Impaired Driver Rehabilitation Program Treatment Information Form

July 2024

Client Information

First Name: ________________________ Middle Initial: _____ Last Name:________________________

Date of Birth: ____________ Phone #: _________________ Email: _____________________________

Address: ____

Evaluation Information

☐ Client **has** completed or shown substantial progress in completing therapy.

☐ Client **has not** completed or shown substantial progress in completing therapy.

Treatment Start Date: _________________ Treatment End Date: __________________

Number of sessions: __________________ # of Treatment Hours: _________________

Participant Diagnosis & Goals (DSM or ICD-10 codes)

Diagnosis Code 1: [ ] Diagnosis Code 2: [ ] Diagnosis Code 3: [ ]

Treatment Goals (must address all identified diagnoses):

1. [ ] Met Not Met
2. [ ] Met Not Met
3. [ ] Met Not Met
4. [ ] Met Not Met

Behavioral changes the client has made to support successful IDRP completion (attach 2nd page if needed):

[ ]

Counselor Name: ________________________ Counselor License #: ________________________

(*If Applicable*) Supervisor Name: _____________________ Supervisor License #: _____________________

Counselor Organization: ____

Counselor Phone #: ________________________ Counselor Email: ___________________________

Counselor Signature: ____________________________ Date: ____________________________

IDRP Evaluator Signature: ________________________ Date: ____________________________