VERMONT
DEPARTMENT OF HEALTH

Impaired Driver Rehabilitation Program
Intake Information

First Name: Middle Initial: Last Name:

Date of Birth: Age: Phone:

Address: City: State: Zip:

Vermont PID: Total Number of Impaired Driving Offenses: Type of Offender

Type of Offense	Date of Offense	BAC for Offense	Injury or Fatality Resulting?		
			☐ Self	☐ Other	☐ None
			☐ Self	☐ Other	☐ None

Highest grade completed: Currently a student? ◯ Yes ◯ No

Currently employed? ◯ Yes ◯ No If yes, number of years employed: ◯ Full-Time ◯ Part-time

Client Signature: Date:

Screening Information (To be completed by IDRP Evaluator)

Location of IDRP Screening: Date Started: Date Paid:

DAST Score: AUDIT Score: License Reinstatement Eligibility Date:

Approximate time since last use: Alcohol: Other 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's Signature: License #: Date: