

NYS Office of Addiction Services and Supports
Client Admission Report
FOR ADMISSIONS DATED 12/01/2018 AND BEYOND

Provider Number _____ **Program Number** _____
Provider Client ID _____ **Special Project (See instructions):** _____
Sex (at birth) Male Female **Birth Date** ___/___/____ **Last 4 SSN** _____
Last Name First 2 Letters _____ **Last Name First 2 Letters** _____ **Admission Date** ___/___/____
(Birth Name) (Current Name)

Part 820 Program Information

Element of Care Stabilization Rehabilitation Reintegration
Reintegration Setting Congregate Scatter-Site

LOCADTR Information

Assessment ID _____ **Created Date** ___/___/____

TRS-61 - Identifying Information (ID)

ID Consent Date ___/___/____ **ID Consent Revoke Date** ___/___/____
(Revoke Date not required)
Last Name _____ **Last Name** _____
(Birth Name) (Current Name)
First Name _____ **Social Security Number** _____-____-____
Medicaid Client ID _____

TRS-49- Criminal Justice (CJ)

NYSID _____ **CJ Consent Date** ___/___/____ **CJ Consent Revoke Date** ___/___/____
(Revoke Date not required)

No. of Assessment Visits/Days ___ **Significant Other** Yes No

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

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

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

Primary Language

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

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

NYS Office of Addiction Services and Supports
Client Admission Report
FOR ADMISSIONS DATED 12/01/2018 AND BEYOND

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

Type of Residence

- | | | |
|--|---|--|
| <input type="checkbox"/> Private Residence | <input type="checkbox"/> Residential Services for SUD/
Congregate | <input type="checkbox"/> MH/DD Community Residence |
| <input type="checkbox"/> Homeless, Shelter | <input type="checkbox"/> Residential Services for
SUD/Scatter-Site | <input type="checkbox"/> Other Group Residential Setting
Institution, other (jail, hospital)
Other |
| <input type="checkbox"/> Homeless, No Shelter | | |
| <input type="checkbox"/> Single Resident Occupancy | | |

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
- *****
- Other

Highest Grade Completed

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

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

NYS Office of Addiction Services and Supports
Client Admission Report
FOR ADMISSIONS DATED 12/01/2018 AND BEYOND

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 Svcs Work Exp Program
 - Soc Svcs Determined, Not Employed/Able to Work
 - Soc Svcs 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 _____

NYS Office of Addiction Services and Supports
Client Admission Report
FOR ADMISSIONS DATED 12/01/2018 AND BEYOND

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

- | | |
|--|--|
| <input type="checkbox"/> F10.____ Alcohol related disorders | <input type="checkbox"/> F15.____ Other stimulant related disorders |
| <input type="checkbox"/> F11.____ Opioid related disorders | <input type="checkbox"/> F16.____ Hallucinogen related disorders |
| <input type="checkbox"/> F12.____ Cannabis related disorders | <input type="checkbox"/> F18.____ Inhalant related disorders |
| <input type="checkbox"/> F13.____ Sedative, hypnotic or anxiolytic related disorders | <input type="checkbox"/> F19.____ Other psychoactive substance related disorders |
| <input type="checkbox"/> F14.____ Cocaine related disorders | |

Primary Substance

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

- 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

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

- 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

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

- 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

NYS Office of Addiction Services and Supports
Client Admission Report
FOR ADMISSIONS DATED 12/01/2018 AND BEYOND

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Hearing Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Mobility Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Sight Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Speech Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Acquired or Traumatic Brain Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Other Major Physical Health Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
HIV Status	<input type="checkbox"/> Known to be Positive	<input type="checkbox"/> Known to be Negative	<input type="checkbox"/> Unknown	
Hepatitis B Status	<input type="checkbox"/> Known to be Positive	<input type="checkbox"/> Known to be Negative	<input type="checkbox"/> Unknown	
Hepatitis C Status	<input type="checkbox"/> Known to be Positive	<input type="checkbox"/> Known to be Negative	<input type="checkbox"/> Unknown	
Result of TB Test	<input type="checkbox"/> Known to be Positive	<input type="checkbox"/> Known to be Negative	<input type="checkbox"/> 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

NYS Office of Addiction Services and Supports
Client Admission Report
FOR ADMISSIONS DATED 12/01/2018 AND BEYOND

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