

**SUBSTANCE ABUSE EVALUATION
(ALCOHOL AND DRUGS)
and
REQUEST FOR HEARING**

Form 2

Client Name:	Driver's License Number:	Date of Birth:
Client Mailing Address:	City:	State and ZIP Code: Telephone No:

Lifetime Conviction History

Ask the client to disclose their complete lifetime history of convictions for operating while intoxicated, impaired driving, drug crimes or any other non-driving convictions involving alcohol or controlled substances.

Offenses and Dates	Bodily Alcohol Content or drug type, if known, at the time of offense	Comments

Testing Instruments (Please attach the actual instrument used, including scores and what the scores mean.)

SALCE-ADE	SASSI-3
ASI	MAST/DAST
AUI	DRI
Other:	

Lifetime Treatment History for Alcohol and/or Drug Abuse (Specify dates, program, city and outcome of treatment.)

[Please review and attach each treatment plan and discharge report.]

Detoxification:
Residential/Inpatient:
Intensive Outpatient:
Outpatient (Individual and/or group):
Education:
Driver safety intervention course:

Lifetime Support Group History (Specify all time periods of attendance and frequency)

Period	Frequency	Type (AA, Women For Sobriety, etc.)	Sponsor Y/N

Evaluator: Please administer and submit a current laboratory report from a 10-panel urinalysis drug screen, including urine sample integrity variables.

Diagnostic Impression (DSM-IV) (Indicate all applicable alcohol, drug and mental health diagnoses, supporting facts and remission status.)

Client Prognosis (Probability for abstinence or disuse and reasons for this opinion. Please indicate last date of use for alcohol and controlled substances, including illicit drugs, narcotic/addictive prescription medications, and NA beer.)

Continuum of Care Recommendations (Including professional treatment, educational courses and community support groups, e.g., AA, Women For Sobriety, Secular Organizations for Sobriety, etc. If none, please state reasons.)

Lifetime Relapse History (Lifetime history of periods of abstinence followed by a return to use of alcohol, controlled substances and/or NA beer.)

Analysis and Other Observations/Factors (Please consider client's current living and work environments, lifestyle, and use of narcotic/addictive prescription medications and indicate whether any of these factors affect the overall prognosis indicated above.)

Authorization and Release

I authorize the Evaluator named below to furnish the information set forth on this form and to discuss the information contained therein with the Michigan Department of State. I understand this form may also be used as my written request for hearing.		
Client's Name (Printed or Typed)	Signature:	Date:

Certification of Evaluator

In signing below I certify that all statements contained in this evaluation are true to the best of my knowledge and belief.			
Name (Printed or Typed):	Qualifications/Degrees:	Date:	
Signature:		Telephone Number:	
Program Name:		Program License Number:	
Address:	City:	State:	Zip Code: