



**Department of Behavioral Health
Substance Use Disorder and Recovery Services**

San Bernardino County DBH-SUDRS CalOMS Administrative Discharge

First Name		Last Name	
Counselor Name		Date	
Client ID			

Discharge

Date of Discharge

Please enter date of discharge. _____

Time of Discharge

Please enter time of discharge. _____

Discharge Practitioner

Please enter the name of the discharging practitioner that is closing the CalOMS episode.

Type of Discharge

Please select the type of CalOMS **Administrative** Discharge (check appropriate box):

- SUD left Before Comp w/Satisfactory Progress – Administrative
 SUD left Before Comp w/Unsatisfactory Progress Administrative
 SUD Incarceration Administrative
 SUD Death Administrative

Demographics

Current First Name

Please enter the client's current first name.

Ask: What is your current first name? _____

Current Last Name

Please enter the client's current last name.

Ask: What is your current last name? _____

Address

Please enter the client's address with city, county and state.

Ask: What is your address at your current residence? _____

Ask: What is the city at your current residence? _____

Ask: What is the county at your current residence? _____

Ask: What is the state at your current residence? _____

Zip Code at Current Residence

Please enter the client's current zip code.

Ask: What is the zip code at your current residence? _____

Home Phone Number

Please enter the client's phone number.

Ask: What is your current home phone number? _____

Education**Highest School Grade Completed**

Please select the client's highest school grade completed (check appropriate box):

Ask: What is the highest school grade you completed?

- | | |
|--|--|
| <input type="checkbox"/> 1 Year Preschool | <input type="checkbox"/> 14 Years |
| <input type="checkbox"/> 2 Years Or More Preschool | <input type="checkbox"/> 15 Years |
| <input type="checkbox"/> 1 Year | <input type="checkbox"/> 16 Years |
| <input type="checkbox"/> 2 Years | <input type="checkbox"/> 17 Years |
| <input type="checkbox"/> 3 Years | <input type="checkbox"/> 18 Years |
| <input type="checkbox"/> 4 Years | <input type="checkbox"/> 19 Years |
| <input type="checkbox"/> 5 Years | <input type="checkbox"/> 20+ Years |
| <input type="checkbox"/> 6 Years | <input type="checkbox"/> 1 Year Special Education |
| <input type="checkbox"/> 7 Years | <input type="checkbox"/> 2 Years Or More Special Education |
| <input type="checkbox"/> 8 Years | <input type="checkbox"/> 1 Year Vocational/Technical |
| <input type="checkbox"/> 9 Years | <input type="checkbox"/> 2 Years Vocational/Technical |
| <input type="checkbox"/> 10 Years | <input type="checkbox"/> Completed vocational training without high school diploma |
| <input type="checkbox"/> 11 Years | <input type="checkbox"/> None |
| <input type="checkbox"/> 12 Years | <input type="checkbox"/> Other |
| <input type="checkbox"/> 13 Years | <input type="checkbox"/> Unknown |

Employment Status

Please select the client's employment status (check appropriate box):

Ask: What is your current employment status?

- Full Time (32+ Hours A Week Not Including Armed Forces)
- Full time training
- Not in Labor Force - Homemaker
- Not in the Labor Force - Other Not Seeking Employment In Past 30 Days
- Not in the Labor Force - Resident/Inmate Of
- Not in the Labor Force - Retired
- Not in the Labor Force - Student
- Not in the Labor Force
- Part Time (16-32 Hours A Week)
- Part time training
- Rehab 20-39 hours/less
- Rehab 39 hours/more
- Unemployed – Seeking Employment
- Unknown
- Volunteer Work
- Other

Cal-OMS Administrative Discharge

Discharge Status

Please select the type of CalOMS **Administrative** Discharge (check appropriate box):

- Left before Completion With Satisfactory Progress/Administrative Discharge (status 4)
- Left before Completion With Unsatisfactory Progress/Administrative Discharge (status 6)
- Death (status 7)
- Incarceration (status 8)

Disability

Please select identified disability per client's report (check appropriate box):

Ask: What type of disability/disabilities do you have, if any?

- None
- Hearing
- Visual
- Speech
- Mobility
- Mental
- Developmentally Disabled
- Other
- Client declined to state
- Client unable to answer

Current First Name

Please enter the client's current first name.

Ask: What is your current first name? _____

Current Last Name

Please enter the client's current last name.

Ask: What is your current last name _____

Alcohol and Drug Use

Primary Drug

Please select the client's primary drug of use (check appropriate box):

If **Other (Specify)** is selected, enter the name of the client's primary drug in the **Primary Drug Name**.

Ask: What is your primary alcohol or other drug problem?

- | | |
|---|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Other Amphetamines |
| <input type="checkbox"/> Cocaine/Crack | <input type="checkbox"/> Other Club Drugs |
| <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Other Hallucinogens |
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Other Opiates and Synthetics |
| <input type="checkbox"/> Inhalants | <input type="checkbox"/> Other Sedatives or Hypnotics |
| <input type="checkbox"/> Marijuana/ Hashish | <input type="checkbox"/> Other Stimulants |
| <input type="checkbox"/> Methamphetamines | <input type="checkbox"/> Other Tranquilizers |
| <input type="checkbox"/> Non-Prescription Methadone | <input type="checkbox"/> Over-the-Counter |
| <input type="checkbox"/> None | <input type="checkbox"/> OxyCodone/OxyContin |
| | <input type="checkbox"/> PCP |
| | <input type="checkbox"/> Tranquilizer (Benzodiazepine) |

Primary Drug Route of Administration

Please select the client's primary drug route (check appropriate box):

Ask: What usual route of administration do you use most often for your primary drug of abuse?

- Oral
- Smoking
- Inhalation
- Injection (IV or intramuscular)
- None or Not Applicable
- Other

Pregnant At Any Time During Treatment

Please select **Yes, No or Not Sure/Don't Know** if the client was pregnant at any time during treatment (check appropriate box):

If the client is not male, at discharge, **Ask:** Were you pregnant at any time during treatment?

- Yes No Not Sure/Don't know

Zip Code at Current Residence

Please enter the client's current zip code.

Ask: What is the zip code at your current residence? _____

Record to be Submitted

Please select the type of discharge that is being submitted (check appropriate box):

- Discharge Discharge Update Discharge Delete None