NYS Office of Addiction Services and Supports

# Client Admission Report
## FOR ADMISSIONS DATED 12/01/2018 AND BEYOND

Clear Form

**Provider Number** __ __ __ __ __ **Program Number** __ __ __ __ __

**Provider Client ID** __ __ __ __ __ __ __ __ __ __ **Special Project (See instructions):**_____

**Sex** (at birth) ☐ Male ☐ Female ☐ X **Birth Date** __ __ /__ __/__ __ __ __ **Last 4 SSN** __ __ __ __

**Last Name First 2 Letters** __ __ (Birth Name) **Last Name First 2 Letters** __ __ (Current Name) **Admission Date** __ __ / __ __ / __ __ __ __

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**Part 820 Program Information**

**Element of Care** ☐ Stabilization ☐ Rehabilitation ☐ Reintegration

**Reintegration Setting** ☐ Congregate ☐ Scatter-Site

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**LOCADTR Information**

**Assessment ID** __ __ __ __ __ __ __ **Created Date** __ __/ __ __/ __ __ __ __

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***TRS-61 - Identifying Information (ID)***

**ID Consent Date** __ __/__ __/__ __ __ __ **ID Consent Revoke Date** __ __/__ __/__ __ __ __ (Revoke Date not required)

**Last Name** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ (Birth Name) **Last Name** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ (Current Name)

**First Name** __ __ __ __ __ __ __ __ __ __ __ **Social Security Number** __ __ __- __ __ - __ __ __ __

**Medicaid Client ID** __ __ __ __ __ __ __ __

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***TRS-49- Criminal Justice (CJ)***

**NYSID** __ __ __ __ __ __ __ __ __ **CJ Consent Date** __ __/__ __/__ __ __ __ **CJ Consent Revoke Date** __ __/__ __/__ __ __ __ (Revoke Date not required)

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**No. of Assessment Visits/Days** __ **Significant Other** ☐ Yes ☐ No

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***Sexual Orientation***

- ☐ Straight
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Don't Know/Not Sure
- ☐ Didn't Answer

***Gender Identity***

- ☐ Not transgender
- ☐ Transgender- male to female
- ☐ Transgender – female to male
- ☐ Transgender - other
- ☐ Don't Know/Not Sure
- ☐ Didn't Answer

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***Race***

- ☐ Alaska Native
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other

***Hispanic Origin***

- ☐ Cuban
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Other Hispanic
- ☐ Hispanic, Not Specified
- ☐ Not of Hispanic Origin

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***Primary Language***

- ☐ Arabic
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ Greek
- ☐ Hindi
- ☐ Japanese
- ☐ Portuguese
- ☐ Russian
- ☐ Sign Language
- ☐ Spanish
- ☐ Other

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***Veteran Status***

**Veteran** ☐ Yes ☐ No

***U.S. Military Status (if applicable, select one; if not, skip)***

- ☐ Active Duty
- ☐ Reserves/National Guard
- ☐ Both Active Duty and Reserves/National Guard

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NYS Office of Addiction Services and Supports

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**FOR ADMISSIONS DATED 12/01/2018 AND BEYOND**

**Zip Code of Residence** ___ ___ ___ ___ ___ (For Canada use 88888) **County of Residence** _____

***Type of Residence***

- ☐ Private Residence
- ☐ Homeless, Shelter
- ☐ Homeless, No Shelter
- ☐ Single Resident Occupancy
- ☐ Residential Services for SUD/ Congregate
- ☐ Residential Services for SUD/Scatter-Site
- ☐ MH/DD CommunityResidence
- ☐ Other Group Residential Setting
- ☐ Institution, other (jail, hospital)
- ☐ Other

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

***Principal Referral Source***

***Criminal Justice Services***

- ☐ District Attorney
- ☐ Drug Court
- ☐ Probation
- ☐ Parole General
- ☐ Parole Release Shock
- ☐ Parole Release Willard
- ☐ Parole Release Resentence
- ☐ Impaired Driver Referral
- ☐ Police
- ☐ Family Court
- ☐ Other Court
- ☐ Alternatives to Incarceration
- ☐ City/County Jail
- ☐ NYS Department of Correctional and Community Supervision
- ☐ Office of Children and Family Services

***Self, Family, Other***

- ☐ Self-Referral Family, Friends, Other
- ☐ Individuals
- ☐ Self-Help Group
- ☐ HOPEline

***Substance Use Disorder Treatment (SUD)***

- ☐ SUD Program in New York State
- ☐ SUD Program Out of State
- ☐ SUD VA Program
- ☐ SUD Private Practitioner

***Prevention/Intervention Services***

- ☐ School-Based Prevention Program
- ☐ Community-Based Prevention Program
- ☐ Employee Assistance Program
- ☐ Other Prevention/Intervention Program

***Health Care Services***

- ☐ Developmental Disabilities Program
- ☐ Mental Health Provider
- ☐ Managed Care Provider
- ☐ Health Care Provider
- ☐ AIDS Related Services
- ☐ Primary Health Care Professional
- ☐ Comprehensive Psychiatric Emergency Program (CPEP)
- ☐ Hospital Emergency Department
- ☐ TBI Waiver

***Employer/Educational/Special Services***

- ☐ Employer/Union (Non-EAP)
- ☐ School (Other than Prevention Program)
- ☐ Special Services (Homeless/Shelters)

***Social Services***

- ☐ Local Social Services-Child Protect Services/CWA
- ☐ Local Social Services Dist-Income Maintenance
- ☐ Local Social Services Dist Treatment Mandate/Public Assistance
- ☐ Local Social Services Dist Treatment Mandate/Medicaid Only
- ☐ Other Social Services Provider

***Recovery Support Services***

- ☐ Recovery Community and Outreach Center
- ☐ Youth Clubhouse
- ☐ Peer Advocate
- ☐ Open Access Center
- ☐ Family Support Navigator
- ☐ Regional Addiction Resource Center

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- ☐ Other

***Highest Grade Completed***

- ☐ No education
- ☐ 1st
- ☐ 2nd
- ☐ 3rd
- ☐ 4th
- ☐ 5th
- ☐ 6th
- ☐ 7th
- ☐ 8th
- ☐ 9th
- ☐ 10th
- ☐ 11th
- ☐ High School Diploma
- ☐ General Equivalency Diploma
- ☐ Vocational Cert w/o Diploma/GED
- ☐ Vocational Cert w/ Diploma/GED
- ☐ Some College-No degree
- ☐ Associates Degree
- ☐ Bachelors Degree
- ☐ Graduate Degree

Does client have an Individual Education Plan (IEP)? ☐ Yes ☐ No ☐ Unknown

***Employment Status***

- ☐ Employed Full Time-35+ hrs/wk
- ☐ Employed Part Time-<35 hrs/wk
- ☐ Employed in Sheltered Workshop
- ☐ Unemployed, In Treatment
- ☐ Unemployed, Looking for Work
- ☐ Unemployed, Not Looking for Work
- ☐ Not in Labor Force, Child Care
- ☐ Not in Labor Force, Disabled
- ☐ Not in Labor Force, In Training
- ☐ Not in Labor Force, Inmate
- ☐ Not in Labor Force, Retired
- ☐ Not in Labor Force, Student
- ☐ Not in Labor Force, Other
- ☐ Soc Srvcs Work Exp Program
- ☐ Soc Srvcs Determined, Not Employed/Able to Work
- ☐ Soc Srvcs Determined, Unable to Work, Mandated Treatment

***Primary Source of Income at Admission***

- ☐ None
- ☐ Wages/Salary
- ☐ Alimony/Child Support
- ☐ Department of Veterans Affairs
- ☐ Family and/or Spouse Contribution
- ☐ SSI/SSDI or SSA
- ☐ Safety Net Assistance (SNA)
- ☐ Temp Asst for Needy Families (TANF)
- ☐ Other

***Family History***

**Marital Status** ☐ Married ☐ Never Married ☐ Living as Married ☐ Separated ☐ Divorced ☐ Widowed

**Child of Someone Who Misuses Alcohol/Other Substances** ☐ **No** ☐ **Both** ☐ **Child of Someone Who Misuses Alcohol**

☐ **Child of Someone Who Misuses Other Substances**

**Number of Children** ☐ **Number of Children Living with Client** ☐ **Number of Children Living in Foster Care** ☐

**Case with Children Protective Services** ☐ **Yes** ☐ **No**

***Criminal Justice Information***

**Criminal Justice Status (check all that apply)**

- ☐ None
- ☐ Probation
- ☐ Parole
- ☐ Work Release
- ☐ In Prison/Jail
- ☐ In OCFS Facility
- ☐ Charges Pending
- ☐ Any Treatment or Specialty Court
- ☐ Other (e.g., District Attorney)

