



CalOMS Information

Confidential Patient Information under HIPAA
& 42 CFR Part 2

Consumer Name:	MRN:
Assessment Date:	Assessment Time:
Assessment Source: One on One Interview	Event Referent: <input type="checkbox"/> Admission
Author Last Name:	<input type="checkbox"/> Discharge
Admission Facility:	<input type="checkbox"/> Annual Update

General

Number of Prior Admissions: Client Declined Not Sure/ Don't Know Client unable to answer (Level 3.2 WM only)

Days Waited to Enter Treatment: Client Declined Client unable to answer (Level 3.2 WM only)

Admission Transaction Type Initial Admission Transfer or Change in Service

Consent for Future Contact No Yes

Home and Family

Number of Children 5 or Younger: Client Unable to Answer (Level 3.2 WM Only)

Number of Children 17 or Younger: Client Unable to Answer (Level 3.2 WM Only)

Number of Children in CPS Placement: Client Unable to Answer (Level 3.2 WM Only)

Number of Children in CPS Placement and Parental Rights Terminated: Client Unable to Answer (Level 3.2 WM Only)

In the Last 30 Days

Days with Family Conflict: Client Declined Client Unable to Answer (Level 3.2 WM Only)

Days Living with Substance User: Client Declined Client Unable to Answer (Level 3.2 WM Only)

Days Participated in Social Support Recovery Activities: Client Declined Client Unable to Answer (Level 3.2 WM Only)

Participant is a CalWorks Recipient No Yes

Health

Medi-Cal Beneficiary No Yes Client Unable to Answer (Level 3.2 WM Only)

Diagnosed with Tuberculosis No Yes Client Declined to State Client Unable to Answer (Level 3.2 WM Only)

Diagnosed with Hepatitis C No Yes Client Declined to State Client Unable to Answer (Level 3.2 WM Only)

Diagnosed with Sexually Transmitted Disease No Yes Client Declined to State Client Unable to Answer (Level 3.2 WM Only)

Has Been HIV/AIDS Tested No Yes Client Declined to State Client Unable to Answer (Level 3.2 WM Only)

Received HIV/AIDS Results No Yes Client Declined to State Client Unable to Answer (Level 3.2 WM Only)

Diagnosed with Mental Illness at Any Time No Yes Not Sure/Don't Know

Disabilities (choose all that apply)	Medication Prescribed as part of DA Program
<input type="checkbox"/> None <input type="checkbox"/> Mobility <input type="checkbox"/> Speech <input type="checkbox"/> Client Declined to State <input type="checkbox"/> Visual <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only) <input type="checkbox"/> Metal <input type="checkbox"/> Other Disability <input type="checkbox"/> Hearing	<input type="checkbox"/> Acamprosate <input type="checkbox"/> LAAM <input type="checkbox"/> Naltrexone <input type="checkbox"/> Buprenorphine (Subutex) <input type="checkbox"/> Methadone <input type="checkbox"/> None <input type="checkbox"/> Buprenorphine (Suboxone) <input type="checkbox"/> Naloxone <input type="checkbox"/> Other

In the Last 30 Days

Emergency Room Visits for Physical Health: Client Unable to Answer (Level 3.2 WM Only)

Hospital Overnight Stays for Physical Health: Client Unable to Answer (Level 3.2 WM Only)

Days with Physical Health Problem: Client Unable to Answer (Level 3.2 WM Only)

Emergency Room Visits for Mental Health: Client Unable to Answer (Level 3.2 WM Only)

Psychiatric Facility Stays (more than 24 hours): Client Unable to Answer (Level 3.2 WM Only)

Prescribed Mental Health Medication Taken No Yes Client Unable to Answer (Level 3.2 WM Only)

Pregnancy

Pregnant at Admission No Yes Not Sure/Don't Know N/A

Pregnant during Treatment No Yes Not Sure/Don't Know N/A

Employment

Number of Paid Work Days last 30 Days: Client Declined to State Client Unable to Answer (Level 3.2 WM Only)

Enrolled in School No Yes Client Declined to State Client Unable to Answer (Level 3.2 WM Only)

Enrolled in Job Training No Yes Client Declined to State Client Unable to Answer (Level 3.2 WM Only)

Military Veteran No Yes Client Declined to State Client Unable to Answer (Level 3.2 WM Only)

Criminal Justice			
CDCR Number:	<input type="checkbox"/> Client Declined to State	<input type="checkbox"/> Not Sure/Don't Know	<input type="checkbox"/> N/A <input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only)
<i>In the Last 30 Days</i>			
Number of Arrests:	<input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only)		
Number of Days in Jail:	<input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only)		
Number of Days in Prison:	<input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only)		
<i>Programs</i>			
Parolee Services Network (PSN)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only)
FOTEP Parolee	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only)
<i>FOTEP Priority Status</i>			
<input type="checkbox"/> None	<input type="checkbox"/> Any woman paroling from CIW	<input type="checkbox"/> Completed Forever Free and released & enrolled in treatment program	
<input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only)		<input type="checkbox"/> Completed Forever Free and goes direct to FOTEP facility	
Alcohol & Drug Use: Primary Substance			
<input type="checkbox"/> None	<input type="checkbox"/> Other Amphetamines	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Tranquilizers (Benzodiazepine)
<input type="checkbox"/> Heroin	<input type="checkbox"/> Other Stimulants	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Other Tranquilizers
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Cocaine/Crack	<input type="checkbox"/> PCP	<input type="checkbox"/> Non-Prescription Methadone
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Marijuana/Hash	<input type="checkbox"/> Oxycodone/OxyContin	<input type="checkbox"/> Inhalants
<input type="checkbox"/> PCP	<input type="checkbox"/> Other Opiates or Synthetics	<input type="checkbox"/> Other Sedatives or Hypnotics	<input type="checkbox"/> unknown
<input type="checkbox"/> Oxycodone/OxyContin	<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Other Hallucinogens	
<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Heroin	<input type="checkbox"/> Other - Substance Name:	
Frequency of Use (last 30 days):	<input type="checkbox"/> None or Not Applicable		
Route of Administration	<input type="checkbox"/> Oral	<input type="checkbox"/> Smoking	<input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Other <input type="checkbox"/> None
Age of First Use:	<input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only)		
Alcohol & Drug Use: Secondary Substance			
<input type="checkbox"/> None	<input type="checkbox"/> Other Amphetamines	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Tranquilizers (Benzodiazepine)
<input type="checkbox"/> Heroin	<input type="checkbox"/> Other Stimulants	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Other Tranquilizers
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Cocaine/Crack	<input type="checkbox"/> PCP	<input type="checkbox"/> Non-Prescription Methadone
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Marijuana/Hash	<input type="checkbox"/> Oxycodone/OxyContin	<input type="checkbox"/> Inhalants
<input type="checkbox"/> PCP	<input type="checkbox"/> Other Opiates or Synthetics	<input type="checkbox"/> Other Sedatives or Hypnotics	<input type="checkbox"/> unknown
<input type="checkbox"/> Oxycodone/OxyContin	<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Other Hallucinogens	
<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Heroin	<input type="checkbox"/> Other - Substance Name:	
Frequency of Use (last 30 days):	<input type="checkbox"/> None or Not Applicable		
Route of Administration	<input type="checkbox"/> Oral	<input type="checkbox"/> Smoking	<input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Other
Age of First Use:	<input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only)		
Alcohol & Drug Use: Recent History			
Days Alcohol Consumed (last 30 days):	<input type="checkbox"/> None or Not Applicable		
Days Using IV Drugs (last 30 days):	<input type="checkbox"/> Client declined to state	<input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only)	
Used Needles in the Past 12 Months	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Unable to Answer (Level 3.2 WM Only)	
Special Services Contract			
Special Services Contract County Code	<input checked="" type="checkbox"/> None or Not Applicable		
Special Services Contract Number	<input checked="" type="checkbox"/> None or Not Applicable		

AOD Counselor Printed Name/Title	AOD Counselor Signature/Title	Date
Time of Entry: _____	Date of Entry: ____ / ____ / _____	Data Entry Staff Initials: _____
		Data Entry Staff ID: _____