

Uniform Record Manual
For Alcohol and Drug Treatment
Providers
(June 2014)

CLIENT FILE ORDER

Form #	Section 1: Intake/Financial
101	DMC Tracking Form*
101a	Non-MC Tracking Form
102a,b	QAR Review Worksheets*
103	DMC Eligibility Printout*
104	Initial Screening/Intake Form
104a	Minor Children Information
105	Client Fee Collection Form
106	Copy of ID/Social Security Card
107	Copy of Medi-Cal Card*
108	Financial Responsibility & Info
109	CalOMS Admission
110	CalOMS Annual Update
	Additional Intake/Financial

Form #	Section 4: Health/Medical
401	Client 12-Hours Intensive Observation Log (Detox)
402	Centrally Stored Medication List (Residential and Detox)
403	Health Questionnaire
404	TB Screening Questionnaire and Results
405	Physical Exam Waiver*
406	Physician Direction Form*
407	MD Recommendations/Orders to Client*
408	Proof of Pregnancy (Perinatal)
409	Medical Necessity Note*
	Additional Medical Documents

Form #	Section 2: Consents
201	Consent to Release Information
202	Admissions Agreement/Consent for Treatment
203	Client Personal Rights
204	Title 22 Fair Hearing Rights*
205	Notice of Privacy Practices/HIPAA
206	Consent to Follow Up
207	Consent for Photo, TV, Video
208	Coordination of Care Consent
	Additional Policies and Consents

Form #	Section 5: Planning
501	Recovery/Treatment Plan
	Additional Planning Documents

Form #	Section 6: Progress Notes
601a,b	Progress Notes

Form #	Section 3: Assessments
301	Stay Review Justification*
302	Alcohol/Drug History
303	ASI/YAI
304	Co-Occurring Conditions Screening
305a,b	High Risk Assessment & Index(BHS)
	Additional Assessments

Form #	Section 7: Discharge
701	Discharge Summary
702	10-Day Letter to Client*
703	CalOMS Discharge
704	Client Discharge Questionnaire
	Additional Discharge Documents

Form #	Section 8: Drug Test Results/Reports
801	Drug Test & Results Log
802	Drug Test Results from Lab
803	Progress Reports
804	Case Management Notes & Plans
805	Referral Source Documents
	Additional Correspondence
	Additional Forms

***Medi-Cal Providers Only**

Section 1 Intake/Financial

F101	DMC Tracking Form *
F101a	Non-Drug Medi-Cal Clients Tracking Form
F102a,b	QAR Review Worksheets *
F103	DMC Eligibility Printout *
F104	Initial Screening/Intake Form
F104a	Minor Children Information Form
F105	Client Fee Collection Form
F106	Copy of ID/Social Security Card
F107	Copy of Medi-Cal Card*
F108	Financial Responsibility & Information Form
F109	CalOMS Admission
F110	CalOMS Annual Update
	Additional Intake/Financial

*Medi-Cal providers

DMC Client Tracking Form

REQUIRED FORM:

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

WHEN:

At client's first DMC billable service and every billable visit thereafter

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **ODF/DCH:** Check appropriate box for Outpatient Drug Free (ODF) or Day Care Habilitative (DCH).
- **Client Name:** Complete with client's full name.
- **Client ID#:** Complete the client ID number as determined by agency guidelines.
- **Admit Date:** Complete the date of admission.
- **Date D/MC Billing Began:** Complete the date of client's first face-to-face billable service.
- **M/C (BIC#):** Complete client's Medi-Cal, Benefit Identification Card (BIC) number.
- **Birth Date:** Complete client's month/day/year of birth.
- **DSM-IV Dx Code:** Complete client's substance abuse diagnostic code extracted from DSM-IV.
- **Gender:** Complete with appropriate answer.
- **Race:** Complete with appropriate answer.
- **Tracking Chart:**
 - (1) **Service Date:** Complete each date of client's DMC billable services.
 - (2) **Service Type & Counselor (CO):** Complete the type of service client received from County billing activity codes. (e.g., Code 2-Individual Counseling/Intake, Code 3-Individual Counseling/Planning, Code 4-Individual Counseling/Crisis/Intervention, Code 6-Group Counseling, Code 19-Day Treatment.)
 - (3) **Date Billed:** Complete the date Medi-Cal billing was submitted to the County.
- **Review Date:** The date tracking form is reviewed at Quality Assurance Review (QAR).
- **QA Reviewer Signature:** QAR representative must sign after reviewing tracking form.
- **QAR Determination:** QAR representative must select and check the appropriate box according to the review determination.
- **Upcoming Review Dates:** QAR representative must check the box for "no more review dates" or select upcoming review dates.

NOTES:

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

D/MC CLIENT TRACKING FORM

ODF DCH

Client Name: _____

Client ID#: _____

Admit Date: _____

Date D/MC Billing Began: _____

M/C (BIC#): _____ Birth date _____

DSM IV Dx Code _____

Gender: _____ Race: _____

Service Date	Service Type & CO	Date Billed	Service Date	Service Type & CO	Date Billed	Service Date	Service Type & CO	Date Billed
1.			21.			41.		
2.			22.			42.		
3.			23.			43.		
4.			24.			44.		
5.			25.			45.		
6.			26.			46.		
7.			27.			47.		
8.			28.			48.		
9.			29.			49.		
10.			30.			50.		
11.			31.			51.		
12.			32.			52.		
13.			33.			53.		
14.			34.			54.		
15.			35.			55.		
16.			36.			56.		
17.			37.			57.		
18.			38.			58.		
19.			39.			59.		
20.			40.			60.		

<p>Review Date: _____</p> <hr style="border: 0.5px solid black;"/> <p>QA Reviewer Signature</p>	<table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><u>QAR Determination</u></p> <p><input type="checkbox"/> Client file in full compliance</p> <p><input type="checkbox"/> Corrective Action Required</p> <p><input type="checkbox"/> Approved Discharge</p> <p><input type="checkbox"/> Please note denials were noted on QAR Worksheet</p> </td> <td style="width: 50%; vertical-align: top;"> <p><u>Upcoming Review Dates</u></p> <p>No more Review Dates <input type="checkbox"/></p> <p>Extension Review due by: _____</p> <p>Stay Review due by: _____</p> </td> </tr> </table>	<p><u>QAR Determination</u></p> <p><input type="checkbox"/> Client file in full compliance</p> <p><input type="checkbox"/> Corrective Action Required</p> <p><input type="checkbox"/> Approved Discharge</p> <p><input type="checkbox"/> Please note denials were noted on QAR Worksheet</p>	<p><u>Upcoming Review Dates</u></p> <p>No more Review Dates <input type="checkbox"/></p> <p>Extension Review due by: _____</p> <p>Stay Review due by: _____</p>
<p><u>QAR Determination</u></p> <p><input type="checkbox"/> Client file in full compliance</p> <p><input type="checkbox"/> Corrective Action Required</p> <p><input type="checkbox"/> Approved Discharge</p> <p><input type="checkbox"/> Please note denials were noted on QAR Worksheet</p>	<p><u>Upcoming Review Dates</u></p> <p>No more Review Dates <input type="checkbox"/></p> <p>Extension Review due by: _____</p> <p>Stay Review due by: _____</p>		

Non Medi-Cal Tracking Form

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

QAR Review Worksheet

INITIAL REVIEW

REQUIRED FORM:

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

WHEN:

All Medi-Cal client files will be reviewed at QAR (Quality Assessment Review). These Medi-Cal client files will be taken to the QAR for an Initial Review (within sixty days from admit)

COMPLETED BY:

Authorized agency representative will complete top section of this form. QA Reviewer attending the QAR will review the file and complete remaining sections of this form

REQUIRED ELEMENTS:

The top part of all QAR forms should be completed by staff prior to QAR.

- **Program:** Complete the name of program.
- **Admission Date:** Complete client's date of admission.
- **D/MC Eligible Date:** Complete the date client's Drug Medi-Cal billing started.
- **Date of Review:** Complete the date file will be reviewed at QAR.
- **ODF/DCH:** Check appropriate treatment modality.
- **Check the appropriate type of QAR review:** Initial Review, Re-admission or D/C, or Transfer out.
- **Client I.D.:** Complete the Client ID number as determined by agency guidelines.
- **Primary Counselor's Name:** Complete primary counselor's name responsible for file.

NOTES:

The file will be reviewed at the QAR and the remainder of form will be completed by QAR reviewer.

INITIAL REVIEW

Program _____ Admission Date _____ D/MC Billing began Date _____ Date of Review _____	___ ODF ___ DCH ___ Initial Review ___ Re-admission ___ D/C or Transfer out	CLIENT I.D. _____ Primary Counselor's Name: _____
--	--	--

NOTE: All items must have a or N/A. If an item is missing, circle the line and identify corrective action in bottom section.

