New York State Office of Addiction Services and Supports

OPIOID TREATMENT ANNUAL UPDATE

FOR UPDATES DATED 04/01/2017 AND BEYOND

Provider Number __ __ __ __ __ **Program Number** __ __ __ __ __ **Client ID** __ __ __ __ __ __ __ __ __ __

Sex (at birth) ☐ Male ☐ Female ☐ X **Birth Date** __ __ /__ __/__ __ __ __ **Last 4 SSN** __ __ __ __ **Last Name First 2 Letters** __ __
(Birth Name)

Date Update Due __ __ /__ __/__ __ __ __ **Date Update Completed** __ __/__ __/__ __ __ __

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 __ __ __ __ __ __ __ __

Zip Code of Residence __ __ __ __ __ **County of Residence** _____

Type of Residence

☐ Private Residence
☐ Homeless/Unstably Housed, Shelter
☐ Homeless/Unstably Housed, No Shelter
☐ Single Resident Occupancy
☐ Residential Services for SUD/ Congregate
☐ Residential Services for SUD/Scatter-Site
☐ MH/DD Community Residence
☐ Other Group Residential Setting
☐ County operated or other local jail
☐ DOCCS operated prison
☐ Institution other (hospital, etc.)
☐ 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
☐ Associate degree
☐ Bachelor's degree
☐ Graduate Degree

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

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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 Legal System Involvement

Current Criminal Legal System Involvement Status (check all that apply)

☐ None
☐ Probation
☐ Parole
☐ Work Release
☐ In Prison/Jail
☐ In OCFS Facility
☐ Charges Pending
☐ Any Treatment or Specialty Court
☐ Other

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Criminal Arrests/Incarceration

Is client in treatment as a result of an alternative to incarceration? ☐ Yes ☐ No

Number of Criminal Arrests in Prior 30 Days ___ ___
Number of Criminal Arrests in Prior 6 Months ___ ___ ___
Number of Days Incarcerated in Prior 6 Months ___ ___ ___

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 every three weeks
☐ Once per month
☐ None

Addiction Medications Used during 12 Month Review Period
CHECK ALL THAT APPLY. *Select* ***"NONE"*** *if no addiction medication was used.*

☐ Methadone
☐ Buprenorphine
☐ Zyban/Wellbutrin
☐ Naltrexone (Revia)
☐ Naltrexone (Vivitrol)
☐ Antabuse
☐ Nicotine Lozenges
☐ Nicotine Gum
☐ Nicotine Patch
☐ Chantix
☐ Campral
☐ Naloxone (Narcan, Nalone, Narcanti)
☐ Vaccines (NicVAX)
☐ Clonidine (Catapres)
☐ Baclofen (Kemstro, Lioresal, Liofen)
☐ Gabapentin (Neurontin)
☐ Other Addiction Medications
☐ None

Physical Health-Related Conditions

Asthma	☐ Yes ☐ No	☐Unknown	
Treated for Asthma during this review period	☐ Yes ☐ No		
Hypertension	☐ Yes ☐ No	☐Unknown	
Treated for Hypertension during this review period	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	☐Unknown	
Treated for Diabetes during this review period	☐ Yes ☐ No		
HIV Status	☐ Known to be Positive	☐ Known to be Negative	☐ Unknown
Tested for HIV during this review period	☐ Yes ☐ No		☐ Unknown
Hepatitis B Status	☐ Known to be Positive	☐ Known to be Negative	☐ Unknown
Tested for Hepatitis B during this review period	☐ Yes ☐ No		☐Unknown
Hepatitis C Status	☐ Known to be Positive	☐ Known to be Negative	☐ Unknown
Tested for Hepatitis C during this review period	☐ Yes ☐ No		☐Unknown
Result of TB Test	☐ Known to be Positive	☐Known to be Negative	☐Unknown
Treated for Latent TB during this review period	☐ Yes ☐ No		

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Substance(s) used in the last 6 months listed by seriousness of misuse
(Do not include substances used appropriately as prescribed)

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

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

Nicotine

Has the client used nicotine since admission or the last Opioid Treatment Annual Update Report? ☐ 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

For Provider Use (Optional)

_____ _____ _____
Signature Title Date