SECTION: Record Management

Clinic Information

1. Select the SBIRT-funded clinic site for which you are reporting:

    a. Cassopolis
    b. Catherine's Health Center
    c. Taylor Teen Health Center
    d. Saginaw Valley State University Campus Mental Health & Wellness Center
    e. Standish-Sterling School Based Health Center
    f. Whittemore-Prescott SBHC

Patient Information

1. Patient ID: _____
2. GPRA survey date (MM/DD/YYYY): _____

SECTION H

SBIRT Program Specific Questions

The following items are intended to be completed administratively by clinic staff and should not be asked of the patient.

1. Please indicate which type of funding was/will be used to pay for the SBIRT services provided to this patient. *Select all that apply.*

    a. Current SAMHSA grant funding
    b. Other federal grant funding
    c. State funding
    d. Patient's private insurance
    e. Medicaid/Medicare
    f. TRICARE
    g. Other (SPECIFY): _____

2. When the SBIRT was administered, how did the patient screen? *Indicate the highest level of screening or assessment completed*.

a. Negative (negative screen OR negative brief assessment)
b. Positive

3. What was the patient's screening and/or assessment score? Provide details for screening/assessment results **ONLY** for screening/assessment tools utilized with the patient. Do **NOT** complete sections for screening/assessment tools not utilized

- ○ NIAAA-Single Alcohol Score: _____
- ○ NIDA-Single Drug (+Marijuana) Score: _____
- ○ CRAFFT Part A Score: _____
- ○ RAAPS Score: _____
- ○ Alcohol Use Disorders Identification Test (AUDIT) Score: _____
- ○ Drug Abuse Screening Test (DAST) Score: _____
- ○ CRAFFT Part B Score: _____

4. Was the patient willing to continue their participation in SBIRT services?

- ○ Yes
- ○ No

5. If the patient screened positive for substance misuse or a substance use disorder, which of the following SBIRT services was the patient **assigned** to?

- ○ Brief Intervention
- ○ Brief Treatment
- ○ Referral to Treatment

6. Which of the following SBIRT services did the patient **receive**?

- ○ Brief Intervention **(skip to Q8)**
- ○ Brief Treatment **(continue to Q7)**
- ○ Referral to Treatment

7. Patients receiving **Brief Treatment** must complete a DISCHARGE GPRA survey at the completion of service. Indicate if the GPRA survey to be entered is a Brief Treatment Intake OR Discharge.

- ○ Intake
- ○ Discharge

8. Patients receiving **Brief Intervention** must complete a DISCHARGE GPRA survey at the completion of SBIRT service. Indicate if the GPRA survey to be entered is a Brief Intervention Intake and/or Discharge**. For patients receiving 1 session of Brief Intervention**, a GPRA intake survey and discharge can be completed in one sitting.

   - ○ Intake
   - ○ Discharge
   - ○ Intake AND Discharge (1 session of BI provided)

SECTION A: Demographics (INTAKE)

This section collects demographic information on the patient. While some of the information may seem apparent, ask all questions for clarification. Do not complete a response based on the client's appearance. Ask the question and make the response given by the client.

1. What is the patient's birth **month** and **year**?
   a. Date of birth (MM/YYYY): _____
   b. REFUSED
   c. Information Unavailable

2. What do you consider yourself to be?
   a. Male
   b. Female
   c. Transgender (Male to Female)
   d. Transgender (Female to Male)
   e. Gender non-conforming
   f. Other (SPECIFY): _____
   g. REFUSED
   h. Information Unavailable

3. Are you Hispanic, Latino/a, or of Spanish origin?
   a. Yes **(go to Q4)**

b. No **(skip to Q5)**
c. REFUSED **(skip to Q5)**
d. Information Unavailable **(skip to Q5)**

4. ***If Yes, to Q3:*** What ethnic group do you consider yourself?
    a. Central American
    b. Cuban
    c. Dominican
    d. Puerto Rican
    e. South American
    f. Mexican
    g. Other (SPECIFY): _____
    h. REFUSED
    i. Information Unavailable

5. What is your race?
    a. Black or African American
    b. White
    c. American Indian
    d. Alaska Native
    e. Asian Indian
    f. Chinese
    g. Filipino
    h. Japanese
    i. Korean
    j. Vietnamese
    k. Other Asian
    l. Native Hawaiian
    m. Guamanian or Chamorro
    n. Samoan
    o. Other Pacific Islander
    p. Other (SPECIFY): _____

q. REFUSED
r. Information Unavailable

6. The assessment was conducted in:
    a. English
    b. Spanish
7. Do you speak a language other than English at home?
    a. Yes **(go to Q8)**
    b. No **(skip to Q9)**
    c. REFUSED **(skip to Q9)**
    d. Information Unavailable **(skip to Q9)**

