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

Section A – COMPLETED BY RSC CSW

Participant Name: _____ **Address:** _____ _____ **Phone:** _____ **Date of Birth:** _____	**RSC CSW Name:** _____ **DCFS Address:** _____ _____ **Phone:** _____ **Email:** _____

Case Name: _____	**Primary Language:** _____	**Notes:** _____

Section B – COMPLETED BY SUD TREATMENT PROVIDER

The following appointment has been scheduled:

Date: _____ **Time:** _____

Treatment Provider Name: _____

Address: _____

Care Navigator: _____	**Phone:** _____	**Email:** _____

Any known disability? NO ☐ YES ☐ If yes, describe any accommodations needed: _____

Section C – COMPLETED BY SUD TREATMENT PROVIDER (Return to RSC CSW within 5 working days)

Results of the admission appointment: **Participant did not attend / complete the information** ☐ **Participant completed admission** ☐	**Date:**

Intake Staff:	**Phone:**	**Email:**

Section D – COMPLETED BY PARTICIPANT

I authorize the release of information concerning my treatment admission to Department of Children and Family Services and to the Recovery Support Court.

_____ _____

DCFS Participant's Signature **Date**

Disposition: RSC CSW completes Section A (green). Provider completes Sections B&C (yellow). Participant completes Section D (white).
Updated: July 2025