OASAS Improving Lives.
NEW YORK STATE
OFFICE OF ALCOHOLISM & SUBSTANCE ABUSE SERVICES
Addiction Services for Prevention, Treatment, Recovery

PART 822-5 Pre-Admissions Assessment Form

The following form contains questions needed to comply with pre-admissions requirements for the Part 822-5 Programs. The first page is for recording the content of each assessment visit. The subsequent pages contain questions that must be completed prior to the patient being admitted. Please be aware of areas that require a dated signature by clinical staff, the physician, and the patient. For further questions regarding the completion of this form contact the OASAS Technical Assistance Unit at TechnicalAssist@oasas.ny.gov.

PART 822-5 Opioid Treatment Program Admissions Assessment

Patient Name	Patient ID

Date of Service	Duration of Service	Type of Service		
		☐ Brief (15 min)	☐ Normative (30 min)	☐ Extended (75 min) *

Results of the Service, including data evaluated, any determination to recommended level of care and planned next steps; including any recommendations or determinations for initial, continued or revised treatment for the patient.

Signature of Staff Member Providing Service	Date

Date of Service	Duration of Service	Type of Service		
		☐ Brief (15 min)	☐ Normative (30 min)	☐ *Extended (75 min)

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Signature of Staff Member Providing Service	Date

**Note only one extended assessment session can be billed per episode of care.*

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Patient Name	Patient ID

Central Registry Verification	Date of Verification	Time
☐ Patient ***is not*** presently enrolled in another Opioid Treatment Program.		
☐ Patient ***is*** enrolled in another Opioid Treatment Program		
Name of Program		
Comments		
Signature of Staff Member Verifying		Date

Identity Verification

Patient Name	Date of Birth
Address	

Method of Verification: *√where appropriate* (attach copy of form of verification)

☐ Driver's License	☐ Non-Driver's ID
☐ Passport	☐ Medicaid ID Card
☐ Other	☐ Other

Signature of Staff Member Verifying	Date

☐ **Toxicology Test has been performed results are attached.**

RULES/ REGULATI ONS, PATI ENT RI GHTS AND VOLUNTARY BASI S

- I have been provided with a copy of the Patient Handbook which contains Program Rules and Regulations, Patient Rights, a Summary of Federal Confidentiality Laws and Tobacco Policies. I have been given the opportunity to discuss these rules and to have my questions answered. By signing this form I am indicating that I understand these rules and rights.
- I also understand that all treatment services are provided on a voluntary basis and that I have the right to discharge myself from treatment at any time.
- I have participated in the development of my preliminary treatment goals.

Patient Signature	**Date**

PART 822-5 Opioid Treatment Program Admissions Assessment

Patient Name	Patient ID

Parent/Guardian Signature, if applicable	Date
Counselor Signature	**Date**

Substance Type	Age of Onset	Frequency/Amount	Date of last use
☐ Alcohol			
☐ Amphetamines			
☐ Benzodiazepines			
☐ Cannabis			
☐ OTC			
☐ Cocaine			
☐ Hallucinogens			
☐ Inhalants			
☐ Nicotine			
☐ Opioids			
☐ PCP			
☐ Sedative/Hypnotics			
Other:			

DSM-IV DIAGNOSIS

Based on information gathered in the above assessments please complete the following:

Dependence Criteria * ***Please indicate the appropriate substance and √the corresponding criteria:***	Primary Substance		Secondary Substance		Tertiary Substance	
Increased tolerance	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Withdrawal	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Use more or longer than intended	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Desire to control or unsuccessful efforts to control use	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Pre-occupation with acquiring the drug(s)	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Lifestyle change due to use	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Continued use despite consequences	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

* 3 or more of dependence criteria met within the past 12 months.

Abuse Criteria ** ***Please indicate the appropriate substance and √the corresponding criteria:***	Primary Substance		Secondary Substance		Tertiary Substance	
Failure to meet major role obligations	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Use Interferes with safety	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Substance Related Legal Problems	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Continued use knowing it causes problems	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

** 1 or more of abuse criteria met within past 12 months.

Please indicate specific diagnosis of alcohol related or psychoactive substance related disorder in accordance with the current version of the DSM:

AXIS I:

PART 822-5 Opioid Treatment Program Admissions Assessment

Patient Name	Patient ID

Mental Health Screening

Are you now or have you ever received Mental Health Counseling? ☐ Yes ☐ No

If so what is/was your Mental Health Provider's Name and where are they located?

What is/was your diagnosis or reason for counseling?

Signed consent(s) for release? ☐ Yes ☐ No

Have you ever been admitted into a Psychiatric Hospital? ☐ **Yes** ☐ **No** **If yes, please give the following information:**

Date	Name of Hospital	Reason for Hospitalization

Please list any mental health medications the patient has taken and indicate whether they are current or past (approximate date):

	☐ current	☐ past		☐ current	☐ past
	☐ current	☐ past		☐ current	☐ past
	☐ current	☐ past		☐ current	☐ past
	☐ current	☐ past		☐ current	☐ past

****Attach completed Modified Mini Screen (MMS)**** **Score on Modified Mini:**

Score of 1-5 Low Likelihood Mental Health Issues **Score of 6-8 Moderate Likelihood**

Score of 9+ High Likelihood **Patient referred for further assessment?** ☐ **Yes** ☐ **No**

Question #4 answered: ☐ **Yes** ☐ **No** **If yes patient referred for further assessment** ☐ **Yes** ☐ **No**

#14 and #15 Both Yes? ☐ **Yes** ☐ **No** **If yes patient referred for further assessment** ☐ **Yes** ☐ **No**

Based on the results of the Modified Mini Screen and the information given above is there any indication that the patient's mental health may adversely affect their ability to succeed in the outpatient level of care?

Please list any mental health related issues the patient needs to address between now and until the development of the treatment/recovery plan:

PART 822-5 Opioid Treatment Program Admissions Assessment

Patient Name	Patient ID

Physical Health

Medication(s): ***Please list additional medication information on backside of sheet as needed.***

Medication	Purpose	Prescriber

Current Medical History

Provider(s) Name	Condition being Treated	Signed Release Y/N

Communicable Disease Assessment ☐ **Attach completed OASAS 822 Communicable Disease Assessment Form.**

Patient identified Medical Needs

OTHER Identified Patient Needs

Referrals (as indicated)

Patient Name	Patient ID

Physician's Evaluation of Opioid Dependency

☐ Physician's Evaluation of Opioid Dependency documented in:

OR

☐ Physician's Evaluation of Opioid Dependency documented below:

PART 822-5 Opioid Treatment Program Admissions Assessment

Patient Name	Patient ID

ADMISSION DECISION

Section 1 Admitted Patients

The patient will be admitted to Opioid Treatment Program Services based on the following criteria:

☐ The prospective patient has a current physiological dependence on opioids for a minimum period of one year AND

☐ The prospective patient has an opioid dependency diagnosis.

OR

☐ Patient voluntarily completed treatment in another OTP within the past two years, the previous treatment lasted at least six months, and a physician determines treatment is medically and clinically indicated.

OR

☐ For all prospective patients less than 18 years of age, there are

- ☐ At least two prior and unsuccessful treatment experiences at a chemical dependence withdrawal and stabilization service or inpatient service within a 12-month period, and;
- ☐ Current physiological dependence on opioids for a minimum period of two years.

OR

☐ Prospective patient is under the age of 16; OASAS approval is attached.

☐ **For admitted patients completed below "Informed Consent Form."**

Physician's Signature	**Date**

Section 2 Non-Admitted Patients

☐ The patient is *ineligible* for Opioid Treatment admission for the following reasons:

The patient has been referred for the following services (if applicable):

By my signature below I attest that I have been informed of the reasons for my not being admitted into the Opioid Treatment program and have been given a referral if appropriate:

Patient's Signature	**Date**
Physician' Signature	**Date**

Patient Name	Patient ID

Consent to Participation in Opioid Pharmacotherapy Treatment[1]

Print Program Name:

I hereby authorize and give voluntary consent to the above listed program and its medical personnel to dispense and administer opioid pharmacotherapy (including methadone or buprenorphine) as part of the treatment of my addiction to opioid drugs. Treatment procedures have been explained to me, and I understand that this will involve my taking the prescribed opioid drug at the schedule determined by the program physician, or his/her designee, in accordance with Federal and State regulations.

It has been explained that, like all other prescription medications, opioid treatment medications can be harmful if not taken as prescribed. I further understand that opioid treatment medications produce dependence and, like most other medications, may produce side effects. Possible side effects, as well as alternative treatments and their risks and benefits, have been explained to me.

I understand that it is important for me to inform any medical provider who may treat me for any medical problem that I am enrolled in an opioid treatment program so that the provider is aware of all the medications I am taking, can provide the best possible care, and can avoid prescribing medications which might affect my opioid pharmacotherapy or my chances of successful recovery from addiction.

I understand that I may withdraw voluntarily from this treatment program and discontinue the use of the medications prescribed at any time. Should I choose this option, I understand I will be offered medically supervised tapering.

***For Female Patients of Childbearing** Age:* There is no evidence that methadone pharmacotherapy is harmful during pregnancy. If I am or become pregnant, I understand that I should tell my medical provider right away so that I can receive appropriate care and referrals. I understand that there are ways to maximize the healthy course of my pregnancy while I am in opioid pharmacotherapy.

Patient's Signature	**Date**
Physician's Signature	**Date**

[1] **Adapted from Medication-Assisted Treatment For Opioid Addition in Opioid Treatment Programs, TIP 43; U.S. Department of Health and Human Services, SAMSHA; page 61.**