State of Vermont

PROJECT CRASH
TREATMENT INFORMATION

108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
Phone: 802-651-1574 Fax: 802-651-1564

*Note: The information on this form does **NOT** authorize approval for reinstatement, and is not considered accepted until the CRASH Evaluator and the DDRP director or his/her designee have signed the form. If an individual has an alcohol related offense, and they live in the State of Vermont, they need to attend a Project CRASH Intake. If they have completed a Project CRASH Intake, they have been given a copy of the test results and information from the intake.*

Client's Name _____ Date of Birth _____ Telephone Number _____

Client's Address _____

Total Number of Alcohol Related Offenses _____ State(s)/Date(s) of these Offense(s)_____

Current intake information available from client or local Project CRASH Evaluator: BAC: _____ MAST_____CAGE_____

SALCE suggested substance abuse diagnosis_____ _____ _____

Please check one:

_____ Client has made substantial gains in their therapy program and will be continuing in his/her therapy.
_____ Client has successfully completed their therapy program.
_____ Client has NOT made substantial gains/completed their therapy program.
Please explain_____

Treatment began _____ and ended _____. Number of sessions _____ Number of hours _____
If there was a lapse in treatment, the individual was seen for an update on _____ to _____, Number of sessions _____

Modality of Treatment: ___Inpatient, From _____ to _____
___ Intensive Out-Patient From _____ to _____
___ Outpatient From _____ to _____
Method of Treatment: ___Individual ___Group ___Couples ___Other, explain _____

DSM 5 Diagnosis List:_____

Treatment goals
1. _____Met/Not Met
2. _____Met/Not Met
3. _____Met/Not Met
4. _____Met/Not Met

Behavioral changes the client has made to support his/her treatment completion (Must be filled out)
_____
_____
_____
_____

Comments
_____
_____
_____

The above named individual has met all stated treatment goals and has made sufficient progress in the treatment of his/her substance abuse/dependence issues to assure that, at this time, risk of further violation is minimal.

Client's Signature _____ Date _____

Counselor (Please Print) _____ Agency _____

Counselor's Signature _____ State Approval Number _____ Date _____

CRASH Evaluator's Signature _____ Date _____

CRASH Director or His/Her Designee _____ Date _____

STATE OF VERMONT

PROJECT CRASH
RELEASE OF
CONFIDENTIAL INFORMATION

I, _____, date of birth: ___/___/___, authorize Project CRASH to disclose information about the facts of my enrollment, current status, and completion of the Project CRASH School/therapy program to, and to obtain information to assist in determining completion of the Project CRASH School/therapy program from:

The Vermont Department of Motor Vehicles,
The Vermont Department of Corrections, including Probation & Parole,
Applicable Vermont District or Superior Court(s),
Court Diversion and/or Teen Alcohol Safety Program

Please check any additional agencies/persons to whom information may be disclosed:

- ❑ Spouse and/or other family member (MUST list names) _____
- ❑ Attorney (MUST give name or agency) _____
- ❑ Department of Motor Vehicles in a State other than Vermont (MUST give department and address)_____
- ❑ Counselor/Treatment facility (MUST give name of facility and/or counselor)_____ _____
- ❑ Other agency or person _____

The purpose of the disclosure authorized herein is to:

Satisfy the conditions of my probation/parole and/or
Satisfy conditions for the reinstatement of my driving privileges and/or
Other _____.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically upon my release from probation/parole and/or upon reinstatement of my driving privileges.

Signature of Participant: _____ Date: _____

Department of Health, Project CRASH, 108 Cherry Street, PO Box 70, Burlington, VT 05402-0070
Telephone: 802-651-1574 Fax: 802-651-1564 03/14