



Department of
**COUNSELING AND
PSYCHOLOGICAL SERVICES**
Division of Student Affairs

735 McMillan Road
Clemson, SC 29634-4022
(864)656-2451
Fax: 800-747-3293

ACTT Student Agreement & Referral Form

Name: _____
Last First
 XID: C _____
 Date of Birth: ____/____/____
MM DD YYYY
 Today's Date: ____/____/____
MM DD YYYY

Student Agreement:

You have been referred to the Assessment, Choices, Treatment and Transitions (ACTT) Program at Counseling and Psychological Services (CAPS). You have three (3) business days from the date of this notice to make the initial phone contact with CAPS by calling **(864) 656-2451** to set up your ACTT assessment. Should you attempt phone contact and need to leave a voice message, you must provide the following information: full name, XID, date of birth, and a telephone number where a voice message can be left. You are responsible for regularly checking your voice messages and your web portal account (<http://redfernweb.clemson.edu>) where you may receive secure messages from CAPS staff. All intake paperwork to include intake questionnaire, surveys and self-assessment are required to be completed prior to checking in for your initial assessment.

Your initial assessment will take approximately 60 minutes. Please arrive early to allow yourself time to find parking (if applicable) and complete your post check in surveys. 24-hour notice is required if you must reschedule the appointment. CAPS will only attempt to contact you twice to schedule or reschedule your appointment. If we are unsuccessful in contacting you or if you fail to comply with the treatment recommendations your referral source will be notified of your noncompliance. A mandated student is defined as a student who is being referred for ACTT services by an agency, organization, legal service, or by a part of Clemson University. Mandated students are charged a \$100 processing fee to be paid on your web portal account (<http://redfernweb.clemson.edu>) or in person at the Redfern Health Center Pharmacy.

For a complete description of the program visit: www.clemson.edu/redfern/alcohol/actt

I, _____, have read the above student agreement and understand the process, expectations, and fees. I understand that I must comply with my referring agency by following ACTT treatment recommendations. I understand that failure to do so will result in consequences determined by the referring agency.

Student Signature: _____ **Date:** ____/____/____

Referral Agency:

Agency Name: _____ Contact Name: _____
 Address: _____ Phone: _____
 _____ Fax: _____

Brief Description of Referral Incident and Relevant Comments: *(Please forward all relevant incident reports, tickets, etc.)*

Staff Signature: _____ **Date:** ____/____/____

Printed Staff Name: _____