

NYS Office of Addiction Services and Supports
Client Discharge Report
FOR DISCHARGES DATED 10/01/2018 AND BEYOND

Provider Number _____ Program Number _____
 Client ID _____
 Sex (at birth) Male Female X Birth Date ___/___/____ Last 4 SSN _____ Last Name 2 Letters ___ (Birth Name)
 Date Last Treated ___/___/____

Part 820 Program Element Information

Days in Stabilization X X Days in Rehabilitation X X
 Days in Reintegration (Congregate) X X Days in Reintegration (Scatter-Site) X X

LOCADTR Information

Assessment ID _____ Created Date ___/___/____

Education at Discharge (if education at admission was entered incorrectly, it must be updated in "Client Management" online)

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

Employment

Employment Status

- | | | |
|---|--|---|
| <input type="checkbox"/> Employed Full Time-35+ hrs/wk | <input type="checkbox"/> Not in Labor Force, Disabled | <input type="checkbox"/> Social Services Work Exp Program |
| <input type="checkbox"/> Employed Part Time-<35 hrs/wk | <input type="checkbox"/> Not in Labor Force, In Training | <input type="checkbox"/> Social Services Determined, Not Employed/Able to Work |
| <input type="checkbox"/> Employed in Sheltered Workshop | <input type="checkbox"/> Not in Labor Force, Inmate | <input type="checkbox"/> Social Services Determined, Unable to Work, Mandated Treatment |
| <input type="checkbox"/> Unemployed, Looking for Work | <input type="checkbox"/> Not in Labor Force, Retired | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Unemployed, Not Looking for Work | <input type="checkbox"/> Not in Labor Force, Student | |
| <input type="checkbox"/> Not in Labor Force, Child Care | <input type="checkbox"/> Not in Labor Force, Other | |

Length of Employment at Discharge: 0-30 Days 31-60 Days 61-90 Days 91-120 Days 121+ Days

Type of Residence

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

Living Arrangements Living Alone Living w/ Non-Related Persons Living with Spouse/Relatives

Primary Payment Source

- | | | |
|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Medicaid Pending | <input type="checkbox"/> Private Insurance – Fee for Service |
| <input type="checkbox"/> Self-Pay | <input type="checkbox"/> Medicare | <input type="checkbox"/> Private Insurance – Managed Care |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> DSS Congregate Care | <input type="checkbox"/> Other |
| <input type="checkbox"/> Medicaid Managed Care | <input type="checkbox"/> Department of Veterans Affairs | |

Mental Health

- | | |
|--|--|
| Co-existing Psychiatric disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ever Treated for mental illness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ever Hospitalized for mental illness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ever Hospitalized 30 or more days for mental illness | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Gambling & Nicotine Goal Achievements

- | Gambling | Nicotine |
|--|--|
| <input type="checkbox"/> Achieved | <input type="checkbox"/> Achieved |
| <input type="checkbox"/> Partial Achievement | <input type="checkbox"/> Partial Achievement |
| <input type="checkbox"/> Not Achieved | <input type="checkbox"/> Not Achieved |
| <input type="checkbox"/> Not Applicable | <input type="checkbox"/> Not Applicable |

Total Treatment Visits – For use only by Outpatient Programs (Excluding Opioid Treatment Programs)

Total Treatment Visits _____ Family Counseling Sessions _____
 Individual Counseling Sessions _____
 Group Counseling Sessions _____

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Recent History:

Number of Criminal Arrests in Prior 30 Days ____ (or during treatment if stay was less than 30 days)

Six Months Prior to Discharge (or during treatment if stay was less than 6 months)

Number of Criminal Arrests ____ Days Incarcerated ____

Days Hospitalized ____ Days in Inpatient Detox ____

Number of ER Episodes ____

Status of Alcohol and Other Drug Use at Discharge

Status of Problem Substances Reported at Admission			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
	Substance*	Frequency of Use at Discharge	
Primary			
Secondary			
Tertiary			

*Note: Substance(s) reported at admission will be pre-filled on the Client Data System
**If treatment cycle is less than 30 days, this should be used. Please refer to PAS-45N Instructions.

Status of Different Problem Substances Used and Not Reported at Admission (if any)

First Problem 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 | |

Route of Administration Inhalation Injection Oral Smoking Vaping Other
Frequency of Use No use last 30 days 1-3 times last 30 days 1-2 times per week 3-6 times per week Daily

Second Problem 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 | |

Route of Administration Inhalation Injection Oral Smoking Vaping Other
Frequency of Use No use last 30 days 1-3 times last 30 days 1-2 times per week 3-6 times per week Daily

Third Problem 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"/> Othe |
| <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 | |

Route of Administration Inhalation Injection Oral Smoking Vaping Other
Frequency of Use No use last 30 days 1-3 times last 30 days 1-2 times per week 3-6 times per week Daily

Nicotine

Frequency of Use in Past 30 Days (if stay is less than 30 days report use since admission or since last OTAU (for Opioid treatment programs):
 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** ____ (not entered if stay is less than 30 days)

Primary Route of Administration: Smoking Vaping Chewing

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Physical Health-Related Conditions

