

**STATE AODA SUPPLEMENTAL REPORTING REQUIREMENTS**

PROVIDER NAME _____
ADDRESS _____
PREPARED BY _____
TELEPHONE _____

DCDHS Client Number: \_\_\_\_\_ DCDHS Program Number: \_\_\_\_\_

Client Name (Last, First, M.I.): \_\_\_\_\_

Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referral Source: \_\_\_\_\_

Co-Dependent/Collateral: Yes No (if yes, no more information is required)

Brief Service: Yes No (if yes, no more information is required)

Education At Time of Admission: \_\_\_\_\_ Support Group w/in 30 days \_\_\_\_\_

Family Relationships: \_\_\_\_\_ Living Situation \_\_\_\_\_

Employment Status: \_\_\_\_\_ # Arrests w/in 30 days \_\_\_\_\_

Pregnant At Time of Admission: Yes No

**Substance Information:**

	Primary	Secondary	Tertiary
Substance Problem			
Route of Administration			
Use Frequency			
Age of First Use/Abuse (drug use or alcohol intoxication)			

*Please refer to the HSRS Handbook for instructions on completing this form. If you have other questions, please call 242-6475.*