

YOUTH ASSESSMENT INDEX ver. 4.0c

(Sponsored by: QuickStart Systems, Inc.)

Dr. David Metzger

A. Thomas McLellan, Ph.D.

Remember: This is an interview, not a test.

Call QuickStart Systems at (214)342-9020 for:

- Free copies of the Youth Assessment Index
- Free copies of the Clinical/Training ASI
- The Easy-YAI software, and
- Other Treatment Tracking Software.

INTRODUCING THE YAI:

Eight potential problem areas:

Current living situation, Legal, Medical, Family Relationships, Education/Work, Drug/Alcohol, Psycho/Social Adjustment, and Personal Relationships. All clients receive this same standard interview. All information gathered is confidential.

There are two time periods we will discuss:

- 0 - Has never occurred
- 1 - Occurred more than 30 days ago
- 2 - Occurred the last 30 days
- 3 - Occurred during and before the last 30 days

Client Input:

Client input is important. For each area, I will ask you to let me know how bothered you have been by any problems in each section. I will also ask you how important counseling is to you for the area being discussed. The response to these questions will be a yes or no.

If you are uncomfortable giving an answer, then don't answer. Please do not give inaccurate information! Remember: This is an interview, not a test.

INTERVIEWER INSTRUCTIONS:

Leave no blanks.

Make plenty of Comments (if another person reads this YAI, they should have a relatively complete picture of the client's perceptions of his/her problems).

3. X = Question not answered.
4. N = Question not applicable.
5. Privately interview the youth about drug and alcohol use and personal relationships unless parents are reluctant or unwilling to leave.

HALF TIME RULE: If a question is interested in the number of months, round up periods of 14 days or more to 1 month. If the question is only interested in the number of years, round up 6 months or more to 1 year.

ALCOHOL/DRUG USE INSTRUCTIONS:

The following questions look at two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days.

- > 30 day questions only require the number of days used.
- > Lifetime use is asked to determine extended periods of use.
- > How to ask these questions:
 - > How many days in the past 30 have you used....?
 - > How many years in your life have you regularly used....?
- > Use 99 percent to represent number of times used is one hundred or more

- 01 = Family /Friend
- 05 = Self Referral
- 06 = Employer
- 07 = School
- 09 = Technician Alternatives to Street Crime (TASC)
- 32 = Physician
- 33 = Council on alcohol and Drug Abuse
- 34 = Employee Assistance Program (EAP)
- 37 = Clergy
- 38 = Texas Rehabilitation Commission (TRC)
- 39 = Court Commitment
- 40 = Texas Dept. of Human Services (DPW, DHR)
- 41 = Substitute for Foster Care
- 50 = State Hospital Outreach Program
- 51 = AA, NA, Alanon, Alateen, Other Peer Support
- 52 = Community MHMR Center
- 53 = Other Non-Residential Program
- 60 = State Hospital
- 61 = Other Hospital
- 62 = Halfway House - Intermediate Care
- 63 = Long Term Care
- 64 = Non-Hospital Detox Facility
- 65 = Other Residential Program
- 70 = Police
- 71 = Probation (non-DWI)
- 72 = Probation (DWI)
- 73 = Parole
- 74 = Other Law Enforcement
- 75 = Texas Youth Commission
- 76 = TDJC/ID
- 77 = TAIP
- 78 = City/County Jail
- 80 = Other Individual
- 81 = Other Community Agency(not treatment, not law enforcement)

LIST OF COMMONLY USED DRUGS:

- | | |
|----------------|---|
| Alcohol: | Beer, wine, liquor |
| Methadone: | Dolophine, LAAM |
| Opiates: | Pain killers = Morphine, Dilaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Syrups = Robitussin, Fentanyl |
| Barbiturates: | Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol |
| Sed/Hyp/Tranq: | Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = ChloralHydrate (Noctex), Quaaludes |
| Cocaine | Cocaine Crystal, Free-Base Cocaine or "Crack", and "Rock Cocaine" |
| Amphetamines: | Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal, |
| Cannabis: | Marijuana, Hashish |
| Hallucinogens: | LSD(Acid), Mescaline, Mushrooms(Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstasy |
| Inhalants: | Nitrous Oxide, Amyl Nitrate (Whippets, Poppers), Glue, Solvents, Gasoline, Toluene, Etc. |
- Just note if these are used:
- Antidepressants,
 - Ulcer Meds = Zantac, Tagamet
 - Asthma Meds = Ventoline Inhaler, Theodur
 - Other meds = Antipsychotics, Lithium

Source or referral:

YOUTH ASSESSMENT INDEX ver. 4.0c

- 2. Group Home
- 3. Prison

5. Hospital-Based Program

- 2=Divorced
- 3=Separated (married, not living together nor incarcerated)

6=Mother Deceased

2. With whom do you live (current caretakers)?

- | | |
|-----------------------------|-------------------|
| 1=Both Parents | 7=Institution |
| 2=Mother Only | 8=Alone |
| 3=Father Only | 9=other |
| 4=Mother & Stepfather | 0=Other Relatives |
| 5=Father & Stepmother | A=Friends |
| 6=Substitute or Foster Care | |

3a. Current marital status of natural parents:

- | | |
|-------------------------------|-------------------|
| 0=Never Married | 4=Both Deceased |
| 1=Married and living together | 5=Father Deceased |

3b. If either parent(s) is (are) deceased, how old were you at the time of their death:

| | | |
|--------|----------------------|----------------------|
| Mother | <input type="text"/> | <input type="text"/> |
| Father | <input type="text"/> | <input type="text"/> |

3c. Who has custody if parents are divorced/separated?

- | | | |
|-------------------------------|--------------------|---------|
| N=N/A, Not divorced/separated | 3=Mother | 6=Other |
| 1=N/A, Youth is over 18 | 4=Other Individual | |
| 2=Father | 5=Institution | |

c. Address: _____

City _____ State _____ Zip _____ County _____

d. Phone: (____) _____ - _____

e. Date of Birth: ____/____/____

f. Social Security #:

g. Current employment Status:

- 1=Unemployed, has not sought employment in the last 30 days
- 2=Unemployed, has sought employment in last 30 days
- 3=Part-Time (less than 35 hours/week)
- 4=Full-Time (35 or more hours/week)

<<if working>>

h. Occupation: _____

i. Employer: _____

j. Address: _____

(city) (state) (zip) (county)
k. (____) - _____ Hours: ____:____ - ____:____
Work Phone From To

<<If not working>>

l. Primary reason for no paid employment

- | | |
|---|-----------------------------|
| 0=Cannot find a job | 5=Not interested in working |
| 1=Unable to work for health reasons | 6=Lack of transportation |
| 2=unable to keep job due to substance abuse problems | 7=Lack of job skills |
| 3=Needed at home to work or take care of other family members | 8=Retired |
| 4=Attending School | 9=Other |
| | N=Not applicable (employed) |

m. Income:

| | | | |
|--------------------|----------|----------|----------|
| Employment: | \$ _____ | Pension: | \$ _____ |
| Public Assistance: | \$ _____ | Family: | \$ _____ |
| Disability: | \$ _____ | Illegal: | \$ _____ |

n. Marital status of Head of Household:

- | | |
|-------------------------------|--|
| 0=Never Married | 3=Separated(married, not living together nor incarcerated) |
| 1=Married and living together | 4=Deceased |
| 2=Divorced | |

o. Highest Grade Completed:

6. OTHER INVOLVED ADULTS:

a. _____
Name

b. _____
Relationship

c. _____

4. HEAD OF HOUSEHOLD:

a. Name: _____

b. Relationship: _____

c. Address: _____

City _____ State _____ Zip _____ County _____

d. Phone: (____) _____ - _____

e. Date of Birth: ____/____/____

f. Social Security #:

g. Current employment Status:

- 1=Unemployed, has not sought employment in the last 30 days
- 2=Unemployed, has sought employment in last 30 days
- 3=Part-Time (less than 35 hours/week)
- 4=Full-Time (35 or more hours/week)

<<if working>>

Occupation: _____

i. Employer: _____

j. Address: _____

(city) (state) (zip) (county)
k. (____) - _____ Hours: ____:____ - ____:____
Work Phone From To

<<If not working>>

l. Primary reason for no paid employment

- | | |
|---|-----------------------------|
| 0=Cannot find a job | 5=Not interested in working |
| 1=Unable to work for health reasons | 6=Lack of transportation |
| 2=unable to keep job due to substance abuse problems | 7=Lack of job skills |
| 3=Needed at home to work or take care of other family members | 8=Retired |
| 4=Attending School | 9=Other |
| | N=Not applicable (employed) |

m. Income:

| | | | |
|--------------------|----------|----------|----------|
| Employment: | \$ _____ | Pension: | \$ _____ |
| Public Assistance: | \$ _____ | Family: | \$ _____ |
| Disability: | \$ _____ | Illegal: | \$ _____ |

n. Marital status of Head of Household:

- | | |
|-------------------------------|--|
| 0=Never Married | 3=Separated(married, not living together nor incarcerated) |
| 1=Married and living together | 4=Deceased |
| 2=Divorced | |

o. Highest Grade Completed:

OTHER PRIMARY CARETAKER:

a. Name: _____

b. Relationship: _____

YOUTH ASSESSMENT INDEX ver. 4.0c

SECTION VI: EDUCATION/WORK

Comments on Education/Work:
(Include the question number with your notes)

Name of current or last school attended _____

2. _____

School Address Line 1 _____

School Address Line 2 _____

3. Current School Status:

- | | |
|--|--|
| 1 = Graduated (or GED) | 5 = Enrolled in other educational skill development program |
| 2 = Quit or dropped out | 6 = Enrolled in or transferred from an institutional educational program |
| 3 = Suspended | |
| 4 = Still in School (incl. Summer vacn). | |

4. Current or highest grade completed:

Days

5. Days absent from school during last 6 week period:

6. Have you ever received any special programming?

0=No
1=Yes

7. Number of D's or F's on last report card:

a.) <OPT> Are you currently failing any classes?

0=No
1=Yes

8. Have you ever failed or repeated a grade:

0=No
1=Yes

Times

9. How many times have you been suspended or expelled (include in-school suspensions):

Times

a. Suspended? b. Expelled?

Times

c. Are you currently suspended or expelled

0=No
1=Yes

Days

d. # of days suspended in the last 6 weeks?

0=No
1=Yes

10. Do you plan on graduating (or getting a GED)?

11. Have you ever:

a. skipped school or cut classes more than one time a week?

0=No
1=Month+
2=Past Mo.
3=Past&Bfr

b. <OPT> If yes, have you gotten high when you skip?

0=No
1=Yes

c. had your parents been called by the school because of your behavior?

0=No
1=Month+
2=Past Mo.
3=Past&Bfr

d. Had a serious argument or fight with a teacher?

0=No
1=Month+
2=Past Mo.
3=Past&Bfr

12. What are your current source(s) of income (check all that apply):

Employment Public Assistance Other
 Parents Social Security

<<If working>>

a. Number of hours:

Hours

b. Net Income/week: \$

13. Have you ever been fired from a job?

0=No
1=Yes

14. On average, how many weeks do you stay on a job?

Weeks

15. Do you have any skills or training that could help you get a job? (If yes, specify in comments).

0=No
1=Yes

16. Do you feel that you have a school or work problem?

0=No
1=Yes

17. Would you like counseling for these problems?

0=No
1=Yes

Interviewer Severity Rating:

0=No Need
2=Moderate

1=Minor
3=Urgent

Confidence Rating:

0=No
1=Yes

SECTION VII: DRUG / ALCOHOL

Co-Occurring Conditions Screening Form

REQUIRED FORM:

This form is an optional document in client file

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Client will complete the questionnaire and authorized agency representative will review and score

REQUIRED ELEMENTS:

(Co-occurring conditions screening form, page 1)

- **Client Name:** Complete the client's full name.
- **Program Name:** Complete the program's name.
- **Sections one, two, and three:** Client responds yes or no by checking each question
- **Client Signature:** Complete with client signature.
- **Date:** Complete the date the form is completed.

(Co-occurring conditions scoring form, page 2)

- **Staff scoring page one must follow directions outlined on page two.**
- **Observations/Comments:** Staff documents any observations or makes additional comments.
- **Referral(s) Made:** Document any referral given to client based on this screening.
- **Staff Signature:** Staff scoring the form must sign.
- **Date:** Complete the date the screening was completed.

NOTES:

This form is used as a screening tool for determining appropriateness of client for a program and/or referral for further mental health assessment. This form is not intended to be used as a diagnostic tool.

CO-OCCURRING CONDITIONS SCREENING FORM

Client Name: _____ Program: _____

| SECTION I | YES | NO |
|--|------------|-----------|
| | √ | √ |
| 1. In the past year, have you been diagnosed by a doctor with a mental health condition such as anxiety, depression, bipolar, psychosis, or any other emotional conditions? If yes, specify: | | |
| 2. Are you currently taking any medication(s) for mental health or emotional issues? (i.e., Prozac, Paxil, Zoloft, Wellbutrin, Serzone, Lithium, Klonopin, Trazadone, Xanax, Valium, Risperdal, Zyprexa, Clozapine, Depakote, Neurontin, Mellaril, etc.). List medications you take: | | |
| SECTION II | | |
| 3. In the past year, have you had any serious thoughts, plans, or attempts of suicide, or serious plans to harm others? If yes, explain: | | |
| 4. Have you ever been treated for serious mental health problems? If yes, where (i.e., crisis house, hospital, clinic, etc.)? | | |
| 5. Do you receive SSI or SSDI for mental health or emotional problems? | | |
| 6. Do you have a history of chronic relapses or failed attempts at sobriety? | | |
| SECTION III | | |
| 7. Before you were using any alcohol or drugs, or after you were clean from alcohol and other drugs for 60 days, have you ever: | | |
| A. Felt so depressed that you had difficulty taking care of yourself, going to work or school, or keeping up with family responsibilities? | | |
| B. Felt extreme panic around other people or in public places, or been completely unable to leave the house for a noticeable length of time? | | |
| C. Seen or heard things that other people didn't see or hear, such as seeing shadows or hearing voices telling you what to do? | | |
| D. Felt suspicious of other people, believing that they were following you or spying on you, or talking about you, or were going to harm you? | | |
| E. Believed that someone could control your mind by putting thoughts into or taking thoughts out of your head? | | |
| F. Do things repeatedly in order to keep something bad from happening (i.e., counting, re-checking the door locks, frequent hand-washing, or other rituals)? | | |
| G. Had a period of a week or more when you didn't need to sleep, had constant racing thoughts, or go on spending or sexual binges? | | |
| H. Had unwanted, repeated thoughts or nightmares of a traumatic event that made you feel just as anxious, scared, or numb as when the event happened? | | |

Client Signature: _____ Date: _____

CO-OCCURRING CONDITIONS SCORING FORM

| | |
|---|---------------------|
| <p>DIRECTIONS: For each section, count the number of “yes” answers and put that number by the corresponding score.</p> | |
| <p>SECTION I: GENERAL SIGNS <u>1</u> “yes” to any question in this section plus 1 from another section may indicate a need for referral.</p> <p>A “yes” in this section is not necessarily an automatic referral point, but should be considered in the referral decision process (use your clinical judgment).</p> | <p>SCORE: _____</p> |
| <p>SECTION II: Serious Indicators Of The Need For Further Assessment If <u>1</u> from this section is present, it may mean that referral is important to determine the client’s stability level.</p> <p>If <u>1</u> from this section is combined with any <u>1</u> of Section III, referral is strongly recommended.</p> | <p>SCORE: _____</p> |
| <p>SECTION III: Specific Disorder Indicators If <u>1</u> from this section with no score in any other section, a referral for assessment may be made during the course of treatment for consultation and/or assessment.</p> <p>If <u>2 or more</u> from this section are marked, referral to a dual diagnosis program is recommended, and strongly recommended when combined with a score in Section II.</p> | <p>SCORE: _____</p> |

NOTES:

Section 1, Question #1: If clients states “no” to this question, then ask: Have you ever been diagnosed by a doctor with anxiety, depression, bi-polar, psychosis, or other emotional issues?

Section I, Question #2: If client states they are currently taking no medications for mental health or emotional issues, then ask: Have you ever in your lifetime taken medications for mental health or emotional issues? If yes, what are they and how long did you take each?

Section II, Question #3: If client states that in the past year they have had serious thoughts, plans, or attempts of suicide or serious plans to harm others, then ask how recently and get detailed information.

Section III, Question #7: If client says they have never had a sustained period of sobriety, ask client if they have ever experienced the symptoms listed in A-H.

