New York State Office of Alcoholism and Substance Abuse Services

METHADONE CLIENT ANNUAL STATUS REPORT

FOR UPDATES DATED 4/1/2009 AND BEYOND

Provider Number __ __ __ __ __ **Program (PRU) Number** __ __ __ __ __ **Client ID** __ __ __ __ __ __ __ __ __ __

Sex ☐ Male ☐ Female **Birth Date** __ __/__ __/__ __ __ __ **Last 4 SSN** __ __ __ __ **Birth Last Name First 2 Char** __ __

Date Update Due __ __/__ __/__ __ __ __ **Date Annual Status Completed** __ __/__ __/__ __ __ __

Zip Code of Residence __ __ __ __ __ **County of Residence** ______________________________

Type of Residence:

☐ Private Residence
☐ Homeless, Shelter
☐ Homeless, No Shelter
☐ Single Resident Occupancy
☐ CD Community Residence
☐ CD Supportive Living
☐ MH/MRDD Community Residence
☐ Other Group Residential Setting
☐ Institution (jail, hospital)
☐ Other

Living Arrangements*:*

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

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Highest Grade Completed:

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

Employment

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, Retired
☐ Not in Labor Force, Student
☐ Not in Labor Force, Other
☐ Social Services Work Exp Prog.
☐ Social Services Determined, Not Employed/Able to Work
☐ Social Services Determined, Unable to Work, Mandated Treatment

Length of Employment at Update

Days Employed at Update: ☐ 0-30 Days ☐ 31-60 Days ☐ 61-90 Days ☐ 91-120 Days ☐ 121+ Days

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Primary Payment Source:

☐ None
☐ Self-Pay
☐ Medicaid
☐ Medicaid Managed Care
☐ Medicaid Pending
☐ Medicare
☐ DSS Congregate Care
☐ Department of Veterans Affairs
☐ Private Insurance – Fee for Service
☐ Private Insurance – Managed Care
☐ Other

Criminal Justice Information

Current 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

Arrests/Incarceration

Is client in treatment as 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 ___ ___ ___

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Current Opiate Addiction Medicine:

- ☐ Methadone
- ☐ Buprenorphine
- ☐ None

Daily Dose: __ __ __

Current Pick-Up Schedule:

- ☐ Daily
- ☐ 6 days per week
- ☐ 5 days per week
- ☐ 4 days per week
- ☐ 3 days per week
- ☐ 2 days per week
- ☐ Once per week
- ☐ Once every two weeks
- ☐ Once a Month
- ☐ None

Current DSM IV or ICD 10 Diagnoses – Axis 1: Include all substance-related and diagnosed psychiatric conditions.

Diagnosis Type: ☐ **ICD 10** ☐ **DSM IV**

1. __ __ __ . __ __ **2.** __ __ __ . __ __ **3.** __ __ __ . __ __ **4.** __ __ __ . __ __

Current Health Status:

Tuberculosis Symptomatic:
☐ Yes ☐ No

Hepatitis B Symptomatic:
☐ Yes ☐ No

Hepatitis C Symptomatic:
☐ Yes ☐ No

AIDS Symptomatic:
☐ Yes ☐ No

Substance(s) used in the last 6 months listed by seriousness of <u>abuse</u>: (Do not include substances used appropriately as prescribed)

None
Alcohol
Cocaine
Crack
Marijuana/Hashish
Heroin
Buprenorphine
Non-Rx Methadone
OxyContin
Other Opiate/Synthetic
Alprazolam (Xanax)
Barbiturate
Benzodiazepine (e.g., Klonopin)
Catapres (Clonidine)
Other Sedative/Hypnotic
Elavil
GHB
Khat
Other Tranquilizer
Methamphetamine
Other Amphetamine
Other Stimulant
PCP
Ecstasy
Other Hallucinogen
Ephedrine
Inhalant
Ketamine
ROHYPNOL
Viagra
Over-the-Counter
Other

Frequency of Use
No use in last 30 days
1-3 times last 30 days
1-2 times per week
3-6 times per week
Daily

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Primary: ________________________________ Frequency Last 30 Days: ____________________

Secondary: ________________________________ Frequency Last 30 Days: ____________________

Tertiary: ________________________________ Frequency Last 30 Days: ____________________

For the Six-month Period Prior to Anniversary Date

Number of days the client was in drug and/or alcohol inpatient detox: __ __ __

Number of emergency room episodes for which the client received treatment: __ __

Number of days the client has been hospitalized for non-detox services: __ __ __

If hospitalized, specify reason:

☐ Medical Or ☐ Both
☐ Psychiatric
☐ Not Applicable

Tobacco

Has the client ever used tobacco (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 ☐ Chewing

For Provider Use (Optional)

________________________________ ________________________________ ______________
Signature **Title** **Date**