# Connecticut Department of Mental Health and Addiction Services
# DDaP – ADMISSION FORM

## DEMOGRAPHICS

**NAME**: _____

**SOCIAL SECURITY NUMBER**: _____ - _____ - _____

**NO SSN GIVEN / REASON:** ☐ UNKNOWN ☐ NOT COLLECTED ☐ CLIENT REFUSED

**DATE OF BIRTH**: _____ / _____ / _____

**NO DOB GIVEN / REASON:** ☐ UNKNOWN ☐ NOT COLLECTED ☐ CLIENT REFUSED

| **RELIGION**: *(check one box only)* | | | | | |
|---|---|---|---|---|---|
| 01 | ☐ | PROTESTANT | 07 | ☐ | ORTHODOX |
| 02 | ☐ | CATHOLIC | 08 | ☐ | HINDU |
| 03 | ☐ | JEWISH | 10 | ☐ | PENTECOSTAL |
| 04 | ☐ | MUSLIM | 95 | ☐ | NONE |
| 05 | ☐ | BUDDHIST | 96 | ☐ | OTHER |
| 06 | ☐ | MORMON | 97 | ☐ | UNKNOWN |

| **MARITAL STATUS**: *(check one box below)* | | | | | |
|---|---|---|---|---|---|
| 01 | ☐ | NEVER MARRIED | 08 | ☐ | WIDOWED |
| 02 | ☐ | MARRIED | 09 | ☐ | CIVIL UNION |
| 03 | ☐ | SEPARATED | 96 | ☐ | OTHER |
| 04 | ☐ | DIVORCED/ANNULLED | 97 | ☐ | UNKNOWN |

| **ETHNIC ORIGIN**: *(check one box only)* | | | | | |
|---|---|---|---|---|---|
| 01 | ☐ | HISPANIC OTHER | 04 | ☐ | HISPANIC MEXICAN |
| 02 | ☐ | NON-HISPANIC | 05 | ☐ | HISPANIC CUBAN |
| 03 | ☐ | HISPANIC PUERTO RICAN | 97 | ☐ | UNKNOWN |

| **LANGUAGE:** *(check one Primary box, check one Secondary box, as applicable)* | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Primary** | **Secondary** | | | **Primary** | **Secondary** | |
| **16** | ☐ | ☐ | **CANTONESE** | **05** | ☐ | ☐ | **POLISH** |
| **43** | ☐ | ☐ | **ENGLISH** | **04** | ☐ | ☐ | **PORTUGUESE** |
| **03** | ☐ | ☐ | **FRENCH** | **20** | ☐ | ☐ | **RUSSIAN** |
| **07** | ☐ | ☐ | **GREEK** | **42** | ☐ | ☐ | **SIGN LANGUAGE** |
| **41** | ☐ | ☐ | **HAITIAN CREOLE** | **01** | ☐ | ☐ | **SPANISH** |
| **02** | ☐ | ☐ | **ITALIAN** | **10** | ☐ | ☐ | **VIETNAMESE** |
| **17** | ☐ | ☐ | **JAPANESE** | **96** | ☐ | ☐ | **OTHER** |
| **11** | ☐ | ☐ | **LAOTIAN** | **97** | ☐ | **UNKNOWN** | |
| **23** | ☐ | ☐ | **LATVIAN** | **44** | ☐ | **NONE** | |
| **15** | ☐ | ☐ | **MANDARIN** | | | | |

**VETERAN:** ☐ **YES** ☐ **NO** ☐ **UNKNOWN**

***MILITARY START DATE:** _____ / _____ / _____
****START DATE required if Veteran = Yes.***

**MILITARY END DATE:** _____ / _____ / _____

| **RACE:** *(check all appropriate boxes)* | | | | | |
|---|---|---|---|---|---|
| **01** | ☐ | **AMERICAN INDIAN/NATIVE ALASKAN** | **06** | ☐ | **WHITE/CAUCASIAN** |
| **02** | ☐ | **ASIAN** | **96** | ☐ | **OTHER** |
| **03** | ☐ | **BLACK/AFRICAN AMERICAN** | **97** | ☐ | **UNKNOWN** |
| **04** | ☐ | **NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER** | | | |

