ADSAP/EDUCATION/TREATMENT REFERRAL FORM

ENROLLMENT REQUIRED WITHIN 30 DAYS

CMS

COURT USE

A

Court:____ City/County:____________________________
Referring Judge Name:_________________________________ Court Phone: (___)________________
Court Address:____
Court Fax: (___)________________________________ Court Email: ____________________________
Defendant Name:____
Address:____ Phone: (___)________________
City & State:____ Date of Birth:______________
Ticket/Warrant #______________ Driver's License #_______________ Driver's License State:________

Convicted of (CDR Code-Description): _____________________

Date of Conviction:_________________ Indictment #:____________________

B

REFERRAL *(Please check appropriate boxes)*

_______Defendant is to enroll within 30 days, attend and complete a South Carolina certified ADSAP (Alcohol Drug Safety Action Program) pursuant to SC Code of Law sections 56-5-2930, 56-5-2933 and 56-5-2990. Defendant is subject to contempt of this court if there is failure to enroll within 30 days. Defendant is required to attend and complete a SC certified ADSAP and comply with recommendations of ADSAP.

_______SC Department of Probation, Parole and Pardon Services (SCDPPPS) to receive notification if there is failure to enroll, attend and complete a SC certified ADSAP and comply with recommendations of ADSAP if the defendant is currently on supervision for the referred offense.

ADSAP Site:_________________ (See Site List) Enroll by Date:___________________
Agency Name__________________________________ Phone Number: (___)________________
Address:____
ADSAP Fax: (___)________________________________ ADSAP Email: __________________________

C

NON-ADSAP ASSESSMENT/TREATMENT PROGRAM REFERRAL (See Site List.)

Program Site:_______________________Reason for Referral:_____________________________
Address:____
City/State Zip:____
Other Instructions:____
____ Enroll by Date:____________________

PROGRAM USE

D

ADSAP/OTHER PROGRAM REPORT

- ☐ Failed to Enroll
- ☐ Failed to Complete (Summary Attached)
- ☐ Assessment Date:________________
- ☐ Completion Date:________________(for SCDPPPS)

____
Clinical Counselor **(Signature)**

______________________________ ________
Clinical Counselor Name **(Print)** Date

Treatment Recommendations:

- ☐ PRI
- ☐ Outpatient
- ☐ Intensive Outpatient
- ☐ Inpatient
- ☐ Relapse Prevention
- ☐ ________________ (Alternative Services)

_________________________ ______
Defendant's Signature (If applicable) Date

E

ADSAP COUNSELOR

The counselor's signature indicates that treatment has been completed in accordance with South Carolina law and that the defendant is in compliance with the recommendations of the ADSAP program and order of the court.

____
Clinical Counselor Name **(Signature)**

______________________________ ____________________
Clinical Counselor Name **(Print)** Date

Distribution: Original – Court; Copies – Defendant; ADSAP (and SCDPPPS if applicable)

ADSAP Form 101 02/2009