

TREATMENT 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 _____
Date Update Due ___/___/___ Date Update Completed ___/___/___

TRS-61 - Identifying Information (ID)

ID Consent Date ___/___/___ ID Consent Revoke Date ___/___/___
Last Name _____ Last Name _____
First Name _____ Social Security Number _____
Medicaid Client ID _____

Zip Code of Residence _____ County of Residence _____

Type of Residence

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

Living Arrangements

- [] Living Alone [] Living w/ Non-Related Persons [] Living with Spouse/Relatives

Highest Grade Completed

- [] No education [] 6th [] 11th [] Some College-No degree
[] 1st [] 7th [] High School Diploma [] Associate degree
[] 2nd [] 8th [] General Equivalency Diploma (GED) [] Bachelor's degree
[] 3rd [] 9th [] Vocational Cert w/o Diploma/GED [] Graduate Degree
[] 4th [] 10th [] Vocational Cert w/Diploma/GED

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

Employment

Employment Status

- [] Employed Full Time-35+ hrs/wk [] Unemployed, Not Looking for Work [] Not in Labor Force, Other
[] Employed Part Time-<35 hrs/wk [] Not in Labor Force, Child Care [] Social Services Work Exp Prog.
[] Employed in Sheltered Workshop [] Not in Labor Force, Disabled [] Social Services Determined,
[] Unemployed, In Treatment [] Not in Labor Force, In Training Not Employed/Able to Work
[] Unemployed, Looking for Work [] Not in Labor Force, Retired [] Social Services Determined, Unable to
[] Not in Labor Force, Student 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

Primary Payment Source

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

Criminal Legal System Involvement

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

- [] None [] Work Release [] Charges Pending
[] Probation [] In Prison/Jail [] Any Treatment or Specialty Court
[] Parole [] In OCFS Facility [] 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 _____

Medication for Addiction Treatment

Select the medication included in client's treatment (select all that apply):

- Methadone Dispensed at the Window
- Buprenorphine Dispensed at the Window
- Naltrexone for MOUD Administered at Program Site
- Naltrexone for AUD Administered at Program Site
- Buprenorphine Prescribed by Program Practitioner
- Other AUD Prescribed by Program Practitioner
- No MOUD or AUD Medication within Program

If Methadone or Buprenorphine is dispensed at window by the program, provide daily dose and schedule:

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.

- | | | |
|--|--|---|
| <input type="checkbox"/> Methadone | <input type="checkbox"/> Nicotine Gum | <input type="checkbox"/> Clonidine (Catapres) |
| <input type="checkbox"/> Buprenorphine | <input type="checkbox"/> Nicotine Patch | <input type="checkbox"/> Baclofen (Kemstro, Lioresal, Liofen) |
| <input type="checkbox"/> Zyban/Wellbutrin | <input type="checkbox"/> Chantix | <input type="checkbox"/> Gabapentin (Neurontin) |
| <input type="checkbox"/> Naltrexone (Revia) | <input type="checkbox"/> Campral | <input type="checkbox"/> Other Addiction Medications |
| <input type="checkbox"/> Naltrexone (Vivitrol) | <input type="checkbox"/> Naloxone (Narcan, Nalone, Narcanti) | <input type="checkbox"/> None |
| <input type="checkbox"/> Antabuse | <input type="checkbox"/> Vaccines (NicVAX) | |
| <input type="checkbox"/> Nicotine Lozenges | | |

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

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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

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 Treatment 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 _____