

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): _____

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: _____

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 (**go to Q5**)
- c. REFUSED (**go to Q5**)
- d. Information Unavailable (**go to Q5**)

4. **If Yes, to Q3:** What ethnic group do you consider yourself? *Select all that apply.*

- 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? *Select all that apply.*

- 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 (**go to Q9**)
 - c. REFUSED (**go to Q9**)
 - d. Information Unavailable (**go 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	<input type="radio"/> Yes	<input type="radio"/> No
Opioids	<input type="radio"/> Yes	<input type="radio"/> No
Cannabis (Marijuana)	<input type="radio"/> Yes	<input type="radio"/> No
Sedatives, Hypnotics, or Anxiolytics	<input type="radio"/> Yes	<input type="radio"/> No
Cocaine	<input type="radio"/> Yes	<input type="radio"/> No
Other Stimulants (Methamphetamine)	<input type="radio"/> Yes	<input type="radio"/> No
Hallucinogens & Other Psychedelics	<input type="radio"/> Yes	<input type="radio"/> No
Inhalants	<input type="radio"/> Yes	<input type="radio"/> No
Other Psychoactive Substances (Ketamine/Bath Salts)	<input type="radio"/> Yes	<input type="radio"/> No
Tobacco & Nicotine	<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 were 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 – PAST 30 DAYS (continue if SEDATIVES, HYPNOTICS, OR ANXIOLYTICS were 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 were 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 were 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 were 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 were 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 were 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 _____
- 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 evidence-based interventions did you receive for the treatment of 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 ANY INTERVENTION FOR A DIAGNOSED STIMULANT USE DISORDER
- PATIENT DOES NOT REPORT SUCH A DIAGNOSIS
- Information Unavailable

B5. Have you been diagnosed with a **tobacco use disorder**, if so which FDA-approved medication did you receive for the treatment of 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

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)