Intake/Screening Form

Date :Dec. 31, 2019 **Name**:Sardar Dawar

Type of Insurance :ujnkm

Insurance/Medicaid # :uijk,

Name of Insurance Holder:Sardar Dawar

DOB :Dec. 31, 2019

SSH# :+

Race :uojm

Address :Mughalpura lahore

Home Tel#:321441836

Cell Tel# :+44321441836

Emergency Contact :Sardar Dawar

Relationship to ct:iokl

Tel # :+44321441836

Permission to contact :no

Referral Source +

Substance Abuse History :no

Drug (s) of Choice :ioj

Date Last Used: Dec. 31, 2019

Drug Used:jioolk

Amt Used :oikl

Treatment History :iojml

Comments:

Disposition::iklm

Recommendation :+44321441836

Dx :kmlk;,l

Client meets criteria for:jkml,

Alcohol use disorder

0

305.00

0

F10.20

0

Cocaine use disorder,Severe

0

No Further Services Needed:no

Referral(s) To: :Inpatient

Other Referral(s) To: :

Recommended Program ::kopl,.

Further Evaluation/Treatment Needed (Please Explain):: ojikl

Intake Appointment: :Oct. 10, 2019, 8:31 p.m.

Date and Time:2019-10-10 20:31:13

Counselor:no

Appt. Kept:no

Rescheduled

Date:Dec. 31, 2019, midnight

Counselor:iojlm,iokl

Appt. Kept:no

Counselor Name::Sardar Dawar

Date:

Signature:_____

ASSESSMENT TOOL- ADULTS (PAPER VERSION)

Demographic information		
Name: uijk	Date: Oct. 27, 2019	Phone Number: 5612 Okat to leave voicemail? ☑ Yes ☐ No
Address: uijnk		
Date of Birth:	Age:	Gender:
Race/Ethnicity:	Preferred Language:	Medi-Cal ID #: Other ID# (Plan):
Insurance Type: ☐ None ☐ MyHealthLA	☐ Medicare ☐ Medi-Cal (Plan): (Plan):	☐ Private ☐ Other (Plan): (Plan):
Living Arrangement: ☐ Homeless ☐ Independent living ☐ Other (specify):		
Referred by (specify): SELF REFERRED		

Explanation of why patient is currently seeking treatment: Current symptoms, functional impairment, severity, duration of symptoms (e.g., unable to work/school, relationship/housing problems):

Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential

1. Substance use history:

Alcohol and/or Drug Types	Recently Used? (Past 6 Months)	Prior Use? (Lifetime)	Route (Inject, Smoke, Snort)	Frequency (Daily, Weekly, Monthly)	Duration (Length of Use)	Date of Last Use
Amphetamines (Meth, Ice, Crank)	☐	☐				
Alcohol	☐	☐				
Cocaine/Crack	☐	☐				
Heroin	☐	☐				

Alcohol and/or Drug Types **Marijuana**	Recently Used? (Past 6 Months)	Prior Use? (Lifetime)	Route (Inject, Smoke, Snort)	Frequency (Daily, Weekly, Monthly)	Duration (Length of Use)	Date of Last Use
Opioid Pain Medications Misuse or without prescription	☐	☐				
Sedatives (Benzos, Sleeping Pills) Misuse or without prescription	☐	☐				
Hallucinogens	☐	☐				
Inhalants	☐	☐				
Over-the-Counter Medications (Cough Syrup, Diet Aids)	☐	☐				
Nicotine	☐	☐				
Other:	☐	☐				

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Medi-Cal ID:

Treatment Agency:

Additional Information:

2. Do you find yourself using more alcohol and/or drugs than you intend to? ☐ **Yes** ☑ **No**

Please describe:

3. Do you get physically ill when you stop using alcohol and/or drugs? ☐ **Yes** ☑ **No**

Please describe:

4. Are you currently experiencing withdrawal symptoms, such as tremors, excessive sweating, rapid heart rate,blackouts, anxiety, vomiting, etc.? ☐ **Yes** ☑ **No**

Please describe specific symptoms and consider immediate referral for medical evaluation:

5. Do you have a history of serious withdrawal, seizures, or life-threatening symptoms during withdrawal? ☐ **Yes** ☑ **No**

Please describe and specify withdrawal substance(s):

6. Do you find yourself using more alcohol and/or drugs in order to get the same high? ☐ Yes ☑ No

Please describe:

7. Has your alcohol and/or drug use changed recently (increase/ decreased, changed route of use)? ☐ Yes ☑ No

Please describe:

8. Please describe family history of alcohol and/or drug use:

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Please circle one of the following levels of severity

Severity Rating- Dimension 1 (Substance Use, Acute Intoxication and/or Withdrawal Potential)				
0 ○ None	1 ○ Mild	2 ○ Moderate	3 ○ Severe	4 ○ Very Severe
No signs of withdrawal / intoxication present	Mild/moderate intoxication, interferers with daily functioning. Minimal risk of severe withdrawal. No danger to self/others.	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others.	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal.	Incapacitated. Severe signs and symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life.

Additional Comments:

Dimension 2: Biomedical Conditions and Complications

9. Please list known medical provider(s)

Physician Name	Specialty	Contact Information

Physician Name	Specialty	Contact Information

10. Do you have any of the following medical conditions:

☐ Heart Problems	☐ Seizure/Neurological	☐ Muscle/Joint Problems	☐ Diabetes
☐ High Blood Pressure	☐ Thyroid Problems	☐ Vision Problems	☐ Sleep Problems
☐ High Cholesterol	☐ Kidney Problems	☐ Hearing Problems	☐ Chronic Pain
☐ Blood Disorder	☐ Liver Problems	☐ Dental Problems	☐ Pregnant
☐ Stomach/Intestinal Problems	☐ Asthma/Lung Problems	☐ Sexually Transmitted Disease(s):	
☐ Cancer (specify type[s]):		☐ Infection(s):	
☐ Allergies:		☐ Other:	

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11. Do any of these conditions significantly interfere with your life? ☐ **Yes** ☑ **No**

Please describe:

12. Provide additional comments on medical conditions, prior hospitalizations (include dates and reasons):

13. <u>Question to be answered by interviewer:</u> Does the patient report medical symptoms that would be considered lifethreatening or require immediate medical attention? ☐ **Yes** ☑ **No**

** If yes, consider immediate referral to emergency room or call 911*

14. List all current medication(s) for medical condition(s):

Medication	Dose/Frequency	Reason	Effectiveness/Side Effects

Please circle one of the following levels of severity

Severity Rating- Dimension 2 (Biomedical Conditions and Complications)				
0 ○ None	1 ○ Mild	2 ○ Moderate	3 ○ Severe	4 ○ Very Severe
Fully functional/ able to cope with discomfort or pain	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with physical discomfort.	Some difficulty tolerating physical problems. Acute, nonlife threatening problems present, or serious biomedical problems are neglected.	Serious medical problems neglected during outpatient or intensive outpatient treatment. Severe medical problems present but stable. Poor ability to cope with	Incapacitated with severe medical problems.

Additional Comments:

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications

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15. Do you consider any of the following behaviors or symptoms to be problematic?

Mood

☐ Depression/sadness	☐ Loss of Pleasure/Interest	☐ Hopelessness	☐ Irritability/Anger
☐ Impulsivity	☐ Pressured Speech	☐ Grandiosity	☐ Racing Thoughts

Anxiety

☐ Anxiety/Excessive Worry	☐ Obsessive Thoughts	☐ Compulsive Behaviors	☐ Flashbacks

Psychosis

☐ Paranoia	☐ Delusions:	☐ Hallucinations:

Other

☐ Sleep Problems	☐ Memory/Concentration	☐ Gambling	☐ Risky Sex Behaviors

☐ Suicidal Thoughts: please describe

☐ Thoughts of Harming Others: please describe

☐ Abuse (physical, emotional, sexual): please describe

☐ Traumatic Event(s): please describe

☐ Other:

16. Have you ever been diagnosed with a mental illness? ☐ **Yes** ☐ **No** ☐ **Not Sure**

Please describe (e.g., diagnosis, medications?)

17. Are you currently or have you previously received treatment for psychiatric or emotional problems? ☐ **Yes** ☑ **No**

Please describe (e.g., treatment setting, hospitalizations, duration of treatment):

18. Are you currently or have you previously received treatment for psychiatric or emotional problems? ☐ **Yes** ☑ **No**

Please describe:

authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.	Medi-Cal ID: Treatment Agency:

19. <u>Question to be answered by interviewer:</u> Based on previous questions, is further assessment of mental health needed? ☐ **Yes** ☐ **No**

20. List all current medication(s) for psychiatric condition(s):

Medication	Dose/Frequency	Reason	Effectiveness/Side Effects

21. Please list mental health provider(s):

Provider Name	Contact Information

Provider Name	Contact Information

Please circle one of the following levels of severity

Severity Rating- Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications)				
0 ○ None	1 ○ Mild	2 ○ Moderate	3 ○ Severe	4 ○ Very Severe
N Good impulse control and coping skills. No dangerousness, good social functioning and	Suspect diagnosis of EBC, requires intervention, but does not interfere with recovery. Some relationship impairment.	Persistent EBC. Symptoms distract from recovery, but no immediate threat to self/others. Does not prevent independent functioning.	Severe EBC, but does not require acute level of care. Impulse to harm self or others, but not dangerous in a 24-hr setting.	Severe EBC. Requires acute level of care. Exhibits severe and acute life-threatening symptoms (posing imminent danger to self/others).

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Additional Comments:

Dimension 4: Readiness to Change

22. Is your alcohol and/or drug use affecting any of the following?

☐ Work	☐ Mental Health	☐ Physical Health	☐ Finances
☐ School	☐ Relationships	☐ Sexual Activity	☐ Legal Matters
☐ Handling Everyday Tasks	☐ Self-esteem	☐ Hygiene	☐ Recreational Activities

☐ Others:

23. Do you continue to use alcohol or drugs despite having it affect the areas listed above? ☐ **Yes** ☐ **No**

Please describe:

24. Have you received help for alcohol and/or drug problems in the past? ☐ **Yes** ☐ **No**

Please list mental health provider(s):

Provider Name	Contact Information

25. What would help to support your recovery?

26. What are potential barriers to your recovery (e.g., financial, transportation, relationships, etc.)?

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27. How important is it for you to receive treatment for:

Alcohol Problems:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Considerably	☐ Extremely
Drug Problems:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Considerably	☐ Extremely

Please describe:

Please circle one of the following levels of severity

Severity Rating- Dimension 4 (Readiness to Change)				
0 ○ None	1 ○ Mild	2 ○ Moderate	3 ○ Severe	4 ○ Very Severe
Willing to engage in treatment.	Willing to enter treatment, but ambivalent to the need to change.	Reluctant to agree to treatment. Low commitment to change substance use. Passive engagement in treatment.	Unaware of need to change. Unwilling or partially able to follow through with recommendations for treatment.	Not willing to change. Unwilling/unable to follow through with treatment recommendations.

Additional Comments:

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

28. In the last 30 days, how often have you experienced cravings, withdrawal symptoms, disturbing effects of use?

Alcohol Problems:	☐ None	☐ Occasionally	☐ Frequently	☐ Constantly
Drug Problems:	☐ None	☐ Occasionally	☐ Slightly	☐ Constantly

Please describe:

29. Do you find yourself spending time searching for alcohol and/or drugs, or trying to recover from its effects? ☐ **Yes** ☐ **No**

Please describe:

30. Do you feel that you will either relapse or continue to use without treatment or additional support? ☐ **Yes** ☐ **No**

Please describe:

31. Are you aware of your triggers to use alcohol and/or drugs? ☐ **Yes** ☐ **No**

Please check off any triggers that may apply:

☐ Strong Cravings	☐ Work Pressure	☐ Mental Health	☐ Relationship Problems
☐ Difficulty Dealing with Feelings	☐ Financial Stressors	☐ Physical Health	☐ School Pressure
☐ Environment	☐ Unemployment	☐ Chronic Pain	☐ Peer Pressure

☐ Others:

Client Name:

Medi-Cal ID:

Treatment Agency:

32. What do you do if you are triggered?

33. Can you please describe any attempts you have made to either control or cut down on your alcohol and/or drug use?

34. What is the longest period of time that you have gone without using alcohol and/or drugs?

35. What helped and didnâ€™t help?

Please circle one of the following levels of severity

Severity Rating- Dimension 5 (Relapse, continued Use, or Continued Problem Potential)				
0 ○ None	1 ○ Mild	2 ○ Moderate	3 ○ Severe	4 ○ Very Severe
Low/no potential for relapse. Good ability to cope.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition of risk for relapse. Able to self-manage with prompting.	Little recognition of risk for relapse, poor skills to cope with relapse.	No coping skills for relapse/ addiction problems. Substance use/behavior, places self/other in imminent danger.

Additional Comments:

Dimension 6: Recovery/Living Environment

36. Do you have any relationships that are supportive of your recovery? (e.g., family, friends)

37. What is your current living situation (e.g., homeless, living with family/alone)?

38. Do you currently live in an environment where others are using drugs? ☐ **Yes** ☐ **No**

Please describe:

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39. Are you currently involved in relationships or situations that pose a threat to your safety? ☐ **Yes** ☐ **No**

Please describe:

40. Are you currently involved in relationships or situations that would negatively impact your recovery? ☐ **Yes** ☐ **No**

Please describe:

41. Are you currently employed or enrolled in school? ☐ **Yes** ☐ **No**

Please describe (e.g., where employed, duration of employment, name and type of school):

42. Are you currently involved with social services or the legal system (e.g., DCFS, court mandated, probation, parole)? ☐ **Yes** ☐ **No**

Please describe:

If on parole/probation:

Provider Name	Contact Information

Please circle one of the following levels of severity

Severity Rating- Dimension 6 Recovery/Living Environment				
0 ○ None	1 ○ Mild	2 ○ Moderate	3 ○ Severe	4 ○ Very Severe
Able to cope in environment/ supportive.	Passive/disinterested social support, but still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment, difficulty coping even with clinical structure.	Environment toxic/hostile to recovery. Unable to cope and the environment may pose a threat to safety.

Additional Comments:

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Summary of Multidimensional Assessment					
Dimension	**Severity Rating** (Based on Ratings Above)				**Rationale**
Dimension 1 Substance Use, Acute Intoxication and/or Withdrawal Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 2 Biomedical Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 4 Readiness to Change	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	

Dimension	Severity Rating (Based on Ratings Above)				Rationale
Dimension 5 Relapse, Continued Use, or Continued Problem Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 6 Recovery/Living Environment	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	

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Diagnosis: Diagnostic Statistical Manual, 5th Edition (DSM-5) Criteria For Substance Use Disorder

Please check off any symptoms that have occurred in the past 12 months.

	Substance Use Disorder Criteria (DSM-5)	Name of Substance(s)		
		#1:	#2:	#3:
1	Substance often taken in larger amounts or over a longer period than was intended.	☐	☐	☐
2	There is a persistent desire or unsuccessful efforts to cut down or control substance use.	☐	☐	☐
3		☐	☐	☐

	Substance Use Disorder Criteria (DSM-5)	Name of Substance(s) #1:	#2:	#3:
4	A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects. Craving, or a strong desire or urge to use the substance.	☐	☐	☐
5	Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.	☐	☐	☐
6	Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.	☐	☐	☐
7	There is a persistent desire or unsuccessful efforts to cut down or control substance use.	☐	☐	☐
8	Recurrent substance use in situations in which it is physically hazardous.	☐	☐	☐
9	Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.	☐	☐	☐
10	Tolerance, as defined by either of the following: - A need for markedly increased amounts of the substance to achieve intoxication or desired effect. - A markedly diminished effect with continued use of the same amount of the substance.	☐	☐	☐
11	Withdrawal, as manifested by either of the following: - The characteristic withdrawal syndrome for the substance. - Substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.	☐	☐	☐
	Total Number of Criteria			

List of Substance Use Disorder(s) that Meet DSM-5 Criteria and Date of DSM-5 Diagnosis (specify severity level):

1.

*The presence of at least 2 of these criteria indicates a substance use disorder.

** The severity of the substance use disorder is defined as:

- **Mild:** Presence of **2-3 criteria**
- **Moderate:** Presence of **4-5 criteria**
- **Severe:** Presence of **6 or more criteria**

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ASAM LEVEL OF CARE DETERMINATION TOOL

Instructions: For each dimension, indicate the least intensive level of care that is appropriate based on the patientâ€™s severity/functioning and service needs.

ASAM Criteria Level of Care-Withdrawal Management	ASAM Level	Dimension 1 Substance Use, Acute Intoxication and/or Withdrawal Potential				Dimension 2 Biomedical Condition and Complications				Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications				Dimension 4 Readiness to Change				Dimension 5 Relapse, Continued Use, or Continued Problem Potential				Dimension 6 Recovery/Living Environment			
Severity / Impairment Rating		None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM	☐	☐	☐	☐																				
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM	☐	☐	☐	☐																				
Clinically Managed Residential Withdrawal Management	3.2-WM			☐	☐																				
Medically Monitored Inpatient Withdrawal Management	3.7-WM				☐																				
Medically Managed Intensive Inpatient Withdrawal Management	4-WM				☐																				

ASAM Criteria Level of Care- Other Treatment and Recovery Services																									
Severity / Impairment Rating		None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev
Early Intervention	0.5	☐	☐			☐	☐			☐	☐			☐	☐			☐	☐			☐	☐		
Outpatient Services	1	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐	
Intensive Outpatient Services	2.1	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐		☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Partial Hospitalization Services	2.5																								
Clinically Managed Low-Intensity Residential Services	3.1			☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Clinically Managed Population-Specific High-Intensity Residential Services	3.3			☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐			☐	☐			☐	☐
Clinically Managed High-Intensity Residential Services	3.5				☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐			☐	☐			☐	☐
					☐			☐	☐			☐				☐	☐			☐	☐				☐

Consider referral to mental health facility

ASAM Criteria Level of Care-Withdrawal Management	ASAM Level	Dimension 1 Substance Use, Acute Intoxication and/or Withdrawal Potential				Dimension 2 Biomedical Condition and Complications				Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications				Dimension 4 Readiness to Change				Dimension 5 Relapse, Continued Use, or Continued Problem Potential				Dimension 6 Recovery/Living Environment			
Services																									
Medically Managed Intensive Inpatient Services	4				☐			☐	☐			☐				☐	☐			☐	☐				☐

ASAM Criteria Level of Care- Other Treatment and Recovery Services																									
Severity / Impairment Rating		None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev
Opioid Treatment Program	OTP	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Would the patient with alcohol or opioid use disorders benefit from and be interested in Medication-Assisted Treatment (MAT)? ☐ Yes ☐ No

Please describe

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Placement Summary

Level of Care: Enter the ASAM Level of Care (e.g., 3.1, 2.1, 3.2, W.M) number that offers the most appropriate treatment setting given the patientâ€™s current severity and functioning

Level of Care Provided: If the most appropriate Level of Care is not utilized, then enter the next appropriate Level of Care and check off the reason for this discrepancy (below):

Reason for Discrepancy:

☐ Not Applicable	☐ Service Not Available	☐ Provider Judgment	☐ Patient Preference
☐ Transportation	☐ Accessibility	☐ Financial	☐ Preferred to Wait
☐ Language/ Cultural Considerations	☐ Environment	☐ Mental Health	☐ Physical Health

☐ Others:

Briefly Explain Discrepancy:

Designated Treatment Location and Provider Name:

Counselor Name (if applicable)	**Signature**	**Date**
Licensed-eligible LPHA Name (if applicable)	**Signature**	**Date**
***Licensed LPHA Name**	**Signature**	**Date**

Licensed-eligible LPHAâ€™s are psychological assistants, associate social workers (ASWs), marriage and therapy family interns (MFTI/IMFT), professional clinical counselor interns (PCCIs).

A Licensed LPHA is required to sign the ASAM assessment. Licensed LPHA (Licensed Practitioner of the Healing Arts) includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCPs), Licensed Clinical Social Workers (LCSWs), Licensed Professional Clinical Counselors (LPCCs), and Licensed Marriage and Family Therapists (LMFTs)

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The Drug Abuse Screening Test (DAST)

Substance Abuse Screening Instrument (O4/05)

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has "exhibited valid psychometric properties" and has been found to be "a sensitive screening instrument for the abuse of drugs other than alcohol.

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.

1. Have you used drugs other than those required for medical reasons? :yes

2. Have you abused prescription drugs? : yes

3. Do you abuse more than one drug at a time? : yes

4. Can you get through the week without using drugs (other than those required for medical reasons)? : yes

5. Are you always able to stop using drugs when you want to? : yes

6. Do you abuse drugs on a continuous basis? : yes

7. Do you try to limit your drug use to certain situations? : yes

8. Have you had "blackouts" or "flashbacks" as a result of drug use? : yes

9. Do you ever feel bad about your drug abuse? : yes

10. Does your spouse (or parents) ever complain about your involvement with drugs? : yes

11. Do your friends or relatives know or suspect you abuse drugs? : yes

12. Has drug abuse ever created problems between you and your spouse? : yes

13. Has any family member ever sought help for problems related to your drug use? : yes

14. Have you ever lost friends because of your use of drugs? : yes

15. Have you ever neglected your family or missed work because of your use of drugs? : yes

16. Have you ever been in trouble at work because of drug abuse? : yes

17. Have you ever lost a job because of drug abuse? : yes

18. Have you gotten into fights when under the influence of drugs? :yes

19. Have you ever been arrested because of unusual behavior while under the influence of drugs? : yes

20. Have you ever been arrested for driving while under the influence of drugs? : yes

21. Have you engaged in illegal activities in order to obtain drug? : yes

22. Have you ever been arrested for possession of illegal drugs? :yes

23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake? : no

24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? : no

25. Have you ever gone to anyone for help for a drug problem? : yes

26. Have you ever been in a hospital for medical problems related to your drug use? : yes

27. Have you ever been involved in a treatment program specifically related to drug use? : yes

28. Have you been treated as an outpatient for problems related to drug abuse? : yes

Scoring and interpretation: A score of "1" is given for each YES response, except for items 4,5, and 7, for which a NO response is given a score of "1." Based on data from a heterogeneous psychiatric patient population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of les than 11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorders. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4,7,16,20, and 22.

Michigan Alcohol Screening Test
MAST

NOTE: This test can be downloaded in PDF format, but Adobe Acrobat is required.

The MAST Test is a simple, self scoring test that helps assess if you have a drinking problem. Please answer YES or NO to the following questions:

Do you enjoy drinking now and then? :yes

Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people) :yes

Have you ever awakened the morning after some drinking the night before and :yes

Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking? :yes

Can you stop drinking without a struggle after one or two drinks? :yes

Do you ever feel guilty about your drinking?:yes

Do friends or relatives think you are a normal drinker? :yes

Are you able to stop drinking when you want to? :yes

Have you ever attended a meeting of Alcoholics Anonymous (AA)? :yes

Have you gotten into physical fights when drinking? :yes

Has you drinking ever created problems between you and your wife, husband, a parent, or other relative?:yes

Has your wife, husband (or other family members) ever gone to anyone for help about your drinking? :yes

Have you ever lost friends because of your drinking? :yes

Have you ever gotten into trouble at work or school because of drinking? :yes

Have you ever lost a job because of drinking? :yes

Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking? :yes

Do you drink before noon fairly often? :yes

Have you ever been told you have liver trouble? Cirrhosis? :yes

After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices, or seen things that are really not there? :yes

Have you ever gone to anyone for help about your drinking? :yes

Have you ever been in a hospital because of drinking? :yes

Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?:yes

Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem? :yes

Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, How many times? :yes

Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? (If YES, How many times?) :yes

Scroing

Add up the points for every question you answered with YES, for Q23 and Q24 multiply the number of times by points _____

0-3
4
5 or more
No apparent problem
Early or middle problem drinker
Problem drinker (Alcoholic)

Programs using the above scoring system find it very sensitive at the five point level an it tends to find more people alcoholic than anticipated. However, it is a screening test and should be sensitive at its lower levels.