**GENDER:** ☐ **FEMALE** ☐ **MALE** ☐ **UNKNOWN**

**PROVIDER CLIENT ID:** _____
***(Optional field for Provider's use)***

| **ADDRESS:** | | |
|---|---|---|
| **CLIENT STREET ADDRESS 1:** | | |
| **CLIENT STREET ADDRESS 2:** | | |
| **CITY:** | **STATE:** | **ZIP CODE:** |

## INSURANCE INFORMATION

*(Select Insurance Type 1 - 4, as applicable)*

| INSURANCE TYPE(S) used by clients | | INSURANCE TYPE 1 | INSURANCE TYPE 2 | INSURANCE TYPE 3 | INSURANCE TYPE 4 |
|---|---|---|---|---|---|
| 02 | NO HEALTH INSURANCE | ☐ | | | |
| 04 | OTHER PRIVATE INSURANCE | ☐ | ☐ | ☐ | ☐ |
| 05 | MEDICARE | ☐ | ☐ | ☐ | ☐ |
| 06 | CHAMPUS (U.S. Military) | ☐ | ☐ | ☐ | ☐ |
| 08 | MEDICAID HUSKEY C* | ☐ | ☐ | ☐ | ☐ |
| 09 | HMO (including Managed Medicaid) | ☐ | ☐ | ☐ | ☐ |
| 12 | GA-SAGA (General Assistance- State Administered) | ☐ | ☐ | ☐ | ☐ |
| 14 | ATR (Access to Recovery) | ☐ | | | |
| 15 | SELF PAY | ☐ | | | |
| 16 | MEDICAID LIA HUSKEY D* | ☐ | ☐ | ☐ | ☐ |
| 17 | MEDICARE PART A | ☐ | ☐ | ☐ | ☐ |
| 18 | MEDICARE PART B | ☐ | ☐ | ☐ | ☐ |
| 19 | MONEY FOLLOWS THE PERSON (MFP) | | | | |
| 20 | NURSING HOME WAIVER | | | | |
| 21 | Medicaid BHH | ☐ | ☐ | ☐ | ☐ |
| 22 | Medicaid-Husky A | ☐ | ☐ | ☐ | ☐ |
| 96 | OTHER | ☐ | ☐ | ☐ | ☐ |
| 97 | UNKNOWN | ☐ | | | |

**Policy Number is required if INSURANCE TYPE is MEDICAID.*

***(Complete based on corresponding INSURANCE TYPE selected, except 02, 97, 14, 15)***

**INSURANCE TYPE 1**

**POLICY NUMBER : (if applicable)** _____

**INSURANCE POLICY START DATE:** _____ / _____ / _____

**INSURANCE POLICY END DATE:** _____ / _____ / _____

**INSURANCE TYPE 2**

**POLICY NUMBER : (if applicable)** _____

**INSURANCE POLICY START DATE:** _____ / _____ / _____

**INSURANCE POLICY END DATE:** _____ / _____ / _____

**INSURANCE TYPE 3**

**POLICY NUMBER : (if applicable)** _____

**INSURANCE POLICY START DATE:** _____ / _____ / _____

**INSURANCE POLICY END DATE:** _____ / _____ / _____

**INSURANCE TYPE 4**

**POLICY NUMBER : (if applicable)** _____

**INSURANCE POLICY START DATE:** _____ / _____ / _____

**INSURANCE POLICY END DATE:** _____ / _____ / _____

## ADMISSION

**ADMISSION PROGRAM:** _____

**ADMISSION DATE:** _____ / _____ / _____

**DATE OF FIRST SERVICE REQUEST:** _____ / _____ / _____

| PRIMARY REFERRAL SOURCE: (check one box below) | | | | |
|---|---|---|---|---|
| 01 | ☐ | SELF | 11 | ☐ DEPT OF SOCIAL SERVICES |
| 02 | ☐ | FAMILY/FRIEND | 12 | ☐ DEPT OF DEVELOPMENTAL DISABILITIES |
| 03 | ☐ | MENTAL HEALTH PROVIDER | 13 | ☐ OTHER COMMUNITY REFERRAL |
| 04 | ☐ | SUBSTANCE ABUSE PROVIDER | 14 | ☐ COURT ORDER |
| 05 | ☐ | MEDICAL HEALTH PRACTITIONER | 15 | ☐ PROBATION/PAROLE |
| 06 | ☐ | SCHOOL | 16 | ☐ POLICE |
| 07 | ☐ | EMPLOYER/SUPERVISOR | 17 | ☐ SHELTER |
| 08 | ☐ | EMPLOYEE ASSISTANCE PROGRAM | 18 | ☐ DEPARTMENT OF CORRECTIONS (DOC) |
| 09 | ☐ | CLERGY/CHURCH/SYNAGOGUE | 96 | ☐ OTHER |
| 10 | ☐ | DEPT OF CHILDREN AND FAMILIES | 97 | ☐ UNKNOWN |

**TOBACCO USE:** ☐ YES ☐ NO ☐ UNKNOWN

**PREGNANCY STATUS:** ☐ YES ☐ NO ☐ UNKNOWN
***(Required for Females)***

## DIAGNOSIS

**EFFECTIVE DATE OF DIAGNOSIS:** _____ / _____ / _____

***(Enter Client's clinical diagnoses below.)***

| AXIS I | *(Enter Diagnosis)* | Description |
|---|---|---|
| 1 | ___ ___ ___.___ ___ **(Primary Dx)** | |
| 2 | ___ ___ ___.___ ___ | |
| 3 | ___ ___ ___.___ ___ | |
| 4 | ___ ___ ___.___ ___ | |
| 5 | ___ ___ ___.___ ___ | |
| 6 | ___ ___ ___.___ ___ | |
| 7 | ___ ___ ___.___ ___ | |

| AXIS II | *(Enter Diagnosis)* | Description |
|---|---|---|
| 1 | ___ ___ ___.___ ___ | |
| 2 | ___ ___ ___.___ ___ | |
| 3 | ___ ___ ___.___ ___ | |
| 4 | ___ ___ ___.___ ___ | |
| 5 | ___ ___ ___.___ ___ | |

| AXIS III | *(Enter Diagnosis)* | Description |
|---|---|---|
| 1 | ___ ___ ___.___ ___ | |
| 2 | ___ ___ ___.___ ___ | |
| 3 | ___ ___ ___.___ ___ | |
| 4 | ___ ___ ___.___ ___ | |
| 5 | ___ ___ ___.___ ___ | |

| AXIS IV | *(Select Yes or No)* | | |
|---|---|---|---|
| 2 | PROBLEMS RELATED TO THE SOCIAL ENVIRONMENT | ☐ YES | ☐ NO |
| 1 | PROBLEMS WITH PRIMARY SUPPORT GROUP | ☐ YES | ☐ NO |
| 9 | OTHER PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS | ☐ YES | ☐ NO |
| 7 | PROBLEMS WITH ACCESS TO HEALTH SERVICES | ☐ YES | ☐ NO |
| 4 | OCCUPATIONAL PROBLEMS | ☐ YES | ☐ NO |
| 3 | EDUCATIONAL PROBLEMS | ☐ YES | ☐ NO |
| 6 | HOUSING PROBLEMS | ☐ YES | ☐ NO |
| 5 | ECONOMIC PROBLEMS | ☐ YES | ☐ NO |
| 8 | PROBLEMS RELATED TO THE LEGAL SYSTEM / CRIME | ☐ YES | ☐ NO |

**AXIS V – GAF SCORE**: ***(ENTER 0 – 100)*** ☐

## PERIODIC ASSESSMENT

**ASSESSMENT DATE:** _____ / _____ / _____

**EMPLOYMENT STATUS:** *(check one box only)*

| | | | | | |
|---|---|---|---|---|---|
| 30 | ☐ | EMPLOYMENT FULL TIME (in competitive employment) | 46 | ☐ | NOT IN LABOR FORCE; retired |
| 32 | ☐ | EMPLOYMENT PART TIME (in competitive employment) | 48 | ☐ | NOT IN LABOR FORCE; SSI SSDI |
| 34 | ☐ | UNEMPLOYMENT (looking for work in the past 30 days, or on a layoff) | 50 | ☐ | NOT IN LABOR FORCE; Inmate of institution |
| 36 | ☐ | PAID BUT NON-COMPETITIVE WORK (transitional employment programs) | 52 | ☐ | NOT IN LABOR FORCE; other reason |
| 38 | ☐ | PAID BUT NON-COMPETITIVE WORK (work inside the clubhouse or treatment agency, mobile work crews and consumer-run businesses) | 96 | ☐ | OTHER |
| 42 | ☐ | NOT IN LABOR FORCE; student enrolled in a school or job training program) | 97 | ☐ | UNKNOWN |
| 44 | ☐ | NOT IN LABOR FORCE; homemaker | | | |

**HIGHEST GRADE COMPLETED: Highest school grade completed by Client at the time of Assessment.** *(Enter 0 – 32)* ☐ **UNKNOWN**

**PERSONS DEPENDENT ON INCOME:** *(Enter 1 – 15)*

**MINORS DEPENDENT ON INCOME:** *(Enter 0 – 14)*

**PRINCIPAL SOURCE OF SUPPORT:** *(check one box only)*

| | | | | | |
|---|---|---|---|---|---|
| 0 | ☐ | NONE | 4 | ☐ | DISABILITY |
| 1 | ☐ | PUBLIC ASSISTANCE | 96 | ☐ | OTHER |
| 2 | ☐ | RETIREMENT | 97 | ☐ | UNKNOWN |
| 3 | ☐ | SALARY | | | |

**LIVING SITUATION:** *(check one box only)*

| | | | | | |
|---|---|---|---|---|---|
| 30 | ☐ | PRIVATE RESIDENCE, client owns or holds lease | 46 | ☐ | PSYCHIATRIC/SA/MEDICAL INPATIENT |
| 32 | ☐ | PRIVATE RESIDENCE, friend or relative owns the residence or holds lease. | 48 | ☐ | CORRECTIONAL FACILITY |
| 34 | ☐ | SINGLE ROOM OCCUPANCY (Hotel, YMCA, Rooming House) | 50 | ☐ | DOMESTIC VIOLENCE SHELTER |
| 36 | ☐ | PRIVATE RESIDENCE, Community agency owns or holds lease | 52 | ☐ | HOMELESS SHELTER |
| 38 | ☐ | RESIDENTIAL CARE HOME / BOARD AND CARE | 54 | ☐ | HOMELESS (including on street) |
| 40 | ☐ | CONGREGATE RESIDENTIAL CARE (24-hour supervision, group setting, services focus on MH, SA, &/or MR issues, Recovery House.) | 96 | ☐ | OTHER |
| 42 | ☐ | CRISIS / RESPITE BED | 97 | ☐ | UNKNOWN |
| 44 | ☐ | SKILLED NURSING FACILTY/ INTERMEDIATE CARE FACILTY/ NURSING HOME | | | |

☐ YES ☐ NO ☐ UNKNOWN

**Was Client Homeless in the Last Six Months?**

**Number of Days in the Last 30 that client lived in a Controlled Environment?** *(Enter 0 – 30)* ☐

**Number of Arrests in the Last 30 Days?** *(Enter 0 – 30)* ☐ ☐ **UNKNOWN**

**SOCIAL SUPPORT VOLUNTARY: Number of Self-Help programs/meetings attended in last 30 days** *(Enter 0 – 50)* ☐ ☐ **UNKNOWN**

**SOCIAL SUPPORT FAMILY/FRIENDS: Indicate whether or not Client interacted with Family/Friends supportive of recovery in the thirty days preceding assessment.** ☐ **YES** ☐ **NO** ☐ **UNKNOWN**

## SUBSTANCE ABUSE

***(Select client's lifetime number of prior Admissions to Inpatient/Residential Substance Abuse treatment.)***

**SA IP.RES. ADMISSIONS: LIFETIME**

| | | | | | |
|---|---|---|---|---|---|
| **0** | ☐ | **NO PRIOR ADMISSIONS** | **04** | ☐ | **4 PRIOR ADMISSIONS** |
| **01** | ☐ | **1 PRIOR ADMISSION** | **05** | ☐ | **5 PRIOR ADMISSIONS** |
| **02** | ☐ | **2 PRIOR ADMISSIONS** | **06** | ☐ | **GREATER THAN 5 PRIOR ADMISSIONS** |
| **03** | ☐ | **3 PRIOR ADMISSIONS** | | | |