<p style="text-align: center;"><u>INTAKE</u></p> ___ Medical Necessity present (M.D. Signature) Date MD signed Med. Nec. _____ (Within 30 days) ___ • Perinatal / EPSDT Eligibility ___ Intake Screening Form ___ Drug History or ASI ___ Client Assessment or ASI ___ SanWITS completed (Medi-Cal beneficiary?) ___ Financial Form <p style="text-align: center;"><u>CONSENT FORMS</u></p> ___ Release of Information ___ Treatment consent ___ Program Rules & Regulations ___ Follow-up Consent ___ Client Rights (including Fair Hearing Rights) <p style="text-align: center;"><u>PHYSICAL</u></p> ___ Health Questionnaire Complete ___ MD Reviewed; Date MD signed Physical Waiver _____ ___ MD Reviewed within 30 days of admission (If not see disallowances below) Exam/Lab work: () ordered () waived () recommended ___ Follow-up on Medical orders &/or recommendations in file (Letter to client) ___ Medical problems adequately addressed on TX plan/notes (e.g.: dual dx, TB medication, Hep follow-up, pregnancy, etc)	<p style="text-align: center;"><u>TREATMENT PLAN(S) TIMELINE</u></p> Initial Treatment Plan Development Date _____ *** ___ Initial Plan developed within 30 days of admission? Date physician signed Initial TX Plan _____ ___ MD signature within 15 days? (If either date is late, see disallowances below) ___ DSM IV DX Code(s) on plan: # _____ <p style="text-align: center;"><u>TREATMENT PLAN(S)</u></p> ___ TX Goals appropriate to client's stage in treatment ___ Long/Short Term Goals & Target dates identified ___ Action Steps measurable & attainable ___ Type of counseling identified in Action Steps ___ Frequency of Counseling is identified in Action Steps (Minimum = 2 times monthly) <p style="text-align: center;"><u>DISCHARGE</u></p> Date of last contact (SanWITS D/C date) _____ Discharge Summary date (counselor signed) _____ ___ Discharge SanWITS completed ___ 10 Day Notice <p style="text-align: center;"><u>PROGRESS NOTES</u></p> ___ Monthly DMC Eligibility Reports in file ___ Progress Notes address ALL problems on TX Plan ___ P Notes document Ct. progress toward TX Plan goals ___ Each billing has acceptable documentation ___ Multiple 2nd Service Billings in File ___ ADP 7700 Present
---	--

<p><u>QAR DETERMINATION</u></p> ___ Client file in full compliance ___ Corrective action required - See Below ___ Approved Discharge	<p><u>UPCOMING REVIEW DATES</u></p> _____ Next Extension Review Date (3 months from now) _____ Next Stay Review Date (6 months from admit date) _____ Check this line if Discharge Review completed today
---	--

D/MC DENIALS No Denials noted in this chart
 A State auditor would probably deny D/MC funding from _____ through _____. # Visits denied _____
 List the dates of visits that would be denied in a State audit: _____
 List reason(s) for denied visits _____

CORRECTIVE ACTION REQUIRED (Title 22 related)

Please give letter to client w/MD orders/recommendations

QAR COMMENTS & RECOMMENDATIONS:

Please follow up with client regarding medical tests (letter has already been given to client & is in file)

QA Reviewer Signature _____ Date _____ Second QA Reviewer Signature _____ Date _____

QAR Review Worksheet

EXTENSION/STAY/DISCHARGE REVIEW

REQUIRED FORM:

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

WHEN:

All Medi-Cal client files will be reviewed at QAR (Quality Assessment Review). These Medi-Cal client files will be taken to the QAR for Extension Review (ninety days from Initial Review), Stay Review (six months from admit date), and at discharge (sixty days from client's discharge)

COMPLETED BY:

Authorized agency representative will complete top section of this form. QA Reviewer attending the QAR (Quality Assurance Review) will review the file and complete remaining sections of this form

REQUIRED ELEMENTS:

The top part of all QAR forms should be completed by staff prior to QAR.

- **Program:** Complete the name of program.
- **Admission Date:** Complete client's admission date.
- **D/MC Billing began date:** Complete the date client's Drug Medi-Cal billing started.
- **Date of Review:** Complete the date file will be reviewed at QAR.
- **Date of Last Review:** Complete the last date the file was reviewed at QAR.
- **Date MD signed last Stay Review:** Complete the date the Medical Director signed last Stay Review.
- **Stay Review Due Date:** Complete the date the Stay Review is due for completion.
- **ODF/DCH:** Check appropriate treatment modality.
- **Check the appropriate type of QAR review:** Extension Review, Stay Review, D/C or Transfer out, or Last Corrective Action completed.
- **Client I.D.:** Complete the Client ID number determined by agency guidelines
- **Primary Counselor's Name:** Complete primary counselor's name responsible for file.

NOTES:

The file will be reviewed at the QAR and the remainder of form will be completed by QAR reviewer.

**QUALITY ASSESSMENT REVIEW WORKSHEET
EXTENSION/STAY/DISCHARGE REVIEW**

Program _____ Admission Date _____ D/MC Billing began Date _____ Date of Review _____ Date of Last Review _____ Date MD signed last Stay Review: _____ Stay Review Due Date: _____	___ ODF ___ DCH ___ Extension Review ___ Stay Review ___ D/C or Transfer out ___ Last Corrective Action complete	CLIENT I.D. _____ Primary Counselor's Name _____
--	---	---

NOTE: All items must have a \checkmark or N/A. If an item is missing, circle the line and identify corrective action in bottom section.

<p align="center"><u>MEDICAL/HEALTH REVIEW</u></p> Follow-up on MD Orders & Recommendations in chart? (Client notified) <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a Client cleared for participation? <input type="checkbox"/> yes <input type="checkbox"/> no Annual Health Questionnaire needed? <input type="checkbox"/> yes <input type="checkbox"/> no <p align="center"><u>STAY REVIEW</u></p> Has QAR reviewed latest Stay Review? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a (check previous Review forms for accurate dates) Stay Review Justification present & signed by MD? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a Date MD Signed latest Stay Review _____ (See disallowances below if MD signed later than 6 months) <p align="center"><u>DISCHARGE</u></p> Date of last contact (SanWITS D/C date) _____ Discharge Summary date (counselor signed) _____ ___ Discharge SanWITS completed ___ 10 Day Notice <p align="center"><u>LAST QAR FORM</u></p> Corrective Action complete: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a Comments/Recommendations incorporated in charting? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a <i>Note: Corrective Action must be completed, however, not all comments or recommendations must be adhered to. Check with QAR Chair if you have questions.</i>	<p align="center"><u>TREATMENT PLAN(S) TIMELINE</u></p> Development Date of last TX Plan reviewed (See last QAR Review Form for this date): 1) _____ TX Plan due date(s) (90 days from last TX Plan(s)) 2) _____ & 4) _____ Review of TX Plan(s) needed? <input type="checkbox"/> yes <input type="checkbox"/> no (if no, skip to Progress Note section) TX Plan Development date(s): 3) _____ & 5) _____ New TX plan(s) developed in timely manner? <input type="checkbox"/> yes <input type="checkbox"/> no Date MD signed TX Plan(s) _____ & _____ MD signature within 15 days? yes <input type="checkbox"/> no <input type="checkbox"/> & <input type="checkbox"/> yes <input type="checkbox"/> no (If either date is late, see disallowances below) DSM IV DX Code(s) on all tx plan(s): # _____ TX Goals appropriate to client's stage in TX: () & () Long/Short Term Goals & Target dates identified: () & () Action Steps measurable & attainable: () & () Type of counseling identified in Action Steps () & () Frequency of Counseling is identified in Action Steps (minimum = 2 times monthly) () & () <p align="center"><u>PROGRESS NOTES</u></p> ___ Monthly DMC Eligibility Reports in file ___ Progress Notes address ALL problems on TX Plan ___ PNotes document Clt. progress toward TX Plan goals ___ Each billing has acceptable documentation (if not, see disallowances below) ___ Multiple 2nd Service Billings in File ___ ADP 7700 Present
--	--

<p><u>QAR DETERMINATION</u></p> ___ Client file in full compliance ___ Corrective action required - See Below ___ Approved Discharge	<p align="center"><u>UPCOMING REVIEW DATES</u></p> _____ Next Extension Review Date (3 months from now) _____ Next Stay Review Date (6 months from admit date or last MD signature on Stay Review) _____ Check this line if D/C review completed today
---	---

D/MC DENIALS No Denials noted in this chart
 A State auditor would probably deny D/MC funding from _____ through _____. # Visits denied _____
 List the dates of visits that would be denied in a State audit: _____
 List reason(s) for denied visits _____

CORRECTIVE ACTION REQUIRED (Title 22 related)

Please give letter to client w/MD orders/recommendations

QAR COMMENTS & RECOMMENDATIONS:

Please follow up with client regarding medical tests (letter has already been given to client & is in file)

QA Reviewer Signature _____ Date _____ Second QA Reviewer Signature _____ Date _____

DMC Eligibility Printout

REQUIRED FORM:

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

WHEN:

Completed at Intake/Admission or when client becomes Medi-Cal eligible

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Subscriber ID:** This is the client's Medi-Cal subscriber number. You may also use the client's social security number.
- **Client's Birth Date:** This is the client's date of birth. The format is as follows: 00/00/0000
- **Service Date:** This is the date of service you will be billing to Medi-Cal
- **Issue Date:** This is the date that Medi-Cal was issued to the client. If you do not have the issue date, you may use today's date in the following format: 00/00/0000

NOTES:

Providers may verify Medi-Cal eligibility in one of three ways:

1. POS (Point of Service) Machine – See the POS User Guide for instructions
2. Online using the Eligibility Verification System (EVS) – See Medi-Cal Program and Eligibility Manual for instructions
3. Automated Eligibility Verification System (AEVS) – See Medi-Cal Program and Eligibility Manual for instructions

All clients who are eligible for Medi-Cal must have a verification of eligibility in their file. **It is suggested that all program participants should be checked for Medi-Cal eligibility on a monthly basis regardless of their current Medi-Cal status.**

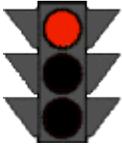
Programs using POS or EVS must have the Eligibility Printout in the file. **POS or EVS must be done monthly and placed in the client file for the duration of the clients treatment episode or until the client becomes ineligible for Medi-Cal.**

Programs using the AEVS by phone must have documentation of AEVS eligibility in the client file. **AEVS phone verification must be done monthly and documentation placed in the client file for the duration of the client's treatment episode or until the client becomes ineligible for Medi-Cal.**

-----Refer to the following three samples of Medi-Cal eligibility documentation-----

Eligibility Response

Eligibility transaction performed by provider:



Subscriber ID:		
Service Date:	Subscriber Birth Date:	Issue Date:
Primary Aid Code:		First Special Aid Code:
Second Special Aid Code:		Third Special Aid Code:
Subscriber County:		HIC Number:
Primary Care Physician Phone #:		Service Type:
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message:		

Initial Screening/Intake Form

REQUIRED FORM:

This form is a required document in the client file

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Authorized agency representative with client

REQUIRED ELEMENTS:

- **Client ID#:** Complete the client's ID number as determined by agency guidelines.
- **Staff Completing the Form:** Complete the name of staff conducting the screening/intake.
- **Date of Screening/Intake:** Complete the date screening/intake was conducted.
- **Place of Screening/Intake:** Complete the location of screening/intake such as jail, program site, trolley station, etc.
- **Referral source:** Complete client's referral source (e.g., probation, CWS, Parole, etc.)

