SUBSTANCE USE EVALUATION
(ALCOHOL AND DRUGS)

CLEAR FORM

SECTION 1: GENERAL INFORMATION and HISTORY (to be completed by driver/applicant)

Please print or type. Attach additional pages where necessary. PLEASE KEEP COPIES OF ALL DOCUMENTS (INCLUDING THIS FORM) THAT YOU SUBMIT.

Name (First, Middle, Last)	Date of Birth	Driver's License Number
TIMOTHY ROBERT NOUSIAINEN	04/10/1984	N255793745280
Street Address		Telephone Number 8 a.m. – 5 p.m.
3063 N HWY 123 BYP APT 932		
City	State	ZIP
SEGUIN	TX	78155

Lifetime Conviction History: List all driving convictions (e.g., operating while intoxicated or impaired driving) and nondriving convictions (e.g., drug crimes, domestic violence, MIP, or disorderly persons) involving alcohol or controlled substances. Include juvenile dispositions.

Driving Convictions	Date	Bodily Alcohol Content or Drug Type (If known)	Nondriving Convictions	Date	Bodily Alcohol Content or Drug Type (If known)
OPERATING-IMPAIRE	9/7/2006	.246			
OWI 1	3/4/2008	.248			

I authorize the Evaluator named on Page 2 to furnish the information set forth on this form and to discuss the information with the Michigan Department of State. I understand this form may also be used as my written request for hearing. I certify that my responses contained in this document are true and accurate to the best of my knowledge and belief.

Driver/Applicant's Signature_____**Date**_____

SECTION 2: HISTORY and EVALUATION (to be completed by evaluator)

Please print or type. Attach additional pages where necessary.

Lifetime Treatment History for Alcohol and/or Drug Use Disorders: Attach each treatment plan and discharge report.

Program Type (e.g., Detoxification, Residential/Inpatient, Intensive Outpatient, Outpatient [individual and/or group], Education, Driver Safety Intervention Course)	Beginning and Ending Dates	Name of Program, Therapist or Group Leader, and Location	Treatment Outcome

Medication assisted treatment (e.g., Methadone, Antabuse, Buprenorphine, or Campral): Medication: _____

Prescribing Physician: _____ Date started: _____ Date ended:_____

Lifetime Support Group History: List all time periods of attendance and frequency.

Period	Frequency	Type (e.g., AA/NA or Women For Sobriety)	Sponsor Yes or No?

Diagnostic Impression (DSM-IV): Indicate all past and present alcohol, drug and mental health diagnoses.

Diagnoses:

Supporting facts for diagnostic impression:

Course specifiers (check all that apply):

☐ Early Full Remission ☐ Sustained Full Remission ☐ On Agonist Therapy ☐ Sustained Recovery
☐ Early Partial Remission ☐ Sustained Partial Remission ☐ In a Controlled Environment ☐ None Applicable

Testing Instruments: Attach the actual instrument used.

Testing Instruments Used (e.g., ASI, SASSI-3, MAST/DAST)	Score	Interpretation of results	Explain how the results of this test correlate with the DSM-IV diagnosis on Page 1
Test 1:			
Test 2:			

Drug Screen: Administer a 10-panel urinalysis drug screen (or refer client) and submit a current laboratory report that includes at least two urine integrity variables. Please include the confirmation test for any positive screen results.

Comments:

If you administered an ethyl-glucoronide alcohol test, what were the results?

Lifetime Abstinence History:

Period of Abstinence (Beginning and Ending Dates)	Abstinence Period Abated by What? (Any abuse of prescription medication or use of alcohol, controlled substance, or NA beer)	Comments

Client Prognosis:

Please check one: ☐Poor ☐Guarded ☐Fair ☐Good ☐Excellent

Provide supporting facts for this prognosis (consider the client's current living and work environments, lifestyle, relapse history, use of addictive prescribed medications, and any other relevant factors that may affect the overall prognosis):

Date of last use of: Alcohol and/or NA Beer: Controlled Substances: (Include illicit and addictive prescription drugs)

Continuum of Care Recommendations:

Please check all that apply:

☐Professional Treatment ☐Educational Course ☐Community Support Group (e.g., AA/NA, Women for Sobriety, SMART Recovery) ☐Other _____ ☐None

Reasons for recommendation or if none, please state reasons:

Certification of Evaluator:

As of this date, I certify that I have reviewed Section 1 and completed Section 2 and that this Substance Use Evaluation is true to the best of my knowledge and belief based on information obtained from the client, the client's known substance use disorder and mental health history, and a client examination. I understand that the decision to grant, suspend, or reinstate an individual's driving privileges rests solely with the Department of State, which may consider other facts or conditions when making this decision.

Evaluator's Name (printed or typed)	Qualifications/Degrees	Date
Evaluator's Signature		Telephone Number
Program Name		Program License Number
Address	City	State / ZIP