

CSAT GPRA Client Outcome Measures for Discretionary Programs

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A. RECORD MANAGEMENT

Client ID |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Client Type:
 Treatment client
 Client in recovery

Contract/Grant ID |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Interview Type *[CIRCLE ONLY ONE TYPE.]*

Intake [GO TO INTERVIEW DATE]

6 month follow-up → → → Did you conduct a follow-up interview? Yes No
[IF NO, GO DIRECTLY TO SECTION I.]

3 month follow-up *[ADOLESCENT PORTFOLIO ONLY]* →
Did you conduct a follow-up interview? Yes No *[IF NO, GO DIRECTLY TO SECTION I.]*

Discharge → → → Did you conduct a discharge interview? Yes No
[IF NO, GO DIRECTLY TO SECTION J.]

Interview Date |_|_|_|_| / |_|_|_|_| / |_|_|_|_|_|_|_|_|_|
 Month Day Year

FOR SBIRT GRANTS ONLY: REPORTED ONLY AT INTAKE/BASELINE

How did the client screen? Negative Positive

What was his/her screening score? AUDIT = |_|_|_|_|
 CAGE = |_|_|_|_|
 DAST = |_|_|_|_|
 DAST-10 = |_|_|_|_|
 NIAAA Guide = |_|_|_|_|
 Other (Specify) _____ = |_|_|_|_|

Was he/she willing to continue his/her participation in the SBIRT program? Yes No

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

A. RECORD MANAGEMENT (Continued)

PLANNED SERVICES [REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT INTAKE/BASELINE]

Identify the services you plan to provide to the client during the client's course of treatment/recovery. [CIRCLE 'Y' FOR YES OR 'N' FOR NO FOR EACH ONE.]

Modality	Yes	No
[SELECT AT LEAST ONE MODALITY.]		
1. Case Management	Y	N
2. Day Treatment	Y	N
3. Inpatient/Hospital (Other Than Detox)	Y	N
4. Outpatient	Y	N
5. Outreach	Y	N
6. Intensive Outpatient	Y	N
7. Methadone	Y	N
8. Residential/Rehabilitation	Y	N
9. Detoxification (Select Only One)		
A. Hospital Inpatient	Y	N
B. Free Standing Residential	Y	N
C. Ambulatory Detoxification	Y	N
10. After Care	Y	N
11. Recovery Support	Y	N
12. Other (Specify) _____	Y	N

Treatment Services	Yes	No
[SBIRT GRANTS: YOU MUST CIRCLE 'Y' FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]		
1. Screening	Y	N
2. Brief Intervention	Y	N
3. Brief Treatment	Y	N
4. Referral to Treatment	Y	N
5. Assessment	Y	N
6. Treatment/Recovery Planning	Y	N
7. Individual Counseling	Y	N
8. Group Counseling	Y	N
9. Family/Marriage Counseling	Y	N
10. Co-Occurring Treatment/Recovery Services	Y	N
11. Pharmacological Interventions	Y	N
12. HIV/AIDS Counseling	Y	N
13. Other Clinical Services (Specify) _____	Y	N

Case Management Services	Yes	No
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	Y	N
2. Child Care	Y	N
3. Employment Service		
A. Pre-Employment	Y	N
B. Employment Coaching	Y	N
4. Individual Services Coordination	Y	N
5. Transportation	Y	N
6. HIV/AIDS Service	Y	N
7. Supportive Transitional Drug-Free Housing Services	Y	N
8. Other Case Management Services (Specify) _____	Y	N

Medical Services	Yes	No
1. Medical Care	Y	N
2. Alcohol/Drug Testing	Y	N
3. HIV/AIDS Medical Support & Testing	Y	N
4. Other Medical Services (Specify) _____	Y	N

After Care Services	Yes	No
1. Continuing Care	Y	N
2. Relapse Prevention	Y	N
3. Recovery Coaching	Y	N
4. Self-Help and Support Groups	Y	N
5. Spiritual Support	Y	N
6. Other After Care Services (Specify) _____	Y	N

Education Services	Yes	No
1. Substance Abuse Education	Y	N
2. HIV/AIDS Education	Y	N
3. Other Education Services (Specify) _____	Y	N

Peer-To-Peer Recovery Support Services	Yes	No
1. Peer Coaching or Mentoring	Y	N
2. Housing Support	Y	N
3. Alcohol- and Drug-Free Social Activities	Y	N
4. Information and Referral	Y	N
5. Other Peer-to-Peer Recovery Support Services (Specify) _____	Y	N