***Arrests/Incarceration***

**Is this admission a result of an alternative to incarceration?** ☐ Yes ☐ No

**No. of Arrests in Prior 30 Days** ___ ___

**No. of Arrests in Prior 6 Months** ___ ___ **No. of Days Incarcerated in Prior 6 Months** ___ ___ ___

***Primary ICD-10 Diagnosis Code (Select one and enter up to 3 additional characters, skip if significant other)***

- ☐ F10.___ ___ ___ Alcohol related disorders
- ☐ F11.___ ___ ___ Opioid related disorders
- ☐ F12.___ ___ ___ Cannabis related disorders
- ☐ F13.___ ___ ___ Sedative, hypnotic or anxiolytic related disorders
- ☐ F14.___ ___ ___ Cocaine related disorders
- ☐ F15.___ ___ ___ Other stimulant related disorders
- ☐ F16.___ ___ ___ Hallucinogen related disorders
- ☐ F18.___ ___ ___ Inhalant related disorders
- ☐ F19.___ ___ ___Other psychoactive substance related disorders

***Primary Substance***

- ☐ None
- ☐ Alcohol
- ☐ Cocaine
- ☐ Crack
- ☐ Marijuana/Hashish
- ☐ Synthetic Cannabinoid
- ☐ Heroin
- ☐ Buprenorphine
- ☐ Non-Rx Methadone
- ☐ OxyContin
- ☐ Other Opiate/Synthetic
- ☐ Alprazolam (Xanax)
- ☐ Barbiturate
- ☐ Benzodiazepine
- ☐ Catapres (Clonidine)
- ☐ Other Sedative /Hypnotic
- ☐ Elavil
- ☐ GHB
- ☐ Khat
- ☐ Other Tranquillizer
- ☐ Methamphetamine
- ☐ Other Amphetamine
- ☐ Synthetic Stimulant
- ☐ Other Stimulant
- ☐ PCP
- ☐ Ecstasy
- ☐ Other Hallucinogen
- ☐ Ephedrine
- ☐ Inhalant
- ☐ Ketamine
- ☐ Rohypnol
- ☐ Over-the-Counter
- ☐ Other

**Primary Route** ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Vaping ☐ Other
**Primary Frequency** ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily
**Primary Age of First Use** ___ ___

***Secondary Substance***

- ☐ None
- ☐ Alcohol
- ☐ Cocaine
- ☐ Crack
- ☐ Marijuana/Hashish
- ☐ Synthetic Cannabinoid
- ☐ Heroin
- ☐ Buprenorphine
- ☐ Non-Rx Methadone
- ☐ OxyContin
- ☐ Other Opiate/Synthetic
- ☐ Alprazolam (Xanax)
- ☐ Barbiturate
- ☐ Benzodiazepine
- ☐ Catapres (Clonidine)
- ☐ Other Sedative /Hypnotic
- ☐ Elavil
- ☐ GHB
- ☐ Khat
- ☐ Other Tranquillizer
- ☐ Methamphetamine
- ☐ Other Amphetamine
- ☐ Synthetic Stimulant
- ☐ Other Stimulant
- ☐ PCP
- ☐ Ecstasy
- ☐ Other Hallucinogen
- ☐ Ephedrine
- ☐ Inhalant
- ☐ Ketamine
- ☐ Rohypnol
- ☐ Over-the-Counter
- ☐ Other

**Secondary Route** ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Vaping ☐ Other
**Secondary Frequency** ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily
**Secondary Age of First Use** ___ ___

***Tertiary Substance***

- ☐ None
- ☐ Alcohol
- ☐ Cocaine
- ☐ Crack
- ☐ Marijuana/Hashish
- ☐ Synthetic Cannabinoid
- ☐ Heroin
- ☐ Buprenorphine
- ☐ Non-Rx Methadone
- ☐ OxyContin
- ☐ Other Opiate/Synthetic
- ☐ Alprazolam (Xanax)
- ☐ Barbiturate
- ☐ Benzodiazepine
- ☐ Catapres (Clonidine)
- ☐ Other Sedative /Hypnotic
- ☐ Elavil
- ☐ GHB
- ☐ Khat
- ☐ Other Tranquillizer
- ☐ Methamphetamine
- ☐ Other Amphetamine
- ☐ Synthetic Stimulant
- ☐ Other Stimulant
- ☐ PCP
- ☐ Ecstasy
- ☐ Other Hallucinogen
- ☐ Ephedrine
- ☐ Inhalant
- ☐ Ketamine
- ☐ Rohypnol
- ☐ Over-the-Counter
- ☐ Other

