

# Vermont Impaired Driver Rehabilitation Program

## Evaluation Information

March 2024

Client Information					
First Name:		Middle Initial:		Last Name:	
Date of Birth:		Phone:		VT PID:	
Address:			Email Address:		
Education Level:			Employment:		

Type of Offense	Date of Offense	Offense BAC

*By signing this form, I attest all the information I provided is true to the best of my knowledge. I understand I must complete the IDRP in its entirety within five (5) years from this Evaluation date, or I will be required to restart the Program, including payment of all applicable fees.*

Client Signature:		Date:	
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Evaluation Information (To be completed by IDRP Evaluator)					
Location of Evaluation:				Date of Evaluation:	
DAST Score:		AUDIT Score:		Offender Type:	
Last use (approximate):	Alcohol:			Drugs:	

Evaluator Comments:

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History of Substance Use (alcohol, cannabis, illicit substances):

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Current Substance Use (alcohol, cannabis, illicit substances):

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Family History:

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Additional comments, areas of concern, Evaluator recommendations:

Treatment Required?      Yes                  No

Evaluator expectations for IDRP treatment provider (i.e. goals/behaviors to address):

Exit interview required?      Yes                  No

*By signing this form, I attest all the information provided here is true to the best of my knowledge.*

IDRP Evaluator Signature:		Date:	
License #:			
Supervisor Name & License # (if applicable):			