

CalOMS Admission Form Instructions

REQUIRED FORM:

The Admission Form is a required document in the client's file. Each participant's initial admission to the facility and any subsequent transfers or changes in service should be reported on a separate CalOMS Tx Admission form.

WHEN:

This form will be created at Intake-Admission to be defined as the first day of the participant's treatment/service. All Admission data must be gathered within seven days of a person's first day of treatment and completed in SanWITS by the 10th of the month following the report month.

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- For instructions on each specific field, refer to CalOMS Data Collection Guide/CalOMS Treatment Data Dictionary.

NOTE:

If the client transfers or has a change in service, the episode must be discharged and a new episode opened with a new admission form. The discharge should reflect "referred" and the admission under the new episode would be marked as a "transfer".

The "Special Population Program" question is now reflecting specific populations and is no longer tracking funding sources.



CalOMS Admission

Provider Id: _____
 Client Name: _____
 Client #: _____
 Data Entry Date: _____
 Data Entry Int: _____
 CalOMS Serial #:W _____

ADMISSION ADMINISTRATION		*REQUIRED
Screening		
Potential Client for MH <input type="checkbox"/> Yes <input type="checkbox"/> No	Basis for Decision	<input type="checkbox"/> Based on Screening <input type="checkbox"/> Based on Referral <input type="checkbox"/> Based on Testing Result <input type="checkbox"/> Court Ordered Treatment <input type="checkbox"/> Ct Ord Screening/Assessment
Potential Client for TBI <input type="checkbox"/> Yes <input type="checkbox"/> No	Basis for Decision	<input type="checkbox"/> Based on Screening <input type="checkbox"/> Based on Referral <input type="checkbox"/> Based on Testing Result <input type="checkbox"/> Court Ordered Treatment <input type="checkbox"/> Ct Ord Screening/Assessment
* Admission Date (mm / dd / yyyy)	Codependent/Collateral <input type="checkbox"/> Yes <input type="checkbox"/> No	
* Admission/Transaction Type <input type="checkbox"/> 1-Initial Admission <input type="checkbox"/> 2-Transfer of Change in Service	* CalWORKs Recipient <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure/Don't Know	
*Type of Treatment Service <input type="checkbox"/> 1-Nonresidential/Outpatient Treatment/Recovery <input type="checkbox"/> 2-Nonresidential/Outpatient Day Program- intensive <input type="checkbox"/> 3-Nonresidential/Outpatient Detoxification <input type="checkbox"/> 5-Residential Detoxification (non-hospital)	<input type="checkbox"/> 6-Residential Treatment/recovery (30 days or less) <input type="checkbox"/> 7-Residential Treatment/recovery (31 days or more)	*SA Tx Under CalWORK <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure/Don't Know
* Submit to CalOMS <input type="checkbox"/> Yes <input type="checkbox"/> No	* Admission Staff	
* # of Days Waited to Enter Tx	*Special Services Contract ID (Always NA) <input type="checkbox"/> NA	
*# of Prior Episodes	*Special Services/Contract County Code (Always Not Applicable) <input type="checkbox"/> Not Applicable	
Record Status		
Record Created By	Created Date	
Last Updated By	Last Updated Date	
CalOMS Form Serial #	Last Upload to State Date	
CADDs Form Serial #		

ADMISSION ADMINISTRATION		*REQUIRED
Program Fees	Intake Fees	
Drug Testing Participation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure/Don't Know	Testing Level Indicator (Please indicate color)	
Baseline UA Completed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure/Don't Know	Drug Screening Fees	
Pictures Taken <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure/Don't Know	Encounter Fees	



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ADMISSION ADMINISTRATION ***REQUIRED**