***(Select client's lifetime number of prior Admissions to Outpatient Substance Abuse treatment.)***

**SA OP.RES. ADMISSIONS: LIFETIME**

| | | | | | |
|---|---|---|---|---|---|
| **0** | ☐ | **NO PRIOR ADMISSIONS** | **04** | ☐ | **4 PRIOR ADMISSIONS** |
| **01** | ☐ | **1 PRIOR ADMISSION** | **05** | ☐ | **5 PRIOR ADMISSIONS** |
| **02** | ☐ | **2 PRIOR ADMISSIONS** | **06** | ☐ | **GREATER THAN 5 PRIOR ADMISSIONS** |
| **03** | ☐ | **3 PRIOR ADMISSIONS** | | | |

## PERIODIC ASSESSMENT – SUBSTANCE USE

***(Select Drug Type 1 - 5, as applicable)***

| DRUG TYPE(S) used by clients | | DRUG TYPE 1 | DRUG TYPE 2 | DRUG TYPE 3 | DRUG TYPE 4 | DRUG TYPE 5 |
|---|---|---|---|---|---|---|
| 0 | NONE | ☐ | | | | |
| 01 | AMPHETAMINES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 02 | ALCOHOL | ☐ | ☐ | ☐ | ☐ | ☐ |
| 03 | BARBITUATES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 04 | BENZODIAZEPINES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 05 | COCAINE | ☐ | ☐ | ☐ | ☐ | ☐ |
| 06 | CRACK | ☐ | ☐ | ☐ | ☐ | ☐ |
| 07 | HALLUCINOGENS: LSD, DMS, STP, etc. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 08 | HEROIN | ☐ | ☐ | ☐ | ☐ | ☐ |
| 09 | INHALANTS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10 | MARIJUANA, HASHISH, THC | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11 | METHAMPHETAMINES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12 | NON-PRESCRIPTIVE METHADONE | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13 | OTHER OPIATES AND SYNTHETICS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14 | OTHER SEDATIVES OR HYPNOTICS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15 | OTHER STIMULANTS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16 | OVER-THE-COUNTER | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17 | PCP | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18 | TRANQUILIZERS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 96 | OTHER | ☐ | ☐ | ☐ | ☐ | ☐ |
| 97 | UNKNOWN | ☐ | | | | |

**DRUG METHOD USE FIELD 1:** ***(Complete based on corresponding DRUG TYPE 1 selected, except 0 & 97.)***

| | | | | | |
|---|---|---|---|---|---|
| 01 | ☐ | ORAL | 04 | ☐ | INJECTION |
| 02 | ☐ | SMOKING | 96 | ☐ | OTHER |
| 03 | ☐ | INHALATION | 97 | ☐ | UNKNOWN |

**DAYS USED FIELD 1:**
**Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 1 field?** ***(Enter 0 – 30)*** ☐

**AGE FIRST USED FIELD 1:**
**Age at which the client used the Drug specified in the Drug Type 1 field?** ***(Enter Age)*** ☐

**DRUG METHOD USE FIELD 2:** ***(Complete based on corresponding DRUG TYPE 2 selected, except 0 & 97.)***

| | | | | | |
|---|---|---|---|---|---|
| **01** | ☐ | **ORAL** | **04** | ☐ | **INJECTION** |
| **02** | ☐ | **SMOKING** | **96** | ☐ | **OTHER** |
| **03** | ☐ | **INHALATION** | **97** | ☐ | **UNKNOWN** |

**DAYS USED FIELD 2:**

**Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 2 field?** ***(Enter 0 – 30)*** ☐

**AGE FIRST USED FIELD 2:**

**Age at which the client used the Drug specified in the Drug Type 2 field?** ***(Enter Age)*** ☐

**DRUG METHOD USE FIELD 3:** ***(Complete based on corresponding DRUG TYPE 3 selected, except 0 & 97.)***

| | | | | | |
|---|---|---|---|---|---|
| **01** | ☐ | **ORAL** | **04** | ☐ | **INJECTION** |
| **02** | ☐ | **SMOKING** | **96** | ☐ | **OTHER** |
| **03** | ☐ | **INHALATION** | **97** | ☐ | **UNKNOWN** |