**Tertiary Route** ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Vaping ☐ Other
**Tertiary Frequency** ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily
**Tertiary Age of First Use** ___ ___

***Treatment Plan***

Is Medication-Assisted Opioid Therapy part of the client's treatment plan? ☐ Yes ☐ No

***Self-Help***

Is the client currently attending substance use self-help group meetings (last 30 days)? ☐ Yes ☐ No

***Nicotine***

**Has the client ever used nicotine?** ☐ Yes ☐ No

**Age of First Use** ___ ___

**Frequency of Use (in past 30 days):**
☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily

**Date Last Used: Month** __ __ **Year** __ __ __ __

**Primary Route of Administration:** ☐ Smoking ☐ Vaping ☐ Chewing

***Prior Treatment Episodes***

Number of prior Substance Use Disorder treatment episodes __ *(Enter 0 to 5).*
If the number of prior treatment episodes is greater than 5, use 5.

***Physical Health-Related Conditions***

| | | | |
|---|---|---|---|
| Pregnant | ☐ Yes ☐ No | | |
| Asthma | ☐ Yes ☐ No | ☐ Unknown | |
| Hypertension | ☐ Yes ☐ No | ☐ Unknown | |
| Diabetes | ☐ Yes ☐ No | ☐ Unknown | |
| Hearing Impairment | ☐ Yes ☐ No | | |
| Mobility Impairment | ☐ Yes ☐ No | | |
| Sight Impairment | ☐ Yes ☐ No | | |
| Speech Impairment | ☐ Yes ☐ No | | |
| Acquired or Traumatic Brain Injury | ☐ Yes ☐ No | | |
| Other Major Physical Health Condition | ☐ Yes ☐ No | | |
| HIV Status | ☐ Known to be Positive | ☐ Known to be Negative | ☐ Unknown |
| Hepatitis B Status | ☐ Known to be Positive | ☐ Known to be Negative | ☐ Unknown |
| Hepatitis C Status | ☐ Known to be Positive | ☐ Known to be Negative | ☐ Unknown |
| Result of TB Test | ☐ Known to be Positive | ☐ Known to be Negative | ☐ Unknown |

***Mental Health-Related Conditions***

Intellectual Disability/Developmental Disability ☐ Yes ☐ No Co-existing Psychiatric Disorder ☐ Yes ☐ No

***History of Mental Health Treatment***

| | | |
|---|---|---|
| Ever Treated for Mental Illness | ☐ Yes | ☐ No |
| Ever Hospitalized for Mental Illness | ☐ Yes | ☐ No |
| Ever Hospitalized 30 or More Days for Mental Illness | ☐ Yes | ☐ No |

***Six Months Prior to Admission***

No. Days in Inpatient Detox ___ ___ No. of Emergency Room Episodes ___ ___
No. of Days Hospitalized for Non-Detox Services ___ ___ ___
Reason for Hospitalization ☐ Medical ☐ Psychiatric ☐ Both

***Gambling***

**Did the client screen positive for a gambling problem?** ☐ Yes ☐ No ☐ Not Screened

***Trauma***

**Client ever experience/witness trauma that impacts current life experience?** ☐ Yes ☐ No ☐ Unknown ☐ Refused to Answer
**Client ever a victim of Domestic Violence/Intimate Partner Violence?** ☐ Yes ☐ No ☐ Unknown ☐ Refused to Answer
**Client ever a perpetrator of Domestic Violence/Intimate Partner Violence?** ☐ Yes ☐ No ☐ Unknown ☐ Refused to Answer

***Orientation to Change*** *(For use only by Residential Rehabilitation Services for Youth Programs or Other Program Types Participating in Special Projects with OASAS)*

**Which statement best characterizes this patient's orientation to change with respect to alcohol/drug use at the time of admission?**

☐ Ambivalent
☐ Change Oriented
☐ Planning Change
☐ Active Early Recovery
☐ Ongoing Recovery and Recurrence Prevention

**For Provider Use (Optional)**

| _____ | _____ | _____ |
|---|---|---|
| **Signature** | **Title** | **Date** |