PERSONAL INFORMATION

- **Name:** Complete client's first name, middle initial, and last name.
- **Social Security Number:** Complete client's social security number. If client has no social security number, follow agency guidelines.
- **Birth date/Age:** Complete client's month/day/year of birth and age.
- **Address:** Complete client's physical address. If client is homeless, document "homeless" in this space.
- **Phone Number:** Complete client's phone number. Circle if the phone number is personal or message.
- **Homeless:** Circle appropriate yes or no answer.
- **Gender:** Circle appropriate answer.
- **Preferred language:** Complete client's preferred language.
- **Veteran Status:** Circle appropriate yes or no answer.
- **Pregnant /Due date:** Complete client's pregnancy status. If pregnant, complete due date. Inform client that they may be required to provide documentation such as proof of pregnancy.
- **Number of Children Under 18:** Complete client's number of children under the age of 18. Programs requiring additional information may refer to "Supplemental A: Minor Children Information Form."

- **Do you have Medi-Cal:** Circle appropriate yes or no answer. If yes, complete Medi-Cal card number. Inform client that they may be required to provide documentation of Medi-Cal eligibility. Follow agency guidelines for Medi-Cal eligibility.
- **Health Insurance:** Circle appropriate yes or no answer. If yes, complete Insurance Company's name. Inform client that they may be required to provide documentation of insurance information. Follow agency guidelines for health insurance eligibility.

EMERGENCY CONTACT

- **Emergency Contact:** Complete name, relationship, and phone number of person to contact in case of emergency. The second emergency contact information is optional.

PARENT/GUARDIAN INFORMATION

(Adolescent Programs Only)

- **Parent/Guardian Information:** Complete name, relationship, and phone number of person responsible for minor entering treatment.

MENTAL HEALTH

- **Have you ever been diagnosed with mental health conditions:** Circle appropriate yes or no answer. If yes, specify diagnosis.
- **Prescription Medications:** List all medications the client is taking for mental health condition(s).

ALCOHOL AND DRUG

- **Date Last Used:** Complete the date client last used any drugs, including alcohol.
- **Days in a Row:** Complete the number of days in a row the client has been using alcohol or other drugs, up to the last date used.
- **Problem Length:** Complete the length of time the client reports having problem(s) with alcohol or drugs.
- **Primary Drug:** List the client's primary drug of use. Complete the number of days the client used the primary drug in the last 30 days. Complete the route of administration (e.g., oral, inhalation, smoking, I.V.) Complete the date the client last used the primary drug.
- **Secondary Drug:** List the client's secondary drug of use. Complete the number of days the client used the secondary drug in the last 30 days. Complete the route of administration (e.g., oral, inhalation, smoking, I.V.) Complete the date the client last used the secondary drug.

- **Tertiary Drug:** List the client's tertiary drug of use. Complete the number of days the client used the tertiary drug in the last 30 days. Complete the route of administration (e.g., oral, inhalation, smoking, I.V.) Complete the date the client last used the tertiary drug.
- **Have You Used Needles in the Past 12 Months:** Circle the appropriate yes or no answer.

DETOX CLIENTS ONLY

(This section should be completed by programs screening clients for residential detox)

- **History of seizures or DT's:** Circle appropriate yes or no answer. If yes, specify whether the client experiences seizures, DT's or both.
- **Staff Follow Up:** Use this space to document appropriate follow up per agency guidelines.

LEGAL

- **Are you on Probation/Parole/Both:** Circle appropriate answer
- **Pending Court date(s):** Circle appropriate yes or no answer. If yes, complete reasons, and court dates.
- **Arrests/charged/convicted/registered for arson:** Circle appropriate yes or no answer. If yes, follow agency guidelines.
- **Arrests/charged/convicted/registered for sex crime(s):** Circle appropriate yes or no answer. If yes, follow agency guidelines.

POTENTIAL RISK ASSESSMENT

Purpose of this section is to evaluate the client's physical safety and concerns for the safety of others in relationship with the client.

- **Current Thoughts of Harm:** Circle appropriate yes or no answer.
- **Safety Concerns:** Circle appropriate yes or no answer
- **Action Taken:** If client answered "Yes" to any of the above questions, describe the action taken. Refer to your agency guidelines for potential risk guidelines.

OUTCOME

- **Accepted to Treatment:** Circle appropriate yes or no answer.
- **Modality:** Complete modality of treatment the client is accepted (i.e. Outpatient, Residential, Detox, ect.)
- **Waiting List:** Circle appropriate yes or no answer.

- **Informed of Voter Registration:** Circle appropriate yes or no answer.
- **Referred To:** List all appropriate referrals given to the client whether they are accepted for treatment at your program or not (e.g. Shelter, mental health assessment, other treatment providers, etc.)
- **Staff Summary/Comments:** Use this space to summarize the overall assessment of the client as they presented in the screening/intake. This space may also be used for any additional client information not asked in the screening/intake form.

CERTIFICATION

- **Client Signature:** Client is required to sign and date this form to certify that all information given is true and correct.
- **Staff Signature:** The staff member who conducted the screening/intake is required to sign.

NOTE:

This a required form for all San Diego County funded alcohol and drug programs. This form may be used as a screening tool or intake admission form depending on your program guidelines.

Initial Screening/Intake Form

Client ID # _____

Staff completing the form: _____ Date of screening: _____

Place of interview: _____ Referral source: _____

PERSONAL INFORMATION

First Name: _____ M.I. _____ Last Name: _____

Social Security Number: _____ Birth Date: ____/____/____ Age: _____

Address: _____

Street

City

State

Zip Code

Phone Number: (____) _____ Personal Message Are you homeless (Circle one)? YES NO

Gender Male Female Other Preferred Language: _____

Are you a veteran? YES NO

Are you pregnant? YES NO Due Date: _____ # of Children under 18: _____

Do you have Medi-Cal? YES NO Medi-Cal Card #: _____

Health Insurance? YES NO Insurance Company: _____

FIRST EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone # (____) _____

SECOND EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone # (____) _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship: _____ Phone # (____) _____

Client Name: _____

MENTAL HEALTH

Have you ever been diagnosed with mental health condition(s)? YES NO

If yes, specify: _____

If you are taking any prescription medication for mental health condition(s), please specify: _____

ALCOHOL & DRUG

Date you last used any drugs including alcohol: ____/____/____ Number of days in a row you have been using: ____

How long do you think you have had a problem with alcohol and/or other drugs? _____

Primary Drug _____ # of days used in the last month _____ Route _____ Last Used ____/____/____

Secondary Drug _____ # of days used in the last month _____ Route _____ Last Used ____/____/____

Tertiary Drug _____ # of days used in the last month _____ Route _____ Last Used ____/____/____

Have you used needles in the past 12 months? YES NO

(DETOX CLIENTS ONLY)

Do you have history of seizures/DTs when you stop drinking? YES NO Specify: _____

Staff follow up: _____

Client Name: _____

LEGAL

Are you on (circle one): Probation Parole Both None

Pending court date(s)? YES NO

If yes, state reason(s) and date(s): _____

Have you ever been arrested/charged/convicted/registered for arson? YES NO

Have you ever been arrested/charged/convicted/registered for sex crime(s)? YES NO

POTENTIAL RISK ASSESSMENT

Do you have any current thoughts of hurting yourself or others? YES NO

Do you have any concerns for the safety of yourself or your immediate family? YES NO

If client answered "YES" to any of the above questions, describe the action(s) taken: _____

For Staff use only

OUTCOME

Accepted into treatment: YES NO Modality: _____

Placed on waiting list: YES NO

Informed of Voter Registration: YES NO

Referred to: _____

Staff Summary/Comments: _____

I certify that all information I have furnished on this form is true and correct.

Client Signature

Staff Signature

Date

Minor Children Information Form

REQUIRED FORM:

This is not a required form. This form will be used as a supplement in programs collecting additional information regarding minor children

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Authorized agency representative and client

REQUIRED ELEMENTS:

- **Client's Name:** Complete client's full name.
- **Date of Admission:** Complete the admission date.
- **Child's Name:** Complete child's full name.
- **Gender:** Complete child's gender (e.g., Male, Female).
- **Age:** Complete the age of the child.
- **Who Do They Live With:** Complete the child's current living situation (e.g., with the client, grandparents, foster care, other parent, etc.).
- **Will They Be Entering the Program:** Complete appropriate yes or no.

Minor Children Information Form

Client's Name: _____

Date of Admission: _____

Child's Name	Gender	Age	With whom do they live?	Will they be entering the program? Y/N

Client Fee Collection Form

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

Copies of Identification / Social Security Cards

REQUIRED FORM

This form is optional and not a required document in the client file

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Agency authorized representative

REQUIRED ELEMENTS:

None

Copy of Identification and Social Security Card

This section is optional. If your agency is requiring copy of ID and SS card from clients, place it in this section.

Copy of Medi-Cal Card

REQUIRED FORM:

This form is optional and not a required document in the client file

WHEN:

Completed at Screening/Intake Admission or when the client becomes Medi-Cal eligible

COMPLETED BY:

Agency authorized representative

REQUIRED ELEMENTS:

None

Copy of Medi-Cal Card

This section is optional. If your agency is requiring copy of Medi-Cal card from clients, place it in this section.

