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www.SBCounty.gov

SAN BERNARDINO COUNTY

Department of Behavioral Health

San Bernardino County DBH-SUDRS CalOMS Standard Discharge

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

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 **Standard** Discharge (check appropriate box):

☐ Completed treatment/recovery plan, goals/referred/standard (status 1)
☐ Completed treatment/recovery plan, goals/not referred/standard (status 2)
☐ Left before completion with satisfactory progress/referred/standard (status 3)
☐ Left before completion with unsatisfactory progress/referred/standard (status 5)

Demographics

Address

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

_____

Zip Code

Please enter the client's current zip code _____

Home Phone Number

Please enter the client's 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)

Consent

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

CalOMS Discharge

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

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

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

☐ Discharge ☐ Discharge Update ☐ Discharge Delete ☐ None

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

☐ Completed treatment/recovery plan, goals/referred/standard (status 1)
☐ Completed treatment/recovery plan, goals/not referred/standard (status 2)
☐ Left before completion with satisfactory progress/referred/standard (status 3)
☐ Left before completion with unsatisfactory progress/referred/standard (status 5)

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	

Days of Primary Drug Use in the Last 30 Days
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:

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	

Days of Secondary Drug Use in the Last 30 Days

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

In the **Secondary Drug Route of Administration**

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

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

Days of Alcohol Use in the Last 30 Days
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.

How many days in the past 30 days has the client used alcohol? _____
*__If the participant's primary or secondary drug problem is alcohol, enter 99902.__

Days of IV Use (Needle Use) in the Last 30 Days
Please enter the frequency of the IV use.

How many days has the client used needles to inject drugs in the past 30 days? _____

Employment

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)	

Days of Paid Works in the Last 30 Days
Please enter the number of work days the client has had in the past 30 days _____

Enrolled in School
Please select the client's enrollment status (check appropriate box):

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

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

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

Criminal Justice

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?:

Medical/Physical Health

Number of Emergency Room Visits in the Last 30 Days

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

Days of Hospital Overnight Stay in the Last 30 Days

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

Days with Medical Problems in the Last 30 Days

How many days in the past 30 days has the client experienced physical health problems? _____

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	☐ Does Not Apply

HIV Tested

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

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

Please indicate if the client has received 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):

☐ 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 _____

Mental Health Medication

Please indicate if the client has taken any prescribed mental health prescription medication use in the last 30 days. (check appropriate box):

☐ 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 such as: 12-step meetings, other self-help meetings, religious/faith recovery or self-help meetings, meetings of organizations other than those listed above, interactions with family members and/or friend support of recovery?

_____

Current Living Arrangements

Please select the client's current living arrangement (check appropriate box):

☐ Homeless	☐ Independent Living	☐ Dependent Living

Days 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.

_____

Days with Family Conflict in the 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 does the client have aged 17 or younger (birth or adopted) whether they live with the client 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 these children aged 17 or under have the clients' parental rights been terminated? _____