

OBHIS DISCHARGE RECORD FIELDS

Discharge Type* <input type="checkbox"/> AOD Only <input type="checkbox"/> MH Only <input type="checkbox"/> AOD/MH	ID/Name:	
Living Arrangement at Discharge* <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"/> Private Residence-Child <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Homeless <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Employment at Discharge* <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Sheltered <input type="checkbox"/> Unemployed but actively looking for work Not in Labor Force <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"/> Unknown	
Current Educational Enrollment* <input type="checkbox"/> K – 12 th Grade <input type="checkbox"/> GED Classes <input type="checkbox"/> College <input type="checkbox"/> Other Schooling (e.g., Adult Basic Ed., Literacy) <input type="checkbox"/> Vocational/Job Training <input type="checkbox"/> Has not attended school in the last three months <input type="checkbox"/> Unknown	Highest Education Level Completed* <input type="checkbox"/> < 1st Grade <input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> 1st Grade <input type="checkbox"/> Technical School <input type="checkbox"/> 2nd Grade <input type="checkbox"/> Some College <input type="checkbox"/> 3rd Grade <input type="checkbox"/> 2 Yr. College/Assoc. Degree <input type="checkbox"/> 4th Grade <input type="checkbox"/> 4 Yr. College/Bach. Degree <input type="checkbox"/> 5th Grade <input type="checkbox"/> Graduate Degree <input type="checkbox"/> 6th Grade <input type="checkbox"/> Unknown <input type="checkbox"/> 7th Grade <input type="checkbox"/> 8th Grade <input type="checkbox"/> 9th Grade <input type="checkbox"/> 10th Grade <input type="checkbox"/> 11th Grade	
Education Type (If K-12 Selected)* <input type="checkbox"/> Has Individual Education Plan (IEP) <input type="checkbox"/> Does Not Have Individual Education Plan (IEP) <input type="checkbox"/> Unknown	Does Client Use Tobacco Products at Discharge?* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
A. Was Client Pregnant at Admission?* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of Arrests in Past 30 Days*	
B. Is Client Currently Pregnant?* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes to either A or B, Stage of Pregnancy: <input type="checkbox"/> 1 st Trimester <input type="checkbox"/> Birth Occurred: Drug Free <input type="checkbox"/> 2 nd Trimester <input type="checkbox"/> Birth Occurred: Not Drug Free <input type="checkbox"/> 3 rd Trimester <input type="checkbox"/> Pregnancy Terminated <input type="checkbox"/> Unknown <input type="checkbox"/> Miscarriage	
Special Populations*		
<input type="checkbox"/> SMD/SED <input type="checkbox"/> Early Childhood Risk for SED <input type="checkbox"/> Forensic/Legal Status <input type="checkbox"/> Sexual Offender <input type="checkbox"/> Suicidal <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 <input type="checkbox"/> Blind or Visually Impaired	<input type="checkbox"/> Speech Impaired <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Physical Abuse Victim <input type="checkbox"/> Sexual Abuse Victim <input type="checkbox"/> Domestic Violence Victim/Witness <input type="checkbox"/> Child of Alcohol/Drug User <input type="checkbox"/> Non-Conforming Gender Identity <input type="checkbox"/> Gay/Lesbian/Bisexual <input type="checkbox"/> Multiple Service System Involvement <input type="checkbox"/> NO SPECIAL POPULATION	

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DISCHARGE REASON*	
<input type="checkbox"/> Assessment & Evaluation Only, Client Rejected Recommendations <input type="checkbox"/> Assessment & Evaluation Only, Successfully Completed no Further Services Recommended <input type="checkbox"/> Client Moved <input type="checkbox"/> Death <input type="checkbox"/> Incarcerated Due to Offense Committed while in Treatment/Recovery with SATISFACTORY Progress <input type="checkbox"/> Incarcerated Due to Offense Committed while in Treatment/Recovery with UNSATISFACTORY Progress <input type="checkbox"/> Incarcerated Due to Old Warrant/Charge from Before Entering Treatment/Recovery with SATISFACTORY Progress <input type="checkbox"/> Incarcerated Due to Old Warrant/Charge from Before Entering Treatment/Recovery with UNSATISFACTORY Progress <input type="checkbox"/> Involuntarily Discharged Due to Non-Participation <input type="checkbox"/> Involuntarily Discharged Due to Violation of Rules <input type="checkbox"/> Left on Own, Against Staff Advice WITH Satisfactory Progress <input type="checkbox"/> Left on Own, Against Staff Advice WITHOUT Satisfactory Progress <input type="checkbox"/> Needed Services Not Available <input type="checkbox"/> Referred to Another Program or Service with SATISFACTORY Progress <input type="checkbox"/> Referred to Another Program or Service with UNSATISFACTORY Progress <input type="checkbox"/> Successful Completion/Graduate <input type="checkbox"/> Transferred to Another Facility for Health Reasons <input type="checkbox"/> Other	
Date of Discharge* (mm/dd/yyyy)	Date of Last Service* (mm/dd/yyyy)

Mental Health Discharge Fields		
Diagnostic Code Type* (must select one) <input type="checkbox"/> IDC-10 Codes <input type="checkbox"/> DSM-5 Codes		
Primary Diagnostic Code*	Secondary Diagnostic Code	Tertiary Diagnostic Code
Care Setting at Discharge* <input type="checkbox"/> Community <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Type 1 Bed Residential		

Alcohol and Other Drug Discharge Fields		
Diagnostic Code Type* (must select one) <input type="checkbox"/> IDC-10 Codes <input type="checkbox"/> DSM-5 Codes		
Primary Diagnostic Code*	Secondary Diagnostic Code	Tertiary Diagnostic Code
Level of Care at Discharge*		
<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 Pop-Specific 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	
Did the client choose another provider due to religious preference?* <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the Client Screened for Gambling?* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

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Social Connectedness*		
<i>Frequency of Attendance at Self-Help Programs 30 Days Prior to Discharge</i>		
<input type="checkbox"/> 1-3 times in the past month (less than once per week)	<input type="checkbox"/> Some attendance in the past month, but frequency unknown	
<input type="checkbox"/> 4-7 times in the past month (about once per week)	<input type="checkbox"/> No attendance in the past month	
<input type="checkbox"/> 8-15 times in the past month (2 or 3 times per week)	<input type="checkbox"/> Unknown	
<input type="checkbox"/> 16-30 times in the past month (4 or more times per week)		
DRUG OF CHOICE		
<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"/> Inhalation	
<input type="checkbox"/> 1 – 3 Times in Past Month	<input type="checkbox"/> Injection	
<input type="checkbox"/> 1 – 2 Times in Past Week	<input type="checkbox"/> Oral	
<input type="checkbox"/> 3 – 6 Times in Past Week	<input type="checkbox"/> Other	
<input type="checkbox"/> Daily	<input type="checkbox"/> Smoking	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	
Secondary Drug of Choice:		
Frequency of Use	Route of Administration	
<input type="checkbox"/> No Use in Last Month	<input type="checkbox"/> Inhalation	
<input type="checkbox"/> 1 – 3 Times in Past Month	<input type="checkbox"/> Injection	
<input type="checkbox"/> 1 – 2 Times in Past Week	<input type="checkbox"/> Oral	
<input type="checkbox"/> 3 – 6 Times in Past Week	<input type="checkbox"/> Other	
<input type="checkbox"/> Daily	<input type="checkbox"/> Smoking	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	
Tertiary Drug of Choice:		
Frequency of Use	Route of Administration	
<input type="checkbox"/> No Use in Last Month	<input type="checkbox"/> Inhalation	
<input type="checkbox"/> 1 – 3 Times in Past Month	<input type="checkbox"/> Injection	
<input type="checkbox"/> 1 – 2 Times in Past Week	<input type="checkbox"/> Oral	
<input type="checkbox"/> 3 – 6 Times in Past Week	<input type="checkbox"/> Other	
<input type="checkbox"/> Daily	<input type="checkbox"/> Smoking	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	