Print Form

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health
1901 North DuPont Highway, New Castle, Delaware 19720

DELAWARE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH CONSUMER REPORTING FORM
DISCHARGE REPORT

M ODALITY (SELECT ONLY ONE)

[ ] **MH** MENTAL HEALTH
[ ] **AD** ALCOHOL /DRUG
[ ] **DU** CO - OCCURRING (MH & AD)
[ ] **GA** GAMBLING

LAST NAME _____

FIRST NAME _____ M.I. ____

STREET *(Optional)* _____

CITY _____ STATE _____

ZIP [ ][ ][ ][ ][ ] - [ ][ ][ ][ ]

COUNTY [ ]

HOME TELEPHONE *(Optional)* ([ ][ ][ ]) [ ][ ][ ] - [ ][ ][ ][ ]

TREATMENT UNIT NAME _____

TREATMENT UNIT ID # [ ][ ][ ][ ][ ][ ] - [ ][ ]

DSAMH ADMISSION DATE

[ ][ ] / [ ][ ] / [ ][ ]

MCI # 0 0 0 [ ][ ][ ][ ][ ][ ][ ]

MARITAL STATUS

[ ] **M** MARRIED
[ ] **S** SINGLE
[ ] **D** DIVORCED
[ ] **X** SEPARATED
[ ] **W** WIDOWED
[ ] **U** UNKNOWN

RESIDENTIAL ARRANGEMENT

[ ] **PU** PRIVATE RESIDENCE - UNSUPERVISED
[ ] **PS** PRIVATE RESIDENCE - SUPERVISED
[ ] **FC** ADULT FOSTER CARE
[ ] **BH** BOARDING HOUSE
[ ] **GU** GROUP SETTING/ UNSUPERVISED
[ ] **GS** GROUP SETTING/ SUPERVISED
[ ] **NH** NURSING HOME/ ICF/SNF
[ ] **CJ** CORRECTIONS FACILITY/JAIL
[ ] **I** OTHER INSTITUTION
[ ] **O** OTHER
[ ] **N** NONE/HOMELESS
[ ] **U** UNKNOWN

PRIMARY HEALTH INSURANCE

[ ] **M** MEDICARE
[ ] **A** MEDICAID
[ ] **E** MEDICAID MCO
[ ] **C** CHAMPUS
[ ] **B** BLUE CROSS/ BLUE SHIELD
[ ] **V** VA
[ ] **H** HMO
[ ] **G** OTHER GOVERNMENT FUNDS FOR CARE
[ ] **P** OTHER PRIVATE COMMERCIAL
[ ] **O** OTHER
[ ] **N** NONE
[ ] **U** UNKNOWN

EDUCATION
WRITE IN HIGHEST GRADE COMPLETED

[ ][ ]

01-12 ELEMENTARY/ HIGH SCHOOL

13-16 COLLEGE/ POST SECONDARY

17 MASTERS

18 PHD/MD

19 POST DOCTORAL

96 NEVER COMPLETED ANY GRADE HIGHER THAN PRE-SCHOOL OR KINDERGARTEN

97 UNKNOWN

VETERAN STATUS

[ ] **VP** VETERAN/PREVIOUS MILITARY SERVICE (See Instructions)

[ ] **AD** ACTIVE DUTY

[ ] **FM** IMMEDIATE FAMILY MEMBER of MILITARY or VETERAN (See Instructions)

[ ] **NA** NONE OF THE ABOVE

[ ] **U** UNKNOWN

HOMELESS AT ANY TIME DURING PAST 30 DAYS?

[ ] **Y** YES
[ ] **N** NO
[ ] **U** UNKNOWN

PRIMARY EMPLOYMENT (DURING PAST 30 DAYS)

[ ] **F** FULL TIME
[ ] **P** PART TIME
[ ] **E** SHELTERED NON-COMPET (**MH ONLY**)
[ ] **M** MILITARY ARMED FORCES
[ ] **L** UNEMPLOYED - LOOKING FOR WORK
[ ] **N** UNEMPLOYED - NOT LOOKING
[ ] **D** DISABLED/UNABLE TO WORK
[ ] **H** HOMEMAKER
[ ] **S** STUDENT
[ ] **R** RETIRED
[ ] **I** INMATE/RESIDENT OF INSTITUTION
[ ] **V** VOLUNTEER
[ ] **O** OTHER
[ ] **U** UNKNOWN

CURRENT LEGAL INVOLVEMENT

[ ] **CP** CHARGES PENDING
[ ] **SP** CONVICTED - SENTENCE PENDING
[ ] **UP** SENTENCED - UNSUPERVISED PROBATION (SENTAC I)
[ ] **FS** SENTENCED - FIELD SUPERVISION (SENTAC II)
[ ] **IS** SENTENCED - INTENSE SUPERVISION (SENTAC III)
[ ] **QI** SENTENCED - QUASI-INCARCERATION (SENTAC IV)
[ ] **CJ** SENTENCED - PRISON/CORRECTIONS/JAIL (SENTAC V)
[ ] **HX** HISTORY OF LEGAL INVOLVEMENT BUT NOT CURRENT
[ ] **N** NO CURRENT INVOLVEMENT OR HISTORY
[ ] **U** UNKNOWN

NUMBER OF ARRESTS 30 DAYS PRIOR TO DISCHARGE

[ ][ ]

CONSUMER'S PRIMARY SOURCE OF INCOME

[ ] **S** SOCIAL SECURITY
[ ] **SI** SSI
[ ] **SD** SSDI
[ ] **VD** VA - DISABILITY
[ ] **VR** VA - RETIREMENT
[ ] **U I** UNEMPLOYMENT INSURANCE
[ ] **I L** ILLEGAL
[ ] **E** EMPLOYMENT
[ ] **S** SPOUSE
[ ] **F** FAMILY/FRIENDS
[ ] **A** TANF
[ ] **G** GENERAL ASSISTANCE
[ ] **P** PENSION/RETIREMENT (IRA, KEOGH, SEP)
[ ] **W** WORKERS' COMPENSATION
[ ] **D** PRIVATE DISABILITY INSURANCE
[ ] **I** INVESTMENTS/SAVINGS
[ ] **O** OTHER
[ ] **N** NONE
[ ] **U** UNKNOWN

CONSUMER'S GROSS INCOME PER YEAR

$ [ ][ ] , [ ][ ][ ]

NUMBER DEPENDENT ON CONSUMER'S INCOME

WRITE IN NUMBER (01 - 20)

[ ][ ] 97 UNKNOWN

SUBSTANCE ABUSE CODES ONLY

CODE [ ][ ][ ] . [ ][ ][ ]

CODE [ ][ ][ ] . [ ][ ][ ]

CODE [ ][ ][ ] . [ ][ ] / [ ]

SEE MANUAL

DSAMH CONSUMER REPORTING FORM - DISCHARGE REPORT

DATE OF LAST SERVICE ___ / ___ / ___

DISCHARGE DATE ___ / ___ / ___

TREATMENT UNIT ID # ___ - ___

MCI # 0 0 0 ___

CURRENTLY PREGNANT

[ ] **Y** YES
[ ] **N** NO
[ ] **U** UNKNOWN

INJECTION DRUG USE EVER

[ ] **Y** YES
[ ] **N** NO
[ ] **U** UNKNOWN

ALERT INFORMATION
S - SELF REPORT; C - CLINICIAN REPORT
MARK ALL THAT APPLY

S [ ] C [ ] TB ACTIVE
S [ ] C [ ] TB HISTORY
S [ ] C [ ] HISTORY OF SUBSTANCE ABUSE
S [ ] C [ ] PREVIOUS TREATMENT FOR ALCOHOL AND/OR DRUGS
S [ ] C [ ] HISTORY OF MENTAL ILLNESS
S [ ] C [ ] PREVIOUS TREATMENT FOR MENTAL ILLNESS
S [ ] C [ ] PSYCHIATRIC DISABILITY
S [ ] C [ ] HISTORY OF PATHOLOGICAL GAMBLING
S [ ] C [ ] NONE

