658 East Brier Drive, Suite 250, San Bernardino, CA | Phone: 909-501-0728 • Fax: 909-501-0831



# 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? _____