Office of Substance Abuse

Waiting List Report Form

Agency Name: ________________________________ **Location:** __________________________________

Contact Person: ___________________________________	Reporting Month and Year:
Contact Phone #: (_______) __________-_____________	___________________________________

Service Setting	Residential No. of Beds	Residential No. of Beds Filled	Non-Residential Client Capacity	Non-Residential End of the Month Census

Priority Population Code	TDS Client ID	Initial Contact Date	Date and Agency Referred for Prenatal Care	Date and Agency Referred for HIV Testing	Date and Agency Entered Substance Abuse Treatment	Date of Agency Follow-up, Comments Disposition*

Priority Population Codes:
1 - Pregnant Injection Drug User
2 - Pregnant Substance Abuser
3 - Injection Drug User (within last 5 years)
4 - Male/Female Substance Abuser
5 - All Others (affected family members, ACOSs, etc.)

**Please place the date and a check mark in this box if the client doesn't call in to remain on the waiting list.*
Please return the completed form to the Office of Substance Abuse no later than the 15th of the following month to Mary Beaudoin
Fax: (207) 287-8910 or email to Mary.Beaudoin@maine.gov

For OSA Use Only

Tx ________ ________ *Log* _______ ________ *DE* ________ ________