

### COURT ORDERED ASSESSMENT AND PLAN REPORT

**Use of form:** Completion of this form meets the requirements of s. 23.33(13)(e), 30.80(6)(d), 961.472, or 350.11(3)(d), Wis. Stats.

**FROM:** Judge \_\_\_\_\_ Court: \_\_\_\_\_

Address - Court: \_\_\_\_\_  
(Street, City, State, Zip Code)

**CLIENT INFORMATION**

Name - Client (Last, First, MI)		Birthdate (mm/dd/yyyy)	Occupation
Address (Street, City, State, Zip Code)		County of Residence	Telephone Number

**ARREST / CONVICTION INFORMATION**

Date of Arrest	Date of Conviction	Case Number	Offense <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third or more
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Note: Motorized Recreational Vehicle (MRV) includes boats, snowmobiles and all-terrain vehicles.

Blood alcohol concentration: _____	<input type="checkbox"/> Implied Consent Refusal - MRV	<input type="checkbox"/> Intoxicated Great Bodily Harm - MRV
and / or _____	<input type="checkbox"/> Operating While Intoxicated - MRV	<input type="checkbox"/> Intoxicated Homicide - MRV
Controlled substance: _____	<input type="checkbox"/> Intoxicated Injury - MRV	<input type="checkbox"/> Possession of controlled substance

**ASSESSMENT FINDINGS** Note: "Substance" includes alcohol or controlled substances. Check appropriate box below.

<input type="checkbox"/> Did not complete assessment - Reason: _____
<input type="checkbox"/> Irresponsible substance use <input type="checkbox"/> Substance dependency
<input type="checkbox"/> Irresponsible substance use - borderline <input type="checkbox"/> Substance dependency in remission
<input type="checkbox"/> Suspected substance dependency

Check substance use pattern and chronicity when the assessment finding is suspected dependency, dependency or borderline.

Pattern: <input type="checkbox"/> Intermittent      Chronicity: <input type="checkbox"/> Early	Primary substance - Specify: _____
<input type="checkbox"/> Recurrent <input type="checkbox"/> Moderately advanced	Secondary substance(s) - Specify: _____
<input type="checkbox"/> Steady <input type="checkbox"/> Far advanced	

Physiological, behavioral, psychological and / or attitudinal symptoms identified - Specify below.

Assessment instrument used:

WAID     Other - Identify: \_\_\_\_\_

**COMPLETE F-20934A FORM**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_, hereby consent to the release of the results of this assessment and  
(Name - Client)

the recommended plan administered by \_\_\_\_\_  
(Name - Person completing assessment. Include title / certification.)

of the \_\_\_\_\_, located at  
(Name - Assessment Facility)

\_\_\_\_\_, and all status, treatment and attendance records  
(Address - Assessment Facility) (Street, City, State, Zip Code)

and information required prior to the expiration of this release to the \_\_\_\_\_

staff of the county department under s. 51.42; the referring court and / or my probation agency \_\_\_\_\_

and the plan provider(s) of my choice:

The purpose for this disclosure is to aid in determining compliance with the court order for assessment and determination of any need for treatment. I further authorize the person / facility administering the assessment to follow-up and verify my compliance with any treatment plan. I understand that I may withdraw my consent at any time, prior to the expiration of this release except where revocation is prohibited according to s. 2.39, 42 CFR.

Release Date (mm/dd/yyyy)	<b>SIGNATURE</b> - Parent or Guardian (if client is under age 18)	Date Signed
Release Expiration Date (mm/dd/yyyy)	<b>SIGNATURE</b> - Client	Date Signed

**Distribution:** Original – Court      Copies – Client, Recommended plan provider, Probation agent, Assessment facility / 51.42 staff