VERMONT
DEPARTMENT OF HEALTH

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 Address: _____

Counselor Phone #: _____ Counselor Email: _____

Counselor Signature: _____ Date:_____