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SAN BERNARDINO COUNTY

Department of Behavioral Health

www.SBCounty.gov

Reset

San Bernardino County DBH-SUDRS CalOMS Administrative Discharge

First Name		**Last Name**	
Counselor Name		**Date**	
Client ID		**Reporting Unit**	
Date of Birth			

Discharge

Date of Discharge _____ (Please enter date of discharge)

Time of Discharge _____ (Please enter time of discharge)

Discharge Practitioner

Name of the discharging practitioner 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

Address

Please enter the client's address with **City, County** and **State**.

_____

Current Residence Zip Code

Please enter client's zip code: _____

Home Phone Number

Please enter client's current phone number: _____

Education

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

☐ 1 Year of Preschool	☐ 14 Years
☐ 2 Years or More of Preschool	☐ 15 Years
☐ 1 Year	☐ 16 Years
☐ 2 Years	☐ 17 Years
☐ 3 Years	☐ 18 Years
☐ 4 Years	☐ 19 Years
☐ 5 Years	☐ 20 + Years
☐ 6 Years	☐ 1 Year of Special Education
☐ 7 Years	☐ 2 Years or More of Special Education
☐ 8 Years	☐ 1 Year of Vocational/Technical
☐ 9 Years	☐ 2 Years of Vocational/Technical
☐ 10 Years	☐ Completed Vocational Training (without a High School Diploma)
☐ 11 Years	☐ Unknown
☐ 12 Years	☐ None
☐ 13 Years	☐ Other:

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

☐ Full Time (32+ Hours per Week not including Armed Forces)	☐ Not in the Labor Force - Homemaker
☐ Full Time Training	☐ Not in the Labor Force – Other, Not Seeking Employment in the Past 30 Days
☐ Part Time (16 – 32 Hours per Week)	☐ Not in the Labor Force – Resident/Inmate of: _____
☐ Part Time Training	☐ Not in the Labor Force - Retired
☐ Unemployed – Seeking Employment	☐ Not in the Labor Force - Student
☐ Volunteer Work	☐ Not in the Labor Force
☐ Unknown	☐ Rehab - (20 – 39 Hours/less)
☐ Other: _____	☐ Rehab - (39 Hours/More)

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?

☐ Hearing	☐ **None**
☐ Visual	☐ Other: _____
☐ Speech	☐ Client Declined to State
☐ Mobility	☐ Client Unable to Answer
☐ Mental	
☐ Developmentally Disabled	

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 client's primary drug route of administration (check appropriate box). If selecting **other,** specify the primary drug route of administration:

☐ 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):

☐ Yes	☐ No	☐ Not Sure/Don't know

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

☐ Discharge	☐ Discharge Update	☐ Discharge Delete	☐ None