

**OBHIS ADMISSION RECORD FIELDS**

<b>Admission Type*</b> <input type="checkbox"/> AOD Only <input type="checkbox"/> MH Only <input type="checkbox"/> AOD/M		<b>ID/Name:</b>	
<b>Date of First Contact*</b> (mm/dd/yyyy)		<b>Date of Admission*</b> (mm/dd/yyyy)	
<b>Marital Status*</b> <input type="checkbox"/> Divorced <input type="checkbox"/> Married (Living Together as Married) <input type="checkbox"/> Separated <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown		<b>Highest Education Level Completed*</b> <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"/> High School Diploma/GED <input type="checkbox"/> 3rd Grade <input type="checkbox"/> Technical School <input type="checkbox"/> 4th Grade <input type="checkbox"/> Some College <input type="checkbox"/> 5th Grade <input type="checkbox"/> 2 Yr. College/Assoc. Degree <input type="checkbox"/> 6th Grade <input type="checkbox"/> 4 Yr. College/Bach. Degree <input type="checkbox"/> 7th Grade <input type="checkbox"/> Graduate. Degree <input type="checkbox"/> 8th Grade <input type="checkbox"/> Unknown <input type="checkbox"/> 9th Grade	
<b>Current Educational Enrollment*</b> <input type="checkbox"/> Pre-School <input type="checkbox"/> K – 12 <sup>th</sup> Grade <input type="checkbox"/> GED Classes <input type="checkbox"/> College <input type="checkbox"/> Other Schooling (e.g., Adult Basic Ed., Literacy) <input type="checkbox"/> Vocation/Job Training <input type="checkbox"/> Has not attended school at any time the last three months <input type="checkbox"/> Unknown		<b>Education Type (If K-12 Selected)*</b> <input type="checkbox"/> Has Individual Education Plan (IEP) <input type="checkbox"/> Does Not Have Individual Education Plan (IEP) <input type="checkbox"/> Unknown	
<b>Primary Reimbursement*</b> <input type="checkbox"/> Blue Cross <input type="checkbox"/> Other Health Ins. Company <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Paym Source <input type="checkbox"/> Medicare <input type="checkbox"/> Self-Pay <input type="checkbox"/> No Charge <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Other Government Payments		<b>Employment at Admission*</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Sheltered <input type="checkbox"/> Unemployed but actively looking for work <b>Not in Labor Force</b> <input type="checkbox"/> Disabled <input type="checkbox"/> Engaged in Residential/Hospitalization <input type="checkbox"/> Homemaker <input type="checkbox"/> Inmate in Jail/Prison/Corrections <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Volunteer Worker <input type="checkbox"/> Other Not in Labor Force <input type="checkbox"/> Unknown	
<b>Primary Source of Income/Support*</b> <input type="checkbox"/> Disability (SSI/SSD, WC) <input type="checkbox"/> Wages/Salary <input type="checkbox"/> Family/Relative <input type="checkbox"/> None <input type="checkbox"/> Public Assistance <input type="checkbox"/> Other <input type="checkbox"/> Retirement/Pension <input type="checkbox"/> Unknown		<b>Living Arrangement at Admission*</b> <input type="checkbox"/> Private Residence - Adult <input type="checkbox"/> Private Residence - Child <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Residential Care/Group Home/ACF <input type="checkbox"/> Community Residence <input type="checkbox"/> Temporary Housing <input type="checkbox"/> Foster Care <input type="checkbox"/> DD Licensed/Operated Facility <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Homeless <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