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: â€œnot at all,â€ â€œless than once a week,â€ or â€œonce a week or more.â€

played cards for money :not at all

bet on horses, dogs or other animals (in off-track betting, at the track or with a bookie) :not at all

Other 0

bet on sports (parley cards, with a bookie, or at jai alai) :not at all

Other 0

played dice games (including craps, over and under, or other dice games) for money :

Other 0

went to casino (legal or otherwise) :not at all

Other 1

played the numbers or bet on lotteries :not at all

Other 1

played bingo :not at all

Other 1

played the stock and/or commodities market :not at all

Other 1

played slot machines, poker machines or other gambling machines :not at all

Other 1

bowled, shot pool, played golf or played some other game of skill for money :Less than once a week

Other 1

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

Other 0

3. Do (did) your parents have a gambling problem? :both my father and mother gamble (or gambled)

Other 0

4. When you gamble, how often do you go back another day to win back money you lost? :never

Other 0

5. Have you ever claimed to be winning money gambling but werenâ€™t really? In fact, you lost? :never (or never gamble

Other 0

6. Do you feel you have ever had a problem with gambling? :no

Other 0

7. Did you ever gamble more than you intended? :no

Other 0

8. Have people criticized your gambling? :yes

9. Have you ever felt guilty about the way you gamble or what happens when you gamble? :yes

10. Have you ever felt like you would like to stop gambling but didnâ€™t think you could? :yes

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? :yes

12. Have you ever argued with people you like over how you handle money? :yes

13. (If you answered â€œyesâ€ to question 12): Have money arguments ever centered on your gambling? :yes

14. Have you ever borrowed from someone and not paid them back as a result of your gambling? :yes

15. Have you ever lost time from work (or school) due to gambling? :yes

16. If you borrowed money to gamble or to pay gambling debts, where did you borrow from? (Check â€œyesâ€ or â€œnoâ€ for each)

from household money :yes

from your spouse :yes

from other relatives or in-laws :yes

from banks, loan companies or credit unions :yes

from credit cards :yes

from loan sharks (Shylocks):yes

your cashed in stocks, bonds or other securities :yes

you sold personal or family property :yes

you borrowed on your checking account (passed bad checks) :yes

you have (had) a credit line with a bookie :yes

you have (had) a credit line with a casino :yes

Scoring Rules for SOGS

Scores are determined by adding up the number of questions that show an â€œat riskâ€ response, indicated as follows. If you answer the questions above with one of the following answers, mark that in the space next to that question: Questions 1-3 are not counted
___ Question 4: most of the time I lost, or every time I lost
___ Question 5: yes, less than half the time I lose, or yes, most of the time
___ Question 6: yes, in the past, but not now, or yes
___ Question 7: yes
___ Question 8: yes
___ Question 9: yes
___ Question 10: yes
___ Question 11: yes
Question 12 is not counted
___ Question 13: yes
___ Question 14: yes
___ Question 15: yes
___ Question 16a: yes
___ Question 16b: yes
___ Question 16c: yes
___ Question 16d: yes
___ Question 16e: yes
___ Question 16f: yes
___ Question 16g: yes
___ Question 16h: yes
___ Question 16i: yes

Questions 16j and 16k are not counted
Total = _____ (20 questions are counted)
**3 or 4 = Potential pathological gambler (Problem gambler)
**5 or more = Probable pathological gambler

Grievance Procedure

PURPOSE:
To ensure that all clients are aware of the clientâ€™s rights and the procedure for filing a grievance at iojkl..including the appeals procedure for involuntary discharges.
Policy:
kpo; recognizes the right of every individual to voice complaints and concerns regarding services provided and other areas provided by law. Clients shall be provided by the client grievance policy upon admission and have the procedures explained to them as a part of their admission to the program.
PROCEDURE:
If a client has a grievance, the complaint is first presented to program manage or clinical supervisor. If the client is not satisfied after speaking with the program manager or clinical supervisor, he/she may submit the grievance in writing to the program director. The program director will meet with the client within five (5) working days to address clientâ€™s complaints. Resolutions will be documented in writing and given to the client and forwarded to the Chief Executive Director within five days of meeting with the program director. If a client is not satisfied with the program directorâ€™s decision, the client may submit an appeal in writing to the Chief Executive Officer within (5) working days from the date of the decision. If the CEO cannot resolve the client issue within 5 working days, the client may file a complaint with any of the following: >**Complaint Hot Line # 1-877-712-1868**

Advocacy Organizations:

Division of Mental Health and Addiction Services PO Box 700, Trenton, NJ 08625; (609)-984-4813 1-800-382-6717	Office of MHA Mental Health Administrator 125 Fairview Avenue Cedar Grove, NJ 07009 (973) 228-8172

Division of Youth and Family (DCPS) Essex County Office 153 Halsey St., 3rd Floor Newark, NJ 07101 (973) 648-4200 1-800-392-9532	Adult Protective Services FOCUS, Hispanic Center for Human Development, Inc. 441-443 Broad Street Newark, NJ 07102 (973) 624-2528 ext. 135 After Hrs: 911 or local police

DCPS-Bloomfield District Office 650 Bloomfield Ave., 3rd Floor Bloomfield, NJ 07003 (973) 680-3587 1-800392-9536	Child Abuse/Neglect Hotline 1-877-652-2873

DCPS-East Orange District Office 240 South Harrison Street East Orange, NJ 07018 (973) 414-4200 1-800-392-2843	Community Health Law Project 650 Bloomfield Avenue Bloomfield, NJ 07003 973 680 5599

Disability Rights NJ 210 South Broad Street, 3rd Floor Trenton, NJ 0868 (609) 292-9742 1-800-922-7233 (in NJ only)	Essex County Welfare Agency Essex County Department of Citizen Services Division of Welfare 18 Rector St., 9th Floor Newark, NJ 07102 (973) 733-3000

Division of Health Facilities Evaluation and Licensing New Jersey State Department of Health P O Box 367 Trenton, NJ 08625-0367 609-792-9770	State of New Jersey Office of the Ombudsman for the Institutionalized Elderly PO Box 808 Trenton, NJ 08625-0808 609-624-4262

You will be provided a copy of this form during your admission process. It will be reviewed with you again during your Orientation.
Client Signature: _____ Date: _____
Witness Signature: _____ Date: _____

Rights of Each Client/Bill of Rights

Purpose: To ensure that all clients or their legal guardians are informed of the clients' rights
Policy: It is the policy of ikkop that all clients or their legal guardian be informed of their rights as a client of 0 which will be evidenced by the client's written acknowledgement or documentation in the clients file by the counselor.
PROCEDURE:
okpl; shall inform the clients of the following rights:
â¦ The right to be informed of these rights, as evidenced by the client's written acknowledgment or by documentation by staff in the clinical record that the client was offered a written copy of these rights and given a written or verbal explanation of these rights in terms the client could understand;
â¦ The right to be notified of any rules and policies the program has established governing client conduct in the facility;
â¦ The right to be informed of services available in the program, the names and professional status of the staff providing and/or responsible for the client's care, and fees and related charges, including the payment, fee, deposit, and refund policy of the program and any charges for services not covered by sources of third-party payment or the program's basic rate;
â¦ The right to be informed if the program has authorized other health care and educational institutions to participate in his or her treatment, the identity and function of these institutions, and to refuse to allow their participation in his or her treatment;
â¦ The right to receive from his or her physicians or clinical practitioner(s) an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks(s) of treatment, and expected result(s), in terms that he or she understands;
i. If, in the opinion of the medical director or director of substance abuse counseling, this information would be detrimental to the client's health, or if the client is not capable of understanding the information, the explanation shall be provided to a family member, legal guardian or significant other, as available;
ii. Release of information to a family member, legal guardian or significant other, along with the reason for not informing the client directly, shall be documented in the client's clinical record; and
iii. All consents to release information shall be signed by client or their parent, guardian or legally authorized representative;

â¦ The right to participate in the planning of his or her care and treatment, and to refuse medication and treatment;
â¦ A client's refusal of medication or treatment shall be documented in the client's clinical record;
â¦ The right to participate in experimental research only when the client gives informed, written consent to such participation, or when a guardian or legally authorized representative gives such consent for an incompetent client in accordance with law, rule and regulation;
â¦ The right to voice grievances or recommend changes in policies and services to program staff, the governing authority, and/or outside representatives of his or her choice either individually or as group, free from restraint, interference, coercion, discrimination, or reprisal;
â¦ The right to be free from mental and physical abuse, exploitation, and from use of restraints;
â¦ A client's ordered medications shall not be withheld for failure to comply with facility rules or procedures, unless the decision is made to terminate the client in accordance with this chapter; medications may only be withheld when the facility medical staff determines that such action is medically indicated;
â¦ The right to confidential treatment of information about the client;
â¦ Information in the client's clinical record shall not be released to anyone outside the program without the client's written approval to release the information in accordance with Federal statutes and rules for the Confidentiality of Alcohol and Drug Abuse Client Records at 42 U.S.C. §§290dd-2, and 290ee-2, and 42 CFR Part 2 §§2.1 et seq., and the provisions of the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Parts 160 and 164, unless the release of the information is required and permitted by law, a third-party payment contract, a peer review, or the information is needed by DAS for statutorily authorized purposes; and
â¦ The program may release data about the client for studies containing aggregated statistics only when the client's identity is protected and masked;
â¦ The right to be treated with courtesy, consideration, respect, and with recognition of his or her dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy;
â¦ The client's privacy also shall be respected when program staff are discussing the client with others;

â¦ The right to exercise civil and religious liberties, including the right to independent personal decisions;
â¦ No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any client;
â¦ The right to not be discriminated against because of age, race, religion, sex, nationality, sexual orientation, disability (including, but not limited to, blind, deaf, hard of hearing), or ability to pay; or to be deprived of any constitutional, civil, and/or legal rights.
â¦ Programs shall not discriminate against clients taking medications as prescribed;
â¦ The right to be transferred or discharged only for medical reasons, for the client's welfare, that of other clients or staff upon the written order of a physician or other licensed clinician, or for failure to pay required fees as agreed at time of admission (except as prohibited by sources of third-party payment);
â¦ Transfers and discharges, and the reasons therefore, shall be documented in the client's clinical record; and
â¦ If a transfer or discharge on a non-emergency basis is planned by the outpatient substance abuse treatment program, the client and his or her family shall be given at least 10 days advance notice of such transfer or discharge, except as otherwise provided for in N.J.A.C. 10:161B-6.4(c);
â¦ The right to be notified in writing, and to have the opportunity to appeal, an involuntary discharge; and
â¦ The right to have access to and obtain a copy of his or her clinical record, in accordance with the program's policies and procedures and applicable Federal and State laws and rules.

_____
Client Signature Date

_____
Witness Signature Date

Statement of Confidentiality

All services are strictly confidential between you and program staff, with the following exceptions:

If you represent an immediate threat to yourself or someone else
If you are believed to be a threat to the emotional or physical welfare of a minor as in the suspicion of child abuse (i.e. emotional, physical, or sexual)
If you have signed the release or consent form authorizing the release of information or permission to obtain information from a specified source for a clearly stated purpose.
When the agency is required due to court order or other legal proceedings, to release information.
In addition, the State of New Jersey, Department of Human Services, Division of Mental Health, and/ persons of appropriate licensing or acceding bodies (Accreditation Bodies) will periodically review records and documents related to the professional services rendered by the agency. This review is solely for the purpose of assessing the agency's compliance with regulations and standards set down the governing bodies of treatment programs in New Jersey.

