



Organization Name:	Program Name:	Date:
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Individual's Name (First MI Last):	Record #:	DOB:
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Provider Number:	Program Number:
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Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date Last Treated:
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Education at Discharge
(if education at admission was entered incorrectly, it must be updated in "Client Management" online)

Highest Grade Completed		
<input type="checkbox"/> No formal education	<input type="checkbox"/> 6th	<input type="checkbox"/> High School Diploma
<input type="checkbox"/> 1st	<input type="checkbox"/> 7th	<input type="checkbox"/> General Equivalency Diploma
<input type="checkbox"/> 2nd	<input type="checkbox"/> 8th	<input type="checkbox"/> Vocational Cert w/o Diploma/GED
<input type="checkbox"/> 3rd	<input type="checkbox"/> 9th	<input type="checkbox"/> Vocational Cert w/ Diploma/GED
<input type="checkbox"/> 4 th	<input type="checkbox"/> 10th	<input type="checkbox"/> Some College – No degree
<input type="checkbox"/> 5th	<input type="checkbox"/> 11 th	<input type="checkbox"/> Associates Degree
		<input type="checkbox"/> Bachelors Degree
		<input type="checkbox"/> Graduate Degree

Employment

Employment Status		
<input type="checkbox"/> Employed FullTime-35+ hrs/wk	<input type="checkbox"/> Not in Labor Force, Disabled	<input type="checkbox"/> Soc Svcs Work Exp Program
<input type="checkbox"/> Employed Part Time-<35 hrs/wk	<input type="checkbox"/> Not in Labor Force, In Training	<input type="checkbox"/> Soc Svcs Determined, Not Employed/Able to Work
<input type="checkbox"/> Employed in Sheltered Workshop	<input type="checkbox"/> Not in Labor Force, Inmate	<input type="checkbox"/> Soc Svcs Determined, Unable to Work, Mandated Treatment
<input type="checkbox"/> Unemployed, In Treatment	<input type="checkbox"/> Not in Labor Force, Retired	
<input type="checkbox"/> Unemployed, Looking for Work	<input type="checkbox"/> Not in Labor Force, Student	
<input type="checkbox"/> Not in Labor Force, Child Care	<input type="checkbox"/> Not in Labor Force, Other	

Length of Employment at Discharge: 0-30 Days 31- 60 Days 61-90 Days 91-120 Days 121 + Days

Individual's Place of Residence

Type of Residence		
<input type="checkbox"/> Private Residence	<input type="checkbox"/> CD Community Residence	<input type="checkbox"/> MH/OPWDD Community Residence
<input type="checkbox"/> Homeless, Shelter	<input type="checkbox"/> CD Supportive Living	<input type="checkbox"/> Other Group Residential Setting
<input type="checkbox"/> Homeless, No Shelter		<input type="checkbox"/> Institution, Other (Jail/Hospital)
<input type="checkbox"/> Single Resident Occupancy		<input type="checkbox"/> Other

Living Arrangements: Living Alone Living w/ Non-Related Persons Living with Spouse/Relatives

Primary Payment Source (Select One)		
<input type="checkbox"/> None	<input type="checkbox"/> Medicaid Pending	<input type="checkbox"/> Private Insurance – Fee for Service
<input type="checkbox"/> Self-Pay	<input type="checkbox"/> Medicare	<input type="checkbox"/> Private Insurance – Managed Care
<input type="checkbox"/> Medicaid	<input type="checkbox"/> DSS Congregate Care	<input type="checkbox"/> Other:
<input type="checkbox"/> Medicaid Managed Care	<input type="checkbox"/> Department of Veterans Affairs	

Mental Health

Co-existing Psychiatric disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ever Treated for a mental illness problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ever Hospitalized for mental illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No



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Ever Hospitalized for 30 or more days for mental illness Yes No

Total Treatment Visits
(For use only by Outpatient Programs-Excluding Methadone Maintenance Programs)

Total Treatment Visits:	Individual Counseling Sessions:	(Provided by a primary counselor)
	Group Counseling Sessions:	(Provided by a primary counselor)
	Family Counseling Sessions:	(Provided by any direct care staff)

Recent History

Has the Individual attended 12 step or other self-help groups in the last 30 days? No Yes

No. of Arrests in Prior 30 Days (or during treatment if stay was less than 30 days):

Six Months Prior to Discharge (or during treatment if stay was less than 6 months):
 No. of Arrests: No. of Days Incarcerated:

No. of Days Hospitalized: No. of Days in Inpatient Detox:

No. of ER Episodes:

Status of Alcohol and Other Drug Use at Discharge

	Substance*	Frequency of Use at Discharge**
Primary		
Secondary		
Tertiary		

* Substance(s) reported at admission will be pre-filled on the Client Data System
 ** Frequency of Use: No use in last 30 days; 1-3 times last 30 days; 1-2 times per week; 3-6 times per week; Daily

Status of Different Problem Substances Used and Not Reported at Admission (if any)

Primary Substance (listed alphabetically):

