Prevention and Training Services, Inc.

252 S. Waverly Rd., Lansing, MI 48917
PH: (517) 323-8149 Fax: (517) 323-1653 Email: services@patslansing.com

INSTRUCTIONS - ***You have been ordered to attend the program(s) listed below. You are responsible for calling P.A.T.S. and enrolling within 3 days of receiving this order. Program information can be found on our website patslansing.com.***

CASE NO: _____

PBT = _____ **BAC =** _____

ADDITIONAL COMMENTS:

EDUCATION

- ☐ Alcohol & Substance Use Education Weekend
- ☐ Alcohol & Substance Use Continuing Education (6 sessions) (**Alcohol & Substance Use Weekend prerequisite)*
- ☐ Economic Crime Program

SUBSTANCE ABUSE PROGRAMS

(Education Component required as part of Phase I Substance Abuse Treatment for adults)

- ☐ Adolescent Substance Abuse Treatment Sessions (13-17 years. Individual sessions)
- ☐ Adult Outpatient Substance Abuse Treatment (12-24 sessions)
- ☐ Adult Intensive Outpatient Substance Abuse Treatment (36 groups and 4 individual sessions)
- ☐ Adult Relapse Treatment (12 sessions. Must have completed a treatment program & had a reasonable period of sobriety)
- ☐ Women's Outpatient Substance Abuse Treatment (12-24 sessions - **Women only**)

CRIMINAL THINKING PROGRAM

- ☐ Moral Reconation Therapy (**MRT**) (16-36 group sessions)

DOMESTIC ABUSE INTERVENTION/ANGER MANAGEMENT PROGRAMS

- ☐ Domestic Abuse Intervention Weekend + 24-50 Weeks (Men only)
- ☐ Domestic Abuse Intervention Weekend+ 50 Weeks (Men Only)
- ☐ Domestic Abuse Intensive 50 sessions + 8 sessions 2x week (Men only)
- ☐ Assaultive Behavior Change (Non Domestic Partner Offense)

Prior Assaults?	☐ Yes	☐ No
PPO?	☐ Yes	☐ No
No Contact Order	☐ Yes	☐ No
Victim Injured?	☐ Yes	☐ No

ASSESSMENTS:

- ☐ Substance Abuse Assessment
- ☐ Relapse Evaluation
- ☐ ORAS – Criminal Risks and Needs Assessment
- ☐ Psychological & Mental Health Evaluation

DRUG AND ALCOHOL TESTING:

Urinalysis Lab: ☐ ETG Only ☐ 6 panel+ETG ☐ 9 panel+ETG ☐ 10 panel+ETG ☐ 12 panel+EtG ☐ 14 panel+ETG

____ One time Only ____ days per _____ Start Date_____ **Bring Picture ID at time of test*

☐ PBT ____ One time Only ____ days per _____ Start Date_____ **Must have full cash payment to test*

MENTAL HEALTH THERAPY:

- ☐ Adolescent Psychotherapy
- ☐ Adult Psychotherapy

☐ **BILL SERVICES TO:** **CLIENT** ☐ **OTHER AGENCY** ☐ _____

NAME: _____ (Last / First / M.I.) **Sex:** Female **PHONE:** _____ (Home) / _____ (Work)

ADDRESS: _____ (No. / Street / Apt. # / City / State / Zip Code)

REFERRED BY: _____ (Court/Agency) **REASON FOR REFERRAL** _____ (Offense)

PROBATION OFFICER _____ **DATE OF BIRTH** _____ **PROBATION DUE DATE** _____

AGREEMENT TO ATTEND AND CONSENT TO RELEASE REPORT

I,_____, hereby authorize the above-mentioned program to exchange information with the _____Court. The extent of the information to be disclosed will be the assessment report, relevant data and information, comments on my attitude and participation when necessary, recommendations for additional referral services, drug testing results, and discharge summary. This consent will expire when I am terminated from probation/parole or whenever the program receives written notice of a change in my legal status whichever is later. The purpose of this disclosure is to assist the referring agency in reaching a satisfactory disposition of my case. In addition, I hereby agree to attend and satisfactorily complete the program according to the rules and regulations. I am aware that a program termination may result if I do not attend per the rules and the program designee has the authority to terminate without prior notification.

_____ (WITNESSED BY / DATE) _____ (CLIENT'S SIGNATURE / DATE)

EMAIL PRINT