I have read the above information and understand the meaning.

I have been provided a copy of this informed consent, and therefore my signature is attached to affirm my consent to treatment.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Informed Consent and Disclosure

As a client at this outpatient program, you have the right to receive a full explanation of all treatment models employed, and the expected benefits, risks, and time frames for results of each modality. You have the right to choose to receive treatment, to stop treatment at any time, or to seek treatment from another provider outside of this agency, and the staff will provide supports to carry out your decision. As a result of your rights the following disclosure is being made to you: This is a notice of disclosure that the kop Outpatient Program may periodically engage in the training and supervision of college level and CADC ready interns to provide support services to the program during your enrollment in the program. An intern is a student who is in the process of completing a degree or an area of learning in the field of substance abuse as a prerequisite to graduating from a University, College, or obtaining a credential as a substance abuse counselor. All potential interns must complete a thorough employment application, including a background check, reference verification and a general physical through the ikp administration and after which, interns are subject to a second level screening by the clinical supervisor to determine the intern's appropriateness for the program. Consumers are also surveyed fur feedback on the effectiveness of the Intern Program.

Your treatment program is scheduled to last approximately 4-6 months with you attending up to 3 days per week depending on the severity of the substance use disorder. ***For clients on Subutex and Suboxone for opioid maintenance or detoxification the following guideline shall apply: 1. Clients who have abstained from alcohol and illicit drugs for 90 days or more shall attend group therapy once weekly for up to 4 -6 months, 2. Clients who has maintained sobriety for less that 90 days shall attend group therapy twice weekly for up to 4 -6 months, 3. Clients who are actively using illicit drugs and unable to quit will be referred to either IOP or inpatient treatment program with an affiliate agency.***

It is the intent of the program to provide you with caring and professional services delivered by professionals with experience in addressing SUD with sensitivity to female issues. While in the program, you may expect to benefit from the services delivered, however, due to the nature of such treatment and because of facts beyond the staff persons' control such benefits cannot be guaranteed. However, regular attendance and high levels of active participation in your treatment will produce maximum benefits. You will be expected to be present at the scheduled times of your treatment and if you are unable to be present, call the office to report that you will either be late or absent. Someone will take your message and forward it to your counselor, should they be unavailable to speak with you directly. Regular attendance and high levels of participation in your treatment will produce maximum benefits. While you are in treatment you maintain your rights as an adult and citizen in the United States and you will be provided with a grievance procedure should you feel that your rights have been violated. If you decide to end the treatment relationship it would be best done in writing with as much advance notice as possible to assure appropriate after care planning, however, you are free to terminate treatment at your will

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

HRRS RECORD RELEASE AUTHORIZATION

Address: Mughalpura lahore

Phone: 321441836

Clientâ€™s Name:weuioifjnkns; Date of Birth:Oct. 15, 2019

Precious Name:nonnnnne Social Security #:nonnnnne

I request and authorizenonnnnne
to

release healthcare/substance abuse treatment information of the client named above to:

Name:
nonnnnne

Address: dsfskdfnds

City:
skldsnldskfnState:ldskfn Zip Code:lsdkfn

This request and authorization apply to:nonnnnne

Healthcare information relating to the following treatment, condition, or dates:nonnnnne

Other Healthcare information relating to the following treatment, condition, or dates:nonnnnne

All healthcare/Substance abuse treatment information/Toxicology

Other:nonnnnne

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No = I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No= I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Client Signature:_____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Subject to the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2), information concerning, as applicable, the treatment recommendation, diagnosis, attendance, scope of treatment, treatment progress and quality of participation, dates and results of toxicology testing, and termination or completion of treatment concerning the above named client. Any application for disclosure of information pursuant to 42 C.F.R. Part 2 shall be made in accordance with 42 C.F.R. Â§Â§ 2.61 â€“ 2.65 and other a

Initial Treatment Plan

Date:Oct. 10, 2019

Review Date:Oct. 15, 2019

* (Out Patient-SUD Tx) Initial treatment plan completed with 30 days. Updates completed every 30 days thereafter.

*(MH) Initial plan completed by the 5th session within 60 days of the date of the intake.

Updates every 3 months for the first year and - (6) months thereafter by the psychiatrist.

Master Treatment Plan: Pre-contemplation

Patient's Name:nonnnnne

DSM V code	Other DSM V code	Diagnosis
0	0	0

Strength
uhijk,mvfyvghjk 0
Stressor
ugvhjikl;:lkmjnihbghj 0
Barriers/Limitations to Treatments:
yvguhijokplpkmjnhbghjk 0

Overall Goal for Discharge Criteria (Long Term):

Date	No.	Issues	Long term Goals	Short term Goal	Therapeutic
Oct. 15, 2019	hbnjkl;l	0	0		jbknjlk
Oct. 15, 2019	hbnjkl;l	0	0		jbknjlk
Oct. 15, 2019	hbnjkl;l	0	0		jbknjlk
Oct. 15, 2019	hbnjkl;l	0	0		jbknjlk

Client:hnjk	Date:
Clinician:hnjk	Date:
Clinical Supervisor:bhjklkmhnbnklmk	Date:

HRRS PROGRESS NOTE

Client's Name: weuioifjnkns

Date: :Oct. 10, 2019

Time: 8:55 p.m.

SESSION TYPE: ikj

Other SESSION TYPE:

TYPE OF GROUP: iojklm

Other group:

TOPIC OF DISSCUSSION: klm .

Discussion:pko;,.

ASSESSMENT

1.Acute
0

other

Intoxication /Withdrawal:
olp,,,.

2.Biomedical
0

Other Biomedical

Conditions/ Complications:
mkl ,

3.Emotional/Behavioural
0

Other Emotional/Behavioural

Conditions/Complications.
iojmklm

4.Treatment Acceptance/ Resistance.
ipkm;,

Other Treatment Acceptance/ Resistance.

5.Relapse Potential.
mikl,.

