

Vermont Impaired Driver Rehabilitation Program

Macluumaadka Qiimaynta

Maarso 2024

Macluumaadka Macmiilka					
Magaca Koobaad:		Xarafka u hoeeya Magaca Dhexe:		Magaca u Dambeeya:	
Taariikhda Dhalashada:		Talefoonka:		VT PID:	
Cinwaanka Deegaanka:			Cinwaanka Iimaylka:		
Heerka Waxbarasho:			Shaqada:		

Nooca Dambiga	Taariikhda Dambiga Dhacay	Dambiga BAC

Saxeexitaanka foomkan, waxaan cadaynayaa in dhamaan macluumaadka aan bixiyay ay run yihiin inta aan ogahay. Waxaan fahamay inay tahay inaan dhamaystiro IDRP guud ahaan shan (5) sano gudahood laga bilaabo taariikhda Qiimaynta, ama waxaa la iga baahan doonaa inaan dib u bilaabo barnaamijka, oo ay ku jiraan bixinta dhamaan kharashyada khuseeya.

Saxeexa macmiilka:		Taariikhda:	
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Macluumaadka Qiimaynta (Waxaa buuxinaya Qiimeeyaha IDRP)			
Goobta Qiimaynta:		Taariikhda Qiimaynta	
Dhibcaha DAST:		Dhibcaha AUDIT:	
		Nooca Dambilaha:	
Adeegsiga u dambeeyay (qiyaas):	Khamri:		Darogo:

Faalooyinka Qiimeeyaha:

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Isticmaalka Maandooriye ee Taariikh ahaaneed (khamriga, xashiishad, maandooiye sharci daro ah):

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Isticmaalka Maandooriye ee Hadda (khamriga, xashiishad, maandooiye sharci daro ah):

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Taariikhda Qoyska:

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Faalo dheeri ah, waxyaabaha walaalka laga qabo, talooyinka Qiimeeyaha:

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Daaweyn ayaa loo baahan yahay? Haa Maya

Filashooyinka qiimeeyaha ee bixiyaha daawaynta IDRPs (sida hadafyada/hab-dhaqana wax laga qabanayo):

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Ka bixitaanka waraysiga ayaa loo baahan yahay? Haa Maya

Saxeexitaanka foomkan, waxaan cadaynayaa in dhamaan macluumaadka halkan lagu bixiyay ay run yihiin inta aan ogahay.

Saxeexa Qiimeeyaha IDRPs:		Taariikhda:	
Ruqsada #:			
Magaca kormeeraha shatiga ama Ruqsada # ka Qeybqaataha (hadii ay jiraan):			

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 IDRPs 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 IDRPs 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):			