Prop. 36 Start Date	Prop. 36 End Date	JURIS #
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*Special Population Program (Not related to Funding Source)	<input type="checkbox"/> Non BHS Contract <input type="checkbox"/> AB 109 Participant <input type="checkbox"/> CalWORKs Participant <input type="checkbox"/> Drug Court Participant <input type="checkbox"/> Juvenile Drug Court Participant	<input type="checkbox"/> ReEntry Court Participant <input type="checkbox"/> Prop 47 Participant <input type="checkbox"/> PC 1000 Participant <input type="checkbox"/> None
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*How did you hear about us? <input type="checkbox"/> 1-Access and Crisis Line (ACL) <input type="checkbox"/> 2-SUD/Prevention Brochures <input type="checkbox"/> 3-County SUD Web Site <input type="checkbox"/> 4-Help/Info Line (211)	<input type="checkbox"/> 5-Crim Justice i.e., Probation/Court/Parole/Law Enforcement <input type="checkbox"/> 6-ER/Trauma/Hospital <input type="checkbox"/> 7-Homeless Shelter <input type="checkbox"/> 8-Mental Health Program <input type="checkbox"/> 9-Primary Care Physician / Health Clinic	<input type="checkbox"/> 10-Family Member <input type="checkbox"/> 11-Outreach Worker (HOW, HOT, etc.) <input type="checkbox"/> 12-Return Participant <input type="checkbox"/> 13-Other - Please Explain <input type="checkbox"/> 14-Not Applicable
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If Other, Specify

Administrative Checklist (Select all that apply)	<input type="checkbox"/> Personal Rights Given <input type="checkbox"/> Emergency Contract release signed <input type="checkbox"/> Property Inventory done <input type="checkbox"/> Have the rules been read and signed <input type="checkbox"/> Medical assessment form <input type="checkbox"/> Release of Information Form has been signed	<input type="checkbox"/> Acknowledgement of receipt of privacy <input type="checkbox"/> Chemical Free agreement, has it been read and signed <input type="checkbox"/> Orientation Packet been reviewed and signed <input type="checkbox"/> Consent to Treatment <input type="checkbox"/> Health Questionnaire Given
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ALCOHOL & DRUG USE ***REQUIRED**

Primary Drug

*Drug Type <input type="checkbox"/> 0-None (Will be rejected) <input type="checkbox"/> 1-Heroin <input type="checkbox"/> 2-Alcohol <input type="checkbox"/> 3-Barbiturates <input type="checkbox"/> 4-Other Sedatives or Hypnotics <input type="checkbox"/> 5-Methamphetamine	<input type="checkbox"/> 6-Other Amphetamines <input type="checkbox"/> 7-Other Stimulants <input type="checkbox"/> 8-Cocaine / Crack <input type="checkbox"/> 9-Marijuana / Hashish <input type="checkbox"/> 10-PCP <input type="checkbox"/> 11-Other Hallucinogens <input type="checkbox"/> 12-Tranquilizers (e.g. Benzodiazepine) <input type="checkbox"/> 13-Other Tranquilizers	<input type="checkbox"/> 14-Non-Prescription Methadone <input type="checkbox"/> 15-Oxycodone / OxyContin <input type="checkbox"/> 16-Other Opiates or Synthetics <input type="checkbox"/> 17-Inhalants <input type="checkbox"/> 18-Over-the-Counter <input type="checkbox"/> 19-Ecstasy <input type="checkbox"/> 20-Other Club Drugs <input type="checkbox"/> 99903-Other (specify)
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*Number of Days Used in Past 30 Days Number between 0 and 30 99902-None or Not Applicable	*Route of Administration <input type="checkbox"/> 1-Oral <input type="checkbox"/> 2-Smoking <input type="checkbox"/> 3-Inhalation	<input type="checkbox"/> 4-Injection (IV or intramuscular) <input type="checkbox"/> 99902-None or not applicable <input type="checkbox"/> 99903-Other
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***Age of First Use** Must select # between 5 and 105 | 99904-Unable to answer (only if client is in detox or developmentally disabled)



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ALCOHOL & DRUG USE ***REQUIRED**