8. ***If Yes, to Q7:*** What is this language? (If other, please specify.)
    a. Spanish
    b. Other (SPECIFY): _____
    c. REFUSED
    d. Information Unavailable
9. Do you think of yourself as… *Select all that apply.*
    a. Straight or Heterosexual
    b. Bisexual
    c. Asexual
    d. Homosexual (Gay or Lesbian)
    e. Queer, Pansexual, and/or Questioning
    f. Other (SPECIFY): _____
    g. REFUSED
    h. Information Unavailable
10. What is your relationship status?
    a. Married
    b. Single
    c. Divorced
    d. Separated
    e. Widowed

f. In a relationship
g. In multiple relationships
h. REFUSED
i. Information Unavailable

11. **(If MALE was not selected)** Are you currently pregnant?
    a. Yes
    b. No
    c. Do not know
    d. REFUSED
    e. Information Unavailable

12. Do you have children? *Refers to children both living and/or who may have died.*
    a. Yes **(continue to Q13)**
    b. No **(skip to Q18)**
    c. REFUSED **(skip to Q18)**
    d. Information Unavailable **(skip to Q18)**

13. How many children under the age of 18 do you have?
    a. Number: _____ **(if 0, skip to Q18)**
    b. REFUSED **(skip to Q18)**
    c. Information Unavailable **(skip to Q18)**

14. Are any of your children, who are under the age of 18, living with someone else due to a court's intervention?
    a. Yes **(continue to Q15)**
    b. No **(skip to Q18)**
    c. REFUSED **(skip to Q18)**
    d. Information Unavailable **(skip to Q18)**

15. How many of your children, who are under the age of 18, are living with someone else due to a court's intervention?

a. Number: _____
b. REFUSED
c. Information Unavailable

16. Have you been reunited with any of your children, under the age of 18, who have previously been removed from your care?
    a. Yes **(continue to Q17)**
    b. No **(skip to Q18)**
    c. REFUSED **(skip to Q18)**
    d. Information Unavailable **(skip to Q18)**

17. How many children, under the age of 18, have you been reunited with who were previously removed from your care?
    a. Number: _____
    b. REFUSED
    c. Information Unavailable

18. Have you ever served in the Armed Forces, in the Reserves, in the National Guard, or in other Uniformed Services? *If served,* What area, the Armed Forces, Reserves, National Guard, or other did you serve?
    a. No
    b. Yes, in the Armed Forces
    c. Yes, in the Reserves
    d. Yes, in the National Guard
    e. Yes, Other Uniformed Service (includes NOAA, USPHS)
    f. REFUSED
    g. Information Unavailable

19. How long does it take you, on average, to travel to the location where you receive services provided by this grant?
    a. Half an hour or less
    b. Between half an hour and one hour (30 minutes - 1 hour)

c. Between one hour and one and a half hours (1 hour - 1.5 hours)
d. Between one and a half hours and two hours (1.5 hours - 2 hours)
e. Two hours or more
f. REFUSED
g. Information Unavailable

SECTION B: Substance Use (INTAKE)

This section contains items to measure alcohol and other substance use in the past 30 days; substance use and mental health diagnoses; receipt of FDA-approved medications to treat alcohol, opioid, tobacco, and stimulant disorders; overdose and treatment history.

B1. During the **past 30 days**, have you used any of the following substances? **If no substance use in the past 30 days, skip to Question B2.**

Alcohol	○ Yes	○ No
Opioids	○ Yes	○ No
Cannabis (Marijuana)	○ Yes	○ No
Sedatives, Hypnotics, or Anxiolytics	○ Yes	○ No
Cocaine	○ Yes	○ No
Other Stimulants (Methamphetamine)	○ Yes	○ No
Hallucinogens & Other Psychedelics	○ Yes	○ No
Inhalants	○ Yes	○ No
Other Psychoactive Substances (Ketamine/Bath Salts)	○ Yes	○ No
Tobacco & Nicotine	○ Yes	○ No

During the **past 30 days**, how many days have you used any substance, and how do you take the substance?

A. **The number of days, in the past 30 days, that the client reports using a substance (DO NOT READ TO PATIENT)**
   The client should be encouraged to list the substances on their own. If they are unsure, the list from the table below can be read to the client. Please note that not all substance use is considered harmful or illicit - it may be that a substance is prescribed by a licensed provider, or that the client uses the substance in accordance with official, national safety guidelines. In such instances, clarification from the client should be sought, but if the substance is only taken as prescribed or used on each occasion in accordance with official, national safety guidelines, then it is not considered misuse.
B. **The route by which the substance is used. (DO NOT READ TO PATIENT)**
   Mark one route only for each substance used. But, if the client identifies more than one route, chose the corresponding routs with the highest associated number value: (1) Oral, (2) Nasal, (3) Smoking, (4) Non-IV Injection, and (5) Intravenous (IV) Injection.

ALCOHOL – PAST 30 DAYS (continue if ALCOHOL was selected in B1. Skip if NOT SELECTED)

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OPIOIDS – PAST 30 DAYS (continue if OPIOIDS was selected in B1. Skip if NOT SELECTED)

HEROIN

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

MORPHINE

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

FENTANYL (PRESCIPTION DIVERSION OR ILLICIT SOURCE)

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

DILAUDID

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

DEMEROL

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

PERCOCET

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

CODEINE

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

TYLENOL 2, 3,4

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OXYCONTIN/OXYCODONE

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

NON-PERSCRIPTION METHADONE

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

NON-PERSCRIPTION BUPRENORPHINE

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER (PLEASE SPECIFY): _____

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

CANNABIS – PAST 30 DAYS (continue if CANNABIS was selected in B1. Skip if NOT SELECTED)

CANNABIS (MARIJUANA)

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

SYNTHETIC CANNABINOIDS

Number of days used: _____

Route of administration

a. Oral
a. Nasal
b. Smoking
c. Non-IV Injection
d. Intravenous (IV) Injection

OTHER (PLEASE SPECIFY): _____

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

SEDATIVES, HYPNOTICS, OR ANXIOLYTICS – (continue if SEDATIVES, HYPNOTICS, OR ANXIOLYTICS was selected in B1. Skip if NOT SELECTED)

SEDATIVES

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

HYPNOTICS

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

BARBITUATES

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

ANXIOLYTICS/BENZODIAZEPINES

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER (PLEASE SPECIFY): _____

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

COCAINE – <u>PAST 30 DAYS</u> (continue if COCAINE was selected in B1. Skip if NOT SELECTED)

COCAINE

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

CRACK

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER (PLEASE SPECIFY): _____

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER STIMULANTS – <u>PAST 30 DAYS</u> (continue if OTHER STIMULANTS was selected in B1. Skip if NOT SELECTED)

METHAMPHETAMINE

Number of days used: _____

Route of administration

f. Oral
g. Nasal
h. Smoking
i. Non-IV Injection
j. Intravenous (IV) Injection

STIMULANT MEDICATIONS

Number of days used: _____

Route of administration

f. Oral
g. Nasal
h. Smoking
i. Non-IV Injection
j. Intravenous (IV) Injection

OTHER (PLEASE SPECIFY): _____

Number of days used: _____

Route of administration

f. Oral
g. Nasal
h. Smoking
i. Non-IV Injection
j. Intravenous (IV) Injection

HALLUCINOGENS & OTHER PSYCHEDELICS – <u>PAST 30 DAYS</u> (continue if HALLUCINOGENICS & OTHER PSYCHEDELICS was selected in B1. Skip if NOT SELECTED)

PCP

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

MDMA

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

LSD

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

MUSHROOMS

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

MESCALINE

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

SALVIA

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

DMT

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER (PLEASE SPECIFY): _____

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

INHALANTS – PAST 30 DAYS (continue if INHALANTS was selected in B1. Skip if NOT SELECTED)

INHALANTS

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER (PLEASE SPECIFY): _____

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER PSYCHOACTIVE SUBSTANCES – PAST 30 DAYS (continue if OTHER PSYCHOACTIVE SUBSTANCES was selected in B1. Skip if NOT SELECTED)

NON-PRESCIPTION GHB

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

KETAMINE

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

MDPV/BATHSALTS

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

KRATOM

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

KHAT

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER TRANQUILZERS

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER DOWNERS

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER SEDATIVES

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER HYPNOTICS

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

OTHER (PLEASE SPECIFY): _____

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

TOBACCO & NICOTINE – <u>PAST 30 DAYS</u> (continue if TOBACCO & NICOTINE was selected in B1. Skip if NOT SELECTED)

TOBACCO

Number of days used: _____

Route of administration

f. Oral
g. Nasal
h. Smoking
i. Non-IV Injection
j. Intravenous (IV) Injection

NICOTINE (INCLUDING VAPE PRODUCTS)

Number of days used: _____

Route of administration

f. Oral
g. Nasal
h. Smoking
i. Non-IV Injection
j. Intravenous (IV) Injection

OTHER (PLEASE SPECIFY): _____

Number of days used: _____

Route of administration

a. Oral
b. Nasal
c. Smoking
d. Non-IV Injection
e. Intravenous (IV) Injection

B2. Have you been diagnosed with an **alcohol use disorder**, if so which U.S. Food and Drug Administration (FDA)-approved medication did you receive for the treatment for this alcohol use disorder in the **past 30 days? Select all that apply.**

- ○ Naltrexone - if received, specify how many days received _____
- ○ Extended-release naltrexone – if received, specify how many days _____
- ○ Disulfiram – if received, specify how many days _____
- ○ Acamprosate– if received, specify how many days _____
- ○ PATIENT DID NOT RECEIVE AN FDA-APPROVED MEDICATION FOR A DIAGNOSED ALCOHOL USE DISORDER
- ○ PATIENT DOES NOT REPORT SUCH A DIAGNOSIS
- ○ Information Unavailable

B3. Have you been diagnosed with an **opioid use disorder**, if so which U.S. Food and Drug Administration (FDA)-approved medication did you receive for the treatment for this opioid use disorder in the **past 30 days? Select all that apply.**

