



Connecticut Department of Mental Health and Addiction Services  
DDaP – UPDATE / DISCHARGE FORM

**CLIENT INFORMATION**

**NAME:** \_\_\_\_\_

**SOCIAL SECURITY NUMBER:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**ADDRESS:**

**CLIENT STREET ADDRESS 1:** \_\_\_\_\_

**CLIENT STREET ADDRESS 2:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_

**PROVIDER CLIENT ID:** \_\_\_\_\_

**ADMISSION:**

**ADMISSION DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**ADMISSION PROGRAM:** \_\_\_\_\_

**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	<input type="checkbox"/> YES	<input type="checkbox"/> NO
1	PROBLEMS WITH PRIMARY SUPPORT GROUP	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9	OTHER PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7	PROBLEMS WITH ACCESS TO HEALTH SERVICES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4	OCCUPATIONAL PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3	EDUCATIONAL PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6	HOUSING PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5	ECONOMIC PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8	PROBLEMS RELATED TO THE LEGAL SYSTEM / CRIME	<input type="checkbox"/> YES	<input type="checkbox"/> NO

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

Complete if applicable.

**DISCHARGE**

DISCHARGE DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**DISCHARGE REASON: (check one box below)**

- |  |   |
|--|---|
| 41 <input type="checkbox"/> AMA (AGAINST MEDICAL ADVICE)                 | 42 <input type="checkbox"/> LEFT AGAINST ADVICE       |
| 30 <input type="checkbox"/> AWOL FOR INPATIENT ONLY                      | 44 <input type="checkbox"/> MOVED OUT OF AREA         |
| 40 <input type="checkbox"/> CLIENT DISCONTINUED TX                       | 46 <input type="checkbox"/> NON COMPLIANCE WITH RULES |
| 32 <input type="checkbox"/> DEATH  | 96 <input type="checkbox"/> OTHER                     |
| 51 <input type="checkbox"/> DISCHARGED TO NEW SERVICE (FACILITY CONCURS) | 48 <input type="checkbox"/> RECOVERY PLAN COMPLETED   |
| 34 <input type="checkbox"/> EVALUATION ONLY                              | 50 <input type="checkbox"/> RELEASED BY COURT         |
| 36 <input type="checkbox"/> INCARCERATED                                 | 97 <input type="checkbox"/> UNKNOWN                   |
| 38 <input type="checkbox"/> IP DISCHARGE FOR IP MEDICAL TX               |   |

PROVIDER SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PERIODIC ASSESSMENT**

ASSESSMENT DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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

- |  |   |
|--|---|
| 30 <input type="checkbox"/> EMPLOYMENT FULL TIME (in competitive employment)   | 46 <input type="checkbox"/> NOT IN LABOR FORCE; retired               |
| 32 <input type="checkbox"/> EMPLOYMENT PART TIME (in competitive employment)   | 48 <input type="checkbox"/> NOT IN LABOR FORCE; SSI SSDI              |
| 34 <input type="checkbox"/> UNEMPLOYMENT (looking for work in the past 30 days, or on a layoff)  | 50 <input type="checkbox"/> NOT IN LABOR FORCE; Inmate of institution |
| 36 <input type="checkbox"/> PAID BUT NON-COMPETITIVE WORK (transitional employment programs)   | 52 <input type="checkbox"/> NOT IN LABOR FORCE; other reason          |
| 38 <input type="checkbox"/> PAID BUT NON-COMPETITIVE WORK (work inside the clubhouse or treatment agency, mobile work crews and consumer-run businesses) | 96 <input type="checkbox"/> OTHER                                     |
| 42 <input type="checkbox"/> NOT IN LABOR FORCE; student enrolled in a school or job training program)  | 97 <input type="checkbox"/> UNKNOWN                                   |
| 44 <input type="checkbox"/> 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: <i>(check one box only)</i>			
0	<input type="checkbox"/>	NONE	4 <input type="checkbox"/> DISABILITY
1	<input type="checkbox"/>	PUBLIC ASSISTANCE	96 <input type="checkbox"/> OTHER
2	<input type="checkbox"/>	RETIREMENT	97 <input type="checkbox"/> UNKNOWN
3	<input type="checkbox"/>	SALARY	

LIVING SITUATION: <i>(check one box only)</i>			
30	<input type="checkbox"/>	PRIVATE RESIDENCE, client owns or holds lease	46 <input type="checkbox"/> PSYCHIATRIC/SA/MEDICAL INPATIENT
32	<input type="checkbox"/>	PRIVATE RESIDENCE, friend or relative owns the residence or holds lease.	48 <input type="checkbox"/> CORRECTIONAL FACILITY
34	<input type="checkbox"/>	SINGLE ROOM OCCUPANCY (Hotel, YMCA, Rooming House)	50 <input type="checkbox"/> DOMESTIC VIOLENCE SHELTER
36	<input type="checkbox"/>	PRIVATE RESIDENCE, Community agency owns or holds lease	52 <input type="checkbox"/> HOMELESS SHELTER
38	<input type="checkbox"/>	RESIDENTIAL CARE HOME / BOARD AND CARE	54 <input type="checkbox"/> HOMELESS (including on street)
40	<input type="checkbox"/>	CONGREGATE RESIDENTIAL CARE (24-hour supervision, group setting, services focus on MH, SA, &/or MR issues, Recovery House.)	96 <input type="checkbox"/> OTHER
42	<input type="checkbox"/>	CRISIS / RESPIRE BED	97 <input type="checkbox"/> UNKNOWN
44	<input type="checkbox"/>	SKILLED NURSING FACILITY/ INTERMEDIATE CARE FACILITY/ NURSING HOME	

**Was Client Homeless in the Last Six Months?**       YES       NO       UNKNOWN

**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 – 90)             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

**PERIODIC ASSESSMENT – SUBSTANCE USE**

DRUG TYPE(S) used by clients (Select Drug Type 1 - 5, as applicable)		DRUG TYPE 1 Primary	DRUG TYPE 2 Secondary	DRUG TYPE 3 Tertiary	DRUG TYPE 4	DRUG TYPE 5
0	NONE	<input type="checkbox"/>				
01	AMPHETAMINES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	BARBITUATES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04	BENZODIAZEPINES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	COCAINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
06	CRACK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
07	HALLUCINOGENS: LSD, DMS, STP, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
08	HEROIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
09	INHALANTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	MARIJUANA, HASHISH, THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	METHAMPHETAMINES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	NON-PRESCRIPTIVE METHADONE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	OTHER OPIATES AND SYNTHETICS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	OTHER SEDATIVES OR HYPNOTICS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	OTHER STIMULANTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	OVER-THE-COUNTER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	TRANQUELIZERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
96	OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
97	UNKNOWN	<input type="checkbox"/>				

<b>DRUG METHOD USE FIELD 1:</b> (Complete based on corresponding DRUG TYPE 1 selected, except 0 & 97.)					
01	<input type="checkbox"/>	ORAL	04	<input type="checkbox"/>	INJECTION
02	<input type="checkbox"/>	SMOKING	96	<input type="checkbox"/>	OTHER
03	<input type="checkbox"/>	INHALATION	97	<input type="checkbox"/>	UNKNOWN
<b>DAYS USED FIELD 1:</b>					
Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 1 field? (Enter 0 – 30)					<input type="text"/>
<b>AGE FIRST USED FIELD 1:</b>					
Age at which the client used the Drug specified in the Drug Type 1 field? (Enter Age)					<input type="text"/>

<b>DRUG METHOD USE FIELD 2: (Complete based on corresponding DRUG TYPE 2 selected, except 0 &amp; 97.)</b>			
01	<input type="checkbox"/>	ORAL	04 <input type="checkbox"/> INJECTION
02	<input type="checkbox"/>	SMOKING	96 <input type="checkbox"/> OTHER
03	<input type="checkbox"/>	INHALATION	97 <input type="checkbox"/> UNKNOWN
<b>DAYS USED FIELD 2:</b>			
Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 2 field?		(Enter 0 – 30)	<input type="text"/>
<b>AGE FIRST USED FIELD 2:</b>			
Age at which the client used the Drug specified in the Drug Type 2 field?		(Enter Age)	<input type="text"/>

<b>DRUG METHOD USE FIELD 3: (Complete based on corresponding DRUG TYPE 3 selected, except 0 &amp; 97.)</b>			
01	<input type="checkbox"/>	ORAL	04 <input type="checkbox"/> INJECTION
02	<input type="checkbox"/>	SMOKING	96 <input type="checkbox"/> OTHER
03	<input type="checkbox"/>	INHALATION	97 <input type="checkbox"/> UNKNOWN
<b>DAYS USED FIELD 3:</b>			
Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 3 field?		(Enter 0 – 30)	<input type="text"/>
<b>AGE FIRST USED FIELD 3:</b>			
Age at which the client used the Drug specified in the Drug Type 3 field?		(Enter Age)	<input type="text"/>

<b>DRUG METHOD USE FIELD 4: (Complete based on corresponding DRUG TYPE 4 selected, except 0, 97.)</b>			
01	<input type="checkbox"/>	ORAL	04 <input type="checkbox"/> INJECTION
02	<input type="checkbox"/>	SMOKING	96 <input type="checkbox"/> OTHER
03	<input type="checkbox"/>	INHALATION	97 <input type="checkbox"/> UNKNOWN
<b>DAYS USED FIELD 4:</b>			
Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 4 field?		(Enter 0 – 30)	<input type="text"/>
<b>AGE FIRST USED FIELD 4:</b>			
Age at which the client used the Drug specified in the Drug Type 4 field?		(Enter Age)	<input type="text"/>

<b>DRUG METHOD USE FIELD 5: (Complete based on corresponding DRUG TYPE 5 selected, except 0 &amp; 97.)</b>			
01	<input type="checkbox"/>	ORAL	04 <input type="checkbox"/> INJECTION
02	<input type="checkbox"/>	SMOKING	96 <input type="checkbox"/> OTHER
03	<input type="checkbox"/>	INHALATION	97 <input type="checkbox"/> UNKNOWN
<b>DAYS USED FIELD 5:</b>			
Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 5 field?		(Enter 0 – 30)	<input type="text"/>
<b>AGE FIRST USED FIELD 5:</b>			
Age at which the client used the Drug specified in the Drug Type 5 field?		(Enter Age)	<input type="text"/>