Table of Contents

(Each Section listed Top to bottom)

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(Each Section listed Top to bottom)

Section 6

The Recovery Council – Discharge Summary/Transition Plan

Client Name:_____ **Date:**_____

DISCHARGE SUMMARY/TRANSITION PLAN

Level of Care and Service(s) Provided during Course of Treatment:

☐ Assessment ☐Group Counseling ☐Other Support Services

☐Case Management ☐Individual Counseling ☐Outpatient

☐Crisis Intervention ☐Non-medical residential ☐Urinalysis

Reason for Discharge:

☐Completed ☐Asked to leave by staff ☐Left ASA ☐Other

Client Discharged because of aggressive behavior? ☐Yes ☐No

Additional services or supports recommended? ☐Yes ☐No

Staff identified to follow up: _____

Unplanned discharge? ☐Yes ☐No

Type of follow up completed:

☐Letter sent ☐Phone call made ☐Mail returned as undeliverable

☐Unable to reach client by phone/phone disconnected/number changed

Comments:

Client status at last contact:

☐Actively engaged in services ☐Inconsistent attendance ☐Other

☐Compliant with treatment goals ☐Noncompliant with treatment goals

Client progress/response to treatment services/achievement of goals and objectives. Include statement of Strengths, Needs, Abilities, and Preferences. Include gains achieved during program participation.

Describe:

Recommendations for services, including aftercare options, and/or supports, including referral source and contact information.

Describe:

Medication Information: ☐Listed below ☐N/A – no medications at discharge

If applicable, list medication information (include any medications client is taking at discharge):

Client statement: ☐Client unavailable to sign ☐I do not want a copy of Transition Plan

☐ I received a copy of the Transition Plan

Admission Level of Care: What LOC was client initially admitted to for this tx episode?

☐Detox ☐Non-Intensive Outpatient ☐Other ☐Intensive Outpatient ☐Non-medical Residential

The Recovery Council – Discharge Summary/Transition Plan

Discharge Level of Care Determination:

Dimension 1 – Intoxication/Withdrawal Potential:

☐High symptoms ☐ Moderate symptoms ☐Low symptoms ☐No need for detox ☐No symptoms

Dimension 2- Biomedical Conditions and/or Complications:

☐No symptoms ☐Symptoms present but do not interfere ☐Symptoms require immediate referral

Dimension 3 – Emotional/Behavioral/Cognitive Conditions and Complications:

☐Minimal risk of hurting self/others ☐Symptoms present but do not interfere ☐Symptoms require immediate referral

Dimension 4 – Treatment Acceptance and Resistance:

☐Can be motivated ☐High resistance, unwilling ☐Moderate resistance ☐No/low resistance

Dimension 5 – Relapse Potential:

☐High relapse potential ☐Moderate relapse potential ☐No/low relapse potential

☐Would benefit from additional services

Dimension 6 – Recovery Environment:

☐Environment can be reinforced ☐High symptoms – dangerous to return to environment

☐Moderate symptoms ☐Low symptoms ☐No symptoms

<u>YOUTH ONLY</u>

Dimension 7 – Caregiver/Family Functioning:

☐Family able to provide appropriate support ☐Family needs help to meet needs

☐Home unstable, inconsistent, non-supportive ☐Use of substances in home environment

Relevant Comments:

Abstinence Achieved? ☐Yes ☐No **Employed at discharge? ☐Yes ☐No**

Criminal justice involvement since admission? ☐Yes ☐No **Stable living environment? ☐Yes ☐No**

_____ _____

Client Signature Date

_____ _____

Staff Signature/Credentials Date

_____ _____

Supervisor Signature/Credentials Date

Ohio Behavioral Health
Discharge Form

Unique Provider Number:	**Provider Episode Number:**
First Name:	**Last Name:**
Unique Client Id:	**Date of Birth (mm/dd/yyyy):**
Last Date of Service:	**Closure Date:**

Discharge Reason

- ☐ Successful Completion/Graduate
- ☐ Assessment & Evaluation Only, Successfully Completed no Further Services Recommended
- ☐ Assessment & Evaluation Only, Client Rejected Recommendations
- ☐ Left on Own, Against Staff Advice WITH Satisfactory Progress
- ☐ Left on Own, Against Staff Advice WITHOUT Satisfactory Progress
- ☐ Involuntarily Discharged Due to Non-Participation
- ☐ Involuntarily Discharged Due to Violation of Rules
- ☐ Referred to Another Program or Service with SATISFACTORY Progress
- ☐ Referred to Another Program or Service with UNSATISFACTORY Progress
- ☐ Incarcerated Due to Offense Committed while in Treatment/Recovery with SATISFACTORY Progress
- ☐ Incarcerated Due to Offense Committed while in Treatment/Recovery with UNSATISFACTORY Progress
- ☐ Incarcerated Due to Old Warrant/Charged from Before Entering Treatment/Recovery with SATISFACTORY Progress
- ☐ Incarcerated Due to Old Warrant/Charged from Before Entering Treatment/Recovery with UNSATISFACTORY Progress
- ☐ Transferred to Another Facility for Health Reasons
- ☐ Death
- ☐ Client Moved
- ☐ Needed Services Not Available
- ☐ Other

Did client choose another provider due to religious preference? Yes / No (Faith Based Provider Only)

Educational Level Completed

- ☐ Less Than One Grade
- ☐ First Grade
- ☐ Second Grade
- ☐ Third Grade
- ☐ Fourth Grade
- ☐ Fifth Grade
- ☐ Sixth Grade
- ☐ Seventh Grade
- ☐ Eighth Grade
- ☐ Ninth Grade
- ☐ Tenth Grade
- ☐ Eleventh Grade
- ☐ High School Diploma/GED
- ☐ Technical School
- ☐ Some College
- ☐ 2 Yr. College/Assoc. Degree
- ☐ 4 Yr College/Undergraduate Degree
- ☐ Masters/Doctorate/Other Profession Degree
- ☐ Unknown

Education Enrollment

- ☐ K – 12th Grade
- ☐ GED Classes
- ☐ Vocational/Job Training
- ☐ College
- ☐ Other School; Adult Basic Ed., Literacy
- ☐ Not Enrolled

Pregnancy/Birth Status (if applicable)

- ☐ 1st Trimester
- ☐ 2nd Trimester
- ☐ 3rd Trimester
- ☐ Unknown
- ☐ Birth Occurred: Drug Free Birth
- ☐ Birth Occurred: Not Drug Free
- ☐ Pregnancy Terminated
- ☐ Miscarriage

Employment Status

- ☐ Full Time
- ☐ Part Time
- ☐ Sheltered
- ☐ Unemployed but Actively Looking for Work
- ☐ Homemaker
- ☐ Student
- ☐ Volunteer Worker
- ☐ Retired
- ☐ Disabled
- ☐ Inmate in Jail/Prison/Corrections
- ☐ Engaged in Residential/Hospitalization
- ☐ Other not in Labor Force
- ☐ Unknown

Primary Source of Income/Support

- ☐ Wages/Salary Income
- ☐ Family/Relative
- ☐ Public Assistance
- ☐ Retirement/Pension
- ☐ Disability
- ☐ Other
- ☐ Unknown
- ☐ None

Living arrangements

- ☐ Independent Living (Own Home)
- ☐ Homeless
- ☐ Other's Home
- ☐ Residential Care
- ☐ Respite Care
- ☐ Foster Care
- ☐ Crisis Care
- ☐ Temporary Housing
- ☐ Community Residence
- ☐ Nursing Facility
- ☐ License MR Facility
- ☐ State MH/MR Institution
- ☐ Hospital
- ☐ Correctional Facility
- ☐ Other
- ☐ Unknown

Primary Diagnosis Code

Secondary Diagnosis Code

Tertiary Diagnosis Code

Quaternary Diagnosis Code

Available Drug Choices

Alcohol	Other Hallucinogens	Other Non-Barbiturate Sedatives or Hypnotics
Cocaine/Crack	Methamphetamines	Inhalants
Marijuana/Hashish	Other Amphetamines	Over-the-Counter Medications
Heroin	Other Stimulants	Nicotine
Non-prescription methadone	Benzodiazepines	Other Medications
Other Opiates and Synthetics	Other Non-Barbiturate Tranquilizers	Unknown
PCP	Barbiturates	

☐ No Drug of Choice

Primary Drug of Choice	**Frequency of Use**	**Route of Administration**
(Select from above)	☐ No Use in the last Past Month	☐ Oral
	☐ 1 – 3 Times in the Past Month	☐ Smoking
	☐ 1 – 2 Time in the Past Week	☐ Inhalation
	☐ 3 – 6 Time in the Past Week	☐ Injection
	☐ Daily	☐ Other
	☐ Unknown	☐ Unknown

Secondary Drug of Choice	**Frequency of Use**	**Route of Administration**
(Select from above)	☐ No Use in the last Past Month	☐ Oral
	☐ 1 – 3 Times in the Past Month	☐ Smoking
	☐ 1 – 2 Time in the Past Week	☐ Inhalation
	☐ 3 – 6 Time in the Past Week	☐ Injection
	☐ Daily	☐ Other
	☐ Unknown	☐ Unknown

Tertiary Drug of Choice	**Frequency of Use**	**Route of Administration**
(Select from above)	☐ No Use in the last Past Month	☐ Oral
	☐ 1 – 3 Times in the Past Month	☐ Smoking
	☐ 1 – 2 Time in the Past Week	☐ Inhalation
	☐ 3 – 6 Time in the Past Week	☐ Injection
	☐ Daily	☐ Other
	☐ Unknown	☐ Unknown

Number of Arrests in the Past 30 Days ☐	**Primary Reimbursement**	**Frequency of attendance at self-help programs in the 30 days prior to discharge?**
If an arrest occurred, were you charged with a criminal offense for which the incident was alleged to have happened after you were admitted to this program? Yes / No	☐ Self-Pay ☐ Blue Cross/Blue Shield ☐ Medicare ☐ Medicaid ☐ Other Government Payments ☐ Worker's Compensation ☐ Other Health Insurance Companies ☐ No Charge ☐ Other Payment Source	☐ No attendance in the past month ☐ 1-3 times in the past month ☐ 4-7 times in the past month ☐ 8-15 times in the past month ☐ 16-30 times in the past month ☐ Some attendance in the past month, but frequency unknown ☐ Unknown

Access and Retention Measures	**Family Reunification**	**Women's Program**
2nd Day of Service:	Were children returned to home? Yes / No	Was child care provided? Yes / No
3rd Day of Service:		Did the program provide transportation? Yes / No
4th Day of Service:		Was a referral made for prenatal care? Yes / No

TASC:

Discharge Status: ☐ Successful ☐ Neutral ☐ Unsuccessful	Number of Positive Breathalyzer Screens: ☐	Has the Client been Rearrested? Yes / No
Did the Client Complete Treatment? ☐ Yes ☐ No ☐ Not Applicable	Number of Negative Breathalyzer Screens: ☐	If yes: Has the Client Been Sent to Prison Resulting From the Re-arrest? Yes / No
Is the Client Compliant with all Legal Requirements? Yes / No	Is the client compliant with all legal requirements? Yes / No	What Level of Crime Was Committed? ☐ Misdemeanor ☐ Felony
Number of Positive Urine Screens: ☐	Has the Client Improved Family Relationships? Yes / No	
Number of Negative Urine Screens: ☐		

RECOVERY COUNCIL

Initial Transition Planning Worksheet

1. **The Written Transition Plan:** **a**) Is prepared / updated to ensure seamless transition when a person served: 1) Transfers to another level of care or an aftercare program. 2) Prepares for planned discharge**. b**) Identifies the persons current: 1) Progress in his/her own recovery or move toward well-being 2) Gains achieved during program participation. **c**) Identifies the persons need for support systems or other types of services that will assist in continuing his/her recovery, well-being , or community integration. **d**) Includes information on the continuity of the person's medication(s) when applicable. **e**) Includes referral information, such as contact name, telephone #, locations, hours and days of services, when applicable. **f**) Includes communications of information on options and resources available if symptoms recur or additional services are needed, when applicable.

2. **The Written Transition Plan is: a**) developed with the input and participation of person served and other pertinent entities (family, legal, referral source, etc.). **b**) Given to individuals who participate in development of the transition plan, when permitted.

Date: _____

Client Name: _____

_____

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The Recovery Council

Individualized Treatment Plan

Client Name: _____

Level of Care: _____

Date: _____

Statement of Problems:

1. _____

2. _____

3. _____ Deferred / Referred

4. _____ Deferred / Referred

5. _____ Deferred / Referred

6. _____ Deferred / Referred

7. _____ Deferred / Referred

Referrals to other programs / needs beyond the scope of practice at this agency:

_____

_____

_____

_____

_____

_____

_____

Client Statement of Goals (in client's own words):

_____

_____

_____

_____

_____

_____

_____

The Recovery Council

Individualized Treatment Plan

Client Name: _____ Date: _____

GOALS	OBJECTIVES/INTERMEDIATE STEPS	TARGET DATE
The client will:		
1.	A. B. C.	
2.	A. B. C.	

The Recovery Council

Individualized Treatment Plan

Client Name: _____ Date: _____

GOALS	OBJECTIVES/INTERMEDIATE STEPS	TARGET DATE
The client will:		
3.	A. B. C.	
4.	A. B. C.	

The Recovery Council

Individualized Treatment Plan

Client Name: _____ Date: _____

GOALS	OBJECTIVES/INTERMEDIATE STEPS	TARGET DATE
The client will:		
5.	A. B. C.	
6.	A. B. C.	
7.	A. B. C.	

The Recovery Council

Individualized Treatment Plan

Services to be Provided: Note type, frequency, and duration of treatment services as described in rule 3793-1-08 of the administrative code [2-1-06(k)(6)].

TYPES OF TREATMENT SERVICES

S7 Assessment
S8 Crisis Intervention
S9 Case Management
S10 Individual Counseling
S11 Group Counseling
S12 Family Counseling
S13 Intensive Outpatient
S14 Urinalysis
S15 Medical/Somatic
S16 Methadone Administration
S17 Adjunctive Alcohol/Drug Serv.

Types of Treatment Services	Frequency of Treatment Services	Duration of Treatment Services

Comments/Recommendations:

_____
_____
_____
_____
_____
_____
_____

_____ _____
Client Signature **Date**

_____ _____
Parent/Legal Guardian Signature **Date**

_____ _____
Signature/Credentials of Person Completing ISP **Date**

_____ _____
Signature/Credentials of Clinical Supervisor **Date**

Recovery Council
Care Management Assessment

Name: _____ Date: _____

Address: _____ Phone: _____

Instructions:
Provide any pertinent information in each area of need identified by the client

Financial Assistance / Budgeting _____

Medical/Dental / Vision _____

Recreation & Leisure_____

Transportation _____

Parenting/Children Services_____

Education _____

Criminal Justice / Legal Issues _____

Housing_____

Drug & Alcohol _____

Mental Health_____

Home Care _____

Basic Needs _____

Employment Assistance _____

Applying for social assistance_____

Overall, is there anything else you feel you need that is not covered in the above areas that is related to your substance abuse recovery?
_____
_____
_____

Thank you. Your input is appreciated and will be taken into consideration in the development of your treatment plan.

_____
Client Signature/Date

_____
Clinician/Date

Care Management Plan

(INSTRUCTIONS: This form must be completed every 90 days. Number those needs that apply and list below, then fill in below grid with corresponding numbers. Include ALL Needs)

Client Name _____ Name of Person Completing Service Plan _____ Service Site _____

Needs to be addressed:

_____ Monitoring of Client Services	_____ Parenting/Children Services	_____ Mental Health	_____ Other _____
_____ Financial Assistance/Budgeting	_____ Education Assistance	_____ Home Care	_____ Other _____
_____ Medical/Dental/Vision Services	_____ Legal Assistance	_____ Basic Needs	_____ Other _____
_____ Recreation/Leisure	_____ Housing Assistance	_____ Employment Assistance	_____ Other _____
_____ Transportation	_____ Substance Abuse	_____ Other _____	_____ Other _____

Number	*Client Will Do:*	*Staff Person Will Do:*	*Date Due:*	*Date Done/Code (Below)*

Codes: **C**=completed, **P**=pending (paperwork filed, awaiting decision) **DNF**=did not follow through (indicate who), **CL**=closed

Client Signature: _____ Date: _____ Case Manager Signature: _____ Date: _____

Next Service Plan Due in 90 days: _____ Supervisor Signature (if needed): _____ Date: _____

Personal Safety Plan

Triggers and evaluation of the risk for dangerous behaviors:

What are the triggers in your life?

Current Coping Skills

What do you do now that helps you deal with difficult situations?

Warning Signs

What things start to happen when you are getting frustrated, when your anger is out of control?

Preferred Interventions:

When we see things going bad for you, how do you want us to intervene?

Advanced Directives, when available:

Ohio Behavioral Health
Transfer Form

Unique Provider Number: 01446	Provider Episode Number:
First Name:	Last Name:
Unique Client Id:	Date of Birth (mm/dd/yyyy):
Admission Date:	Transfer Date:

Level of care
☐ Pre-treatment
☐ Non-intensive Outpatient
☐ Intensive Outpatient
☐ Day Treatment
☐ Non-Medical Community Residential
☐ Medical Community Residential
☐ Ambulatory Detoxification
☐ Sub-Acute Detoxification
☐ Acute Detoxification

National Council on Alcoholism / Alcohol Screening Test (NCA)

Name: _____ Date: _____

1. Yes [] No [] Do you occasional drink after a disappointment, quarrel, or when the boss gives you a hard time?
2. Yes [] No [] When you have trouble or feel under pressure, do you always drink more heavily than usual?
3. Yes [] No [] Have you noticed that you are able to handle more liquor than you did when you were first drinking?
4. Yes [] No [] Did you ever wake up on the "morning after "and discover you could not remember part of the evening before, even though your friends tell you that you did not pass out?
5. Yes [] No [] When drinking with other people, do you try to have a few extras when others will not know?
6. Yes [] No [] Are there certain occasions when you feel uncomfortable when alcohol is not available?
7. Yes [] No [] Have you recently noticed that when you begin drinking you are in more of a hurry to get that first drink than you used to be?
8. Yes [] No [] Do you sometimes feel a little guilty about your drinking?
9. Yes [] No [] Are you secretly irritated when your family or friends discuss your drinking?
10. Yes [] No [] Have you recently noticed an increase in your memory blackouts?
11. Yes [] No [] Do you often find that you wish to continue drinking after your friends say they have had enough?
12. Yes [] No [] Do you usually have a reason for the occasions when you drink heavily?
13. Yes [] No [] When you are sober, do you often regret the things you have said and done while you were drinking?
14. Yes [] No [] Have you tried switching brands or following different plans for controlling your drinking?
15. Yes [] No [] Have you often failed to keep the promises you have made to yourself about controlling your drinking?
16. Yes [] No [] Have you ever tried to control your drinking by making a change in jobs or moving to a new location?
17. Yes [] No [] Do you try to avoid family or close friends while you are drinking?
18. Yes [] No [] Are you having an increase number of financial or work problems?
19. Yes [] No [] Do more people seem to be treating you unfairly without good reason?
20. Yes [] No [] Do you eat very little or irregularly when you are drinking?
21. Yes [] No [] Do you sometimes have the "shakes" in the morning and find that it helps to have a little drink?
22. Yes [] No [] Have you recently noticed that you cannot drink as much as you once could?
23. Yes [] No [] Do you sometimes stay drunk for several days at a time?
24. Yes [] No [] Do you sometimes feel very depressed and wonder whether life is worth living?
25. Yes [] No [] Sometimes after periods of drinking, do you see or hear things that aren't there?

Michigan Alcoholism Screening Test (M.A.S.T.)

Name: _____ Date: _____

1. Yes [ ] No [ ]	Do you feel you are a normal drinker?
2. Yes [ ] No [ ]	Have you ever awakened the morning after some drinking the night before and found that you could not remember part of the evening before?
3. Yes [ ] No [ ]	Does Your spouse/parents ever worry or complain about your drinking?
4. Yes [ ] No [ ]	Can you stop drinking without a struggle after 1-2 drinks?
5. Yes [ ] No [ ]	Do you feel bad about your drinking?
6. Yes [ ] No [ ]	Do Friends or relatives think you are a normal drinker?
7. Yes [ ] No [ ]	Do you ever try to limit your drinking to certain times of day or certain places?
8. Yes [ ] No [ ]	Are you always able to stop drinking when you want to?
9. Yes [ ] No [ ]	Have you ever attended a meeting of Alcoholics Anonymous?
10. Yes [ ] No [ ]	Have you gotten into fights when drinking?
11. Yes [ ] No [ ]	Has drinking ever created problems with you and your spouse?
12. Yes [ ] No [ ]	Has your wife/husband or other family members ever gone to anyone for help about your drinking?
13. Yes [ ] No [ ]	Have you ever lost friends or girlfriends/boyfriends because of your drinking?
14. Yes [ ] No [ ]	Have you ever gotten into trouble at work because of your drinking?
15. Yes [ ] No [ ]	Have you ever lost a job because of your drinking?
16. Yes [ ] No [ ]	Have You Ever neglected your obligations, your family, or your work for 2 or more days because of your drinking?
17. Yes [ ] No [ ]	Do You ever drink before noon?
18. Yes [ ] No [ ]	Have you ever been told you have liver trouble? Cirrhosis?
19. Yes [ ] No [ ]	Have you ever had delirium tremors (DT's), severe shaking heard voices, or seen things that weren't really there after heavy drinking?
20. Yes [ ] No [ ]	Have you ever gone to anyone for help about your drinking?
21. Yes [ ] No [ ]	Have you ever been in a hospital because of your drinking?
22. Yes [ ] No [ ]	Have you ever been a patient in a psychiatric hospital or a psychiatric ward of a general hospital where drinking was a part of the problem?
23. Yes [ ] No [ ]	Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, or clergyman for help with an emotional problem in which drinking played a role?
24. Yes [ ] No [ ]	Have you ever been arrested, even for a few hours, because of drunken behavior?
25. Yes [ ] No [ ]	Have you ever been arrested for drunk driving or driving under the influence?

Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

Name: _____ Date: _____

1. ____ Yes ____No Have you used drugs other than those required for medical reasons?
2. ____ Yes ____No Have you abused prescription drugs?
3. ____ Yes ____No Do you abuse more than one drug at a time?
4. ____ Yes ____No Can you get through the week without using drugs (other than those required for medical reasons)?
5. ____ Yes ____No Are you always able to stop using drugs when you want to?
6. ____ Yes ____No Do you abuse drugs on a continuous basis?
7. ____ Yes ____No Do you try to limit your drug use to certain situations?
8. ____ Yes ____No Have you had "blackouts" or "flashbacks" as a result of drug use?
9. ____ Yes ____No Do you ever feel bad about your drug abuse?
10. ____ Yes ____No Does your spouse (or parents) ever complain about your involvement with drugs?
11. ____ Yes ____No Do your friends or relatives know or suspect you abuse drugs?
12. ____ Yes ____No Has drug abuse ever created problems between you and your spouse?
13. ____ Yes ____No Has any family member ever sought help for problems related to your drug use?
14. ____ *Yes* ____*No* Have you ever lost friends because of your use of drugs?
15. ____ *Yes* ____*No* Have you ever neglected your family or missed work because of your use of drugs?
16. ____ *Yes* ____*No* Have you ever been in trouble at work because of drug abuse?
17. ____ *Yes* ____*No* Have you ever lost a job because of drug abuse?
18. ____ *Yes* ____*No* Have you gotten into fights when under the influence of drugs?
19. ____ *Yes* ____*No* Have you ever been arrested because of unusual behavior while under the influence of drugs?
20. ____ *Yes* ____*No* Have you ever been arrested for driving while under the influence of drugs?
21. ____ *Yes* ____*No* Have you engaged in illegal activities in order to obtain drug?
22. ____ *Yes* ____*No* Have you ever been arrested for possession of illegal drugs?
23. ____ *Yes* ____*No* Have you ever experienced withdrawal symptoms as a result of heavy drug intake?
24. ____ *Yes* ____*No* Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?
25. ____ *Yes* ____*No* Have you ever gone to anyone for help for a drug problem?
26. ____ *Yes* ____*No* Have you ever been in a hospital for medical problems related to your drug use?
27. ____ *Yes* ____*No* Have you ever been involved in a treatment program specifically related to drug use?
28. ____ *Yes* ____*No* Have you been treated as an outpatient for problems related to drug abuse?

SOUTH OAKS GAMBLING SCREEN (SOGS)

1. Indicate which of the following types of gambling you have done in your lifetime. For each type, mark one answer: "not at all," "less than once a week," or "once a week or more."

Not at all	Less than once a week	Once a week or more	
			a. played cards for money
			b. bet on horses, dogs or other animals (in off-track betting, at the track or with a bookie)
			c. bet on sports (parley cards, with a bookie, or at jai alai)
			d. played dice games (including craps, over and under, or other dice games) for money
			e. went to casino (legal or otherwise)
			f. played the numbers or bet on lotteries
			g. played bingo
			h. played the stock and/or commodities market
			i. played slot machines, poker machines or other gambling machines
			j. bowled, shot pool, played golf or played some other game of skill for money

2. What is the largest amount of money you have ever gambled with any one day?

___ never have gambled

___ more than $100 up to $1000

___ $10 or less

___ more than $1000 up to $10,000

___ more than $10 up to $100

___ more than $10,000

3. Do (did) your parents have a gambling problem?

___ both my father and mother gamble (or gambled) too much

___ my father gambles (or gambled) too much

___ my mother gambles (or gambled) too much

___ neither gambles (or gambled) too much

4. When you gamble, how often do you go back another day to win back money you lost?

___ never

___ some of the time (less than half the time) I lost

___ most of the time I lost

___ every time I lost

5. Have you ever claimed to be winning money gambling but weren't really? In fact, you lost?

___ never (or never gamble)

___ yes, less than half the time I lost

___ yes, most of the time

6. Do you feel you have ever had a problem with gambling?

___ no

___ yes, in the past, but not now

___ yes

	Yes	No
7. Did you ever gamble more than you intended?	____	____
8. Have people criticized your gambling?	____	____
9. Have you ever felt guilty about the way you gamble or what happens when you gamble?	____	____
10. Have you ever felt like you would like to stop gambling but didn't think you could?	____	____
11. Have you ever hidden betting slips, lottery tickets, gambling money, or other signs of gambling from your spouse, children, or other important people in you life?	____	____
12. Have you ever argued with people you like over how you handle money?	____	____
13. (If you answered "yes" to question 12)**: Have money arguments ever centered on your gambling?**	____	____
14. Have you ever borrowed from someone and not paid them back as a result of your gambling?	____	____

	Yes	No
15. Have you ever lost time from work (or school) due to gambling?	____	____
16. If you borrowed money to gamble or to pay gambling debts, where did you borrow from? (Check "yes" or "no" for each)	____	____

a. from household money		
b. from your spouse		
c. from other relatives or in-laws		
d. from banks, loan companies or credit unions		
e. from credit cards		
f. from loan sharks (Shylocks)		
g. your cashed in stocks, bonds or other securities		
h. you sold personal or family property		
i. you borrowed on your checking account (passed bad checks)		
j. you have (had) a credit line with a bookie		
k. you have (had) a credit line with a casino		

Clinical Insitutue Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ Blood pressure:_____

NAUSEA AND VOMITING — Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TREMOR — Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

PAROXYSMAL SWEATS — Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

ANXIETY — Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION — Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES — Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning ornumbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

AUDITORY DISTURBANCES — Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

VISUAL DISTURBANCES — Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD — Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 no present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM — Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total CIWA-Ar Score _____

Rater's Initials _____

Maximum Possible Score 67

Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction* 84:1353-1357, 1989.

Client Referral Form

The Recovery Council

To: _____

Assigned Primary Counselor

From: _____

Assessing Counselor

Re: _____

Client Name

SS#: _____

DOB: _____

_____Assessed on _____

Client Name **Date of Assessment**

Client's Referral Source: _____

_____

_____

_____

Treatment Recommendations: _____

_____

_____

_____

_____

_____

The Recovery Council

Address: _____ **Phone #:** _____
Admission Date: _____ **Assessment Date:** _____
Start Time: _____ **End Time:** _____
Sex: _____ **Male** _____ **Female** **Race:** _____
Comments:

_____
_____
_____
_____
_____
_____

ALCOHOL & OTHER DRUG ASSESSMENT

All questions contained in this questionnaire are strictly confidential
and will become part of your client record

Name *(Last, First, M.I.):*	**DOB:** _____**AGE:**_____
Referral Source Information ☐ Probation ☐ Parole ☐ Employment ☐ School ☐ Self ☐ Other_____	
Person Making the Referral:_____ _____ Position:_____ Agency:_____ _____ Address:_____ _____	**Phone #:**_____ **Fax #:** _____

PRESENTING PROBLEMS(S) AND/OR PRECIPITATING FACTORS LEADING TO NEED FOR AN ASSESSMENT

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HISTORY OF ALCOHOL AND OTHER DRUG USE BY CLIENT, FAMILY MEMBERS AND/OR SIGNIFICANT OTHERS

Route of Administration: 1] Oral 2] Nasal 3] Smoking 4] IV	ROUTE OF ADMINISTRATION	AGE OF FIRST USE-AMOUNT	PAST 30 DAYS USE	LAST USE-AMOUNT	USE IN LIFETIME
Alcohol-Any Use					
Alcohol-To Intoxication					
Amphetamines					
Barbiturates					
Cannabis					
Crack/Cocaine					
Hallucinogens					
Heroin					
Inhalants					
Methadone					
Other Opiates					
Other Sedative/Tranquilizers					
More Than One Substance Per Day Including Alcohol					

Which Substance(s) are the major problems?

How long was your last period of voluntary abstinence from this major substance?

How many months ago did this abstinence end?

How many times have you had: Alcohol related withdrawal symptoms?

Overdosed on other drugs?

How much money would you say you spent during the past 30 days on: Alcohol? _____

Drugs? _____

How many days have you been treated on an outpatient basis for alcohol or other drugs in the past 30 days?
_____

How many AA/NA/CA meetings have you attended in the past 30 days? _____

How many days in the past 30 have you experienced: Alcohol problems? _____   **Other Drug problems? _____**

Does your significant other drink or use other drugs? **If yes, what types? _____**	☐ **Yes**	☐ **No**
Do any of your children use alcohol or other drugs? **What types? _____**	☐ **Yes**	☐ **No**
Does your significant other have a problem with alcohol/drugs or were you ever concerned about their use of alcohol or other drugs?	☐ **Yes**	☐ **No**
Do any of your children have a problem with alcohol or other drugs or were you ever concerned about their use of alcohol or other drugs?	☐ **Yes**	☐ **No**
Have any of your other blood-related relatives had what you would call a significant drinking and/or drug use problem? If so, please mark Yes in the following table.	☐ **Yes**	☐ **No**

DRINKING AND/OR DRUG USE FAMILY PROBLEMS					
		Substance Used			**Substance Used**
Father	☐ **No** ☐ **Yes**		**Grandmother** *Maternal*	☐ **No** ☐ **Yes**	
Mother	☐ **No** ☐ **Yes**		**Grandfather** *Maternal*	☐ **No** ☐ **Yes**	
Brother #1	☐ **No** ☐ **Yes**		**Grandmother** *Paternal*	☐ **No** ☐ **Yes**	
Brother #2	☐ **No** ☐ **Yes**		**Grandfather** *Paternal*	☐ **No** ☐ **Yes**	
Sister #1	☐ **No** ☐ **Yes**		**Aunt** *Paternal*	☐ **No** ☐ **Yes**	
Sister #2	☐ **No** ☐ **Yes**		**Uncle** *Paternal*	☐ **No** ☐ **Yes**	
Aunt *Maternal*	☐ **No** ☐ **Yes**			☐ **No** ☐ **Yes**	
Uncle *Maternal*	☐ **No** ☐ **Yes**			☐ **No** ☐ **Yes**	

HISTORY OF TREATMENT FOR ALCOHOL OR OTHER DRUG ABUSE

Have you ever received treatment for Alcohol or Other Drug Abuse? ☐ **No** ☐ **Yes**
If yes fill in the information below

Name of facility you received treatment	**Type of Treatment**	**Dates of Treatment**	**Successful Completion?**

Additional Comments: _____

MEDICAL HISTORY

Are you currently taking any prescription medication? ☐ **Yes** ☐ **No**

Are you currently taking any over-the-counter medication? ☐ **Yes** ☐ **No**

If yes, please fill in the information below.

Name the Medication	**Strength**	**Frequency Taken**
Name of Medication	**Strength**	**Frequency Taken**

Allergies to medications? ☐ **Yes** ☐ **No**

Allergies to foods? ☐ **Yes** ☐ **No**

Allergies to anything else? ☐ **Yes** ☐ **No**

If yes, please fill in the information below.

Medications/foods/other	**Reactions you had**

Check if you have, or have had, any problems in the following areas:

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder Stomach	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	

Have you ever been abused physically? If yes, who was the person(s) who did this? _____ ☐ **Yes** ☐ **No**

Additional Comments:_____
_____
_____
_____
_____

EDUCATION HISTORY

EDUCATION

High School(s)	Did or has your Alcohol or Drug use caused education problems? ☐ **Yes** ☐ **No**	
From: To:	Did you Graduate? ☐ **Yes** ☐ **No** **If you did not graduate please tell why below in comments**	
College		
From: To:	Did you Graduate? ☐ **Yes** ☐ **No** **If you did not graduate please tell why below in comments**	
Other		
From: To:	Did you Graduate? ☐ **Yes** ☐ **No** **If you did not graduate please tell why below in comments**	

Additional Comments:_____
_____
_____
_____
_____

EMPLOYMENT HISTORY

How many jobs have you had in your lifetime? _____		
Current/Previous Employment (most recent first)		
Current Job:		**Did or Has your Alcohol or Other Drug use caused work problems? If yes explain below. ☐ Yes ☐ No**
Address:		
Job Title:		
Responsibilities:		
From:	**To:**	**Reason for Leaving:**
Work Problems:		
Previous Job:		**Did or Has your Alcohol or Other Drug use caused work problems? If yes explain below. ☐ Yes ☐ No**
Address:		
Job Title:		
Responsibilities:		
From:	**To:**	**Reason for Leaving:**
Work Problems:		
Previous Job:		**Did or Has your Alcohol or Other Drug use caused work problems? If yes explain below. ☐ Yes ☐ No**
Address:		
Job Title:		
Responsibilities:		
From:	**To:**	**Reason for Leaving:**
Work Problems:		

Additional Comments:_____

LEGAL HISTORY

Are you currently on Probation? Name of Probation Officer:_____	☐ Yes	☐ No
Are you currently on Parole? Name of Parole Officer:_____	☐ Yes	☐ No
Do you have any pending legal charges? Court Date_____	☐ Yes	☐ No

How many times in your life have you been arrested or charged with the following?

Year	Charge	Alcohol or Other Drugs involvement?
	Arson	☐ **Yes** ☐ **No**
	Assault	☐ **Yes** ☐ **No**
	Burglary/Larceny/B & E	☐ **Yes** ☐ **No**
	Contempt of Court	☐ **Yes** ☐ **No**
	Disorderly Conduct	☐ **Yes** ☐ **No**
	Domestic Violence	☐ **Yes** ☐ **No**
	Driving While Intoxicated	☐ **Yes** ☐ **No**
	Drug Charges	☐ **Yes** ☐ **No**
	Forgery	☐ **Yes** ☐ **No**
	Homicide/Manslaughter	☐ **Yes** ☐ **No**
	Major Driving Violations	☐ **Yes** ☐ **No**
	Parole/Probation Violations	☐ **Yes** ☐ **No**
	Prostitution	☐ **Yes** ☐ **No**
	Public Intoxication	☐ **Yes** ☐ **No**
	Rape	☐ **Yes** ☐ **No**
	Robbery	☐ **Yes** ☐ **No**
	Shoplifting/Vandalism	☐ **Yes** ☐ **No**
	Vagrancy	☐ **Yes** ☐ **No**
	Weapons Offense	☐ **Yes** ☐ **No**
	Other Offense not listed:	☐ **Yes** ☐ **No**

How many of the arrests above resulted in convictions?
_____

How many days/months/years were you incarcerated in your life?
_____

How many days in the past 30, were you detained or incarcerated? _____

How many days in the past 30 have you engaged in illegal activities for profit? _____

Additional Comments:
_____
_____
_____
_____

Emotional and Cognitive Status

Do you ever feel upset about things you have done or haven't done? Explain
Do you ever find yourself thinking about these things over and over again? Explain
Are these thoughts emotionally painful or upsetting for you? Explain

Do you ever feel really angry with someone or something and found it difficult to stop feeling angry? Explain
At this time do you feel angry about things that have happened in your life? Explain
Using a scale of 1-10 (ten being the most angry) how angry have you felt now or in the past at someone or something? Explain
Do you find it difficult to forgive people who have hurt you in some way? Explain

Have you ever returned to drinking and/or taking drugs after a period of intentional abstinence? Some people refer to this as a relapse. Explain

PSYCHIATRIC HISTORY

How many times have you been treated for any psychological or emotional problems?

In a hospital or inpatient setting? _____

Outpatient or Private Practice? _____

Have you had a significant period of time(that was not a direct result of alcohol/drug use) in which you have: Experienced Serious Depression?	☐ Yes	☐ No
Experienced Serious Anxiety/Tension?	☐ Yes	☐ No
Experienced Hallucinations?	☐ Yes	☐ No
Experienced Trouble Understanding, Concentrating or Remembering?	☐ Yes	☐ No
Experienced Trouble Controlling Violent Behavior?	☐ Yes	☐ No
Experienced Serious Thoughts of Suicide?	☐ Yes	☐ No
Attempted Suicide?	☐ Yes	☐ No
Been Prescribed Medication for Any Psychological Problems?	☐ Yes	☐ No
How many days in the past 30 have you experienced these psychological problems?_____		
Have you been abused emotionally-made to feel bad through harsh words? If **Yes**, who was the person(s) that did this? _____	☐ Yes	☐ No

Additional Comments:_____

_____

_____

MENTAL STATUS SCREEN

Appearance	**Motor Activity**	**Mood**
___Well-groomed	___Calm	___Euthymic
___Disheveled	___Overactive	___Depressed
___Seductive	___Poor Coordination	___Anxious
___Meticulous	___Tremors	___Euphoric
___Depressed	___Motor Retardation	
___Other_____		
___Bizarre/Eccentric	___Other_____	
___Other_____		

MENTAL STATUS SCREEN

Attitude	Affect	Speech
___Cooperative	___Appropriate	___Normal
___Uncooperative	___Flat	___Delayed
___Guarded	___Labile	___Soft
__Suspicious	__Anxious/Worrisome	__Loud
___Belligerent	___Expansive	___Slurred
___Angry	___Other_____	__Excessive
___Other_____		___Pressured
		___Other_____

Thought Content

Hallucinations	__Not Present	___Present	___Auditory	___Visual	___Olfactory
Delusions	__Not Present	___Present	___Persecutory	___Controlled	___Grandiose
Suicide	__Not Present	___Present	___Plan	___Means	
Homicide	__Not Present	___Present	___Plan	___Means	
Orientation	__Time	___Place	___Person		
Memory/Recent	___Intact	__Impaired	___Confabulation		
Memory/Remote	___Intact	__Impaired	___Amnesia		
Intellect	___Above Average	__Average	___Below Average		

Additional
Comments:_____

FAMILY HISTORY

Marital Status:

___Married ___Widowed ____Divorced ___Significant Relationship

___Remarried ___Separated ___Never Married

	Years	Months
How long have you been in this marital status? (if never married, then number of years since age 18)		
Are you satisfied with this situation?	☐ Yes	☐ No

Usual living arrangement the past 3 years:

___With spouse
__With sexual partner and children ___With Friends ___With parents
___With sexual partner alone ___Alone ___With family
___With children alone ___No stable arrangement ___Controlled environment

How long have you lived in these arrangements?	**Years**	**Months**
Are you satisfied with these arrangements?	☐ Yes	☐ No
Do you live with someone who has a serious Alcohol or Other drug problem?	☐ Yes	☐ No
With whom do you spend most of your free time? ☐ Family ☐ Friends ☐ Alone Are you satisfied with spending your free time this way?	☐ Yes	☐ No
How many close friends do you have? _____		
Have you had serious problems getting along with any of your family members in your life? **Please name below the problems or circumstance surrounding the problems** _____ _____	☐ Yes	☐ No

Additional Comments:

_____
_____
_____
_____

SEXUAL HISTORY

Sexual Orientation

__Heterosexual ___Homosexual ___Bisexual

At what age did you first start having sexual relations?		Years	Months
When you are sexually active do you use condoms?	☐Sometimes	☐ Always	☐ Never

What other type of contraceptives are used?

___Birth control pill ___IUD ___Diaphragm
___Norplant ___Depo Prevara ___Rhythm method

Have you every forced someone to engage in sex when they did not want to?	☐ Yes	☐ No
Have you ever been sexually abused-forced sexual advances/acts? If Yes, who was the person(s) that did this? _____	☐ Yes	☐ No
Are you more sexually promiscuous when under the influence of alcohol or other drugs?	☐ Yes	☐ No
Have you been sexually active when under the influence of alcohol or other drugs?	☐ Yes	☐ No
Have you ever traded sex for **food**, **drugs/alcohol**, or a **place to stay**? (circle the appropriate)	☐ Yes	☐ No
Have you ever had sex with someone who has or may have AIDS?	☐ Yes	☐ No
Have you been tested for AIDS or other sexually transmitted disease? If so when_____	☐ Yes	☐ No

Additional Comments:

_____
_____
_____
_____

RELIGIOUS/SPIRITUAL ORIENTATION

What is your religious or spiritual affiliation

___Protestant ___Catholic ___Jewish ___Muslim ___Buddhist ___Other_____
Please name

Presently, are you still involved with religious/spiritual activities?	☐ Yes	☐ No

Do you have a higher power/spiritual beliefs? Please describe below:_____

_____

Additional
Comments:_____
_____
_____
_____

STRENGTHS/ASSETS

What do you believe are your
strengths/assets:_____
_____
_____

What does the clinician believe are the client's strengths/assets which will help them achieve sobriety: _____
_____
_____

WEAKNESSES/LIMITATIONS

What do you believe are your
weaknesses/limitations:_____
_____
_____

What does the clinician believe are the client's weaknesses/limitations that will interfere with
sobriety:_____
_____
_____

Client Centered summary/life story process/current status

The Clinical / Interpretative Summary is Based Upon Information Provided By (Check all that apply)

[] Client [] Parent(s) [] Guardian(s) [] Family / Friend [] Physician [] Records
[] Law Enforcement [] Service Provider [] School Personnel [] Others:

Narrative Summary – Include etiology of presenting problem and maintenance of the problem; mental health history; AoD history; Severity of problem; where problem occurs; (functioning at home, at work, in community); onset of problem (acute vs. Chronic); client motivation; whether problem is known to be responsive to treatment.

_____ _____
Signature and Credentials of Staff Person Completing Assessment Date

_____ _____
Clinical Supervisor, if applicable Date

SECTION XIX: DEGREE OF SEVERITY FOR THE SEVEN DIMENSIONS/ADMISSION CRITERIA

Admission Criteria - Adult Protocol Level of Care (Must meet 4 out of 6 dimensions in each level of care. Check all boxes that apply in all dimensions)

	Level I-A: Non-Intensive Outpatient Treatment	**Level I-B:** Intensive Outpatient Treatment	**Level I-C:** Day Treatment	**Level II-A:** Non-Medical Community Residential	**Level II-B:** Medical Community Residential	**Level III-A:** Ambulatory Detoxification	**Level III-B:** 23 Hour Observation Bed	**Level III-C:** Sub-Acute Care	**Level IV:** Acute Hospital Detoxification
Dimension 1 Acute Intoxication Withdrawal	☐ No need for detoxification ☐ Low risk of withdrawal ☐ Medical management not required	☐ Low to moderate withdrawal risk ☐ Medical management not required	☐ Low to moderate withdrawal risk ☐ Not at high risk for severe withdrawal	☐ Low to moderate withdrawal risk ☐ 24 hour medical management not needed	☐ Moderate risk of severe withdrawal ☐ Needs medical monitoring 24 hours per day	☐ Detoxification can be conducted on an outpatient basis ☐ Withdrawal symptoms are severe, medication or monitoring can be conducted outpatient	☐ Moderate to high risk of severe withdrawal, requires daily medical management ☐ Has used substances in the past two weeks	☐ Serious risk of severe withdrawal, requires daily medical management and monitoring	☐ Serious risk of withdrawal, requires inpatient medical management ☐ Other symptoms require hospital setting
Comments:									
Dimension 2 Biomedical Conditions and/or Complication (BMC/C)	☐ No BMC/C beyond capacity of milieu ☐ BMC/C stable do not distract from tx.	☐ BMC/C are being addressed ☐ BMC/C does not interfere with tx.	☐ BMC/C low to moderate, professional supervision is needed ☐ BMC/C do not require daily medical monitoring	☐ BMC/C minimal to moderate ☐ BMC/C do not require 24 hour per day medical monitoring ☐ BMC/C are being addressed	☐ BMC/C requires 24 hour per day medical monitoring ☐ BMC/C can be addressed at this level	☐ Health seriously damaged by addiction ☐ BMC/C can be safely monitored at this level	☐ Moderate BMC/C ☐ Sustained medical management required ☐ Close medical management required ☐ BMC/C could interfere with treatment in the absence tx. and medical management	☐ BMC/C or pregnancy needs medical monitoring for detoxification ☐ Recurring seizures requires medical care ☐ Other complicate-ions require medical care	☐ BMC/C or pregnancy needs medical stabilization and treatment ☐ Recurring seizures requires medical management, tx. ☐ Other medical symptoms require medical tx.
Comments:									
Dimension 3 Emotional/ Behavioral/ Cognitive Conditions and/or Complications (EBC/C)	☐ No EBC/C ☐ Some EBC/C conditions but does not interfere with treatment ☐ Cognitive impairment, non-Interfering with tx. , AND ☐ Minimal risk of harm to self or others	☐ Low to moderate conditions ☐ EBCC can be addressed in this level ☐ Not at risk of harm to self or others	☐ Low to moderate ☐ EBC/C, structured day tx. needed ☐ EBC/C do not require daily medical monitoring	☐ EBC/C do not interfere with treatment in this level ☐ Co-existing disorder(s) do not require 24 hour per day treatment ☐ Cognitive impairment requires close supervision	☐ EBC/C do not interfere with treatment ☐ EBC/C are moderate to high and require 24 hour structured treatment ☐ Requires residential treatment to manage EBC/C	☐ EBC/C do not interfere with treatment ☐ EBC/C interferes with recovery, treatment referral after detoxification required ☐ EBC/C are a problem and can be monitored in this level of care	☐ EBC/C do not interfere with treatment ☐ EBC/C requires sustained medical management ☐ EBC/C requires additional medical evaluation before disposition plan can be made	☐ EBC/C unstable, structured monitoring needed ☐ Cognitive impairment needs 24 hr. monitoring ☐ Potential for harm to self or others ☐ Mental confusion requires monitoring ☐ Other EBC/C post detox. TX. required	☐ EBC/C requires medical assessment, and tx. ☐ Stabilization and medical tx. needed. ☐ High risk behaviors, potential harm to self or others ☐ Other conditions require medical management
Comments:									

SECTION XIX: DEGREE OF SEVERITY FOR THE SEVEN DIMENSIONS/ADMISSION CRITERIA

Admission Criteria - Adult Protocol Level of Care (Must meet 4 out of 6 dimensions in each level of care. Check all boxes that apply in all dimensions)

	Level I-A: Non-Intensive Outpatient Treatment	**Level I-B:** Intensive Outpatient Treatment	**Level I-C:** Day Treatment	**Level II-A:** Non-Medical Community Residential	**Level II-B:** Medical Community Residential	**Level III-A:** Ambulatory Detoxification	**Level III-B:** 23 Hour Observation Bed	**Level III-C:** Sub-Acute Care	**Level IV:** Acute Hospital Detoxification
Dimension 4 Treatment Acceptance Resistance	☐ Aware of problem, willing to engage in treatment ☐ Resistant but can be motivated to engage in treatment	☐ Resistance requires structured treatment ☐ Intensive clinical treatment needed to motivate client for treatment	☐ Denial/ Resistance requires intense structured treatment ☐ Client motivated for treatment	☐ Motivated to receive structured treatment 24 hours per day ☐ Moderate resistance to tx. requires motivation 24 hours per day	☐ Motivated to receive structured treatment 24 hours per day ☐ Moderate resistance to tx. requires motivation 24 hours per day ☐ History of non-compliance at a less intensive level of care	☐ Minimal awareness of addiction, treatment referral after detoxification is required ☐ Potential to be motivated for treatment if additional interventions are provided	☐ Resistant to treatment, requires medical treatment for acute addiction symptoms ☐ Acceptance, resistance requires additional evaluation and medical supervision	☐ Minimal awareness of addiction, tx. referral after detox. Required ☐ Some awareness of addiction, yet requires intensive inpatient intervention	☐ Acute crisis, referral after detox required ☐ Resisted tx. at lower level of care ☐ Some awareness of addiction, but intensive intervention needed
Comments:									
Dimension 5 Relapse Potential	☐ Moderate to high relapse risk without treatment ☐ Low relapse potential	☐ Moderate to high relapse risk without treatment ☐ Close monitoring needed to prevent relapse	☐ Moderate to high relapse risk without day tx. ☐ Client has history of relapse in a less structured setting	☐ Moderate to high relapse risk without 24 hour treatment ☐ Client has history of relapse in a less intensive level of care	☐ Moderate to high relapse risk without 24 hour supervision ☐ Client has history of relapse in a less intensive level of care	☐ Acute addiction crisis, no immediate recovery potential without treatment referral after detoxification ☐ History of repeated complicated detoxifications	☐ Symptoms require immediate medical management in a structured setting ☐ Relapse potential requires medical evaluation and management	☐ Acute addiction crisis, needs treatment to prevent relapse ☐ Has a history of relapse	☐ Acute addiction crisis requires immediate treatment ☐ History of relapse at a lower level of care
Comments:									
Dimension 6 Recovery Environment (Environ.)	☐ Supportive environment ☐ Has access to social and peer support ☐ Tx. will help client cope with environment ☐ Environment does not interfere with treatment at this level	☐ Environment supportive ☐ Needs regular reinforcement to cope with environment ☐ Environ-mint not supportive, treatment can increase coping skills	☐ Environment interfering with tx. progress, needs structured tx. ☐ Environment unstable, ongoing reinforcement needed.	☐ Environment does not support recovery ☐ Environment has deteriorated 24 hour per day residential treatment is required immediately	☐ Environment does not support recovery ☐ Environment has deteriorated and 24 hour per day stabilization is necessary ☐ No means of developing a support system	☐ Environment stable, supportive, can follow detoxification regimen on outpatient basis ☐ Environment poor for recovery, yet is able to cope at this level of care	☐ Environment not supportive of recovery, needs stabilization elsewhere ☐ Diagnostic evaluation indicates a need to remove client from environment	☐ ENVIRONMENT NOT A FACTOR IN ADMISSION	☐ ENVIRONMENT NOT A FACTOR IN ADMISSION
Comments:									

RECOMMENDATIONS FOR TREATMENT

Level of care recommended:

Level of care placed:

If not placed in level of care recommended, check reasons **below:**

_____Waiting list **_____ Level of care offered, client not able to attend**
_____Level of care not available **_____Client refuses level of care**

Comments:_____
_____
_____
_____
_____
_____

DSM IV DIAGNOSIS

DSM IV Diagnostic Code and Written Description:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

_____ _____
Signature and Credentials of Staff Person Rendering Diagnosis Date

Date Diagnosis Rendered: _____

_____ _____
Counter-signature and Credentials, if required Date

Date Counter-signed:_____

Diagnostic Criteria for Substance Dependence. Check all that apply and provide a description of specific symptoms present in the individual's life, three (3) criteria needed for diagnosis. Indicate tie substance to which each symptom is linked.

Client Name: _____

Date: _____

Substance: _____

[ ] 1) Tolerance as defined by either of the following.

[ ] (A) A need for markedly increased amounts of the substance in order to achieve intoxication or desired effect.

_____

_____

[ ] (B) Markedly diminished effect with continued use of the same amount of the substance.`

_____

_____

[ ] 2) Withdrawal, as manifested by either of the following.

[] (A) The characteristic withdrawal syndrome for the substance.

_____

_____

[ ] (B) The same (or closely related substance), is taken to relieve or avoid withdrawal symptoms.

_____

_____

[ ] 3) The substance is often taken in larger amounts or over a longer period than was intended.

_____

_____

[ ] 4) There is a persistent desire or unsuccessful attempts to cut down or control substance use.

_____

_____

[] 5) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

_____

_____

[ ] 6) Important social, occupational, recreational, activities are given up or reduced because of substance use.

_____

_____

[] 7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance use.

_____

_____

Substance Dependence Specifies: Check if applicable.

[ ] Early full remission (no criteria met for 1-11 months).
[ ] Early partial remission (meets one or more criteria, but not full criteria for 1-11 months).
[ ] Sustained full remission (no criteria met for 12 months or more).
[ ] Sustained partial remission (meets one or more criteria, but not full criteria for 12 months or more.
[ ] On agonist therapy
[ ] in a controlled environment.

Diagnostic Criteria for Substance abuse. Check all that apply and provide a description of specific symptoms present in the individual's life. Symptom must not meet, currently or in the past, the criteria for dependence. Indicate the substance which the symptoms are linked.

Substance: _____

[ ] 1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.

_____

_____

[ ] 2) Recurrent substance use in situations in which it is physically hazardous.

_____

_____

[ ] 3) Recurrent substance-related legal problems.

_____

_____

[ ] 4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by effects of the substance.

_____

_____

The Pike County Recovery Council

Client Name: _____ Date: _____

Please list your personal: (In clients own words)

Strengths:

_____
_____
_____
_____

Needs:

_____
_____
_____
_____

Abilities:

_____
_____
_____
_____

Preferences:

_____
_____
_____
_____

Weaknesses:

_____
_____
_____
_____

AUTHORIZATION TO DISCLOSE INFORMATION

Name of Client _____ Date _____

The following programs are authorized to: { } Disclose, { } Receive or, { } Exchange Information as noted below:

_____

Program Authorized to Make Disclosure

_____

Authorized Individual / Organization to Whom Disclosure is Made

Purpose of Disclosure: { } To Coordinate Treatment, { } To gather information for treatment planning, { } Other (specify)

_____

Type of information to be Disclosed: { } Progress notes, { } diagnostic assessment information, { } Progress in treatment, { } lab results, { } urine screening, { } attendance, { } HIV/AIDS testing status, { } pregnancy testing, { } prenatal care, { } Diagnosis, { } information on mental illness and / or treatment, { } other (specify)

_____

Amount of information to be Disclosed: { } information covering the previous three months, { } information covering th most recent admission, { } other (specify)

_____

_____

Signature and Date of Client or Other Person Authorized to Permit Disclosure

_____

Signature and Date of Staff or Witness

Revocation: This authorization is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it. Drug and/or alcohol clients can revoke consent either verbally or in writing.

I hereby revoke consent in writing: _____

Client's Signature and Date

Authorization was verbally revoked: Date _____ Time _____

_____

Signature and Date of Person Witnessing Verbal or Written Revocation

This authorization expires (specify event, date, and/or condition) _____

Prohibition Against Re- Disclosure: this information has been disclosed to you from records protected by Federal Confidentiality rules. The Federal rules prohibit you form making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by 42 C.F.R., Part 2 A general authorization for the release of medical information or other information is not sufficient to this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure).

THE RECOVERY COUNCIL
CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION:
CRIMINAL JUSTICE SYSTEM REFERRAL

I, _____, hereby consent to communication between
[(Name of client/defendant]

The Recovery Council and _____
[Alcohol/drug treatment program] [Court, probation, parole and/or other referring agency]

The purpose of and need for the disclosure is to inform the criminal justice agency (ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

_____

_____

I understand that this consent will remain in effect and cannot be revoked by me until:

_____ there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

_____ One Year after file closure

I also understand that any disclosure made is bound by the federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records [42 U.S.C. '290dd-2; 42 C.F.R. Part 2] and that recipients of this information may re-disclose it only in connection with their official duties.

Dated: _____ _____
[Signature of defendant/client]

_____
Signature of parent, guardian or authorized representative if required]

Ohio Behavioral Health
Admission Form

Unique Provider Number:	**Provider Episode Number:**
First Name:	**Last Name:**
Date of First Contact:	**Admission Date:**
Unique Client Id:	**Date of Birth (mm/dd/yyyy):**

Race: ☐ Alaska Native ☐ American Indian ☐ Black/African-American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ Other Single Race ☐ Two or More Races ☐ Unknown

Gender: ☐ Male ☐ Female ☐ Unknown

Ethnicity: ☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Other Specific Hispanic ☐ Not of Hispanic Origin ☐ Unknown

Level of care
- ☐ Pre-treatment
- ☐ Non-intensive Outpatient
- ☐ Intensive Outpatient
- ☐ Day Treatment
- ☐ Non-Medical Community Residential
- ☐ Medical Community Residential
- ☐ Ambulatory Detoxification
- ☐ Sub-Acute Detoxification
- ☐ Acute Detoxification
- ☐ No Treatment Recommended
- ☐ Not Applicable (MH Only)

Consistent with assessment (AOD Only)?
☐ Yes ☐ No **If no, select reason below.**
- ☐ Agency Financial Constraints
- ☐ Appropriate LOC not available
- ☐ Undue Client Hardship
- ☐ Other Specify: _____

Referred by
- ☐ Individual (includes self-referral/family/friend)
- ☐ AOD Care Provider
- ☐ Mental Health Provider
- ☐ Other Health Care Provider
- ☐ School
- ☐ Employer/EAP
- ☐ Child Welfare Agency (i.e. CDJFS, CSBS)
- ☐ Other Community Referral
- ☐ Courts/Other Criminal Justice
- ☐ Unknown

Mental Health Only
- ☐ Prison
- ☐ Forensic
- ☐ Jail
- ☐ Ohio Families and children first council

TASC
- ☐ Courts/CJ Felony
- ☐ Courts/CJ Municipal
- ☐ Courts/CJ Juvenile

Marital status
- ☐ Single/Never Married
- ☐ Married/Living Together as Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Unknown

Educational Level Completed
- ☐ < 1st Grade
- ☐ 1st Grade
- ☐ 2nd Grade
- ☐ 3rd Grade
- ☐ 4th Grade
- ☐ 5th Grade
- ☐ 6th Grade
- ☐ 7th Grade
- ☐ 8th Grade
- ☐ 9th Grade
- ☐ 10th Grade
- ☐ 11th Grade
- ☐ High School Diploma /GED
- ☐ Some College
- ☐ 2 Yr. College/ Assoc. Degree
- ☐ 4 Yr. College/ Assoc. Degree
- ☐ Masters/Doctorate/ Other Profession
- ☐ Technical School
- ☐ Unknown

Education Enrollment
- ☐ K – 12th Grade
- ☐ GED Classes
- ☐ Vocational/Job Training
- ☐ College
- ☐ Other School; Adult Basic Ed., Literacy
- ☐ Not Enrolled
- ☐ Unknown

Education Type (MH Only, K-12th Enrollment)
- ☐ Not Currently Enrolled as Student
- ☐ Not Behaviorally Handicapped
- ☐ Severe Behavioral Handicapped

Employment Status
- ☐ Full Time
- ☐ Part Time
- ☐ Sheltered
- ☐ Unemployed but Actively Looking for Work
- ☐ Homemaker
- ☐ Student
- ☐ Volunteer Worker
- ☐ Retired
- ☐ Disabled
- ☐ Inmate in Jail/Prison/Corrections
- ☐ Engaged in Residential/Hospitalization
- ☐ Other not in Labor Force
- ☐ Unknown

Primary Source of Income/Support
- ☐ Wages/Salary Income
- ☐ Family/Relative
- ☐ Public Assistance
- ☐ Retirement/Pension
- ☐ Disability
- ☐ Other
- ☐ Unknown
- ☐ None

Living arrangements
- ☐ Independent Living (Own Home)
- ☐ Homeless
- ☐ Other's Home
- ☐ Residential Care
- ☐ Respite Care
- ☐ Foster Care
- ☐ Crisis Care
- ☐ Temporary Housing
- ☐ Community Residence
- ☐ Nursing Facility
- ☐ License MR Facility
- ☐ State MH/MR Institution
- ☐ Hospital
- ☐ Correctional Facility
- ☐ Other
- ☐ Unknown

Prior AOD treatment episodes with Any Agency
- ☐ 0 Previous Episodes
- ☐ 1 Previous Episodes
- ☐ 2 Previous Episodes
- ☐ 3 Previous Episodes
- ☐ 4 Previous Episodes
- ☐ 5 or More Previous Episodes
- ☐ 6 Unknown

Diagnosis type
- ☐ DSM-IV-TR
- ☐ ICD 9

Mental Health History (AOD Only)
☐ **Select if MH problem in addition to AOD problem**

Opioid Replacement Therapy
- ☐ No
- ☐ Yes
- ☐ Unknown

☐ **Number of Children in Household Under 18**

Primary Diagnosis Code

Secondary Diagnosis Code

Tertiary Diagnosis Code

Quaternary Diagnosis Code

Special Populations (Select all that apply)
- ☐ Severely Mentally Disabled
- ☐ Alcohol/Other Drug Abuse
- ☐ Forensic Legal Status
- ☐ Mental Retardation/Developmentally Disabled
- ☐ Deaf/Hearing Impaired
- ☐ Blind/Sight Impaired
- ☐ Physically Disabled
- ☐ Speech Impaired
- ☐ Physical Abuse Victim
- ☐ Sexual Abuse Victim
- ☐ Domestic Violence Victim/Witness
- ☐ Child of Alcohol/Drug Abuser
- ☐ HIV/AIDS
- ☐ Suicidal
- ☐ Language barriers/English Second Language
- ☐ Hepatitis C
- ☐ Transgender
- ☐ Client Custody of (or placed by) ODJFS/Children's Service

Additional Client Information (Female Only)

Child Birth within the last 5 years?
☐ Yes ☐ No

Total Number of Births (live and still) ☐

Stage of pregnancy (if Client is Pregnant)
☐ 1st Trimester
☐ 2nd Trimester
☐ 3rd Trimester
☐ Unknown

Military status (Check all that Apply)

☐ None ☐ Afghanistan Veteran
☐ Discharged ☐ Iraqi Veteran
☐ Active duty
☐ Disabled Veteran

Available Drug Choices

Alcohol	Other Hallucinogens	Other Non-Barbiturate Sedatives or Hypnotics
Cocaine/Crack	Methamphetamines	Inhalants
Marijuana/Hashish	Other Amphetamines	Over-the-Counter Medications
Heroin	Other Stimulants	Nicotine
Non-prescription methadone	Benzodiazepines	Other Medications
Other Opiates and Synthetics	Other Non-Barbiturate Tranquilizers	Unknown
PCP	Barbiturates	

☐ No Drug of Choice

Primary Drug of Choice

(Select from above)

Age of First Use ☐ (Age of first intoxication when Alcohol drug choice)

Frequency of Use
☐ No Use in the last Past Month
☐ 1 – 3 Times in the Past Month
☐ 1 – 2 Time in the Past Week
☐ 3 – 6 Time in the Past Week
☐ Daily
☐ Unknown

Route of Administration
☐ Oral
☐ Smoking
☐ Inhalation
☐ Injection
☐ Other
☐ Unknown

Secondary Drug of Choice

(Select from above)

Age of First Use ☐ (Age of first intoxication when Alcohol drug choice)

Frequency of Use
☐ No Use in the last Past Month
☐ 1 – 3 Times in the Past Month
☐ 1 – 2 Time in the Past Week
☐ 3 – 6 Time in the Past Week
☐ Daily
☐ Unknown

Route of Administration
☐ Oral
☐ Smoking
☐ Inhalation
☐ Injection
☐ Other
☐ Unknown

Tertiary Drug of Choice

(Select from above)

Age of First Use ☐ (Age of first intoxication when Alcohol drug choice)

Frequency of Use
☐ No Use in the last Past Month
☐ 1 – 3 Times in the Past Month
☐ 1 – 2 Time in the Past Week
☐ 3 – 6 Time in the Past Week
☐ Daily
☐ Unknown

Route of Administration
☐ Oral
☐ Smoking
☐ Inhalation
☐ Injection
☐ Other
☐ Unknown

Number of Arrests in the Past 30 Days ☐

Primary Reimbursement

☐ Self-Pay
☐ Blue Cross/Blue Shield
☐ Medicare
☐ Medicaid
☐ Other Government Payments
☐ Worker's Compensation
☐ Other Health Insurance Companies
☐ No Charge
☐ Other Payment Source

Frequency of attendance at self-help programs in the 30 days prior to admission?

☐ No attendance in the past month
☐ 1-3 times in the past month
☐ 4-7 times in the past month
☐ 8-15 times in the past month
☐ 16-30 times in the past month
☐ Some attendance in the past month, but frequency unknown
☐ Unknown

Paying Board/Resident Board of Client

Access and Retention Measures

STAR-SI Participant? Yes / No

Client Group:
☐ 408 Program ☐ Not Applicable
☐ Medicaid/Indigent ☐ Board Funded ☐ Unknown

1st Date of Service:

Family Reunification

HB484 Participant? Yes / No

Were children removed from home? Yes / No

Women's Program

Involved in a Women's Program? Yes / No

At time of Admission was program at or above 90%? Yes / No

Is there a waiting list? Yes / No

Was interim services provider due to client being on waiting list? Yes / No

TASC

Type Of Client
☐ Adult TASC ☐ Unknown
☐ Juvenile TASC
☐ DYS

Parolee
☐ Unknown ☐ Federal Parolee
☐ ODRC Parolee ☐ Unknown
☐ DYS Parolee

Recovery Council

Client Orientation Checklist

I affirm that I have been provided an orientation to the program, its staff, services and facilities, including each of the following areas listed below:

1. **Hours of operation.**
2. **Code of ethics**
3. **Rules, regulation, and expectations.**
4. **Client rights and responsibilities of person served.**
5. **Client fee system explanation, financial arrangements, fees, and obligations.**
6. **Grievance and appeal procedures.**
7. **Full disclosure on all levels, types and duration of services and activities.**
8. **Access to after-hours services.**
9. **Identification of counselor / service coordinator.**
10. **Ways in which client input is given Re: quality of care, outcomes, and satisfaction.**
11. **Copy of program rules to client specifying any restrictions the program may place on a person, events, behaviors or attitudes that may lead to a loss of privileges and the means by which the lost rights / privileges can be regained by the client.**
12. **Developing feasible goals and achievement of outcome.**
13. **Confidentiality policy.**
14. **Site and safety organization (familiarization with premises, emergency exits and / or shelters, fire suppression equipment, first aid kits, etc.)**
15. **Tobacco policy**
16. **Purpose and process of assessment.**
17. **Description of how the individual plan is developed and the client's participation in it.**
18. **Information on transition criteria and procedures.**
19. **Aftercare and Transitional planning.**
20. **Person responsible for services coordination.**
21. **Policy on seclusion and restraint.**
22. **HIV, Hepatitis B and C, Other infectious diseases and universal precautions.**
23. **Education on advanced directives as appropriate.**
24. **Policy regarding illegal, legal, and prescription drugs brought into the program.**
25. **Policy regarding weapons brought into the program.**
26. **When applicable, requirements for the mandated person served, regardless of his/her discharge outcome and expectations for consistent court appearances.**
27. **When applicable, the identification of therapeutic interventions including sanctions, interventions, incentives, and administrative discharge criteria.**

I have been oriented to and understand the above-initialed items by the staff at Pike County Recovery Council, Inc.

_____ _____

Client Signature **Date**

_____ _____

Staff Signature **Date**

The Recovery Council

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

1. You have a right to receive a paper copy of the Notice and/or an electronic copy by email upon request. The Recovery Council has the right to revise this Notice, and if revisions are made to this Notice, you have the right to receive the revised copy.

2. You have the right to file a complaint to our Privacy Officer (Person and position; phone number), if you think we may have violated your privacy rights, or if you disagree with a decision we made about access to your protected health information (PHI). You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington D.C., 20201 or call 1-877-696-6775. There will not be any penalties against you if you make a complaint.

3. The Recovery Council is required to maintain the privacy of the information in your file, and to abide by the terms of this notice.

4. Your protected health information refers to individually identifiable information relating to the past, present, or future physical or mental health or condition of you the client, provision of health care to you, or the past, present, or future payment for health care provided to you.

5. The Recovery Council maintains a limited right to use and/or disclose your PHI for purposes of treatment, payment, and health care operations as follows:

   For Treatment
   We may use medical information about you to provide you with behavioral health and medical treatment or services. We may disclose medical information about you to doctors, nurses, counselors, healthcare professionals in training, or other agency personnel who are involved in taking care of you through the agency. For example, a medical diagnosis may be shared with a specialist to help in your treatment process. Different departments of the agency may also share medical information about you in order to coordinate the different things you need, such as prescriptions, counseling and residential support.

   For Payment
   We may use and disclose medical information about you so that the treatment and services you receive at the agency may be billed to and payment may be collected from you, an insurance company or a third party. For example, we need to give the CMH/ADAMHS Board and/or the State Departments information about counseling you received at the agency so the Board will pay us for the service.

   For Healthcare Operations
   We may use and disclose medical information about you for agency operations. These uses and disclosures are necessary to run the agency and make sure that all of our clients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many agency clients to decide what additional services the agency should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health professionals in training, and other agency personnel for review and learning purposes. We may also combine the medical information we have with medical information from other agencies to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific clients are.

6. The Recovery Council maintains a right or is required by law to use and/or disclose your PHI in certain circumstances without your authorization. Refer to The Recovery Council's HIPAA Policies and Procedures Manual for specific explanations regarding these cases. The following circumstances do not require your authorization: to employers (for medical surveillance activities); concerning victims of abuse, neglect, or domestic violence; to health oversight agencies; for judicial/administrative proceedings; for law enforcement purposes; for approved research; to correctional institutes; to avert a serious threat to health or safety; for workers' compensation purposes; and relating to decedents.

7. You have the right to revoke your authorization at any time to stop future uses and/or disclosures except to the extent that The Recovery Council has already undertaken an action in reliance upon your authorization.

8. The Recovery Council may send appointment reminders and other similar materials to your home unless you provide us with alternative instructions.

9. The Recovery Council may contact you about treatment alternatives or other health related benefits and services.

10. You have the right to request the receipt of confidential communications by alternative means or at alternative locations as long as it is reasonably easy for The Recovery Council to do so.

11. If The Recovery Council informs you about the disclosure in advance and you do not object, The Recovery Council may share with your family, friends, or others involved in your care, information directly related to their involvement in your care, or payment for your care. The Recovery Council may also share PHI with these people to notify them about your location, general condition, or death.

12. You have the right to request restrictions on uses and disclosures of information in your file. The Recovery Council is not required to agree to requested restrictions.

13. You have the right to receive confidential communications of PHI, and you also have the right to inspect, copy, and amend your PHI as permitted under the regulations of HIPAA.

14. You have the right to receive a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure: for treatment, payment, and operations; to you, your family, or the facility director; or pursuant to your written authorization. The list will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 14, 2003. The Recovery Council will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as 6 years.
15. The Recovery Council's Privacy Officer is Michelle Black. The Privacy Officer can be contacted during regular business hours at 740-947-6727. The Privacy Officer is located at 11416 Us Rt 23, Waverly Ohio 45690.

SUBSTANCE ABUSE ONLY

1. The Confidentiality of protected health information related to alcohol and/ or drug abuse is protected by federal law, 42 CFR 2 and regulations. Violations of the applicable federal law and regulations are a crime, and may be reported to appropriate authorities.
2. We may not disclose any information about you unless you authorize the disclosure in writing, except as specified below.
3. We may disclose information about you if a court orders the disclosure.
4. We may disclose information about you in a medical emergency, to permit you to receive needed treatment.
5. We may disclose information about you for purposes of program evaluation, audits, or research.
6. We may disclose information about you if you commit a crime on our premises or against any person who works for us, or if you threaten to commit such a crime.
7, We are required to disclose information about you if we suspect child abuse or neglect.
8. Except as stated in this notice, you have the same rights and protections with respect to you r health information as described in our general Notice of Privacy Practices.

I have read, understand and have received a copy of the Notice of Pricvy Practices Form.

_____ _____

Client Signature Date

Revised 7/18/13

Consent for Alcohol / Drug Treatment / Services
The Recovery Council

[3793-1-06 (F) (3)]

Client: _____ ID# _____

The Pike County Recovery Council provides services to individuals and their families who have substance abuse / chemical dependency problems. The staff members are trained to provide appropriate treatment / services as needed in this area.

I have read and understand the information regarding consent to alcohol / drug treatment services.
I have also received a copy of and understand the following:

- I will pay _____ for each session.
- Program rules and expectation.
- client rights policy and grievance procedure.
- a written summary of the Federal Laws and regulations regarding confidentiality of client records as required by 42 C.F.R., Part 2.
- Education materials on tuberculosis, hepatitis B and C and HIV/AIDS.

I agree to treatment / services as offered by the Pike County Recovery Council for:

_____ Myself _____ My Child / or _____
[Name of person whom I am legal Guardian / Custodian]

Client Signature: _____ Date _____

Legally Responsible
Person's Signature: _____ Date _____

Staff Signature /
Credentials: _____ Date _____

Pike County Recovery Council
Program Rules & Expectations

TERMS AND CONDITIONS AGREED UPON BY PROSPECTIVE CLIENT

1. I have voluntarily requested the services of the Pike County Recovery Council for the length of time as stated in my treatment plan or determined upon re-evaluation.
2. I agree to keep appointments as scheduled, to notify the agency at least 24 hours prior to the appointment time if I cannot attend the session, and to provide a written excuse from an authorized professional (doctor, lawyer, P.O., etc.) when requested.
3. I understand that if I should miss 3 days of my treatment program, I will be considered non-compliant and will be required to restart the program from the beginning.
4. I understand that the agency cannot be held responsible for my conduct or safety outside of the agency premises.
5. I agree to abide by the rules of proper conduct while I am on the agency premises.
6. I understand that services are provided in a confidential manner. I agree to honor confidentiality rules that are established when participating in group and other activities.
7. I agree to advise my counselor of all other counseling, medical or psychiatric care which I receive from another agency or program.
8. I agree to abstain from the use of alcohol and similar mood altering chemicals. **I understand that I will not be released from treatment if I am not drug and alcohol free, as determined by my counselor, by the end of treatment.**
9. I agree to participate in self-help groups as recommended (AA, Al-Anon, NA, etc.)
10. I understand that persistent failure to follow the service plan may result in discharge.
11. I agree to meet with my counselor personally to inform him/her if I decide to terminate my association with the agency for any reason.
12. I agree to allow follow-up contact from staff of the program.
13. I understand that participating in transportation services is voluntary and release the agency from any responsibility or liability during transportation services.
14. I understand and was given a copy of the protection and limitations of client confidentiality as governed by Federal Laws and Regulations 42 CFR, Part B, Paragraph 2.22; I have been read and understand the limits of confidentiality. I understand that if I disclose information about child abuse or endangerment or the intent to harm myself or others, my counselor must report that to the proper authorities. Also, in the event of a medical emergency or subpoena from the courts, information about me as a client may be released. Otherwise, the agency may not release information about me without my written permission (signed Release of Information).
15. I have been informed and given a copy of client rights and agency grievance procedures, the HIPAA Privacy Rule, educational material on hepatitis B, C, tuberculosis, HIV/AIDS, and consent to treatment at the Pike County Recovery Council.
16. I agree to allow the Pike County Recovery staff to contact me by phone or mail or through the emergency contact person I have named.

_____ _____

Client Signature Staff Signature

_____ _____

Date Date

WRITTEN SUMMARY OF FEDERAL CONFIDENTIALITY LAWS & REGULATIONS FOR CLIENTS IN ALCOHOL AND/OR DRUG PROGRAMS

Confidentiality of client records includes the following:

- **Program staff shall not convey to a person outside of the program that a client receives services from the program or disclose any information identifying a client as an alcohol or drug services client unless the client consents in writing for the release of information, the disclosure is allowed by court order, or the disclosure is made to a qualified personnel for a medical emergency, research, audit or program evaluation purposes.**

- **Federal laws and regulations do not protect any threat to commit a crime, any information about a crime committed by a client either at the program or against any person who works for the program.**

- **Federal laws and regulations do not protect any information about suspected child abuse or neglect form being reported under State law to appropriate State or Federal authorities.**

_____ _____

Client Signature **Date**

_____ _____

Staff Signature **Date**

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION ABOUT PERSONS RECEIVING SERVICES FROM *PIKE COUNTY RECOVERY COUNCIL*

I _____ authorize *Pike County Recovery Council*

To disclose to the ADAS/ADAMH Boards(s) from whom I am seeking funding for services the Ohio Departments of Mental Health, Alcohol and Drug Addiction Services and/or Job and Family Services (Departments) the information necessary to accomplish the following purposes:

- To enroll me in the Multi-Agency Community Services Information System (MACSIS) which is the shared computer payment system used by CMH/ADAS/ADAMH Boards and the Departments.
- To determine my eligibility for publicly-funded services.
- To pay claims for services I receive.
- To report information required by the ADAS/ADAMH Board and/or the Departments regarding characteristics of individuals seeking services and the services provided. I understand that the Board and Departments use the information in aggregate form for service planning and evaluation purposes.
- To report information, as required by Ohio Law, about reportable incidents that may occur while I am receiving services to the ADAS/ADAMH Board and Departments.

I understand that I must authorize disclosure of information necessary to payment purposes in order to receive alcohol and drug addiction services. My treatment or payment for my services cannot be conditioned upon my giving authorization for any purpose other than payment.

I understand that I may revoke this authorization at any time, except to the extent action has been taken in reliance on it. If not previously revoked, this authorization will expire at the time my treatment with *Pike County Recovery Council* ends.

I understand that the information disclosed is protected by law; however, I understand that the *Pike County Recovery Council* cannot control the use of this information once it has been disclosed.

_____ _____

Signature of Individual Date

Macisis Residency Verification

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrolment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrolment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.

Adult

Client is an adult [ ] Yes [ ] No If yes, complete the following	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Signature of Client	Date

Minor

Client is a Minor [ ] Yes [ ] No	If yes, indicate if child is in legal custody of the following (this is not the foster Parent) [ ] Parent [ ] CSB [ ] DYS [ ] Court [ ] Other (specify): _____
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone # of Legal Custodian
County of Legal Custodian	
It Parent, Address of Parent (if different from client's physical address on enrolment form)	
Signature of Legal Custodian	Date

Pike County Recovery Council Financial Agreement

Client Name: _____
(First) (mi) (last)

Parent / Legal Guardian: _____

Source of Income or Place of Employment: _____

Source of Income or Place of Employment: _____

Monthly Income_____ Deductions_____ Adjusted Income_____

Including yourself, how many family members live in your home? _____ How many under the age of 18? _____

Method of Payment:

□ Self pay _____per session

□ Insurance (Co. _____ ID#_____ Copay_____)

□ court(case # _____)

□ Other _____

==========

Consent for Service/Authorization for Release of Information:

I authorize the Pike County Recovery Council to use the information necessary for the purpose of treatment, payment, and health care operations to entities including to but not limited to my insurance company, the alcohol drug addiction Mental Health Services Board (ADAMH Board), and the Multi-Agency Community Services Information System (MACSIS). I have received a copy of Notice of Privacy Practices of Pike County Recovery Council. I understand I have the right to review this notice prior to signing this consent form, that the Pike County Recovery Council has the right to change its Private Practices retroactively, that the terms of the notice may change, and that I may request a copy of the notice at any time. I understand that I may revoke my consent in writing except to the extent that Pike County Recovery Council has taken action in reliance on it. I have received a copy of Pike County Recovery Council Program Rules & Client Expectations, Client Rights and Grievances Procedures, a Written Summary of Federal Laws / Regulations regarding the Confidentiality of Client Records, Notice of Enrolment in MACSIS, information regarding exposure to transmission of TB, Hepatitis B & C, HIV / AIDS, I authorize the Pike County Recovery Council to use the telephone numbers and the mailing address that I have provided to contact me. I request and consent to enrolment in the MACSIS Behavioral Health Care Plan and Treatment Services provided by Pike County Recovery Council.

==========

_____ _____
Client Signature **Date**

_____ _____
Staff Signature **Date**

_____ _____
As applicable Signature □ Parent, □ Guardian, **Date**
□ Other (specify) _____

AUTHORIZATION TO DISCLOSE INFORMATION

Name of Client _____ Date _____

The following programs are authorized to: { } Disclose, { } Receive or, { } Exchange Information as noted below:

Pike County Recovery Council

Program Authorized to Make Disclosure

The Medicaid Managed Care Program /

Authorized Individual / Organization to Whom Disclosure is Made

Purpose of Disclosure: { } To Coordinate Treatment, { } To gather information for treatment planning, { } Other (specify)

_____

Type of information to be Disclosed: { } Progress notes, { } diagnostic assessment information, { } Progress in treatment, { } lab results, { } urine screening, { } attendance, { } HIV/AIDS testing status, { } pregnancy testing, { } prenatal care, { } Diagnosis, { } information on mental illness and / or treatment, { } other (specify)

_____

Amount of information to be Disclosed: { } information covering the previous three months, { } information covering th most recent admission, { } other (specify)

_____

_____

Signature and Date of Client or Other Person Authorized to Permit Disclosure

_____

Signature and Date of Staff or Witness

Revocation: This authorization is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it. Drug and/or alcohol clients can revoke consent either verbally or in writing.

I hereby revoke consent in writing: _____

Client's Signature and Date

Authorization was verbally revoked: Date _____ Time _____

_____

Signature and Date of Person Witnessing Verbal or Written Revocation

This authorization expires (specify event, date, and/or condition) _____

Prohibition Against Re- Disclosure: this information has been disclosed to you from records protected by Federal Confidentiality rules. The Federal rules prohibit you form making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by 42 C.F.R., Part 2 A general authorization for the release of medical information or other information is not sufficient to this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure).

Recovery Council

Initial Intake Data Sheet

Intake Date: _____

DOB: _____

Client Information

Sex: _____ Male

Client Name _____ **_____Female**

Address: _____ **Race: _____**

Number / Street **SS#_____**

_____ **Marital Status:**

Apt / Lot Number **____ Married____ Single**

_____ **___ Divorced ____Separated**

City State Zip Code **____ Living as Married**

____ Widow / Widower

County of Residence: _____

Phone Number: _____ Work or Cell Phone: _____

Veteran? ____ Yes ____No

Emergency Contact Information

Name of Emergency Contact: _____

Address: _____

Phone Number: _____ Relationship: _____

Referral Source Information

Self Referral? ____Yes ____No

Name of Referring Entity (if not self): _____

Address: _____

_____

_____

Phone Number: _____

Fax Number: _____

Ohio Behavioral Health
Discharge Form

Unique Provider Number:	**Provider Episode Number:**
First Name:	**Last Name:**
Unique Client Id:	**Date of Birth (mm/dd/yyyy):**
Last Date of Service:	**Closure Date:**

Discharge Reason

- ☐ Successful Completion/Graduate
- ☐ Assessment & Evaluation Only, Successfully Completed no Further Services Recommended
- ☐ Assessment & Evaluation Only, Client Rejected Recommendations
- ☐ Left on Own, Against Staff Advice WITH Satisfactory Progress
- ☐ Left on Own, Against Staff Advice WITHOUT Satisfactory Progress
- ☐ Involuntarily Discharged Due to Non-Participation
- ☐ Involuntarily Discharged Due to Violation of Rules
- ☐ Referred to Another Program or Service with SATISFACTORY Progress
- ☐ Referred to Another Program or Service with UNSATISFACTORY Progress
- ☐ Incarcerated Due to Offense Committed while in Treatment/Recovery with SATISFACTORY Progress
- ☐ Incarcerated Due to Offense Committed while in Treatment/Recovery with UNSATISFACTORY Progress
- ☐ Incarcerated Due to Old Warrant/Charged from Before Entering Treatment/Recovery with SATISFACTORY Progress
- ☐ Incarcerated Due to Old Warrant/Charged from Before Entering Treatment/Recovery with UNSATISFACTORY Progress
- ☐ Transferred to Another Facility for Health Reasons
- ☐ Death
- ☐ Client Moved
- ☐ Needed Services Not Available
- ☐ Other

Did client choose another provider due to religious preference? Yes / No (Faith Based Provider Only)

Educational Level Completed

- ☐ Less Than One Grade
- ☐ First Grade
- ☐ Second Grade
- ☐ Third Grade
- ☐ Fourth Grade
- ☐ Fifth Grade
- ☐ Sixth Grade
- ☐ Seventh Grade
- ☐ Eighth Grade
- ☐ Ninth Grade
- ☐ Tenth Grade
- ☐ Eleventh Grade
- ☐ High School Diploma/GED
- ☐ Technical School
- ☐ Some College
- ☐ 2 Yr. College/Assoc. Degree
- ☐ 4 Yr College/Undergraduate Degree
- ☐ Masters/Doctorate/Other Profession Degree
- ☐ Unknown

Education Enrollment

- ☐ K – 12th Grade
- ☐ GED Classes
- ☐ Vocational/Job Training
- ☐ College
- ☐ Other School; Adult Basic Ed., Literacy
- ☐ Not Enrolled

Pregnancy/Birth Status (if applicable)

- ☐ 1st Trimester
- ☐ 2nd Trimester
- ☐ 3rd Trimester
- ☐ Unknown
- ☐ Birth Occurred: Drug Free Birth
- ☐ Birth Occurred: Not Drug Free
- ☐ Pregnancy Terminated
- ☐ Miscarriage

Employment Status

- ☐ Full Time
- ☐ Part Time
- ☐ Sheltered
- ☐ Unemployed but Actively Looking for Work
- ☐ Homemaker
- ☐ Student
- ☐ Volunteer Worker
- ☐ Retired
- ☐ Disabled
- ☐ Inmate in Jail/Prison/Corrections
- ☐ Engaged in Residential/Hospitalization
- ☐ Other not in Labor Force
- ☐ Unknown

Primary Source of Income/Support

- ☐ Wages/Salary Income
- ☐ Family/Relative
- ☐ Public Assistance
- ☐ Retirement/Pension
- ☐ Disability
- ☐ Other
- ☐ Unknown
- ☐ None

Living arrangements

- ☐ Independent Living (Own Home)
- ☐ Homeless
- ☐ Other's Home
- ☐ Residential Care
- ☐ Respite Care
- ☐ Foster Care
- ☐ Crisis Care
- ☐ Temporary Housing
- ☐ Community Residence
- ☐ Nursing Facility
- ☐ License MR Facility
- ☐ State MH/MR Institution
- ☐ Hospital
- ☐ Correctional Facility
- ☐ Other
- ☐ Unknown

Primary Diagnosis Code

Secondary Diagnosis Code

Tertiary Diagnosis Code

Quaternary Diagnosis Code

Available Drug Choices

Alcohol	Other Hallucinogens	Other Non-Barbiturate Sedatives or Hypnotics
Cocaine/Crack	Methamphetamines	Inhalants
Marijuana/Hashish	Other Amphetamines	Over-the-Counter Medications
Heroin	Other Stimulants	Nicotine
Non-prescription methadone	Benzodiazepines	Other Medications
Other Opiates and Synthetics	Other Non-Barbiturate Tranquilizers	Unknown
PCP	Barbiturates	

☐ No Drug of Choice

Primary Drug of Choice	**Frequency of Use**	**Route of Administration**
(Select from above)	☐ No Use in the last Past Month	☐ Oral
	☐ 1 – 3 Times in the Past Month	☐ Smoking
	☐ 1 – 2 Time in the Past Week	☐ Inhalation
	☐ 3 – 6 Time in the Past Week	☐ Injection
	☐ Daily	☐ Other
	☐ Unknown	☐ Unknown

Secondary Drug of Choice	**Frequency of Use**	**Route of Administration**
(Select from above)	☐ No Use in the last Past Month	☐ Oral
	☐ 1 – 3 Times in the Past Month	☐ Smoking
	☐ 1 – 2 Time in the Past Week	☐ Inhalation
	☐ 3 – 6 Time in the Past Week	☐ Injection
	☐ Daily	☐ Other
	☐ Unknown	☐ Unknown

Tertiary Drug of Choice	**Frequency of Use**	**Route of Administration**
(Select from above)	☐ No Use in the last Past Month	☐ Oral
	☐ 1 – 3 Times in the Past Month	☐ Smoking
	☐ 1 – 2 Time in the Past Week	☐ Inhalation
	☐ 3 – 6 Time in the Past Week	☐ Injection
	☐ Daily	☐ Other
	☐ Unknown	☐ Unknown

Number of Arrests in the Past 30 Days ☐	**Primary Reimbursement**	**Frequency of attendance at self-help programs in the 30 days prior to discharge?**
If an arrest occurred, were you charged with a criminal offense for which the incident was alleged to have happened after you were admitted to this program? Yes / No	☐ Self-Pay ☐ Blue Cross/Blue Shield ☐ Medicare ☐ Medicaid ☐ Other Government Payments ☐ Worker's Compensation ☐ Other Health Insurance Companies ☐ No Charge ☐ Other Payment Source	☐ No attendance in the past month ☐ 1-3 times in the past month ☐ 4-7 times in the past month ☐ 8-15 times in the past month ☐ 16-30 times in the past month ☐ Some attendance in the past month, but frequency unknown ☐ Unknown

Access and Retention Measures	**Family Reunification**	**Women's Program**
2nd Day of Service:	Were children returned to home? Yes / No	Was child care provided? Yes / No
3rd Day of Service:		Did the program provide transportation? Yes / No
4th Day of Service:		Was a referral made for prenatal care? Yes / No

TASC:

Discharge Status: ☐ Successful ☐ Neutral ☐ Unsuccessful	Number of Positive Breathalyzer Screens: ☐	Has the Client been Rearrested? Yes / No
Did the Client Complete Treatment? ☐ Yes ☐ No ☐ Not Applicable	Number of Negative Breathalyzer Screens: ☐	If yes: Has the Client Been Sent to Prison Resulting From the Re-arrest? Yes / No
Is the Client Compliant with all Legal Requirements? Yes / No	Is the client compliant with all legal requirements? Yes / No	What Level of Crime Was Committed? ☐ Misdemeanor ☐ Felony
Number of Positive Urine Screens: ☐	Has the Client Improved Family Relationships? Yes / No	
Number of Negative Urine Screens: ☐		