- ○ Methadone – if received, specify how many days _____
- ○ Buprenorphine – if received, specify how many days _____
- ○ Naltrexone – if received, specify how many days _____
- ○ Extended-release naltrexone – if received, specify how many days _____
- ○ PATIENT DID NOT RECEIVE AN FDA-APPROVED MEDICATION FOR A DIAGNOSED OPIOD USE DISORDER
- ○ PATIENT DOES NOT REPORT SUCH A DIAGNOSIS
- ○ Information Unavailable

B4. Have you been diagnosed with a **stimulant disorder**, if so which U.S. Food and Drug Administration (FDA)-approved medication did you receive for the treatment for this stimulant disorder in the **past 30 days? Select all that apply.**

- ○ Contingency Management – if received, specify how many days _____
- ○ Community Reinforcement – if received, specify how many days _____
- ○ Cognitive Behavioral Therapy – if received, specify how many days _____
- ○ Other evidence-based intervention – if received, specify how many days _____
- ○ PATIENT DID NOT RECEIVE AN FDA-APPROVED MEDICATION FOR A DIAGNOSED STIMULANT DISORDER
- ○ PATIENT DOES NOT REPORT SUCH A DIAGNOSIS
- ○ Information Unavailable

B5. Have you been diagnosed with a **tobacco use disorder**, if so which U.S. Food and Drug Administration (FDA)-approved medication did you receive for the treatment for this tobacco use disorder in the **past 30 days? Select all that apply.**

- ○ Nicotine Replacement – if received, specify how many days _____
- ○ Bupropion – if received, specify how many days _____
- ○ Varenicline – if received, specify how many days _____
- ○ PATIENT DID NOT RECEIVE AN FDA-APPROVED MEDICATION FOR A DIAGNOSED TOBACCO USE DISORDER
- ○ PATIENT DOES NOT REPORT SUCH A DIAGNOSIS
- ○ Information Unavailable

B6. In the **past 30 days**, did you experience an overdose or take too much of a substance that resulted in needing supervision or medical attention?

a. Yes **(continue to B7)**
b. No **(skip to B8)**
c. REFUSED **(skip to B8)**
d. Information Unavailable **(skip to B8)**

B7. In the **past 30 days**, after taking too much of a substance or overdosing, what intervention did you receive? **Select all that apply.**

a. Naloxone (Narcan)
b. Care in an Emergency Department
c. Care from a Primary Care Provider
d. Admission to a hospital
e. Supervision by someone else
f. Other (please specify): _____
g. REFUSED
h. Information Unavailable

B8. Not including this current episode, how many times in your life have you been treated at an inpatient or outpatient facility for a substance use disorder?

a. One time **(continue to B9)**
b. Two times **(continue to B9)**

c. Three times **(continue to B9)**
d. Four times **(continue to B9)**
e. Five times **(continue to B9)**
f. Six or more times **(continue to B9)**
g. Never **(skip to B10)**
h. REFUSED **(skip to B10)**
i. Information Unavailable **(skip to B10)**

B9. Approximately when was the last time you received inpatient or outpatient treatment for a substance use disorder?

a. Less than 6 months ago
b. Between 6 months and one year ago
c. One to two years ago
d. Two to three years ago
e. Three to four years ago
f. Five or more years ago
g. REFUSED
h. Information Unavailable

B10. Have you ever been diagnosed with a **mental health illness** by a health care professional?

a. Yes – please indicate the diagnosis below **(continue)**
b. No **(skip to B11)**
c. REFUSED **(skip to B11)**
d. Information Unavailable **(skip to B11)**

Have you ever been diagnosed with **schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders**? **Select all that apply.**

○ Brief psychotic disorder
○ Delusional disorder

- ○ Schizoaffective disorders
- ○ Schizophrenia
- ○ Schizotypal disorder
- ○ Shared psychotic disorder
- ○ Unspecified psychosis

Have you ever been diagnosed with **mood affective disorders**? **Select all that apply.**

- ○ Bipolar disorder
- ○ Major depressive disorder, recurrent
- ○ Major depressive disorder, single episode
- ○ Manic episode
- ○ Persistent mood (affective) disorders
- ○ Unspecified mood (affective) disorder
- ○ Unspecified psychosis

Have you ever been diagnosed with **phobic anxiety or other anxiety disorders**? **Select all that apply.**

- ○ Agoraphobia without panic disorder
- ○ Agoraphobia with panic disorder
- ○ Agoraphobia, unspecified

- ○ Generalized anxiety disorder
- ○ Panic disorder
- ○ Phobic anxiety disorders
- ○ Social phobias (social anxiety disorder)
- ○ Specific (isolated) phobias

Have you ever been diagnosed with **obsessive compulsive disorders**? **Select all that apply.**

- ○ Excoriation (skin-picking) disorder
- ○ Hoarding disorder
- ○ Obsessive-compulsive disorder
- ○ Obsessive-compulsive disorder with mixed obsessional thoughts and acts

Have you ever been diagnosed with **a reaction to severe stress or adjustment disorders**? **Select all that apply.**

