Alameda County Behavioral Health
Alcohol & Drug Division

Substances Use Disorder Registration

Confidential Patient Information
See Welfare & Institutions Code: 5328

New Registration: ☐ Update: ☐ Data Entry Initials: _____
SmartCare Client ID Number: _____ (***SmartCare data entry staff ONLY***, for new clients enter NEW)
Program: _____
Client Last Name: _____
Client First Name: _____
Client Middle Name: _____ **Client Suffix** if applicable

Please Print Legibly
Highlighted fields are **required**
*Asterisk fields are required for CalOMS data reporting

Program (tab):

Programs Section:

*Primary Program Name: _____
Program Status: ☐ Enrolled
*Assigned Staff: _____ (Staff Client is Assigned To)
Requested Date: Field not used
*Enrolled Date:_____(Date Client is Enrolled to begin Treatment)
Comment: _____(Optional field)

Episode (tab):

Case Information Section:
Initial Referral/Screening Date: Field not used
Registration Date:_____(required on first initial registration into program only, Date should be same as Enrollment Date)
Information: System informational data field only
Registration Comment: System informational data field only

CalOMS Episode Information Section:

Transaction Type: ☐Initial Admission
*CalOMS Program/FSN _____
Request Date: Field not used
First Service Date: Field not used
*Referral Type: _____ ☐ Not Sure/Don't Know ☐Client Unable to Answer
Referral Subtype: Field not used
*How many days was the client on a waiting list before being admitted to this treatment program: _____
☐Not Sure/Don't Know ☐Client Unable to Answer
*What is the number of prior episodes in any alcohol or Drug Treatment program in which the client has participated? ____
☐Not Sure/Don't Know ☐Client Unable to Answer
*Is there a consent form allowing future possible contact, signed by the client, on file with your agency? ☐Yes ☐No

Referral Resource Section: Section not used
Referral Reason: Section not used

Client Name: _____

General (tab)

General Information:

Type Of Client: System informational data field only

Client ID: Auto populates from client information screen

Client SSN: _____(enter clients 9-digit Social Security Number, if no SSN enter all 9's)

*Unable to Obtain SSN Reason ☐Client Decline to State ☐None/Not Applicable ☐Client Unable to Answer

Primary Care Coordinator: Field not used at this time

Medical Provider: Field not used at this time

Prefix: _____ (Enter the Client's Prefix) optional field

Client's Email: _____ optional Active: System informational data field only

*Is the Client a Medi-Cal Beneficiary ☐Yes ☐No ☐Client Unable to Answer Client's Medi-Cal ID: Field not used at this time

Professional Suffix Field not used at this time

*Client's First Name At Birth: _____(enter Same if same as client's current First Name)

Client's Middle Name At Birth: _____(enter Same if same as client's current Middle Name)

*Client's Last Name At Birth: _____ (enter Same if same as client's current Last Name)

Client's Suffix at Birth: _____ (enter Same if same as client's current Suffix name)

Phone Numbers:

Home: (_____)_____ - _____(Client's Home Phone Number) Optional

Mobile: (_____)_____ - _____(Client's Secondary Phone Number) Optional

DNC: Field not used at this time

DNLM: Field not used at this time

Address:

Address Details: Enter Clients Home Address (If homeless Enter the Zip Code for the City Hall of the city where the client indicates they most often sleep (in a shelter or on the street).

Street: _____

City: _____

State: _____

Zip: _____ (zip +4 not required)

Billing: ☐ (Check If The Billing Address Is The Same As Home Address)

Comment: Field not used at this time

Demographic And Client Information (tab):

Identifying Information:

*Date Of Birth:_____(Date Client Was Born)

*Sex: _____ (Client's Sex At Birth)

Marital Status: _____

Gender Identity: _____

Sexual Orientation: _____

Deceased On: Do Not Complete this field

Client Name: _____

Cause Of Death: Do Not Complete this field

*Preferred Pronoun: _____

*Ethnicity: (multi-select field; select as many ethnicities as applicable)

☐Cuban	☐Nicaraguan	☐South American
☐Mexican/Mexican American	☐Non-Hispanic	☐Other Hispanic
☐Other Latino	☐Puerto Rican	☐Salvadoran

*Race: (multi-select field; select as many races as applicable)

☐Alaskan Native	☐Guamanian	☐Other Asian
☐American Indian	☐Hmong	☐Other Pacific Islander
☐Asian Indian	☐Japanese	☐Other Southeast Asian
☐Black or African American	☐Korean	☐Unknown/Not Reported
☐Cambodian	☐Laotian	☐Vietnamese
☐Chinese	☐Mien	☐White or Caucasian
☐Filipino	☐Mixed Race/Multiracial	

Client Declined To Provide: Field not used

Additional Identifying Information Section:

*Place Of Birth – Country: _____ (If client was born outside the United States, then Birth State and Birth County are not required)

*Place Of Birth – State: _____(If client was not born in CA, then the County is not required)

*Place Of Birth – County: _____ (required if client was born in CA)

Special Population: Field not used

*Driver License State: _____☐Client Decline to State ☐None/Not Applicable ☐Client Unable to Answer ☐Other (born outside United State)

*Driver License#: _____

Primary Care Physician (PCP) Section: Section not used

Financial Information Section: Section not used

Family Information Section:

*If the client is not male, is the client pregnant at the time of admission? ☐ Yes ☐ No

*What is the first name of the client's mother, or individual the client considers to be their mother _____

(If unknown, enter "Mother" as first Name)

*How many children does the client have aged 17 or less (birth or adopted), whether they live with the client or not? _____ ☐Client Unable to Answer

*How many children does the client have age 5 or younger? _____ ☐Client Unable to Answer

*How many of the client's children age 17 and under are living with someone else because of a child protection court order?

_____ ☐Client Unable to Answer

Client Name: _____

*If the client has children living with someone else because of a child protection court order, for how many of these children aged 17 or under have the client's parental rights been terminated? _____ ☐Client Unable to Answer

*How many days in the last 30 days has the client experienced family conflict? _____ ☐Client Unable to Answer

Living Arrangement Section:

*Living: _____ (Indicate the living arrangement of the client)

*County Of Residence: _____ (Indicate Which County the Client Lives In)

*County Of Financial Responsibility: _____ (Indicate the County directly or indirectly Financially Responsible for the client's services, if unknown enter Alameda)

Educational/Employment Section:

*Educational Status: _____ (Indicate Client's Highest Level Of Education)

*Veteran Status: ☐Yes ☐No ☐Unknown

*Military Status: _____ ☐Yes ☐No ☐Client Declined to State ☐Client Unable to Answer Due to Disability ONLY

*What is the client's highest school grade completed? _____ ☐Client Declined to State ☐Client Unable to Answer

*Employment Status: _____ (Indicate Client's Current Employment Status)

Employment Information: _____ (Optional)

Additional Educational/Employment Information Section:

*Is this client a CalWORKs Recipient? ☐Yes ☐No ☐Not Sure/Don't know (***If you select "yes", please complete the below follow-up question)***

*Is the client receiving substance abuse treatment under the CalWORKs welfare-to-work plan? ☐Yes ☐No ☐Not Sure/Don't know

*How many days was the client paid for working in the past 30 days? _____ ☐Client Declined to State ☐Client Unable to Answer

*Is the client currently enrolled in school? ☐Yes ☐No ☐Not Sure/Don't know ☐Client Unable to Answer

*Is the client currently enrolled in a job training program? ☐Yes ☐No ☐Client Declined to State ☐Client Unable to Answer

Language Section:

*Primary Language: _____ (Indicate what Primary Language the client speaks)

*Preferred Language: _____ (Indicate what Preferred Language the client speaks)

Client Does Not Speak English: Field not used at this time

*Hispanic Origin: _____ (indicate the client's Hispanic Origin)

Interpreter Services Needed: Field not used at this time

Legal Information Section:

*What is the Clients Criminal Justice status?_____

*How many times has the client been arrested in the past 30 days? _____ ☐Client Unable to Answer

*How many days has the client been in jail in the past 30 days? _____ ☐Client Unable to Answer

*How many days has the client been in prison in the past 30 days? _____ ☐Client Unable to Answer

Client Name: _____

*Is the client a parolee in the Parolee Services Network (PSN) ☐Yes ☐No

*What is the Client's CDCR Identification Number? _____ ☐None ☐Client Declined to State ☐Not Sure/Don't know ☐Client Unable to Answer

*Is the client a parolee in the Female Offender Treatment Program (FOTP)? ☐Yes ☐No

*What is the client's FOTP Priority Status_____

SUD, Medical & Mental Health Tab

Substance Use Information Section:

***Primary Drug Information**

*What is the client's primary alcohol or drug problem? _____

*How many days in the past 30 days has the client used the primary drug? _____ ☐None or not applicable

*What is the client's usual route of administration they use most often for their primary drug of abuse? _____

*What was the client's age of first use for the primary drug of abuse? _____ ☐Client Unable to Answer

***Secondary Drug Information**

*What is the client's primary alcohol or drug problem? _____ (Enter "None" if no secondary drug information.)

