OUT-OF-STATE PETITIONER TREATMENT VERIFICATION

Office of the
Secretary of State
DEPARTMENT OF
ADMINISTRATIVE HEARINGS

Additional forms may be obtained at
www.cyberdriveillinois.com

The rules of the Secretary of State's Department of Administrative Hearings require a petitioner whose alcohol/drug evaluation classification is either "Problematic Use" or "Alcoholism/Chemical Dependency" to document completion of any recommended treatment or provide a treatment waiver as recommended in the Treatment Needs Assessment (TNA). This form may be completed and submitted for these purposes. If more space is needed, attach additional sheets. **Attach to this Treatment Verification form a Comprehensive Discharge Summary and, when applicable, the treatment waiver as recommended in the TNA.**

PETITIONER INFORMATION:

Name: (Last, First, Middle)		Illinois Driver's License Number:	
Address: (Street/City/State/ZIP)			
Sex: ☐ M ☐ F	Date of Birth: / /	Home Telephone Number: ( )	Work Telephone Number: ( )

1. Referral Source: _____

2. Admission Date: _____ Discharge Date: _____
(Primary treatment only; not follow-up/aftercare)

3. Admission Diagnosis: _____

_____

Discharge Diagnosis: _____

_____

OR

TNA Date: _____ Diagnosis: _____

_____

4. Treatment Modality:
   - ☐ Outpatient counseling..... Number of hours completed: _____
   - ☐ Intensive outpatient counseling..... Number of hours completed: _____
   - ☐ Inpatient..... Number of days in inpatient treatment: _____
   - ☐ Individual therapy
   - ☐ Group therapy

5. Prognosis after completing treatment and/or TNA (provide a rationale):

6. Provide a clinical impression of either a "Problematic Use" petitioner's ability to maintain a "Non-Problematic" pattern or an "Alcoholic/Chemically Dependent" petitioner's ability to maintain a stable recovery. Specifically, what is your perception of what the petitioner appears to have gained from the treatment experience, and whether it has substantially reduced the potential for future alcohol/drug-related problems. Report whether the petitioner accepts and acknowledges the severity of his/her alcohol/drug abuse/dependency problem.

7. Recommendations for aftercare/follow-up services:

Aftercare/follow-up service status: ☐ Follow-up completed
☐ Follow-up in progress
☐ Follow-up not initiated

8. Rationale for: a) any modification in the number of treatment hours or change in treatment modality as recommended by the petitioner's last evaluation; b) treatment waiver; or c) additional treatment recommendations as a result of the TNA.

Provider's Name: (type or print)	
Provider's Signature:	Date:
Provider's Title:	Telephone Number:
Program Name:	Accreditation/License Number:
Address: (Street/City/State/ZIP)	

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