Out of State DWI

Thanks for your help in providing assessment and/or services that help this person satisfy this DWI offense in the state of North Carolina. You can do your normal substance abuse assessment but a certified counselor and/or licensed DWI/DUI facility in your state must conduct it. An additional testing instrument must be used like the SASSI or the Mast.

1. If they show no problem and the BAC was less than .15% with no prior DWI, alcohol offenses or drug offenses, they will need only a minimum DWI/DUI class.
2. If they show abuse, had more than one offense, a BAC over 14% or a refusal, they will need at lease a 20 hour DWI /substance abuse class.
3. If they show dependence and have been drinking within the past year-they will need at least a 40-hour program.
4. IOP and in-patient treatment diagnosis would need to complete the required program. In-patient would require at least of 2 months of continuing care after a 30-day stay.
5. Upon completion of the program, send or fax the transfer form and discharge summary to me.

If you have any questions, please call me at 800-776-3022. Thanks for your help.

Sincerely,

Gene P. Smith
P.O. Box 531
Danville, VA 24543
Fax: 434-822-8492

INTERSTATE DUI/DWI TRANSFER FORM

(Must be completed by the assessing agency)

Date_____

NC DWI Agency: Life Changes Counseling
P.O. BOX 531
DANVILLE, VA 24541
Fax: 434-822-8492

Referral's Name:_____
(LAST) (FIRST) (MIDDLE)

Social Security Number:_____ **Date of Birth**:_____/_____/_____
(Month) (Day) (Year)

Address:_____ **Telephone #**_____
(HOME)

_____ _____
(Cell or work)

Driver's License Number: _____ **State Issued:**_____

Date of Conviction:_____ **BAC:**_____

Prior DUI/DWI Conviction/driving record:_____
Testing Instrument used in assessment: SALCE, SASSI, MAST, (etc) _____
Must list instrument used

***Recommendation based on ASAM &DSM : Assessment Diagnosis-Axis I: _____**

1. No problem _____ 2. Abuse ___; 3. Dependence _____; 4. IOP_____, 5. In-Patient____;
Special Conditions: _____

Completion Status:

***1. Alcohol/Drug Education: Intake Date: _____ Completion Date:_____** # of hours_____

***2. Treatment:** 20hr_____; 40hr____; IOP 90hr___; In-patient 90hr____

***Intake Date:_____ Completion Date:_____ Cost:_____**
(Attach Appropriate Documentation and Discharge Summary)

For Additional Information Contact: State facility or ID number: _____

_____
(AGENCY NAME) (Counselor name and credentials)

_____
(ADDRESS) (TELEPHONE NUMBER)

_____
(SIGNATURE)

***-Must be completed by the receiving agency.**

Life Changes
Discharge Summary

Client's Name: _____ Discharge Diagnosis: _____

Beginning Date: ___/___/___ Discharge Date: ___/___/___ Cost: _____ # of Hours: _____

Case Coordinator: _____

(Has/Has Not) Completed all AA meetings and outside requirements? _____

Client's Participation was:

____ Verbal with personalization
____ Verbal with self-exclusion
____ Limited
____ Non-active

Factors limiting client's participation:

____ Education
____ Physical
_____ Other (Please specify)_____
____ None
____ Emotional
_____

How would you describe client's attitude:

Initially?	Finally?
____ Confused	____ Positive
____ Refusal to accept limitations	____ Somewhat motivated; cooperative
____ Unwilling to be there	____ Barely complying
____ Unsatisfactory	____ Negative (Non-complaint)
____ Satisfactory	____ Satisfactory

Has the client indicated changes in his/her drinking patterns since first starting in the group? Yes No

Drug Screens: _____

Do you believe client understood and absorbed the basic information taught?

____Yes ____No ____Only partially

Overall progress evaluation at end of treatment:

____ Very good ____ Good ____ Poor ____ Fair ____ None

Services Summary: _____

_____

_____

Reason for discharge: _____

_____

Follow-up plan/Recommendations/Referrals: _____

_____

_____

_____ _____/_____/_____

Counselor Date