Attachment Y TAP Version III DOC 8-6-2012

SMART TAP Assessment

Client Profile

Client's First Name:_____ Last Name: _____DOC #:_____

SSN#_____ DOB_____ Gender: Male Female

Zip Code_____

Race: White Alaskan Native
Black American Indian
Asian or Pacific Islander
Other

Ethnicity: Puerto Rican Hispanic
Mexican Not Hispanic
Cuban Other

Highest Grade Completed _____
For grades 1-11 enter the number
12/High School Diploma/GED
College Casework
College AA/Associates
BA/BS Degree
Post College/Graduate School Degree

H.S. Diploma:
Earned GED
Earned HS Diploma
No GED, No HS Diploma

Veterans Status
Never in Military
On Active Duty
Veteran
Veteran – In Combat 0-6 months ago
Veteran – In Combat 6-12 months ago
Veteran – In Combat more than 12 months ago.

Explanation for Veterans Status.
When asking about a client's veterans status please select from the list documented here on the form only.

INTAKE

County of Residence:_____ *Injection Drug User*: Yes No Denies

Currently Pregnant: Yes No Unknown (If Yes enter Due Date ____/____/_____) Intake Date___/___/___

Presenting Problem (In Client's own words) _____

_____

Source of Referral:

Aids Administration
Alcohol and Drug Abuse Admin.
Alcohol/Drug Abuse Care Provider
Defense Attorney
Drug Court
DSS/TCA (Temporary Cash Asst.)
DWI/DUI Referral
Employer/EAP
Individual/Self Referral
Juvenile Justice
Local Detention
Other Attorney
Other Community Referral
Other Criminal Justice
Other Health Care Provider
Parent/Guardian/Family
Parole
Poison Control Agency
Pre-Trial Services Agency
Probation
School
State Prison
Student Assistant Program
TASC-Other Diversionary programs
DHMH (HG-8505)
DHMH (HG-507)

TREATMENT ASSIGNMENT PROTOCOL (TAP) ASSESSMENT

Class: Intake Follow-up How Long at Current Address: _____Yrs _____Mos

Is the Residence Owned by You or Family? Yes No

Primary Payment Source

Primary Adult Care (PAC)
ADAA (State Funding)
DHMH Managed Care/Health Choice
Medicaid Other than Health Choice
Medicare
Non-Managed Private Insurance
Private Managed Care/HMO
Out of Pocket Payment
Other Public Funds
Other

Interviewed By:_____

Special Code: N/A, Interview Completed Patient Refused
Patient Terminated Patient Unable to Respond

Religious Preference? Baptist Methodist Non-denominational Protestant
Catholic Jewish Islamic Other None

Controlled Environment past 30 days
No Jail Alcohol/Drug Treatment Medical Treatment Psychiatric Treatment

If in a controlled environment how many days did you spend there?_____

Days Attended AA/NA/Similar Meetings in Last 30 Days_____ Days on Wait List_____

Is this TAP for Concerned Person: Yes No Months Since DC From Last Admission_____

Event Type: Admission Crisis Intervention Placement Screening Event Type Date _____

Substance Matrix Chart to be Used to Indicate Substance Use at Admission and at Discharge

Substance Rating 1=substance most used or abused 2=substance two 3=substance three						
Severity 0=Not a problem (discharge only) 1=Mild Problem 2=Moderate Problem 3=Severe Problem						
Frequency 0=No use past month 1=1-3 times past month 2=1-2 times past week 3=3-6 times per week 4=Once Daily 5=2-3 times daily 6=More than 3 times daily 7=Unknown (Discharge Only)						
Route 1= Oral 2=Smoking 3=Inhalation 4=Injection 5=Other						
Rating	**Prescribed?**	**Substance**	**Severity**	**Freq.**	**Route**	**Age/Use**
		Alcohol				
		Amphetamines - Amphetamine				
		Amphetamines - Methamphetamine (Speed)				
		Amphetamines - Methylenedioxymethamphetamine (MDMA,Ecstacy)				
		Amphetamines - Other				
		Barbiturates - Phenobarbital (Solfoton)				
		Barbiturates - Secobarbital (Seconal)				
		Barbiturates - Secobarbital/Amobarbital (Tuinal)				
		Barbiturates - Other				
		Benzodiazepines - Alprazolam (Xanax)				
		Benzodiazepines - Chlordiazepoxide (Librium)				
		Benzodiazepines - Clonazepam (Klonopin, Rivotril)				
		Benzodiazepines - Clorazepate (Tranxene)				
		Benzodiazepines - Diazepam (Valium)				
		Benzodiazepines - Flunitrazepam (Rohypnol)				
		Benzodiazepines - Flurazepam (Dalmane)				
		Benzodiazepines - Lorazepam (Ativan)				
		Benzodiazepines - Triazolam (Halcion)				
		Benzodiazepines - Other				
		Cocaine - Crack				
		Cocaine - Other				
		Diphenylhydantoin/Phenytoin (Dilantin)				
		GHB/GBL (Gamma-Hydroxybutyrate, Gamma-Butyrolactone)				
		Hallucinogens - LSD				
		Hallucinogens - Other				
		Inhalants - Aerosols				
		Inhalants - Nitrites				
		Inhalants - Solvents				
		Inhalants - Other				
		Ketamine (Special K)				
		Marijuana/Hashish				
		Meprobamate (Miltown)				
		Opiates/Synthetics - Codeine				
		Opiates/Synthetics - Heroin				
		Opiates/Synthetics - Hydracodone (Vicodin)				
		Opiates/Synthetics - Hydromorphone (Dilaudid)				
		Opiates/Synthetics - Meperdine (Demoral)				
		Opiates/Synthetics - Non-Prescription Methadone				
		Opiates/Synthetics - Oxycodone (OxyContin, Percocet, Percodan)				
		Opiates/Synthetics - Pentazocine (Talwin)				
		Opiates/Synthetics - Propoxyphene				
		Opiates/Synthetics - Tramadol (Ultram)				
		Opiates/Synthetics - Other				
		Over The Counter - Diphenhydramine (Benadryl)				
		Over The Counter - Other				
		PCP or PCP Combination				
		Sedatives - Ethchlorvynol (Placidyl)				
		Sedatives - Glutethimide (Doriden)				
		Sedatives - Methaqualone (Quaaludes)				
		Sedatives - Other				
		Stimulants - Methylphenidate (Ritalin)				
		Stimulants - Other				
		Tranquilizers				
		Other Drug				

Alcohol/Drug Usage

For Questions 1-5 complete the Substance Matrix Chart on the following page

1. Which substance/s is considered the client's Primary, Secondary, Tertiary
2. Was the substance prescribed to the client?
3. What was the age of first use?
4. What is the Severity of use?
5. What is the frequency of use?
6. What are the methods of use?

7. Have you ever tried to reduce or control your use of this substance?

a. Primary Yes No b. Secondary Yes No c. Tertiary Yes No

8. Has anyone ever asked you to stop using these substances?

a. Primary Yes No b. Secondary Yes No c. Tertiary Yes No

9. What was the date of last use?

a. Primary _____ b. Secondary _____ c. Tertiary _____

Other Addictions: Eating Disorder Gambling Sex Tobacco

10. Is Methadone Maintenance Planned Yes No

11. Have you ever attended a self-help/support group (AA/NA, R/R, church, etc.)? Yes No

12. Last substance admission environment in the last 10 years

Extended Outpatient	Medically managed Detox
Intensive Outpatient	Medically monitored Detox
Medically monitored intensive res	Medically managed intensive inpt.
Outpatient Detox	Clinically managed high intensity Res.
PMIC	Clinically managed medium intensity Res.
No Previous Admission	Day Treatment partial Hospitalization
Not Applicable	Clinically managed low intensity Res.
	Continuing Care

13. Number of prior substance abuse admissions during the last 10 years _____

Interview Rating:

14. How would you rate the client's potential for continued use?
Critical High Moderate Low Not at all

Notes:

Notes: (How severe was the usage?)

Withdrawal

1. What is the longest # of days in a row that you have gone without using alcohol and/or drugs:

a. In the last 30 days?_____ b. In the last 6 months?_____ c. 30 days prior to incarceration _____

2. Is the client reporting or exhibiting any of the following symptoms:

Abdominal cramps/diarrhea	Headaches
Agitation	Increased pulse rate
Anxiety	Insomnia, Sleep Disturbance
Back spasms	Muscle Aches, bone pain
Depression	Nausea, vomiting
Excessive or periodic sweating	Runny Nose
Excessive Sleeping	Seizures
Excessive Yawning	Tremors
Hallucination	Watery eyes

3. How many times in your life have you been treated for:

a. Alcohol abuse?_____ b. Drug abuse?____

4. How many of these were for:

a. Alcohol detox only?_____ b. Drug detox only?_____

5. How many days in the last 30 have you been treated for alcohol and/or drugs as an:

a. In-patient?_____ b. Out-patient?____

6. How many times in the last 30 days have you used:

a. Alcohol?_____ (30 days prior to incarceration) b. Drugs?_____ (30 days prior to incarceration)

1. 1-2 times per week
2. 1-3 times per month
3. 2-3 times daily
4. 3-6 times per week
5. Daily
6. More than 3 times daily
7. No use in past month
8. Unknown

7. How many days in the last 30 have you experienced:

a. Alcohol problems? (30 days prior to incarceration)_____ b. Drug problems? (30 days prior to incarceration)_____

8. How many times have you had:

a. Alcohol DTs? _____b. A drug overdose?_____

9. Do you sometimes use prescription, over the counter medication, alcohol, or an illicit drug to relieve withdrawal symptoms? Yes No

10. Have you noticed the need to increase the amount you use to achieve the same effect or high, Yes or sometimes feel less effect or high, after using your usual amount? Yes No

11. Would you say that you often use more than you initially intended to over a longer period of time?
Yes No

12. Have you ever had blackouts while drinking or using; drank or used enough that you could not remember what you said or did the next day? Yes No

13. When you were using, would you say that you spent a great deal of time obtaining the substance(s) you used, using them, and/or recovering from their effects? Yes No

14. IV drug use in the past? Yes No

15. Do you currently use tobacco?
No Tobacco Use Cigarettes Cigars and Pipes Smokeless Tobacco Combo/more than 1

16. If yes, indicate daily amount? 1/2 Pack 2 Packs 1-2 Packs ½-1 Pack No tobacco use

17. Would there be adequate support at home for you if you needed help while detoxing? Yes No

18. Do you have significant problems with other possible addictions such as sex, eating disorders, or gambling?
Yes No

Interviewer Rating:

19. How would you rate the client's need for detox treatment?

Critical High Moderate Low Not at all

Notes:

Medical

1. How many times in your life have you been hospitalized for medical treatment? _____

2. How long ago was your last hospitalization for a physical problem? Yrs_____ Mo_____

3. Do you have a history of or current diagnosis of any of the following:
(Select all that apply)

Abscess	Hepatitis B
Arthritis	Hepatitis C
Cirrhosis or liver problems	Kidney Problems
Diabetes	Lung/breathing problems
Emphysema	Pancreatitis
Fractures	Seizures
Gastrointestinal bleeding	Sexually transmitted disease
Hearing Problems	Vision
Hepatitis A	

4. Do you have chronic medical problems which continue to interfere with your life? Yes No

5. Are you taking any prescribed medication on a regular basis for a physical problem? Yes No

If yes please list:

6. How many days in the last 30 have you experienced medical problems? _____
(If answer is greater than 0 proceed to #7. If not proceed to #8)

7. How troubled have you been in the last 30 days by these medical problems?
Not at all Slightly Moderately Considerably Extremely

8. How many times in the last 30 days have you visited an ER?_____ (prior to incarceration)

9. Have you ever been diagnosed with TB? Yes No

10. Are you currently using birth control? Yes No (prior to incarceration)

11. What is your weight? _____ lbs.

12. Have you noticed a recent weight loss? Yes No

13. How many times in the last 6 months have you been hospitalized due to a non-Tx drug and/or alcohol related problem? _____

Interview Rating:

14. How would you rate the client's need for medical treatment?
Critical High Moderate Low Not at all

Notes:

Co-occurring

1, How many times have you been treated for any psychological or emotional problems in a hospital or in-patient setting? _____

Questions 2-9
Have you had a significant period, that was not a direct result of alcohol/drug use, in which you have:

	(*The questions requires a Yes/No response for all three columns*.)	Past 30 Day	Lifetime	30 days prior
2	Experienced serious depression, sadness, hopelessness, lack of interest?			
3	Experienced serious anxiety, tension, inability to relax, unreasonable worry?			
4	Experienced hallucinations or saw/heard things that did not exist?			
5	Experienced trouble understanding, concentrating, remembering?			
6	Experienced trouble controlling violent behavior including rage or violence?			
7	Experienced serious thoughts of suicide?			
8	Attempted suicide?			
9	Been prescribed meds for psychological or emotional problems?			

Do you have access to these medications now? (If # 9 is yes for 30 days or lifetime please specify medications)

10. How many days in the last 30 have you experienced psychological or emotional problems?_____
(If answer is greater than 0 proceed to #11. If not proceed to #12)

11. How troubled have you been in the last 30 days by these emotional problems?
Not at all Slightly Moderately Considerably Extremely

12. Psychiatric problem in addition to alcohol/drug problem? Yes No

Interview Rating:

At the time of the interview was the client:

13. Obviously withdrawn/depressed? Yes No
14. Obviously hostile? Yes No
15. Obviously anxious/nervous? Yes No
16. Having trouble with reality testing, thought disorders, paranoid thinking? Yes No
17. Having trouble comprehending, concentrating, remembering? Yes No
18. Having suicidal thoughts? Yes No
19. How would you rate the client's need for treatment for emotional problems?
Not at all Slightly Moderately Considerably Extremely

Notes:

Motivation

1 Is the client motivated to change his/her alcohol/drug use? Yes No

2.Are there any medical conditions which interfere with the client's treatment needs? Yes No

If yes please specify:

3. How important now to the client is treatment for these medical problems?
Not at all Slightly Moderately Considerably Extremely

4. Are there any psychological conditions which interfere with the client's treatment needs? Yes No

5. How important now to the client is treatment for these psychological problems?
Not at all Slightly Moderately Considerably Extremely

Interview Rating:

6. How would you rate the client's readiness to change?
Action Contemplation Determination Maintenance Pre-contemplation Relapse

Notes:

Employment

1. Education completed? _____

2. Training or technical education? Yrs___ Mo_____

3. Do you have a profession, trade, or skill? Yes No

If yes please specify:

4. Do you have a valid driver's license? Yes No

5. Do you have an automobile available for use? Yes No

6. Longest full time job? Yrs____Mo____

7. Usual or last occupation?

Farming, Forestry and Fishing occupations
Homemaker
Management and Professional Specialty
Occupation not reported
Operators, Fabricators, and Laborers
Precision Production Craft and Repair Occupations
Refused to answer
Service Occupations
Technical, Sales and Administrative

8. Does someone contribute to your support in any way? Yes No *(if yes answer #9. If no cont. to #10)*

9. If yes, does this constitute the majority of your support? Yes No

10. Employment Status

Employed Full Time (35 hours or more per week)
Self-Employed
Unemployed
Unemployed, seeking work
Unemployed, note seeking work
Employed Part Time in Steady Job
Disabled (cannot work)
Incarcerated (cannot work)
Homemaker Full Time
Attending School Full Time-Not Working
In Skills Development, Training or School full time
Retired/Permanently Out of Work Force
Other, Out of Work Force
Unemployed, not seeking work

11. Employer_____

12. How many days in the last 30 were you paid for work? (Include under the table) _____

How much money did you receive from the following resources in the last 30 days:

13. Employment (gross)? $_____

14. Unemployment comp? $_____

15. Welfare? $_____

16. Pension, SS, benefits? $_____

17. Mate, family, friends? $_____

18. Illegal? $_____

Current Gross/Taxable
Individual monthly income $_____

19. What is your primary source of income? (Prior to incarceration)

Disability	Self-employment
Other	Unemployment compensation
Public Assistance/TCA	Unknown
Retirement/pension	Wages/Salary

19a Other Income Sources

Disability	Self-employment
Other	Unemployment compensation
Public Assistance/TCA	Unknown
Retirement/pension	Wages/Salary

20. How many months have you been employed during the last 6 months? _____

21. How many days in the last 30 have you experienced employment problems? _____

22. How many days of work and/or school have you missed in the last 6 months due to substance abuse related problems? _____

23. Do you have current health insurance?

DHMH Medicaid Managed Care	No Health Insurance
Medicaid (Other than Health Choice)	Non-Managed Private Insurance
Medicare	Other Public Funds
PAC (Primary Adult Care)	Private Managed Care (HMO)

24. If yes, does it cover substance abuse treatment? Yes No

Interview Rating:

25. How would you rate the client's need for employment services?

Critical High Moderate Low Not at all

Notes:

Family/Social Relationships

1. What is your current relationship status?

Common Law/Domestic Partner	Unknown
Divorced	Separated
Married	Widowed
Never Married	

2. Are you satisfied with this situation? Yes No Indifferent

If no please specify:

3. What has been your usual living arrangement? (prior to incarceration)

Child/Adolescent Foster Care	Private Residence (apartment, home)
Group Home	Residential Substance Abuse Treatment
Halfway House, Transitional Housing	Shelter
Hospital, Nursing Home	Sober Living Facility
Independent Living	Street/Outdoors (sidewalk, abandon buildings)
Jail/Prison/Detention Facility	Dependent Living

4. How long have you lived in these arrangements? Yrs___ Mo___

5. Are you satisfied with these arrangements? Yes No Indifferent

6. Do you live with anyone who:

   a. Has a current alcohol problem? Yes No

   b. Uses non-prescribed drugs? Yes No

7. With whom do you spend most of your free time? Alone Family Friends

8. Are you satisfied spending your free time this way? Yes No Indifferent

9. How many close friends do you have? _____

10. Select the people with whom you have had a close, long lasting relationship:
    Mother Father Sister/Brother Children Friends

11. Have you had significant periods in the last 30 days or in your lifetime in which you have experienced serious problems getting along with your:

(*The questions require a Yes/No response for both columns*.)	Past 30 Day	Lifetime
Mother?		
Father?		
Brother/sister?		
Sexual partner/spouse?		
Children?		
Other significant family?		
Close friends?		
Neighbors?		
Co-workers?		

12. Have any of these people abused you? If so, how and when?
(*The questions require a Yes/No response for all columns*.)

	Past 30 Days			Lifetime		
	Emotionally	Physically	Sexually	Emotionally	Physically	Sexually
Mother						
Father						
Brother/sister						
Sexual Partner/spouse						
Children						
Other Significant Family						
Close friend						
Neighbor						
Co-worker						
Other/Specify						

13. How many children do you have age 17 or less (birth, adopted, or stepchildren) whether they live with you or not? _____ *(If answer is greater than 0 proceed to # 14 & 15. If not proceed to #16)*

14. How many of these children spent the last 6 months (prior to incarceration) living with you?_____

15. Are any of your children living with someone else because of a child protection order? Yes No

16. Has your substance use caused problems at home with your partner, kids, or home obligations?
Yes No

17. Do you have a DSS case worker? Yes No

18. How troubled have you been in the last 30 days prior to incarceration by:

a. Family problems? Not at all Slightly Moderately Considerably Extremely

b. Social problems? Not at all Slightly Moderately Considerably Extremely

19. How troubled have you been in the last 30 days by:

a. Family problems? Not at all Slightly Moderately Considerably Extremely

b. Social problems? Not at all Slightly Moderately Considerably Extremely

20. Have you given up or reduced your involvement in important social or recreational activities that did NOT include drinking or using? Yes No

21. Is there a family history of substance abuse or dependency? Yes No

Interview Rating:

22. How would you rate the client's need for family or social counseling?
Critical High Moderate Low Not at all

Notes

Legal

1. Was this admission prompted by the criminal justice system? Yes No

2. Are you on parole or probation? Yes No

How many times have you been arrested and/or charged and/or convicted for the following:
Leave gray areas blank

	Arrested	Charged	Convicted
3. Shoplifting/vandalism?			
4. Parole/probation violation?			
5. Drug charges?			
6. Forgery?			
7. Weapons offense?			
8. Burglary, larceny, B & E?			
9. Robbery?			
10. Assault?			
11. Arson?			
12. Rape?			
13. Homicide/manslaughter?			
14. Prostitution?			
15. Contempt of court?			
16. Driving While Intoxicated past 12 months?			
17. Non-drug or alcohol-related crime while under the influence in the last 12 months?			
18. Non-drug or alcohol-related crime while not under the influence in the last 12 months?			
19. Drug or alcohol-related crime in the last 12 months?			
20. Other?			

21. How many times have you been arrested in the past 12 months (prior to incarceration and include this one)? _____

22. How many times have you been arrested in the past 30 days? _____ 30 days prior to incarceration?____

23. How many months were you incarcerated in your life? Yrs_____Mos_____Days_____

24. How long was your last incarceration? Yrs_____Mos_____Days_____

25. What was it for?

26. Are you presently awaiting charges, trial, or sentence? Yes No

27. If yes, what for?

28. How many days in the last 30 were you detained or incarcerated? _____30 days prior to incarceration?_____

29. How many days in the last 30 have you engaged in illegal activities for profit? _____

30. How serious do you feel your current legal problems are?

Not at all Slightly Moderately Considerably Extremely

Interview Rating:

31. How would you rate the client's need for legal services?

Critical High Moderate Low Not at all

Notes:

ASAM - PPC2R ***(*** *Recommended but not required)*

Dimension	Level of Risk	Level of Care
1. Acute Intoxication and/or Withdrawal Potential Comments:	_____	_____
2. Biomedical Conditions and Complications Comments:	_____	_____
3. Emotional, Behavioral, or Cognitive Conditions and Complications Comments:	_____	_____
4. Readiness to Change Comments:	_____	_____
5. Relapse, Continued Use, or Continued Problem Potential Comments:	_____	_____
6. Recovery/Living Environment Comments:	_____	_____

For Level of Risk

0 – Not at all
1 – Slightly
2 – Moderately
3- Considerably
4 - Extremely

Environments

Counseling
Mental Health
Substance Abuse
Substance Abuse/Mental Health

For Level of Care enter the corresponding number

0.5 Early Intervention
I Outpatient
I .D Outpatient Ambulatory Detox.
I OMT Opiod Maintenance Therapy
II.1 Intensive Outpatient Treatment
II.D Intensive Outpatient Detox
II.5 Partial Hospitalization
III. 1 Clinically Managed – Low Intensity
III. 3 Clinically Managed – Medium Intensity
III. 5 Clinically Managed – High Intensity
III. 7 Medically Monitored Intensive Inpatient
III.7-D Medically Monitored Intensive Inpatient Detox.
IV Medically Managed Intensive Inpatient
IV.D Medically Managed Intensive Inpatient Detox
OMT.D Opioid Maintenance Thearpy-Detox

Clinical Override:

Clinical Judgment	Managed Care Refusal
Lack of Insurance	N/A
Legal Issues	Other
Level of Care Not Available	Patient Opinion

Recommended Level of Care _____

Recommended Environment _____

Actual Level of Care_____

Actual Environment_____

Comments:

Summary

Interviewer Confidence Rating:

1. In your opinion, is the information in this assessment significantly distorted due to client's misrepresentation?

Not at all Slightly Moderately Considerably Extremely

2. In your opinion, is the information in this assessment significantly distorted due to client's ability to understand?

Not at all Slightly Moderately Considerably Extremely

Comments

Assessment Duration

Interview: Start Date_____ End Date_____ Total Interview Time_____