

OH BH SMD-SED Update Form

Unique Provider Number:	Episode Number:	Medicaid ID:
Name (first/last):		Paying Board:
Unique Client ID:		Date of Birth (mm/dd/yyyy):
Last Date of Service:		Update Date:

Highest Educational Level Completed (Choose One)	Living Arrangements (Continued)	Special Populations (Continued)								
<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"/> 12th Grade <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"/> Residential Care / Group Home / ACF <input type="checkbox"/> Type 1 Residential Treatment Bed <input type="checkbox"/> Respite Care <input type="checkbox"/> Foster Care <input type="checkbox"/> Crisis Care <input type="checkbox"/> Temporary Housing <input type="checkbox"/> Community Residence <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	<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"/> None of the above								
Educational Enrollment (Choose One)		ODMH: BIOMARKERS Source of Height/Weight Information								
<input type="checkbox"/> Pre-School <input type="checkbox"/> College <input type="checkbox"/> K-12th Grade <input type="checkbox"/> Other: ECOT, etc. <input type="checkbox"/> GED Classes <input type="checkbox"/> Not Enrolled <input type="checkbox"/> Voc/Job Training <input type="checkbox"/> Unknown		<input type="checkbox"/> Self-Reported <input type="checkbox"/> Measured								
If K – 12: Education Type (Choose One)	Diagnosis Type (Choose One)	Height and Weight								
<input type="checkbox"/> Not Enrolled <input type="checkbox"/> Not SBH (No IEP) <input type="checkbox"/> SBH (Has IEP)	<input type="checkbox"/> DSM IV <input type="checkbox"/> ICD9	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border: none;"></td> <td style="width: 50%; border: none;">Height (feet and inches)</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Weight (lbs)</td> </tr> </table>		Height (feet and inches)		Weight (lbs)				
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	Weight (lbs)									
Arrests (MH NOM)	Primary Diagnostic Code	Does client report/provide evidence of any of the following conditions in past year?								
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; border: none;"></td> <td style="border: none;">Number of arrests in last 30 days (99 = Unknown)</td> </tr> </table>		Number of arrests in last 30 days (99 = Unknown)		<input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Cardiovascular Disease <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) <input type="checkbox"/> None						
	Number of arrests in last 30 days (99 = Unknown)									
Tobacco Use	Secondary Diagnostic Code	Health Care Utilization								
Does the client use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know		How frequently (in days) has the client used the following in the last 6 months?								
Employment Status (Choose One)	Tertiary Diagnostic Code									
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Sheltered <input type="checkbox"/> Unemployed, but actively looking for work <input type="checkbox"/> Unknown <input type="checkbox"/> Not in Labor Force (Choose One Below) <input type="checkbox"/> Homemaker <input type="checkbox"/> Disabled <input type="checkbox"/> Student <input type="checkbox"/> Inmate <input type="checkbox"/> Volunteer <input type="checkbox"/> Institutionalized <input type="checkbox"/> Retired <input type="checkbox"/> Other		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border: none;"></td> <td style="width: 50%; border: none;">Hospital Admissions (psychiatric or general)</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Emergency Room Visits/Admits (psychiatric or physical health)</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Outpatient Primary Care Visits (physical health)</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Dental Visits</td> </tr> </table>		Hospital Admissions (psychiatric or general)		Emergency Room Visits/Admits (psychiatric or physical health)		Outpatient Primary Care Visits (physical health)		Dental Visits
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	Outpatient Primary Care Visits (physical health)									
	Dental Visits									
Living Arrangements (Choose One)	Global Assessment of Functioning									
<input type="checkbox"/> Independent living (own home) <input type="checkbox"/> Homeless <input type="checkbox"/> Others' Home	<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"/> HIV/AIDS <input type="checkbox"/> Child of Alcohol/Drug Abuser									
	Special Populations (Select all that Apply)									

Primary Reimbursement (Select One)	Primary Sources of Income / Support	
<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	<input type="checkbox"/> Wages/Salary <input type="checkbox"/> Family/Relative <input type="checkbox"/> Disability <input type="checkbox"/> Other <input type="checkbox"/> Public Assistance <input type="checkbox"/> Retirement/Pension <input type="checkbox"/> Unknown <input type="checkbox"/> None	
	Evidence Based Practices	
	Did the client receive any of the following EBP's since admission or last update?	
	Adult Practices	Child & Adolescent Practices
	<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	<input type="checkbox"/> Therapeutic Foster Care <input type="checkbox"/> Multi-Systemic Therapy (MST) <input type="checkbox"/> Functional Family Therapy <input type="checkbox"/> Intensive Home-based Treatment (IHBT)