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Department of Behavioral Health

www.SBCounty.gov

Reset

# San Bernardino County DBH-SUDRS CalOMS Admission

| | | | | | |
|---|---|---|---|---|---|
| **First Name** | | | **Last Name** | | |
| **Current First Name** | | | **Current Last Name** | | |
| **Social Security Number** | | **ZIP Code** | | **Place of Birth (County)** | |
| **Place of Birth (State)** | | **Driver's License Number** | | **Driver's License State** | |
| **Mother First Name** | | | **Client ID** | | |
| **Counselor Name** | | | **Date** | | |
| **Reporting Unit** | | | **Date of Birth** | | |

| **Race** | | |
|---|---|---|
| Please select each of the client's races. You may check up to 5 boxes (check appropriate boxes): | | |
| ☐ Hawaiian | ☐ Korean | ☐ Asian Indian |
| ☐ Samoan | ☐ Japanese | ☐ Black/ African American |
| ☐ Guamanian | ☐ Filipino | ☐ White/Caucasian |
| ☐ Chinese | ☐ Cambodian | ☐ Native American |
| ☐ Vietnamese | ☐ American Indian | ☐ Multi-Racial: |
| ☐ Laotian | ☐ Other Asian: | ☐ Other: |

| **Disability** | |
|---|---|
| Please select the client disability (check appropriate box): | |
| ☐ Hearing | ☐ **None** |
| ☐ Visual | ☐ Other: |
| ☐ Speech | ☐ Client Declined to State |
| ☐ Mobility | ☐ Client Unable to Answer |
| ☐ Mental | |
| ☐ Developmentally Disabled | |

| **Ethnicity** | |
|---|---|
| Please select client's ethnicity (check appropriate box): | |
| ☐ Not Hispanic | ☐ Mexican/Mexican American |
| ☐ Cuban | ☐ Puerto Rican |
| ☐ Other Hispanic/Latino: | |

| **Veteran** | | | |
|---|---|---|---|
| Please select the client's veteran status (check appropriate box): | | | |
| ☐ Yes | ☐ No | ☐ Client declined to state | ☐ Client unable to answer |

| Consent | |
|---|---|
| Please select **Yes or No** if the client has given consent to be contacted in the future (check appropriate box): | |
| ☐ Yes | ☐ No |

| Transaction | |
|---|---|
| **Admission Transaction** | |
| Please select the type of admission (check appropriate box): | |
| ☐ Initial Admission | ☐Transfer of change in service |

| Admission | |
|---|---|
| **Source of Referral** | |
| Please select the referral source (check appropriate box): | |
| ☐ Individual (includes self-referral) | ☐ Alcohol/Drug Abuse Program |
| ☐ Other Healthcare Provider | ☐ School/Educational |
| ☐ Employer/EAP | ☐ 12 Step Mutual Aid |
| ☐ DUI/DWI | ☐ Adult Felon Drug Court |
| ☐ Dependency Drug Court | ☐ Non-SACPA Court/Criminal Justice |
| ☐ Other Community Referral | ☐ Dependency Court/Child Protective Services |
| ☐ SACPA/Prop36/OTP/Probation or Parole | ☐ Post-Release Community Supervision (AB109) |

**Days Waited to Enter Treatment**

| | |
|---|---|
| Please enter the total number of days the client was on a waiting list before being admitted into a treatment program.<br>**(Do not include any time incarcerated)** | |

**Number of Prior Episodes**

| | |
|---|---|
| Please enter the total number of episodes the client has participated in treatment as a primary client, not as a codependent. | |

**CalWORKs Recipient**

Please select **Yes or No** if the client is a CalWORKs recipient (check appropriate box):

| | |
|---|---|
| ☐ Yes | ☐ No |

**Substance Abuse Treatment Under CalWORKs**

Please select **Yes** if the client received substance abuse treatment under CalWORKs Program (check box):

| | |
|---|---|
| ☐ Yes | ☐ No |

**Special Services Contract County Code**

Please select **Yes or No** in the special services contract county (check appropriate box):

| | |
|---|---|
| ☐ Yes | ☐ No |

**Special Services Contract ID**

| | |
|---|---|
| Please enter the contract ID<br>* Enter **99902** or the **Special Services Contract County Code if applicable.** | |

## Alcohol and Drug Use

**Primary Drug**
Please select the client's primary drug of use (check appropriate box)

If **Other/Other Drug (Name)/Over-the-Counter** is selected, you **MUST** check the box **AND** enter the name of the client's **Primary Drug** in the field immediately next to the selection.

| | |
|---|---|
| ☐ Alcohol | ☐ Tranquilizer (Benzodiazepine) |
| ☐ Barbiturates | ☐ Other Amphetamines: |
| ☐ Cocaine/Crack | ☐ Other Club Drugs: |
| ☐ Ecstasy | ☐ Other Hallucinogens: |
| ☐ Heroin | ☐ Other Opiates and Synthetics: |
| ☐ Inhalants | ☐ Other Sedatives or Hypnotics: |
| ☐ Marijuana/ Hashish | ☐ Other Stimulants: |
| ☐ Methamphetamines | ☐ Other Tranquilizers: |
| ☐ Non-Prescription Methadone | ☐ Over-the-Counter: |
| ☐ None | ☐ Other: |
| ☐ OxyCodone/OxyContin | |
| ☐ PCP | |

**Primary Drug Frequency**

| | |
|---|---|
| Please enter the number of days of primary drug use in the last 30 days | |

**Primary Drug Route of Administration**

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

| | |
|---|---|
| ☐ Oral | ☐ Smoking |
| ☐ Inhalation | ☐ Injection (IV or Intramuscular) |
| ☐ None or Not Applicable | ☐ Other: |

**Primary Drug Age of First Use**

| | |
|---|---|
| Please enter client's age at the time of first drug use | |

**Secondary Drug**
Please select the client's secondary drug of use (check appropriate box):

If **Other/Other Drug (Name)/Over-the-Counter** is selected, you **MUST** check the box **AND** enter the name of the client's **Secondary Drug** in the field immediately next to the selection.

| | |
|---|---|
| ☐ Alcohol | ☐ Tranquilizer (Benzodiazepine) |
| ☐ Barbiturates | ☐ Other Amphetamines: |
| ☐ Cocaine/Crack | ☐ Other Club Drugs: |
| ☐ Ecstasy | ☐ Other Hallucinogens: |
| ☐ Heroin | ☐ Other Opiates and Synthetics: |
| ☐ Inhalants | ☐ Other Sedatives or Hypnotics: |
| ☐ Marijuana/ Hashish | ☐ Other Stimulants: |
| ☐ Methamphetamines | ☐ Other Tranquilizers: |
| ☐ Non-Prescription Methadone | ☐ Over-the-Counter: |
| ☐ None | ☐ Other: |
| ☐ OxyCodone/OxyContin | |
| ☐ PCP | |

In the **Secondary Drug Frequency**

| Please enter the number of days of secondary drug use in the last 30 days | |
|---|---|

In the **Secondary Drug Route of Administration**

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

| | |
|---|---|
| ☐ Oral | ☐ Smoking |
| ☐ Inhalation | ☐ Injection (IV or Intramuscular) |
| ☐ None or Not Applicable | ☐ Other: |

**Secondary Drug Age of First Use**

| Please enter client's age at the time of secondary drug use began | |
|---|---|

**Alcohol Frequency**

Please enter the frequency of alcohol use in the last 30 days. This field is used when the primary and secondary drugs are not alcohol.

| In the past 30 days, how many times has the client used alcohol? | |
|---|---|

**If the participant's primary or secondary drug problem is alcohol, enter 99902.**

**IV Use**

Please enter the frequency of IV use.

| In the past 30 days, how many times has the client used needles to inject drugs | |
|---|---|

**Needle Use in the Last 12 Months**

Please select **Yes or No** if the client has used a needle drug in the last 12 months (check appropriate box):

| | |
|---|---|
| ☐ Yes | ☐ No |

## Employment

**Enrolled in School**

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

| | | | |
|---|---|---|---|
| ☐ Yes | ☐ No | ☐ Client Declined to State | ☐ Client Unable to Answer |

**Highest School Grade Completed**

| Please enter client's highest school grade completed: | |
|---|---|

Enter "**99900**" to indicate that the client declines to state
Enter "**99904**" to indicate that the client is unable to answer.

**Employment Status**

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

| | |
|---|---|
| ☐ Employed Full Time (35 hours or more) | ☐ Unemployed – Looking for Work |
| ☐ Employed Part Time (Less than 35 hours) | ☑ Unemployed – Not Looking for Work |
| ☐ Not in the Labor Force (Not seeking work) | |

**Enrolled in Job Training**

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

| | | | |
|---|---|---|---|
| ☐ Yes | ☐ No | ☐ Client Declined to State | ☑ Client Unable to Answer |

**Work Past 30 Days**

| Please enter the number of work days the client has had in the past 30 days: | |
|---|---|

## Criminal Justice

**Criminal Justice Status**

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

| | |
|---|---|
| ☐ No Criminal Justice Involvement | ☐ Under Parole Supervision by CDC |
| ☐ On Parole from Another Jurisdiction | ☐ Incarcerated |
| ☐ Awaiting Charges, Trial or Sentencing | ☐ Client Unable to Answer |
| ☐ Post-Release Community Service (AB 109) or on Probation from any Federal, State or Local Jurisdiction | ☐ Admitted Under Diversion from Any Court Under CA Penal Code Section 1000 |

**CDC Identification Number**

Please enter the client's California Department of Corrections (CDC) identification number.

| | |
|---|---|
| What is the client's CDCR number? * **Response will always be 99902** | **99902** |

**Number of** – Please enter the number of times the client has been involved with the specified activity in the last 30 days.

| | |
|---|---|
| In the past 30 days, how many times has the client been arrested? | |
| In the past 30 days, how many days was the client in jail? | |
| In the past 30 days, how many days was the client in prison? | |

**Parolee Services Network** (PSN)

Please enter the client's Parolee Services Network status.

| | |
|---|---|
| Is the client a parolee in the PSN program? * **Response will always be No** | No |

**FOTP Parolee**

Please enter the client's Female Offender Treatment Program (FOTP) status.

| | |
|---|---|
| Is the client a parolee in the Female Offender Treatment Program (FOTP)? * **Response will always be No** | No |

**FOTP Priority Status**

Please enter the client's FOTP priority status.

| | |
|---|---|
| What is the client's FOTP priority status? * **Response will always be None or Not Applicable** | None |

## Medical/Physical Health

**Medi-Cal Beneficiary**

Please select whether the client is a Medi-Cal beneficiary (check appropriate box):

| | | |
|---|---|---|
| ☐ Yes | ☐ No | ☐ Client Unable to Answer |

**Last 30 Days**

Please enter the number of times the client has been involved with the following activities in the last 30 days.

| | |
|---|---|
| In the past 30 days, how many times has the client visited the emergency room for physical health problems? | |
| In the past 30 days, how many days has the client stayed overnight in a hospital for physical health problems? | |
| In the past 30 days, how many days the client experienced physical health problems? | |

**Pregnant At Admission**
Please select **Yes, No or Not Sure/Don't Know** if the client was pregnant at the time of admission (check appropriate box):

Is the client pregnant? (If the client is **not** male)

| ☐ Yes | ☐ No | ☐ Not Sure/Don't know |
|---|---|---|

**Medication Prescribed As Part of Treatment**
Please select the medication prescribed for the client as part of treatment (check appropriate box):

This field is not intended to capture the individual's prescriptions for non-addiction treatment purposes, so providers should only report those medications prescribed by the provider for SUD treatment. In addition, this field is checked against the Master Provider File (MPF). This is to ensure the services being reported are consistent with what the provider is certified or licensed to provide:

| ☐ **None** | ☐ Buprenorphine (Subutex) |
|---|---|
| ☐ Methadone | ☐ Buprenorphine (Suboxone) |
| ☐ LAAM | ☐ Other: |

**Communicable Diseases**
Please select the client's status with the disease (check appropriate box):

Has the client been diagnosed with Tuberculosis?

| ☐ Yes | ☐ No | ☐ Client Declined to State | ☐ Client Unable to Answer |
|---|---|---|---|

Has the client been diagnosed with Hepatitis C?

| ☐ Yes | ☐ No | ☐ Client Declined to State | ☐ Client Unable to Answer |
|---|---|---|---|

Has the client been diagnosed with any sexually transmitted diseases?

