VERMONT
DEPARTMENT OF HEALTH

Impaired Driver Rehabilitation Program
Treatment Information Form

December 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: _____

Client Signature: _____ Date: _____