CLEMSON
COUNSELING & PSYCHOLOGICAL SERVICES

Box 344022
Clemson, SC 29634-4022
(864)656-2451
Fax: (864)656-0760

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, Training 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 have 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. Should you have to leave a message, someone from CAPS will contact you within two (2) business days to schedule your ACTT assessment. However, if you have attempted phone contact with CAPS for scheduling and not heard back from someone within two (2) business days, you are expected to call again.

Your initial assessment will take approximately 90 minutes. Please arrive early to allow yourself time to find parking and complete your initial paperwork. If you must reschedule the appointment, you must provide 24 hour notice. 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. Mandated students are charged a $75 processing fee to be paid at the Redfern Health Center Pharmacy. 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.

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: _____

This Referral Form and the Authorization for Release of Confidential Information are available online at the above mentioned link. Give copy of completed Referral Form to student, fax or mail the original Student Agreement and Referral Form and Authorization for Release of Confidential Information to the ACTT Program.