OPIOID TREATMENT ANNUAL UPDATE REPORT INSTRUCTIONS (PAS-26N)

FOR UPDATES DATED 04/01/2017 AND BEYOND

These instructions are for the purpose of completing the PAS-26N form only. They do not supersede or replace existing regulations.

PROVIDER NUMBER

Enter the five-digit provider number assigned by OASAS that identifies the treatment service provider.

PROGRAM NUMBER

Enter the five-digit number assigned by OASAS that identifies the program.

CLIENT ID INFORMATION

PROVIDER CLIENT ID

The client identification number selected by the program may contain a maximum of 10 alpha-numeric digits. The number may be entered using any of the available 10 spaces. Do not use the client's Social Security number as the client ID number.

For all clients prescribed methadone, the identification number randomly assigned by the NYS Central Registry must be used. If the client was readmitted, the most current Provider Client ID Number will be displayed.

SEX (at birth)

Enter gender, **Male** or **Female,** as documented on birth certificate. If the client is transsexual, choose the gender that was recorded at time of birth.

BIRTH DATE

Enter two digits each for the month and day and a four-digit year of birth (e.g., March 8, 1998 would be 03/08/1998).

LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER

Enter the last four digits of the **client's** Social Security number (SSN), as assigned by the Social Security Administration. If the client does not have an SSN, enter 0000. If another person is providing insurance coverage, be sure to use the client's SSN, not the SSN of the insured. Please be sure that the numbers are entered in the correct order. These numbers are critical to OASAS' ability to track clients as they move through the treatment system.

FIRST TWO LETTERS OF LAST NAME AT BIRTH

Enter the first two letters of the client's last name **at birth** (Smith = SM, O'Brien = OB). For clients who have changed their last name, use their BIRTH name (e.g., Maiden Name).

DATE ANNUAL UPDATE DUE

The anniversary of the client's original admission date is pre-filled by the computer system and cannot be changed. However, you may want to fill in this field so that the data entry person can prioritize the order of updates. **If more than one Opioid Treatment Annual Update is overdue for the client (i.e., there is at least one update more than a year overdue), the most overdue update(s), must be entered first.**

The above items will prefill when entering data into the Client Data System. If any of the above items need to be changed or updated, this must be done through Client Management.

DATE ANNUAL STATUS COMPLETED

Enter the date you are completing the PAS-26N. This date may be up to 30 days prior to the date it is due.

TRS-61 IDENTIFYING INFORMATION (ID)

Authorization for Release of Behavioral Health Information

The data items that are addressed by this authorization of disclosure were added to the data collected by OASAS to assist OASAS in implementing Governor Cuomo's Medicaid Redesign initiative and to comply with mandatory federal reporting requirements. Clients should be offered the opportunity to sign the *Authorization for Release of Behavioral Health Information Form (TRS-61)* at the time of admission or, if admitted prior to October 1, 2014 and participating in an Opioid Treatment Program, at the completion of the Opioid Treatment Annual Update. The client should be aware that signing or refusing to sign the consent form does not impact admission disposition. A client can sign the consent form at any time during their treatment episode with the knowledge that it allows consent of the data for the entire treatment episode, from admission through discharge and is valid for three years following the last date of service. Clients have the right to revoke this consent at any time. OASAS will not re-disclose any information. Please see the document titled *Guidance for Using the Authorization for Release of Behavioral Health Information (TRS-61) for further information.* ***If a client refuses to sign the TRS-61, the program is STILL required to report all other data items in the Opioid Treatment Annual Update. The only exception to this is HIV status which should be reported as "Unknown".***

ID Consent Date

This is the date that the client signed the *Authorization for Release of Behavioral Health Information Form (TRS-61).* Enter two digits for the month, two digits for the day, and four digits for the year. The date may be prior to the date of admission. The date of signature cannot be a future date. If the client signs and dates the TRS-61, the following data items may be entered: Last Name (Birth), Last Name (Current), First Name, and Medicaid Client ID. If a date has been entered in the ID Consent Date field, then, at a minimum, the client's Last Name at Birth and Current Last Name are required.

ID Consent Revoke Date

This date is not required but if entered, it must be ON or AFTER the ID Consent Date. Enter two digits for the month, two digits for the day, and four digits for the year.

Last Name (Birth Name)

Enter the letters of client's full last name as recorded at birth. This item is required if a date has been entered in ID Consent Date.

Last Name (Current Name)

Enter the letters of client's current full last name. This item is required if a date has been entered in ID Consent Date.

First Name

Enter the letters of the client's full first name.

Medicaid Client ID

Enter the client's full Medicaid Client ID if applicable. This is usually two letters followed by five numeric digits and ending with one letter.

Social Security Number

Enter the client's full nine-digit Social Security number. The full Social Security number should only be entered if, in addition to signing and dating the TRS-61, the client also initialed the section allowing disclosure of Social Security number to OASAS.

ZIP CODE OF RESIDENCE

Enter the five-digit zip code for the client's county of residence. If the client is homeless and does not live in a shelter, use the program's zip code. If the client is homeless and lives in a shelter, use the shelter's zip code. **For Canada use 88888.**

COUNTY OF RESIDENCE

From the drop-down list, click on the NY county code or the values for any of the listed border states. If the zip code for Canada was entered (88888), click on "**Canada**." If the client's zip code is outside of these geographic areas, the user should click on **"Other"** from the drop-down list. County of residence must match the zip code entered or an error message will be displayed. Do not enter the incorrect county. If necessary, first correct the zip code.

Connecticut	**CT**
New Jersey	**NJ**
Pennsylvania	**PA**
Massachusetts	**MA**
Vermont	**VT**
Other	**OTHER**
Canada	**CANADA**

TYPE OF RESIDENCE

Enter the category that best describes the client's type of residence at the time of update.

Private Residence

Homeless: shelter Includes a person or family who is undomiciled, has no fixed address, lacks a regular nighttime residence, and is residing in some type of temporary accommodation (i.e., hotel, shelter, residential program for the victims of domestic violence).

Homeless: **no shelter or circulates among acquaintances** Includes a person or family who is undomiciled, has no fixed address, lacks a regular nighttime residence, and circulates among acquaintances or is residing in a place not designed or originally used as a regular sleeping accommodation for human beings.

Single Resident Occupancy Hotel, rooming house, adult home, or residence for adults.

Residential Services for SUD*/Congregate A community living experience in one location with onsite staff available seven days a week, twenty-four hours a day, such as a community residence or a Part 820 residential program.

Residential Services for SUD/Scatter-Site A community living experience where housing is provided at various locations where staff provide, at a minimum, case management and supervision through weekly in-house visits. Examples include supportive living or Part 820 residential programs with a reintegration setting of scatter-site.

MH/DD Community Residence Mental Health/Developmental Disabilities Community Residence

Other Group Residential Setting Other Group Residential may include group homes, supervised apartments, college housing or military barracks.

Institution, Other (e.g., jail, hospital)

Other

*SUD=Substance Use Disorder

LIVING ARRANGEMENTS

Indicate the client's living arrangements at his/her anniversary date.

Living Alone
Living with Non-related persons
Living with Spouse/Relatives

HIGHEST GRADE COMPLETED

Indicate the client's highest grade completed at the time of the update. If the client is in a special education class, select the grade that most accurately reflects the client's level of performance.

No Education
01 to Grade 11– Indicate grade completed
High School Diploma
General Equivalency Diploma (GED)
Vocational Certificate w/o Diploma/GED (A Vocational Certificate is any certificate received as a result of vocational training or special skill trade.)
Vocational Certificate w/Diploma/GED
Some College - No Degree
Associate Degree
Bachelor's Degree
Graduate Degree

INDIVIDUAL (INDIVIDUALIZED) EDUCATION PLAN (IEP)

Indicate **Yes** or **No**. Select **Unknown** if this information is not known.

Note: An IEP is offered for a variety of disabilities not just Intellectual/Developmental Disabilities. Someone could have been diagnosed on an IEP as having an emotional disability which is the term the Education Department uses for young people. A specific DSM V diagnosis is made when the individual becomes an adult. Other disabilities severe enough to warrant an IEP include: hearing loss, spinal cord injuries, cerebral palsy, muscular dystrophy, traumatic brain injury, visual impairments and severe burns. This status will follow him/her for life and will allow access to the state vocational rehabilitation system, such as ACCESS-VR (formerly VESID) as an adult, and may even support evidence

or need for Social Security benefits.

EMPLOYMENT STATUS

Indicate the client's employment status at his/her anniversary date. If a client may be counted in more than one category, please choose the status which most appropriately indicates their *employment* status. (*For example: if an individual is employed part-time and is also a student or a homemaker or a retired person, he/she is part of the labor force and the status should be "Employed Part-Time. "Active military personnel status should be "Employed Full-Time." "Unemployed Looking for Work" should only be used if client has **actively** sought employment within the last 30 days.* ***A client working off-the-books or in a volunteer position is not considered employed.***

Employed Full-Time (35 + Hrs per Week)
Employed Part-Time (<35 Hrs per Week)
Employed in Sheltered Workshop
Unemployed, In Treatment The reason that the client is unemployed is that **immediately prior** to this admission, the client was in an inpatient or residential treatment program.
Unemployed, Looking for Work
Unemployed, Not Looking for Work Programs may use this code for clients who are working off-the-books or in a volunteer position.
Not in Labor Force–Child Care
Not in Labor Force–Disabled For public assistance purposes, the client has been assessed as disabled and is not required to work.
Not in Labor Force–In Training To be used when a client is unemployed but taking part in a formal training program such as a program via ACCES-VR, Department of Labor, BOCES, etc.
Not in Labor Force–Retired
Not in Labor Force–Student Only use if the client is not working part-time or full-time.
Not in Labor Force–Other
Social Services Work Experience Program (WEP) A specific set of work/work related tasks to which a public assistance recipient is assigned for a specific number of hours per week by a local social services district as a condition for receipt of a public assistance grant and/or related benefit.
Social Services Determined, Not Employed/Able to Work The client has been assessed by treatment program staff or an OASAS credentialed individual acting on behalf of a local Social Services District as able to engage in work but is not employed at the time of admission.
Social Services Determined, Unable to Work, Mandated Treatment The client has been assessed by an OASAS credentialed individual acting on behalf of a local Social Services District as unable to work and is in treatment as a condition for receiving public assistance.

LENGTH OF EMPLOYMENT AT UPDATE

Select the category that best represents the number of consecutive days that the client has been employed at his or her current job on his/her anniversary date. If Employment Status is not Employed Full-Time (35 + Hrs per Week) or Employed Part-Time (<35 Hrs per Week), length of employment should be blank.

0-30 Days
31-60 Days
61-90 Days
91-120 Days
121+ Days

PRIMARY PAYMENT SOURCE

Indicate the primary source of payment for the client's treatment in this PRU at the time of his/her anniversary date.

Funding received from OASAS or other sources and not attributable to a specific client should not be included as a primary payment source. The primary payment source reflects payments from the client or other sources based upon the client's qualifications for assistance.

None To be used only if there is no direct public (i.e., Medicaid, Medicare), private (i.e., health insurance) or client payment (i.e., self-pay).

Self-Pay

Medicaid Inpatient Rehab, Part 822 Outpatient Services, Residential Rehabilitation Services for Youth, Opioid Treatment Programs, Medically Managed Detoxification, Medically Supervised Withdrawal Inpatient/Outpatient, and Residential Part 820 services excluding Reintegration. *Note: To be used when a provider receives a Medicaid payment in response to a claim submitted by the provider to the NYS Medicaid payment contractor.*

Medicaid Managed Care Inpatient Rehab, Part 822 Outpatient Services, Residential Rehabilitation Services for Youth, Opioid Treatment Programs, Medically Managed Detoxification, Medically Supervised Withdrawal Inpatient/Outpatient, and Residential Part 820 services excluding Reintegration. To be reported when a managed care organization (MCO) has authorized reimbursement or has reimbursed the provider for a service rendered to a Medicaid recipient. An MCO is defined as any group operating or implementing healthcare through managed care concepts of service including authorization, utilization review and/or a fixed network of providers. Payment under the Child Health Plus programs is included under this category.

Medicaid Pending Inpatient Rehab, Part 822 Outpatient Services, Residential Rehabilitation Services for Youth, Opioid Treatment Programs, Medically Managed Detoxification, Medically Supervised Withdrawal Inpatient/Outpatient, and Residential Part 820 services excluding Reintegration. To be reported when the program and/or the client has applied for Medicaid, and is anticipating that the application will be successful, but the client/program has not yet been notified that the application has been approved at the time that the client is being discharged from treatment.

Medicare

DSS Congregate Care (Residential Only) – NOTE*: To be used **only** by non-Medicaid eligible residential programs, including intensive residential, community residences and supportive living programs, that received congregate care payments for the client. Congregate Care here is defined as inclusive of SSI, Safety Net and TANF.*

Department of Veterans Affairs

Private Insurance – Fee for Service To be reported when a provider receives payment for an individual that is insured by a company that is not an MCO as defined above. These payments are health insurance benefits provided through entities

such as an employer, union, or a commercial or nonprofit insurer such as Metropolitan, Aetna, Blue Cross or Blue Shield respectively. Private insurance benefits may be provided as an individual plan or a group plan.

Private Insurance – Managed Care To be reported when a provider has been authorized or receives payment for an individual insured by an MCO. This code should not be used for MCO services provided to a Medicaid recipient.

Other To be used only for other types of payment received directly from the client or from others on behalf of client**.** *NOTE: This is not to be used when programs receive net deficit funding from OASAS, and the client has no payment source.*)

CRIMINAL JUSTICE INFORMATION

CURRENT CRIMINAL JUSTICE STATUS

Please select the code or codes that reflect the client's current criminal justice status (check all that apply).

None
Probation The client is under the supervision of any Department of Probation.
Parole The client is under the supervision of the New York State Division of Parole.
Work Release The client is currently in the custody of the New York State Department of Corrections and Community Supervision or a local jail and is participating in a work release program.
In Prison/Jail The client is currently in the custody the New York State Department of Corrections and Community Supervision or a local jail (and **is not** participating in a work release program).
In OCFS Facility The client is currently in the custody of the New York State Office of Children and Family Services.
Charges Pending The client has criminal charges pending but has been released into the community awaiting disposition.
Any Treatment or Specialty Court The client is participating in Drug Court or other Specialty Court programs.
Other

IS THIS TREATMENT THE RESULT OF AN ALTERNATIVE TO INCARCERATION?

Indicate whether the client's involvement in treatment since the last update is the result of his/her participation in one of the various alternatives to incarceration programs.

NO. OF ARRESTS IN PRIOR 30 DAYS

Enter the number of arrests in the 30 days prior to the client's anniversary date. An arrest should be counted if the client was legally processed and detained.

NO. OF ARRESTS IN PRIOR 6 MONTHS

Enter the number of arrests in the six months prior to the client's anniversary date. An arrest should be counted if the client was legally processed and detained. Any arrest that the client had in the last 30 days will also be counted here since the last 30 days is part of the last 6 months.

NO. OF DAYS INCARCERATED IN PRIOR 6 MONTHS

Enter the number of whole or partial days that the client was remanded (incarcerated) to jail or prison in the six months prior to his/her anniversary date.

ADDICTION MEDICINE

CURRENT OPIATE ADDICTION MEDICINE

Indicate the opiate addiction medication currently being administered to the client (**Methadone or Buprenorphine).**

Use **None** if the client has tapered off these addiction medications, neither of these medications are currently being administered to the client, and he/she remains active on census.

DAILY DOSE

Enter the daily dose of the addiction medication being administered to the client as of his/her anniversary date. Enter "0" if the client has tapered off his/her addiction medication, neither Methadone nor Buprenorphine is currently being administered to the client, and he/she remains active on census.

CURRENT PICK-UP SCHEDULE

Indicate the category that best represents the current medication pick-up schedule for the client. If it has recently changed, choose the code that reflects the pick-up schedule the client had on his/her anniversary date.

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 per month
None Use **None** only if the client has been tapered off his/her addiction medication, neither Methadone nor Buprenorphine is currently being administered to the client, and he/she remains active on census.

Addiction Medications Used During 12 Month Review Period

Indicate if any of the medications listed below have been prescribed as part of the client's treatment plan during the 12-month review period. If Methadone or Buprenorphine was selected as a current opiate addiction medication, it must be selected from this list. Check all that apply.

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)
Balcofen (Kemstro, Lioresal, Liofen)
Gabapentin (Neurontin)
Other Addiction Medications
None

HEALTH-RELATED CONDITIONS

PHYSICAL HEALTH-RELATED CONDITIONS

Asthma

Select **Yes** if the client reports diagnosis of Asthma.
Select **No** if the client denies diagnosis of Asthma.
Select **Unknown** if client is unsure.

Treated for Asthma during This Review Period

Select **Yes** if the client is known to have been treated for Asthma during this review period. It is not necessary for treatment to have taken place at the program site. Treatment may have taken place at a healthcare/primary care provider, public health clinic, etc.
Select **No** if the client has denied being treated for Asthma during this review period.

Hypertension

Select **Yes** if the client reports diagnosis of Hypertension.
Select **No** if the client denies diagnosis of Hypertension.
Select **Unknown** if client is unsure.

Treated for Hypertension during This Review Period

Select **Yes** if the client is known to have been treated for Hypertension during this review period. It is not necessary for treatment to have taken place at the program site. Treatment may have taken place at a healthcare/primary care provider, public health clinic, etc.
Select **No** if the client has denied being treated for Hypertension during this review period.

Diabetes

Select **Yes** if the client reports diagnosis of Diabetes.
Select **No** if the client denies diagnosis of Diabetes.
Select **Unknown** if client is unsure.

Treated for Diabetes during This Review Period

Select **Yes** if the client is known to have been treated for Diabetes during this review period. It is not necessary for treatment to have taken place at the program site. Treatment may have taken place at a healthcare/primary care provider, public health clinic, etc.
Select **No** if the client has denied being treated for Diabetes during this review period.

HIV Status

Select **Known to be Positive** if the client has self-reported a positive status or your program has received records indicating a positive status.
Select **Known to be Negative** if the client has self-reported a negative status or your program has received records indicating a negative status.
Select **Unknown** if the client has NOT authorized consent to release this information by initialing the "HIV-AIDS Related" section of the *Authorization for Release of Behavioral Health Information TRS-61* or if the client has not reported an HIV status and HIV status has not been indicated in history/client record. Also, if prior to the completion of this annual update, the client has revoked consent to release "HIV-AIDS Related" information, select **Unknown**. If the client has revoked consent, it is not necessary to edit the admission or previous Opioid Treatment Annual Update records to **Unknown**.

Tested for HIV during This Review Period

Select **Yes** if the client is known to have participated in testing for HIV during this review period. It is not necessary for testing to have taken place at the treatment site. Testing may have taken place at a healthcare/primary care provider, public health clinic, etc.
Select **No** if the client has denied any participation in testing for HIV during this review period.
Select **Unknown** if the client has neither affirmed nor denied participation in testing for HIV during this review period.

Hepatitis B Status

Select **Known to be Positive** if the client has self-reported a positive status or your program has received records indicating a positive status.
Select **Known to be Negative** if the client has self-reported a negative status or your program has received records indicating a negative status.
Select **Unknown** if the client has not reported a status and status has not been indicated in history/client record.

Tested for Hepatitis B during This Review Period

Select **Yes** if the client is known to have participated in testing for Hepatitis B during this review period. It is not necessary for testing to have taken place at the treatment site. Testing may have taken place at a healthcare/primary care provider, public health clinic, etc.
Select **No** if the client has denied any participation in testing for Hepatitis B during this review period.
Select **Unknown** if the client has neither affirmed nor denied participation in testing for Hepatitis B during this review period.

Hepatitis C Status

Select **Known to be Positive** if the client has self-reported a positive status or your program has received records indicating a positive status.
Select **Known to be Negative** if the client has self-reported a negative status or your program has received records indicating a negative status.
Select **Unknown** if the client has not reported a status and status has not been indicated in history/client record.

Tested for Hepatitis C during This Review Period

Select **Yes** if the client is known to have participated in testing for Hepatitis C during this review period. It is not necessary for testing to have taken place at the treatment site. Testing may have taken place at a healthcare/primary care provider, public health clinic, etc.
Select **No** if the client has denied any participation in testing for Hepatitis C during this review period.
Select **Unknown** if the client has neither affirmed nor denied participation in testing for Hepatitis C during this review period.

Result of TB (Tuberculosis) Test

Select **Known to be Positive** if the client has self-reported a positive status or your program has received records indicating a positive status.
Select **Known to be Negative** if the client has self-reported a negative status or your program has received records indicating a negative status.
Select **Unknown** if the client has not reported a status and status has not been indicated in history/client record.

Treated for Latent TB (Tuberculosis) during This Review Period

Select **Yes** if the client is known to have been treated for Latent TB during this review period. It is not necessary for treatment to have taken place at the program site. Treatment may have taken place at a healthcare/primary care provider, public health clinic, etc.
Select **No** if the client has denied being treated for Latent TB during this review period.

SUBSTANCE(S) USED IN THE LAST 6 MONTHS LISTED BY SERIOUSNESS OF MISUSE

From the following list, indicate up to three substances and list by seriousness of misuse. The order should be determined by the number of positive urine screens, clinical judgment and frequency of use, client's perception, medical issues, and problem areas of client functioning with the substance.

DO NOT LIST A DRUG UNLESS THE CLIENT HAS USED THAT DRUG DURING THE LAST SIX MONTHS (INCLUDING HEROIN OR OTHER OPIATES BUT EXCLUDING PROGRAM-PRESCRIBED MEDICATIONS WHEN TAKEN AS PRESCRIBED).