Financial Responsibility and Information Form

REQUIRED FORM:

This form is a required document in the client file

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Authorized agency representative or client

REQUIRED ELEMENTS:

- **Client's name:** Complete client's first and last name.
- **Parent or authorized representative's name:** If minor, complete name of parent or authorized representative.
- **Do you and/or your family have health coverage:** Circle appropriate yes, no, or N/A answer. If client does not have health coverage, client must be provided a referral to 2-1-1 and Covered California website.
- **Medical Eligible:** Circle appropriate yes or no answer.
- **Currently have Medi-Cal:** Circle appropriate yes or no answer.
- **Cal-Works recipient:** Circle appropriate yes or no answer.
- **Number dependent on income (including self):** Complete the number of people, dependent on the income of the client including self.
- **Gross Family Income (before taxes):** Complete the client's gross family income earned before taxes.
- **Court-ordered revenue and recovery expenses:** Complete total deductions taken for court ordered revenue and recovery expenses. Client may be asked to provide proof of payments.
- **Adjusted Income:** This is gross family income minus court-ordered revenue and recovery expenses.
- **Fee based on sliding scale:** Use the County Sliding Fee Scale to determine the fee.
- **Adjusted Fee:** This is the final fee based on client's ability to pay or funding source (e.g., indigent, Medi-Cal eligible, CalWorks, third party pay).
- **Reason for fee adjustment:** This is an explanation of why client's fee was adjusted.
- **Client signature:** Client must sign and date affirming all statements are true and correct.
- **Parent or authorized Representative Signature:** If minor, parent or authorized representative must sign and date.
- **Screened by:** The staff screening this form must sign and date.

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

FINANCIAL RESPONSIBILITY AND INFORMATION

If the client is seeking treatment without the knowledge or consent of a parent or authorized representative, the information given below should be based only on the client's financial information. If the client is seeking treatment with the knowledge and/or consent of a parent or authorized representative, the information given below should be based on the parent or authorized representative's financial information.

Client's Name: _____

Parent or authorized representative's name: _____

Do you and/or your family have health coverage? YES NO N/A

Were you provided a referral to 2-1-1 and Medi-Cal or Covered California? YES NO

Medi-Cal eligible: Yes No Do you currently have Medi-Cal? YES NO

Cal-Works Recipient: Yes No

Number dependent on income (*including self*): _____

Gross Family Income (*before taxes*) \$ _____

Court-ordered revenue and recovery expenses
(*Client may be asked to provide proof of payments*) \$ _____

Adjusted income (*gross minus court expenses*) \$ _____

Fee based on sliding scale \$ _____

Adjusted fee \$ _____

Reason for fee adjustment: _____

Indigent Clients

It has been determined that it is an important treatment tool to require clients to pay a minimum fee even when indigent. This helps clients value and take responsibility for treatment. Although no service will be refused due to client's inability to pay, the fee is owed to the program.

I affirm that the statements made herein are true and correct to the best of my knowledge:

Client Signature: _____ Date: _____

Parent or authorized
Representative Signature: _____ Date: _____

Screened by: _____ Date: _____

CalOMS Admission Form

REQUIRED FORM:

This form is a required document in client file

WHEN:

This form will be completed at Intake Admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

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

Data Entry Date: _____
Data Entry Int. _____

CalOMS Profile

Provider 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*)

Highlighted fields are required.

Client Profile		Mid Int <input type="text"/>	(System generated)	<input type="text"/>
Current First Name	<input type="text"/>	State Client ID	<input type="text"/>	<input type="text"/>
Current Last Name	<input type="text"/>	Provider Client ID	<input type="text"/>	<input type="text"/>
Birth First Name	<input type="text"/>	SSN	<input type="text"/>	<input type="text"/>
Birth Last Name	<input type="text"/>	Driver's License	State Abbr.	Number
Mother's First Name	<input type="text"/>	Medicaid#	<input type="text"/>	
Gender	Circle: Male/ Female/ Other	Date of Death	mm / dd / yyyy	
Date of Birth	<input type="text"/>	Place of Birth	County	State Abbr.
No Readmit Until	<input type="text"/>	Consent on File	No	
		Has Paper File	Circle: Y / N	

Alternate Names	
Last Name	<input type="text"/>
First Name	<input type="text"/>
Middle Name	<input type="text"/>

Highlighted fields are required.

Additional Information

Ethnicity Circle one: **1. Not Hispanic** **3. Cuban**
2. Mexican/Mexican American **4. Puerto Rican** **5. Other Hispanic/Latino**

Primary Race/Ethnicity (Circle one):
White Black/African-American Mexican/Latino/Hispanic Asian/Pacific Islander Native American Other

Race (Enter Codes. If multi-racial, may select up to five codes) - - - -

- Select from the following codes:
- | | | | |
|-----------------------------|----------------|-----------------|------------------|
| 01 - White | 06 – Cambodian | 11 – Japanese | 16 – Other Asian |
| 02 - Black/African-American | 07 – Chinese | 12 – Korean | 17 – Other Race |
| 03 – American Indian | 08 – Filipino | 13 – Laotian | 18 – Mixed Race |
| 04 – Alaskan Native | 09 - Guamanian | 14 – Samoan | |
| 05 – Asian Indian | 10 – Hawaiian | 15 – Vietnamese | |

Disabilities

- Circle all that apply:
- 1 - None
 - 2 - Visual
 - 3 - Hearing
 - 4 – Speech
 - 5 – Mobility
 - 6 – Mental
 - 7 - Developmentally Disabled
 - 8 - Other Disability (not Alcohol or Drug)
 - 99900 - Declined to State
 - 99904 - Unable to Answer

General Client Comments: _____

Preferred Language: _____

Interpreter Needed: Y/N

Religious Preference

U.S. Veteran? (Circle):

1 – Yes

2 – No

99900 - Declined to State

99904 - Unable to Answer

Highlighted fields are required.

SanWITS Intake

FSN _____
Data Entry Date: _____
Data Entry Int. _____
Client ID _____

Client Name: _____

Date of Birth

mm	/	dd	/	yyyy
----	---	----	---	------

<p>Intake</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;">Intake Facility</td> <td></td> </tr> <tr> <td>Intake Staff</td> <td></td> </tr> <tr> <td>Initial Contact</td> <td></td> </tr> <tr> <td>Residence</td> <td></td> </tr> </table> <p>Source of Referral (enter code)</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 70%; height: 40px;"></td> <td style="width: 30%;"></td> </tr> </table> <p>Source of Referral Codes: 1 = Individual, including self-referral 2 = Alcohol/Drug Abuse program 3 = Other Health Care provider 4 = School/Educational 5 = Employer/EAP 6 = 12 Step Mutual Aid 7 = SACPA /Prop36/OTP/Probation or Parole 8 = Post-Release Coummunity Supervision(AB109) 9 = DUI/DWI 10 = Adult Felon Drug Court 11 = Dependency Drug Court 12 = Non SACPA /Criminal Justice 13 = Other Community Referral 14 = Child Protective Services</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;">Referral Contact</td> <td rowspan="4" style="background-color: #cccccc; text-align: center;">[Cross-hatched pattern]</td> </tr> <tr> <td>Referral Date</td> </tr> <tr> <td>Assessment Date</td> </tr> <tr> <td>Date Closed</td> </tr> </table>	Intake Facility		Intake Staff		Initial Contact		Residence				Referral Contact	[Cross-hatched pattern]	Referral Date	Assessment Date	Date Closed	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"># of Previous Cases</td> <td colspan="2" style="text-align: center;">Populated By System</td> </tr> <tr> <td>Case Status</td> <td colspan="2" style="text-align: center;">OPEN ACTIVE</td> </tr> <tr> <td>Intake Date</td> <td style="width: 20%;"></td> <td style="width: 30%;"></td> </tr> <tr> <td>Pregnant</td> <td>Circle: Y / N</td> <td>Due Date _____</td> </tr> <tr> <td>Chronic Life Threatening Illness (CLTI)</td> <td>Circle: Y / N</td> <td></td> </tr> <tr> <td>Injection Drug User</td> <td>Circle: Y / N</td> <td></td> </tr> </table>	# of Previous Cases	Populated By System		Case Status	OPEN ACTIVE		Intake Date			Pregnant	Circle: Y / N	Due Date _____	Chronic Life Threatening Illness (CLTI)	Circle: Y / N		Injection Drug User	Circle: Y / N	
Intake Facility																																		
Intake Staff																																		
Initial Contact																																		
Residence																																		
Referral Contact	[Cross-hatched pattern]																																	
Referral Date																																		
Assessment Date																																		
Date Closed																																		
# of Previous Cases	Populated By System																																	
Case Status	OPEN ACTIVE																																	
Intake Date																																		
Pregnant	Circle: Y / N	Due Date _____																																
Chronic Life Threatening Illness (CLTI)	Circle: Y / N																																	
Injection Drug User	Circle: Y / N																																	

Presenting Problem

Highlighted fields are required.

SanWITS Admission Profile

FSN _____
Data Entry Date: _____
Data Entry Int. _____
Client ID _____

Client Name: _____

Date of Birth

mm	/	dd	/	yyyy
----	---	----	---	------

Screening	
Potential Client for MH? Circle: Y / N	<ol style="list-style-type: none"> 1. Court Ordered Treatment 2. Court Ordered Screening/Assessment 3. Based on Screening 4. Based on Referral 5. Based on Test Result
Potential Client for TBI? Circle: Y / N	<ol style="list-style-type: none"> 1. Court Ordered Treatment 2. Court Ordered Screening/Assessment 3. Based on Screening 4. Based on Referral 5. Based on Test Result

Admission Profile			
Admission Date	mm / dd / yyyy		
Admission/Transaction Type <small>1 = Initial Admit 2= Transfer</small>		Codependent/Collateral?	
Type of Treatment Service 1 = Nonresidential/Outpatient/ Recovery 2 = Nonresidential/Outpatient/ Intensive 3 = Nonresidential/Outpatient/ Detox 5 = Residential Detox (non-hospital) 6 = Residential Tx/ Recovery (30 days or less) 7 = Residential Tx/ Recovery (31 days or +)		CalWORKs Recipient	Circle: Y / N
Submit to CalOMS?	YES	SA Tx Under CalWORKs	Circle: Y / N
# of Days Waited to Enter Tx		Special Services Contract ID	
# of Prior Episodes		Special Services Contract County	

Note: For number of days waited to enter treatment, enter the number of days a client waited for services beginning on the day they were accepted for treatment services and ending on the first day of receiving such services.

