

DEPARTMENT OF PUBLIC HEALTH-SUBSTANCE ABUSE PREVENTION AND CONTROL RECOVERY SUPPORT COURT (RSC) REFERRAL FORM

Section A – CLIENT INFORMATION (COMPLETED BY DCFS RSC Children's Social Worker)

Client Name:	CSW Name:
Client Address:	DCFS Office Address:
Client Phone:	CSW Phone:
Client Email:	CSW Email:
Date of Birth: Primary Language:	Case Name:
Client's RSC Status: ☐ Enrolled in RSC ☐ Observer (Client is interested, but not officially enrolled)	Referral Date:
Notes:	

Section B – INTAKE APPOINTMENT DETAILS (COMPLETED BY SUD TREATMENT PROVIDER)

The following appointment has been scheduled:	
Date:	Time:
Treatment Provider Agency Name:	
Address:	
Phone:	Email:
Any known disability? ☐ NO ☐ YES If yes, describe any accommodations needed: _____	

Section C – TREATMENT ADMISSION INFORMATION (COMPLETED BY SUD TREATMENT PROVIDER)

Return this form to DCFS within 5 working days as long as the client has completed a Release of Information (ROI).

ROI forms are available on [SAPC's website](#).

Result of the client admission appointment: ☐ Client did not attend or complete appointment ☐ Client completed treatment admission ☐ Client screened negative (SUD treatment not recommended) ☐ Other (specify): _____		Intake Date:
Intake Staff Name:	Phone:	Email:
Notes:		