

CalOMS Discharge Form Instructions

REQUIRED FORM:

The Discharge form is a required document in the client file

WHEN:

This form will be created at the end of the client's treatment episode 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.

NOTES:

SUD treatment providers must schedule and conduct a discharge interview with every client to ask each of the required CalOMS Tx standard discharge questions and document the responses. Providers should attempt to ensure the discharge interview is a face-to-face interview, but if a client is unable to appear for the scheduled discharge interview, then providers are strongly encouraged to contact the client by phone. Administrative discharges should only be reported in the event the client cannot be located, either in person or by telephone, to answer the CalOMS Tx questions. The unsuccessful attempts to contact a client for a CalOMS Tx discharge interview must be documented in the client's file. Providers should never complete responses on behalf of an absent client for the required CalOMS Tx discharge questions.

When to report an administrative discharge

Non-residential/outpatient programs: report an administrative discharge if the client has not had at least one face to face visit with a treatment counselor in 30 consecutive days. The discharge date should be the date the treatment counselor last saw the client.

Residential or day-program: report an administrative discharge if the client has been absent from the program without leave (from the program or treatment counselor) for 7 consecutive days. If leave has been granted and the client does not return by the date expected, begin counting from the day the client was due back to the program.

Definition of an administrative discharge

1. The client has stopped coming for treatment services without leave or notification to the SUD treatment program and the client cannot be located to be discharged and complete the CalOMS Tx discharge interview. Depending on the client's progress (as determined from the client's file or the counselor's interactions with the client while they were in the program) prior to leaving the program, the provider should report either "did not complete, made

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- satisfactory progress, not referred” (status 4), or “did not complete, made unsatisfactory progress, not referred” (status 6).
2. The client has died (status 7) prior to completing all of the planned SUD treatment services and thus cannot be interviewed for CalOMS Tx discharge data collection.
 3. The client has become incarcerated (status 8) prior to completing all of the planned SUD treatment services and thus cannot be interviewed for CalOMS Tx discharge data

Discharge Status

Under the Discharge Status question, **do not select “No Treatment Received”** for CalOMS submittals.



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

CalOMS Discharge

DISCHARGE PROFILE		(*REQUIRED)
*Discharge Date (mm / dd / yyyy)		*Admission Date (Auto-populates)
*Discharge Status -Do Not Use- "No Treatment Received"	1-Completed Tx/Recovery Plan Goals/Refer/Standard 2-Completed Tx/Recovery Plan Goals/Not Refer/Standard 3-Left Before Completion w/Satisfactory Progress/Standard 4-Left Before Completion w/Satisfactory Progress/Admin	5-Left Before Completion w/Unsatisfactory Progress/Standard 6-Left Before Completion w/Unsatisfactory Progress/Admin 7-Death 8-Incarceration 9-No Treatment Received
Ancillary Services Referral (Select all that apply)	0-None/No Other 1-Education/Literacy 2-Mental Health 3-Medical	4-Vocational 5-Family Counseling 6-Sober Living 7-Other
ALCOHOL & DRUG USE AT DISCHARGE		(*REQUIRED)
Primary Drug		
*Drug Type	0-None 1-Heroin 2-Alcohol 3-Barbiturates+ 4-Other Sedatives or Hypnotics+ 5-Methamphetamine 6-Other Amphetamines+ 7-Other Stimulants+	8-Cocain/Crack 9-Marijuana/Hashish 10-PCP 11-Other Hallucinogens+ 12-Tranquilizers(e.g.Benzodiazepine)+ 13-Other Tranquilizers+ 14-Non-Prescription Methadone 15-OxyCodone/OxyContin 16-Other Opiates or Synthetics+ 17-Inhalants+ 18-Over-the-Counter+ 19-Ecstasy 20-Other Club Drugs+ 99903-Other (specify)+
Drug Name (+Must specify name)		
*Number of Days Used in Past 30 Days	Must select # between 0 and 30 99902-None or not applicable	
*Route of Administration	1-Oral 2-Smoking	3-Inhalation 4-Injection (IV or intramuscular) 99902-None or not applicable (Will be rejected) 99903-Other
Secondary Drug		
*Drug Type	0-None 1-Heroin 2-Alcohol 3-Barbiturates+ 4-Other Sedatives orHypnotics+ 5-Methamphetamine 6-Other Amphetamines+ 7-Other Stimulants+	8-Cocain/Crack 9-Marijuana/Hashish 10-PCP 11-Other Hallucinogens+ 12-Tranquilizers(e.g. Benzodiazepine)+ 13-Other Tranquilizers+ 14-Non-Prescription Methadone 15-OxyCodone/OxyContin 16-Other Opiates or Synthetics+ 17-Inhalants+ 18-Over-the-Counter+ 19-Ecstasy 20-Other Club Drugs+ 99903-Other (specify)+
Drug Name (+Must specify name)		
*Number of Days Used in Past 30 Days	Must select # between 0 and 30 99902-None or not applicable	
*Route of Administration	1-Oral 2-Smoking	3-Inhalation 4-Injection (IV or intramuscular) 99902-None or not applicable 99903-Other
Tertiary Drug		
Drug Type	0-None 1-Heroin 2-Alcohol 3-Barbiturates+ 4-Other Sedatives or Hypnotics+ 5-Methamphetamine 6-Other Amphetamines+ 7-Other Stimulants+	8-Cocain/Crack 9-Marijuana/Hashish 10-PCP 11-Other Hallucinogens+ 12-Tranquilizers (e.g. Benzodiazepine)+ 13-Other Tranquilizers+ 14-Non-Prescription Methadone 15-OxyCodone/OxyContin 16-Other Opiates or Synthetics+ 17-Inhalants+ 18-Over-the-Counter+ 19-Ecstasy 20-Other Club Drugs+ 99903-Other (specify)+