Observations / Comments: _____

Referral(s) made: _____

Staff Signature: _____ Date: _____

High Risk Assessment (HRA)

REQUIRED FORM:

This form is a required document in client file

WHEN:

This form must be completed within the following timelines:

Outpatient- within 30 days of admission and anytime thereafter as clinically indicated

Long-term residential- (31 days or more) – within 14 days of admission and anytime thereafter as clinically indicated

Short-term residential- (30 days or less) – within 10 days of admission

COMPLETED BY:

Authorized agency representative with client

REQUIRED ELEMENTS:

- **Client Name:** Complete the client's full name.
- **Case Number:** Complete the client's file ID number.
- **Assessment of Immediate Risk Factors:** Document client's responses by checking the boxes marked yes, no, or refuse/cannot assess.
- **Additional Youth Risk Factors:** For adolescent clients, document response by checking the box marked yes, no, or refuses/cannot assess.
- **Protective Factors:** Discuss protective factors with client (examples are listed on the form) and ask the client to identify their own protective factors. Document responses in the space provided.
- **Self-Injury/Suicide/Violence Management Plan:** If client responds yes to any of the Immediate Risk Factors, completion of a Self-Injury/Suicide/Violence Management Plan is required. Staff should document the developed plan in the space provided.
- **Tarasoff Assessment:** Staff checks the corresponding boxes, for yes, no, or refuse/cannot assess, following the prompts indicated on the form.
- **Reported To:** If the Tarasoff assessment is marked yes, complete this field with the law enforcement agency representative to whom the Tarasoff report was given.
- **Current Domestic Violence:** Staff checks the corresponding boxes for yes, no, or refuse/cannot assess, following the prompts indicated on the form.
- **Reported To:** If there is current domestic violence, complete this field with the CPS/APS representative to whom the report was given.

- **Signature of Staff or Clinician Requiring Co-Signature:** Any unlicensed staff administering the HRA sign here and date.
- **Signature of Clinician Completing/Accepting Assessment:** Licensed staff member signs here upon completion of assessment. If unlicensed staff signed above, a licensed staff member must co-sign here.

NOTES:

Self-Injury/Suicide/Violence Management Plan

This is the safety management plan located in the middle of the first page of the HRA. A safety management plan must be completed documenting the **ACTIONS** to be taken.

- If found that there is an **Immediate Risk** and staff is not licensed/licensed eligible, then a consultation with the supervisor must be completed before the client leaves your program.

What to include in the Self-Injury/Suicide/Violence Management Plan:

- Documentation about the consultation
- Referrals made to higher level of care such as a crisis house or psychiatric hospital.
- Referrals to Psychiatric Emergency Response Team (PERT), CPS and/or APS.
- Considerations of higher level of services or additional services such as case management, more frequent sessions, and/or coordination for care with current MH treatment providers.
- Documentation about any emergency contacts made such as calling the client's spouse or parents.
- Linkage to additional resources such as providing client with referrals to 211 of Access & Crisis Line (1888-724-7240).
- If applicable, documentation about changes made to the client's treatment plan.
- The documentation should also include how the use of Protective Factors will be employed by the client

HIGH RISK ASSESSMENT (HRA)

Current Violent Impulses and/or Homicidal ideation toward a reasonably identified victim?

No Yes Refuse/Cannot Assess

Tarasoff Warning Indicated?

No Yes

If yes, include victim(s) name and contact information (Tarasoff Warning Details):

Reported To: _____

Date: _____

CURRENT DOMESTIC VIOLENCE?

No Yes Refuse/Cannot Assess

If yes, detailed documentation and child/adult protective services question mandatory. Describe situation:

Child/Adult Protective Services Notification Indicated?

No Yes

Reported To: _____

Date: _____

Signature of Staff or Clinician Requiring Co-Signature: _____ Date: _____

Signature of Staff or Clinician Completing/Accepting Assessment: _____ Date: _____

High Risk Index (HRI)

REQUIRED FORM:

This form is an optional document in the client file

WHEN:

Completed at assessment or anytime thereafter as clinically indicated. It is strongly encouraged to use this form as a supplemental tool when a client is found to be at high risk.

COMPLETED BY:

Authorized agency representative with client

REQUIRED ELEMENTS:

Client Name: Complete the client's full name

Case Number: Complete the client's file ID number

This form is completed to determine persistent risk level (e.g. mild, moderate, severe) apart from immediate risk indicators: * Indicates a particularly SEVERE RISK FACTOR

- **Demographic and historical factors:** Document the client's response by checking the boxes marked yes, no, or refuse/cannot assess
- **Comments:** Document comments that are pertinent to this section.
- **Trauma exposure and/or major life stress:** Document the client's response by checking the boxes marked yes, no, or refuse/cannot assess
- **Comments:** Document comments that are pertinent to this section.
- **Clinical and/or social history:** Document the client's response by checking the boxes marked yes, no, or refuse/cannot assess
- **Comments:** Document comments that are pertinent to this section.
- **High risk behaviors:** Document the client's response by checking the boxes marked yes, no, or refuse/cannot assess
- **Comments:** Document comments that are pertinent to this section.
- **Protective Factors:** Document the client's response by checking the boxes marked yes, no, or refuse/cannot assess
- **Comments:** Document comments that are pertinent to this section.
- **Persistent risk level based upon comprehensive review of high risk index and protective factors:** Document the appropriate box based on review marked low, medium, or high
- **Comments:** Document comments pertinent to this section.

- **Signature of Staff or Clinician Requiring Co-Signature:** Any unlicensed staff administering the HRI sign here and date.
- **Signature of Clinician Completing/Accepting Assessment:** Licensed staff member signs here upon completion of assessment. If unlicensed staff signed above, a licensed staff member must co-sign here.

HIGH RISK INDEX (HRI)

CLIENT NAME: _____ CASE NUMBER: _____

HIGH RISK INDEX: A guide to determining persistent risk level (e.g. mild, moderate, severe) apart from immediate risk indicators. * Indicates a particularly **SEVERE RISK FACTOR**.

Demographic and historical factors:

- | | | | |
|--|-----------------------------|------------------------------|---|
| High risk demographic factors (age, gender, race, social status) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Sexual orientation or gender identity issues | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Suicide of 1 st degree relative | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Access to firearms or lethal means | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

Comments: _____

Trauma exposure and/or major life stress:

- | | | | |
|---|-----------------------------|------------------------------|---|
| Witness of suicide | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Military/veteran | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Recent (under 1 year) return from combat zone | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Stressful caretaking role | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Law enforcement (past or present employment) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Recent/ongoing victimization –commercial sex exploitation, sexual abuse, incest, physical abuse, domestic violence, bullying, or other assault | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Recent and unresolved major loss (people, employment, shelter, pets) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Catastrophic legal or financial problems - (Recent, within approx. 3 mos.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Release from criminal custody – (Recent, within 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

Comments: _____

Clinical and/or social history:

- | | | | |
|--|-----------------------------|------------------------------|---|
| Discharge from 24 hour program (hospital, IMD, START, residential treatment, etc.) – (Recent, within 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Alcohol/drug residential treatment failure – (Recent, within 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Anniversary of important loss, Date: | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Health deterioration of self or significant others – (Recent, within 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Gravely disabled – (Recent, within approximately 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Current extreme social isolation (real or perceived) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Immigration/refugee issues | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Justice system involvement (past or present) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Current gang exposure or involvement | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Homelessness or imminent risk thereof | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Previous attempts to harm self/others | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Experience in handling firearms | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Documented eating disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Sleeplessness | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Psychomotor agitation | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Panic attacks | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Guilt or worthlessness | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Frequent and/or uncontrollable rage | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Impulse control problem | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Substance abuse relapse – (Recent, within 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Co-occurring mental and substance abuse disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

HIGH RISK INDEX (HRI)

Current abuse or misuse of drugs and other substances No Yes Refuse/Cannot Assess
Significant change in mood – (Recent, within approx. 3 mos.) No Yes Refuse/Cannot Assess

Comments: _____

High risk behaviors:

*Anti-social behavior – (Recent, within approx. 3 mos.) No Yes Refuse/Cannot Assess
Acts of property damage – (Recent, within approx. 3 mos.) No Yes Refuse/Cannot Assess
Risk taking or self-destructive acts No Yes Refuse/Cannot Assess
Documented borderline, anti-social, or other personality disorder No Yes Refuse/Cannot Assess

Comments: _____

PROTECTIVE FACTORS

Strong religious, cultural, or inherent values for prohibition on hurting self/others No Yes Refuse/Cannot Assess
Strong social support system No Yes Refuse/Cannot Assess
Positive planning for future No Yes Refuse/Cannot Assess
Engages in treatment No Yes Refuse/Cannot Assess
Valued care giving role (people or pets) No Yes Refuse/Cannot Assess
Strong attachment/responsibility to others No Yes Refuse/Cannot Assess

Comments: _____

Persistent risk level based upon comprehensive review of high risk index and protective factors:

- Low – no immediate plan required.
- Medium – consider enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. Consult, collaborate and document.
- High – consider enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. Consult, collaborate and document.

Comments: _____

For all unlicensed staff, documentation of a consultation is strongly suggested for Medium and High risk levels identified. For trainees specifically, review with supervisor should occur prior to end of session.