A. RECORD MANAGEMENT - DEMOGRAPHICS [ASKED ONLY AT INTAKE/BASELINE]

1. What is your gender?

- MALE
- FEMALE
- TRANSGENDER
- OTHER (SPECIFY) _____
- REFUSED

2. Are you Hispanic or Latino?

- YES
- NO
- REFUSED

[IF YES] What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Central American	Y	N	Refused
Cuban	Y	N	Refused
Dominican	Y	N	Refused
Mexican	Y	N	Refused
Puerto Rican	Y	N	Refused
South American	Y	N	Refused
Other	Y	N	Refused [IF YES, SPECIFY BELOW]
	(Specify) _____		

3. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Black or African American	Y	N	Refused
Asian	Y	N	Refused
Native Hawaiian or other Pacific Islander	Y	N	Refused
Alaska Native	Y	N	Refused
White	Y	N	Refused
American Indian	Y	N	Refused

4. What is your date of birth?*

____/____/_____
MONTH DAY

YEAR

- REFUSED

***THE SYSTEM WILL ONLY SAVE MONTH AND YEAR. DAY IS NOT SAVED TO MAINTAIN CONFIDENTIALITY.**

B. DRUG AND ALCOHOL USE

		Number of Days	REFUSED	DON'T KNOW
1.	During the past 30 days how many days have you used the following:			
a.	Any alcohol <i>[IF ZERO, SKIP TO ITEM B1c.]</i>	_ _ _	○	○
b1.	Alcohol to intoxication (5+ drinks in one sitting)	_ _ _	○	○
b2.	Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	_ _ _	○	○
c.	Illegal drugs	_ _ _	○	○
d.	Both alcohol and drugs (on the same day)	_ _ _	○	○

Route of Administration Types:

1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
 *NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

		Number of Days	RF	DK	Route*	RF	DK
2.	During the past 30 days, how many days have you used any of the following:						
a.	Cocaine/Crack	_ _ _	○	○	_ _	○	○
b.	Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)	_ _ _	○	○	_ _	○	○
c.	Opiates:						
1.	Heroin (Smack, H, Junk, Skag)	_ _ _	○	○	_ _	○	○
2.	Morphine	_ _ _	○	○	_ _	○	○
3.	Dilaudid	_ _ _	○	○	_ _	○	○
4.	Demerol	_ _ _	○	○	_ _	○	○
5.	Percocet	_ _ _	○	○	_ _	○	○
6.	Darvon	_ _ _	○	○	_ _	○	○
7.	Codeine	_ _ _	○	○	_ _	○	○
8.	Tylenol 2,3,4	_ _ _	○	○	_ _	○	○
9.	Oxycontin/Oxycodone	_ _ _	○	○	_ _	○	○
d.	Non-prescription methadone	_ _ _	○	○	_ _	○	○
e.	Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel) MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms or Mescaline	_ _ _	○	○	_ _	○	○
f.	Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)	_ _ _	○	○	_ _	○	○

B. DRUG AND ALCOHOL USE (Continued)

Route of Administration Types:

1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV

*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following:		Number of Days	RF	DK	Route*	RF	DK
g.	1. Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estazolam (Prosom and Rohypnol—also known as roofies, roche, and cope)	____ ____	<input type="radio"/>	<input type="radio"/>	____	<input type="radio"/>	<input type="radio"/>
	2. Barbiturates: Mephobarbital (Mebacut); and pentobarbital sodium (Nembutal)	____ ____	<input type="radio"/>	<input type="radio"/>	____	<input type="radio"/>	<input type="radio"/>
	3. Non-prescription GHB (known as Grievous Bodily Harm; Liquid Ecstasy; and Georgia Home Boy)	____ ____	<input type="radio"/>	<input type="radio"/>	____	<input type="radio"/>	<input type="radio"/>
	4. Ketamine (known as Special K or Vitamin K)	____ ____	<input type="radio"/>	<input type="radio"/>	____	<input type="radio"/>	<input type="radio"/>
	5. Other tranquilizers, downers, sedatives or hypnotics	____ ____	<input type="radio"/>	<input type="radio"/>	____	<input type="radio"/>	<input type="radio"/>
h.	Inhalants (poppers, snappers, rush, whippets)	____ ____	<input type="radio"/>	<input type="radio"/>	____	<input type="radio"/>	<input type="radio"/>
i.	Other illegal drugs (Specify) _____	____ ____	<input type="radio"/>	<input type="radio"/>	____	<input type="radio"/>	<input type="radio"/>

3. In the past 30 days have you injected drugs?

- YES
- NO
- REFUSED
- DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW GO TO SECTION C.]

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton or water that someone else used?

- Always
- More than half the time
- Half the time
- Less than half the time
- Never
- REFUSED
- DON'T KNOW

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time? [DO NOT READ RESPONSE OPTIONS TO CLIENT.]

- SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)
- STREET/OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)
- INSTITUTION (HOSPITAL, NURSING HOME, JAIL/PRISON)
- HOUSED:
 - OWN/RENT APARTMENT, ROOM, OR HOUSE
 - SOMEONE ELSE'S APARTMENT, ROOM OR HOUSE
 - HALFWAY HOUSE
 - RESIDENTIAL TREATMENT
 - OTHER HOUSED (SPECIFY) _____
- REFUSED
- DON'T KNOW

2. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?

- Not at all
- Somewhat
- Considerably
- Extremely
- NOT APPLICABLE
- REFUSED
- DON'T KNOW

3. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?

- Not at all
- Somewhat
- Considerably
- Extremely
- NOT APPLICABLE
- REFUSED
- DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (Continued)

4. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems?

- Not at all
- Somewhat
- Considerably
- Extremely
- NOT APPLICABLE
- REFUSED
- DON'T KNOW

5. [IF NOT MALE,] Are you currently pregnant?

- YES
- NO
- REFUSED
- DON'T KNOW

6. Do you have children?

- YES
- NO
- REFUSED
- DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW GO TO SECTION D.]

a. How many children do you have?

____|____| REFUSED DON'T KNOW

b. Are any of your children living with someone else due to a child protection court order?

- YES
- NO
- REFUSED
- DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW GO TO SECTION D.]

c. [IF YES,] How many of your children are living with someone else due to a child protection court order?

____|____| REFUSED DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (Continued)

d. For how many of your children have you lost parental rights? *[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.]*

____|____| REFUSED DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? *[IF ENROLLED,]* Is that full time or part time?

- NOT ENROLLED
- ENROLLED, FULL TIME
- ENROLLED, PART TIME
- OTHER (SPECIFY) _____
- REFUSED
- DON'T KNOW

2. What is the highest level of education you have finished, whether or not you received a degree?

- NEVER ATTENDED
- 1ST GRADE
- 2ND GRADE
- 3RD GRADE
- 4TH GRADE
- 5TH GRADE
- 6TH GRADE
- 7TH GRADE
- 8TH GRADE
- 9TH GRADE
- 10TH GRADE
- 11TH GRADE
- 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
- COLLEGE OR UNIVERSITY/1ST YEAR COMPLETED
- COLLEGE OR UNIVERSITY/2ND YEAR COMPLETED/ASSOCIATES DEGREE (AA, AS)
- COLLEGE OR UNIVERSITY/3RD YEAR COMPLETED
- BACHELOR'S DEGREE (BA, BS) OR HIGHER
- VOC/TECH PROGRAM AFTER HIGH SCHOOL BUT NO VOC/TECH DIPLOMA
- VOC/TECH DIPLOMA AFTER HIGH SCHOOL
- REFUSED
- DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME (Continued)

3. Are you currently employed? [CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.]

- EMPLOYED FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
- EMPLOYED PART TIME
- UNEMPLOYED, LOOKING FOR WORK
- UNEMPLOYED, DISABLED
- UNEMPLOYED, VOLUNTEER WORK
- UNEMPLOYED, RETIRED
- UNEMPLOYED, NOT LOOKING FOR WORK
- OTHER (SPECIFY) _____
- REFUSED
- DON'T KNOW

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from...

		RF	DK
a. Wages	\$ __ __ , __ __	<input type="radio"/>	<input type="radio"/>
b. Public assistance	\$ __ __ , __ __	<input type="radio"/>	<input type="radio"/>
c. Retirement	\$ __ __ , __ __	<input type="radio"/>	<input type="radio"/>
d. Disability	\$ __ __ , __ __	<input type="radio"/>	<input type="radio"/>
e. Non-legal income	\$ __ __ , __ __	<input type="radio"/>	<input type="radio"/>
f. Family and/or friends	\$ __ __ , __ __	<input type="radio"/>	<input type="radio"/>
g. Other (Specify)	\$ __ __ , __ __	<input type="radio"/>	<input type="radio"/>

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested?

|__|__| TIMES REFUSED DON'T KNOW

[IF NO ARRESTS, GO TO ITEM E3.]

2. In the past 30 days, how many times have you been arrested for drug-related offenses?

|__|__| TIMES REFUSED DON'T KNOW

3. In the past 30 days, how many nights have you spent in jail/prison?

|__|__| NIGHTS REFUSED DON'T KNOW

E. CRIME AND CRIMINAL JUSTICE STATUS (Continued)

4. In the past 30 days, how many times have you committed a crime? [CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c ON PAGE 4. ANSWER HERE IN E4 MUST BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]

|_|_|_| TIMES REFUSED DON'T KNOW

5. Are you currently awaiting charges, trial, or sentencing?

- YES
- NO
- REFUSED
- DON'T KNOW

6. Are you currently on parole or probation?

- YES
- NO
- REFUSED
- DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your overall health right now?

- Excellent
- Very good
- Good
- Fair
- Poor
- REFUSED
- DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Cont.)

2. During the past 30 days, did you receive:

a. Inpatient Treatment for:

	<i>[IF YES]</i>				
	Altogether				
	YES	for how many nights	NO	RF	DK
i. Physical complaint	<input type="radio"/>	_____ nights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ii. Mental or emotional difficulties	<input type="radio"/>	_____ nights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
iii. Alcohol or substance abuse	<input type="radio"/>	_____ nights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

b. Outpatient Treatment for:

	<i>[IF YES]</i>				
	Altogether				
	YES	for how many times	NO	RF	DK
i. Physical complaint	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ii. Mental or emotional difficulties	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
iii. Alcohol or substance abuse	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

c. Emergency Room Treatment for:

	<i>[IF YES]</i>				
	Altogether				
	YES	for how many times	NO	RF	DK
i. Physical complaint	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ii. Mental or emotional difficulties	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
iii. Alcohol or substance abuse	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Cont.)

3. During the past 30 days, did you engage in sexual activity?

- Yes
- No → **[GO TO F4.]**
- NOT PERMITTED TO ASK → **[GO TO F4.]**
- REFUSED → **[GO TO F4.]**
- DON'T KNOW → **[GO TO F4.]**

[IF YES] Altogether, how many:

	Contacts	RF	DK
a. Sexual contacts (vaginal, oral, or anal) did you have?	_ _ _ _	<input type="radio"/>	<input type="radio"/>
b. Unprotected sexual contacts did you have? [IF ZERO, GO TO F4.]	_ _ _ _	<input type="radio"/>	<input type="radio"/>
c. Unprotected sexual contacts were with an individual who is or was:			
1. HIV positive or has AIDS	_ _ _ _	<input type="radio"/>	<input type="radio"/>
2. An injection drug user	_ _ _ _	<input type="radio"/>	<input type="radio"/>
3. High on some substance	_ _ _ _	<input type="radio"/>	<input type="radio"/>

4. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

	Days	RF	DK
a. Experienced serious depression	_ _ _	<input type="radio"/>	<input type="radio"/>
b. Experienced serious anxiety or tension	_ _ _	<input type="radio"/>	<input type="radio"/>
c. Experienced hallucinations	_ _ _	<input type="radio"/>	<input type="radio"/>
d. Experienced trouble understanding, concentrating, or remembering	_ _ _	<input type="radio"/>	<input type="radio"/>
e. Experienced trouble controlling violent behavior	_ _ _	<input type="radio"/>	<input type="radio"/>
f. Attempted suicide	_ _ _	<input type="radio"/>	<input type="radio"/>
g. Been prescribed medication for psychological/emotional problem	_ _ _	<input type="radio"/>	<input type="radio"/>

[IF CLIENT REPORTS ZERO DAYS TO ALL ITEMS IN QUESTION 4, SKIP TO SECTION G.]

5. How much have you been bothered by these psychological or emotional problems in the past 30 days?

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely
- REFUSED
- DON'T KNOW

G. SOCIAL CONNECTEDNESS

1. **In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization that is devoted to helping individuals who have addiction related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.**

- YES **[IF YES] SPECIFY HOW MANY TIMES _____** REFUSED DON'T KNOW
- NO
- REFUSED
- DON'T KNOW

2. **In the past 30 days, did you attend any religious/faith affiliated recovery self-help groups?**

- YES **[IF YES] SPECIFY HOW MANY TIMES _____** REFUSED DON'T KNOW
- NO
- REFUSED
- DON'T KNOW

3. **In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?**

- YES **[IF YES] SPECIFY HOW MANY TIMES _____** REFUSED DON'T KNOW
- NO
- REFUSED
- DON'T KNOW

4. **In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?**

- YES
- NO
- REFUSED
- DON'T KNOW

5. **To whom do you turn when you are having trouble? [SELECT ONLY ONE.]**

- NO ONE
- CLERGY MEMBER
- FAMILY MEMBER
- FRIENDS
- REFUSED
- DON'T KNOW
- OTHER SPECIFY: _____

[IF THIS IS AN INTAKE/BASELINE INTERVIEW, STOP NOW, THE INTERVIEW IS COMPLETE. REMEMBER TO FILL IN PLANNED SERVICES ON PAGE 2.]