Secondary Drug

<p>*Drug Type</p> <input type="checkbox"/> 0-None (Will be rejected) <input type="checkbox"/> 1-Heroin <input type="checkbox"/> 2-Alcohol <input type="checkbox"/> 3-Barbiturates <input type="checkbox"/> 4-Other Sedatives or Hypnotics <input type="checkbox"/> 5-Methamphetamine	<input type="checkbox"/> 6-Other Amphetamines <input type="checkbox"/> 7-Other Stimulants <input type="checkbox"/> 8-Cocaine / Crack <input type="checkbox"/> 9-Marijuana / Hashish <input type="checkbox"/> 10-PCP <input type="checkbox"/> 11-Other Hallucinogens <input type="checkbox"/> 12-Tranquilizers (e.g. Benzodiazepine) <input type="checkbox"/> 13-Other Tranquilizers	<input type="checkbox"/> 14-Non-Prescription Methadone <input type="checkbox"/> 15-Oxycodone / OxyContin <input type="checkbox"/> 16-Other Opiates or Synthetics <input type="checkbox"/> 17-Inhalants <input type="checkbox"/> 18-Over-the-Counter <input type="checkbox"/> 19-Ecstasy <input type="checkbox"/> 20-Other Club Drugs <input type="checkbox"/> 99903-Other (specify)
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<p>*Number of Days Used in Past 30 Days Number between 0 and 30 99902-None or Not Applicable</p>	<p>*Route of Administration</p> <input type="checkbox"/> 1-Oral <input type="checkbox"/> 2-Smoking <input type="checkbox"/> 3-Inhalation	<input type="checkbox"/> 4-Injection (IV or intramuscular) <input type="checkbox"/> 99902-None or not applicable <input type="checkbox"/> 99903-Other
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***Age of First Use** Must select # between 5 and 105 | 99904-Unable to answer (only if client is in detox or developmentally disabled)

Tertiary Drug

<p>*Drug Type</p> <input type="checkbox"/> 0-None (Will be rejected) <input type="checkbox"/> 1-Heroin <input type="checkbox"/> 2-Alcohol <input type="checkbox"/> 3-Barbiturates <input type="checkbox"/> 4-Other Sedatives or Hypnotics <input type="checkbox"/> 5-Methamphetamine	<input type="checkbox"/> 6-Other Amphetamines <input type="checkbox"/> 7-Other Stimulants <input type="checkbox"/> 8-Cocaine / Crack <input type="checkbox"/> 9-Marijuana / Hashish <input type="checkbox"/> 10-PCP <input type="checkbox"/> 11-Other Hallucinogens <input type="checkbox"/> 12-Tranquilizers (e.g. Benzodiazepine) <input type="checkbox"/> 13-Other Tranquilizers	<input type="checkbox"/> 14-Non-Prescription Methadone <input type="checkbox"/> 15-Oxycodone / OxyContin <input type="checkbox"/> 16-Other Opiates or Synthetics <input type="checkbox"/> 17-Inhalants <input type="checkbox"/> 18-Over-the-Counter <input type="checkbox"/> 19-Ecstasy <input type="checkbox"/> 20-Other Club Drugs <input type="checkbox"/> 99903-Other (specify)
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<p>*Number of Days Used in Past 30 Days Number between 0 and 30 99902-None or Not Applicable</p>	<p>*Route of Administration</p> <input type="checkbox"/> 1-Oral <input type="checkbox"/> 2-Smoking <input type="checkbox"/> 3-Inhalation	<input type="checkbox"/> 4-Injection (IV or intramuscular) <input type="checkbox"/> 99902-None or not applicable <input type="checkbox"/> 99903-Other
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***Age of First Use** Must select # between 5 and 105 | 99904-Unable to answer (only if client is in detox or developmentally disabled)

<p>* # of Days Alcohol Used in Past 30</p>	<p>* # of Days IV Used in Past 30</p>	<p>* Used Needles in Past 12 Months</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client unable to answer
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TOBACCO / NICOTINE ***REQUIRED**

***Have you ever used Tobacco/Nicotine products?**
 (*Answering NO or UNKNOWN will cause remaining fields to auto-populate; if YES, continue answering the questions.)