Signature of Staff or Clinician Requiring Co-Signature: _____ Date: _____

Signature of Staff or Clinician Completing/Accepting Assessment: _____ Date: _____

Section 4 Health/Medical

| | |
|------|--|
| F401 | Client 12 - Hours Intensive Observation Log (Detox) |
| F402 | Centrally Stored Medication List (Residential and Detox) |
| F403 | Health Questionnaire |
| F404 | TB Screening Questionnaire and Results |
| F405 | Physical Exam Waiver * |
| F406 | Physician Direction Form * |
| F407 | MD Recommendations/Orders to Client* |
| F408 | Proof of Pregnancy (Perinatal) |
| F409 | Medical Necessity Note * |
| | Additional Medical Documents |

*Medi-Cal providers

Client 12-Hour Intensive Observation Log (Detox)

REQUIRED FORM:

This form is a required document in the client file for detox programs. Providers may use their own version of the 12-hour observation log. In accordance with Alcohol and/or Other Drug Program the observation log must document close observation and physical checks every 30 minutes for the first 12 hours of admission into detox program.

WHEN:

Completed at Intake/Admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Program Name:** Complete name of the program.
- **Client Name:** Complete client's full name.
- **Client ID#:** Complete the client ID number as determined by agency guidelines.
- **Admission Date:** Complete the date client was admitted to program.
- **Admission Time:** Complete the time client was admitted to program.
- **Time:** Start time according to the client's time of admission to program. Every 30 minutes after admission the staff must complete the activity field. The log must be completed for the first 12 hours of client's admission.
- **Client Activity:** Client's activity must be checked every 30 minutes for the first twelve hours in detox and documented (e.g., resting, asleep, withdrawal signs, etc.)
- **Initial:** Staff completing the log must initial each entry.

12 – Hours Intensive Observation Log (DETOX)

Client Name: _____ Client ID #: _____

Admission Date: _____ Admission Time: _____

| Time | Client Activity | Initial | Time | Client Activity | Initial |
|------------|-----------------|---------|------------|-----------------|---------|
| 12:00 a.m. | | | 12 noon | | |
| 12:30 a.m. | | | 12:30 p.m. | | |
| 1:00 a.m. | | | 1:00 p.m. | | |
| 1:30 a.m. | | | 1:30 p.m. | | |
| 2:00 a.m. | | | 2:00 p.m. | | |
| 2:30 a.m. | | | 2:30 p.m. | | |
| 3:00 a.m. | | | 3:00 p.m. | | |
| 3:30 a.m. | | | 3:30 p.m. | | |
| 4:00 a.m. | | | 4:00 p.m. | | |
| 4:30 a.m. | | | 4:30 p.m. | | |
| 5:00 a.m. | | | 5:00 p.m. | | |
| 5:30 a.m. | | | 5:30 p.m. | | |
| 6:00 a.m. | | | 6:00 p.m. | | |
| 6:30 a.m. | | | 6:30 p.m. | | |
| 7:00 a.m. | | | 7:00 p.m. | | |
| 7:30 a.m. | | | 7:30 p.m. | | |
| 8:00 a.m. | | | 8:00 p.m. | | |
| 8:30 a.m. | | | 8:30 p.m. | | |
| 9:00 a.m. | | | 9:00 p.m. | | |
| 9:30 a.m. | | | 9:30 p.m. | | |
| 10:00 a.m. | | | 10:00 p.m. | | |
| 10:30 a.m. | | | 10:30 p.m. | | |
| 11:00 a.m. | | | 11:00 p.m. | | |
| 11:30 a.m. | | | 11:30 p.m. | | |

Centrally Stored Medication and Destruction Record

REQUIRED FORM:

This form is a required document in client file for detox and residential programs

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Completed by authorized agency representative

REQUIRED ELEMENTS:

Centrally Stored Medication Instruction:

- **Resident's Name:** Complete client's full name.
- **Admission Date:** Complete the client's date of admission.
- **Attending Physician:** Complete the name of the client's primary physician.
- **Facility Name:** Complete the name of the program.
- **Facility ID Number:** This number will be provided by your agency.
- **Program Director:** Complete the full name of the program director.
- **Medication Name:** Complete the name of the medication as stated on the medication label.
- **Strength/Quantity:** List the strength and the amount of the medication brought in at the time of admission (e.g., 20mg/30 pills).
- **Instructions/ Control/Custody:** List directions for the administration of the medication as prescribed by the physician.
- **Expiration Date:** Document the medication's expiration date as stated on the medication label.
- **Date Filled:** Document the date prescription was filled as stated on the medication label.
- **Prescribing Physician:** Document the name of the physician prescribing the medication as stated on the medication label.
- **Prescription Number:** Document the prescription number as stated on the medication label.
- **Number of Refills:** Document the number of refills as stated on the medication label.
- **Name of Pharmacy:** Document the name of pharmacy which filled the prescription.

Medication Destruction Record Instruction:

- **Medication Name:** Complete the name of the medication as stated on the medication label.
- **Strength/Quantity:** List the strength and the amount of the medication to be destroyed (e.g., 20mg/30 pills).
- **Date Filled:** Document the date prescription was filled as stated on the medication label.

- **Prescription Number:** Document the prescription number as stated on the medication label.
- **Disposal Date:** Document the actual disposal date of the medication as outlined by the agency's policies and procedures.
- **Name of Pharmacy:** Document the name of pharmacy which filled the prescription.
- **Administrator's Signature:** The administrator of the agency responsible for the disposal of the medications must sign.
- **Witness' Signature:** Staff member other than the administrator witnessing the disposal of the medications must sign.

NOTE:

For additional space, you may duplicate this form.

| | | |
|------------------|------------------|----------------------|
| Resident's Name: | Admission Date: | Attending Physician: |
| Facility Name: | Facility ID No.: | Program Director: |

CENTRALLY STORED MEDICATION INSTRUCTIONS: Licit medications which are permitted by the licensee shall be controlled as specified by the licensee's written goals, objectives and procedures.

| Medication Name | Strength/ Quantity | Instructions Control/Custody | Expiration Date | Date Filled | Prescribing Physician | Prescription Number | No. Refills | Name of Pharmacy |
|-----------------|-----------------------|---------------------------------|--------------------|----------------|--------------------------|------------------------|----------------|---------------------|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

MEDICATION DESTRUCTION RECORD INSTRUCTIONS: Prescription drugs not taken with the resident upon termination of services or otherwise disposed of shall be destroyed in the facility by the Program Director or designated representative and witnessed by one other authorized individual (NON-RESIDENT).

| Medication Name | Strength/ Quantity | Date Filled | Prescription Number | Disposal Date | Name of Pharmacy | Administrator's Signature | Witness' Signature |
|-----------------|-----------------------|----------------|------------------------|------------------|---------------------|---------------------------|--------------------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Health Questionnaire

REQUIRED FORM:

This form is a required document in client file

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Completed by the client and reviewed by authorized agency representative

REQUIRED ELEMENTS:

- **Name:** Complete client's full name.
- **Date of Birth:** Complete client's month/day/year of birth.
- **Date:** Complete date the health questionnaire was completed.
- **Section 1:** Complete questions 1-5 by marking the appropriate yes or no answer. If the answer to a question is "yes", client must give date and details.
- **Section 2:** Complete questions 6-11 by marking the appropriate yes or no answer. If the answer to a question is "yes", client must give date and details.
- **Section 3:** Complete questions 12-29 by marking the appropriate yes or no answer. If the answer to a question is "yes", client must give date and details. Complete question 30 by listing the type of drug including alcohol and route of administration used by the client in the past 7 days. Complete question 31 by listing the type of drug including alcohol and route of administration used in the past year.
- **Signature & Date:** Client must sign and date the form when completed.
- **Scoring Key:** After completion of the form by the client, the staff will refer to the Health Questionnaire Scoring Key in determining an individual's suitability for treatment/recovery services in a non-medical facility.

AUTHORIZATION FOR RELEASE OF PSYCHIATRIC/MEDICAL RECORDS FORM

- **Name:** Complete client's full name.
- **Date of Birth:** Complete client's month/day/year of birth.
- **Release to:** Fill in the program name, address, and program director's name.
- **Authorization:** In this section you must state specifically what information the client is authorizing for release (e.g., treatment records, medical records, treatment plans, medications prescribed.)
- **Purpose:** In this section you must state specifically the purpose of the authorization (e.g., treatment collaboration, disclosure, treatment plan development.)

- **Expiration Date:** In this section you must fill in the date this release will expire.
- **Information Requested:** Mark appropriate box(s) for information requested.
- **Signatures:** Client and Authorized Program Representative must both sign and date the form when it is completed.

NOTE:

Client may modify or revoke this authorization at any time.

