VERMONT
DEPARTMENT OF HEALTH

Vermont Impaired Driver Rehabilitation Program

Evaluation Information

First Name:		Middle Initial:		Last Name:	
Date of Birth:		Phone:		VT PID:	
Address:					

Education Level:		Employment:	

Type of Offense	Date of Offense	BAC for Offense

By signing this form, I am attesting that all the information that I provided is true to the best of my knowledge and that I must complete the IDRP in it's entirety within five (5) years from today's date or will be required to start the Program over and pay all applicable fees.

Client Signature:		Date:	

Evaluation Information (To be completed by IDRP Evaluator)

Location of IDRP Evaluation:				Date of Evaluation:	
DAST Score:		AUDIT Score:		Offender Type:	
Approximate time since last use:		Alcohol:		Drugs:	

Clinician Comments:

Brief History of Substance Use:

Present Use:

Family History:

Additional Comments or Areas of Concern (including information about participation in IDRP Education Program):

Evaluator expectations for IDRP clinician:

Exit interview required? ☐ Yes ☐ No

By signing this form, I am attesting that all of the information that I provided is true to the best of my knowledge.

IDRP Evaluator Signature:		Date:	
License #:			