*How many days in the past 30 days has the client used the primary drug? _____ ☐None or not applicable

*What is the client's usual route of administration they use most often for their primary drug of abuse? _____

*What was the client's age of first use for the primary drug of abuse? _____ ☐Client Unable to Answer

Additional Substance Use Information Section

*How many days has the client used needles to inject drugs in the past 30 days? _____ ☐Client Declined to State ☐Client Unable to Answer

*Has the client used needles to inject drugs in the past twelve months? ☐Yes ☐ No ☐Client Unable to Answer

*How many days in the past 30 days has the client lived with someone who uses alcohol or drugs? _____ ☐Client Declined to State ☐Client Unable to Answer

*How many days in the last 30 days has the client participated in any social support recovery activities such as: 12-step meetings, other self-help meetings, religious / faith recovery or self-help meetings, meetings of organizations other than those listed above, interactions with family members and/or friend support of recovery? _____ (enter "0" if none)

Mental Health Information Section

*Has the client ever been diagnosed with a mental illness. ☐Yes ☐ No ☐Not Sure/Don't know

*In the past 30 days, has the client taken prescribed medication for mental health needs? ☐Yes ☐ No ☐Client Unable to Answer

*How many days in the past 30 days has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs? _____ ☐Client Unable to Answer

*How many times in the past 30 days has the client received outpatient emergency services for mental health needs? _____ ☐Client Unable to Answer

Medical Information Section:

*How many times has the client visited an emergency room in the past 30 days? _____ ☐Client Unable to Answer

*How many days has the client stayed overnight in a hospital in the last 30 days for physical health problems? _____ ☐Client Unable to Answer

Client Name: _____

*How many days in the past 30 days has the client experienced physical health problems? _____ ☐Client Unable to Answer

*What type of disability/disabilities does the client have, if any? (multi-select field; select as many disabilities as applicable)

☐None ☐Visual ☐Hearing ☐Speech ☐Mobility ☐Mental ☐Developmentally Disabled ☐Other Disability (not SUD) ☐Client Declined to State ☐Client Unable to Answer

*What medication is prescribed as part of treatment? _____

*Has the client been diagnosed with Tuberculosis? ☐Yes ☐No ☐Client Declined to State ☐Client Unable to Answer

*Has the client been diagnosed with Hepatitis C? ☐Yes ☐No ☐Client Declined to State ☐Client Unable to Answer

*Has the Client been diagnosed with any sexually transmitted diseases? ☐Yes ☐No ☐Client Declined to State ☐Client Unable to Answer

*Has the client been tested for HIV/AIDS? ☐Yes ☐No ☐Client Declined to State ☐Client Unable to Answer

*Does the client have the results of the HIV/AIDs Test? ☐Yes ☐No ☐Client Declined to State ☐Client Unable to Answer

Alias (TAB):

First Name: _____ First Name: _____

Middle Name: _____ Middle Name: _____

Last Name: _____ Last Name: _____

Type: _____ Type: _____

Client Contacts (TAB): Optional at this time (if information is collected, must completed the required fields to insert and save the Client Contact information)

Relation: _____ (Enter Relationship)

First Name: _____ (enter Relationship First name)

Last Name: _____ (enter Relationship Last Name)

Suffix: _____ (enter Relationship suffix name if applicable)

Check Whether the Client's Relation Is the Following:

☐Financially Responsible	☐Care Team Member
☐Household Member	☐Guardian
☐Emergency Contact	☐Healthcare Decision Maker

Phone Numbers: OPTIONAL (enter Relationship's phone number)

Home: (_____) _____ - _____

Mobile: (_____)_____ - _____

DNC: Field not used at this time

DNLM: Field not used at this time

Addresses: OPTIONAL (enter Relationship's address)

Street: _____

Zip: _____

City: _____

State: _____

Billing: ☐ (Check If the Billing Address Is The Same As Home Address)