- ○ Acute stress disorder; reaction to severe stress, and adjustment disorders
- ○ Body dysmorphic disorder
- ○ Dissociative identity disorder
- ○ Somatoform disorders
- ○ Adjustment disorders
- ○ Dissociative and conversion disorders
- ○ Post traumatic stress disorder

Have you ever been diagnosed with **behavioral syndromes associated with physiological disturbances and physical factors**? **Select all that apply.**

- ○ Eating disorders
- ○ Sleep disorders not due to a substance or known physiological condition

Have you ever been diagnosed with **disorders of adult personality and behavior**? **Select all that apply.**

- ○ Antisocial personality disorder
- ○ Avoidant personality disorder
- ○ Borderline personality disorder
- ○ Dependent personality disorder
- ○ Histrionic personality disorder
- ○ Intellectual disabilities
- ○ Obsessive-compulsive personality disorder
- ○ Other specific personality disorder
- ○ Paranoid personality disorder
- ○ Personality disorder, unspecified
- ○ Pervasive and specific developmental disorders
- ○ Schizoid personality disorder

B11. Was the patient screened by **your program**, using an evidence-based tool, or set of questions, for co-occurring mental health and/or substance use disorders?

a. Yes
b. No

[IF YES] Did the patient screen positive for co-occurring mental health and substance use disorders?

a. Yes
b. No

[IF YES] Was the patient referred for further assessment for a co-occurring mental health and substance use disorder?

a. Yes
b. No

SECTION B: Planned Services (INTERVENTION ONLY)

The following section is meant to identify grant funded services the patient is planned to receive under the MI-PHL project. **Check all that apply in the section.** These items are intended to be completed administratively by staff and should not be asked of the patient.

Indicate the types of service categories to be provided to the patient. You will then provide service type in the following section based on category responses.

- ○ Treatment modalities (Inpatient/Outpatient Treatment) **(Continue to B12a)**

- ○ Case management services **(Skip to B12b)**
- ○ Medical Services **(Skip to B12c)**
- ○ After Care Services **(Skip to B12d)**
- ○ Education Services **(Skip to B12e)**
- ○ Recovery Support Services **(Skip to B12f)**

B12a. Identify the treatment modality or modalities you plan to provide to the patient during the patient's course of treatment/recovery in your program. **Select at least ONE modality.**

- ○ Case management
- ○ Intensive outpatient treatment
- ○ Inpatient/Hospital (other than withdrawal management)
- ○ Outpatient therapy
- ○ Outreach
- ○ Medication – Methadone
- ○ Medication – Buprenorphine
- ○ Medication – Naltrexone (Short Acting)
- ○ Medication – Naltrexone (Long Acting)
- ○ Medication – Disulfiram
- ○ Medication – Acamprosate
- ○ Medication – Nicotine replacement
- ○ Medication – Bupropion
- ○ Medication – Varenicline
- ○ Residential/Rehabilitation
- ○ Withdrawal Management: **SPECIFY ONE OF THE FOLLOWING DETOX SERVICES**
  - ○ Hospital inpatient
  - ○ Free standing residential
  - ○ Ambulatory
- ○ Detoxification
- ○ After care
- ○ Recovery support
- ○ Other (please specify): _____

Identify the treatment service(s) you plan to provide to the patient during the patient's course of treatment/recovery. **You must select "Yes" for at least ONE of these treatment services numbered 1-4**. For negative screens/assessments, only screening should be selected.

TREATMENT SERVICES

- ○ **Screening**
- ○ **Brief Intervention**
- ○ **Brief Treatment**
- ○ **Referral to Treatment**
- ○ Assessment
- ○ Treatment Planning
- ○ Recovery Planning
- ○ Individual Counseling
- ○ Group Counseling
- ○ Contingency Management
- ○ Community Reinforcement
- ○ Cognitive Behavioral Therapy
- ○ Family/Marriage Counseling
- ○ Co-Occurring Treatment Services
- ○ Pharmacological Interventions
- ○ HIV/AIDS Counseling
- ○ Cultural Interventions/Activities
- ○ Other clinical services (please specify): _____

B12b CASE MANAGEMENT SERVICES:

- ○ Family Services (Including Marriage Education, Parenting, Child Development Services)
- ○ Childcare
- ○ Employment Services **SPECIFY ONE OF THE FOLLOWING EMPLOYMENT SERVICES:**
  - ○ Pre-Employment
  - ○ Employment Coaching
- ○ Individual Services Coordination
- ○ Transportation
- ○ HIV/AIDS Services - If Neg, Pre-Exposure Prophylaxis
- ○ HIV/AIDS Services - If Neg, Post-Exposure Prophylaxis
- ○ HIV/AIDS Services - If Positive, HIV Treatment
- ○ Transitional Drug-Free Housing Services
- ○ Housing Support
- ○ Health Insurance Enrollment
- ○ Other Case Management Services (please specify): _____

B12c MEDICAL SERVICES:

- ○ Medical Care
- ○ Alcohol/Drug Testing
- ○ OB/GYN Services
- ○ HIV/AIDS Medical Support & Testing
- ○ Dental Care
- ○ Viral Hepatitis Medical Support & Testing
- ○ Other STI Support & Testing
- ○ Other Medical Services (please specify): _____

B12d AFTER CARE SERVICES:

- ○ Continuing Care
- ○ Relapse Prevention
- ○ Recovery Coaching)
- ○ Self-Help and Mutual Support Groups
- ○ Spiritual Support
- ○ Other After Care Services (please specify): _____

B12e EDUCATION SERVICES:

- ○ Substance Use Education
- ○ HIV/AIDS Education
- ○ Naloxone Training
- ○ Fentanyl Test Strip Training
- ○ Viral Hepatitis Education
- ○ Other STI Education Services (please specify): _____
- ○ Other Education Services (please specify): _____

B12f RECOVERY SUPPORT SERVICES:

- ○ Peer Coaching or Mentoring
- ○ Vocational Support
- ○ Recovery Housing
- ○ Recovery Planning
- ○ Case Management Services to Specifically Support Recovery
- ○ Alcohol- and Drug-Free Social Activities
- ○ Information & Referral
- ○ Other Recovery Support Services (please specify): _____
- ○ Other Peer Recovery Support Services (please specify):

  _____

SECTION J & K : Discharge status & Services received (DISCHARGE ONLY)

The following section is intended to be completed administratively by staff and should not be asked of the patient.

1. On what date was the patient discharged?
    a. Month: _____
    b. Day: _____
    c. Year: _____

2. What is the patient's discharge status?

    ○ Completion/Graduate **(skip to 4)**

    ○ Termination **(continue to 3)**

3. **If the patient was terminated,** what was the reason for termination?

    ○ Left on own against staff advice with satisfactory progress

    ○ Left on own against staff advice without satisfactory progress

    ○ Involuntarily discharged due to nonparticipation

    ○ Involuntarily discharged due to violation of rules

    ○ Referred to another program or other services with satisfactory progress

    ○ Referred to another program or other services with unsatisfactory progress

    ○ Incarcerated due to offense committed while in treatment/recovery with satisfactory progress

    ○ Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress

    ○ Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress

    ○ Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress

    ○ Transferred to another facility for health reasons

    ○ Death

    ○ Other (please specify) _____

4. Did the program order an HIV test for this patient?

   ○ Yes

   ○ No

5. Did the program refer this patient for HIV testing with another provider?

   ○ Yes

   ○ No

6. Did the program provide Naloxone and/or Fentanyl Test Strips to this patient at any time during their involvement in grant funded services?

   ○ Naloxone

   ○ Fentanyl Test Strips

   ○ Both Naloxone and Fentanyl Test Strips

   ○ Neither

7. Is the patient fully vaccinated against the virus that causes COVID-19?

   ○ Yes

   ○ No, partially vaccinated with plans to receive the subsequent vaccination on time

   ○ No, partially vaccinated with no plan to receive the subsequent vaccination

   ○ No, patient refused vaccination

   ○ REFUSED to answer

   ○ Information Unavailable

8. Which of the following **service categories** did the patient **receive** services from? Service type will be provided in the next section

    ○ Service Modalities (Inpatient/Outpatient Treatment) **(continue to 9 if selected)**

    ○ Case Management Services

    ○ Medical Services

    ○ After Care Services

    ○ Education Services

    ○ Recovery Support Services

    ○ Information Unavailable

9. Identify the number of **DAYS** of service provided to the patient during the patient's course of treatment/recovery.

- ○ Case management Number of days: _____
- ○ Intensive Outpatient Treatment Number of days: _____
- ○ Inpatient/Hospital (Other than withdrawal management) Number of days: _____
- ○ Outpatient therapy Number of days: _____
- ○ Outreach Number of days: _____
- ○ Medication: Methadone Number of days: _____
- ○ Medication: Buprenorphine Number of days: _____
- ○ Medication: Naltrexone Short Acting Number of days: _____
- ○ Medication: Naltrexone Long Acting **(Report 28 days for each one injection)** Number of days: _____
- ○ Medication: Disulfiram Number of days: _____
- ○ Medication: Acamprosate Number of days: _____
- ○ Medication: Nicotine Replacement Number of days: _____
- ○ Medication: Bupropion Number of days: _____
- ○ Medication: Varenicline Number of days: _____
- ○ Residential/Rehabilitation Number of days: _____
- ○ Withdrawal management: Hospital inpatient Number of days: _____
- ○ Withdrawal management: Free standing residential Number of days: _____
- ○ Withdrawal management: Ambulatory Detoxification Number of days: _____
- ○ After care Number of days: _____
- ○ Recovery support Number of days: _____
- ○ Other (please specify): _____
- ○ Information Unavailable

TREATMENT SERVICES

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery. SBIRT interventions must be provided accordingly.

- ○ **Screening** Number of sessions: _____
- ○ **Brief Intervention** Number of sessions: _____
- ○ **Brief Treatment** Number of sessions: _____
- ○ **Referral to Treatment** Number of sessions: _____
- ○ Assessment Number of sessions: _____
- ○ Treatment planning Number of sessions: _____
- ○ Recovery planning Number of sessions: _____
- ○ Individual counseling Number of sessions: _____
- ○ Group counseling Number of sessions: _____
- ○ Contingency management Number of sessions: _____
- ○ Community reinforcement Number of sessions: _____
- ○ Cognitive behavioral therapy Number of sessions: _____
- ○ Family/marriage counseling Number of sessions: _____
- ○ Co-occurring treatment services Number of sessions: _____
- ○ Pharmacological interventions Number of sessions: _____
- ○ HIV/AIDS counseling Number of sessions: _____
- ○ Cultural interventions/activities Number of sessions: _____
- ○ Other clinical services (please specify): _____
  Number of sessions: _____
- ○ Information Unavailable

CASE MANAGEMENT SERVICES (only complete if CASE MANAGEMENT SERVICES was SELECTED in question 8)

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery.

- ○ Family services (e.g., marriage education, parenting, child development services) Number of sessions: _____
- ○ Childcare Number of sessions: _____
- ○ Employment service: Pre-employment Number of sessions: _____
- ○ Employment service: Employment coaching Number of sessions: _____
- ○ Individual services coordination Number of sessions: _____
- ○ Transportation Number of sessions: _____
- ○ HIV/AIDS Services and counseling Number of sessions: _____
- ○ Transitional drug-free housing services Number of sessions: _____
- ○ Housing support Number of sessions: _____
- ○ Health insurance enrollment Number of sessions: _____
- ○ Other case management services (please specify): _____ Number of sessions: _____
- ○ Information Unavailable

MEDICAL SERVICES (only complete if MEDICAL SERVICES was SELECTED in question 8)

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery.

- ○ Medical care Number of sessions: _____
- ○ Alcohol/drug testing Number of sessions: _____
- ○ OB/GYN services Number of sessions: _____
- ○ HIV/AIDS medical support and testing Number of sessions: _____
- ○ Hepatitis medical support and testing Number of sessions: _____
- ○ Other STI support and testing Number of sessions: _____
- ○ Dental care Number of sessions: _____
- ○ Other medical services (please specify): _____
  Number of sessions: _____
- ○ Information Unavailable

AFTERCARE SERVICES (only complete if AFTERCARE SERVICES was SELECTED in question 8)

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery.

- ○ Continuing care Number of sessions: _____
- ○ Relapse Prevention testing Number of sessions: _____
- ○ Recovery Coaching Number of sessions: _____
- ○ Self-Help & Mutual Support Groups Number of sessions: _____
- ○ Spiritual Support Number of sessions: _____
- ○ Other After Care Services (SPECIFY): Number of sessions: _____
- ○ Information Unavailable

EDUCATON SERVICES (only complete if EDUCATION SERVICES was SELECTED in question 8)

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery.

- ○ Substance misuse education Number of sessions: _____
- ○ HIV/AIDS education Number of sessions: _____
- ○ Hepatitis education Number of sessions: _____
- ○ Other STI education services Number of sessions: _____
- ○ Naloxone training Number of sessions: _____
- ○ Fentanyl test strip training Number of sessions: _____
- ○ Other education services (please specify): _____
  Number of sessions: _____
- ○ Information Unavailable

RECOVERY SUPPORT SERVICES (only complete if RECOVERY SERVICES was SELECTED in question 8)

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery.

- ○ Peer coaching or mentoring Number of sessions: _____
- ○ Vocational support Number of sessions: _____
- ○ Recovery housing Number of sessions: _____
- ○ Recovery planning Number of sessions: _____
- ○ Case management services to specifically support recovery
  Number of sessions: _____
- ○ Alcohol- & Drug-Free Social Activities Number of sessions: _____
- ○ Information and referral Number of sessions: _____

- ○ Other recovery support services (please specify): _____
  Number of sessions: _____
- ○ Other peer-to-peer recovery support services (specify): _____
  Number of sessions: _____
- ○ Information Unavailable

10. **For the clinic site completing the GPRA survey**: Has the patient attended 60% or more of their planned services?

    - ○ Yes
    - ○ No

11. Did the patient receive any services via telehealth or a virtual platform?

    - ○ Yes
    - ○ No

SERVICES RECEIVED – OPIOID USE DISORDER

12. Has this patient previously been diagnosed with an opioid use disorder?

    ○ Yes **(continue to 13)**

    ○ No **(skip to 15)**

13. In the **past 30 days**, which FDA-approved medication did the patient receive for the treatment of this opioid use disorder? ***Select all that apply***.

    ○ Methadone (if received, specify how many days): _____

    ○ Buprenorphine (if received, specify how many days): _____

    ○ Naltrexone(if received, specify how many days): _____

    ○ Extended release naltrexone (if received, specify how many days): _____

    ○ PATIENT DID NOT RECEIVE AN FDA APPROVED MEDICATION FOR A DIAGNOSED OPIOID USE DISORDER **(skip to 15)**

14. Has this patient taken the medication as prescribed?

    ○ Yes

    ○ No

SERVICES RECEIVED – ALCOHOL USE DISORDER

15. Has this patient previously been diagnosed with an alcohol use disorder?

    ○ Yes **(continue to 16)**

    ○ No **(skip to 18)**

16. In the **past 30 days**, which FDA-approved medication did the patient receive for the treatment of this alcohol use disorder? ***Select all that apply***.

    ○ Naltrexone (if received, specify how many days): _____

    ○ Extended-release naltrexone (if received, specify how many days): _____

    ○ Disulfiram (if received, specify how many days): _____

    ○ Acamprosate (if received, specify how many days): _____

    ○ PATIENT DID NOT RECEIVE AN FDA APPROVED MEDICATION FOR A DIAGNOSED ALCOHOL USE DISORDER **(skip to 18)**

17. Has this patient taken the medication as prescribed?

    ○ Yes

    ○ No

SERVICES RECEIVED – STIMULANT USE DISORDER

18. Has this patient previously been diagnosed with a stimulant use disorder?

    ○ Yes **(continue to 19)**

    ○ No **(skip to 21)**

19. In the **past 30 days**, which FDA-approved medication did the patient receive for the treatment of this stimulant use disorder? ***Select all that apply***.

    ○ Contingency management (if received, specify how many days): _____

    ○ Community reinforcement (if received, specify how many days): _____

    ○ Cognitive behavioral therapy (if received, specify how many days): _____

    ○ Other treatment approach (if received, specify how many days): _____

    ○ PATIENT DID NOT RECEIVE AN FDA APPROVED MEDICATION FOR A DIAGNOSED STIMULANT USE DISORDER **(skip to 21)**

20. Has this patient taken the medication as prescribed?

    ○ Yes

    ○ No

SERVICES RECEIVED – TOBACCO USE DISORDER

21. Has this patient previously been diagnosed with a tobacco use disorder?

    ○ Yes **(continue to 22)**

    ○ No **(skip to END)**

22. In the **past 30 days**, which FDA-approved medication did the patient receive for the treatment of this tobacco use disorder? ***Select all that apply***.

    ○ Nicotine replacement (if received, specify how many days): _____

    ○ Bupropion (if received, specify how many days): _____

    ○ Varenicline (if received, specify how many days): _____

    ○ PATIENT DID NOT RECEIVE AN FDA APPROVED MEDICATION FOR A DIAGNOSED TOBACCO USE DISORDER **(skip to END)**

23. Has this patient taken the medication as prescribed?

- ○ Yes
- ○ No

Contact Information ROI

GPRA Follow-Up Surveying:

Wayne State University has partnered with the Michigan Department of Health and Human Services (MDHHS) to manage Government Performance Report Act (GPRA) data collection to fulfil reporting requirements outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Michigan-Promoting Healthy Lifestyles Grant was awarded to MDHHS to fund SUD Screening, Brief Intervention, and Referral to Treatment (SBIRT) services.

As a recipient of SBIRT services, you are eligible to participate in 6-month GPRA follow-up surveying conducted by WSU. You will receive a $30 gift card at the end of the 6-month follow-up survey in appreciation for your time.

An SBIRT Release of Information (ROI) document MUST be completed by the patient before proceeding. **Has an ROI been secured?**

If the patient does not consent to a release of information, select refused below and the patient will NOT participate in GPRA follow up surveying.

- ○ ROI Completed and Signed
- ○ Patient refused to complete ROI
- ○ Unable to complete ROI. If so, explain: _____

To monitor the SBIRT program, follow-up GPRA surveys are completed with patients 6 months after Intake. The survey is completed by Wayne State University and is anonymous. To get in touch with you, we are going to ask for information that may help us locate you. Personal information provided is NOT part of the GPRA survey and will not be used for any purpose other than to reach you to complete the follow up GPRA survey.

Providing us with this information is voluntary, if the patient refuses to provide contact information write REFUSED next to each that is refused.

Patient Name: _____

Phone Number: _____

Permanent Address: _____

Email: _____

Social Media or Other Contact Information: _____

Collateral Contacts

In the event you cannot be contacted for 6-Month GPRA follow-up surveying, provide 2 additional contacts (can include emergency contacts) that may be able to locate you. Providing additional contact information for up to two friends or family members will increase the likelihood that you can be reached for surveying.

Personal information, including treatment details, will not be shared with any additional contacts provided.

Contact #1 First Name: _____

Contact #1 Relationship to Patient: _____

Contact #1 Phone Number: _____

Contact #2 First Name: _____

Contact #2 Relationship to Patient: _____

Contact #2 Phone Number: _____

END OF SURVEY

Were any questions answered incorrectly in an instance where the back function did not operate correctly?

After submitting a GPRA via Qualtrics, there are 48 hours to request changes.

Data must be uploaded to the federal SPARS system as soon as possible, so no delays in the process are permitted.

If an error was made, you may submit a change by emailing: Bb0903@wayne.edu

Please use "DATA ERROR" as the subject heading and include the following in the body of the email:

Clinical Site Name

Patient ID Number

Description of Question Requiring Change: (include question # or description and indicate the correct response)