Highlighted fields are required.

SanWITS Admission Administration

FSN _____
Data Entry Date: _____
Data Entry Int. _____
Client ID _____

Client Name: _____

Date of Birth

mm	/	dd	/	yyyy
----	---	----	---	------

Program Fees:		Intake Fees:	
Drug Testing Participation:	Circle: Y / N	Testing Level Indicator	
Baseline UA Completed	Circle: Y / N	Drug Screening Fees	
Pictures Taken	Circle: Y / N	Encounters Fees	

Prop 36 questions must be answered for Drug MediCal billing

	Start Date	End Date	JURIS #
Prop. 36			

Special Population Program	<ol style="list-style-type: none"> 1. Medi-Cal Participant 2. CalWorks Funded 3. FIT Grant Participant 4. Perinatal Funded/Non DDC/Non DMC 5. HIV Funded Participant 6. Bridge to Recovery Referral 7. Juvenile Drug Court 8. Drug Court Participant 	<ol style="list-style-type: none"> 9. ReEntry Court Funded 10. Parolee Partnership Program 11. AB 109 Participant 12. EBSPSP Funded 13. None (County ADS Funded) 14. Fee-For-Service 15. Non ADS Funded Participant
How did you hear about us?	<ol style="list-style-type: none"> 1. Get Off Meth Brochure 2. ADS Web Site 3. Help/Info Line (211) 4. Any Criminal Justice ie Probation/Court/Parole/Law Enforcement 5. Other – Please Explain 	<ol style="list-style-type: none"> 6. Not Applicable 7. ER/Trauma/Hospital/Health Clinic 8. Homeless Shelter 9. Bridge to Recovery Referral 10. EBSPSP
If Other, Specify:		

Highlighted fields are required.

SanWITS Admission Substance Abuse

FSN _____
Data Entry Date: _____
Data Entry Int. _____
Client ID _____

Client Name: _____

Date of Birth

mm	/	dd	/	yyyy
----	---	----	---	------

Alcohol and Drug Use

Primary Drug	
Drug Type	
Drug Name	
# of Days Used in Past 30 Days	
Route of Administration	
Age of First Use	

Secondary Drug	
Drug Type	
Drug Name	
# of Days Used in Past 30 Days	
Route of Administration	
Age of First Use	

Tertiary Drug	
Drug Type	
# of Days Used in Past 30 Days	
Route of Administration	
Age of First Use	

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 = Oxy Codone/ Oxy Contin
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 <small>If 1st or 2nd drug is Alcohol, answer NA)</small>	
# of Days Used IV in Past 30 Days	
Used Needles in Past 12 Months	Circle: Y/ N

Highlighted fields are required.

SanWITS Tobacco / Family Social

FSN _____
Data Entry Date: _____
Data Entry Int. _____
Client ID _____

Client Name: _____

Date of Birth

mm	/	dd	/	yyyy
----	---	----	---	------

Tobacco / Nicotine			
(Circle correct answer)			
Have you ever used Tobacco/Nicotine products?	Yes No Unknown	In the past 30 days, what tobacco/nicotine product did you use most frequently?	No tobacco Use Cigarettes Cigars or Pipes Smokeless Tobacco Other Nicotine Product Combo/more than 1
Smoker Status	Current Every Day Smoker Current Some Day Smoker Smoker, current status Unk Former Smoker	In the past 30 days, how often did you use tobacco/nicotine product(s)?	1. 1-3 times last 30 days 2. Once a week 3. 3-6 times a wk 4. Daily 5. 3-6 times a day 6. More than 6 x a day 97 Unknown
At what age did you first use tobacco/nicotine products?	1. Age 10 or younger 2. Between 11 and 14 3. Between 15 and 19 4. Between 20 and 25 5. Between 26 and 30 6. 31 or older 7. Unknown	In the past 30 days, how many cigarettes did you smoke per week?	Enter actual number

Family/Social			
(Enter number in box next to question)			
# of Days Social Support in Past 30		# of Children Under 18	
Current Living Arrangements 1-Homeless 2-Dependent Living 3-Independent Living		# of Children Age 5 or less	
# of Days Living w/User of Alcohol or Durg in Past 30		# of children Living w/Someone Else Because of a Child Protection Order	
# of Days Family Conflict in Past 30		# of Children Living w/Someone Else for whom Parental Rights have been Terminated	
Current Zip Code			

Abuse Characteristics				
(Circle correct answer)				
Does episode involve physical abuse?	Perpetrator	Victim	No	Unwilling to Answer
Does episode involve sexual abuse?	Perpetrator	Victim	No	Unwilling to Answer
Does episode involve domestic abuse?	Perpetrator	Victim	No	Unwilling to Answer

Highlighted fields are required.

SanWITS Admission Employment/Legal/Health

FSN _____
Data Entry Date: _____
Data Entry Int. _____
Client ID _____

Client Name: _____

Date of Birth

mm	/	dd	/	yyyy
----	---	----	---	------

Employment		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)		
Employment Status (enter code)	<input style="width: 100%;" type="text"/>			
Number of Paid Work Days in Past 30 Days	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>			
Enrolled in School?	Circle: Y / N			
Enrolled in Job Training?	Circle: Y / N			
Graduated from High School?	Circle: Y / N			
Highest School Grade Completed	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>			

Legal/Criminal Justice		Drop down values for Criminal Justice Status 1-No Criminal Justice Involvement 2-Under parole supervision by CDC 3-On parole from any other jurisdiction 4-Post-release Community Service(AB109) or on probation from any federal, state, or local jurisdiction 5-Admitted under other diversion from any court under CA Penal code, Section 1000 6-Incarcerated 7-Awaiting trial, charges or sentencing 99904-Client unable to answer		
# of Arrests in Last 30 Days	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>			
# of Jail Days in Last 30	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>			
# of Prison Days in Last 30	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>			
# of Arrests in Last 6 Months	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>			
Criminal Justice Status	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>			
Type of Sentence	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>			
CDC Number (Enter number or NA)	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>			
Parolee Services Network(PSN)	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px; text-align: center;">Y</td><td style="width: 30px; height: 20px; text-align: center;">N</td></tr></table>	Y	N	
Y	N			
FOTP Parolee	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px; text-align: center;">N</td></tr></table>		N	
	N			
FOTP Priority Status	99902			
		Drop down values for Type of Sentence 1-Conditional Sentence 2-Formal Probation 3-Parole		
		Drop down values for FOTP Priority Status 99902- None or not Applicable		

Medical/Physical Health										
# of Times Emergency Room in Past 30	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>					Medi-Cal Beneficiary	Y	N	DS	UA
# of Hospital Overnights in Past 30 Days	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>					Medication Prescribed as Part of Tx				
# of Days Medical Problems in Past 30	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>					Communicable Diseases: Tuberculosis	Y	N	DS	UA
HIV Tested	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px; text-align: center;">Y</td><td style="width: 30px; height: 20px; text-align: center;">N</td><td style="width: 30px; height: 20px; text-align: center;">DS</td><td style="width: 30px; height: 20px; text-align: center;">UA</td></tr></table>	Y	N	DS	UA	Communicable Diseases: Hepatitis C	Y	N	DS	UA
Y	N	DS	UA							
HIV Test Results Received	<table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px; text-align: center;">Y</td><td style="width: 30px; height: 20px; text-align: center;">N</td><td style="width: 30px; height: 20px; text-align: center;">DS</td><td style="width: 30px; height: 20px; text-align: center;">UA</td></tr></table>	Y	N	DS	UA	Communicable Diseases: STD	Y	N	DS	UA
Y	N	DS	UA							
Drop down values for Medication Prescribed 1-None 5-Buprenorphine (Suboxone)	Pregnant at Admission		Y	N	DS	UA				

Highlighted fields are required.

Mental Health	
Mental Illness Diagnosed	Circle: Y / N / 99901 (Not Sure/Don't Know)
Number of Times Outpatient ER MH Services in Past 30 Days	
Number of Days of Psychiatric Facility Stay of more than 24 Hrs in Past 30 Days	
Mental Health Medication in Past 30 Days	Circle: Y / N
Suicide Attempts	Circle: Y / N

CalOMS Annual Update Form

REQUIRED FORM:

This form is a required document in client file

WHEN:

Annual updates are required for those program participants that are in treatment for a period of twelve months or more, continuously (no break in services exceeding 30 days). For such individuals, providers must collect the CalOMS treatment data approximately one year from the day the individual was admitted to the program. Annual update information can be collected earlier than twelve months, as early as 60 days prior to the individual's admission date of anniversary

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

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

CalOMS Annual Update

FSN _____
Data Entry Date: _____
Data Entry Int. _____

Provider ID

Form Serial Number

W

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

Client Profile (Enter name and complete other fields if any changes.)			
*^Client First Name	<input type="text"/>	Mid Int	<input type="text"/>
^Client Last Name	<input type="text"/>	State Client ID	<input type="text"/>
*Birth First Name	<input type="text"/>	Provider Client ID	<input type="text"/>
Birth Last Name	<input type="text"/>	+*^SSN	<input type="text"/> - <input type="text"/> - <input type="text"/>
Mother's First Name	<input type="text"/>	+*^Driver's License	<input type="text"/>
Gender	Circle: Male Female Other	+^Current Zip Code	<input type="text"/>
Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	Homeless enter 00000	<input type="text"/>
		Place of Birth	<input type="text"/>
		Consent on File	Circle: Y / N

Annual Update Profile	
Admission Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Annual Update Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Number of the Annual Update Being Reported	<input type="text"/>

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

Alcohol and Drug Use

Primary Drug

Drug Type	
If Other, Specify Name	
# of Days Used in Past 30 Days	
Route of Administration	
Age of First Use	

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*

Secondary Drug

Drug Type	
If Other, Specify	
# of Days Used in Past 30 Days	
Route of Administration	
Age of First Use	

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

# of Days Social Support Recovery Activities in Past 30 Days		
Current Living Arrangements 1 = Homeless 2 = Dependent Living 3 = Independent Living		
+^ # of Days Living w/ Alcohol or Drug User in Past 30 Days		
+^ # of Days Serious Family Conflict in Past 30 Days		

^ Number of Children Under 18

^ Number of Children Age 5 or Less

^ Number of Children Living w/ Someone Else because of a Child Protection Court Order
 ^ 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.

