SELECT ONE:
Initial Registration o
Continued Stay Review o

Electronic Registration System II (ERS II) Treatment Review Form

Client Name (Last, First):_____
EMS ID# or Social Security Number:_____
Client's Date of Birth:_____ Admission Date:_____
Client's Address:_____
Provider Name:_____
Provider Service Address:_____

Service Type (MUST select one):

- ☐ OP Substance Abuse (SA I.1)
- ☐ Ambulatory Detox (SA I.D)
- ☐ OP Methadone Detox (SA I.2)
- ☐ Methadone Maintenance (SA I.3)
- ☐ Recovery House Services
- ☐ OP Mental Health (MH I.1)
- ☐ MH Intensive Outpatient (MH II.1)
- ☐ SA Intensive Outpatient (SA II.1)

DIAGNOSES – AXIS I – V (Required)
Axis I: (1)_____ (2)_____ (3)_____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: Current GAF: _____ Highest GAF/Past Yr: _____ Lowest GAF/Past Yr: _____
Treatment Plan:_____
_____

Frequency of Visits (FOR IOP LEVEL OF CARE ONLY):
☐ 3 Days Per Week ☐ 4 Days Per Week ☐ 5 Days Per Week

Type of Visits Requested (Required for Level I.1 only – MUST check at least one):
☐ Initial Evaluation ☐ Group Therapy ☐ Family Therapy
☐ Individual Therapy ☐ Medication Management

Requested Number of Units (Required): _____

Projected Discharge Plan (Required):
Anticipated Discharge Date: _____
Referral Projected to: _____ (Service/Level of Care)
_____ (Provider Name)

Substance Use History (Required for all SA & Dual Admissions except Level I.1):

Substance	Date Last Used	Method of Use	Age at First Use	Quantity	Frequency

Current Medications: ☐ No Medications

Medication	Dosage	Frequency	Method	Ended On

Status Checklist
- ☐ Medication Compliant
- ☐ Medication Non-compliant
- ☐ Significant Risk for Relapse
- ☐ Vocational/Job Issues
- ☐ Housing Issues
- ☐ Current/Chronic Medical Issues
- ☐ Pending/Current Legal Issues
- ☐ Attending 12-Step Recovery Groups
- ☐ Using Community Supports
- ☐ Frequent Therapeutic Intervention Needed
- ☐ Frequently Misses Appointments
- ☐ Compliant with Treatment
- ☐ Refusing Treatment Recommendations
- ☐ Stable/Preparing for Discharge
- ☐ In Need of Higher Service Intensity
- ☐ Progress Made/Further Stabilization Needed
- ☐ No Progress Made/Improvement Expected
- ☐ Lacks Necessary Community Supports

Date/Results of Drug Toxicology (required for Continued Care, Levels I.2SA, I.3SA):
Results: ☐ Positive ☐ Negative

Date of Most Recent Drug Toxicology: _____
If Positive, MUST select at least one:
☐ Opiates ☐ Benzodiazepines ☐ Cannabis ☐ Cocaine

Symptom Checklist (Select at least one – Required
- ☐ Isolation
- ☐ Eat/Sleep Disturbance
- ☐ Manic Behavior
- ☐ Inadequate Self Care
- ☐ Recent Relapse
- ☐ Current symptoms of withdrawal
- ☐ Delusions/Hallucinations
- ☐ Peer/Relationship Difficulty
- ☐ Suicidal/Homicidal Ideation
- ☐ Sexually Inappropriate Behavior
- ☐ Active Substance Abuse
- ☐ Paranoia
- ☐ Bizarre Behavior
- ☐ Violent/Aggressive Behavior
- ☐ Attention/Impulse Disorder
- ☐ Confusion/Disorientation
- ☐ Early Recovery Issues
- ☐ Obsessive/Compulsive Behaviors
- ☐ Depression
- ☐ Nightmares/Flashbacks
- ☐ Anxiety/Panic Attacks
- ☐ Recent suicide attempt(s)
- ☐ Intense/Frequent Drug Cravings
- ☐ Cognitive Impairment
- ☐ Substance-related Medical Issues
- ☐ Acute psychosocial stressors
- ☐ Thought Disorder
- ☐ Inappropriate Affect

Form Completed By:_____ Telephone #:_____ Date:_____

GABHP Reviews may be faxed to: Advanced Behavioral Health, Inc. at (860) 704-6145
Please keep a record of this transaction for your records

Updated 5/18/05