CLIENT HEALTH QUESTIONNAIRE

HEALTH QUESTIONNAIRE SCORING KEY

This self-administered questionnaire is designed to provide programs with a set of general guidelines to assist in determining an individual's **suitability for treatment/recovery services in a non-medical facility**. It is intended as a guideline only and should not be substituted for common sense or any other available data which contradicts this questionnaire. When in doubt, always consider the severity of the issue and, above all, the well-being of the client. The potential value of a thorough Health Screening administered by a nurse practitioner or physician should never be underestimated.

The high incidence of illness at time of admission to a program calls for caution and attention to detail. No client can benefit from a program if he or she is too ill to participate fully. Conversely, no program can succeed if its clients are unable to utilize the services offered.

Section 1

A **yes** answer to any of the questions in section 1 indicates the existence of a potentially life threatening condition. You should strongly consider referring the individual to a qualified physician, requesting that they provide you with a medical clearance to participate in a program. Enrollment in the program prior to receiving a medical clearance is at the discretion of the program.

Section 2

A **yes** answer to any of the questions in section 2 indicates the existence of a serious health condition. Although admission into your program may be appropriate, a thorough Health Screening should be scheduled at the time of admission. Continuing participation in the program should be at the discretion of program.

Section 3

A **yes** answer to any of the questions in section 3 does not necessarily indicate the existence of a serious health condition. However, **multiple yes** answers could be cause for concern and indicative of a generally poor health condition. Multiple yes answers in section 3 may warrant a Health Screening. At a minimum information gathered in section 3 should be available to staff in order to better serve the client.

CLIENT HEALTH QUESTIONNAIRE

Name: _____

Date of Birth: _____

Date: _____

This brief questionnaire is about your health. It will assist us in determining your ability to participate in our program. This information is confidential.

Section 1

1. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? If yes, please give details.

No Yes Date: _____ Details: _____

2. Have you ever had a stroke? If yes, please give details.

No Yes Date: _____ Details: _____

3. Have you ever had a head injury that resulted in a period of loss of consciousness? If yes, please give details.

No Yes Date: _____ Details: _____

4. Have you ever had any form of seizures, delirium tremens or convulsions? If yes, please give details.

No Yes Date: _____ Details: _____

5. Have you experienced or suffered any chest pains? If yes, please give details.

No Yes Date: _____ Details: _____

Section 2

6. Have you ever had a heart attack or any problem associated with the heart? If yes, please give details.

No Yes Date: _____ Details: _____

7. Do you take any medications for a heart condition? If yes, please give details.

No Yes Date: _____ Details: _____

8. Have you ever had blood clots in the legs or elsewhere that required medical attention? If yes, please give details.

No Yes Date: _____ Details: _____

9. Have you ever had high-blood pressure or hypertension? If yes, please give details.

No Yes Date: _____ Details: _____

10. Do you have a history of cancer? If yes, please give details.

No Yes Date: _____ Details: _____

11. Do you have a history of any other illness that may require frequent medical attention? If yes, please give details.

No Yes Date: _____ Details: _____

CLIENT HEALTH QUESTIONNAIRE

Section 3

12. Do you have any allergies to medications, foods, animals, chemicals, or any other substance. If yes, please give details.
No Yes Date: _____ Details: _____
13. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? If yes, please give details.
No Yes Date: _____ Details: _____
14. Have you ever been diagnosed with diabetes? If yes, please give details, including insulin, oral medications, or special diet.
No Yes Date: _____ Details: _____
15. Have you ever been diagnosed with any type of hepatitis or other liver illness? If yes, please give details.
No Yes Date: _____ Details: _____
16. Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? If yes, please give details.
No Yes Date: _____ Details: _____
17. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If yes, please give details.
No Yes Date: _____ Details: _____
18. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder. If yes, please give details.
No Yes Date: _____ Details: _____
19. Do you have any of the following; arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If yes, please give details, including any ongoing pain or disabilities.
No Yes Date: _____ Details: _____
20. Please describe any surgeries or hospitalizations due to illness or injury that you have had.
Date: _____
21. When was the last time you saw a physician? What was the purpose of the visit?
Date: _____
22. Do you take any prescription medications including psychiatric medications? If yes, please list type(s) and dosage(s).
No Yes Details: _____
23. Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? If yes, list the medication(s) and how often you take it.
No Yes Details: _____

CLIENT HEALTH QUESTIONNAIRE

24. Do you take over the counter digestive medications such as Tums or Maalox? If yes, list the medication(s) and how often you take it.

No Yes Details: _____

25. Do you wear or need to wear glasses, contact lenses, or hearing aids? If yes, please give details.

No Yes Details: _____

26. When was your last dental exam? Date: _____

27. Are you in need of dental care? If yes, please give details.

No Yes Details: _____

28. Do you wear or need to wear dentures or other dental appliances that may require dental care? If yes, please give details.

No Yes Details: _____

29. Are you pregnant?

No Yes Due Date: _____

30. In the past seven days what types of drugs, including alcohol, have you used?

| Type of Drug | Route of Administration |
|--------------|-------------------------|
| | |
| | |
| | |
| | |

31. In the past year what types of drugs, including alcohol, have you used?

| Type of Drug | Route of Administration |
|--------------|-------------------------|
| | |
| | |
| | |
| | |

I declare that the above information is true and correct to the best of my knowledge:

Client Signature: _____ Today's Date: _____

Reviewing Facility/Program Staff Name:

Reviewing Facility/Program Staff Signature: _____ Date: _____

TB Screening Questionnaire

REQUIRED FORM:

This form is a required document in client file

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **Date of Birth:** Complete client's month/day/year of birth.
- **ID #:** Complete the client ID number as determined by agency guidelines.

The next five questions are to determine possible signs of tuberculosis. The responses to the questions may exclude signs and symptoms related to alcohol or drug use, withdrawal signs, voluntary weight loss, or current diagnosed medical conditions.

- **Are you coughing for more than 3 weeks?** Complete yes or no answer.
- **Have you recently coughed up blood?** Complete yes or no answer.
- **Have you lost more than 5 lbs in the last 2 months?** Complete yes or no answer.
- **Have you had frequent fevers in the last month?** Complete yes or no answer.
- **Have you had unusual sweating, especially at night?** Complete yes or no answer.

The following three questions are to determine client's previous history of TB skin test.

- **Have you ever had a TB skin test?** Complete yes or no answer.
- **What was the result?** The screener should ask for the client's last TB skin test result. Circle the appropriate answer.
- **Do you have proof of your test?** Complete yes or no answer. If yes, the client must provide copy of result.
- **Previous test documentation:** If the client is able to provide proof of either negative or positive TB test result, complete the test date and the size in mm. Retain the copy of the result for program and client records.

Summary: This section applies to action taken by the agency for compliance with TB Control of County of San Diego. Check all applicable actions.

- **Test not known/No previous test done:** Place a checkmark if TB test is not known or no previous test was performed.
- **Test negative (no documentation available):** Place a checkmark if previous test was negative but no documentation is provided.
- **Test negative (documented as done within last 3 months):** Place a checkmark if the test was negative and the client provided copy of the test result. The test result must be within the last 3 months.
- **Test positive history (No documentation):** Place a checkmark if client reported positive test result and no documentation was provided.
- **Test positive history (documented; date and size recorded above):** Place a checkmark if client reported positive test result and provided with documentation. If client presents documented proof of a “normal” X-ray done within the last 3 months, record date in box titled Chest X-ray date.
- ***TB SUSPECT* (cough with one or more TB symptoms):** Contact TB control at 619-692-5565 to arrange immediate evaluation.
- **Staff completing this form:** The staff completing this form is required to sign and date this form.

NOTES:

This is a required form for all San Diego County funded alcohol and drug programs.

Physical Exam Waiver

REQUIRED FORM:

This form is a required document in client file for Medi-Cal providers only

WHEN:

This form must be completed within 30 days of client's admission

COMPLETED BY:

Medical Director

REQUIRED ELEMENTS:

- **From:** Medical Director reviewing the client's Health Questionnaire, medical and substance abuse history, and/or most recent physical examination will complete his/her full name.
- **Client's Name:** Complete client's full name.
- **Medical Director's Signature and Date:** Medical Director reviewing client file must sign and date, affirming that physical examination for this client has been waived and client may participate in the program.

NOTES:

If Physical Exam Waiver is missing from client's file, all Medi-Cal billings submitted after the date due (30 days from admission date) will be disallowed.

Physical Exam Waiver

FROM: _____
Medical Director

Client's Name: _____

Based upon review of the client's Health Questionnaire, medical history, substance abuse history, and/or most recent physical examination, I am waiving the physical examination for this client and they may participate in the program.