Yes No Unknown

<p>*Smoker Status</p> <input type="checkbox"/> Current every day smoker <input type="checkbox"/> Current some day smoker <input type="checkbox"/> Smoker, current status unknown <input type="checkbox"/> Former smoker	<p>At what age did you first use tobacco/nicotine product(s)?</p> <input type="checkbox"/> 1-<=10 <input type="checkbox"/> 2-11-14 <input type="checkbox"/> 3-15-19 <input type="checkbox"/> 4-20-25 <input type="checkbox"/> 5-26-30 <input type="checkbox"/> 6->=31 <input type="checkbox"/> 97-Unknown
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TOBACCO / NICOTINE	*REQUIRED
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In the past 30 days, what tobacco/nicotine product did you use most frequently?
 0-No Tobacco Use 1-Cigarettes 2-Cigars or Pipes 3-Smokeless Tobacco 4-Combo/more than 1

Other/Please Describe *(Unable to add or modify information in this field – leave blank)*

<p>In the past 30 days, how often did you use tobacco/nicotine product(s)?</p> <input type="checkbox"/> 1-1-3 times in the past 30 days <input type="checkbox"/> 5-3-6 times a day <input type="checkbox"/> 2-Once a week <input type="checkbox"/> 6-More than 6 times a day <input type="checkbox"/> 3-3-6 times a week <input type="checkbox"/> 97-Unknown <input type="checkbox"/> 4-Daily	<p>In the past 30 days, how many cigarettes did you smoke per week?</p>
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FAMILY / SOCIAL	*REQUIRED
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<p>*# of Days Social Support in Past 30 (Select # between 0 and 30)</p>	<p>*# of Children Under 18 (Select # between 0 and 30)</p>
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<p>*Current Living Arrangements</p> <input type="checkbox"/> 1-Homeless/In Shelter <input type="checkbox"/> 2-Dependent Living <input type="checkbox"/> 1-Homeless/Living w Other(s) <input type="checkbox"/> 3-Independent Living <input type="checkbox"/> 1-Homeless/Out of Shelter	<p>*# of Children Age 5 or Less (Select # between 0 and 30)</p>
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<p>*# of Days Living w/User of Alcohol or Drugs in Past 30 (Select # between 0 and 30)</p>	<p>*# of Children Living w/Someone Else Because of a Child Protection Order (Select # between 0 and 30)</p>
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<p>*# of Days Family Conflict in Past 30 (Select # between 0 and 30)</p>	<p>*# of Children Living w/Someone Else for whom Parental Rights have been Terminated (Select # between 0 and 30)</p>
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***Current Zip Code** (00000-Homeless)