<input type="checkbox"/> NONE	<input type="checkbox"/> Crack	<input type="checkbox"/> Khat	<input type="checkbox"/> Viagra
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Marijuana/Hashish	<input type="checkbox"/> Other Amphetamine
<input type="checkbox"/> Alprazolam (Xanax)	<input type="checkbox"/> Ephedrine	<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Other Hallucinogen
<input type="checkbox"/> Barbiturate	<input type="checkbox"/> Elavil	<input type="checkbox"/> Methadone (Non-Rx)	<input type="checkbox"/> Other Opiate/Synthetic
<input type="checkbox"/> Benzodiazepine (Klonopin)	<input type="checkbox"/> GHB	<input type="checkbox"/> Over-the-Counter	<input type="checkbox"/> Other Sedative/Hypnotic
<input type="checkbox"/> Buprenorphine	<input type="checkbox"/> Heroin	<input type="checkbox"/> OxyContin	<input type="checkbox"/> Other Stimulant
<input type="checkbox"/> Catapres (Clonidine)	<input type="checkbox"/> Inhalant	<input type="checkbox"/> PCP	<input type="checkbox"/> Other Tranquillizer
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Ketamine	<input type="checkbox"/> Rohypnol	<input type="checkbox"/> Other:

Primary Route: Inhalation Injection Oral Smoking Other

Primary Frequency: No use last 30 days 1-3 times last 30 days 1-2 times per week 3-6 times per week Daily



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Secondary Substance:

<input type="checkbox"/> NONE	<input type="checkbox"/> Crack	<input type="checkbox"/> Khat	<input type="checkbox"/> Viagra
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Marijuana/Hashish	
<input type="checkbox"/> Alprazolam (Xanax)	<input type="checkbox"/> Ephedrine	<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Other Amphetamine
<input type="checkbox"/> Barbiturate	<input type="checkbox"/> Elavil	<input type="checkbox"/> Methadone (Non-Rx)	<input type="checkbox"/> Other Hallucinogen
<input type="checkbox"/> Benzodiazepine (Klonopin)	<input type="checkbox"/> GHB	<input type="checkbox"/> Over-the-Counter	<input type="checkbox"/> Other Opiate/Synthetic
<input type="checkbox"/> Buprenorphine	<input type="checkbox"/> Heroin	<input type="checkbox"/> OxyContin	<input type="checkbox"/> Other Sedative/Hypnotic
<input type="checkbox"/> Catapres (Clonidine)	<input type="checkbox"/> Inhalant	<input type="checkbox"/> PCP	<input type="checkbox"/> Other Stimulant
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Ketamine	<input type="checkbox"/> Rohypnol	<input type="checkbox"/> Other Tranquillizer
<input type="checkbox"/> Other:			

Secondary Route:

Inhalation Injection Oral Smoking Other

Secondary Frequency: No use last 30 days 1-3 times last 30 days 1-2 times per week 3-6 times per week Daily

Tertiary Substance:

<input type="checkbox"/> NONE	<input type="checkbox"/> Crack	<input type="checkbox"/> Khat	<input type="checkbox"/> Viagra
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Marijuana/Hashish	
<input type="checkbox"/> Alprazolam (Xanax)	<input type="checkbox"/> Ephedrine	<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Other Amphetamine
<input type="checkbox"/> Barbiturate	<input type="checkbox"/> Elavil	<input type="checkbox"/> Methadone (Non-Rx)	<input type="checkbox"/> Other Hallucinogen
<input type="checkbox"/> Benzodiazepine (Klonopin)	<input type="checkbox"/> GHB	<input type="checkbox"/> Over-the-Counter	<input type="checkbox"/> Other Opiate/Synthetic
<input type="checkbox"/> Buprenorphine	<input type="checkbox"/> Heroin	<input type="checkbox"/> OxyContin	<input type="checkbox"/> Other Sedative/Hypnotic
<input type="checkbox"/> Catapres (Clonidine)	<input type="checkbox"/> Inhalant	<input type="checkbox"/> PCP	<input type="checkbox"/> Other Stimulant
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Ketamine	<input type="checkbox"/> Rohypnol	<input type="checkbox"/> Other Tranquillizer
<input type="checkbox"/> Other			

Tertiary Route:

Inhalation Injection Oral Smoking Other

Tertiary Frequency: No use last 30 days 1-3 times last 30 days 1-2 times per week 3-6 times per week Daily

Tobacco

Frequency of Use in past 30 days (if stay is less than 30 days report use since admission or since last MCAS (for methadone programs)):

No use last 30 days 1-3 times last 30 days 1-2 times per week 3-6 times per week Daily

Date last used: Month: / Year: (not entered if stay is less than 30 days)

Primary Route of Administration: Smoking Chewing

Discharge Status/Disposition

<p>Discharge Status (Check One)</p> <p><input type="checkbox"/> Completed Treatment: All Goals Met</p> <p><input type="checkbox"/> Completed Treatment: Half or More Goals Met</p> <p><input type="checkbox"/> Treatment Not Completed: Maximum Benefit/Clinical Discharge</p> <p><input type="checkbox"/> Treatment Not Completed: Some Goals Met</p> <p><input type="checkbox"/> Treatment Not Completed: No Goals Met</p>	<p>Discharge Disposition (Check One)</p> <p><input type="checkbox"/> Additional treatment at this level of care no longer necessary</p> <p><input type="checkbox"/> Further treatment at this level unlikely to yield added clinical gains</p> <p><input type="checkbox"/> Left against clinical advice: Formal referral made/offered</p> <p><input type="checkbox"/> Left against clinical advice: Lost to contact (no referral possible)</p> <p><input type="checkbox"/> Left against clinical advice: Termination of third party funds</p> <p><input type="checkbox"/> Discharged due to non-compliance with program rules</p> <p><input type="checkbox"/> Discharged due to regulatory requirements (note: crisis programs)</p> <p><input type="checkbox"/> Individual arrested/incarcerated</p> <p><input type="checkbox"/> Individual could no longer participate for medical/psych. reasons</p> <p><input type="checkbox"/> Individual death</p> <p><input type="checkbox"/> Individual relocated</p> <p><input type="checkbox"/> Program closed</p>
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Referral Disposition (Check One)



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<input type="checkbox"/> No referral made <input type="checkbox"/> Individual not in need of additional services <input type="checkbox"/> Referred back to Chemical Dependence (CD) program <input type="checkbox"/> Referred to other CD program	<input type="checkbox"/> Referred to Mental Health (MH) Program <input type="checkbox"/> Referred to non-CD or non-MH program <input type="checkbox"/> Referred to Gambling Program <input type="checkbox"/> Refused referral
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Referral Category (Check One)

Chemical Dependency (CD) Programs <input type="checkbox"/> CD Program in New York State <input type="checkbox"/> CD Program Out of State <input type="checkbox"/> CD VA Program <input type="checkbox"/> CD Private Practitioner	Mental Health Programs <input type="checkbox"/> Mental Health Community Residence <input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Mental Health Outpatient <input type="checkbox"/> Office of Persons with Developmental Disabilities (OPWDD)	Health Institutions <input type="checkbox"/> Hospital <input type="checkbox"/> Hospital (Long Term) <input type="checkbox"/> Nursing Home, Long Term Care <input type="checkbox"/> Group Home, Foster Care <input type="checkbox"/> Other Referral <input type="checkbox"/> No Referral Made <input type="checkbox"/> Refused Referral
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Evaluation of Individual's Goal Achievement

1. (a) Chemical Dependence/ Abuse (DRUG USE)	1. (b) Chemical Dependence/ Abuse (ALCOHOL USE)	1. (c) Chemical Dependence/ Abuse (TOBACCO/NICOTINE)	2. Medical/Physical Health Conditions
<input type="checkbox"/> Achieved	<input type="checkbox"/> Achieved	<input type="checkbox"/> Achieved	<input type="checkbox"/> Achieved
<input type="checkbox"/> Partial Achievement	<input type="checkbox"/> Partial Achievement	<input type="checkbox"/> Partial Achievement	<input type="checkbox"/> Partial Achievement
<input type="checkbox"/> Not Achieved	<input type="checkbox"/> Not Achieved	<input type="checkbox"/> Not Achieved	<input type="checkbox"/> Not Achieved
<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Not Applicable
3. Emotional/Mental Health Functioning	4. Vocational/Educational Employment	5. Social/Leisure Functioning	6. Family Situation
<input type="checkbox"/> Achieved	<input type="checkbox"/> Achieved	<input type="checkbox"/> Achieved	<input type="checkbox"/> Achieved
<input type="checkbox"/> Partial Achievement	<input type="checkbox"/> Partial Achievement	<input type="checkbox"/> Partial Achievement	<input type="checkbox"/> Partial Achievement
<input type="checkbox"/> Not Achieved	<input type="checkbox"/> Not Achieved	<input type="checkbox"/> Not Achieved	<input type="checkbox"/> Not Achieved
<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Not Applicable
7. Legal	8. Gambling		
<input type="checkbox"/> Achieved	<input type="checkbox"/> Achieved		
<input type="checkbox"/> Partial Achievement	<input type="checkbox"/> Partial Achievement		
<input type="checkbox"/> Not Achieved	<input type="checkbox"/> Not Achieved		
<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Not Applicable		

**Addiction Medications Used During Treatment (Check All That Apply).
Select "None" if no addiction medications were used.**

<input type="checkbox"/> None <input type="checkbox"/> Antabuse <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Campral <input type="checkbox"/> Chantix <input type="checkbox"/> Methadone	<input type="checkbox"/> Naltrexone/Revia/Vivitrol <input type="checkbox"/> Nicotine Gum <input type="checkbox"/> Nicotine Lozenges <input type="checkbox"/> Nicotine Patch <input type="checkbox"/> Zyban/Wellbutrin <input type="checkbox"/> Other Addiction Medications
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Domestic Violence



Organization Name:		Program Name:	Date:
Individual's Name (First MI Last):		Record #:	DOB:
<p>Has the individual ever experienced domestic violence:</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined to Answer</p> <p>Has the individual ever acted toward another in a manner which would be considered domestic violence:</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined to Answer</p>			
Completed By – Print Name/Credentials:		Staff Signature:	Date: