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 PROFILE (*REQUIRED)

Screening

Potential Client for MH ☐ **YES** ☐ **NO**	☐ Based on Screening ☐ Based on Referral ☐ Based on Testing Result	☐ Court Ordered Treatment ☐ Court Ordered Screening/Assessment
Potential Client for TBI ☐ **YES** ☐ **NO**	☐ Based on Screening ☐ Based on Referral ☐ Based on Testing Result	☐ Court Ordered Treatment ☐ Court Ordered Screening/Assessment

***Admission Date**	**Codependent/Collateral** ☐ **YES** ☐ **NO**
***Admission/Transaction Type** 1-Initial Admission 2-Transfer or 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 CalWORKs** ☐ **YES** ☐ **NO** ☐ **Not Sure/Don't Know**

***Submit to CalOMS** (All DHCS funded programs must submit CalOMS. Check with program manager if unsure.)

☐ **YES** ☐ **NO**

***Admission Staff** (Auto-populates based on staff login; can be changed to reflect actual intake staff)

***Number of Days Waited to Enter Tx** Must select # between 0 and 999 Number of days waited for services due to unavailability of slots starting on the day client was accepted for treatment services, ending first day services began. Do not include days waited due to other circumstances unique to client's life.	***Special Services Contract ID** (Always NA) ☐ **NA**
***Number of Prior Episodes**	***Special Services/Contract County Code** (Always Not Applicable) ☐ **Not Applicable**

ADMISSION ADMINISTRATION (*REQUIRED)

Program Fees	**Intake Fees**
Drug Testing Participation ☐ **YES** ☐ **NO** ☐ **Not Sure/Don't Know**	**Testing Level Indicator**
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**

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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-Any 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** **Drug Name** (+Must specify name)	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-Cocain/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+ 99901-Unknown (Will be rejected) 99903-Other (specify)+

***Number of Days Used in Past 30 Days**	Must select # 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 (Will be rejected) 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)

Secondary Drug

***Drug Type**	0-None (Will be rejected) 1-Heroin 2-Alcohol 3-Barbiturates+	8-Cocain/Crack 9-Marijuana/Hashish 10-PCP 11-Other Hallucinogens+	16-Other Opiates or Synthetics+ 17-Inhalants+ 18-Over-the-Counter+ 19-Ecstasy

***Required Field**

County of San Diego
Behavioral Health Services

Provider Id: _____
Client Name: _____
Client #: _____
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CalOMS Admission

Drug Name (+Must specify name)	4-Other Sedatives or Hypnotics+ 5-Methamphetamine 6-Other Amphetamines+ 7-Other Stimulants+	12-Tranquilizers (e.g.Benzodiazepine)+ 13-Other Tranquilizers+ 14-Non-Prescription Methadone 15-OxyCodone/OxyContin	20-Other Club Drugs+ 99901-Unknown (Will be rejected) 99903-Other (specify)+

***Number of Days Used in Past 30 Days**	Must select # between 0 and 30 99902-N/A or None		
***Route of Administration**	1-Oral 2-Smoking	3-Inhalation 4-Injection (IV / 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** **Drug Name** (+Must specify name)	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-Cocain/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+ 99901-Unknown (Will be rejected) 99903-Other (specify)+

***Number of Days Used in Past 30 Days**	Must select # between 0 and 30 99902-N/A or None		
***Route of Administration**	1-Oral 2-Smoking	3-Inhalation 4-Injection (IV / 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)		

***Number of Days Alcohol Used in Past 30 Days**	***Number of Days IV Used in Past 30 Days**	***Used Needles in Past 12 Months** ☐ **YES** ☐ **NO** ☐ **Unable to Answer/99904**

TOBACCO / NICOTINE (*REQUIRED)

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

***Required Field**

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CalOMS Admission

TOBACCO / NICOTINE (*REQUIRED)

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)

