

# Ohio Behavioral Health Integrated ODMH/ODADAS Admission Form

<b>Unique Provider ID:</b>		<b>Unique Client ID:</b>		<b>Medicaid ID:</b>					
<b>First Name:</b>			<b>Last Name:</b>						
<b>Date of Birth (mm/dd/yyyy):</b>			<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown						
<b>Race:</b> <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native American <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Two or More Races <input type="checkbox"/> Other Single Race			<b>Ethnicity:</b> <input type="checkbox"/> Other Specific Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic – Origin not Specified <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Mexican <input type="checkbox"/> Unknown						
<b>First Contact Date:</b>		<b>Marital Status</b>		<b>NOM: Living Arrangement (Choose One)</b>					
<b>Admission Date:</b>		<input type="checkbox"/> Single <input type="checkbox"/> Married		<input type="checkbox"/> Independent living (own home)					
<b>Episode Number:</b>		<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<input type="checkbox"/> Homeless					
<b>Level of Care (AOD Only)</b>		<input type="checkbox"/> Separated <input type="checkbox"/> Unknown		<input type="checkbox"/> Others' Home					
<input type="checkbox"/> Pre-treatment <input type="checkbox"/> Non-intensive Outpatient <input type="checkbox"/> Intensive Outpatient <input type="checkbox"/> Day Treatment <input type="checkbox"/> Non-Medical Community Residential <input type="checkbox"/> Medical Community Residential <input type="checkbox"/> Ambulatory Detoxification <input type="checkbox"/> Sub-Acute Detoxification <input type="checkbox"/> Acute Detoxification <input type="checkbox"/> Not Applicable (MH Only)		<b>NOM: Highest Ed Level Completed:</b>		<input type="checkbox"/> Residential Care / Group Home / ACF					
<b>Consistent with assessment (AOD Only)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, select reason below</b> <input type="checkbox"/> Agency Financial Constraints <input type="checkbox"/> Appropriate LOC Not Available <input type="checkbox"/> Undue Client Hardship <input type="checkbox"/> Other, Specify _____		<input type="checkbox"/> < 1st Grade <input type="checkbox"/> 10th Grade <input type="checkbox"/> 1st Grade <input type="checkbox"/> 11th Grade <input type="checkbox"/> 2nd Grade <input type="checkbox"/> HS Diploma <input type="checkbox"/> 3rd Grade <input type="checkbox"/> Tech School <input type="checkbox"/> 4th Grade <input type="checkbox"/> Some College <input type="checkbox"/> 5th Grade <input type="checkbox"/> 2 Yr Coll Degree <input type="checkbox"/> 6th Grade <input type="checkbox"/> 4 Yr Coll Degree <input type="checkbox"/> 7th Grade <input type="checkbox"/> Grad Degree <input type="checkbox"/> 8th Grade <input type="checkbox"/> Unknown <input type="checkbox"/> 9th Grade		<input type="checkbox"/> Type 1 Residential Treatment Bed					
		<b>NOM: Ed Enrollment (Choose One)</b>		<input type="checkbox"/> Respite Care					
		<input type="checkbox"/> Pre-School <input type="checkbox"/> College		<input type="checkbox"/> Crisis Care					
		<input type="checkbox"/> K-12th Grade <input type="checkbox"/> Other		<input type="checkbox"/> Temporary Housing					
		<input type="checkbox"/> GED Classes <input type="checkbox"/> Not Enrolled		<input type="checkbox"/> Community Residence					
		<input type="checkbox"/> Voc/Job Training <input type="checkbox"/> Unknown		<input type="checkbox"/> Nursing Facility					
				<input type="checkbox"/> Licensed MR Facility					
				<input type="checkbox"/> State MH/MR Institution					
				<input type="checkbox"/> Hospital					
				<input type="checkbox"/> Correctional Facility					
				<input type="checkbox"/> Other					
				<input type="checkbox"/> Unknown					
<b>Referral Source</b>		<b>Education Type – Choose if K-12 Selected:</b>		<b>Prior AOD Treatment Episodes</b>					
