

**SUBSTANCE USE EVALUATION  
(ALCOHOL AND DRUGS)**

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

Please print or type. Attach additional pages where necessary.

Name (First, Middle, Last) <i>Robert Patrick Schack</i>	Date of Birth <i>11-11-1981</i>	Driver's License Number			
Street Address	Telephone Number (8 a.m. - 5 p.m.)				
City <i>Lakeland</i>	State <i>FL</i>	ZIP Code			
<b>Lifetime Conviction History:</b> 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)

I authorize the Evaluator named on Page 10 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 a hearing. I certify that my responses contained in this document are true and accurate to the best of my knowledge and belief.

Date \_\_\_\_\_

Driver/Applicant's Signature \_\_\_\_\_

**SECTION 2: HISTORY and EVALUATION (To be completed by the evaluator)**

Please print or type. Attach additional pages when necessary.

<b>Lifetime Treatment History for Alcohol and/or Drug Use Disorders:</b> 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
<i>Outpatient (Group)</i>	<i>Unspecified</i>	<i>Burton Heights Counseling</i>	<i>Good/Success</i>
<i>Education (DIP)</i>	<i>Pre-03/2003</i>	<i>Beauchamp Counseling</i>	<i>Good/Success</i>

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?
<i>12/2000 - 9/2002</i>	<i>Unspecified - approx weekly AA</i>		<i>Yes</i>

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

Diagnoses: *303.90 Alcohol Dependence (Full Remission)*  
Supporting facts for diagnostic impression: *Criteria for: tolerance; trouble abstaining; physically hazardous use; use despite interpersonal issues.*

Course Specifiers (Check all that apply): *... interpersonal issues.*

- |                                                  |                                                              |                                                      |                                             |
|--------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Early Full Remission    | <input checked="" type="checkbox"/> Sustained Full Remission | <input type="checkbox"/> On Agonist Therapy          | <input type="checkbox"/> Sustained Recovery |
| <input type="checkbox"/> Early Partial Remission | <input type="checkbox"/> Sustained Partial Remission         | <input type="checkbox"/> In a Controlled Environment | <input type="checkbox"/> None Applicable    |

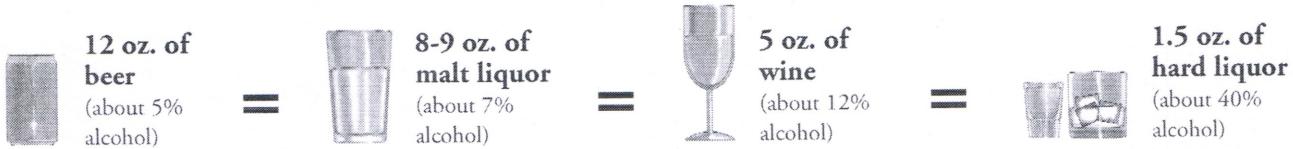
<b>Testing Instruments:</b> Attach the actual instrument used			
<b>Testing Instruments Used</b> (e.g. ASI, SASSI-3, MAST/DAST)	<b>Score</b>	<b>Interpretation of Results</b>	Explain how the results of this test correlate with the DSM-IV diagnosis on Page 9
Test 1: <b>MAST</b>	15	Indicative of past problem alcohol use as reported.	Consistent w/ DSM diagnosis.
Test 2: <b>AUDIT</b>	0	Supports reported Sobriety.	Consistent w/ reported Sobriety.
<b>Drug Screen:</b> 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: <u>No items of concern</u>			
If you administered an ethyl-glucoronide alcohol test, what were the results?			
<b>Lifetime Abstinence History:</b>			
<b>Period of Abstinence</b> (Beginning and Ending Dates)	<b>Abstinence Period Abated by What?</b> (Any abuse of prescription medication or use of alcohol, controlled substances or NA beer)		<b>Comments</b>
02/2015 - Current			Self-reported
<b>Client Prognosis:</b>			
Please check one: <input type="checkbox"/> Poor <input type="checkbox"/> Guarded <input checked="" type="checkbox"/> Fair - <input checked="" type="checkbox"/> Good <input type="checkbox"/> 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):			
<p>No recent legal history. Collateral contacts. Risks: Recent divorce; lack of recent formal treatment</p> <p>Date of last use of: Alcohol and/or NA Beer: Controlled Substances: NA and/or ongoing support.</p> <p>(Including illicit drugs and addictive prescription medications)</p>			
<b>Continuum of Care Recommendations (please check all that apply):</b>			
<input checked="" type="checkbox"/> Professional Treatment <input type="checkbox"/> Educational Course <input checked="" type="checkbox"/> Community Support Group <input checked="" type="checkbox"/> Other ETG Screening <input type="checkbox"/> None (e.g. AA/NA, Women for Sobriety, SMART Recovery)			
Reasons for recommendation or, if none, please state reasons:			
2x monthly counseling/monitoring w/ ETG testing (random) to ensure Sobriety and per previous ruling. Explore adding support options as necessary. Follow-up provider to update recommendations as necessary.			
<b>Certification of Evaluator:</b>			
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	
Trevor Davis	CDCA	8-17-2016	
Evaluator's Signature	Telephone Number		
Trevor Davis		614-888-9200	
Program Name	Program License Number		
Directions Counseling Group	#150427		
Address	City	State	ZIP Code
6797 N. High St #350	Columbus	OH	43085

# AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:



Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	<input checked="" type="radio"/>	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	<input checked="" type="radio"/>	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have 5 or more drinks on one occasion?	<input checked="" type="radio"/>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	<input checked="" type="radio"/>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	<input checked="" type="radio"/>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	<input checked="" type="radio"/>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	<input checked="" type="radio"/>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	<input checked="" type="radio"/>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	<input checked="" type="radio"/>	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	<input checked="" type="radio"/>	No		Yes, but not in the last year		Yes, during the last year
					<b>Total</b>	<input checked="" type="radio"/>

**Note:** This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at [www.who.org](http://www.who.org).



NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE  
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## Michigan Alcohol Screening Test

NOTE: This test can be downloaded in PDF format, but Adobe Acrobat is required.

The MAST Test is a simple, self scoring test that helps assess if you have a drinking problem. Please answer YES or NO to the following questions:

### MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

- | 0.  | Do you enjoy drinking now and then?                                                                                                               | YES    NO                                                    | Points |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------|
| *   | 1. Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people)                                                | <input type="checkbox"/> <input checked="" type="checkbox"/> | (2)    |
| 2.  | Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?              | <input checked="" type="checkbox"/> <input type="checkbox"/> | (2)    |
| 3.  | Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?                                             | <input type="checkbox"/> <input checked="" type="checkbox"/> | (1)    |
| *   | 4. Can you stop drinking without a struggle after one or two drinks?                                                                              | <input checked="" type="checkbox"/> <input type="checkbox"/> | (2)    |
| 5.  | Do you ever feel guilty about your drinking?                                                                                                      | <input checked="" type="checkbox"/> <input type="checkbox"/> | (1)    |
| *   | 6. Do friends or relatives think you are a normal drinker?                                                                                        | <input type="checkbox"/> <input checked="" type="checkbox"/> | (2)    |
| *   | 7. Are you able to stop drinking when you want to?                                                                                                | <input checked="" type="checkbox"/> <input type="checkbox"/> | (2)    |
| 8.  | Have you ever attended a meeting of Alcoholics Anonymous (AA)?                                                                                    | <input checked="" type="checkbox"/> <input type="checkbox"/> | (5)    |
| 9.  | Have you gotten into physical fights when drinking?                                                                                               | <input type="checkbox"/> <input checked="" type="checkbox"/> | (1)    |
| 10. | Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?                                          | <input checked="" type="checkbox"/> <input type="checkbox"/> | (2)    |
| 11. | Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?                                                | <input type="checkbox"/> <input checked="" type="checkbox"/> | (2)    |
| 12. | Have you ever lost friends because of your drinking?                                                                                              | <input type="checkbox"/> <input checked="" type="checkbox"/> | (2)    |
| 13. | Have you ever gotten into trouble at work or school because of drinking?                                                                          | <input type="checkbox"/> <input checked="" type="checkbox"/> | (2)    |
| 14. | Have you ever lost a job because of drinking?                                                                                                     | <input type="checkbox"/> <input checked="" type="checkbox"/> | (2)    |
| 15. | Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?                      | <input type="checkbox"/> <input checked="" type="checkbox"/> | (2)    |
| 16. | Do you drink before noon fairly often?                                                                                                            | <input type="checkbox"/> <input checked="" type="checkbox"/> | (1)    |
| 17. | Have you ever been told you have liver trouble? Cirrhosis?                                                                                        | <input type="checkbox"/> <input checked="" type="checkbox"/> | (2)    |
| **  | 18. After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices, or seen things that are really not there? | <input type="checkbox"/> <input checked="" type="checkbox"/> | (2)    |
| 19. | Have you ever gone to anyone for help about your drinking?                                                                                        | <input type="checkbox"/> <input checked="" type="checkbox"/> | (5)    |
| 20. | Have you ever been in a hospital because of drinking?                                                                                             | <input type="checkbox"/> <input checked="" type="checkbox"/> | (5)    |

21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?   (2)
22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem?   (2)
- \*\*\* 23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, How many times? 2)   (2)
- \*\*\* 24. Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? (If YES, How many times?   )   (2)
- \* Alcoholic response is negative
- \*\* 5 points for Delirium Tremens
- \*\*\* 2 points for each arrest

#### **SCORING**

Add up the points for every question you answered with YES, for Q23 and Q24 multiply the number of times by points

15

- 0 - 3      No apparent problem
- 4              Early or middle problem drinker
- 5 or more      Problem drinker (Alcoholic)

Programs using the above scoring system find it very sensitive at the five point level and it tends to find more people alcoholic than anticipated. However, it is a screening test and should be sensitive at its lower levels.

#### References

Selzer, M.L., *The Michigan Alcoholism Screening Test (MAST): The Quest for a New Diagnostic Instrument*. American Journal of Psychiatry, 3:176-181, 1971.

Selzer, M.L., Vinokur, A., and van Rooijen, L., *Self-Administered Short Version of the Michigan Alcoholism Screening Test (SMAST)*. Journal of Studies on Alcohol, 36:117-126, 1975

[Print Form](#)

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