ADSAP/EDUCATION/TREATMENT REFERRAL FORM
ENROLLMENT REQUIRED WITHIN 30 DAYS

NON 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: ☐DUAC: 1st Offense ☐DUI: 1st Offense
☐DUAC: 2nd Offense ☐DUI: 2nd Offense
☐DUAC: 3rd Offense ☐DUI: 3rd Offense
☐DUAC: 4th Offense ☐DUI: 4th or Subsequent
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 ☐Relapse Prevention
☐Outpatient ☐_____
☐Intensive Outpatient (Alternative Services)
☐Inpatient

_____ _____
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 102 02/2009