



AGENCY NUMBER

# DBHR Target Detox Short Form

### Client Identification

1. LAST NAME		2. FIRST NAME		3. MIDDLE NAME	
4. OTHER LAST NAME			5. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		6. DATE OF BIRTH
7. SOCIAL SECURITY NUMBER*			8. WASHINGTON DRIVER'S LICENSE OR ID NUMBER		
8. WHICH RACE/ETHNICITY GROUP WOULD YOU IDENTIFY YOURSELF WITH (CHECK A MAXIMUM OF FOUR THAT APPLY)					
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Native American	<input type="checkbox"/> Thai		
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hawaiian (Native)	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Vietnamese		
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> White/European American		
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Race		Tribal Code (No. 1) _____	
<input type="checkbox"/> Filipino	<input type="checkbox"/> Laotian	<input type="checkbox"/> Refused to Answer		Tribal Code (No. 2) _____	
<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Samoan				
9. SPANISH/HISPANIC/LATINO (CHECK ONE BOX ONLY)					
<input type="checkbox"/> Cuban	<input type="checkbox"/> Not Spanish/Hispanic/Latino	<input type="checkbox"/> Puerto Rican			
<input type="checkbox"/> Mexican, Mexican American, Chicano	<input type="checkbox"/> Other Spanish/Hispanic/Latino	<input type="checkbox"/> Refused to answer			

### Treatment Information

BEGIN DATE	BEGIN TIME	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	END DATE	END TIME	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
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### Key Codes

PST CODES	ADMINISTRATION CODES	FREQUENCY OF USE / PEAK USE PER MONTH
Primary (1)	Inhalation (I) Oral (O)	1 - No use 4 - 13 or more times
Secondary (2)	Injection (J) Other (X)	2 - 1 to 3 times 5 - Daily
Tertiary (3)	Intra nasal (N) Smoking (S)	3 - 4 to 12 times 6 - Unknown

### Substances

SUBSTANCE	PST (CHECK ONE BOX PER SUBSTANCE)			SUBSTANCE	PST (CHECK ONE BOX PER SUBSTANCE)		
	1	2	3		1	2	3
1. Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. No substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Other Sedatives or Hypnotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Other Opiates and Synthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Over the Counter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Oxy/Hydro Codone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Prescribed Opiate Substitute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Major tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Substance Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Marijuana – Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Tobacco products (cannot be primary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 1. IN THE FOLLOWING TABLE DESCRIBE SUBSTANCE USE WITH THE ABOVE KEY CODES.

PST	SUBSTANCE (CODE)	ADMIN (CODE)	AGE OF FIRST USE	FREQUENCY OF USE IN LAST 30 DAYS (CODE)	PEAK USE PER MONTH IN LAST YEAR (CODE)	DATE LAST USED MM/DD/YYYY	AMOUNT TAKEN/COMMENTS
1							
2							
3							

\* The Social Security Act provides for the collection of Social Security Number to assist in the administration of public funded programs.

**DBHR Target Detox Short Form**

CLIENT NAME		AGENCY NUMBER	STAFF IDENTIFICATION
2. CONTRACT (CHECK ONE BOX ONLY)			
<input type="checkbox"/> Adult Outpatient	<input type="checkbox"/> Criminal Justice (CJ)	<input type="checkbox"/> Criminal Justice – Innovation	<input type="checkbox"/> Local Sales Tax
<input type="checkbox"/> Other/None	<input type="checkbox"/> Pregnant/Post Partum	<input type="checkbox"/> Youth Treatment	
3. FUND SOURCE (CHECK ONE BOX ONLY)			
<input type="checkbox"/> Agency Funded	<input type="checkbox"/> Federal Direct	<input type="checkbox"/> Private Pay	<input type="checkbox"/> State Non DSHS
<input type="checkbox"/> County Community Services	<input type="checkbox"/> Other	<input type="checkbox"/> State Direct	<input type="checkbox"/> Tribal Community Services
4. TITLE XIX FUNDED		5. INSURANCE PAYMENT (CHECK ONE BOX ONLY)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Less than 50%	<input type="checkbox"/> 50% or greater
		<input type="checkbox"/> No Insurance Payment	
6. SPECIAL PROJECT STATE		7. SPECIAL PROJECT COUNTY	8. SPECIAL PROJECT AGENCY
9. CURRENT PUBLIC ASSISTANCE (CHECK ONE BOX ONLY)			
<input type="checkbox"/> Applicant	<input type="checkbox"/> None		
<input type="checkbox"/> Aged, Blind or Disabled (ABD)	<input type="checkbox"/> Refugee Assistance		
<input type="checkbox"/> Medicaid Alternative Benefit Plan (ABP)	<input type="checkbox"/> Supplemental Security Income (SSI; S01)		
<input type="checkbox"/> Medical Assistance Only	<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)		
10. ENTRY REFERRAL (CHECK ALL THAT APPLY)			
<input type="checkbox"/> Alcohol/Drug Treatment Program	<input type="checkbox"/> Employer / EAP	<input type="checkbox"/> Other Health Care Provider	
<input type="checkbox"/> At Risk Youth (ARY / CHINS)	<input type="checkbox"/> First Steps or PPP Case	<input type="checkbox"/> Pharmacist	
<input type="checkbox"/> Attorney	<input type="checkbox"/> Gambling Facility	<input type="checkbox"/> Phone Book	
<input type="checkbox"/> BECCA Involved	<input type="checkbox"/> Group Care	<input type="checkbox"/> Police	
<input type="checkbox"/> Court / Probation	<input type="checkbox"/> Help Line	<input type="checkbox"/> School/Education	
<input type="checkbox"/> DCFS / CPS	<input type="checkbox"/> Involuntary Commitment	<input type="checkbox"/> Self/Help	
<input type="checkbox"/> Department of Corrections (DOC)	<input type="checkbox"/> JRA	<input type="checkbox"/> Self/Family	
<input type="checkbox"/> Department of Licensing (DOL)	<input type="checkbox"/> Mass Media	<input type="checkbox"/> Social Security Administration	
<input type="checkbox"/> Detoxification Facility	<input type="checkbox"/> MD / Primary Care Provider	<input type="checkbox"/> Website	
<input type="checkbox"/> Diversion	<input type="checkbox"/> Mental Health Provider	<input type="checkbox"/> Other:	
<input type="checkbox"/> DSHS Community Services Office	<input type="checkbox"/> Other Alcohol / Drug Facility		
11. DETOX END REFERRAL (CHECK ALL THAT APPLY)			
<input type="checkbox"/> ATR Services	<input type="checkbox"/> Medical/Dental Services	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> CSO	<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Referred to CD Treatment	
<input type="checkbox"/> Housing Support Services	<input type="checkbox"/> None	<input type="checkbox"/> Self-Help Group	
<input type="checkbox"/> Involuntary Treatment (ITA)	<input type="checkbox"/> Not Amenable to Treatment /		
<input type="checkbox"/> Gambling Treatment	<input type="checkbox"/> Lacks Engagement		
12. DISCHARGE OR CLOSURE TYPE (CHECK ONE BOX ONLY)			
<input type="checkbox"/> Client Died	<input type="checkbox"/> Inappropriate Admission	<input type="checkbox"/> Transferred to Different Facility	
<input type="checkbox"/> Completed Treatment	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Withdrew Against Program Advice	
<input type="checkbox"/> Funds Exhausted	<input type="checkbox"/> Rule Violation	<input type="checkbox"/> Withdrew With Program Advice	
13. GOVERNING COUNTY		14. RECOMMENDED ASAM PLACEMENT LEVEL	
15. HOMELESS OR ON THE STREET		16. STAFF ID	
<input type="checkbox"/> Yes	<input type="checkbox"/> No		