

DBHR Target Detox Short Form

AGENCY NUMBER

Client Identification

1. LAST NAME		2. FIRST NAME		3. MIDDLE NAME	
4. OTHER LAST NAME			5. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		6. DATE OF BIRTH
7. SOCIAL SECURITY NUMBER*			8. WASHINGTON DRIVER'S LICENSE OR ID NUMBER		
8. WHICH RACE/ETHNICITY GROUP WOULD YOU IDENTIFY YOURSELF WITH (CHECK A MAXIMUM OF FOUR THAT APPLY)					
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Native American	<input type="checkbox"/> Thai		
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hawaiian (Native)	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Vietnamese		
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> White/European American		
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Race	Tribal Code (No. 1) _____		
<input type="checkbox"/> Filipino	<input type="checkbox"/> Laotian	<input type="checkbox"/> Refused to Answer	Tribal Code (No. 2) _____		
<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Samoan				
9. SPANISH/HISPANIC/LATINO (CHECK ONE BOX ONLY)					
<input type="checkbox"/> Cuban	<input type="checkbox"/> Not Spanish/Hispanic/Latino	<input type="checkbox"/> Puerto Rican			
<input type="checkbox"/> Mexican, Mexican American, Chicano	<input type="checkbox"/> Other Spanish/Hispanic/Latino	<input type="checkbox"/> Refused to answer			

Treatment Information

BEGIN DATE	BEGIN TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	END DATE	END TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
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Key Codes

PST CODES Primary (1) Secondary (2) Tertiary (3)	ADMINISTRATION CODES Inhalation (I) Oral (O) Injection (J) Other (X) Intra nasal (N) Smoking (S)	FREQUENCY OF USE / PEAK USE PER MONTH 1 - No use 4 - 13 or more times 2 - 1 to 3 times 5 - Daily 3 - 4 to 12 times 6 - Unknown
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Substances

SUBSTANCE	PST (CHECK ONE BOX PER SUBSTANCE)			SUBSTANCE	PST (CHECK ONE BOX PER SUBSTANCE)		
	1	2	3		1	2	3
1. Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. No substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Other Sedatives or Hypnotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Other Opiates and Synthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Over the Counter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Oxy/Hydro Codone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Prescribed Opiate Substitute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Major tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Substance Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Marijuana – Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Tobacco products (cannot be primary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. IN THE FOLLOWING TABLE DESCRIBE SUBSTANCE USE WITH THE ABOVE KEY CODES.

PST	SUBSTANCE (CODE)	ADMIN (CODE)	AGE OF FIRST USE	FREQUENCY OF USE IN LAST 30 DAYS (CODE)	PEAK USE PER MONTH IN LAST YEAR (CODE)	DATE LAST USED MM/DD/YYYY	AMOUNT TAKEN/COMMENTS
1							
2							
3							

* The Social Security Act provides for the collection of Social Security Number to assist in the administration of public funded programs.

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CLIENT NAME		AGENCY NUMBER		STAFF IDENTIFICATION	
2. CONTRACT (CHECK ONE BOX ONLY) <input type="checkbox"/> Adult Outpatient <input type="checkbox"/> Criminal Justice (CJ) <input type="checkbox"/> Criminal Justice – Innovation <input type="checkbox"/> Local Sales Tax <input type="checkbox"/> Other/None <input type="checkbox"/> Pregnant/Post Partum <input type="checkbox"/> Youth Treatment					
3. FUND SOURCE (CHECK ONE BOX ONLY) <input type="checkbox"/> Agency Funded <input type="checkbox"/> Federal Direct <input type="checkbox"/> Private Pay <input type="checkbox"/> State Non DSHS <input type="checkbox"/> County Community Services <input type="checkbox"/> Other <input type="checkbox"/> State Direct <input type="checkbox"/> Tribal Community Services					
4. TITLE XIX FUNDED <input type="checkbox"/> Yes <input type="checkbox"/> No		5. INSURANCE PAYMENT (CHECK ONE BOX ONLY) <input type="checkbox"/> Less than 50% <input type="checkbox"/> 50% or greater <input type="checkbox"/> No Insurance Payment			
6. SPECIAL PROJECT STATE		7. SPECIAL PROJECT COUNTY		8. SPECIAL PROJECT AGENCY	
9. CURRENT PUBLIC ASSISTANCE (CHECK ONE BOX ONLY) <input type="checkbox"/> Applicant <input type="checkbox"/> None <input type="checkbox"/> Aged, Blind or Disabled (ABD) <input type="checkbox"/> Refugee Assistance <input type="checkbox"/> Medicaid Alternative Benefit Plan (ABP) <input type="checkbox"/> Supplemental Security Income (SSI; S01) <input type="checkbox"/> Medical Assistance Only <input type="checkbox"/> Temporary Assistance for Needy Families (TANF)					
10. ENTRY REFERRAL (CHECK ALL THAT APPLY) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Alcohol/Drug Treatment Program <input type="checkbox"/> At Risk Youth (ARY / CHINS) <input type="checkbox"/> Attorney <input type="checkbox"/> BECCA Involved <input type="checkbox"/> Court / Probation <input type="checkbox"/> DCFS / CPS <input type="checkbox"/> Department of Corrections (DOC) <input type="checkbox"/> Department of Licensing (DOL) <input type="checkbox"/> Detoxification Facility <input type="checkbox"/> Diversion <input type="checkbox"/> DSHS Community Services Office </div> <div style="width: 33%;"> <input type="checkbox"/> Employer / EAP <input type="checkbox"/> First Steps or PPP Case <input type="checkbox"/> Gambling Facility <input type="checkbox"/> Group Care <input type="checkbox"/> Help Line <input type="checkbox"/> Involuntary Commitment <input type="checkbox"/> JRA <input type="checkbox"/> Mass Media <input type="checkbox"/> MD / Primary Care Provider <input type="checkbox"/> Mental Health Provider <input type="checkbox"/> Other Alcohol / Drug Facility </div> <div style="width: 33%;"> <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Pharmacist <input type="checkbox"/> Phone Book <input type="checkbox"/> Police <input type="checkbox"/> School/Education <input type="checkbox"/> Self/Help <input type="checkbox"/> Self/Family <input type="checkbox"/> Social Security Administration <input type="checkbox"/> Website <input type="checkbox"/> Other: </div> </div>					
11. DETOX END REFERRAL (CHECK ALL THAT APPLY) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> ATR Services <input type="checkbox"/> CSO <input type="checkbox"/> Housing Support Services <input type="checkbox"/> Involuntary Treatment (ITA) <input type="checkbox"/> Gambling Treatment </div> <div style="width: 33%;"> <input type="checkbox"/> Medical/Dental Services <input type="checkbox"/> Mental Health Services <input type="checkbox"/> None <input type="checkbox"/> Not Amenable to Treatment / Lacks Engagement </div> <div style="width: 33%;"> <input type="checkbox"/> Other: _____ <input type="checkbox"/> Referred to CD Treatment <input type="checkbox"/> Self-Help Group </div> </div>					
12. DISCHARGE OR CLOSURE TYPE (CHECK ONE BOX ONLY) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Client Died <input type="checkbox"/> Completed Treatment <input type="checkbox"/> Funds Exhausted </div> <div style="width: 33%;"> <input type="checkbox"/> Inappropriate Admission <input type="checkbox"/> Incarcerated <input type="checkbox"/> Rule Violation </div> <div style="width: 33%;"> <input type="checkbox"/> Transferred to Different Facility <input type="checkbox"/> Withdrew Against Program Advice <input type="checkbox"/> Withdrew With Program Advice </div> </div>					
13. GOVERNING COUNTY				14. RECOMMENDED ASAM PLACEMENT LEVEL	
15. HOMELESS OR ON THE STREET <input type="checkbox"/> Yes <input type="checkbox"/> No		16. STAFF ID			