Medical Director's Signature

Date

Physician Direction Form

REQUIRED FORM:

This form is a required document in client file for Medi-Cal providers only

WHEN:

This form must be completed within thirty days of client's admission

COMPLETED BY:

Medical Director

REQUIRED ELEMENTS:

- **Client's Name:** Complete client's full name.
- **Client ID#:** Complete the client ID number as determined by agency guidelines.

The selection of next three directives is determined by Medical Director based on review of client's Health Questionnaire, medical, and drug history.

- **#1:** Medical Director will check this box when client is ordered further tests and/or examinations **to screen for infectious or communicable disease**. Space is provided for Medical Director to list types of tests and/or examinations. Client may not participate in program while the tests are being completed or until physical examination has been waived by Medical Director. Results must be returned to Medical Director.
- **#2:** Medical Director will check this box when client should have the listed tests and/or examinations in the space available **to rule out infectious or communicable disease**. Results may be returned to Medical Director for further review and input into treatment plan.
- **#3:** Medical Director will check this box when client is referred for listed tests and/or examinations for client's own information.

Medical Director Follow-Up

This section does not need to be completed by Medical Doctor unless box #1 is checked and file has been returned to Medical Director for review of results. If the results are acceptable by Medical Director, the client may be cleared to participate in program.

- **#1:** Medical Director will check this box if client is permitted to participate in program.
- **Medical Director's Signature and Date:** Medical Director reviewing client's file must sign and date.

PHYSICIAN DIRECTION FORM

Based on my review of the client’s Health Questionnaire, medical, and drug history the following client:

Client Name _____ Client ID# _____

1. **Must** have the following tests and/or examinations to screen for infectious or communicable disease: _____
I do not waive the physical examination at this time. After my orders are completed, the results **must** be returned to me for review. The client **may not** participate in the program while the tests are being completed or until I have waived the physical examination.

2. **Should** have the following tests and/or examinations to rule out infectious or communicable disease and provide further information for treatment planning purposes: _____

The results may be returned to me for review and further input into treatment planning.

3. **May be** referred for the following tests and/or examinations for his/her own information and health promotion: _____

Medical Director’s Signature

Date

MEDICAL DIRECTOR FOLLOW-UP

Based on my follow-up review of the results of the above tests and/or examinations, the client:

1. **May** participate in the program.

Medical Director’s Signature

Date

HIV testing, other than court ordered testing, cannot be mandated.

MD Recommendations- Orders to Client*

This is not a standardized form. If your agency is currently using this form, place it in this section.

***Medi-Cal Providers Only**

Proof of Pregnancy (Perinatal)

REQUIRED FORM

This is a required document ONLY for clients participating in DMC certified programs

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Provided by the client

REQUIRED ELEMENTS:

- Proof of pregnancy must have verification by client's medical provider.

Proof of Pregnancy (DMC Certified Programs)

This is not a standardized form. Place current proof of pregnancy documentation provided by client in this section.

Medical Necessity Note

REQUIRED FORM:

This form is required in client file for Medi-Cal providers only

WHEN:

Completed within thirty days of admission

COMPLETED BY:

Authorized agency representative and reviewed and established by Medical Director

REQUIRED ELEMENTS:

- **Client Name:** Complete with client's full name.
- **Client ID#:** Complete the client ID number as determined by agency guidelines.
- **Primary Counselor:** Complete name of client's primary counselor.
- **Date:** Complete date medical necessity was documented.
- **Activity Code:** Complete appropriate activity code (e.g. 2-Individual Counseling-Intake, 3-Individual Counseling-Planning, 4-Crisis Intervention).
- **Medical Necessity Documentation:** Establish and document client's medical necessity from criteria in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) or newest published version.
- **Diagnosis Code(s) and Name (s):** Document DSM-IV code including name (DSM-IV criteria for Substance Abuse or Substance Dependence and Perinatal/EPSTDT eligibility.)
- **Date:** Complete date diagnosis and name was documented.
- **Counselor Signature:** Complete name of counselor who developed diagnosis and name according to the criteria.
- **Medical Director Date and Signature :** Medical Director will date and signed.

NOTES:

Must be reviewed by QAR for an initial, stay, extension, and discharge.

Section 5 Planning

| | |
|------|-------------------------------|
| F501 | Recovery/Treatment Plan |
| | Additional Planning Documents |

Recovery/Treatment Plan

REQUIRED FORM:

Based on State (ADP) guidelines, a client file must include a treatment plan or a recovery plan. The Recovery/Treatment Plan is a required document in client file. This form may be used as treatment plan or recovery plan.

WHEN:

This form must be completed in accordance with the timeframe specified below:

- For outpatient programs, within 30 days from the client's admission date
- For long-term residential programs (31 days or more), within 14 days from the date of admission
- For short-term residential programs (30 days or less), within 10 days from the date of admission

COMPLETED BY:

Developed by primary counselor or agency representative with client, based on client's initial intake and assessment

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **Primary Counselor:** Complete primary counselor name.
- **Client ID#:** Complete the client ID number determined by agency guidelines.
- **Admission Date:** Complete date client was admitted to program.
- **Problem:** Complete statement of problem(s) experienced by the client to be addressed.
- **Goal:** Complete statement of goal(s) to be reached that address each problem.
- **Short-Term/Long-Term:** A treatment plan must include short-term and long-term goals. The length of the term is determined by the modality of the agency.
- **Action Plan:** Complete action steps that will be taken by program and/or client to accomplish the identified goal and objectives.
- **Responsible (C=Client / P= Program)** - Complete the responsible party by specifying 'C' for client and/or 'P' for program for action step.
- **Target Dates:** Complete target date(s) for accomplishment of each action step and/or goal.
- **Resolution Date:** Complete with actual date of accomplishment of each action step and/or goal.
- **Client Signature and Date:** Client is required to sign and date each treatment plan when developed.
- **Counselor Signature and Date:** Counselor or authorized agency representative is required to sign and date when developed.
- **Chemical Dependency and Significant Associated Diagnosis and Code(s):** Document DSM IV (or most current DSM) code including name for chemical dependency and any other significant associated diagnosis.
- **M.D. Review Signature and Date (Required for Medi-Cal billing):** Medical Director must sign and date within 15 days of counselor's signature to verify the review of treatment plan.
- **Program Manager Signature and Date:** Program Manager may sign and date verifying review of treatment plan.

Recovery/Treatment Plan

Client Name: _____

Primary Counselor: _____

Client ID# _____

Admission Date: _____

| PROBLEM | GOAL | S=Short Term L=Long Term | ACTION PLAN | RESPONSIBLE C=Client P=Program | TARGET DATE | RESOLUTION DATE |
|---------|------|-----------------------------|-------------|--------------------------------------|-------------|-----------------|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |

Client Signature: _____ Date: _____ Counselor Signature: _____ Date: _____

Chemical dependency & significant associated diagnosis codes: _____

M.D. REVIEW SIGNATURE (Required for Medi-Cal billing): _____ Date: _____
(within 15 days of Counselor's signature & date)

Program Manager Signature: _____ Date: _____

Section 6 Progress Notes

F601a,b

Progress Notes

Progress Notes

REQUIRED FORM:

This form is a required document in the client file to document progress toward achieving the client's recovery or treatment plan goals.

WHEN:

This form must be completed within the following guidelines (State ADP):

- Outpatient programs shall document each client's progress for each individual or group session attended.
- Residential programs shall document each client's progress on a weekly basis.

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **Counselor Name:** Complete primary counselor's name.
- **Client ID:** Complete the client ID number as determined by agency guidelines.
- **Week of:** Complete the beginning date **through** the ending date of the service week (optional)
- **Date:** Complete date of the service.
- **Time:** Complete beginning and ending time of the service.
- **Minutes:** Complete service minutes elapsed.
- **Problem Area:** Address problem areas from Recovery/Treatment plan.
- **Activity Code:** Complete activity code consistent with the service provided from the list of activity codes from the bottom of page.
- **Progress Notes:** A complete progress note addresses:
 1. Client's problem towards one or more goals in the client's recovery or treatment or plan
 2. New issues or problems that affect the client's recovery or treatment plan
 3. Types of supports provided by the program or other appropriate health care providers
 4. All entries must be signed by staff completing the progress note.

NOTES:

Two progress note samples are provided. Agencies may select either form based on their own policies and procedures. If agencies choose to use their own form, all required elements must be included.