**DAYS USED FIELD 3:**

**Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 3 field?** ***(Enter 0 – 30)*** ☐

**AGE FIRST USED FIELD 3:**

**Age at which the client used the Drug specified in the Drug Type 3 field?** ***(Enter Age)*** ☐

**DRUG METHOD USE FIELD 4:** ***(Complete based on corresponding DRUG TYPE 4 selected, except 0, 97.)***

| | | | | | |
|---|---|---|---|---|---|
| **01** | ☐ | **ORAL** | **04** | ☐ | **INJECTION** |
| **02** | ☐ | **SMOKING** | **96** | ☐ | **OTHER** |
| **03** | ☐ | **INHALATION** | **97** | ☐ | **UNKNOWN** |

**DAYS USED FIELD 4:**

**Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 4 field?** ***(Enter 0 – 30)*** ☐

**AGE FIRST USED FIELD 4:**

**Age at which the client used the Drug specified in the Drug Type 4 field?** ***(Enter Age)*** ☐

**DRUG METHOD USE FIELD 5:** ***(Complete based on corresponding DRUG TYPE 5 selected, except 0 & 97.)***

| | | | | | |
|---|---|---|---|---|---|
| **01** | ☐ | **ORAL** | **04** | ☐ | **INJECTION** |
| **02** | ☐ | **SMOKING** | **96** | ☐ | **OTHER** |
| **03** | ☐ | **INHALATION** | **97** | ☐ | **UNKNOWN** |

**DAYS USED FIELD 5:**

**Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 5 field?** ***(Enter 0 – 30)*** ☐

**AGE FIRST USED FIELD 5:**

**Age at which the client used the Drug specified in the Drug Type 5 field?** ***(Enter Age)*** ☐

## CO-OCCURRING SCREENING

**CO-OCCURRING SCREENING DATE:** _____ / _____ / _____

## MENTAL HEALTH

**MH SCREENING USED:** ***(check one box only)***

| | | | | | |
|---|---|---|---|---|---|
| **01** | ☐ | **MENTAL HEALTH SCREEN FORM III*** | **02** | ☐ | **MODIFIED MINI*** |
| **08** | ☐ | **DECLINED** | **09** | ☐ | **MEDICALLY OR CLINICALLY INAPPROPRIATE** |

**MH SCREENING SCORE:** ***(*Required if MH SCREENING USED field is a value of 1 or 2.)***

**MENTAL HEALTH SCREEN FORM III SCORE:** ***(Enter 0-15)*** ☐

**MODIFIED MINI SCORE:** **(Enter 0-23)** ☐

**MH SCREEN MOD MINI # 4:** ***(Yes Response to Suicidality)*** ☐ **YES** ☐ **NO**

**MH SCREEN MOD MINI # 14 and # 15:** ***(Yes Response to 2 Trauma Questions on Modified Mini Survey)*** ☐ **YES** ☐ **NO**

**MH SCREEN Gambling Question Response:** ***(Yes Response to Form III # 16 or Modified # 23 related to gambling)*** ☐ **YES** ☐ **NO**

## SUBSTANCE ABUSE

**SA SCREENING USED:** ***(check one box only)***

| | | | | | |
|---|---|---|---|---|---|
| **01** | ☐ | **SSI ALCOHOL AND DRUGS**** | **02** | ☐ | **CAGE – Adapted to Include Drugs**** |
| **08** | ☐ | **DECLINED** | **09** | ☐ | **MEDICALLY OR CLINICALLY INAPPROPRIATE** |

**SA SCREENING SCORE:** ***(**Required if SA SCREENING USED field is a value of 1 or 2.)***

**SSI ALCOHOL AND DRUG SCREENING SCORE:** ***(Enter 0-14)*** ☐

**CAGE - Adapted to Include Drugs screening SCORE** ***(Enter 0-8)*** ☐

**PROVIDER SIGNATURE:** _____

**DATE:** _____ / _____ / _____