|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DDAP-EFM-1007 12/15 | | | | | | | | **Client Discharge**  (Required fields are in **BOLD**) | | | | | | | | | **Provider Location:**  **Provider Name:**  **DDAP License #:** | | | | | | | | | | |
| **UCN:** |  | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **First Name:** | |  | | | | | | | | M.I.: |  | | | **Last Name**: | |  | | | | | | | | Suffix: |  | |  |
|  | | |  | | | | | | | | | |  | | | | | | | |  | | | | | |  |
| **Admit Date:** | | |  | | | | | | | | | | **Discharge Date**: | | | | | | |  | | | | | |  | |
| **Last Treatment Date**: | | | | | |  | | | | | | | **Discharge Reason**: | | | | | | | | |  | | | |  | |
|  | | | | | | | | | | | | | (Please Select) | | | | | | | | | | | | | |  |
| If Discharge Reason is “Terminated by Facility” or “Transferred to Other D&A Facility”, then answer the following: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Did the client request an alternate provider referral?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, was an alternate referral made?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason why client requested provider change? | | | | | | | | | | | |  | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | (Please Select) | | | | | | | | | | | | | | | |
| **GENERAL** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Living Arrangement**: | | | | | | |  | | | | | | | | | | | | | | | | | | | |  |
| (Please Select) | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Employment Status**: | | | | |  | | | | | | | | Detail not in Labor Force: | | | | | | | | | |  | | | |  |
| (Please Select) | | | | | | | | | | | | | (**Required if Employment Status is “Not in Labor Force”)** | | | | | | | | | | | | | |  |
| **No. of Client Arrests 30 Days Prior to Discharge**: | | | | | | | | |  | | | | | | | | | | | | | | | | | |  |
| **Frequency of self-help program attendance in the 30 days prior to discharge**: | | | | | | | | | | | | | | | | | | |  | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | (Please Select) | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **SUBSTANCE ABUSE AT DISCHARGE** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PRIMARY DRUG** | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Substance Abused**: | | | |  | | | | | | | | | | | **Frequency**: | | |  | | | | | | | | |  |
| (Please Select) (Please Select) | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **SECONDARY DRUG** | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Substance Abused: | | | |  | | | | | | | | | | | Frequency: | | |  | | | | | | | | |  |
| (Please Select) (Please Select) | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **TERTIARY DRUG** | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Substance Abused: | | | |  | | | | | | | | | | | Frequency: | | |  | | | | | | | | |  |
| (Please Select) (Please Select) | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Additional Information: | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Form to be submitted to SCA if required by the SCA for case management purposes.

INFORMATION MUST BE RETAINED BY THE PROVIDER FOR FEDERAL REPORTING