



## San Bernardino County DBH-SUDRS CalOMS Admission – Instructions

### Client Information

**Enter Birth First Name.** Please enter the client's first name at birth.

- Enter "99902" if the client does not have a birth first name.
- Enter "99904" if the client is unable to provide an answer.

**Birth Last Name.** Please enter the client's last name at birth.

- Enter "99904" if the client is unable to provide an answer.

**Current First Name.** Please enter the client's first name if different from the birth name.

- Enter "99904" if the client is unable to provide an answer.

**Current Last Name.** Please enter the client's last name if different from the birth name.

- Enter "99904" if the client is unable to provide an answer.

**Social Security Number.** Please enter the client's social security number.

- Enter "99900" to indicate that the client declines to state their social security number.
- Enter "99902" to indicate that the client does not have a social security number.
- Enter "99904" to indicate that the client is unable to answer.

**ZIP Code at Current Residence.** Please enter the client's ZIP code.

Please enter the zip code on the Admission Outpatient form to indicate that the client is homeless and update the **Current Living Arrangements** on the **Family/Social** section accordingly.

- Enter "99900" to indicate that the client declines to state their ZIP code.
- Enter "99904" to indicate that the client is unable to answer.

**Place of Birth – County.** Please select the county from the list.

Choose **Other** if the client was born outside California.

**Place of Birth – State.** Please select the client's place of birth.

**Driver's License Number.** Please enter the client's driver's license.

- Enter "99900" to indicate that the client declines to state their driver's license number.
- Enter "99902" to indicate that the client has no or no applicable driver's license number.
- Enter "99904" to indicate that the client is unable to answer.

**Driver's License State.** Please enter client's state.

**Mother's First Name.** Please enter the client's mother's first name. See CalOMS Treatment Data Collection Guide for other options.

**Client ID.** Please enter the client's ID.

**Counselor Name -** Please enter the name of the counselor who completed this form.

**Date -** Please enter the date the form is being completed.

**Reporting Unit -** Please enter the reporting unit of the provider.

**Date of Birth -** Please enter the client's date of birth.

### Demographics

**Race.** Please select each of the client's races. You may check up to five (5) boxes.

**Disability.** Please select the client disability.

**Ethnicity.** Please select the client's ethnicity.

**Veteran.** Please select the client's veteran status.

### Consent

**Consent.** Please select **Yes or No** if the client has given consent to be contacted in the future.

### Transaction

**Admission Transaction.** Please select the type of admission.

### Admission

**Source of Referral.** Please select the referral source.

**Days Waited to Enter Treatment.** Please enter the total number of days (not including any time incarcerated); the client was on a waiting list before being admitted into a treatment program.

**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.

**Substance Abuse Treatment Under CalWORKs.** Please select **Yes** if the client received substance abuse treatment under CalWORKs.

**Special Services Contract County Code.** Please select **Yes or No** in the special services contract county.

**Special Services Contract ID.** Please enter the contract ID.

• 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.

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.

**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.

**Primary Drug Age of First Use.** Please enter the client's age at the time of first drug use.

**Primary Drug Age of First Use.** Please enter the client's age at the time of first drug use.

**Secondary Drug.** Please select the client's secondary drug of use.

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.

**Secondary Drug Frequency.** Please enter the number of days of secondary drug use in the last 30 days.

**Secondary Drug Route of Administration.** Please select the client's secondary drug route.

**Secondary Drug Age of First Use.** Please enter the client's age at the time 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.

• Enter "99902" if the participant's primary or secondary drug problem is alcohol.

**IV Use.** Please enter the frequency of the IV use.

**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.

### **Employment**

**Enrolled in School.** Please select the client's enrollment status.

**Highest School Grade Completed.** Please select the 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.

**Enrolled in Job Training.** Please select the client's enrollment status.

**Work Past 30 Days.** Please enter the number of workdays the client has had in the past 30 days.

### **Criminal Justice**

**Criminal Justice Status.** Please select client's criminal justice status.

**CDC Identification Number.** Please enter the client's California Department of Corrections (CDC) identification number. \* Response will always be 99902.

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

How many times has the client been arrested in the past 30 days?

How many days in the past 30 days was the client in jail?

How many days has the client been in prison in the past 30 days?

**Parolee Services Network (PSN).** Please enter the client's Parolee Services Network status. \* Response will always be No.

**FOTP Parolee.** Please enter the client's Female Offender Treatment Program (FOTP) status. \* Response will always be No

**FOTP Priority Status.** Please enter the client's FOTP priority status. \* Response will always be None or Not Applicable.

### **Medical/Physical Health**

**Medi-Cal Beneficiary.** Please select whether the client is a Medi-Cal beneficiary.

**Last 30 Days.** Please enter the number of times the client has been involved with the activity in the last 30 days.

How many times has the client visited an emergency room in the past 30 days for physical health problems?

How many days the client stayed overnight in a hospital in the last 30 days for physical health problems?

How many days in the past 30 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.

**Medication Prescribed As Part of Treatment.** Please select the medication prescribed for the client as part of treatment. **Please note:** 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.

**Communicable Diseases.** Please select the client's status with the disease.

Has the client been diagnosed with Tuberculosis?

Has the client been diagnosed with Hepatitis C?

Has the client been diagnosed with any sexually transmitted diseases?

**HIV Tested.** Please select the client's HIV testing status and results.

Has the client been tested for HIV/AIDS?

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

### **Mental Illness**

**Mental Illness.** Please select **Yes, No or Not Sure/Don't Know** if the client has mental illness

**Emergency Room Use/Mental Health.** Please enter the number of times in the past 30 days 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.

**Mental Health Medication.** Please select **No, Yes, or Client unable to answer** if the client has taken any prescribed mental health prescription medication use in the last 30 days.

### **Family/Social**

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

**Current Living Arrangements.** Please select the client's current living arrangements.

**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.

**Family Conflict Last 30 Days.** Please enter the number of days in the last 30 days the client had serious conflicts with their family.

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

How many children the client has aged 17 or younger (birth or adopted) whether they live with you or not?

How many children (birth or adopted) the client has 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 these children aged 17 or under have your parental rights been terminated?

## **Emergency Contact**

**Emergency Contact.** Please enter the emergency contact information.  
Please select Yes or No if the contact lives with the client.

Please select Emergency Contact Relationship.