Abuse Characteristics

***Does episode involve physical abuse?** Perpetrator Victim No Unwilling to Answer

***Does episode involve sexual abuse?** Perpetrator Victim No Unwilling to Answer

***Does episode involve domestic abuse?** Perpetrator Victim No Unwilling to Answer



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EMPLOYMENT		*REQUIRED																																				
*Employment Status <input type="checkbox"/> 1-Employed Full Time (35 hours or more) <input type="checkbox"/> 2-Part time (less than 35 hours) <input type="checkbox"/> 3-Unemployed looking for work <input type="checkbox"/> 4-Unemployed not in the labor force (not seeking) <input type="checkbox"/> 5-Not in the labor force (not seeking)	*# of Paid Work Days in Past 30 (Select # between 0 and 30) 99900-Dcline to state 99904-Unable to answer (only if client is in detox or developmentally disabled)																																					
*Enrolled in School <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client declined to state <input type="checkbox"/> Client unable to answer (Only if client is in detox or developmentally disabled)																																						
*Enrolled in Job Training <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client declined to state <input type="checkbox"/> Client unable to answer (Only if client is in detox or developmentally disabled)																																						
*Graduated from High School <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client declined to state <input type="checkbox"/> Client unable to answer (Only if client is in detox or developmentally disabled)																																						
*Highest School Grade Completed <table style="width:100%; border: none;"> <tr> <td style="width: 33%; border: none;"><input type="checkbox"/> 00-Kindergarten</td> <td style="width: 33%; border: none;"><input type="checkbox"/> 11-11th Grade</td> <td style="width: 33%; border: none;"><input type="checkbox"/> 23-23</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 01-1st Grade</td> <td style="border: none;"><input type="checkbox"/> 12-12th Grade</td> <td style="border: none;"><input type="checkbox"/> 24-24</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 02-2nd Grade</td> <td style="border: none;"><input type="checkbox"/> 13-13</td> <td style="border: none;"><input type="checkbox"/> 25-25</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 03-3rd Grade</td> <td style="border: none;"><input type="checkbox"/> 14-14</td> <td style="border: none;"><input type="checkbox"/> 26-26</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 04-4th Grade</td> <td style="border: none;"><input type="checkbox"/> 15-15</td> <td style="border: none;"><input type="checkbox"/> 27-27</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 05-5th Grade</td> <td style="border: none;"><input type="checkbox"/> 16-16</td> <td style="border: none;"><input type="checkbox"/> 28-28</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 06-6th Grade</td> <td style="border: none;"><input type="checkbox"/> 17-17</td> <td style="border: none;"><input type="checkbox"/> 29-29</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 07-7th Grade</td> <td style="border: none;"><input type="checkbox"/> 18-18</td> <td style="border: none;"><input type="checkbox"/> 30-30</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 08-8th Grade</td> <td style="border: none;"><input type="checkbox"/> 19-19</td> <td style="border: none;"><input type="checkbox"/> 99900-Client declined to state</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 09-9th Grade</td> <td style="border: none;"><input type="checkbox"/> 20-20</td> <td style="border: none;"><input type="checkbox"/> 99904-Client unable to answer</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 10-10th</td> <td style="border: none;"><input type="checkbox"/> 21-21</td> <td style="border: none;">(only if client is in detox or developmentally disabled)</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> 22-22</td> <td style="border: none;"></td> </tr> </table>			<input type="checkbox"/> 00-Kindergarten	<input type="checkbox"/> 11-11 th Grade	<input type="checkbox"/> 23-23	<input type="checkbox"/> 01-1st Grade	<input type="checkbox"/> 12-12 th Grade	<input type="checkbox"/> 24-24	<input type="checkbox"/> 02-2 nd Grade	<input type="checkbox"/> 13-13	<input type="checkbox"/> 25-25	<input type="checkbox"/> 03-3rd Grade	<input type="checkbox"/> 14-14	<input type="checkbox"/> 26-26	<input type="checkbox"/> 04-4th Grade	<input type="checkbox"/> 15-15	<input type="checkbox"/> 27-27	<input type="checkbox"/> 05-5th Grade	<input type="checkbox"/> 16-16	<input type="checkbox"/> 28-28	<input type="checkbox"/> 06-6th Grade	<input type="checkbox"/> 17-17	<input type="checkbox"/> 29-29	<input type="checkbox"/> 07-7th Grade	<input type="checkbox"/> 18-18	<input type="checkbox"/> 30-30	<input type="checkbox"/> 08-8th Grade	<input type="checkbox"/> 19-19	<input type="checkbox"/> 99900-Client declined to state	<input type="checkbox"/> 09-9th Grade	<input type="checkbox"/> 20-20	<input type="checkbox"/> 99904-Client unable to answer	<input type="checkbox"/> 10-10th	<input type="checkbox"/> 21-21	(only if client is in detox or developmentally disabled)		<input type="checkbox"/> 22-22	
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LEGAL / CRIMINAL JUSTICE		*REQUIRED																																				
*# of Arrests in Last 30 Days (Select # between 0 and 30)	*# of Jail Days in Last 30 (Select # between 0 and 30)																																					
*# of Prison Days in Last 30 (Select # between 0 and 30)	*# of Arrests in Last 6 Months (Select # between 0 and 30)																																					
*Criminal Justice Status <input type="checkbox"/> 1-No criminal justice involvement <input type="checkbox"/> 2-Under parole supervision from CDC <input type="checkbox"/> 3-On parole from any other jurisdiction <input type="checkbox"/> 4-Post-release Community Service (AB109) or on probation from any federal, state, or local jurisdiction <input type="checkbox"/> 5-Admitted under other diversion from any court under CA Penal Code Section 1000 <input type="checkbox"/> 6-Incarcerated <input type="checkbox"/> 7-Awaiting trial, charges or sentencing <input type="checkbox"/> 99904-Client unable to answer (only if client is in detox or developmentally disabled)																																						
*CDC Number	*Parolee Services Network (PSN) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client unable to answer (only if client is in detox or developmentally disabled)																																					
NOTE: CDC number is a valid six-character string of capital alpha (A-Z) and numeric (0-9) CDCR characters																																						