<input type="checkbox"/> Individual (self-referral/family/friend) <input type="checkbox"/> AOD Care Provider <input type="checkbox"/> Mental Health Provider <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> School <input type="checkbox"/> Employer/EAP <input type="checkbox"/> Child Welfare (CDJFS, CSBS) <input type="checkbox"/> Other Community Referral <input type="checkbox"/> Prison <input type="checkbox"/> Courts/Other Criminal Justice <input type="checkbox"/> Forensic Hospital <input type="checkbox"/> Jail <input type="checkbox"/> FCFC <input type="checkbox"/> Unknown		<input type="checkbox"/> Not Enrolled <input type="checkbox"/> Not SBH (Client does not have an IEP) <input type="checkbox"/> SBH (Client has an IEP )		<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 or more <input type="checkbox"/> Unknown					
		<b>NOM: Employment Status (Choose One)</b>		<b>Diagnosis Type (Choose One)</b>					
		<input type="checkbox"/> Full Time <input type="checkbox"/> Sheltered		<input type="checkbox"/> DSM <input type="checkbox"/> ICD					
		<input type="checkbox"/> Part Time <input type="checkbox"/> Unknown		<b>Mental Health History</b>					
		<input type="checkbox"/> Unemployed, looking		<input type="checkbox"/> Yes					
		<b>Not in Labor Force (Choose One Below)</b>		<b>Opioid Replacement Therapy</b>					
		<input type="checkbox"/> Homemaker <input type="checkbox"/> Disabled		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
		<input type="checkbox"/> Student <input type="checkbox"/> Inmate		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="text-align: center;"><b>Number of Children in Household Under 18</b></td> </tr> <tr> <td style="width: 50%;"></td> <td style="text-align: center;"><b>Global Assessment of Functioning (GAF – Required)</b></td> </tr> </table>			<b>Number of Children in Household Under 18</b>		<b>Global Assessment of Functioning (GAF – Required)</b>
	<b>Number of Children in Household Under 18</b>								
	<b>Global Assessment of Functioning (GAF – Required)</b>								
		<input type="checkbox"/> Volunteer <input type="checkbox"/> Institutionalized							
		<input type="checkbox"/> Retired <input type="checkbox"/> Other		<b>Primary Diagnostic Code</b>					
		<b>Primary Income/Support (Choose One)</b>		<b>Secondary Diagnostic Code:</b>					
		<input type="checkbox"/> Wages/Salary							
		<input type="checkbox"/> Family/Relative							
		<input type="checkbox"/> Public Assistance							
		<input type="checkbox"/> Retirement/Pension		<b>Tertiary Diagnostic Code:</b>					
		<input type="checkbox"/> Disability <input type="checkbox"/> Unknown							
		<input type="checkbox"/> Other <input type="checkbox"/> None							

<b>Special Pops (Select all that Apply)</b>		<b>Drug of Choice (continued)</b>		<b>Go to Next Page for Secondary and Tertiary Drug of Choice Forms</b>	
<input type="checkbox"/> SMD/SED <input type="checkbox"/> Alcohol/Other Drug Abuse <input type="checkbox"/> Forensic Status <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Deaf/Hard of Hearing <input type="checkbox"/> Blind/Sight Impaired <input type="checkbox"/> Physically Disabled <input type="checkbox"/> Sexual Abuse Victim <input type="checkbox"/> Domestic Violence Victim/Witness <input type="checkbox"/> Child of Alcohol/Drug Abuser <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Suicidal <input type="checkbox"/> Language Barriers/English 2nd Lang. <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Transgendered <input type="checkbox"/> In Custody/Child Welfare <input type="checkbox"/> Multiple Service System Involvement <input type="checkbox"/> Early Childhood: At Risk for SED <input type="checkbox"/> Sexual Offender <input type="checkbox"/> Bisexual/Gay/Lesbian <input type="checkbox"/> Military Family		<input type="checkbox"/> Other Non-Barb. Sedatives/Hypnotics <input type="checkbox"/> Inhalants <input type="checkbox"/> Over-the-Counter Medications <input type="checkbox"/> Nicotine <input type="checkbox"/> Other Medications <input type="checkbox"/> Unknown <input type="checkbox"/> None <b>Frequency of Use</b> <input type="checkbox"/> No use Past Mo <input type="checkbox"/> 1 – 3 X Past Week <input type="checkbox"/> 1 – 2 X in Past Mo <input type="checkbox"/> 3 – 6 X Past Week <input type="checkbox"/> Daily <input type="checkbox"/> Unknown <b>Route of Administration</b> <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Smoking <input type="checkbox"/> Other <input type="checkbox"/> Inhalation <input type="checkbox"/> Unknown			
		<input type="checkbox"/> No use Past Mo <input type="checkbox"/> 1 – 3 X Past Week <input type="checkbox"/> 1 – 2 X in Past Mo <input type="checkbox"/> 3 – 6 X Past Week <input type="checkbox"/> Daily <input type="checkbox"/> Unknown		<b>BIOMARKERS</b>	
		<b>Age of First Use – First Intoxication</b> 		<b>Source of Height/Weight Information</b>	
		<b>Primary AOD Code</b> 		<input type="checkbox"/> Self-Reported <input type="checkbox"/> Measured	
		<b>NOM: Number of Arrests past 30 days</b> 		<b>Height (ft./in.) and Weight (lbs.)</b>	
		<b>Primary Reimbursement (Select One)</b> <input type="checkbox"/> Self-Pay <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Government Support <input type="checkbox"/> Worker’s Compensation <input type="checkbox"/> Other Private Health Insurance <input type="checkbox"/> No Charge <input type="checkbox"/> Other Payment Source		<b>What is the client’s height?</b>     <b>What is the client’s weight?</b>	
<b>Military Status</b>		<b>Frequency of attendance at self-help programs in the 30 days prior to admission</b> <input type="checkbox"/> No attendance in past month <input type="checkbox"/> 1-3 times in the past month <input type="checkbox"/> 4-7 times in the past month <input type="checkbox"/> 8-15 times in the past month <input type="checkbox"/> 16-30 times in the past month <input type="checkbox"/> Some attendance in past month but frequency unknown <input type="checkbox"/> Unknown		<b>Does client report/provide evidence of any of the following conditions in past year?</b>	
<input type="checkbox"/> None <input type="checkbox"/> Active Duty <input type="checkbox"/> Discharged <input type="checkbox"/> Disabled Vet		<b>Paying Board</b> 		<input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Cardiovascular Disease (eg. heart attack, stroke) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Kidney Disease/Failure <input type="checkbox"/> Bowel Obstruction (eg. constipation) <input type="checkbox"/> Respiratory Disease (eg. COPD, asthma) <input type="checkbox"/> None	
<b>Served in</b> Afghanistan <input type="checkbox"/> Yes <input type="checkbox"/> No Iraq <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Children’s Global Assessment of Scale (CGAS-Optional)</b> 		<b>Health Care Utilization</b>	
<b>Pregnancies (Females Only)</b>		<b>Does the client use tobacco products?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don’t Know		<b>How frequently (in days) has the client used the following in the last 6 months?</b>          Hospital Admissions (psychiatric or general)          Emergency Room Visits/Admits (psychiatric or physical health)          Outpatient Primary Care Visits (physical health)          Dental Visits	
Given birth in last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Total # of lifetime live births _____ Is client currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Pregnancy Status:</b> <input type="checkbox"/> 1 <sup>st</sup> Trimester <input type="checkbox"/> 3 <sup>rd</sup> Trimester <input type="checkbox"/> 2 <sup>nd</sup> Trimester <input type="checkbox"/> Unknown					
<b>Drug of Choice (Primary)</b>				<b>NOM: Evidence Based Practices (EBPs)</b>	
<input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Marijuana/Hashish <input type="checkbox"/> Heroin <input type="checkbox"/> Non-prescription Methadone <input type="checkbox"/> Other Opiates and Synthetics <input type="checkbox"/> PCP <input type="checkbox"/> Other Hallucinogens <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Other Amphetamines <input type="checkbox"/> Other Stimulants <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Other Non-Barbiturate Tranquilizers <input type="checkbox"/> Barbiturates				<b>Will the client receive any of the following EBPs?</b> <input type="checkbox"/> Supportive Housing <input type="checkbox"/> Supported Employment <input type="checkbox"/> Assertive Community Treatment (ACT) <input type="checkbox"/> Family Psycho-Education <input type="checkbox"/> IDDT <input type="checkbox"/> WMR/Illness Self-Management <input type="checkbox"/> Medication Management	
				<b>Child/Adolescent Practices</b>	
				<input type="checkbox"/> Therapeutic Foster Care <input type="checkbox"/> Multi-Systemic Therapy <input type="checkbox"/> Functional Family Therapy <input type="checkbox"/> Intensive Home-based Treatment (IHBT)	

Drug of Choice (Secondary)		Drug of Choice (Tertiary)	
<input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Marijuana/Hashish <input type="checkbox"/> Heroin <input type="checkbox"/> Non-prescription Methadone <input type="checkbox"/> Other Opiates and Synthetics <input type="checkbox"/> PCP <input type="checkbox"/> Other Hallucinogens <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Other Amphetamines <input type="checkbox"/> Other Stimulants <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Other Non-Barbiturate Tranquilizers <input type="checkbox"/> Barbiturates <input type="checkbox"/> Other Non-Barb. Sedatives/Hypnotics <input type="checkbox"/> Inhalants <input type="checkbox"/> Over-the-Counter Medications <input type="checkbox"/> Nicotine <input type="checkbox"/> Other Medications <input type="checkbox"/> Unknown <input type="checkbox"/> None		<input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Marijuana/Hashish <input type="checkbox"/> Heroin <input type="checkbox"/> Non-prescription Methadone <input type="checkbox"/> Other Opiates and Synthetics <input type="checkbox"/> PCP <input type="checkbox"/> Other Hallucinogens <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Other Amphetamines <input type="checkbox"/> Other Stimulants <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Other Non-Barbiturate Tranquilizers <input type="checkbox"/> Barbiturates <input type="checkbox"/> Other Non-Barb. Sedatives/Hypnotics <input type="checkbox"/> Inhalants <input type="checkbox"/> Over-the-Counter Medications <input type="checkbox"/> Nicotine <input type="checkbox"/> Other Medications <input type="checkbox"/> Unknown <input type="checkbox"/> None	
<b><u>Frequency of Use</u></b> <input type="checkbox"/> No use Past Mo <input type="checkbox"/> 1 – 3 X Past Week <input type="checkbox"/> 1 – 2 X in Past Mo <input type="checkbox"/> 3 – 6 X Past Week <input type="checkbox"/> Daily <input type="checkbox"/> Unknown		<b><u>Frequency of Use</u></b> <input type="checkbox"/> No use Past Mo <input type="checkbox"/> 1 – 3 X Past Week <input type="checkbox"/> 1 – 2 X in Past Mo <input type="checkbox"/> 3 – 6 X Past Week <input type="checkbox"/> Daily <input type="checkbox"/> Unknown	
<b><u>Route of Administration</u></b> <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Smoking <input type="checkbox"/> Other <input type="checkbox"/> Inhalation <input type="checkbox"/> Unknown		<b><u>Route of Administration</u></b> <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Smoking <input type="checkbox"/> Other <input type="checkbox"/> Inhalation <input type="checkbox"/> Unknown	
	Age of First Use – First Intoxication		Age of First Use – First Intoxication
Secondary AOD Code		Tertiary AOD Code	