VERMONT
DEPARTMENT OF HEALTH

Impaired Driver Rehabilitation Program
Treatment Information Form

First Name: | Middle Initial: | Last Name:

Date of Birth: | Phone: | Total Number of Impaired Driving Offenses:

Address: | City: | State: | Zip:

Current Intake Information:

Please check one:

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

☐ Client has NOT completed or shown substantial progress in completing therapy. Please see *Notice of Decision*.

Please explain:

Date Treatment Began: | Date Treatment Completed or Shown Substantial Progress: | Number of sessions: | Number of hours:

If there was a lapse in treatment, please outline the other times the individual sought treatment:

Date Treatment Began: | Date Treatment Completed or Shown Substantial Progress: | Number of sessions: | Number of hours:

Date Treatment Began: | Date Treatment Completed or Shown Substantial Progress: | Number of sessions: | Number of hours:

Clinician Diagnosis(es):

DSM Diagnosis 1: | Diagnosis 2: | Diagnosis 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 his/her treatment completion

Additional Comments:

Client Signature: | Date:

Counselor Name: | Phone: | License #:

Counselor Address:

Counselor City: | Counselor State: | Counselor Zip Code:

Counselor's Signature: | Date:

IDRP Evaluator's Signature: | Date:

IDRP Director (or designee) Signature: | Date: