NYS Office of Alcoholism and Substance Abuse Services

Client Admission Report
FOR ADMISSIONS DATED 04/01/2017 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 __ __ (Birth Name) **Last Name First 2 Letters** __ __ (Current Name) **Admission Date** __ __ / __ __ / __ __ __ __

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 __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ (Birth Name) **Last 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- not male or female
- ☐ Don't Know/Not Sure
- ☐ Didn't Answer

Race

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

Hispanic Origin

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

Primary Language

- ☐ Arabic
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ Greek
- ☐ Hindi
- ☐ Japanese
- ☐ Portuguese
- ☐ Russian
- ☐ Sign Language
- ☐ Spanish
- ☐ 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 Alcoholism and Substance Abuse Services

Client Admission Report

FOR ADMISSIONS DATED 04/01/2017 AND BEYOND

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

Type of Residence

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

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
- ☐ Drinking Driver Referral
- ☐ Police
- ☐ Family Court
- ☐ Other Court
- ☐ Alternatives to Incarceration
- ☐ City/County Jail
- ☐ NYS Department of Correctional Services
- ☐ Office of Children and Family Services

Self, Family, Other

- ☐ Self-Referral
- ☐ Family, Friends, Other Individuals
- ☐ AA/NA and Other Self-Help
- ☐ HOPEline

Chemical Dependence Treatment

- ☐ CD Program in New York State
- ☐ CD Program Out of State
- ☐ CD VA Program
- ☐ CD 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
- ☐ Physician
- ☐ 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

*****

- ☐ Other

Highest Grade Completed

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

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

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 Srvcs Work Exp Program
- ☐ Soc Srvcs Determined, Not Employed/Able to Work
- ☐ Soc Srvcs 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 Alcoholic/Substance Abuser ☐ No ☐ Both ☐ Child of Alcoholic(s) ☐ Child of Substance Abuser(s)
Number of Children ___ **Number of Children Living with Client** ___ **Number of Children Living in Foster Care** ___
Case with Child 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** ___ ___ ___

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

- ☐ F10.___ ___ ___ Alcohol related disorders
- ☐ F11.___ ___ ___ Opioid related disorders
- ☐ F12.___ ___ ___ Cannabis related disorders
- ☐ F13.___ ___ ___ Sedative, hypnotic or anxiolytic related disorders
- ☐ F14.___ ___ ___ Cocaine related disorders
- ☐ F15.___ ___ ___ Other stimulant related disorders
- ☐ F16.___ ___ ___ Hallucinogen related disorders
- ☐ F18.___ ___ ___ Inhalant related disorders
- ☐ F19.___ ___ ___Other psychoactive substance related disorders

Primary Substance

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

Primary Route ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ 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

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

Secondary Route ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ 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

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

Tertiary Route ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ 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 (Methadone or Buprenorphine) part of the client's treatment plan? ☐Yes ☐No

Self-Help

Is the client currently attending 12-step or other self-help group meetings (last 30 days)? ☐ Yes ☐ No

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

Prior Treatment Episodes

Number of prior Substance/Alcohol Abuse treatment episodes __ *(Enter 0 to 5).*
If the number of prior treatment episodes is greater than 5, use 5.

Physical Health-Related Conditions

Pregnant	☐ Yes	☐ No			
Asthma	☐ Yes	☐ No	☐ Unknown		
Hypertension	☐ Yes	☐ No	☐ Unknown		
Diabetes	☐ Yes	☐ No	☐ Unknown		
Hearing Impairment	☐ Yes	☐ No			
Mobility Impairment	☐ Yes	☐ No			
Sight Impairment	☐ Yes	☐ No			
Speech Impairment	☐ Yes	☐ No			
Acquired or Traumatic Brain Injury	☐ Yes	☐ No			
Other Major Physical Health Condition	☐ Yes	☐ No			
HIV Status	☐ Known to be Positive		☐ Known to be Negative	☐ Unknown	
Hepatitis B Status	☐ Known to be Positive		☐ Known to be Negative	☐ Unknown	
Hepatitis C Status	☐ Known to be Positive		☐ Known to be Negative	☐ Unknown	
Result of TB Test	☐ Known to be Positive		☐ Known to be Negative	☐ 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

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 Relapse Prevention

For Provider Use (Optional)

_____ _____ _____
Signature **Title** **Date**