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

Employment					
Employment Status (enter code)	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>				
+^ Number of Paid Work Days in Past 30 Days	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>				
+^ Enrolled in School	Circle: Y / N				
+^ Enrolled in Job Training	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					
^ # of Arrests in Last 30	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>				
^ # of Jail Days in Last 30	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>				
# of Prison Days in Last 30	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>				
# of Arrests in Last 6 Months	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>				

Medical/Physical/Mental Health			
Medical/Physical Health			
^ Number of Times in ER in Past 30 Days	<table border="1"><tr><td></td></tr><tr><td></td></tr></table>		
^ Number of Hospital Overnights in Past 30 Days	<table border="1"><tr><td></td></tr><tr><td></td></tr></table>		
^ Number of Days Medical Problems in Past 30 Days	<table border="1"><tr><td></td></tr><tr><td></td></tr></table>		
+^ HIV Tested	Circle: Y / N		
+^ HIV Test Results Received	Circle: Y / N		
∞ Pregnant at any time during Treatment	Circle: Y / N		
Mental Health			
∞ Mental Illness Diagnosed	Circle: Y / N		
^ Number of Times Outpatient ER MH Services in Past 30 Days	<table border="1"><tr><td></td></tr><tr><td></td></tr></table>		
^ Number of Days of Psychiatric Facility Stay of more than 24 Hrs in Past 30 Days	<table border="1"><tr><td></td></tr><tr><td></td></tr></table>		
^ Mental Health Medication in Past 30 Days	Circle: Y / N		

Section 2 Consents

F201	Consent to Release Information
F202	Admission Agreement / Consent for Treatment
F203	Client Personal Rights
F204	Title 22 Fair Hearing Rights *
F205	Notice of Privacy Practice/HIPAA
F206	Consent to Follow Up
F207	Consent for Photo, TV, Video
F208	Coordination of Care Consent Form
	Additional Policies and Consents

*Medi-Cal providers

Consent to Release Information

This is not a standardized form. Place current consent to release information used by your agency in this section.

Admissions Agreement Consent for Treatment

This is not a standardized form. Place current Admission Agreement/Consent for Treatment used by your agency in this section.

Client Personal Rights

REQUIRED FORM:

This form is a required document in the client file

WHEN:

Completed at Intake/Admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Client Signature:** Client must sign and date the form.

NOTES:

Providers may use their own version of the Client Personal Rights form. In accordance with Alcohol and/or Other Drug Program Certification Standards, the Client Personal Rights form must include the following seven (7) elements:

1. The right to confidentiality as provided for in Title 42, Code of Federal Regulations, Part 2.
2. To be accorded dignity in contact with staff, volunteers, board members and other persons.
3. To be accorded safe, healthful and comfortable accommodations to meet his or her needs.
4. To be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
5. To be informed by the program of the procedures to file a grievance or appeal discharge.
6. To be free from discrimination based on ethnic group identification, religion, age, sex, color, or disability.
7. To be accorded access to his or her file.

The client shall review, sign, and be provided at admission, a copy of the Client Personal Rights. The program shall place the original signed document in the client's file.

CLIENT PERSONAL RIGHTS

In accordance with Alcohol and/or Other Drug Program Certification Standards, the Client Personal Rights include, but are not limited to, the following:

- The right to confidentiality as provided for in Title 42, Code of Federal Regulations, Part 2.
- To be accorded dignity in contact with staff, volunteers, board members and other persons.
- To be accorded safe, healthful and comfortable accommodations to meet his or her needs.
- To be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
- To be informed by the program of the procedures to file a grievance or appeal discharge.
- To be free from discrimination based on ethnic group identification, religion, age, sex, color, or disability.
- The right to refuse religious activities
- To be accorded access to his or her file.

COMPLAINTS

In accordance with Title 9, Chapter 4, Section 10544(c), of the California Code of Regulations, any individual may request an inspection of an alcoholism or drug abuse recovery or treatment facility. Complaints should be directed to:

Department of Health Care Services
SUD Compliance Division
1501 Capitol Avenue
PO Box 997413, MS 2601
Sacramento, CA 95899-7413

Attention: Complaint Coordinator
(916) 322-2911
TTY (916) 445-1942
www.dhcs.ca.gov

Acknowledgement

I have been personally advised and have received a copy of my personal rights and have been informed of the provisions for complaints at the time of my admission to: _____

(Client's Signature)

(Date)

Title 22 Fair Hearing Rights

REQUIRED FORM:

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

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Authorized agency representative and client

REQUIRED ELEMENTS:

- **Print Client's Name:** Print client's full name and client shall have a copy of this document.
- **Client's Signature and Date:** Client must sign and date when reviewed.
- **Staff Signature and Date:** The staff reviewing this form with client will sign and date.

TITLE 22 FAIR HEARING RIGHTS

(STATE ADP- 7-1-97 AMENDMENT)

All clients have the right to a fair hearing related to denial, involuntary discharge, or reduction in Short-Doyle Drug Medi-Cal substance abuse services as it relates to eligibility or benefits, pursuant to Section 50951.

(Provider) shall advise clients in writing at least ten (10) calendar days prior to the effective date of the intended action to terminate or reduce services. The written notice shall include:

1. A statement of the action intends to take
2. The reason for the intended action
3. A citation of the specific regulation(s) supporting the intended action
4. An explanation of the client's rights to a fair hearing for the purpose of appealing the intended action
5. An explanation that the client may request a fair hearing by submitting a written request to:

Department of Social Services
State Hearings Division
P.O. Box 944243, M.S. 9-17-37
Sacramento, CA 94244-2430

Oral request should be directed to:
Telephone: 1-800-952-5253
TDD: 1-800-952-8349

6. An explanation that **(Provider)** shall continue treatment services pending a fair hearing decision only if the client appeals in writing to DSS (address above) for a hearing within ten (10) calendar days of the mailing or personal delivery of the notice of intended action.

ALL FAIR HEARINGS SHALL BE CONDUCTED IN ACCORDANCE WITH SECTION 50953.

I, (Print Client's Name) _____, have read and understand my rights for a fair hearing and have been given a copy of this document.

Client's Signature

Date

Staff Signature

Date

Notice of Privacy Practices/HIPAA

This is not a standardized form. Place current Notice of Privacy Practices/HIPAA used by your agency in this section.

Consent to Follow Up

This is not a standardized form. Place current Consent to Follow Up form used by your agency in this section.

Consent for Photo, TV, Video

This is not a standardized form. Place current Consent for Photo, TV and Video used by your agency in this section.

Coordination of Care Consent Form

REQUIRED FORM:

This form is a required document in the client file. Care Coordination is an essential part of providing behavioral health services to ensure client needs are met, including physical health needs. These forms facilitate communication with primary care at intake regarding significant changes with medication and at client discharge. Within 30 days of opening to services, it is important that client is connected to primary care provider (PCP).

WHEN:

Completed at Intake, but no later than 30 days from admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

There are two forms to facilitate communication with primary care.

FORM 1: Coordination and/or Referral of Physical & Behavioral Health Form (4 page form)

- Provider complete form at intake, but no later than 30 days from admission
- Provider obtain written consent from the client/guardian
- For clients that do not have a PCP, provider will connect them to a medical home
- Provider will send completed form to PCP for completion.
- Provider shall check the appropriate box at the top of form (on pg 1 of 4), noting if this is a:

Referral for ***Physical Healthcare****

Referral for ***Physical Healthcare & Medication Management****

Referral for ***Total Healthcare*** or

Coordination of Care notification only

*if the referral is for ***Physical Healthcare*** or ***Physical Healthcare & Medication Management***, please enter your program name in the blank space and select the appropriate box for program type: Mental Health or Alcohol and Drug

Section A: Client Information

Complete all client information as prompted by the form.

Section B: Behavioral Health Provider Information

Complete this section with your program's information as prompted.

Section C: Primary Care Physician Information

If the client has a Primary Care Physician, provide the PCP's relevant information in this section. If the client does not have a PCP, provide the information of the doctor or clinic to which client is being referred.

Section D: (For Primary Care Physician Completion)

Signature of Individual or Legal Representative:

Client or client's legal representative provides signature and date in this section.

Expiration:

Provide an expiration date, event or condition (i.e. discharge) for the authorization. Client, with the guidance of authorized agency representative, will select the type of information they wish to authorize for release by checking all applicable check boxes.

I Would Like a Copy of This Authorization:

Client or authorized agency staff will check the corresponding yes or no check box indicating whether the client wishes to receive a copy of the authorization.

This form should be faxed to client's Primary Care Physician or Medical Home to which client is being referred.

FORM 2: Coordination of Physical and Behavioral Health Update Form (1 pg form)

- Provider will complete form if there are significant changes to client medication (change in dosage of current medication reported at the discretion of psychiatrist).
- On upper right side box of form—"Date Release of Information Signed" provider are to enter the ***original*** date that was signed by the client/guardian on the ***Coordination and/or Referral of Physical & Behavioral Health Form*** (on pg 3 of 4)
- Provider will send **completed** form to PCP when client is discharged from program (this form shall be completed prior to completion of a discharge summary).