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CalOMS Admission

LEGAL / CRIMINAL JUSTICE		*REQUIRED
*FOTP Parolee <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client unable to answer (only if client is in detox or developmentally disabled)	*FOTP Priority Status <input type="checkbox"/> 1-Completed Forever Free and released and enrolled in treatment program <input type="checkbox"/> 2-Any woman paroling from CIW <input type="checkbox"/> 3-Completed Forever Free and goes direct to FOTP facility <input type="checkbox"/> 99902-None or not Applicable <input type="checkbox"/> 99904-Client unable to answer	
MEDICAL/PHYSICAL HEALTH		*REQUIRED
*# of Times Emergency Room in Past 30 (Select # between 0 and 30)	*Medi-Cal Beneficiary <input type="checkbox"/> 1-Yes <input type="checkbox"/> 0-No <input type="checkbox"/> 99904-Client unable to answer	
*# of Hospital Overnights in Past 30 Days (Select # between 0 and 30)	*Medication Prescribed as Part of Tx <input type="checkbox"/> 1-None <input type="checkbox"/> 2-Any woman paroling from CIW <input type="checkbox"/> 3-LAAM <input type="checkbox"/> 4-Buprenorphine (Subutex) <input type="checkbox"/> 5-Buprenorphine (Suboxone) <input type="checkbox"/> 99903-Other	
NOTE: Medications – Report Only medications prescribed by the provider for SUD treatment; this field is checked against the state’s Master Provider File to ensure the services being reported are consistent with what the provider is certified or licensed to provide.		
*# of Days Medical Problems in Past 30 (Select # between 0 and 30)	*Communicable Diseases: Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client declined to state <input type="checkbox"/> Client unable to answer	
*HIV Tested <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client declined to state <input type="checkbox"/> Client unable to answer	*Communicable Diseases: Hepatitis C <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client declined to state <input type="checkbox"/> Client unable to answer	
*HIV Test Results Received <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client declined to state <input type="checkbox"/> Client unable to answer	*Communicable Diseases: STD <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client declined to state <input type="checkbox"/> Client unable to answer	
*Pregnant at Admission (Auto-populates based on gender and previous pregnancy questions) <input type="checkbox"/> Yes <input type="checkbox"/> No		
MENTAL HEALTH		*REQUIRED
*Mental Illness Diagnosed <input type="checkbox"/> 1-Yes <input type="checkbox"/> 0-No <input type="checkbox"/> 99901-Not Sure / Don't Know	*# of Times Outpatient Emergency MH Services in Past 30 Days (Select # between 0 and 30)	
*# of 24hr Psychiatric Facility Stays in Past 30 Days (Select # between 0 and 30)	*Mental Health Medication in Past 30 Days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client unable to answer	
*Suicide Attempts <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the attempt in the last 30 days? (Required field if suicide answer is YES) <input type="checkbox"/> Yes <input type="checkbox"/> No	