Reset

OUT-OF-STATE PETITIONER TREATMENT VERIFICATION

Office of the Secretary of State
DEPARTMENT OF ADMINISTRATIVE HEARINGS

Additional forms may be obtained at **ilsos**.gov

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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