CalOMS Admission Form Instructions

REQUIRED FORM:

The Admission Form is a required document in the client's file. Each participant's initial admission to the facility and any subsequent transfers or changes in service should be reported on a separate CalOMS Tx Admission form.

WHEN:

This form will be created at Intake-Admission to be defined as the first day of the participant's treatment/service. All Admission data must be gathered within seven days of a person's first day of treatment 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.

NOTE:

If the client transfers or has a change in service, the episode must be discharged and a new episode opened with a new admission form. The discharge should reflect "referred" and the admission under the new episode would be marked as a "transfer".

The "Special Population Program" question is now reflecting specific populations and is no longer tracking funding sources.

County of San Diego
Behavioral Health Services

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

CalOMS Admission

ADMISSION ADMINISTRATION *REQUIRED

Screening

Potential Client for MH ☐ Yes ☐ No	Basis for Decision	☐ Based on Screening ☐ Based on Referral ☐ Based on Testing Result	☐ Court Ordered Treatment ☐ Ct Ord Screening/Assessment
Potential Client for TBI ☐ Yes ☐ No	Basis for Decision	☐ Based on Screening ☐ Based on Referral ☐ Based on Testing Result	☐ Court Ordered Treatment ☐ Ct Ord Screening/Assessment

***Admission Date** (mm / dd / yyyy)	**Codependent/Collateral** ☐ Yes ☐ No
***Admission/Transaction Type** ☐ 1-Initial Admission ☐ 2-Transfer of Change in Service	***CalWORKs Recipient** ☐ Yes ☐ No ☐ Not Sure/Don't Know
***Type of Treatment Service** ☐ 1-Nonresidential/Outpatient Treatment/Recovery ☐ 2-Nonresidential/Outpatient Day Program- intensive ☐ 3-Nonresidential/Outpatient Detoxification ☐ 5-Residential Detoxification (non-hospital) ☐ 6-Residential Treatment/recovery (30 days or less) ☐ 7-Residential Treatment/recovery (31 days or more)	***SA Tx Under CalWORK** ☐ Yes ☐ No ☐ Not Sure/Don't Know
***Submit to CalOMS** ☐ Yes ☐ No	***Admission Staff**
***# of Days Waited to Enter Tx**	***Special Services Contract ID** (Always NA) ☐ NA
***# of Prior Episodes**	***Special Services/Contract County Code** (Always Not Applicable) ☐ Not Applicable

Record Status

Record Created By	Created Date
Last Updated By	Last Updated Date
CalOMS Form Serial #	Last Upload to State Date
CADDS Form Serial #	

ADMISSION ADMINISTRATION *REQUIRED

Program Fees	**Intake Fees**
Drug Testing Participation ☐ Yes ☐ No ☐ Not Sure/Don't Know	**Testing Level Indicator** (Please indicate color)
Baseline UA Completed ☐ Yes ☐ No ☐ Not Sure/Don't Know	**Drug Screening Fees**
Pictures Taken ☐ Yes ☐ No ☐ Not Sure/Don't Know	**Encounter Fees**

***Required Field**
BHS/SUD, S111 (10/23)

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

CalOMS Admission

ADMISSION ADMINISTRATION *REQUIRED

Prop. 36 Start Date	**Prop. 36 End Date**	**JURIS #**

***Special Population Program**
(Not related to Funding Source)

- ☐ Non BHS Contract
- ☐ AB 109 Participant
- ☐ CalWORKs Participant
- ☐ Drug Court Participant
- ☐ Juvenile Drug Court Participant
- ☐ ReEntry Court Participant
- ☐ Prop 47 Participant
- ☐ PC 1000 Participant
- ☐ None

***How did you hear about us?**

- ☐ 1-Access and Crisis Line (ACL)
- ☐ 2-SUD/Prevention Brochures
- ☐ 3-County SUD Web Site
- ☐ 4-Help/Info Line (211)
- ☐ 5-Crim Justice
  i.e., Probation/Court/Parole/Law Enforcement
- ☐ 6-ER/Trauma/Hospital
- ☐ 7-Homeless Shelter
- ☐ 8-Mental Health Program
- ☐ 9-Primary Care Physician / Health Clinic
- ☐ 10-Family Member
- ☐ 11-Outreach Worker (HOW, HOT, etc.)
- ☐ 12-Return Participant
- ☐ 13-Other - Please Explain
- ☐ 14-Not Applicable

If Other, Specify

Administrative Checklist
(Select all that apply)

- ☐ Personal Rights Given
- ☐ Emergency Contract release signed
- ☐ Property Inventory done
- ☐ Have the rules been read and signed
- ☐ Medical assessment form
- ☐ Release of Information Form has been signed
- ☐ Acknowledgement of receipt of privacy
- ☐ Chemical Free agreement, has it been read and signed
- ☐ Orientation Packet been reviewed and signed
- ☐ Consent to Treatment
- ☐ Health Questionnaire Given