None
Alcohol
Cocaine
Crack This is the street name for a more purified form of cocaine that is smoked.
Marijuana/Hashish This includes THC and any other cannabis sativa preparations.
Synthetic Cannabinoids (e.g., K2/Spice)
Heroin
Buprenorphine
Non-Rx Methadone Methadone obtained and used without a legal prescription.
OxyContin
Other Opiate/Synthetic This includes Codeine, Dilaudid, Morphine, Demerol, Opium, and any other drug with morphine-like effects.
Alprazolam (Xanax)
Barbiturate This includes Phenobarbital, Seconal, Nembutal, etc.

Benzodiazepine This includes Diazepam, Flurazepam, Chlordiazepoxide, Clorazepate, Lorazepam, Oxazepam, Prazepam, Triazolam, Clonazepam, Klonopin, and Halazepam.
Catapres Clonidine
Other Sedative/Hypnotic This includes Methaqualone, Chloral Hydrate, Placidyl, Doriden, etc.
Elavil
GHB
Khat
Other Tranquilizer
Methamphetamine (e.g., Ice)
Other Amphetamine This includes Benzedrine, Dexedrine, Preludin, Ritalin, and any other amines and related drugs.
Synthetic Stimulant (e.g., Bath Salts)
Other Stimulant
PCP (Phencyclidine)
Ecstasy
Other Hallucinogen This includes LSD, DMT, STP, Mescaline, Psilocybin, Peyote, etc.
Ephedrine
Inhalant This includes Ether, Glue, Chloroform, Nitrous Oxide, Gasoline, Paint Thinner, etc.
Ketamine
Rohypnol
Over-the-Counter This includes Aspirin, Cough Syrup, Sominex, and any other legally obtained, non-prescription medicine.
Other

FREQUENCY OF USE (LAST 30 DAYS)

For those substances listed as being used by the client during the last 6 months, indicate the client's frequency of use in the last 30 days.

No use in last 30 days
1-3 times in the last 30 days
1-2 times per week
3-6 times per week
Daily

FOR THE 6-MONTH PERIOD PRIOR TO THE CLIENT'S ANNIVERSARY DATE

NUMBER OF DAYS THE CLIENT WAS IN DRUG AND/OR ALCOHOL INPATIENT DETOX

Enter the number of days the client spent in inpatient detoxification during the last six months.

NUMBER OF EMERGENCY ROOM EPISODES FOR WHICH THE CLIENT RECEIVED TREATMENT

Enter the number of separate incidences in which the client used emergency room services during the last six months.

NUMBER OF DAYS THE CLIENT WAS HOSPITALIZED FOR NON-DETOX SERVICES

Enter the number of days that the client spent in a hospital for other than

detoxification services during the last six months.

IF HOSPITALIZED, SPECIFY REASON

If the number of days the client was hospitalized for non-detox services is greater than zero, the type of hospitalization must be indicated. Do not indicate a type of hospitalization if the client was hospitalized only for drug and/or alcohol inpatient detox or had only emergency room visits.

Medical
Psychiatric
Both

NICOTINE

HAS THE CLIENT USED NICOTINE?

Indicate whether the client has smoked or chewed tobacco or vaped nicotine since admission or the last Opioid Update if the current Opioid Update being completed is not the client's first. If the response to this question is **No,** the remaining questions in this Nicotine section can be blank.

Enter Yes or No

AGE OF FIRST USE

Enter the age at which the client reports first using nicotine.

FREQUENCY OF USE (LAST 30 DAYS)

Enter the frequency of the client's use of nicotine during the last 30 days.

No use in last 30 days
1-3 times in past month
1-2 times per week
3-6 times per week
Daily

DATE LAST USED: MONTH, YEAR

Enter the date (month and year) that the client last used a nicotine product.

PRIMARY ROUTE OF ADMINISTRATION

Indicate whether the client usually smokes or chews tobacco or vapes nicotine. If the client reports using multiple routes equally, select *Smoking* if the client reports smoking as one of the routes. If smoking is not one of the identified routes, select *Vaping.*

If the client reports using a nicotine-free e-cigarette or other nicotine-free vaping device, do not report vaping in this section.

For Provider Use (Optional) Box
Some providers may elect to keep OASAS Client Data System PAS reports signed by the clinician in the client's file. This box may be used for that purpose and is not required by OASAS.