



# Office of Alcoholism and Substance Abuse Services

## IMPAIRED DRIVER SYSTEM (IDS)

### IDP PROVIDER FEEDER FORM and TRACKING SHEET

This form is for your convenience and internal use only. It should not be submitted to OASAS or DMV.

IDP PROVIDER INFORMATION						
Provider Name			Provider Number			
GENERAL INFORMATION ABOUT MOTORIST						
NYS DMV Client ID#			IDS Consent Obtained <input type="checkbox"/> Yes, on ____/____/____ <input type="checkbox"/> No			
First Name			Last Name (Current)			
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			Last 4 SSN			
Phone			Email			
IDP Information						
Start Date			Status Date			
Class 1	Class 2	Class 3	Class 4	Class 5	Class 6	Class 7
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>IDP Status</b> <input type="checkbox"/> Completed <input type="checkbox"/> Transferred to _____ <input type="checkbox"/> Re-scheduled for _____ <input type="checkbox"/> Dropped – Non-Payment <input type="checkbox"/> Dropped: Failure to Attend Assmt. <input type="checkbox"/> Dropped: Failure to Participate in Class <input type="checkbox"/> Dropped: Failure to Attend Tx <input type="checkbox"/> Completed: Out of State <input type="checkbox"/> Dropped: Out of State						
<b>Assessment Referral?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Date of Referral</b>			
<b>Reason for Assessment Referral</b> <input type="checkbox"/> RIA Self Inventory Score <input type="checkbox"/> Intoxicated During Class <input type="checkbox"/> Re-Arrested <input type="checkbox"/> Self-Disclosure <input type="checkbox"/> Two or More Prior Convictions						
<b>Assessment 1 Provider</b>		<b>Assessment 1 Provider Outcome</b> <input type="checkbox"/> Tx Recommended <input type="checkbox"/> No Tx Recommended <input type="checkbox"/> Not Completed			<b>Date</b>	
<b>Assessment 2 Provider</b>		<b>Assessment 2 Provider Outcome</b> <input type="checkbox"/> Tx Recommended <input type="checkbox"/> No Tx Recommended <input type="checkbox"/> Not Completed			<b>Date</b>	
<b>Treatment Provider</b>		<b>Treatment Outcome</b> <input type="checkbox"/> Tx Completed <input type="checkbox"/> Tx Not Completed			<b>Date</b>	
Clinician Identification						
<b>Completed By (Print)</b>			<b>Date Completed</b>		<b>Entered into IDS (Initials)</b>	