Other Relapse Potential.

6.Recovery Environment.

Thought Process
kmlm.

Other Thought Process

Mood: kml,

other: 0

Oriented x 3:
yes

If No Explain: oklp;

Dx: ikmp,

Dx: 0

Shared Feelings
no

Open to Feedback
yes

List Treatment Plan Objectives
okpl;,

Discussed

Made Progress in Meeting yes

Treatment Plan Objectives ikpm;, If No Explain: j98juioj

Appeared to Benefit from the Session yes

Clinician Name and Title:
kp;,. jnolm

Clinician Signature:

HRRS PROGRAM SCHEDULE

Screenings
By phone or walk-in, no appointment necessary. Monday- Friday jiokl

Assessments
By appointment only: Monday- Friday ikml,. .

Out Patient -ASAM Level I
Clinical substance use disorder individual counseling and psycho-education (didactic) sessions services shall be provided for less than 9 hours per week:

Individual Counseling: Fridays (from 5am to 7pm)

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

PROGRAM RULES

The following Rules and Regulations are designed for your protection and safety as a client of the iojmklm. Any infractions will be addressed on an individual basis. If you have questions regarding this document, please speak with your counselor.

Clients are expected to be on time for all sessions including individuals, group didactics therapy and education.

No abusive behavior is tolerated, including abusive language, use of profanity, and threats to peers or staff members.

No shorts, tank tops, provocative clothing or shirts with messages about alcohol, drugs, tobacco, or any other negative slogans are allowed. No shorts or skirt above the knee. If you are dressed inappropriately, you are subject to being sent home on your own accord.

No smoking is allowed in the facility. You must smoke outside the building in the designated area.

No client is allowed beyond the stop points posted in the facility unless escorted by your counselor.

No gambling or dice, playing is allowed in the facility.

Use of radios, compact disc players, or headphones is NOT allowed during program hours.

No stealing. Theft can lead to discharge and prosecution.

Absolutely NO profanity, swearing is not permitted in the facility.

No leaving the facility without informing staff.

You must sign in and out at the start of the day and at the end of the day.

Miss use and destruction of agency property is not acceptable, you are responsible for any damage to agency property.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

CASE NOTE

opl;
Staff Signature: _____ Date: _____

Discharge Plan Summary

Clientâ€™s Name: yhi DOB: hiunj

Date of admission: kujnok Date of Projected Discharge:
jo

Treatment Outcome

( ) Treatment Plan Completed ( ) Hospitalized (Medical) ( ) Client Dropped Out ( ) Hospitalized (Psych)

( ) Administrative ( ) Incarcerated ( ) Therapeutic Discharge ( ) Other (Specify) ( ) Deceased

ASAM Criteria Evaluation:

Acute Intoxication /Withdrawal:
Low

Other Acute Intoxication /Withdrawal:

Biomedical Conditions/ Complications:
Low

Other Biomedical Conditions/ Complications:

Emotional/Behavioral Low

Other Emotional?Behavioral:

Conditions/Complications. Low

Other Conditions/Complications:

Treatment Acceptance/ Resistance. Low

Other Treatment Acceptance/ Resistance:

Relapse Potential. Moderate

Other Relapse Potential:

Recovery Environment. Low

Other Recovery Environment:

History Physical/Sexual/Emotional Abuse:nbsp; iuhnjk

Family Issues:nbsp; yhik

Educational Issues:nbsp; uhinjk

Financial Issues:nbsp; ihbkn

Legal Issues: hbikn

Spiritual Issues: inhjkm

Medical Issues: injk

Psychiatric Issues :bihk

Recommendations: nbhikn

Diagnosis: ihnk
DSM V: hink

Counselor's Signature: _____ Date: _____

Agency Name

Chart Review Tool

Client Name: jiokl	Level Of Care Level 1 ☐ Level 2 ☐	
Admit Date : Open Chart ☐ Open Chart ☐	Date Of Review:	Reviewed By :

1st 2nd 3rd **Review**	Date : _____	Comments

Section 1. Intake	Complete	Not	N/A	

1 2 3 Review	Date : _____	Complete		Comments
Screeing/Intake form	☐	☐	☐	
Informed Consemt and Disclosure	☐	☐	☐	
Statement of Confidentiality	☐	☐	☐	
Bill of Rights	☐	☐	☐	
Grivance Procedure	☐	☐	☐	
Program Rules	☐	☐	☐	
Release - Confidentiality Information **(42 CFR)**	☐	☐	☐	
Signature Page	☐	☐	☐	
Program Schedule (signed copy)	☐	☐	☐	
Section 2. Assessments				
Bio-Psychosocial Assessment	☐	☐	☐	
NJSAMS/ASI	☐	☐	☐	
SOGS	☐	☐	☐	
DAST	☐	☐	☐	
MAST	☐	☐	☐	
Psychiatric Evaluation (if applicable)	☐	☐	☐	
Section 3. Progress Note				
Initial Treatment Plan	☐	☐	☐	
Updated Treatment Plan	☐	☐	☐	
Discharge Summary	☐	☐	☐	
Individual/Group Progress Notes	☐	☐	☐	
Individual/Group Attendance Sheet	☐	☐	☐	
Section 4. Medical Information				
HIV Counseling Form	☐	☐	☐	
TB Testing Form	☐	☐	☐	
Medication (If applicable)	☐	☐	☐	
Section 5. Lab Results				
Urine Drug Screening	☐	☐	☐	
Other	☐	☐	☐	
Section 6. Correspondents (In/Out)				
Drug Court reports, SAI, IDRC/DUII	☐	☐	☐	
Probation, Parole, ISP, DFSetc...	☐	☐	☐	
Section 7. Administrative Documentation				
Audit Forms	☐	☐	☐	
☐	☐	☐		
Other	☐	☐	☐	
Section 8. Quality Assurance				
Client Survey (30, 60+90 days)	☐	☐	☐	
QA Statistics	☐	☐	☐	
	☐	☐	☐	

Other 1 2 3 **Review**	Date : _____	Comments