

TREATMENT DATA SYSTEM (TDS)

http://portalx.bisoex.state.me.us/pls/osa/tdsdev.main_menu_2.show

D-1 (Rev. 7/10)

DISCHARGE FORM D-1

A. DATE OF BIRTH MO DAY YEAR				B. LAST FOUR SS#				C. GENDER (Check ONE box only) <input type="checkbox"/> 01 MALE <input type="checkbox"/> 02 FEMALE		D. COUNTY OF RESIDENCE		AGENCY NAME / LOCATION																																		
E. FEDERAL IDENTIFIER CODE				F. CONTRACT NUMBER (Funded Agencies ONLY)				G. PRIMARY SERVICE CODE LIST G ON BACK		H. DATE OF FIRST FACE TO FACE CONTACT MO DAY YEAR				I. LAST FACE TO FACE CONTACT MO DAY YEAR																																
1. LIVING ARRANGEMENTS AT DISCHARGE		2. EMPLOYMENT STATUS (Check ONE box only)		3. EMPLOYABILITY FACTOR (Check ONE box only)		4. IF THE CLIENT HAS LEGAL CUSTODY OF HIS/HER CHILDREN, WHERE WERE THE CHILDREN WHILE THE CLIENT IS IN TREATMENT? IF NO DEPENDENTS GO TO #4 (Check ONE box only)		5. MH/MR ISSUES DIAGNOSIS BASED ON DSM-IV (Check ONE box only)		6. HOW MANY PSYCHIATRIC ADMISSIONS TO A HOSPITAL DID THE CLIENT HAVE DURING TREATMENT?		IF CLIENT AFFECTED/CO-DEPENDENT, GO TO QUESTION #14																																		
<input type="checkbox"/> 01 INDEPENDENT LIVING ALONE <input type="checkbox"/> 02 INDEPENDENT LIVING W/OTHERS <input type="checkbox"/> 03 DEPENDENT LIVING <input type="checkbox"/> 04 HOMELESS		<input type="checkbox"/> 01 FULL-TIME (35 HOURS OR MORE) <input type="checkbox"/> 02 PART-TIME (17-34 HOURS) <input type="checkbox"/> 03 IRREGULAR (LESS THAN 17 HOURS) <input type="checkbox"/> 04 UNEMPLOYED (HAS SOUGHT WORK) <input type="checkbox"/> 05 UNEMPLOYED (HAS NOT SOUGHT WORK) <input type="checkbox"/> 06 NOT IN LABOR FORCE <input type="checkbox"/> 07 FULL-TIME VOLUNTEER <input type="checkbox"/> 08 PART-TIME VOLUNTEER <input type="checkbox"/> 09 IRREGULAR VOLUNTEER		<input type="checkbox"/> 01 EMPLOYABLE OR WORKING NOW <input type="checkbox"/> 02 STUDENT <input type="checkbox"/> 03 HOMEMAKER <input type="checkbox"/> 04 RETIRED <input type="checkbox"/> 05 UNABLE FOR PHYSICAL/ PSYCHOLOGICAL REASONS <input type="checkbox"/> 06 INMATE OF INSTITUTION <input type="checkbox"/> 07 SEASONAL WORKER <input type="checkbox"/> 08 TEMPORARY LAYOFF <input type="checkbox"/> 09 UNABLE DUE TO SKILLS/RESOURCES <input type="checkbox"/> 10 UNABLE DUE TO PROGRAM REQUIREMENTS		<input type="checkbox"/> 01 WITH THE CLIENT <input type="checkbox"/> 02 SPOUSE/OTHER PARENT <input type="checkbox"/> 03 GRANDPARENTS/ RELATIVES <input type="checkbox"/> 04 FRIEND(S) <input type="checkbox"/> 05 BABYSITTER/CAREGIVER <input type="checkbox"/> 06 TEMP. FOSTER CARE <input type="checkbox"/> 99 OTHER		<input type="checkbox"/> 01 DIAGNOSED MENTAL ILLNESS/ DISORDER <input type="checkbox"/> 02 MENTAL RETARDATION <input type="checkbox"/> 00 NONE		7-10 DRUGS LISTED ON ADMISSION FORM		11-14 FREQUENCY OF USE OF DRUGS BY CLIENT (IN LAST 30 DAYS)																																		
15. ASSISTANCE RECEIVED DURING TREATMENT (Check YES or NO for each selection)		16. TYPE OF THERAPY		17. MEDICATION ASSISTED TREATMENT		18. PARTICIPATED IN SCHOOL OR TRAINING WHILE IN TREATMENT		19. FREQUENCY OF ATTENDANCE AT SELF-HELP PROGRAMS IN 30 DAYS PRIOR TO DISCHARGE		20. DID YOU RECOMMEND A SELF-HELP GROUP?																																				
