

Ohio Behavioral Health Integrated ODMH/ODADAS Admission Form

Unique Provider Number:	Unique Client ID:
First Name:	Last Name:
Date of Birth (mm/dd/yyyy):	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Race: <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native American <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Two or More Races <input type="checkbox"/> Other Single Race	Ethnicity: <input type="checkbox"/> Other Specific Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic – Origin not Specified <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Mexican <input type="checkbox"/> Unknown

First Contact Date:	Marital Status	NOM: Living Arrangements (Choose One)				
Admission Date:	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Independent living (own home)				
Episode Number:	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> Homeless				
Level of Care (ODADAS use only)	<input type="checkbox"/> Separated <input type="checkbox"/> Unknown	<input type="checkbox"/> Others' Home				
<input type="checkbox"/> Pre-treatment <input type="checkbox"/> Non-intensive Outpatient <input type="checkbox"/> Intensive Outpatient <input type="checkbox"/> Day Treatment <input type="checkbox"/> Non-Medical Community Residential <input type="checkbox"/> Medical Community Residential <input type="checkbox"/> Ambulatory Detoxification <input type="checkbox"/> Sub-Acute Detoxification <input type="checkbox"/> Acute Detoxification <input type="checkbox"/> Not Applicable (MH Only)	NOM: Highest Ed Level Completed:	<input type="checkbox"/> Residential Care / Group Home / ACF				
	<input type="checkbox"/> Consistent with assessment (AOD Only)?	<input type="checkbox"/> < 1st Grade <input type="checkbox"/> 10th Grade	<input type="checkbox"/> Type 1 Residential Treatment Bed			
	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, select reason below	<input type="checkbox"/> 1st Grade <input type="checkbox"/> 11th Grade	<input type="checkbox"/> Respite Care			
	<input type="checkbox"/> Agency Financial Constraints	<input type="checkbox"/> 2nd Grade <input type="checkbox"/> HS Diploma	<input type="checkbox"/> Foster Care			
	<input type="checkbox"/> Appropriate LOC Not Available	<input type="checkbox"/> 3rd Grade <input type="checkbox"/> Tech School	<input type="checkbox"/> Crisis Care			
	<input type="checkbox"/> Undue Client Hardship	<input type="checkbox"/> 4th Grade <input type="checkbox"/> Some College	<input type="checkbox"/> Temporary Housing			
	<input type="checkbox"/> Other, Specify _____	<input type="checkbox"/> 5th Grade <input type="checkbox"/> 2 Yr Coll Degree	<input type="checkbox"/> Community Residence			
		<input type="checkbox"/> 6th Grade <input type="checkbox"/> 4 Yr Coll Degree	<input type="checkbox"/> Nursing Facility			
		<input type="checkbox"/> 7th Grade <input type="checkbox"/> Grad Degree	<input type="checkbox"/> Licensed MR Facility			
		<input type="checkbox"/> 8th Grade <input type="checkbox"/> Unknown	<input type="checkbox"/> State MH/MR Institution			
	<input type="checkbox"/> 9th Grade	<input type="checkbox"/> Hospital				
	NOM: Ed Enrollment (Choose One)	<input type="checkbox"/> Correctional Facility				
	<input type="checkbox"/> Pre-School <input type="checkbox"/> College	<input type="checkbox"/> Other				
	<input type="checkbox"/> K-12th Grade <input type="checkbox"/> Other	<input type="checkbox"/> Unknown				
	<input type="checkbox"/> GED Classes <input type="checkbox"/> Not Enrolled	Prior AOD Treatment Episodes				
	<input type="checkbox"/> Voc/Job Training <input type="checkbox"/> Unknown	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3				
Referred by	Education Type – Choose if K-12 Selected:	<input type="checkbox"/> 4 <input type="checkbox"/> 5 or more <input type="checkbox"/> Unknown				
<input type="checkbox"/> Individual (self-referral/family/friend)	<input type="checkbox"/> Not Enrolled	Diagnosis Type (Choose One)				
<input type="checkbox"/> AOD Care Provider	<input type="checkbox"/> Not SBH (Client does not have an IEP)	<input type="checkbox"/> DSM <input type="checkbox"/> ICD				
<input type="checkbox"/> Mental Health Provider	<input type="checkbox"/> SBH (Client has an IEP)	Opioid Replacement Therapy				
<input type="checkbox"/> Other Health Care Provider	NOM: Employment Status (Choose One)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
<input type="checkbox"/> School	<input type="checkbox"/> Full Time <input type="checkbox"/> Sheltered	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%;">Number of Children in Household Under 18</td> </tr> <tr> <td></td> <td></td> </tr> </table>		Number of Children in Household Under 18		
	Number of Children in Household Under 18					
<input type="checkbox"/> Employer/EAP	<input type="checkbox"/> Part Time <input type="checkbox"/> Unknown	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%;">Global Assessment of Functioning (GAF – Required)</td> </tr> <tr> <td></td> <td></td> </tr> </table>		Global Assessment of Functioning (GAF – Required)		
	Global Assessment of Functioning (GAF – Required)					
<input type="checkbox"/> Child Welfare (CDJFS, CSBS)	<input type="checkbox"/> Unemployed, looking	Primary Diagnosis Code:				
<input type="checkbox"/> Other Community Referral	Not in Labor Force (Choose One Below)					
<input type="checkbox"/> Prison	<input type="checkbox"/> Homemaker <input type="checkbox"/> Disabled	Secondary Diagnosis Code:				
<input type="checkbox"/> Courts/Other Criminal Justice	<input type="checkbox"/> Student <input type="checkbox"/> Inmate					
<input type="checkbox"/> Forensic Hospital	<input type="checkbox"/> Volunteer <input type="checkbox"/> Institutionalized	Tertiary Diagnosis Code:				
<input type="checkbox"/> Jail	<input type="checkbox"/> Retired <input type="checkbox"/> Other					
<input type="checkbox"/> Families and Children First Council	ODMH: Primary Income/Support (Choose One)					
<input type="checkbox"/> Unknown	<input type="checkbox"/> Wages/Salary <input type="checkbox"/> Disability					
	<input type="checkbox"/> Family/Relative <input type="checkbox"/> Other					
	<input type="checkbox"/> Public Assistance <input type="checkbox"/> Unknown					
	<input type="checkbox"/> Retirement/Pension <input type="checkbox"/> None					