DISCHARGE REASON

[ ] **G** PROGRAM COMPLETED HERE - ALL GOALS
[ ] **S** PROGRAM COMPLETED HERE - SOME GOALS
[ ] **E** ELIGIBILITY LAPSED
[ ] **D** CONSUMER DIED
[ ] **F** FAILED TO MEET CRITERIA
[ ] **A** ADMIN. DISCONTINUATION/ LOST CONTACT
[ ] **C** CORRECTION/JAIL
[ ] **R** REFUSED SERVICE
[ ] **T** TX CONT. OTHER PROGRAM
[ ] **O** OTHER
[ ] **U** UNKNOWN

ALCOHOL & DRUG USE MATRIX	PRIMARY	SECONDARY	TERTIARY
SUBSTANCE TYPE			
FREQUENCY OF USE			
ROUTE OF ADMINISTRATION			
AGE OF FIRST USE			

FREQUENCY OF USE

N NO USE IN PAST MONTH
I INFREQUENT (1-3 TIMES PAST MONTH)
O OFTEN (1-2 TIMES PER WEEK)
F FREQUENTLY (3-6 TIMES PER WEEK)
D DAILY
M MORE THAN TWICE DAILY
U UNKNOWN

SUBSTANCE TYPE CODES TO USE IN BOX ABOVE

AL ALCOHOL
CO COCAINE
CR CRACK
ME METHAMPHETAMINE
AM OTHER AMPHETAMINES
OS OTHER STIMULANTS
HE HEROIN
OP OTHER OPIATES & SYNTHETICS
MD NON-PRESCRIPTION METHADONE
BA BARBITURATES
SE OTHER SEDATIVES OR HYPNOTICS
BE BENZODIAZEPINE S
TR MAJOR TRANQUILIZERS
CS COUGH SYRUPS AND MIXTURES
MA MARIJUANA/HASHISH
PC PCP
LS LSD
HA OTHER HALLUCINOGENS
IN INHALANTS
ST STEROIDS
OC OVER-THE-COUNTER DRUGS
O OTHER
N NONE
U UNKNOWN

ROUTE OF ADMINISTRATION

M BY MOUTH (SWALLOW)
S SMOKE
B BREATHE/INHALE/SNORT
V INTRAVENOUS
I OTHER INJECTION
O OTHER
N NONE
U UNKNOWN

DRUG USE REDUCED

[ ] **Y** YES
[ ] **N** NO
[ ] **U** UNKNOWN
[ ] **X** NOT APPLICABLE

PRIMARY DESTIN./AGENCY CODE

[ ] **T** TRANSFERRED
[ ] **R** REFERRED
[ ] **A** ADVISED FURTHER SERVICE
[ ] **N** NO MORE SERVICES ADVISED
[ ] **U** UNKNOWN

SECOND. DESTIN./AGENCY CODE

[ ] **T** TRANSFERRED
[ ] **R** REFERRED
[ ] **A** ADVISED FURTHER SERVICE
[ ] **N** NO MORE SERVICES ADVISED
[ ] **U** UNKNOWN

TERTIARY DESTIN./AGENCY CODE

[ ] **T** TRANSFERRED
[ ] **R** REFERRED
[ ] **A** ADVISED FURTHER SERVICE
[ ] **N** NO MORE SERVICES ADVISED
[ ] **U** UNKNOWN

SOCIAL SUPPORT/CONNECTEDNESS
(SUPPORT GROUPS - NA, AA, ETC.)

[ ] **Y** YES
[ ] **N** NO
[ ] **U** UNKNOWN

___ FREQUENCY OF ATTENDANCE AT SELF HELP PROGRAMS 30 DAYS PRIOR TO DISCHARGE

PRIMARY THERAPIST _____ **ID** ___

PERSON COMPLETING FORM _____ **ID** ___

DATE OF COMPLETION ___ / ___ / ___