORM**  
*PLEASE PRINT NEATLY*

**GENERAL:**

Name: Last \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_

Address(1): \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Address(2): \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone #: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Email) \_\_\_\_\_

Employer: \_\_\_\_\_

Drug(s) of choice: \_\_\_\_\_

**EMERGENCY CONTACT:** Name: \_\_\_\_\_

Telephone #(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

Name of Child(ren) (first and last)	Date of Birth & FSFN #	Placement of child(ren)

List all other persons residing with you: \_\_\_\_\_

Drivers' License or FL ID #: \_\_\_\_\_

Make/Model of Vehicle(s) Owned/Leased: \_\_\_\_\_

Case Style of Current Dependency Matters:	Dependency Case #s:

Office of the Court Administrator, Fifth Judicial Circuit  
 Marion County Drug Court  
 110 NW 1<sup>st</sup> Avenue, Room 1-1027  
 Ocala, Florida 34475

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Case Worker(s):	Telephone #s:
Name of Protective Investigator	
Name of Family Care Manager:	
Name of Guardian Ad Litem (GAL):	

ATTORNEY(s)/MEDIATOR	Telephone #s:
Name of Mother's attorney	
Name of Father's attorney	
Mediator	

**OPTIONAL: The questions in this section are not required to be completed**

Sex (M/F): \_\_\_\_\_ Race: (circle one) Caucasian/White Native American Alaskan Native African American  
 Hispanic/Latino Asia/Pacific Islander Other: \_\_\_\_\_  
 Marital/Relationship Status (circle one): Single Married Divorced Separated Living as married  
 Spouse Name: \_\_\_\_\_

\_\_\_\_\_  
 PRINTED Name of Person making the referral

\_\_\_\_\_  
 Name of agency

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature

*The Marion County Dependency Drug Court does not discriminate against qualified applicants on the basis of race, color, religion, gender, age, national origin, marital status, handicap (disability) or veteran status or as otherwise prohibited by federal, state or local law.*

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