

Mpango wa Usaidizi wa Madereva Walevi wa Vermont

Taarifa za Tathmini

Machi 2024

Taarifa za Mteja					
Jina la Kwanza:		Harufi ya Kwanza ya Jina la Kati:		Jina la Mwisho:	
Tarehe ya Kuzaliwa:		Simu:		PID YA VT:	
Anwani:		Anwani ya Barua Pepe:			
Kiwango cha Elimu:		Ajira:			

Aina ya Kosa	Tarehe ya Kosa	BAC ya Hatia

Kwa kusaini fomu hii, ninathibitisha kuwa taarifa zote nilizotoa ni za kweli kwa ufahamu wangu bora zaidi. Ninaelewa kuwa lazima nikamilishe IDRP kwa ukamilifu ndani ya miaka mitano (5) kuanzia tarehe hii ya Tathmini, au nitahitajika kuanza Mpango upya, ikiwa ni pamoja na malipo ya ada zote husika.

Saini ya Mteja:		Tarehe:	
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Taarifa za Tathmini (Zitajazwa na Mtathmini wa IDRP)			
Mahali pa Tathmini:		Tarehe ya Tathmini:	
Alama ya DAST:		Alama ya UKAGUZI:	Aina ya Mkosaji:
Matumizi ya mwisho (takriban):	Pombe:		Dawa za kulevya:

Maoni ya Mtathmini:

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Historia ya Matumizi ya Dawa za Kulevya (pombe, bangi, vitu haramu):

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Matumizi ya sasa ya Dawa za Kulevya (pombe, bangi, vitu haramu):

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Historia ya Familia:

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Maoni ya ziada, maeneo ya wasiwasi, mapendekezo ya Mtathmini:

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Je, Matibabu Yanahitajika? Ndiyo Hapana

Matarajio ya Mtathmini kwa mtoa huduma wa matibabu wa IDRP (yaani malengo/tabia za kushughulikia):

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Je, mahojiano ya kumaliza mpango yanahitajika? Ndiyo Hapana

Kwa kusaini fomu hii, ninathibitisha kuwa taarifa zote zilizotolewa hapa ni za kweli kwa ufahamu wangu bora zaidi.

Saini ya Mtathmini wa IDRP:		Tarehe:	
Nambari ya Leseni:			
Jina la Msimamizi na Nambari ya Leseni (<i>ikiwa anahusika</i>):			

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 IDRP 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 IDRP 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):			