

**Georgia Department of Behavioral Health and Developmental Disabilities
Substance Abuse Treatment for DUI Offenders**

Client Transfer Sheet

TO: _____
Treatment Provider Name **Provider Number**

(Mailing Address)

FROM: _____
Treatment Provider Name **Provider Number**

Contact Person **Telephone Number**

RE: _____
Client Name **Driver's License Number**

Original _____
DHR ID Number **ASAM Level** **Date of**
Service Required **Enrollment**

Number _____
Client's Mailing Address **Client Telephone**

Date of Birth

The above name person is being transferred to your program:

___ **As requested by the Client**

___ **For appropriate Level of Services**

___ **Other, _____**

Signature of Program Official