| ☐ Yes | ☐ No | ☐ Client Declined to State | ☐ Client Unable to Answer |
|---|---|---|---|

**HIV Tested**
Please select the client's HIV testing status and results (check appropriate box):

Has the client been tested for HIV/AIDS?

| ☐ Yes | ☐ No | ☐ Client Declined to State | ☐ Client Unable to Answer |
|---|---|---|---|

Did the client receive the results of their HIV/AIDS test?

| ☐ Yes | ☐ No | ☐ Client Declined to State | ☐ Client Unable to Answer |
|---|---|---|---|

## Mental Illness

**Mental Illness**
Please select **Yes, No or Not Sure/Don't Know** if the client has mental illness (check appropriate box):

Has the client ever been diagnosed with a mental illness?

| ☐ Yes | ☐ No | ☐ Not Sure/Don't know |
|---|---|---|

**Emergency Room Use/Mental Health**

| How many times in the past 30 days has the client received outpatient emergency services for mental health needs? | |
|---|---|

**Psychiatric Facility Use**
Please enter the number of days in the last 30 days the client has stayed for more than 24 hours in a hospital or psychiatric facility.

| How many days in the past 30 days has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs? | |
|---|---|

**Mental Health Medication**
Please indicate the client's mental health prescription medication use in the last 30 days (check appropriate box):

In the past 30 days, has the client taken prescribed medication for mental health needs?

| ☐ Yes | ☐ No | ☐ Client Unable to Answer |
|---|---|---|

## Family/Social

**Social Support**

Please enter the number of days in the last 30 days the client has participated in social support recovery activities.

| | |
|---|---|
| How many days has the client participated in any social support recovery activities in the past 30 days such as 12-step meetings, other self-help meetings, religious/faith recovery or self-help meetings, meetings of organization other that those listed above, interactions with family members and/or friend support of recovery? | |

**Current Living Arrangements**
Please select the client's current living arrangements (check appropriate box):

What are the client's current living arrangements?

| ☐ Homeless | ☐ Independent Living | ☐ Dependent Living |
|---|---|---|

**Living with Someone**

Please enter the number of days in the last 30 days the client has lived with someone who uses alcohol or drugs.

| | |
|---|---|
| How many days in the past 30 days has the client lived with someone who uses alcohol or other drugs? | |

**Family Conflict Last 30 Days**

Please enter the number of days in the last 30 days the client had serious conflicts with their family.

| | |
|---|---|
| How many days in the past 30 days has the client had serious conflicts with members of their family? | |

**Number of Children**

Please enter the **number** of children associated with the client.

| | |
|---|---|
| How many children does the client have aged 17 or younger (birth or adopted) whether they live with you or not? | |
| How many children (birth or adopted) does the client have aged five years or younger? | |
| How many of the client's children (birth or adopted) are living with someone else because of a child protection court order? | |
| If the client has children (birth or adopted) living with someone else because of a child protection court order, for how many of those children aged 17 or under have the client's parental rights been terminated? | |

## Emergency Contact Information

**Emergency Contact**

Please enter the emergency contact information.

Emergency Contact Living with Client (check appropriate box):

| ☐ Yes | ☐ No |
|---|---|

Please enter Emergency Contact Name _____

Please enter Emergency Contact Phone Number_____

Please enter Emergency Contact Street Address_____

Please enter Emergency Contact City_____

Please enter Emergency Contact State_____

Please enter Emergency Contact Zip Code _____

Please select Emergency Contact Relationship (check appropriate box):

| | | | |
|---|---|---|---|
| ☐ Aunt | ☐ Grandfather | ☐ Niece | ☐ Step-Sister |
| ☐ Brother | ☐ Grandmother | ☐ Other Family Member | ☐ Uncle |
| ☐ Brother-In-Law | ☐ Grandson | ☐ Sister | ☐ Unknown |
| ☐ Cousin | ☐ Guardian | ☐ Sister-In-Law | ☐ Wife |
| ☐ Father | ☐ Husband | ☐ Spouse/Significant Other | |
| ☐ Father-In-Law | ☐ Mother | ☐ Step- Brother | |
| ☐ Friend | ☐ Mother-In-Law | ☐ Step-Father | |
| ☐ Granddaughter | ☐ Nephew | ☐ Step-Mother | |