ODMH: Special Pops (Select all that Apply)		Drug of Choice (continued)		
<input type="checkbox"/> SMD/SED <input type="checkbox"/> Alcohol/Other Drug Abuse <input type="checkbox"/> Forensic Status <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Deaf/Hard of Hearing <input type="checkbox"/> Blind/Sight Impaired <input type="checkbox"/> Physically Disabled <input type="checkbox"/> Sexual Abuse Victim <input type="checkbox"/> Domestic Violence Victim/Witness <input type="checkbox"/> Child of Alcohol/Drug Abuser <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Suicidal <input type="checkbox"/> Language Barriers/English 2nd Lang. <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Transgendered <input type="checkbox"/> In Custody/Child Welfare <input type="checkbox"/> Multiple Service System Involvement <input type="checkbox"/> Early Childhood: At Risk for SED <input type="checkbox"/> Sexual Offender <input type="checkbox"/> Bisexual/Gay/Lesbian <input type="checkbox"/> Military Family		<input type="checkbox"/> Other Non-Barb. Sedatives/Hypnotics <input type="checkbox"/> Inhalants <input type="checkbox"/> Over-the-Counter Medications <input type="checkbox"/> Nicotine <input type="checkbox"/> Other Medications <input type="checkbox"/> Unknown <input type="checkbox"/> None Frequency of Use <input type="checkbox"/> No use Past Mo <input type="checkbox"/> 1 – 3 X Past Week <input type="checkbox"/> 1 – 2 X in Past Mo <input type="checkbox"/> 3 – 6 X Past Week <input type="checkbox"/> Daily <input type="checkbox"/> Unknown Route of Administration <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Smoking <input type="checkbox"/> Other <input type="checkbox"/> Inhalation <input type="checkbox"/> Unknown		
		Age of First Use – First Intoxication		ODMH: BIOMARKERS
		Primary AOD Code		Source of Height/Weight Information
		Number of Arrests past 30 days (AOD NOM)		<input type="checkbox"/> Self-Reported <input type="checkbox"/> Measured
Military Status		ODMH: Primary Reimbursement (Select One)		ODMH: Height (ft./in.) and Weight (lbs.)
<input type="checkbox"/> None <input type="checkbox"/> Active Duty <input type="checkbox"/> Discharged <input type="checkbox"/> Disabled Vet		<input type="checkbox"/> Self-Pay <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Government Support <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Other Private Health Insurance <input type="checkbox"/> No Charge <input type="checkbox"/> Other Payment Source		<input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Cardiovascular Disease (eg, heart attack, stroke) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Kidney Disease/Failure <input type="checkbox"/> Bowel Obstruction (eg, constipation) <input type="checkbox"/> Respiratory Disease (eg, COPD, asthma) <input type="checkbox"/> None
Served in		Frequency of attendance at self-help programs in the 30 days prior to admission		Does client report/provide evidence of any of the following conditions in past year?
Afghanistan <input type="checkbox"/> Yes <input type="checkbox"/> No Iraq <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No attendance in past month <input type="checkbox"/> 1-3 times in the past month <input type="checkbox"/> 4-7 times in the past month <input type="checkbox"/> 8-15 times in the past month <input type="checkbox"/> 16-30 times in the past month <input type="checkbox"/> Some attendance in past month but frequency unknown <input type="checkbox"/> Unknown		<input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Cardiovascular Disease (eg, heart attack, stroke) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Kidney Disease/Failure <input type="checkbox"/> Bowel Obstruction (eg, constipation) <input type="checkbox"/> Respiratory Disease (eg, COPD, asthma) <input type="checkbox"/> None
Pregnancies (Females Only)		Paying Board		ODMH: Health Care Utilization
Given birth in last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Total # of births _____ Is client currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnancy Status: <input type="checkbox"/> 1 st Trimester <input type="checkbox"/> 3 rd Trimester <input type="checkbox"/> 2 nd Trimester <input type="checkbox"/> Unknown		Children's Global Assessment of Scale (CGAS-Optional)		How frequently (in days) has the client used the following in the last 6 months?
Drug of Choice (Primary)		ODMH: Does the client use tobacco products?		<input type="checkbox"/> Hospital Admissions (psychiatric or general) <input type="checkbox"/> Emergency Room Visits/Admits (psychiatric or physical health) <input type="checkbox"/> Outpatient Primary Care Visits (physical health) <input type="checkbox"/> Dental Visits
<input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Marijuana/Hashish <input type="checkbox"/> Heroin <input type="checkbox"/> Non-prescription Methadone <input type="checkbox"/> Other Opiates and Synthetics <input type="checkbox"/> PCP <input type="checkbox"/> Other Hallucinogens <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Other Amphetamines <input type="checkbox"/> Other Stimulants <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Other Non-Barbiturate Tranquilizers <input type="checkbox"/> Barbiturates		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know		<input type="checkbox"/> None <input type="checkbox"/> High blood pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Kidney Disease/Failure <input type="checkbox"/> Bowel Obstruction (eg, constipation) <input type="checkbox"/> Respiratory Disease (eg, COPD, asthma) <input type="checkbox"/> None
		NOM: Evidence Based Practices (EBPs)		Will the client receive any of the following EBPs?
				<input type="checkbox"/> Supportive Housing <input type="checkbox"/> Supported Employment <input type="checkbox"/> Assertive Community Treatment (ACT) <input type="checkbox"/> Family Psycho-Education <input type="checkbox"/> IDDT <input type="checkbox"/> WMR/Illness Self-Management <input type="checkbox"/> Medication Management
				Child/Adolescent Practices
				<input type="checkbox"/> Therapeutic Foster Care <input type="checkbox"/> Multi-Systemic Therapy <input type="checkbox"/> Functional Family Therapy <input type="checkbox"/> Intensive Home-based Treatment (IHBT)

Drug of Choice (Secondary)		Drug of Choice (Tertiary)	
<input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Marijuana/Hashish <input type="checkbox"/> Heroin <input type="checkbox"/> Non-prescription Methadone <input type="checkbox"/> Other Opiates and Synthetics <input type="checkbox"/> PCP <input type="checkbox"/> Other Hallucinogens <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Other Amphetamines <input type="checkbox"/> Other Stimulants <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Other Non-Barbiturate Tranquilizers <input type="checkbox"/> Barbiturates <input type="checkbox"/> Other Non-Barb. Sedatives/Hypnotics <input type="checkbox"/> Inhalants <input type="checkbox"/> Over-the-Counter Medications <input type="checkbox"/> Nicotine <input type="checkbox"/> Other Medications <input type="checkbox"/> Unknown <input type="checkbox"/> None		<input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Marijuana/Hashish <input type="checkbox"/> Heroin <input type="checkbox"/> Non-prescription Methadone <input type="checkbox"/> Other Opiates and Synthetics <input type="checkbox"/> PCP <input type="checkbox"/> Other Hallucinogens <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Other Amphetamines <input type="checkbox"/> Other Stimulants <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Other Non-Barbiturate Tranquilizers <input type="checkbox"/> Barbiturates <input type="checkbox"/> Other Non-Barb. Sedatives/Hypnotics <input type="checkbox"/> Inhalants <input type="checkbox"/> Over-the-Counter Medications <input type="checkbox"/> Nicotine <input type="checkbox"/> Other Medications <input type="checkbox"/> Unknown <input type="checkbox"/> None	
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<u>Route of Administration</u> <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Smoking <input type="checkbox"/> Other <input type="checkbox"/> Inhalation <input type="checkbox"/> Unknown		<u>Route of Administration</u> <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Smoking <input type="checkbox"/> Other <input type="checkbox"/> Inhalation <input type="checkbox"/> Unknown	
Age of First Use – First Intoxication		Age of First Use – First Intoxication	
Secondary AOD Code		Tertiary AOD Code	