I. FOLLOW-UP STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP]

1. What is the follow-up status of the client? *[THIS IS A REQUIRED FIELD: NA, REFUSED, DON'T KNOW, AND MISSING WILL NOT BE ACCEPTED].*

- 01 = Deceased at time of due date
- 11 = Completed interview within specified window
- 12 = Completed interview outside specified window
- 21 = Located, but refused, unspecified
- 22 = Located, but unable to gain institutional access
- 23 = Located, but otherwise unable to gain access
- 24 = Located, but withdrawn from project
- 31 = Unable to locate, moved
- 32 = Unable to locate, other (SPECIFY) _____

2. Is the client still receiving services from your program?

- Yes
- No

[IF THIS IS A FOLLOW-UP INTERVIEW STOP NOW, THE INTERVIEW IS COMPLETE.]

J. DISCHARGE STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE]

1. On what date was the client discharged?

|_|_|_| / |_|_|_| / |_|_|_|_|_|_|
MONTH DAY YEAR

2. What is the client's discharge status?

- 01 = Completion/Graduate
- 02 = Termination

If the client was terminated, what was the reason for termination? [SELECT ONE RESPONSE.]

- 01 = Left on own against staff advice with satisfactory progress
- 02 = Left on own against staff advice without satisfactory progress
- 03 = Involuntarily discharged due to nonparticipation
- 04 = Involuntarily discharged due to violation of rules
- 05 = Referred to another program or other services with satisfactory progress
- 06 = Referred to another program or other services with unsatisfactory progress
- 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
- 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
- 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
- 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
- 11 = Transferred to another facility for health reasons
- 12 = Death
- 13 = Other (Specify) _____

K. SERVICES RECEIVED

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE]

Identify the number of **DAYS** of services provided to the client during the client's course of treatment/recovery. **[ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]**

Modality	Days
1. Case Management	____
2. Day Treatment	____
3. Inpatient/Hospital (Other Than Detox)	____
4. Outpatient	____
5. Outreach	____
6. Intensive Outpatient	____
7. Methadone	____
8. Residential/Rehabilitation	____
9. Detoxification (Select Only One)	
A. Hospital Inpatient	____
B. Free Standing Residential	____
C. Ambulatory Detoxification	____
10. After Care	____
11. Recovery Support	____
12. Other (Specify) _____	____

Identify the number of **SESSIONS** provided to the client during the client's course of treatment/recovery. **[ENTER ZERO IF NO SERVICES PROVIDED.]**

Treatment Services	Sessions
[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]	
1. Screening	____
2. Brief Intervention	____
3. Brief Treatment	____
4. Referral to Treatment	____
5. Assessment	____
6. Treatment/Recovery Planning	____
7. Individual Counseling	____
8. Group Counseling	____
9. Family/Marriage Counseling	____
10. Co-Occurring Treatment/Recovery Services	____
11. Pharmacological Interventions	____
12. HIV/AIDS Counseling	____
13. Other Clinical Services (Specify) _____	____

Case Management Services	Sessions
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	____
2. Child Care	____
3. Employment Service	
A. Pre-Employment	____
B. Employment Coaching	____
4. Individual Services Coordination	____
5. Transportation	____
6. HIV/AIDS Service	____
7. Supportive Transitional Drug-Free Housing Services	____
8. Other Case Management Services (Specify) _____	____

Medical Services	Sessions
1. Medical Care	____
2. Alcohol/Drug Testing	____
3. HIV/ AIDS Medical Support & Testing	____
4. Other Medical Services (Specify) _____	____

After Care Services	Sessions
1. Continuing Care	____
2. Relapse Prevention	____
3. Recovery Coaching	____
4. Self-Help and Support Groups	____
5. Spiritual Support	____
6. Other After Care Services (Specify) _____	____

Education Services	Sessions
1. Substance Abuse Education	____
2. HIV/AIDS Education	____
3. Other Education Services (Specify) _____	____

Peer-To-Peer Recovery Support Services	Sessions
1. Peer Coaching or Mentoring	____
2. Housing Support	____
3. Alcohol- and Drug-Free Social Activities	____
4. Information and Referral	____
5. Other Peer-to-Peer Recovery Support Services (Specify) _____	____