

## ADMISSION AND DISCHARGE

### REFERRAL AND DECISION TRACKING SUMMARY

Program# \_\_\_\_\_

Client Name: \_\_\_\_\_

Counsellor: \_\_\_\_\_

Date: \_\_\_\_\_

DATE COMPLETED (dd/mm/yyyy)	TOOL					Comments:
	<b>DRUG HISTORY QUESTIONNAIRE</b>					
	<b>ADVERSE CONSEQUENCES</b>					
	<b>SOCRATES</b>		Alcohol	Drug*	Drug*	Comments:
		Recognition				
		Ambivalence				
		Taking Steps				
	<b>DTCQ-8</b>		Alcohol	Drug*	Drug*	Comments:      List: (If applicable) Drug #1 _____  Drug #2 _____
		Unpleasant Emotions				
		Physical Discomfort				
		Pleasant Emotions				
		Testing Personal Control				
		Urges/Temptations				
		Conflict with Others				
		Social Pressure				
		Pleasant Times				
	<b>Global Score=</b>					
	<b>TREATMENT ENTRY QUESTIONNAIRE</b>	Internal Positive ____/28 Internal Negative ____/21 External/Coercion ____/28				Comments:
	<b>BASIS – 32</b>	Relation to Self/Others _____ Daily Living/Role Functioning _____ Depression/Anxiety _____ Impulsive/Addictive _____ Psychosis _____ <b>Overall Score</b> _____				Comments:
	<b>PERCEIVED SOCIAL SUPPORT</b>	Family ____/7 Friends ____/7				Comments:

\*Note: List drug that has been assessed in “Comments” column. If more than 2 drugs, use a separate sheet.

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**CONCERNS FROM HEALTH SCREENING FORM:**

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<b>ADMISSION &amp; DISCHARGE GUIDELINES RECOMMENDED</b>	<b>(Check all that apply)</b>	<b>REFERRAL SUGGESTED; (name agencies)</b>	<b>Accepted?</b>
➤ Withdrawal Management Services	Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>
➤ Stabilization Services	Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>
➤ Community Treatment Services	Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>
➤ Medical/Psychiatric Services	Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>
➤ Residential Treatment Services	Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>
➤ Residential Support Services	Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>

**IF GUIDELINES WERE NOT FOLLOWED, WHY NOT?**

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**CLINICAL NOTES (If more space needed insert third page)**

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\_\_\_\_\_  
Counsellor Signature

Date: \_\_\_\_\_

\*Insert third page if necessary

