

**A qualified evaluator must complete this form on your behalf.**

- ⌚ **Submit this form within 90 days of your evaluation with your evidence package.**

## What you need to do:

- 1 Find** a qualified evaluator to complete this form.
- 2 Schedule** an appointment with the evaluator.  
*Bring your completed Hearing Request Application (SOS-257) to the appointment.*
- 3 Sign and submit** the completed form with your evidence package.

# Background Information

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Substance Use  
Evaluation  
SOS-258

## Contact Information

Evaluator's name

Qualifications/Degrees

Phone number

Program name

Program license number

Address (street address, city, state, ZIP code)

Applicant's name (first, middle, last)

Date of birth

Applicant's phone number

Applicant's email address

Michigan driver's license/state  
ID card number (if known)

## Lifetime Conviction History

List all driving and nondriving convictions involving alcohol and/or drugs.

Conviction

Date of arrest

Blood alcohol content or drug type


# Lifetime Treatment History

## Program Treatment

← Attach treatment plans and discharge reports.

Include treatment history for all mental health diagnoses, alcohol and/or drug use.

Program type	Timeframe	Name of the program, therapist or group leader	Treatment outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Prescription Medication

← The prescribing physician must complete a DA-4P for all prescriptions included.

Include all agonist medication and medication to treat pain, mental or physical health that may impact the applicant's ability to drive.

### PAST

Medication	Prescribing physician	Used for	Dates used Start and end dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### CURRENT

Medication	Prescribing physician	Used for	Dates used Start and end dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# Lifetime Treatment History

## Lifetime Support Group History

Type <i>Such as AA/NA</i>	Timeframe	Frequency of attendance <i>Daily, weekly, monthly</i>	Sponsor's name <i>If applicable</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Lifetime Abstinence History

Periods of abstinence <i>Start and end dates</i>	Comments <i>Cause of relapse and substances used</i>
_____	_____
_____	_____
_____	_____
_____	_____

Date	Comments (if any)
Date of last use of alcohol <i>Including non-alcoholic beer</i>	_____

Date	Comments (if any)
Date of last use of controlled substances <i>Including marijuana and addictive prescription medications</i>	_____

# Diagnostic Impression

## Diagnostic Impression (DSM-IV or DSM-V)

Describe all past and present alcohol, drug, and mental health diagnoses (including self-reported).

Diagnosis	Course specifiers (check all that apply):			
_____	Early Full Remission	Sustained Full Remission	On Agonist Therapy	Sustained Recovery
Supporting facts for diagnosis	Early Partial Remission	Sustained Partial Remission	In a Controlled Environment	Non-Applicable

Diagnosis	Course specifiers (check all that apply):			
_____	Early Full Remission	Sustained Full Remission	On Agonist Therapy	Sustained Recovery
Supporting facts for diagnosis	Early Partial Remission	Sustained Partial Remission	In a Controlled Environment	Non-Applicable

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Diagnosis	Course specifiers (check all that apply):			
_____	Early Full Remission	Sustained Full Remission	On Agonist Therapy	Sustained Recovery
Supporting facts for diagnosis	Early Partial Remission	Sustained Partial Remission	In a Controlled Environment	Non-Applicable

## Testing Instruments

← Attach the actual instrument (such as ASI, SASSI-3, MAST/DAST) used.

### TEST 1

Testing instrument used

Interpretation of results

Score

How do the results of this test correlate with the DSM-IV or DSM-V diagnosis?

### TEST 2

Testing instrument used

Interpretation of results

Score

How do the results of this test correlate with the DSM-IV or DSM-V diagnosis?

## Drug Screen

← Attach the 12-panel drug test results and results for any additional drug tests taken.

I referred a client to a drug screening facility.

I administered a 12-panel urinalysis drug screen and submitted a current laboratory report that includes at least two urine integrity variables such as specific gravity, urine creatinine or pH level.

*This includes: cocaine, marijuana, PCP, amphetamines, opiates, benzodiazepines, barbiturates, methadone, propoxyphene, methaqualone, ecstasy/MDMA, and oxycodone/Percocet.*

What were the results of the applicant's 12-panel urinalysis drug screen?  
If you administered an ethyl-glucurodine alcohol test, include the results.

# Prognosis & Recommendation

## Applicant Prognosis

What is the applicant's prognosis? Check one:

Poor      Guarded      Fair      Good      Excellent

← Consider the applicant's current living and work environments, lifestyle, relapse history, interlock device report (if applicable), use of addictive prescribed medications, and any other relevant factors.

Explain your prognosis in detail:

## Continuum of Care Recommendations

How do you recommend the applicant stay abstinent? Check all that apply:

Mental health treatment      Community support group (such as AA/NA)  
Substance use treatment      Other: \_\_\_\_\_

Explain in detail. If no recommendations, why?

# Additional Information

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Substance Use  
Evaluation  
SOS-258

Is there anything else you would like to share about the applicant's substance use history or current lifestyle?

## Sign Here

← You may e-sign this document.  
Click document field to sign.

I authorize the Evaluator above to furnish the information set forth on this form and to discuss the information with the Michigan Department of State. I certify that my responses contained in this document are true and accurate to the best of my knowledge and belief.

\_\_\_\_\_  
Applicant's name

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

As of this date, I certify that this Substance Use Evaluation is true to the best of my knowledge and belief based on information obtained from the applicant, the applicant's known substance use disorder and mental health history, and examination. I understand that the decision to grant, suspend, or reinstate an individual's driving privileges rests solely with the Department of State, which may consider other facts or conditions when making this decision.

\_\_\_\_\_  
Evaluator's name

\_\_\_\_\_  
Evaluator's signature

\_\_\_\_\_  
Date