- | | | |
|--|--|---|
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Treated for Asthma during this treatment episode | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Treated for Hypertension during this treatment episode | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Treated for Diabetes during this treatment episode | <input type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Tested for HIV during this treatment episode | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <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 |
| Tested for Hepatitis B during this treatment episode | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <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 |
| Tested for Hepatitis C during this treatment episode | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <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 |
| Treated for Latent TB during this treatment episode | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Discharge Reason & Referral Information

Discharge Status

- Completed Treatment: All Goals Met
- Completed Treatment: Half or More Goals Met
- Treatment Not Completed: Maximum Benefit/Clinical Discharge
- Treatment Not Completed: Some Goals Met
- Treatment Not Completed: No Goals Met

Discharge Disposition (CHECK ONE)

- Additional treatment at this level of care no longer necessary
- Further treatment at this level unlikely to yield added clinical gains
- Left against clinical advice: Formal referral made/offered
- Left against clinical advice: Lost to contact (no referral possible)
- Left against clinical advice: Termination of third-party funds
- Discharged due to non-compliance: program rules
- Discharged due to non-compliance: violence
- Discharged due to non-compliance: illegal substance use
- Discharged due to non-compliance: possession of contraband
- Client arrested/incarcerated
- Client could no longer participate for medical/psych. reasons
- Client death
- Client relocated
- Program closed

Referral Disposition (CHECK ONE)

- No referral made
- Client not in need of additional services
- Referred back to SUD* program
- Referred to other SUD* program
- Referred to Mental Health Program
- Referred to non-SUD* or non-MH treatment
- Referred to Gambling Program
- Refused referral

*SUD-Substance Use Dependence

Is the client currently attending substance use self-help group meetings (last 30 days)?

- Yes No

Referral Category (CHECK ONE)

Substance Use Disorder (SUD) Programs

- SUD Program in New York State
- SUD Program Out of State
- SUD VA Program
- SUD Private Practitioner

Health Institutions

- Hospital
- Hospital and Continuing Care
- Hospital (Long Term)/ Nursing Home
- Hospital (Long Term)/ Nursing Home and Continuing Care
- Nursing Home, Long Term Care
- Nursing Home, Long Term Care and Continuing Care
- Group Home, Foster Care
- Group Home, Foster Care and Continuing Care

Mental Health Programs

- Mental Health Community Residence
- Mental Health Community Residence and Continuing Care
- Mental Health Inpatient
- Mental Health Inpatient and Continuing Care
- Mental Health Outpatient
- Mental Health Outpatient and Continuing Care
- Intellectual/Developmental Disabilities Program
- Intellectual/Developmental Disabilities Program and Continuing Care

Recovery Support Services

- Recovery Community and Outreach Center
- Youth Clubhouse
- Peer Advocate
- Open Access Center
- Family Support Navigator
- Regional Addiction Resource Center

- Other Referral
- Other Referral and Continuing Care

- No Referral Made
- Refused Referral
- Continuing Care Only

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Evaluation of Client's Goal Achievement

- Drug Use**
- Achieved
 - Partial Achievement
 - Not Achieved
 - Not Applicable

- Alcohol Use**
- Achieved
 - Partial Achievement
 - Not Achieved
 - Not Applicable

- Medical Conditions**
- Achieved
 - Partial Achievement
 - Not Achieved
 - Not Applicable

- Social Functioning**
- Achieved
 - Partial Achievement
 - Not Achieved
 - Not Applicable

- Vocational/Educational**
- Achieved
 - Partial Achievement
 - Not Achieved
 - Not Applicable

- Legal**
- Achieved
 - Partial Achievement
 - Not Achieved
 - Not Applicable

- Family Situation**
- Achieved
 - Partial Achievement
 - Not Achieved
 - Not Applicable

- Emotional Functioning**
- Achieved
 - Partial Achievement
 - Not Achieved
 - Not Applicable

Medication for Addiction Treatment (MAT):

Was MAT offered by this program during this treatment episode?

- Yes
- No

Was MAT prescribed by this program during this treatment episode? (Skip this question if No was entered for Was MAT offered by this program during this treatment episode?)

- Yes
- No
- Declined

Addiction Medications Used During Treatment

CHECK ALL THAT APPLY. Select "NONE" if no addiction medications were 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

Trauma

- | | | | | |
|--|------------------------------|-----------------------------|----------------------------------|--|
| Client ever experience/witness trauma that impacts current life experience? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Refused to Answer |
| Client treated for trauma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Client ever a victim of Domestic Violence/Intimate Partner Violence? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Refused to Answer |
| Client treated for Domestic Violence/Intimate Partner Violence? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Client ever a perpetrator of Domestic Violence/Intimate Partner Violence? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Refused to Answer |
| Client treated for perpetrating Domestic Violence/Intimate Partner Violence? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |

Orientation to Change (For use only by Residential Rehabilitation 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 discharge?

- Ambivalent
- Change Oriented
- Planning Change
- Active Early Recovery
- Ongoing Recovery and Recurrence Prevention

For Provider Use (Optional)

Signature _____ Title _____ Date _____