<b>Does the Client Use Tobacco Products?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Referred By*</b> <input type="checkbox"/> Individual (self referral/family/friend) <input type="checkbox"/> Other Community Provider <input type="checkbox"/> AOD Care Provider <input type="checkbox"/> State Psychiatric Hospital <input type="checkbox"/> Mental Health Provider <input type="checkbox"/> State Prison <input type="checkbox"/> Other Health Provider <input type="checkbox"/> Jail <input type="checkbox"/> School <input type="checkbox"/> Courts/Other Criminal Justice <input type="checkbox"/> Employer/EAP <input type="checkbox"/> TASC: Courts/CJ - Felony <input type="checkbox"/> Child Welfare (CDJFS, CSBS) <input type="checkbox"/> TASC: Courts/CJ - Juvenile <input type="checkbox"/> Ohio Family & Children First <input type="checkbox"/> TASC: Courts/CJ – Municipal <input type="checkbox"/> Council <input type="checkbox"/> Unknown	
<b>Military Status*</b> <input type="checkbox"/> Active <input type="checkbox"/> Disabled Veteran <input type="checkbox"/> Discharged <input type="checkbox"/> None		<b>Number of Arrests in Past 30 Days*</b>	
<b>Client County of Residence*</b>		<b>Assessment and Referral Only*</b> No <input type="checkbox"/> AOD <input type="checkbox"/> MH <input type="checkbox"/> AOD/MH <input type="checkbox"/>	
<b>Paying Entity/Board*</b>		<b>Provider Client Number</b>	

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<b>Childbirth in the last 5 years?†</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Is the Client Currently Pregnant?†</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Lifetime Number of Births (live and still)†</b> 99 = Unknown	<b>Stage of Pregnancy†</b> <input type="checkbox"/> 1 <sup>st</sup> Trimester <input type="checkbox"/> 2 <sup>nd</sup> Trimester <input type="checkbox"/> 3 <sup>rd</sup> Trimester <input type="checkbox"/> Unknown
<b>Number of Children in Household under 18*</b>	99 = Unknown	†Required if client is female *Required for all clients	
<b>SPECIAL POPULATIONS* (Must choose at least one or No Special Population)</b>			
<input type="checkbox"/> SMD/SED	<input type="checkbox"/> Blind or Visually Impaired	<input type="checkbox"/> Speech Impaired	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Early Childhood Risk for SED	<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Physical Abuse Victim	<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> Forensic/Legal Status	<input type="checkbox"/> Sexual Abuse Victim	<input type="checkbox"/> Domestic Violence Victim/Witness	<input type="checkbox"/> Child of Alcohol/Drug User
<input type="checkbox"/> Sexual Offender	<input type="checkbox"/> Non-Conforming Gender Identity	<input type="checkbox"/> Gay/Lesbian/Bisexual	<input type="checkbox"/> Multiple Service System Involvement
<input type="checkbox"/> Suicidal	<input type="checkbox"/> NO SPECIAL POPULATION		
<input type="checkbox"/> Military Family/Dependent			
<input type="checkbox"/> In Custody of Children's Services			
<input type="checkbox"/> Alcohol/Other Drug Use			
<input type="checkbox"/> Language Barriers/English as a Second Language			
<input type="checkbox"/> Deaf or Hearing Impaired			
<input type="checkbox"/> Developmental Disability			
<input type="checkbox"/> Physically Disabled			
<b>Mental Health Admission Fields</b>			
<b>Diagnostic Code Type*</b> (must select one) <input type="checkbox"/> IDC-10 Codes <input type="checkbox"/> DSM-5 Codes			
<b>Primary Diagnostic Code*</b>	<b>Secondary Diagnostic Code</b>	<b>Tertiary Diagnostic Code</b>	
<b>Care Setting*</b> (must select one) <input type="checkbox"/> Community <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Type 1 Bed Residential			
<b>Alcohol and Other Drug Admission Fields</b>			
<b>Diagnostic Code Type*</b> (must select one) <input type="checkbox"/> IDC-10 Codes <input type="checkbox"/> DSM-5 Codes			
<b>Primary Diagnostic Code*</b>	<b>Secondary Diagnostic Code</b>	<b>Tertiary Diagnostic Code</b>	
<b>Level of Care*</b> <input type="checkbox"/> Early Intervention <input type="checkbox"/> Outpatient <input type="checkbox"/> Intensive Outpatient <input type="checkbox"/> Partial Hospitalization <input type="checkbox"/> Clinically Managed Low-intensity Residential <input type="checkbox"/> Clinically Managed Population-specific High-intensity Residential <input type="checkbox"/> Clinically managed High-intensity Residential <input type="checkbox"/> Medically Monitored Intensive Inpatient <input type="checkbox"/> Medically Managed Intensive Inpatient <input type="checkbox"/> No Treatment Recommended <input type="checkbox"/> Assessment Only	<b>LOC Consistent with Assessment?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  If NO, select reason below: <input type="checkbox"/> Agency Financial Constraints <input type="checkbox"/> Appropriate LOC Not Available <input type="checkbox"/> Undue Client Hardship <input type="checkbox"/> Other Specify:  <b>Mental Health History*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Medication Assisted Therapy*</b> <input type="checkbox"/> Alcohol Addiction <input type="checkbox"/> Nicotine Addiction <input type="checkbox"/> Opiate/Opioid Addiction <input type="checkbox"/> None  <b>Prior AOD Treatment Episodes*</b> <input type="checkbox"/> 0 Previous Episodes <input type="checkbox"/> 1 Previous Episodes <input type="checkbox"/> 2 Previous Episodes <input type="checkbox"/> 3 Previous Episodes <input type="checkbox"/> 4 Previous Episodes <input type="checkbox"/> 5 or More Previous Episodes <input type="checkbox"/> 6 Unknown	

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<b>Social Connectedness</b>		
<i>Frequency of Attendance at Self-help Programs in the 30 Days Prior to Admission</i>		
<input type="checkbox"/> 1-3 times in the past month (less than once per week) <input type="checkbox"/> 4-7 times in the past month (about once per week) <input type="checkbox"/> 8-15 times in the past month (2 or 3 times per week) <input type="checkbox"/> 16-30 times in the past month (4 or more times per week)	<input type="checkbox"/> Some attendance in the past month, but frequency unknown <input type="checkbox"/> No attendance in the past month <input type="checkbox"/> Unknown	
<b>DRUG OF CHOICE</b>		
<i>Available Drug Choices</i>		
Alcohol	Methamphetamines	Other Non-Benzodiazepine Tranquilizers
Barbiturates	Nicotine	Other Opiates and Synthetics
Benzodiazepines	Non-prescription Methadone	Other Stimulants
Cocaine/Crack	Other Amphetamines	Over-the-Counter Medications
Heroin	Other Hallucinogens	PCP
Inhalants	Other Medications	
Marijuana/Hashish	Other Non-Barbiturate Sedative/Hypnotics	
<input type="checkbox"/> Unknown		
Primary Drug of Choice	Frequency of Use	Route of Administration
	<input type="checkbox"/> No Use in Last Month <input type="checkbox"/> 1 – 3 Times in Past Month <input type="checkbox"/> 1 – 2 Times in Past Month <input type="checkbox"/> 3 – 6 Times in Past Week <input type="checkbox"/> Daily <input type="checkbox"/> Unknown	<input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Other <input type="checkbox"/> Smoking <input type="checkbox"/> Unknown
<b>Age of First Use</b> (Age of first intoxication when Alcohol drug choice)		
Secondary Drug of Choice	Frequency of Use	Route of Administration
	<input type="checkbox"/> No Use in Last Month <input type="checkbox"/> 1 – 3 Times in Past Month <input type="checkbox"/> 1 – 2 Times in Past Week <input type="checkbox"/> 3 – 6 Times in Past Week <input type="checkbox"/> Daily <input type="checkbox"/> Unknown	<input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Other <input type="checkbox"/> Smoking <input type="checkbox"/> Unknown
<b>Age of First Use</b> (Age of first intoxication when Alcohol drug choice)		
Tertiary Drug of Choice	Frequency of Use	Route of Administration
	<input type="checkbox"/> No Use in Last Month <input type="checkbox"/> 1 – 3 Times in Past Month <input type="checkbox"/> 1 – 2 Times in Past Week <input type="checkbox"/> 3 – 6 Times in Past Week <input type="checkbox"/> Daily <input type="checkbox"/> Unknown	<input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Other <input type="checkbox"/> Smoking <input type="checkbox"/> Unknown
<b>Age of First Use</b> (Age of first intoxication when Alcohol drug choice)		