ILLINOIS
Counseling Center
STUDENT AFFAIRS

# Confidential Alcohol and Other Drug Incapacitation and Referral Form

**Section 1: Student Information**

Name _____ UIN _____ Gender _____

DOB _____ Age _____ Phone number _____

Address _____

**Section 2: Incident Information**

Is this referral related to a specific incident of concern? ☐ Yes ☐ No

If yes, please complete the following:

Incident Date _____ Incident Time _____

Incident Location _____

Were paramedics called? ☐ Yes ☐ No

Was the student transported? ☐ Yes ☐ No

If so, to which hospital? ☐ Carle ☐ OSF

Reason for referral (please include specific information related to why you are concerned and believe AOD services would be helpful.

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**Section 3: Service(s) Requested**

☐ AOD Assessment ☐ Challenging Alcohol Attitudes Positively (CAAP)

☐ Marijuana Information Class (MIC)

**Section 4: Your Information**

Name _____ Date _____

Phone number _____ Email _____

**Please upload completed form to our secure Box account on our AOD Assessment page on our website.**