



ALCOHOL/SUBSTANCE ABUSE ASSESSMENT

(To be completed by a licensed addiction counselor certified by the Wyoming Department of Health Substance Abuse Program) <http://wdh.state.wy.us/mhsa/treatment/TProviderMap.html>

Printed Name of Client: _____

Date of Birth: _____ Driver License # _____

The Wyoming Department of Transportation has evidence that the above client has or has had an alcohol and/or controlled substance abuse problem. Any driver license, if issued, is subject to at least the following conditions:

- 1. The person must obtain a **current** alcohol and/or controlled substance abuse evaluation, with a recommended course of treatment and/or counseling; and
- 2. The person must show satisfactory completion of (or current attendance in) a recommended course of treatment and/or counseling since the date of their latest offense.

Failure to comply with any of the above conditions and/or any of your requirements/recommendations will result in the cancellation of the client's driver's license and/or driving privileges. We are requesting that you monitor the individual's compliance with the requirements and/or recommendations AND report any non-compliance.

LICENSING RECOMMENDATIONS/REQUIREMENTS:

On the basis of my evaluation concerning this client's use of alcohol and/or a controlled substance(s), I recommend:

() Group Therapy: Frequency: _____
Duration: _____

() Individual Therapy: Frequency: _____
Duration: _____

() Intensive Outpatient Treatment: Frequency: _____
Duration: _____

() Inpatient Treatment: Duration: _____

() Medical Evaluation () Psychiatric Evaluation () Antabuse Program

Other recommendations: _____

I agree to follow the above recommendations and/or requirements. I understand that if I do not comply with these licensing requirements/recommendations, my valid driver's license will be cancelled and/or I will be denied application for a driver's license.

Signature of Client _____ Date _____ Signature of Counselor _____ Date _____

Printed Name of Counselor Submitting Report: _____

Name of Counseling Service: _____ Phone #: _____

Address: _____ City: _____ State: _____

This assessment is valid for 90 days from the date of completion. Clients who do not follow their counselor's recommendations and/or requirements should be reported in writing to Driver Services' Compliance & Review Section.

Return completed form to: WYDOT-Driver Services Program
Driver Compliance/Review Section
5300 Bishop Blvd.
Cheyenne, WY 82009-3340
Phone#: 307-777-4800 Fax#: 307-777-4817