Impaired Driver Rehabilitation Program
Treatment Information Form

VERMONT
DEPARTMENT OF HEALTH

First Name: Middle Initial: Last Name:

Date of Birth Phone #:

Address:

City: State: Zip:

Evaluation Information

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

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

Date Treatment Began: Date Treatment Ended:

This form must be submitted within 60 days of the last treatment session.

Number of Sessions: Number of Hours:

Clinician Diagnosis(es) (use 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 his/her/their completion:

Additional comments:

Client signature: Date:

Counselor name: Counselor license #:

Counselor organization:

Counselor address:

Counselor phone:

Counselor signature: Date:

IDRP Evaluator signature: Date: