

MACSIS Closure

Name: _____ ID: _____

Closure Date: _____ Last Date of Service: _____

Disposition at Discharge (choose one):

- Case Closed with referral to AOD Treatment
- Case closed with referral to MH Treatment
- Case closed with referral to AOD and MH Treatment
- Case closed with AOD aftercare
- Case closed with MH aftercare
- Case closed with MH and AOD aftercare
- Goals Met-No additional services needed
- Needed services not available
- Client rejects continuation
- Client did not return
- Client died
- Other

- Received AOD services at this agency (LOC=B1 else LOC=NA)
- Seeking services as a result of the relationship with alcohol/drug user.

of Previous Alcohol/Drug Addiction Services Episodes:

- _____ Inpatient
- _____ Intensive Outpatient
- _____ General Outpatient
- _____ Rehabilitation
- _____ Age of first intoxication
- _____ # of arrests the past 30 days (any offense).
- Urinalysis required on treatment plan.
- Has a previous mental health treatment history.
- Veteran
- Methadone is being used as part of the current treatment.
- Pregnant on Admission (answer this section only if the client was pregnant upon admission)
 - _____ # of days from referral by primary care physician until assessed for substance abuse
- Medicaid HMO/PPO
 - _____ Which trimester first seen by primary care physician
- Birth Type (pick one)
 - Drug Free/Not Drug Free/Not during treatment/Birth terminated

	Primary Drug	Secondary	Tertiary
Drug Type			
Frequency of Use in Preceding 30 Days			
Route of Administration			
Year First Used			

Health Care Use In Last 12 Months:

- _____ Hospital Admissions
- _____ ER Visits
- _____ Medical Doctor Visits
- _____ Dental Visits
- _____ Other Healthcare Visits

Highest Education Level Completed: _____

Regular/SBH/LD/Hearing/Visually/Multihandicapped/Developmental Handicapped/Orthopedically/Other

Employment Status (Pick One):

Full Time/Part Time/Sheltered Employment/ Unemployed—Seeking Work
Homemaker/Student/Retired/Disabled/Inmate/Other

Income Source (up to 3, rank in order):

Wages/Family/Alimony/Child Support/Savings/Disability-Workers Comp/Unemployment Retirement/
SSR/GR/ADC/SSI/SSDI/Other/None

_____ Individual Monthly Income (not family income)

_____ # of People under age 18 in home(not counting foster siblings—include fetus if pregnant)?

Living Arrangements (Pick One)

Own (Parents)Home/Friend/Relative/Supervised Group/Supervised Apartment/Boarding Home/Crisis Residential/
Child Foster Care/Adult Foster Care/Intermediate Nursing Home/Skilled Nursing Home/Respite Care/
MR-Intermediate/MR-Group Home/State MR Institution/Hospital/Correctional Facility/
Homeless/Convalescent Home/Other

- Child In Legal Custody of ODHS/Children's Services

Legal Status: _____

Special Population Group (all that apply)

- | | |
|---|--|
| <input type="checkbox"/> SMD/SED | <input type="checkbox"/> Speech Impaired |
| <input type="checkbox"/> AOD Abuse | <input type="checkbox"/> Physical Abuse Victim |
| <input type="checkbox"/> Forensic | <input type="checkbox"/> Sexual Abuse Victim |
| <input type="checkbox"/> Developmental Disabled | <input type="checkbox"/> Domestic Violence Victim |
| <input type="checkbox"/> Mentally Ill and Mentally Retarded | <input type="checkbox"/> Child of Substance Abuser |
| <input type="checkbox"/> DUI/DWI | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Suicidal |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> School Drop Out |
| <input type="checkbox"/> Blind | <input type="checkbox"/> Probation/Parole |
| <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> Other |
| <input type="checkbox"/> Physically Disabled | <input type="checkbox"/> None of the Above |

Signature Of Person Completing this Form	Date Completed
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- Entered into MIS System