NOTES:

- Users of these forms are responsible to have a system in place to track:
 1. **Expiration Date** of the authorization
 2. **Written Revocation** of the authorization
 3. **Discontinue** of the authorization upon termination of treatment (60 days after discharge)

Coordination with Primary Care Physicians and Behavioral Health Services

Coordination of care between behavioral health care providers and health care providers is necessary to optimize the overall health of a client. Behavioral Health Services (BHS) values and expects coordination of care with health care providers, linkage of clients to medical homes, acquisition of primary care provider (PCP) information and the entry of all information into the client's behavioral health record. With healthcare reform, BHS providers shall further strengthen integration efforts by improving care coordination with primary care providers. Requesting client/guardian authorization to exchange information with primary care providers is mandatory, and upon authorization, communicating with primary care providers is required. **County providers shall utilize the *Coordination and/or Referral of Physical & Behavioral Health Form & Update Form*, while contracted providers may obtain legal counsel to determine the format to exchange the required information. This requirement is effective immediately and County QI staff and/or COTR will audit to this standard beginning FY 13-14.**

For all clients:

Coordination and/or Referral of Physical & Behavioral Health Form:

- Obtain written consent from the client/guardian on the *Coordination and/or Referral of Physical & Behavioral Health Form*/ contractor identified form at intake, but no later than 30 days of episode opening.
- For clients that do not have a PCP, provider shall connect them to a medical home. Contractor will initiate the process by completing the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form and sending it to the PCP within 30 days of episode opening. It is critical to have the specific name of the treating physician.
- Users of the form shall check the appropriate box at the top of the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form noting if this is a referral for physical healthcare, a referral for physical healthcare and medication management, a referral for total healthcare, or coordination of care notification only. If it is a referral for physical healthcare, or physical healthcare and medication management, type in your program name in the blank, and select appropriate program type.

Coordination of Physical and Behavioral Health Update Form:

- Update and send the *Coordination of Physical and Behavioral Health Update Form* /contractor form if there are significant changes like an addition, change or discontinuation of a medication.
- Notify the PCP when the client is discharged from services by sending the *Coordination of Physical and Behavioral Health Update Form* /contractor form. The form shall be completed prior to completion of a discharge summary.

Tracking Reminders:

- Users of the form shall have a system in place to track the expiration date of the authorization to release/exchange information.
- Users of the form shall have a system in place to track and adhere to any written revocation for authorization to release/exchange information.
- Users of the form shall have a system in place to track and discontinue release/exchange of information upon termination of treatment relationship. Upon termination of treatment the provider may only communicate the conclusion of treatment, but not the reason for termination.



Coordination and/or Referral of Physical & Behavioral Health Form

- Referral for *physical* healthcare – [_____] will continue to provide specialty behavioral health services
 Mental Health Alcohol and Drug
- Referral for *physical* healthcare & Medication Management – [_____] will continue to provide limited specialty behavioral health services
 Mental Health Alcohol and Drug
- Referral for *total* healthcare – [_____] is no longer providing specialty behavioral health services.
 Available for psychiatric consult.
- Coordination of care notification only.

Section A: CLIENT INFORMATION

Client Name: Last	First	Middle Initial	AKA	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address			Date of Birth	
City			Telephone #	
Zip			Alternate Telephone #	

Section B: BEHAVIORAL HEALTH PROVIDER INFORMATION

Name of Treatment Provider:	Name of Treating Psychiatrist (If applicable)
Agency/Program	
Street Address	City, State, Zip
Telephone #	Specific provider secure fax # or secure email address:
Date of Initial Assessment:	
Focus of Treatment (<i>Use Additional Progress Note if Needed</i>)	
Case Manager/ Mental Health Clinician/ Alcohol and Drug Counselor/ Program Manager:	Behavioral Health Nurse: Phone #:



Date Last Seen	Mental Health Diagnoses:
	Alcohol and Drug Related Diagnoses:

Current Mental and Physical Health Symptoms *(Use Additional Progress Note if Needed)*

Current Mental Health and Non-Psychiatric Medication and Doses
(Use Additional Medication/Progress Note if Needed)

Last Psychiatric Hospitalization
 Date: None

Section C: PRIMARY CARE PHYSICIAN INFORMATION

Provider's Name

Organization OR Medical Group

Street Address

City, State, Zip

Telephone #:	Specific provider secure fax # or secure email address:
--------------	---

**Section D: FOR PRIMARY CARE PHYSICIAN COMPLETION
 ACCEPTED FOR TREATMENT OR REFERED BACK TO SDCBHS
 PROGRAM (PLEASE COMPLETE THE FOLLOWING INFORMATION AND
 RETURN TO BEHAVIORAL HEALTH PROVIDER WITHIN TWO WEEKS
 OF RECEIPT)**

Coordination of Care notification received.
 If this is a primary care referral, please indicate appropriate response below:

1. Patient accepted for physical health treatment only
2. Patient accepted for physical healthcare and psychotropic medication treatment while additional services continue with behavioral health program
3. Patient accepted for total healthcare including psychotropic medication treatment
4. Patient not accepted for psychotropic medication treatment and referred back due to:



Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:

I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:
------------	-------

Client Name (Please type or print clearly)

Last:	First:	Middle:
--------------	---------------	----------------

IF SIGNED BY LEGAL REPRESENTATIVE, PRINT NAME:	RELATIONSHIP OF INDIVIDUAL:
--	-----------------------------

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

- | | |
|--|--|
| <input type="checkbox"/> Information Contained on this form
<input type="checkbox"/> Current Medication & Treatment Plan
<input type="checkbox"/> Substance Dependence Assessments
<input type="checkbox"/> Assessment /Evaluation Report | <input type="checkbox"/> Discharge Reports/Summaries
<input type="checkbox"/> Laboratory/Diagnostics Test Results
<input type="checkbox"/> Medical History
<input type="checkbox"/> Other _____ |
|--|--|

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the medical records and Information/updates concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.



I would like a copy of this authorization **Yes** **No**
Clients/Guardians Initials

➔ Please place a copy of this Form in your client's chart

TO REACH A PLAN REPRESENTATIVE

Care1st Health Plan
(800) 605-2556

Community Health Group
(800) 404-3332

Health Net
(800) 675-6110

Kaiser Permanente
(800) 464-4000

Molina Healthcare
(888) 665-4621

Access & Crisis Line
(888) 724-7240





COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH UPDATE FORM

CLIENT NAME

Last First Middle

Date of Birth Male Female

BEHAVIORAL HEALTH UPDATE

Date: _____

Treating Provider Name

Phone _____

FAX _____

Treating Psychiatrist Name (If applicable)

Phone _____

FAX _____

Medications prescribed on _____
Date

Name/Dosage: _____

Medications changed on _____
Date

Name/Dosage: _____

Medications discontinued on _____
Date

Name/Dosage: _____

Medications prescribed on _____
Date

Name/Dosage: _____

Medications changed on _____
Date

Name/Dosage: _____

Medications discontinued on _____
Date

Name/Dosage: _____

Diagnosis Update :

Key Information Update:

Discharge from Treatment Date:

Follow-up Recommendations:

PRIMARY CARE PHYSICIAN UPDATE

Please provide any relevant Update/Change to Patient's Physical Health Status.

Section 3 Assessments

F301	Stay Review Justification *
F302	Alcohol/Drug History
F303	ASI/YAI
F304	Co-Occurring Conditions Screening
F305a,b	High Risk Assessment (HRA) and High Risk Index (HRI)
	Additional Assessments

*Medi-Cal providers

Stay Review Justification

REQUIRED FORM:

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

WHEN:

This form must be completed no sooner than five months and no later than six months from client's admission to program, or last Stay Review Justification.

COMPLETED BY:

Authorized agency representative and Medical Director

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **Admission Date:** Complete the date of admission.
- **Client ID#:** Complete the client ID number as determined by agency guidelines.
- **Client's progress in treatment during the past six months (detailed & descriptive):** Complete a detailed and descriptive summary of client's progress in treatment during the past six months.
- **Medical/psychological reasons to continue treatment (include DSM-IV criteria for substance abuse or substance dependence) (DSM-IV):** Complete DSM-IV code and document medical/psychological reasons that client should continue treatment including criteria for substance abuse or substance dependence.
- **Consequences of discontinuing treatment:** Complete consequences that may occur if client discontinues treatment. (e.g., recidivism, relapse).
- **Target date for client to complete treatment:** Complete the expected target date client will complete treatment.
- **Verification of continued Medi-Cal eligibility confirmed by program:** Complete client's confirmed verification of Medi-Cal eligibility, and then check "yes" box.
- **What is expected to be achieved during continued treatment (Must include Client's Prognosis):** Mark the appropriate box for client's prognosis (good, fair, poor) and explain. Complete a summary of what client is expected to achieve during continued treatment.
- **Primary Counselor Signature and Date:** Counselor completing form and determining that continued treatment is medically necessary must sign and date.
- **Medical Director Signature and Date:** Medical Director reviewing this form to determine the need for continuing services must sign and date.

NOTES:

- If Stay Review Justification to continue services is missing from client's file, all Medi-Cal billings submitted after the date the justification was due (within six months from admission date) will be disallowed.

Stay Review Justification

Client Name: _____ Admission Date: _____

Client I.D. #: _____

Client's progress in treatment during the past six months (detailed & descriptive):

Medical/psychological reasons to continue treatment (include DSM-IV criteria for substance abuse or substance dependence) DSM-IV: _____

Consequences of discontinuing treatment:

Target date for client to complete treatment: _____

Verification of continued Medi-Cal eligibility confirmed by program yes, see file for M/C eligibility report(s).

What is expected to be achieved during continued treatment: **(MUST include Client's Prognosis)**

Client's Prognosis is: Good Fair Poor (elaborate)

After reviewing the above information, I have determined that continued treatment is medically necessary.