ALCOHOL & DRUG USE *REQUIRED

Primary Drug

***Drug Type**

- ☐ 0-None (Will be rejected)
- ☐ 1-Heroin
- ☐ 2-Alcohol
- ☐ 3-Barbiturates
- ☐ 4-Other Sedatives or Hypnotics
- ☐ 5-Methamphetamine
- ☐ 6-Other Amphetamines
- ☐ 7-Other Stimulants
- ☐ 8-Cocaine / 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)

***Number of Days Used in Past 30 Days**
Number 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

***Age of First Use** Must select # between 5 and 105 | 99904-Unable to answer (only if client is in detox or developmentally disabled)

***Required Field**

CalOMS Admission

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

ALCOHOL & DRUG USE *REQUIRED

Secondary Drug

***Drug Type**

- ☐ 0-None (Will be rejected)
- ☐ 1-Heroin
- ☐ 2-Alcohol
- ☐ 3-Barbiturates
- ☐ 4-Other Sedatives or Hypnotics
- ☐ 5-Methamphetamine
- ☐ 6-Other Amphetamines
- ☐ 7-Other Stimulants
- ☐ 8-Cocaine / 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)

***Number of Days Used in Past 30 Days**
Number 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

***Age of First Use** Must select # between 5 and 105 | 99904-Unable to answer (only if client is in detox or developmentally disabled)

Tertiary Drug

***Drug Type**

- ☐ 0-None (Will be rejected)
- ☐ 1-Heroin
- ☐ 2-Alcohol
- ☐ 3-Barbiturates
- ☐ 4-Other Sedatives or Hypnotics
- ☐ 5-Methamphetamine
- ☐ 6-Other Amphetamines
- ☐ 7-Other Stimulants
- ☐ 8-Cocaine / 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)

***Number of Days Used in Past 30 Days**
Number 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

***Age of First Use** Must select # between 5 and 105 | 99904-Unable to answer (only if client is in detox or developmentally disabled)

*** # of Days Alcohol Used in Past 30**

*** # of Days IV Used in Past 30**

*** Used Needles in Past 12 Months**

- ☐ Yes
- ☐ No
- ☐ Client unable to answer

TOBACCO / NICOTINE *REQUIRED

***Have you ever used Tobacco/Nicotine products?**
*(*Answering NO or UNKNOWN will cause remaining fields to auto- populate; if YES, continue answering the questions.)*

☐ Yes ☐ No ☐ Unknown

***Smoker Status**

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Smoker, current status unknown
- ☐ 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

***Required Field**

CalOMS Admission

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

TOBACCO / NICOTINE *REQUIRED

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 *(Unable to add or modify information in this field – leave blank)*

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 *REQUIRED

***# of Days Social Support in Past 30** (Select # between 0 and 30)

***# of Children Under 18** (Select # between 0 and 30)

***Current Living Arrangements**

☐ 1-Homeless/In Shelter
☐ 1-Homeless/Living w Other(s)
☐ 1-Homeless/Out of Shelter
☐ 2-Dependent Living
☐ 3-Independent Living

*** # of Children Age 5 or Less** (Select # between 0 and 30)

***# of Children Living w/Someone Else for whom Parental Rights have been Terminated** (Select # between 0 and 30)

***# of Children Living w/Someone Else Because of a Child Protection Order** (Select # between 0 and 30)

***# of Days Family Conflict in Past 30** (Select # between 0 and 30)

***# of Children Living w/Someone Else for whom Parental Rights have been Terminated** (Select # between 0 and 30)

***Current Zip Code** (00000-Homeless)

Abuse Characteristics

***Does episode involve physical abuse?** ☐ Perpetrator ☐ Victim ☐ No ☐ Unwilling to Answer

***Does episode involve sexual abuse?** ☐ Perpetrator ☐ Victim ☐ No ☐ Unwilling to Answer

***Does episode involve domestic abuse?** ☐ Perpetrator ☐ Victim ☐ No ☐ Unwilling to Answer

***Required Field**

CalOMS Admission

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

EMPLOYMENT *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)

***# of Paid Work Days in Past 30** (Select # between 0 and 30)
99900-Decline to state
99904-Unable to answer (only if client is in detox or developmentally disabled)

***Enrolled in School**
☐ **Yes** ☐ No ☐ **Client declined to state** ☐ **Client unable to answer** (Only if client is in detox or developmentally disabled)

***Enrolled in Job Training**
☐ **Yes** ☐ No ☐ **Client declined to state** ☐ **Client unable to answer** (Only if client is in detox or developmentally disabled)

***Graduated from High School**
☐ **Yes** ☐ No ☐ **Client declined to state** ☐ **Client unable to answer** (Only if client is in detox or developmentally disabled)

***Highest School Grade Completed**
- ☐ 00-Kindergarten
- ☐ 01-1st Grade
- ☐ 02-2nd Grade
- ☐ 03-3rd Grade
- ☐ 04-4th Grade
- ☐ 05-5th Grade
- ☐ 06-6th Grade
- ☐ 07-7th Grade
- ☐ 08-8th Grade
- ☐ 09-9th Grade
- ☐ 10-10th
- ☐ 11-11th Grade
- ☐ 12-12th Grade
- ☐ 13-13
- ☐ 14-14
- ☐ 15-15
- ☐ 16-16
- ☐ 17-17
- ☐ 18-18
- ☐ 19-19
- ☐ 20-20
- ☐ 21-21
- ☐ 22-22
- ☐ 23-23
- ☐ 24-24
- ☐ 25-25
- ☐ 26-26
- ☐ 27-27
- ☐ 28-28
- ☐ 29-29
- ☐ 30-30
- ☐ 99900-Client declined to state
- ☐ 99904-Client unable to answer (only if client is in detox or developmentally disabled)

LEGAL / CRIMINAL JUSTICE *REQUIRED

***# of Arrests in Last 30 Days** (Select # between 0 and 30)

***# of Jail Days in Last 30** (Select # between 0 and 30)

***# of Prison Days in Last 30** (Select # between 0 and 30)

***# of Arrests in Last 6 Months** (Select # between 0 and 30)

***Criminal Justice Status**
- ☐ 1-No criminal justice involvement
- ☐ 2-Under parole supervision from CDC
- ☐ 3-On parole from any other jurisdiction
- ☐ 4-Post-release Community Service (AB109) or on probation from any federal, state, or local jurisdiction
- ☐ 5-Admitted under other diversion from any court under CA Penal Code Section 1000
- ☐ 6-Incarcerated
- ☐ 7-Awaiting trial, charges or sentencing
- ☐ 99904-Client unable to answer (only if client is in detox or developmentally disabled)

***CDC Number**

***Parolee Services Network (PSN)**
- ☐ Yes
- ☐ No
- ☐ Client unable to answer (only if client is in detox or developmentally disabled)

NOTE: CDC number is a valid six-character string of capital alpha (A-Z) and numeric (0-9) CDCR characters

***Required Field**

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

CalOMS Admission

LEGAL / CRIMINAL JUSTICE *REQUIRED

***FOTP Parolee**
☐ Yes
☐ No
☐ Client unable to answer
(only if client is in detox or developmentally disabled)

***FOTP Priority Status**
☐ 1-Completed Forever Free and released and enrolled in treatment program
☐ 2-Any woman paroling from CIW
☐ 3-Completed Forever Free and goes direct to FOTP facility
☐ 99902-None or not Applicable
☐ 99904-Client unable to answer

MEDICAL/PHYSICAL HEALTH *REQUIRED

***# of Times Emergency Room in Past 30**
(Select # between 0 and 30)

***Medi-Cal Beneficiary**
☐ 1-Yes ☐ 0-No ☐ 99904-Client unable to answer

***# of Hospital Overnights in Past 30 Days**
(Select # between 0 and 30)

***Medication Prescribed as Part of Tx**
☐ 1-None
☐ 2-Methadone
☐ 3-LAAM
☐ 4-Buprenorphine (Subutex)
☐ 5-Buprenorphine (Suboxone)
☐ 99903-Other

NOTE: Medications – Report Only medications prescribed by the provider for SUD treatment; this field is checked against the state's Master Provider File to ensure the services being reported are consistent with what the provider is certified or licensed to provide.

***# of Days Medical Problems in Past 30**
(Select # between 0 and 30)

***Communicable Diseases: Tuberculosis**
☐ Yes ☐ No ☐ Client declined to state ☐ Client unable to answer

***HIV Tested**
☐ Yes ☐ No ☐ Client declined to state ☐ Client unable to answer

***Communicable Diseases: Hepatitis C**
☐ Yes ☐ No ☐ Client declined to state ☐ Client unable to answer

***HIV Test Results Received**
☐ Yes ☐ No ☐ Client declined to state ☐ Client unable to answer

***Communicable Diseases: STD**
☐ Yes ☐ No ☐ Client declined to state ☐ Client unable to answer

***Pregnant at Admission** (Auto-populates based on gender and previous pregnancy questions) ☐ Yes ☐ No

MENTAL HEALTH *REQUIRED

***Mental Illness Diagnosed**
☐ 1-Yes ☐ 0-No ☐ 99901-Not Sure / Don't Know

***# of Times Outpatient Emergency MH Services in Past 30 Days**
(Select # between 0 and 30)

***# of 24hr Psychiatric Facility Stays in Past 30 Days**
(Select # between 0 and 30)

***Mental Health Medication in Past 30 Days**
☐ Yes ☐ No ☐ Client unable to answer

***Suicide Attempts**
☐ Yes ☐ No

Was the attempt in the last 30 days?
(Required field if suicide answer is YES)
☐ Yes ☐ No