



**Connecticut Department of Mental Health and Addiction Services  
DDaP – ADMISSION FORM**

**DEMOGRAPHICS**

**NAME:** \_\_\_\_\_

**SOCIAL SECURITY NUMBER:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**NO SSN GIVEN / REASON:**     UNKNOWN     NOT COLLECTED     CLIENT REFUSED

**DATE OF BIRTH:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**NO DOB GIVEN / REASON:**     UNKNOWN     NOT COLLECTED     CLIENT REFUSED

**RELIGION:** *(check one box only)*

- |  |   |
|--|---|
| 01 <input type="checkbox"/> PROTESTANT | 07 <input type="checkbox"/> ORTHODOX    |
| 02 <input type="checkbox"/> CATHOLIC   | 08 <input type="checkbox"/> HINDU       |
| 03 <input type="checkbox"/> JEWISH     | 10 <input type="checkbox"/> PENTECOSTAL |
| 04 <input type="checkbox"/> MUSLIM     | 95 <input type="checkbox"/> NONE        |
| 05 <input type="checkbox"/> BUDDHIST   | 96 <input type="checkbox"/> OTHER       |
| 06 <input type="checkbox"/> MORMON     | 97 <input type="checkbox"/> UNKNOWN     |

**MARITAL STATUS:** *(check one box below)*

- |   |   |
|---|---|
| 01 <input type="checkbox"/> NEVER MARRIED     | 08 <input type="checkbox"/> WIDOWED     |
| 02 <input type="checkbox"/> MARRIED           | 09 <input type="checkbox"/> CIVIL UNION |
| 03 <input type="checkbox"/> SEPARATED         | 96 <input type="checkbox"/> OTHER       |
| 04 <input type="checkbox"/> DIVORCED/ANNULLED | 97 <input type="checkbox"/> UNKNOWN     |

**ETHNIC ORIGIN:** *(check one box only)*

- |   |  |
|---|--|
| 01 <input type="checkbox"/> HISPANIC OTHER        | 04 <input type="checkbox"/> HISPANIC MEXICAN |
| 02 <input type="checkbox"/> NON-HISPANIC          | 05 <input type="checkbox"/> HISPANIC CUBAN   |
| 03 <input type="checkbox"/> HISPANIC PUERTO RICAN | 97 <input type="checkbox"/> UNKNOWN          |

<b>LANGUAGE:</b> (check one Primary box, check one Secondary box, as applicable)							
	Primary	Secondary		Primary	Secondary		
16	<input type="checkbox"/>	<input type="checkbox"/>	CANTONESE	05	<input type="checkbox"/>	<input type="checkbox"/>	POLISH
43	<input type="checkbox"/>	<input type="checkbox"/>	ENGLISH	04	<input type="checkbox"/>	<input type="checkbox"/>	PORTUGUESE
03	<input type="checkbox"/>	<input type="checkbox"/>	FRENCH	20	<input type="checkbox"/>	<input type="checkbox"/>	RUSSIAN
07	<input type="checkbox"/>	<input type="checkbox"/>	GREEK	42	<input type="checkbox"/>	<input type="checkbox"/>	SIGN LANGUAGE
41	<input type="checkbox"/>	<input type="checkbox"/>	HAITIAN CREOLE	01	<input type="checkbox"/>	<input type="checkbox"/>	SPANISH
02	<input type="checkbox"/>	<input type="checkbox"/>	ITALIAN	10	<input type="checkbox"/>	<input type="checkbox"/>	VIETNAMESE
17	<input type="checkbox"/>	<input type="checkbox"/>	JAPANESE	96	<input type="checkbox"/>	<input type="checkbox"/>	OTHER
11	<input type="checkbox"/>	<input type="checkbox"/>	LAOTIAN	97	<input type="checkbox"/>	UNKNOWN	
23	<input type="checkbox"/>	<input type="checkbox"/>	LATVIAN	44	<input type="checkbox"/>	NONE	
15	<input type="checkbox"/>	<input type="checkbox"/>	MANDARIN				

**VETERAN:**     YES                       NO                       UNKNOWN

**\*MILITARY START DATE:**    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*\*START DATE required if Veteran = Yes.*

**MILITARY END DATE:**        \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

<b>RACE:</b> (check all appropriate boxes)							
01	<input type="checkbox"/>	AMERICAN INDIAN/NATIVE ALASKAN	06	<input type="checkbox"/>	WHITE/CAUCASIAN		
02	<input type="checkbox"/>	ASIAN	96	<input type="checkbox"/>	OTHER		
03	<input type="checkbox"/>	BLACK/AFRICAN AMERICAN	97	<input type="checkbox"/>	UNKNOWN		
04	<input type="checkbox"/>	NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER					

**GENDER:**     FEMALE                       MALE                       UNKNOWN

**PROVIDER CLIENT ID:**   
*(Optional field for Provider's use)*

<b>ADDRESS:</b>		
<b>CLIENT STREET ADDRESS 1:</b>		
<b>CLIENT STREET ADDRESS 2:</b>		
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP CODE:</b>

## INSURANCE INFORMATION

*(Select Insurance Type 1 - 4, as applicable)*

	INSURANCE TYPE(S) used by clients	INSURANCE TYPE 1	INSURANCE TYPE 2	INSURANCE TYPE 3	INSURANCE TYPE 4
02	NO HEALTH INSURANCE	<input type="checkbox"/>			
04	OTHER PRIVATE INSURANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	MEDICARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
06	CHAMPUS (U.S. Military)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
08	MEDICAID HUSKEY C*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
09	HMO (including Managed Medicaid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	GA-SAGA (General Assistance- State Administered)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	ATR (Access to Recovery)	<input type="checkbox"/>			
15	SELF PAY	<input type="checkbox"/>			
16	MEDICAID LIA HUSKEY D*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	MEDICARE PART A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	MEDICARE PART B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	MONEY FOLLOWS THE PERSON (MFP)				
20	NURDING HOME WAIVER				
96	OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
97	UNKNOWN	<input type="checkbox"/>			

\*Policy Number is required if INSURANCE TYPE is MEDICAID.

*(Complete based on corresponding INSURANCE TYPE selected, except 02, 97, 14, 15)*

INSURANCE TYPE 1	
<b>POLICY NUMBER</b> : (if applicable)	<input style="width: 95%;" type="text"/>
<b>INSURANCE POLICY START DATE</b> :	_____ / _____ / _____
<b>INSURANCE POLICY END DATE</b> :	_____ / _____ / _____

INSURANCE TYPE 2	
<b>POLICY NUMBER</b> : (if applicable)	<input style="width: 95%;" type="text"/>
<b>INSURANCE POLICY START DATE</b> :	_____ / _____ / _____
<b>INSURANCE POLICY END DATE</b> :	_____ / _____ / _____

INSURANCE TYPE 3	
<b>POLICY NUMBER</b> : (if applicable)	<input style="width: 95%;" type="text"/>
<b>INSURANCE POLICY START DATE</b> :	_____ / _____ / _____
<b>INSURANCE POLICY END DATE</b> :	_____ / _____ / _____

INSURANCE TYPE 4	
<b>POLICY NUMBER</b> : (if applicable)	<input style="width: 95%;" type="text"/>
<b>INSURANCE POLICY START DATE</b> :	_____ / _____ / _____
<b>INSURANCE POLICY END DATE</b> :	_____ / _____ / _____

**ADMISSION**

**ADMISSION PROGRAM:** \_\_\_\_\_

**ADMISSION DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**DATE OF FIRST SERVICE REQUEST:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PRIMARY REFERRAL SOURCE: (check one box below)**

- |    |                          |                               |    |                          |                                    |
|----|--------------------------|-------------------------------|----|--------------------------|------------------------------------|
| 01 | <input type="checkbox"/> | SELF                          | 11 | <input type="checkbox"/> | DEPT OF SOCIAL SERVICES            |
| 02 | <input type="checkbox"/> | FAMILY/FRIEND                 | 12 | <input type="checkbox"/> | DEPT OF DEVELOPMENTAL DISABILITIES |
| 03 | <input type="checkbox"/> | MENTAL HEALTH PROVIDER        | 13 | <input type="checkbox"/> | OTHER COMMUNITY REFERRAL           |
| 04 | <input type="checkbox"/> | SUBSTANCE ABUSE PROVIDER      | 14 | <input type="checkbox"/> | COURT ORDER                        |
| 05 | <input type="checkbox"/> | MEDICAL HEALTH PRACTITIONER   | 15 | <input type="checkbox"/> | PROBATION/PAROLE                   |
| 06 | <input type="checkbox"/> | SCHOOL                        | 16 | <input type="checkbox"/> | POLICE                             |
| 07 | <input type="checkbox"/> | EMPLOYER/SUPERVISOR           | 17 | <input type="checkbox"/> | SHELTER                            |
| 08 | <input type="checkbox"/> | EMPLOYEE ASSISTANCE PROGRAM   | 18 | <input type="checkbox"/> | DEPARTMENT OF CORRECTIONS (DOC)    |
| 09 | <input type="checkbox"/> | CLERGY/CHURCH/SYNAGOGUE       | 96 | <input type="checkbox"/> | OTHER                              |
| 10 | <input type="checkbox"/> | DEPT OF CHILDREN AND FAMILIES | 97 | <input type="checkbox"/> | UNKNOWN                            |

**TOBACCO USE:**  YES  NO  UNKNOWN

**PREGNANCY STATUS:**  YES  NO  UNKNOWN  
*(Required for Females)*

# DIAGNOSIS

EFFECTIVE DATE OF DIAGNOSIS: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

(Enter Client's clinical diagnoses below.)

AXIS I	(Enter Diagnosis)	Description
1	_____ (Primary Dx)	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____
6	_____	_____
7	_____	_____

AXIS II	(Enter Diagnosis)	Description
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____

AXIS III	(Enter Diagnosis)	Description
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____

AXIS IV (Select Yes or No)			
2	PROBLEMS RELATED TO THE SOCIAL ENVIRONMENT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
1	PROBLEMS WITH PRIMARY SUPPORT GROUP	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9	OTHER PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7	PROBLEMS WITH ACCESS TO HEALTH SERVICES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4	OCCUPATIONAL PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3	EDUCATIONAL PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6	HOUSING PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5	ECONOMIC PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8	PROBLEMS RELATED TO THE LEGAL SYSTEM / CRIME	<input type="checkbox"/> YES	<input type="checkbox"/> NO

AXIS V – GAF SCORE: (ENTER 0 – 100)

**PERIODIC ASSESSMENT**

**ASSESSMENT DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**EMPLOYMENT STATUS: (check one box only)**

30	<input type="checkbox"/>	EMPLOYMENT FULL TIME (in competitive employment)	46	<input type="checkbox"/>	NOT IN LABOR FORCE; retired
32	<input type="checkbox"/>	EMPLOYMENT PART TIME (in competitive employment)	48	<input type="checkbox"/>	NOT IN LABOR FORCE; SSI SSDI
34	<input type="checkbox"/>	UNEMPLOYMENT (looking for work in the past 30 days, or on a layoff)	50	<input type="checkbox"/>	NOT IN LABOR FORCE; Inmate of institution
36	<input type="checkbox"/>	PAID BUT NON-COMPETITIVE WORK (transitional employment programs)	52	<input type="checkbox"/>	NOT IN LABOR FORCE; other reason
38	<input type="checkbox"/>	PAID BUT NON-COMPETITIVE WORK (work inside the clubhouse or treatment agency, mobile work crews and consumer-run businesses)	96	<input type="checkbox"/>	OTHER
42	<input type="checkbox"/>	NOT IN LABOR FORCE; student enrolled in a school or job training program)	97	<input type="checkbox"/>	UNKNOWN
44	<input type="checkbox"/>	NOT IN LABOR FORCE; homemaker			

**HIGHEST GRADE COMPLETED:** Highest school grade completed by Client at the time of Assessment. (Enter 0 – 32)   UNKNOWN

**PERSONS DEPENDENT ON INCOME:** (Enter 1 – 15)

**MINORS DEPENDENT ON INCOME:** (Enter 0 – 14)

**PRINCIPAL SOURCE OF SUPPORT: (check one box only)**

0	<input type="checkbox"/>	NONE	4	<input type="checkbox"/>	DISABILITY
1	<input type="checkbox"/>	PUBLIC ASSISTANCE	96	<input type="checkbox"/>	OTHER
2	<input type="checkbox"/>	RETIREMENT	97	<input type="checkbox"/>	UNKNOWN
3	<input type="checkbox"/>	SALARY			

**LIVING SITUATION: (check one box only)**

30	<input type="checkbox"/>	PRIVATE RESIDENCE, client owns or holds lease	46	<input type="checkbox"/>	PSYCHIATRIC/SA/MEDICAL INPATIENT
32	<input type="checkbox"/>	PRIVATE RESIDENCE, friend or relative owns the residence or holds lease.	48	<input type="checkbox"/>	CORRECTIONAL FACILITY
34	<input type="checkbox"/>	SINGLE ROOM OCCUPANCY (Hotel, YMCA, Rooming House)	50	<input type="checkbox"/>	DOMESTIC VIOLENCE SHELTER
36	<input type="checkbox"/>	PRIVATE RESIDENCE, Community agency owns or holds lease	52	<input type="checkbox"/>	HOMELESS SHELTER
38	<input type="checkbox"/>	RESIDENTIAL CARE HOME / BOARD AND CARE	54	<input type="checkbox"/>	HOMELESS (including on street)
40	<input type="checkbox"/>	CONGREGATE RESIDENTIAL CARE (24-hour supervision, group setting, services focus on MH, SA, &/or MR issues, Recovery House.)	96	<input type="checkbox"/>	OTHER
42	<input type="checkbox"/>	CRISIS / RESPITE BED	97	<input type="checkbox"/>	UNKNOWN
44	<input type="checkbox"/>	SKILLED NURSING FACILITY/ INTERMEDIATE CARE FACILITY/ NURSING HOME			

**Was Client Homeless in the Last Six Months?**  YES  NO  UNKNOWN

**Number of Days in the Last 30 that client lived in a Controlled Environment?**

(Enter 0 – 30)

**Number of Arrests in the Last 30 Days?**

(Enter 0 – 30)   UNKNOWN

**SOCIAL SUPPORT VOLUNTARY: Number of Self-Help programs/meetings attended in last 30 days**

(Enter 0 – 50)   UNKNOWN

**SOCIAL SUPPORT FAMILY/FRIENDS: Indicate whether or not Client interacted with Family/Friends supportive of recovery in the thirty days preceding assessment.**

YES  NO  UNKNOWN

**SUBSTANCE ABUSE**

*(Select client's lifetime number of prior Admissions to Inpatient/Residential Substance Abuse treatment.)*

**SA IP.RES. ADMISSIONS: LIFETIME**

0	<input type="checkbox"/>	NO PRIOR ADMISSIONS	04	<input type="checkbox"/>	4 PRIOR ADMISSIONS
01	<input type="checkbox"/>	1 PRIOR ADMISSION	05	<input type="checkbox"/>	5 PRIOR ADMISSIONS
02	<input type="checkbox"/>	2 PRIOR ADMISSIONS	06	<input type="checkbox"/>	GREATER THAN 5 PRIOR ADMISSIONS
03	<input type="checkbox"/>	3 PRIOR ADMISSIONS			

*(Select client's lifetime number of prior Admissions to Outpatient Substance Abuse treatment.)*

**SA OP.RES. ADMISSIONS: LIFETIME**

0	<input type="checkbox"/>	NO PRIOR ADMISSIONS	04	<input type="checkbox"/>	4 PRIOR ADMISSIONS
01	<input type="checkbox"/>	1 PRIOR ADMISSION	05	<input type="checkbox"/>	5 PRIOR ADMISSIONS
02	<input type="checkbox"/>	2 PRIOR ADMISSIONS	06	<input type="checkbox"/>	GREATER THAN 5 PRIOR ADMISSIONS
03	<input type="checkbox"/>	3 PRIOR ADMISSIONS			

**PERIODIC ASSESSMENT – SUBSTANCE USE**

*(Select Drug Type 1 - 5, as applicable)*

DRUG TYPE(S) used by clients		DRUG TYPE 1	DRUG TYPE 2	DRUG TYPE 3	DRUG TYPE 4	DRUG TYPE 5
0	NONE	<input type="checkbox"/>				
01	AMPHETAMINES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	BARBITUATES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04	BENZODIAZEPINES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	COCAINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
06	CRACK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
07	HALLUCINOGENS: LSD, DMS, STP, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
08	HEROIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
09	INHALANTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	MARIJUANA, HASHISH, THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	METHAMPHETAMINES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	NON-PRESCRIPTIVE METHADONE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	OTHER OPIATES AND SYNTHETICS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	OTHER SEDATIVES OR HYPNOTICS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	OTHER STIMULANTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	OVER-THE-COUNTER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	TRANQUILIZERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
96	OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
97	UNKNOWN	<input type="checkbox"/>				

**DRUG METHOD USE FIELD 1: (Complete based on corresponding DRUG TYPE 1 selected, except 0 & 97.)**

01	<input type="checkbox"/>	ORAL	04	<input type="checkbox"/>	INJECTION
02	<input type="checkbox"/>	SMOKING	96	<input type="checkbox"/>	OTHER
03	<input type="checkbox"/>	INHALATION	97	<input type="checkbox"/>	UNKNOWN

**DAYS USED FIELD 1:**

Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 1 field? *(Enter 0 – 30)*

**AGE FIRST USED FIELD 1:**

Age at which the client used the Drug specified in the Drug Type 1 field? *(Enter Age)*



**DRUG METHOD USE FIELD 2: (Complete based on corresponding DRUG TYPE 2 selected, except 0 & 97.)**

- |    |                          |            |    |                          |           |
|----|--------------------------|------------|----|--------------------------|-----------|
| 01 | <input type="checkbox"/> | ORAL       | 04 | <input type="checkbox"/> | INJECTION |
| 02 | <input type="checkbox"/> | SMOKING    | 96 | <input type="checkbox"/> | OTHER     |
| 03 | <input type="checkbox"/> | INHALATION | 97 | <input type="checkbox"/> | UNKNOWN   |

**DAYS USED FIELD 2:**

Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 2 field? (Enter 0 – 30)

**AGE FIRST USED FIELD 2:**

Age at which the client used the Drug specified in the Drug Type 2 field? (Enter Age)

**DRUG METHOD USE FIELD 3: (Complete based on corresponding DRUG TYPE 3 selected, except 0 & 97.)**

- |    |                          |            |    |                          |           |
|----|--------------------------|------------|----|--------------------------|-----------|
| 01 | <input type="checkbox"/> | ORAL       | 04 | <input type="checkbox"/> | INJECTION |
| 02 | <input type="checkbox"/> | SMOKING    | 96 | <input type="checkbox"/> | OTHER     |
| 03 | <input type="checkbox"/> | INHALATION | 97 | <input type="checkbox"/> | UNKNOWN   |

**DAYS USED FIELD 3:**

Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 3 field? (Enter 0 – 30)

**AGE FIRST USED FIELD 3:**

Age at which the client used the Drug specified in the Drug Type 3 field? (Enter Age)

**DRUG METHOD USE FIELD 4: (Complete based on corresponding DRUG TYPE 4 selected, except 0, 97.)**

- |    |                          |            |    |                          |           |
|----|--------------------------|------------|----|--------------------------|-----------|
| 01 | <input type="checkbox"/> | ORAL       | 04 | <input type="checkbox"/> | INJECTION |
| 02 | <input type="checkbox"/> | SMOKING    | 96 | <input type="checkbox"/> | OTHER     |
| 03 | <input type="checkbox"/> | INHALATION | 97 | <input type="checkbox"/> | UNKNOWN   |

**DAYS USED FIELD 4:**

Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 4 field? (Enter 0 – 30)

**AGE FIRST USED FIELD 4:**

Age at which the client used the Drug specified in the Drug Type 4 field? (Enter Age)

**DRUG METHOD USE FIELD 5: (Complete based on corresponding DRUG TYPE 5 selected, except 0 & 97.)**

- |    |                          |            |    |                          |           |
|----|--------------------------|------------|----|--------------------------|-----------|
| 01 | <input type="checkbox"/> | ORAL       | 04 | <input type="checkbox"/> | INJECTION |
| 02 | <input type="checkbox"/> | SMOKING    | 96 | <input type="checkbox"/> | OTHER     |
| 03 | <input type="checkbox"/> | INHALATION | 97 | <input type="checkbox"/> | UNKNOWN   |

**DAYS USED FIELD 5:**

Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 5 field? (Enter 0 – 30)

**AGE FIRST USED FIELD 5:**

Age at which the client used the Drug specified in the Drug Type 5 field? (Enter Age)

**CO-OCCURRING SCREENING**

CO-OCCURRING SCREENING DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**MENTAL HEALTH**

**MH SCREENING USED:** *(check one box only)*

- |    |                          |                                |    |                          |                                       |
|----|--------------------------|--------------------------------|----|--------------------------|---------------------------------------|
| 01 | <input type="checkbox"/> | MENTAL HEALTH SCREEN FORM III* | 02 | <input type="checkbox"/> | MODIFIED MINI*                        |
| 08 | <input type="checkbox"/> | DECLINED                       | 09 | <input type="checkbox"/> | MEDICALLY OR CLINICALLY INAPPROPRIATE |

**MH SCREENING SCORE:** *(\*Required if MH SCREENING USED field is a value of 1 or 2.)*

**MENTAL HEALTH SCREEN FORM III SCORE:** *(Enter 0-15)*

**MODIFIED MINI SCORE:** *(Enter 0-23)*

**MH SCREEN MOD MINI # 4:** *(Yes Response to Suicidality)*  YES  NO

**MH SCREEN MOD MINI # 14 and # 15:** *(Yes Response to 2 Trauma Questions on Modified Mini Survey)*  YES  NO

**MH SCREEN Gambling Question Response:** *(Yes Response to Form III # 16 or Modified # 23 related to gambling)*  YES  NO

**SUBSTANCE ABUSE**

**SA SCREENING USED:** *(check one box only)*

- |    |                          |                         |    |                          |                                       |
|----|--------------------------|-------------------------|----|--------------------------|---------------------------------------|
| 01 | <input type="checkbox"/> | SSI ALCOHOL AND DRUGS** | 02 | <input type="checkbox"/> | CAGE – Adapted to Include Drugs**     |
| 08 | <input type="checkbox"/> | DECLINED                | 09 | <input type="checkbox"/> | MEDICALLY OR CLINICALLY INAPPROPRIATE |

**SA SCREENING SCORE:** *(\*\*Required if SA SCREENING USED field is a value of 1 or 2.)*

**SSI ALCOHOL AND DRUG SCREENING SCORE:** *(Enter 0-14)*

**CAGE - Adapted to Include Drugs screening SCORE** *(Enter 0-8)*

PROVIDER SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_