***Number of Days Social Support in Past 30** Must select # between 0 and 30	***Number of Children Under 18** Must select # between 0 and 30
***Current Living Arrangements** 1-Homeless 2-Dependent Living 3-Independent Living	***Number of Children Age 5 or Less** Must select # between 0 and 30
***Number of Days Living w/User of Alcohol or Drugs in Past 30** Must select # between 0 and 30	***Number of Children Living w/Someone Else Because of a Child Protection Order** Must select # between 0 and 30
***Number of Days Family Conflict in Past 30** Must select # between 0 and 30	***Number of Children Living w/Someone Else for whom Parental Rights have been Terminated** Must 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

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)
***Number of Paid Work Days in Past 30**	Must 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/99900** ☐ **Client unable to answer/99904** (Only if client is in detox or developmentally disabled)

***Required Field**

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Behavioral Health Services

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CalOMS Admission

EMPLOYMENT (*REQUIRED)

***Enrolled in Job Training**

☐ **YES** ☐ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904** (Only if client is in detox or developmentally disabled)

***Graduated from High School**

☐ **YES** ☐ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904** (Only if client is in detox or developmentally disabled)

***Highest School Grade Completed**

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

LEGAL / CRIMINAL JUSTICE (*REQUIRED)

***Number of Arrests in Last 30 Days**	Must select # between 0 and 30 99904-Unable to answer (only if client is in detox or developmentally disabled)
***Number of Jail Days in Last 30**	Must select # between 0 and 30 99904-Unable to answer (only if client is in detox or developmentally disabled)
***Number of Prison Days in Last 30**	Must select # between 0 and 30 99904-Unable to answer (only if client is in detox or developmentally disabled)
***Number of Arrests in Last 6 Months**	Must select # between 0 and 30 99904-Unable to answer (only if client is in detox or developmentally disabled)
***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)
Type of Sentence	Conditional Sentence Formal Probation Parole
***CDC Number**	99900-Declined to state 99904-Unable to answer (only if client is in detox or developmentally disabled) 99901-Not sure 99902-None

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

***Parolee Services Network (PSN)**

☐ **YES** ☐ **NO** ☐ **Client unable to answer/99904 (**only if client is in detox or developmentally disabled)

***FOTP** (Always select NO – not offered in San Diego County) ☐ **NO**	***FOTP Priority Status** (Always select 99902) ☐ **99902**

***Required Field**

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Provider Id: _____
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CalOMS Admission

MEDICAL / PHYSICAL HEALTH (*REQUIRED)

***Number of Times Emergency Room in Past 30** Must select # between 0 and 99	***Medi-Cal Beneficiary** **1- YES 0- NO ☐ 99904- Client unable to answer**	
***Number of Hospital Overnights in Past 30 Days** Must select # between 0 and 30	***Medication Prescribed as Part of Tx** 1-None 2-Methadone 3-LAAM	4-Buprenophrine (Subutex) 5-Buprenorphine (Suboxone) 99903-Other
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.		
***Number of Days Medical Problems in Past 30** Must select # between 0 and 30	***Communicable Diseases: Tuberculosis** ☐ **YES** ☐ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904**	
***HIV Tested** ☐ **YES** ☐ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904**	***Communicable Diseases: Hepatitis C** ☐ **YES** ☐ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904**	
***HIV Test Results Received** ☐ **YES** ☐ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904**	***Communicable Diseases: STD** ☐ **YES** ☐ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904**	
***Pregnant at Admission** ☐ **YES** ☐ **NO**	(Auto-populates based on gender and previous pregnancy questions.)	

MENTAL HEALTH (*REQUIRED)

***Mental Illness Diagnosed** **1-YES 2- NO 3- 99901-Not Sure/Don't Know**	
***Number of Times Outpatient Emergency MH Services in Past 30 Days**	Must select # between 0 and 99 99904-Unable to answer (only if client is in detox or developmentally disabled)
***Number of 24hr Psychiatric Facility Stays in Past 30 Days**	Must select # between 0 and 30 99904-Unable to answer (only if client is in detox or developmentally disabled)
***Mental Health Medication in Past 30 Days** ☐ **YES** ☐ **NO** ☐ **Client unable to answer/99904** (only if client is in detox or developmentally disabled)	
***Suicide Attempts** ☐ **YES** ☐ **NO**	
***Was the attempt in the last 30 days?** (*Required field if suicide answer is YES) ☐ **YES** ☐ **NO**	

***Required Field**