Section 7 Discharge

| | |
|------|--------------------------------|
| F701 | Discharge Summary |
| F702 | 10-Day Letter to Client* |
| F703 | CalOMS Discharge |
| F704 | Client Discharge Questionnaire |
| | Additional Discharge Documents |

*Medi-Cal providers

Discharge Summary

REQUIRED FORM:

This form is a required document in client file

WHEN:

Completed within 30 days from date of client discharge

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **ID #:** Complete the client's ID number as determined by agency guidelines.
- **Admission Date:** Complete client's date of admission to program.
- **Date of Last Contact:** This is the date of the client's last treatment visit and his/her SanWITS discharge date.
- **Date Discharge Summary Completed:** This is the date the authorized agency representative completed the discharge summary. Must be within 30 days of last face-to-face treatment contact with client.
- **Narrative (1):** Summarize client's presenting problems, treatment provided, and outcome. Must include current drug use, legal status/criminal activity, vocational/educational achievements, living situation, and referrals. If a component is not applicable, list and state "not applicable".
- **Prognosis (2):** Mark the appropriate box for client's prognosis (good, fair, poor) and explain.
- **Discharge Plan (3):** Summarize the client's discharge plan including recommendations, transfers, and referrals.
- **Reasons for Discharge (4):** Mark the appropriate box for client's reason for discharge. This must match the client's SanWITS reason for discharge.
- **Involuntary Discharge:** Mark the appropriate yes/no, or not applicable box if client was advised of their Title 22 Fair Hearing Rights.
- **Client Comments:** Use this space to document any client comments at discharge.
- **Counselor Signature:** Counselor completing the discharge summary must sign and date.
- **Client Signature:** Client must sign and date the discharge summary. If client is not available for signature, the "not available" box must be marked.

DISCHARGE SUMMARY

CLIENT NAME: _____ **ID#:** _____

- A. Admission Date: _____
- B. Date of last contact (*last treatment visit & SanWITS discharge date*): _____
- C. Date discharge summary completed (signed by counselor): _____
(Must be within 30 days of last face-to-face treatment contact with client)

1. NARRATIVE SUMMARY OF TREATMENT EPISODE (*Summarize Presenting Problems, treatment provided and outcome*).
The summary MUST include:

| Current Drug Use | Legal Status/Criminal Activity | Vocational/Educational Achievements | Living Situation | Referrals |
|------------------|--------------------------------|-------------------------------------|------------------|-----------|
|------------------|--------------------------------|-------------------------------------|------------------|-----------|

All 5 components must be addressed, or D/C is Deficient. If a component is Not Applicable, list it and state "not applicable"

2. PROGNOSIS: Good Fair Poor Explain:

3. DISCHARGE PLAN (including recommendations, transfers and referrals):

4. REASONS FOR DISCHARGE (*check appropriate discharge status*):
- 1. Completed Treatment/Recovery Plan Goals/Referred/Standard
 - 2. Completed Treatment/Recovery Plan Goals/Not Referred/Standard
 - 3. Left Before Completion w/Satisfactory Progress/Standard
 - 4. Left Before Completion w/Satisfactory Progress/Administrative
 - 5. Left Before Completion w/Unsatisfactory Progress/Standard
 - 6. Left Before Completion w/Unsatisfactory Progress/Administrative
 - 7. Death
 - 8. Incarceration

If discharge was involuntary, was client advised of their Title 22 Fair Hearing Rights?

Check one: Yes No Not applicable (Title 22, CCR, Section 51341.1 [p])

Client comments:

Counselor Signature

Date

Client Signature Not available

Date

10-Day Letter to Client Form

REQUIRED FORM:

This form is a required form in client file for Medi-Cal providers only

WHEN:

This form is completed 10 days before possible discharge

COMPLETED BY:

Authorized agency representative and client

REQUIRED ELEMENTS:

- **Date:** Complete the date when the form is completed.
- **Client's Name:** Complete client's full name.
- **Reason for possible discharge:** Document the reason for client's possible discharge from the program.
- **Printed Staff Name:** The staff completing this form will print their name.
- **Staff Signature:** The staff completing this form will sign.

NOTES:

This form must be completed and given or mailed to client ten days before discharging them from the program to allow them with sufficient time to appeal the decision (discharge), if they choose.

10-Day Letter to Client

Date: _____

To: _____

RE: NOTICE OF DISCHARGE

This is to inform you that you will be discharged from our program unless you contact us within ten (10) days.

The reason for this possible discharge is: _____

According to Title 22, Section 50953, you have a right to a fair hearing to appeal this action. You may request such a fair hearing by sending a written request to:

State Hearings Division
Department of Social Services
P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430
Oral Requests: 800-952-5253 / TDD: 800-952-8349

You have the right to continue treatment services pending a fair hearing decision, if you request an appeal in writing within ten (10) days of the mailing of this discharge notice.

We look forward to hearing from you!

Printed Staff Name: _____

Staff Signature: _____

CalOMS Discharge Form

REQUIRED FORM:

This form is a required document in client file

WHEN:

This form will be completed at client discharge

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- For instructions on each specific field, refer to CalOMS Data Collection Guide/CalOMS Treatment Data Dictionary.

NOTES:

AOD treatment providers must schedule and conduct a discharge interview with every client. A discharge interview is either in person (face-to-face) or via telephone. This interview includes, but is not limited to, asking each of the required CalOMS Tx standard discharge questions and documenting the responses. Providers should make every effort to ensure the discharge interview is a face-to-face interview. However, some clients may be unable to appear for the scheduled discharge interview, despite having made satisfactory progress in treatment. In these situations, providers are strongly encouraged to contact the client by phone to collect the CalOMS Tx standard discharge data. Administrative discharges should only be reported in the event the client cannot be located, either in person or by telephone, to answer the CalOMS Tx questions. Such attempts to contact a client for a CalOMS Tx discharge interview must be documented in the client's file. Providers should never guess or complete responses on behalf of an absent client for the required CalOMS Tx discharge questions.

CalOMS Discharge

| |
|------------------------|
| FSN _____ |
| Name: _____ |
| Data Entry Date: _____ |
| Data Entry Int. _____ |

Client Name |

Client ID

Use the following codes for answers:

Not Applicable = NA Declined to State = DS Unknown or Don't Know = UNK
Unable to Answer = UA (*allowed only if type of service is Detox or disability includes developmentally disabled*)
The answers above are only allowed for questions marked with a corresponding symbol:
* = NA + = DS ∞ = UNK ^ = UA

Discharge Profile

| | |
|----------------------------------|--|
| Admission Date | <input type="text"/> / <input type="text"/> / <input type="text"/> |
| | mm dd yyyy |
| Discharge Date | <input type="text"/> / <input type="text"/> / <input type="text"/> |
| | mm dd yyyy |
| Discharge Status (enter code) | <input type="text"/> |

- Discharge Codes:
- 1 = Completed Treatment/Recovery Plan Goals/Referred/Standard
 - 2 = Completed Treatment/Recovery Plan Goals/Not Referred/Standard
 - 3 = Left Before Completion with Satisfactory Progress/Standard
 - 4 = Left Before Completion with Satisfactory Progress/Administrative
 - 5 = Left Before Completion with Unsatisfactory Progress/Standard
 - 6 = Left Before Completion with Unsatisfactory Progress/Administrative
 - 7 = Death
 - 8 = Incarceration

Ancillary Services Referral – circle appropriate selections

- 1-Education/Literarcy
- 2-Mental Health
- 3-Medical
- 4-Vocational
- 5-Family Counseling
- 6-Sober Living
- 7-Other
- 0-None/No Other

Highlighted fields are required.

* = NA + = DS ∞ = UNK ^ = UA (UA allowed only if type of service is Detox or disability includes developmentally disabled)

Alcohol and Drug Use (Complete for Status as of Discharge)

Primary Drug

| | |
|--------------------------------|--|
| Drug Type | |
| If Other, Specify Name | |
| # of Days Used in Past 30 Days | |
| Route of Administration | |

Secondary Drug

| | |
|--------------------------------|--|
| Drug Type | |
| If Other, Specify | |
| # of Days Used in Past 30 Days | |
| Route of Administration | |

Tertiary Drug

| | |
|--------------------------------|--|
| Drug Type | |
| If Other, Specify | |
| # of Days Used in Past 30 Days | |
| Route of Administration | |

Drug Type Codes (must specify name if *):

- 0 = None
- 1 = Heroin
- 2 = Alcohol
- 3 = Barbiturates*
- 4 = Other Sedatives or Hypnotics*
- 5 = Methamphetamine
- 6 = Other Amphetamines*
- 7 = Other Stimulants*
- 8 = Cocaine/Crack
- 9 = Marijuana/Hashish
- 10 = PCP
- 11 = Other Hallucinogens*
- 12 = Tranquilizers (e.g. Benzodiazepine)*
- 13 = Other Tranquilizers*
- 14 = Non-Prescription Methadone
- 15 = OxyCodone/OxyContin
- 16 = Other Opiates or Synthetics*
- 17 = Inhalants*
- 18 = Over-the-Counter*
- 19 = Ecstasy
- 20 = Other Club Drugs*
- 99901 = Unknown
- 99903 = Other*

Route of Administration

- 1 = Oral
- 2 = Smoking
- 3 = Inhalation
- 4 = Injection (IV or intramuscular)
- 99902 None or not applicable
- 99903 Other

of Days Used Alcohol in Past 30 Days
If primary or secondary drug is Alcohol, must answer NA

of Days Used IV in Past 30 Days

Family/Social (Complete for Status as of Discharge)

| | | | | | | |
|--|--|--|--|--|--|--|
| # of Days Social Support Recovery Activities in Past 30 Days | | | ^ Number of Children Under 18 | | | |
| Current Living Arrangements 1 = Homeless 2 = Dependent Living 3 = Independent Living | | | ^ Number of Children Age 5 or Less | | | |
| +^ # of Days Living w/ Alcohol or Drug User in Past 30 Days | | | ^ Number of Children Living w/ Someone Else because of a Child Protection Court Order | | | |
| +^ # of Days Serious Family Conflict in Past 30 Days | | | ^ Number of Children Living w/ Someone Else for whom Parental Rights have been Terminated | | | |
| | | | Current Zip Code Must be "00000" if homeless, "XXXXX" if declines to state, or "ZZZZZ" if unable to answer. | | | |

Highlighted fields are required.

* = NA + = DS ∞ = UNK ^ = UA (UA allowed only if type of service is Detox or disability includes developmentally disabled)

Employment (Complete for Status as of Discharge)

| | | |
|---|----------------------|----------------------|
| Employment Status (enter code) | <input type="text"/> | |
| +^ Number of Paid Work Days in Past 30 Days | <input type="text"/> | <input type="text"/> |
| +^ Enrolled in School | Circle: Y / N | |
| +^ Enrolled in Job Training | Circle: Y / N | |
| Graduated from High School | Circle: Y / N | |

Employment Status

1 = FT (35 hrs or more)
 2 = PT (less than 35 hrs)
 3 = Unemployed, looking for work
 4 = Unemployed, not in the labor force (not seeking)
 5 = Not in the labor force (not seeking)

Criminal Justice (Complete for Status as of Discharge)

| | | |
|------------------------------------|----------------------|----------------------|
| # of Arrests in Last 30 Days | <input type="text"/> | <input type="text"/> |
| ^ # of Jail Days in Last 30 days | <input type="text"/> | <input type="text"/> |
| ^ # of Prison Days in Last 30 days | <input type="text"/> | <input type="text"/> |
| # of Arrests in Last 6 Months | <input type="text"/> | <input type="text"/> |

Medical/Physical/Mental Health (Complete for Status as of Discharge)

Medical/Physical Health

| | |
|---|------------------------|
| ^ Number of Times in ER in Past 30 Days | <input type="text"/> |
| ^ Number of Hospital Overnights in Past 30 Days | <input type="text"/> |
| ^ Number of Days Medical Problems in Past 30 Days | <input type="text"/> |
| +^ HIV Tested | Circle: Y / N |
| +^ HIV Test Results Received | Circle: Y / N |
| ∞ Pregnant at any time during Treatment | Circle: Y / N |
| Outcome of Pregnancy | Circle: T M D N |

Outcome of Pregnancy
 T = Terminated
 M = Miscarried
 D = Drug Free Birth
 N = Not Drug Free Birth

Mental Health

| | |
|---|----------------------|
| ∞ Mental Illness Diagnosed | Circle: Y / N |
| ^ Number of Times Outpatient ER MH Services in Past 30 Days | <input type="text"/> |
| ^ Number of Days of Psychiatric Facility Stay of more than 24 Hrs in Past 30 Days | <input type="text"/> |
| ^ Mental Health Medication in Past 30 Days | Circle: Y / N |

Highlighted fields are required.

Client Discharge Questionnaire

REQUIRED FORM:

Program shall develop a discharge plan with client at least thirty (30) days prior to anticipated discharge date. Plan shall detail how support will be provided to the client in recovery after completing program.

WHEN:

This form must be completed in accordance with the timeframe specified below:

- For outpatient programs, at least 30 days prior to client's anticipated discharge date
- For long-term residential programs (31 days or more), at least 30 days prior to client's anticipated discharge date
- For short-term residential programs (30 days or less), as early as the first week from the admission date
- For detox participants, the time to complete a discharge plan will be determined by the agency as to the readiness of the participant before the client is discharged.

COMPLETED BY:

Developed with client and reviewed by counselor or agency representative

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **Planned Discharge Date:** Client completes the anticipated discharge date.
- **Questionnaire:** Client completes questions in all sections.
- **Client's Signature and Date:** Client must sign and date after completion of the form.
- **Counselor's Signature and Date:** The counselor must sign and date after reviewing the completed form.

NOTES:

A sample Client Discharge Questionnaire is provided. Agencies may select to use this form or a form based on their own policies and procedures. If agencies use their own form, all required elements must be included.

Client Discharge Questionnaire

Client Name: _____

Planned Discharge Date: _____

In the space below, please answer the following questions regarding your ongoing recovery plans after you are discharged. Describe your plan including who, what, where, and when. Be as precise as you can in the spaces provided.

Recovery Program

Why do you need a discharge plan? _____

Describe your support system: (People I can call who I trust and speak with honestly) _____

Do you have a sponsor? Yes No If yes, please explain how you work together and what step you are working. If no, what are your plans about obtaining a sponsor? _____

What support meetings will you attend? Include specific meetings (i.e. 12-step, home group, faith based etc.). How often will you attend, and how will you get there?

What recovery tools have you learned that you are taking with you? _____

Food and Housing

Where will you be living and who will you live with? Is this a safe, comfortable, clean and sober environment?

What are your arrangements for having healthy nutritious food? _____

Physical and Mental Health

How will you support your physical health (Specify arrangements made with your doctors, dentists, clinics, hospitals to treat any medical concerns? Also include how you will stay healthy with exercise, diet, etc.)

Where will you continue aftercare, counseling, mental health services (Include name of program, type of counseling or therapy, counselor or therapist name, days and times you will attend)?

Financial/Employment/Education

What will you do for financial support (Employment, job searching, or other methods of supporting yourself)?

What will you do to continue your education or improve your job skills (Are you in vocational training, school, etc.)? _____

What will you do for child care if you have children? _____

Legal

Do you have any legal issues or concerns? If so, what is your plan to address them (Are you on probation, parole, CWS, etc., and how will you remain in compliance)? _____

Social life and Use of Leisure Time

How would you manage your free time to avoid boredom? What social activities will you plan with family or other support people with whom you feel comfortable to share enjoyable and relaxing activities?

Client Signature: _____

Date: _____

Counselor Signature: _____

Date: _____

Section 8 Drug Test Results/Reports

| | |
|------|-------------------------------|
| F801 | Drug Test & Results Log |
| F802 | Drug Test Results From Lab |
| F803 | Progress Reports |
| F804 | Case Management Notes & Plans |
| F805 | Referral Source Documents |
| | Additional Correspondence |
| | Additional Forms |

Drug Test and Results Log

REQUIRED FORM:

This form is an optional document in client file

WHEN:

This log will be completed each time alcohol or drug testing is initiated and will be used throughout the client's treatment period

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Client Name:** Complete the client's full name.
- **Client ID #:** Complete the client's ID number as determined by agency guidelines.
- **Date Tested:** Complete the date the specimen was collected.
- **Chain of Custody #:** Complete chain of custody number from the laboratory paperwork. If no paperwork from the laboratory is used, complete by stating N/A, not applicable.
- **Reason for Test:** Complete the reason for testing (e.g., baseline, random, suspicious behavior, etc.).
- **Type of Test:** Complete the type of test used (e.g., urine analysis, breathalyzer, alcohol testing swab).
- **Date Test Results Received:** Complete the date the test results were received.
- **Test Results:** Complete the result of testing (e.g., positive, negative, diluted, etc.).

NOTES:

Authorized agency staff must complete the log as soon as the client is informed of testing by filling in the date, chain of custody number (if applicable), reason for testing, and type of test. If the client failed to provide a sample or refused to test it needs to be reflected in the result column. If the test was successfully conducted, the result must be logged in when received.

Drug Test Results From Lab

This section is optional. If your agency is currently using this form, place it in this section.

Progress Reports

This is not a standardized form. Letters reporting client's progress to outside sources will be placed in this section.

Case Management Notes & Plans

This is not a standardized form. Client's case management notes, plans, referrals, and ongoing utilization of other resources will be placed in this section.

Referral Source Documents

This is not a standardized form. All documents to and from the referral source will be placed in this section.