

**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 (**continue 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.**

<b>Alcohol</b>	<input type="radio"/> Yes	<input type="radio"/> No
<b>Opioids</b>	<input type="radio"/> Yes	<input type="radio"/> No
<b>Cannabis (Marijuana)</b>	<input type="radio"/> Yes	<input type="radio"/> No
<b>Sedatives, Hypnotics, or Anxiolytics</b>	<input type="radio"/> Yes	<input type="radio"/> No
<b>Cocaine</b>	<input type="radio"/> Yes	<input type="radio"/> No
<b>Other Stimulants (Methamphetamine)</b>	<input type="radio"/> Yes	<input type="radio"/> No
<b>Hallucinogens &amp; Other Psychedelics</b>	<input type="radio"/> Yes	<input type="radio"/> No
<b>Inhalants</b>	<input type="radio"/> Yes	<input type="radio"/> No
<b>Other Psychoactive Substances (Ketamine/Bath Salts)</b>	<input type="radio"/> Yes	<input type="radio"/> No
<b>Tobacco &amp; Nicotine</b>	<input type="radio"/> Yes	<input type="radio"/> 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 routes 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 (PRESCRIPTION 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 – PAST 30 DAYS (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 – PAST 30 DAYS (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 – PAST 30 DAYS (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-PRESCRIPTION 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 TRANQUILIZERS**

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 – PAST 30 DAYS (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 OPIOID 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 C: LIVING CONDITIONS (ALL)**

This section pertains to the client's living situation during the **past 30 days**.

1. In the **past 30 days**, where have you been living most of the time?
  - Shelter (Safe Havens, Transitional Living Center, Low-Demand Facilities, Reception Centers, Other temporary day or evening facility)
  - Street/Outdoors (Sidewalk, Doorway, Park, Public or Abandoned Building)
  - Institution (Hospital, Nursing Home, Jail/prison)
  - Housed: Own/Rental Apartment, Room, Trailer, or House
  - Housed: Someone else's Apartment, Room, Trailer, or House (including couch surfing)
  - Housed: Dormitory/College Residence
  - Housed: Halfway House or Transitional Housing
  - Housed: Residential Treatment
  - Housed: Recovery Residence/Sober Living
  - Housed: Other (please specify): \_\_\_\_\_
  - REFUSED
  - Information Unavailable
  
2. Do you currently live with any person who, **over the past 30 days**, regularly used alcohol or other substances?
  - Yes
  - No
  - No, lives alone
  - REFUSED
  - Information Unavailable



**SECTION D: EMPLOYMENT, EDUCATION, AND INCOME (ALL)**

This section collects information about the patient's educational and financial resources.

3. Are you currently enrolled in school or a job training program? **If enrolled**, Is it full time or part time? **If the patient is incarcerated, select not enrolled.**

Not Enrolled (select if incarcerated)

Enrolled, Full Time

Enrolled, Part Time

REFUSED

Information Unavailable

4. What is the highest level of education you have finished, whether or not you received a degree?

Less than 12th Grade

12th Grade/High School Diploma/Equivalent

Vocational/Technical Diploma

Some College or University

Bachelor's Degree (For example: BA, BS)

Graduate Work/Graduate Degree

Other (please specify): \_\_\_\_\_

REFUSED

Information Unavailable

5. Are you currently employed? (Focus on the previous week). **If the patient is incarcerated and has no work outside of jail, indicate not employed, not looking for work.**

- Employed, Full Time (35+ hours per week, or would be, if not for leave or an excused absence)
- Employed, Part Time
- Unemployed--But Looking for Work
- Not Employed, NOT Looking for Work (Student)
- Not working due to a disability
- Retired, not working
- Other (please specify): \_\_\_\_\_
- REFUSED
- Information Unavailable

6. Do you, **individually**, have enough money to pay for the following living expenses? **Select all that apply.**

- Food
- Clothing
- Transportation
- Rent/Housing
- Utilities (Gas/Water/Electric)
- Telephone Connection (Cell or Landline)
- Childcare
- Health Insurance
- None. The patient does not have enough money to pay for any of the expenses. (0)
- REFUSED
- Information Unavailable

7. What is your personal annual income, meaning the total pre-tax income from all sources, earned in the past year?
- \$0 - \$9,999
  - \$10,000 - \$14,999
  - \$15,000 - \$19,999
  - \$20,000 - \$34,999
  - \$35,000 - \$49,999
  - \$50,000 - \$74,999
  - \$75,000 - \$99,999
  - \$100,000 - \$199,999
  - \$200,000 or more
  - REFUSED
  - Information Unavailable

**SECTION D: LEGAL (ALL)**

This section pertains to basic information about the patient's involvement with the criminal justice system. It gathers information about arrests and incarceration or detainment. Even if the patient is court mandated to treatment, these questions must be asked, and the patient's answers recorded. Some patients may be reluctant to offer this information. Reassure them of the confidentiality of this information.

1. In the past 30 days, how many times have you been arrested?
  - Number of Arrests: \_\_\_\_\_
  - REFUSED
  - Information Unavailable
  
2. Are you currently awaiting charges, trial, or sentencing?
  - Yes
  - No
  - REFUSED
  - Information Unavailable
  
3. Are you currently on parole or probation or intensive pretrial supervision?
  - Probation
  - Parole
  - Intensive Pretrial Supervision
  - No
  - REFUSED
  - Information Unavailable
  
4. Do you currently participate in a drug court program or are you in a deferred prosecution agreement?
  - Drug court program
  - Deferred prosecution agreement
  - No, neither of these
  - REFUSED

Information Unavailable

**SECTION F: MENTAL & PHYSICAL HEALTH PROBLEMS & TREATMENT/RECOVERY (ALL)**

This section addresses issues of mental and physical health as well as treatment experiences **in the past 30 days.**

1. How would you rate your quality of life **over the past 30 days?**

- Very poor
- Poor
- Neither poor nor good
- Good
- Very good
- REFUSED
- Information Unavailable

2. In the past 30 days, how many days have you:

- Experienced serious depression? Number of days: \_\_\_\_\_ [ ]REFUSED
- Experienced serious anxiety or tension? Number of days: \_\_\_\_\_ [ ]REFUSED
- Experienced hallucinations? Number of days: \_\_\_\_\_ [ ]REFUSED
- Experienced trouble understanding, concentrating, or remembering? Number of days: \_\_\_\_\_  
[ ]REFUSED
- Experienced trouble controlling violent behavior? Number of days: \_\_\_\_\_ [ ]REFUSED
- Attempted suicide? Number of days: \_\_\_\_\_ [ ]REFUSED
- Been prescribed medication for psychological/emotional problem? Number of days: \_\_\_\_\_  
[ ]REFUSED

3. How much have you been bothered by these psychological or emotional problems in the **past 30 days**?

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely
- NO REPORTED MENTAL HEALTH COMPLAINTS IN THE PAST 30 DAYS
- REFUSED
- Information Unavailable

4. In the **past 30 days**, where have you gone to receive medical care? **Select all that apply.**

- Primary Care Provider
- Urgent Care
- The Emergency Department
- A specialist doctor
- No care was sought
- Other (please specify): \_\_\_\_\_
- REFUSED
- Information Unavailable

5. Do you currently have medical/health insurance?

- Yes (**continue to Q6**)
- No (**skip to next section, Section G**)
- REFUSED (**skip to next section, Section G**)
- Information Unavailable (**skip to next section, Section G**)

6. **If yes to Q5**, what type of insurance do you have? **Select all that apply.**

- Medicare
- Medicaid
- Private Insurance or Employer Provided
- TRICARE or other military health care
- An assistance program (for example, a medication assistance program)
- Any other health insurance or health coverage plan (please specify):  
\_\_\_\_\_
- REFUSED
- Information Unavailable

**SECTION G: SOCIAL CONNECTEDNESS (ALL)**

This section addresses the patient's use of social support and recovery services **during the 30 days prior to the interview.**

1. In the **past 30 days**, did you attend any voluntary mutual support groups for recovery? In other words, did you participate in a non-professional, peer-operated organization that assists individuals who have addiction-related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Secular Organization for Sobriety, Women for Sobriety, religious/faith-affiliated recovery mutual support groups, etc.? Attendance could have been in person or virtual.
  - Yes (**continue to Q2**)
  - No (**skip to Q3**)
  - REFUSED (**skip to Q3**)
  - Information Unavailable (**skip to Q3**)
  
2. Specify how many times in the **past 30 days**:
  - Number of Support Groups Attended: \_\_\_\_\_
  - REFUSED
  - Information Unavailable
  
3. In the **past 30 days**, did you have interaction with family and/or friends that are supportive of your recovery?
  - Yes
  - No
  - REFUSED
  - Information Unavailable



4. How satisfied are you with your personal relationships?

- Very Dissatisfied
- Dissatisfied
- Neither Satisfied nor Dissatisfied
- Satisfied
- Very Satisfied
- REFUSED
- Information Unavailable

5. In the **past 30 days**, did you realize that you need to change those social connections or places that negatively impact your recovery?

- Yes
- No
- REFUSED
- Information Unavailable

**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



**EDUCATION 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](mailto: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)