*Required Field



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CalOMS Discharge

ALCOHOL & DRUG USE AT DISCHARGE (*REQUIRED)

*Number of Days Used in Past 30 Days	Must select # between 0 and 30 99902-None or not applicable
Route of Administration	1-Oral 2-Smoking 3-Inhalation 4-Injection (IV or intramuscular) 99902-None or not applicable 99903-Other
*Number of Days Alcohol Used in Past 30 Days	Auto-populates if 1 st or 2 nd drug is alcohol Must select # between 0 and 30
*Number of Days IV Used in Past 30 Days	Must select # between 0 and 30

TOBACCO / NICOTINE AT DISCHARGE (*REQUIRED)

*Have you ever used Tobacco/Nicotine products? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	<i>*Answering NO or UNKNOWN will cause remaining fields to auto-populate; if YES, continue answering the questions.</i>	
Smoker Status	1-Current every day smoker 2-Current some day smoker	3-Smoker, current status unknown 4-Former smoker
At what age did you first use tobacco/nicotine product(s)?	1-<=10 2-11-14 3-15-19	4-20-25 5-26-30 6->=31 97-Unknown
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 <i>(Unable to add or modify information in this field – leave blank)</i>		
In the past 30 days, how often did you use tobacco/nicotine product(s)?	1- 1-3 times in the past 30 days 2- Once a week 3- 3-6 times a week 4- Daily	5- 3-6 times a day 6- More than 6 times a day 97- Unknown
In the past 30 days, how many cigarettes did you smoke per week?		

FAMILY / SOCIAL AT DISCHARGE (*REQUIRED)

*Number of Days Social Support in Past 30 Must select # between 0 and 30	*Number of Children Under 18 Must select # between 0 and 30
*Current Living Arrangements 1-Homeless/In Shelter 1-Homeless/Living w Oher(s) 1-Homeless/Out of Shelter 2-Dependent Living 3-Independent Living	*Number of Children Age 5 or Less Must select # between 0 and 30

*Required Field



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*Number of Days Living w/User of Alcohol or Drugs in Past 30 Must select # between 0 and 30	*Number of Children Living w/Someone Else Because of a Child Protection Order Must select # between 0 and 30
(*REQUIRED)	
*Number of Days Family Conflict in Past 30 Must select # between 0 and 30	*Number of Children Living w/Someone Else for whom Parental Rights have been Terminated Must select # between 0 and 30
*Current Zip Code 00000-Homeless	
(*REQUIRED)	
*Employment Status	1-Employed Full Time (35 hours or more) 2-Part time (less than 35 hours) 3-Unemployed looking for work 4-Unemployed not in the labor force (not seeking) 5-Not in the labor force (not seeking)
*Number of Paid Work Days in Past 30	Must select # between 0 and 30 99900-Divide 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	
*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	
*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	
(*REQUIRED)	
LEGAL / CRIMINAL JUSTICE AT DISCHARGE	
*Number of Arrests in Last 30 Days	Must select # between 0 and 30
*Number of Jail Days in Last 30	Must select # between 0 and 30
*Number of Prison Days in Last 30	Must select # between 0 and 30
*Number of Arrests in Last 6 Months	Must select # between 0 and 30
(*REQUIRED)	
MEDICAL / PHYSICAL HEALTH	
*Number of Times Emergency Room in Past 30	Must select # between 0 and 99
*Number of Hospital Overnights in Past 30 Days	Must select # between 0 and 30

*Required Field



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*Number of Days Medical Problems in Past 30	Must select # between 0 and 30
MEDICAL / PHYSICAL HEALTH (*REQUIRED)	
*HIV Tested	
<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	
*Pregnant at Any Time During Tx	
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 99901-Not Sure/Don't Know	
*Outcome of Pregnancy (*Required if pregnant during treatment)	<input type="checkbox"/> Still Pregnant <input type="checkbox"/> Drug Free Birth <input type="checkbox"/> Terminated <input type="checkbox"/> Not Drug Free Birth <input type="checkbox"/> Miscarried
MENTAL HEALTH (*REQUIRED)	
*Mental Illness Diagnosed	
1-YES 0-NO 99901-Not Sure/Don't Know	
*Number of Times Outpatient Emergency MH Services in Past 30 Days	Must select # between 0 and 99
*Number of 24hr Psychiatric Facility Stays in Past 30 Days	Must 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/99904	

*Required Field