Primary Counselor

Date

Medical Director Signature

Date

Alcohol and Drug History

REQUIRED FORM:

This form is an optional document in client file

WHEN:

Completed at Screening/Intake Admission or at the time of Assessment

COMPLETED BY:

Authorized agency representative with client

REQUIRED ELEMENTS:

- **Client Name:** Complete the client's full name.
- **Date:** Complete the date the form is completed.
- **Drug Name:** Complete the name of specific drug or type of alcohol.
- **Age First Used:** Complete the age client first used specific alcohol or drug.
- **Age Regular use began:** Complete the age client used specific alcohol or drug regularly. Regular use refers to the pattern of use becoming more frequent.
- **Frequency 30 Days Prior to Treatment:** Complete the frequency of use. Frequency refers to the number of days the specific alcohol or drug used (i.e., daily, every other day, once a week, etc.).
- **Usual Route:** Complete the usual route of administration. Usual route refers to the preferred method(s) the client uses specific alcohol or drugs (e.g., oral, smoking, inhalation, injection, other).
- **Date last Used:** Complete the last date client used specific alcohol or drugs.
- **Average Amount Used at One Time:** This section refers to amount of alcohol or drug client used at one setting (e.g., four 24 oz of light beer, one gram of heroin, etc.).
- **Problem Rank:** This section reflects the client's self-reported level of concern or problem with specific alcohol or drugs. The ranking is numerical, with number one being the most troubling substance.

Alcohol & Drug History

Client Name: _____ Date: _____

Drug (Circle if Ever Used)	Drug Name	Age First Used	Age Regular Use Began	Frequency 30 Days Prior to Treatment	Usual Route (Oral, Smoke, Inhalation, I.V.)	Date Last Used	Average Amount Used at One Setting	Problem Rank*
Alcohol								
Amphetamine								
Cocaine								
Heroin								
Marijuana/Hash								
Other Opiates								
Sedatives								
Hallucinogens								
Inhalants								
Club Drugs								
PCP/Angel Dust								
Non-Prescribed Methadone								
Over The Counter								
Other								

*Rank is numerical with 1 being most troubling substance.

Staff Signature: _____ Date: _____

ASI (Addiction Severity Index Lite) and YAI (Youth Assessment Index)

REQUIRED FORM:

This form is a required document in client's file

WHEN:

This form must be completed within the following timelines:

Outpatient- within 30 days of admission

Long-term residential- (31 days or more) – within 14 days of admission

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

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- All sections of the ASI/YAI must be completed.
- Follow all guidelines on the ASI and YAI instrument.
- Refer to the ASI/YAI manual for any further instructions.

NOTES:

It is a good practice to conduct the ASI/YAI as soon as possible to develop a treatment plan in a timely manner. Programs may complete this form on paper, CalOMS, or other electronic format.

Addiction Severity Index *Lite* - CF

Clinical/Training Version

Thomas McLellan, Ph.D.

John Cacciola, Ph.D.

Deni Carise, Ph.D.

Thomas H. Coyne, MSW

Remember: This is an interview, not a test

≠Item numbers circled are to be asked at follow-up.≠

≠Items with an asterisk* are cumulative and should be rephrased at follow-up.≠

≠Items in a double border gray box are questions for the interviewer. Do not ask these questions of the client.≠

INTRODUCING THE ASI: Seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychological. All clients receive this same standard interview. All information gathered is confidential.

There are two time periods we will discuss:

1. The past 30 days
2. Lifetime Data

Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.

The scale is:

- 0 - Not at all
- 1 - Slightly
- 2 - Moderately
- 3 - Considerably
- 4 - Extremely

If you are uncomfortable giving an answer, then don't answer.

Please do not give inaccurate information!

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.
2. Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. X = Question not answered.
N = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.
6. Tutorial/clarification notes are preceded with "•".

HALF TIME RULE: If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

CONFIDENCE RATINGS: ⇒ Last two items in each section.
⇒ Do not over interpret.
⇒ Denial does not warrant misrepresentation.
⇒ Misrepresentation = overt contradiction in information.

Probe and make plenty of comments!

HOLLINGSHEAD CATEGORIES:

1. Higher execs, major professionals, owners of large businesses.
2. Business managers of medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, small businesses (bank teller, bookkeeper, clerk, draftsman, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeman, chef, electrician, fireman, lineman, machinist, mechanic, paperhanger, painter, repairman, tailor, welder, policeman, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).
8. Homemaker.
9. Student, disabled, no occupation.

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, Tuinal, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinal
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral Hydrate, 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, Psilocybin (Mushrooms), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstasy
Inhalants:	Nitrous Oxide (Whippits), Amyl Nitrite (Poppers), Glue, Solvents, Gasoline, Toluene, Etc.
Just note if these are used:	Antidepressants, Ulcer Meds = Zantac, Tagamet Asthma Meds = Ventolin Inhaler, Theodur Other Meds = Antipsychotics, Lithium

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. However if the client has been incarcerated for more than 1 year, you would only gather lifetime information, unless the client admits to significant alcohol /drug use during incarceration. This guideline only applies to the Alcohol/Drug Section.

- ⇒ 30 day questions only require the number of days used.
- ⇒ Lifetime use is asked to determine extended periods of use.
- ⇒ Regular use = 3+ times per week, binges, or problematic irregular use in which normal activities are compromised.
- ⇒ Alcohol to intoxication does not necessarily mean "drunk", use the words felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule of thumb, 5+ drinks in one setting, or within a brief period of time defines "intoxication".
- ⇒ "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....?"

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 | |

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

3a. Current marital status of natural parents:
0=Never Married 4=Both Deceased
1=Married and living together 5=Father Deceased

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

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)

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 working>>

h. Occupation: _____
i. Employer: _____
j. Address: _____
(city) (state) (zip) (county)
k. (____) - _____ Hours: : - :
Work Phone From To

<<If not working>>

I. 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 7=Lack of job skills
substance abuse problems 8=Retired
3=Needed at home to work or take 9=Other
care of other family members N=Not applicable (employed)
4=Attending School

<<If not working>>

I. 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 7=Lack of job skills
substance abuse problems 8=Retired
3=Needed at home to work or take 9=Other
care of other family members N=Not applicable (employed)
4=Attending School

m. Income: Pension: \$ _____
Employment: \$ _____ Family: \$ _____
Public Assistance: \$ _____ Illegal: \$ _____
Disability: \$ _____

m. Income: Pension: \$ _____
Employment: \$ _____ Family: \$ _____
Public Assistance: \$ _____ Illegal: \$ _____
Disability: \$ _____

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

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:

o. Highest Grade Completed:

OTHER PRIMARY CARETAKER:

a. Name: _____
b. Relationship: _____

6. OTHER INVOLVED ADULTS:

a. _____
Name
b. _____
Relationship
c. _____

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:

Days

6. Have you ever received any special programming?

0=No
1=Yes

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

0=No
1=Yes

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

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

Days

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

0=No
1=Yes

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 1=Minor
2=Moderate 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

DIRECTIONS: For each section, count the number of “yes” answers and put that number by the corresponding score.	
<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>	SCORE: _____
<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>	SCORE: _____
<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>	SCORE: _____

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.

TB Screening Questionnaire

Client Name: _____ DOB: _____ ID #: _____
Last First

- **ARE YOU COUGHING FOR MORE THAN 3 WEEKS?** Yes No
- **Have you recently coughed up blood?** Yes No
- **Have you lost more than 5 lbs in the last 2 months?** Yes No
- **Have you had frequent fevers in the last month?** Yes No
- **Have you had unusual sweating, especially at night?** Yes No

- If YES to cough and YES to one or more of the other TB symptom questions: See **★TB SUSPECT★** below.
- Other findings: Refer to a medical provider, as needed, depending on the severity of symptoms.

- **HAVE YOU EVER HAD A TB SKIN TEST (TST)?** Yes No
 What was the result? Positive Negative
 Do you have proof of your TST? Yes No

PREVIOUS TST DOCUMENTATION: Record TST date and size:
 Copy TST document for program and client records

TST Date:

Size in mm:

SUMMARY (check all applicable):

_____ TST NOT KNOWN/NO PREVIOUS TST DONE: Refer client for TST ASAP (7 days maximum).

_____ TST NEGATIVE (no documentation available): Refer client for TST ASAP (7 days maximum).

_____ TST NEGATIVE (documented as done within last 3 months): No TST needed now. Repeat TST yearly.

_____ TST POSITIVE HISTORY (no documentation): Refer for an evaluation of TST history ASAP (7 days maximum).

_____ TST POSITIVE HISTORY (documented; date and size recorded above):
 Chest X-ray needed within 7 days of admission UNLESS client presents documented proof of a "normal" X-ray done within the last 3 months. Copy X-ray report for clinic record and record date here.

Chest X-ray date:

_____ **★TB SUSPECT★** (cough with one or more TB symptoms): Contact TB Control to arrange immediate evaluation.

Staff completing this form: _____ Date: _____

Developed by TB Control, County of San Diego * 619-692-5565

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.

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	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; border-right: 1px solid black; padding: 5px;">mm</td> <td style="width: 10%; text-align: center; padding: 5px;">/</td> <td style="width: 20%; border-right: 1px solid black; padding: 5px;">dd</td> <td style="width: 10%; text-align: center; padding: 5px;">/</td> <td style="width: 30%; padding: 5px;">yyyy</td> </tr> </table>	mm	/	dd	/	yyyy
mm	/	dd	/	yyyy		
Discharge Date	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; border-right: 1px solid black; padding: 5px;">mm</td> <td style="width: 10%; text-align: center; padding: 5px;">/</td> <td style="width: 20%; border-right: 1px solid black; padding: 5px;">dd</td> <td style="width: 10%; text-align: center; padding: 5px;">/</td> <td style="width: 30%; padding: 5px;">yyyy</td> </tr> </table>	mm	/	dd	/	yyyy
mm	/	dd	/	yyyy		
Discharge Status (enter code)						

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

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	Outcome of Pregnancy T = Terminated M = Miscarried D = Drug Free Birth N = Not Drug Free Birth
+^ HIV Test Results Received	Circle: Y / N	
∞ Pregnant at any time during Treatment	Circle: Y / N	
Outcome of Pregnancy	Circle: T M D N	

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.