YES NO <input type="checkbox"/> 01 <input type="checkbox"/> 02 A MEDICAL CARE <input type="checkbox"/> 01 <input type="checkbox"/> 02 B PRESCRIPTION MEDICATIONS <input type="checkbox"/> 01 <input type="checkbox"/> 02 C ACUPUNCTURE <input type="checkbox"/> 01 <input type="checkbox"/> 02 D CLIENT URINE TESTING <input type="checkbox"/> 01 <input type="checkbox"/> 02 E HIV RISK REDUCTION / ED <input type="checkbox"/> 01 <input type="checkbox"/> 02 F CHILD CARE <input type="checkbox"/> 01 <input type="checkbox"/> 02 G TRANSPORTATION TO TREATMENT <input type="checkbox"/> 01 <input type="checkbox"/> 02 H EMPLOYMENT/COUNSELING <input type="checkbox"/> 01 <input type="checkbox"/> 02 I CRISIS INTERVENTION <input type="checkbox"/> 01 <input type="checkbox"/> 02 J HOUSING ASSISTANCE <input type="checkbox"/> 01 <input type="checkbox"/> 02 K DRUG AND ALCOHOL EDUCATION		YES NO <input type="checkbox"/> 01 <input type="checkbox"/> 02 L FINANCIAL COUNSELING <input type="checkbox"/> 01 <input type="checkbox"/> 02 M ACADEMIC SERVICES <input type="checkbox"/> 01 <input type="checkbox"/> 02 N VOCATIONAL SERVICES <input type="checkbox"/> 01 <input type="checkbox"/> 02 O LEGAL SERVICES <input type="checkbox"/> 01 <input type="checkbox"/> 02 P TUBERCULOSIS SERVICES <input type="checkbox"/> 01 <input type="checkbox"/> 02 Q PRENATAL CARE <input type="checkbox"/> 01 <input type="checkbox"/> 02 R CHILD COUNSELING SERVICES <input type="checkbox"/> 01 <input type="checkbox"/> 02 S SMOKING CESSATION SERVICES <input type="checkbox"/> 01 <input type="checkbox"/> 02 T MENTAL HEALTH SERVICES <input type="checkbox"/> 01 <input type="checkbox"/> 02 Z OTHER		<input type="checkbox"/> 00 NONE <input type="checkbox"/> 01 CBT COGNITIVE BEHAVIORAL THERAPY <input type="checkbox"/> 02 MOTIVATIONAL INTERVIEWING <input type="checkbox"/> 03 DSAT DIFFERENTIAL SUBSTANCE ABUSE TREATMENT <input type="checkbox"/> 04 CYT CANNABIS YOUTH TREATMENT <input type="checkbox"/> 05 INTEGRATED CO-OCCURRING TREATMENT		(Check ONE box only) <input type="checkbox"/> 01 NO <input type="checkbox"/> 02 METHADONE <input type="checkbox"/> 03 LAAM <input type="checkbox"/> 04 BUPRENORPHINE/SUBOXONE/SUBUTEX <input type="checkbox"/> 05 CAMPRAL <input type="checkbox"/> 06 NALTRAXONE <input type="checkbox"/> 07 VIVITROL <input type="checkbox"/> 08 ANTABUSE		(Check ONE box only) <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO		(Check ONE box only) <input type="checkbox"/> 01 NO ATTENDANCE <input type="checkbox"/> 02 1 - 3 TIMES <input type="checkbox"/> 03 4 - 7 TIMES <input type="checkbox"/> 04 8 - 15 TIMES <input type="checkbox"/> 05 16 - 30 TIMES <input type="checkbox"/> 06 SOME ATTENDANCE, FREQUENCY UNKNOWN		(Check ONE box only) <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO																																		
21. "DELIBERATE" REFERRAL TO SUBSTANCE ABUSE SERVICES (Check ONE box only)				22. IF REFERRED - REFERRED AGENCY CODE		23. "DELIBERATE" REFERRAL TO OTHER THAN SUBSTANCE ABUSE TREATMENT																																								
<input type="checkbox"/> 00 NONE <input type="checkbox"/> 01 DETOXIFICATION <input type="checkbox"/> 02 DIAGNOSIS & EVALUATION <input type="checkbox"/> 03 IN-HOME FAMILY SUPPORT <input type="checkbox"/> 04 EXTENDED CARE <input type="checkbox"/> 05 EXTENDED SHELTER <input type="checkbox"/> 06 SHELTER <input type="checkbox"/> 07 OUTPATIENT COUNSELING (GENERAL)				<input type="checkbox"/> 08 INTENSIVE OUTPATIENT <input type="checkbox"/> 09 RES REHAB (SHORT TERM) <input type="checkbox"/> 10 HALF AND QUARTERWAY HOUSE <input type="checkbox"/> 11 ADOLESCENT RES REHAB TRANSITIONAL <input type="checkbox"/> 12 SUBSTANCE ABUSE PROFESSIONAL <input type="checkbox"/> 13 CONSUMER RUN RESIDENCE <input type="checkbox"/> 99 OTHER		SEE APPENDIX		YES NO <input type="checkbox"/> 01 <input type="checkbox"/> 02 A MENTAL HEALTH PROVIDER <input type="checkbox"/> 01 <input type="checkbox"/> 02 B OTHER HEALTH CARE PROVIDER <input type="checkbox"/> 01 <input type="checkbox"/> 02 C VOC REHAB/JOB REPLACEMENT <input type="checkbox"/> 01 <input type="checkbox"/> 02 D HIV ANTIBODY COUNSELING AND TESTING <input type="checkbox"/> 01 <input type="checkbox"/> 02 E SCHOOL COUNSELOR <input type="checkbox"/> 01 <input type="checkbox"/> 02 Z OTHER																																						
24. ARRESTS IN THE PRIOR 30 DAYS		25. NUMBER OF OUI ARRESTS DURING TREATMENT		26. HAS THE DEGREE OF PRESENTING PHYSICAL OR PSYCHOLOGICAL DEPENDENCE ON THE ALCOHOL AND / OR OTHER DRUG SUBSTANCE(S) IMPROVED AT DISCHARGE BASED ON DOCUMENTATION IN THE CLIENT'S RECORD? (Check ONE box only) <input type="checkbox"/> 01 YES <input type="checkbox"/> 02 NO <input type="checkbox"/> 99 AFFECTED OTHER		27. GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE ENTER THE APPROPRIATE LEVEL OF FUNCTIONING BASED ON THE GAF SCALE		28. STATUS AT DISCHARGE IF ANSWERED 30, (LEFT PROGRAM DUE TO LACK OF CHILDCARE) GO TO THE NEXT QUESTION, OTHERWISE SKIP TO QUESTION #30																																						
29. IF THE CLIENT LEFT DUE TO LACK OF CHILDCARE, WHAT WAS THE REASON? (Check ONE box only) <input type="checkbox"/> 01 ACCESSABILITY <input type="checkbox"/> 02 MONEY/COST <input type="checkbox"/> 03 LENGTH OF STAY/ TREATMENT <input type="checkbox"/> 99 OTHER		30. PRIMARY EXPECTED SOURCE OF PAYMENT		31. SECONDARY EXPECTED SOURCE OF PAYMENT (IF DIFFERENT FROM PRIMARY SOURCE)		32. TERTIARY EXPECTED SOURCE OF PAYMENT (IF DIFFERENT FROM PRIMARY OR SECONDARY SOURCE)		33. TOTAL NUMBER OF UNITS AND COST PER UNIT (LIST ON BACK OF FORM)																																						
								<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">CODE</th> <th style="width: 25%;">UNITS</th> <th style="width: 25%;">COST PER UNIT</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>						CODE	UNITS	COST PER UNIT																														
CODE	UNITS	COST PER UNIT																																												
DATE FORM COMPLETED MO DAY YEAR				FORM COMPLETED BY LAST NAME / FIRST				FORM EDITED BY LAST NAME / FIRST																																						

D. COUNTY CODES

AN	Androscoggin	PT	Penobscot
AK	Aroostook	PS	Piscataquis
CD	Cumberland	SC	Sagadahoc
FN	Franklin	ST	Somerset
HK	Hancock	WO	Waldo
KC	Kennebec	WN	Washington
KX	Knox	YK	York
LN	Lincoln	OS	Out of State
OD	Oxford	OC	Out of Country

G. PRIMARY SERVICE CODES

SUBSTANCE ABUSE/AFFECTED CLIENTS

REHABILITATION / RESIDENTIAL

03 Hospital (Other than Detoxification)

04 Short Term (30 Days or Less)

05 Extended Care

06 Halfway House

07 Extended Shelter

15 Adolescent Res. Rehab. Transitional

44 Consumer Run Residence

AMBULATORY

08 Non-Intensive Outpatient

11 Intensive Outpatient

12 Detoxification

13 Evaluation

18 Adolescent Outpatient

38 Adolescent Intensive Outpatient

40 Opioid Replacement Therapy

7-9. SUBSTANCE CODES

0000 None

Alcohol

0100 Alcohol

Marijuana

0200 Marijuana

Cocaine/Crack

0301 Cocaine

0302 Crack

Heroin/Morphine

0400 Heroin/Morphine

Methadone

0500 Methadone

Buprenorphine

0550 Buprenorphine

Other Opiates and Synthetics

0601 Codeine

0602 D-Propoxyphene

0603 Oxycodone (Percodan)

0604 Oxycontin

0605 Meperidine HCL

0606 Hydromorphone

0607 Other Narcotic Analgesics

0608 Pentazocine

PCP

0700 PCP or PCP Combination

Other Hallucinogens

0801 LSD

0802 Other Hallucinogens

Methamphetamine/Speed

0900 Methamphetamine/Speed

Other Amphetamines

1001 Amphetamine

1002 Methylphenidate (Ritalin)

1003 Methylenedioxymethamphetamine (MDMA, Ecstasy)

Other Stimulants

1100 Other Stimulants

Benzodiazepines

1201 Alprazolam (Xanax)

1202 Chlordiazepoxide (Librium)

1203 Clorazpate (Tranzene)

1204 Diazepam (Valium)

1205 Flurazepam (Dalmaine)

(Continued in next column)

1206 Lorazepam (Ativan)

1207 Triazolam (Halcoin)

1208 Other Benzodiazepine

Other Tranquilizers

1301 Meprobarnate (Miltown)

1302 Other Tranquilizers

Barbiturates

1401 Phenobarbital

1402 Secobarbital/Amobarbital (Tuinal)

1403 Secobarbital (Seconal)

Other Sedatives and Hypnotics

1501 Ethchlorvynol (Placidyl)

1502 Glutethimide (Doriden)

1503 Methaqualone

1504 Other Non-Barbiturate Sedatives

1505 Other Sedatives

1506 Flunitrazepam (Rohypnol)

1507 GHB/GBL

1508 Ketamine (Special K)

1509 Clonazepam (Klonopin, Rivotril)

Inhalants

1601 Aerosols

1602 Nitrites

1603 Other Inhalants

1604 Solvents

1605 Anesthetics

Over the Counter

1700 Over the counter, General

1701 Diphenhydramine (Benadryl)

Other

1801 Diphenylhydantoin Sodium (Phenytoin, Dilantin)

1802 Other Drugs

11-13. FREQUENCY OF USE

00 None (Cannot be used on #10)

02 No use past month

03 Once in last 30 days

04 2-3 days per/month

05 Once per/week

06 2-3 days per/week

07 4-6 days per/week

08 Daily

14. TOBACCO PRODUCTS ONLY (FOR USE WITH #14 ONLY)

00 None

09 Not Currently Smoking (Discharge Only)

10 About 1/2 Pack/Can/Pouch a Day or Less

11 About 1 Pack/Can/Pouch a Day

12 About 1 1/2 Pack/Can/Pouch a Day

13 About 2 Packs/Cans/Pouches a Day

14 More than 2 Packs/Cans/Pouches a Day

28. STATUS AT DISCHARGE

01 Client termination without Clinic agreement (i.e. Client leaves without explanation)

02 Treatment is complete

03 Further treatment is not appropriate for Client at this facility

04 Non-compliance with rules & regulations

05 Client refused service/treatment

06 Unable to follow program requirements

30 Client left program due to lack of childcare

07 Client discharged for medical and/or psychological TX

08 Client moved out of catchment area

09 Client cannot get to facility for further service/treatment

10 Client cannot come for service/treatment during facility hours

11 Client incarcerated

12 Client deceased

13 Parents/Legal Guardian withdrew client

14 Termination due to program cut/reduction

15 Treatment completed for affected Other / Co-Dependent

16 Treatment not completed for affected other/co-dependent

17 Evaluation only

21 Evaluation incomplete

30-32. EXPECTED SOURCES OF PAYMENT

00 None (Cannot be used on #27 Primary)

01 OSA

02 Human Services (other than child, adult protective)

03 Corrections

04 Human Services (child, adult protective)

05 Self-pay

06 MaineCare (Medicaid)

07 Medicare

08 Blue Cross/Blue Shield

09 Health Maintenance Organization (HMO)

10 Other private health insurance

11 Town assistance

12 Workers' Compensation

13 Veterans' Administration

99 Other

33. UNITS OF SERVICE CODES

REHABILITATION / RESIDENTIAL

03 Hospital (Other than Detoxification)

04 Short Term Res. Rehab.

05 Extended Care

06 Halfway House

07 Extended Shelter

11 Consumer Run Residence

21 Res. Rehab. Adolescent Transitional

AMBULATORY

08 Individual

09 Family

10 Group

13 Intensive Outpatient

15 Evaluation

16 Opioid Replacement Therapy