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CENTRAL INTAKE UNIT MANUAL

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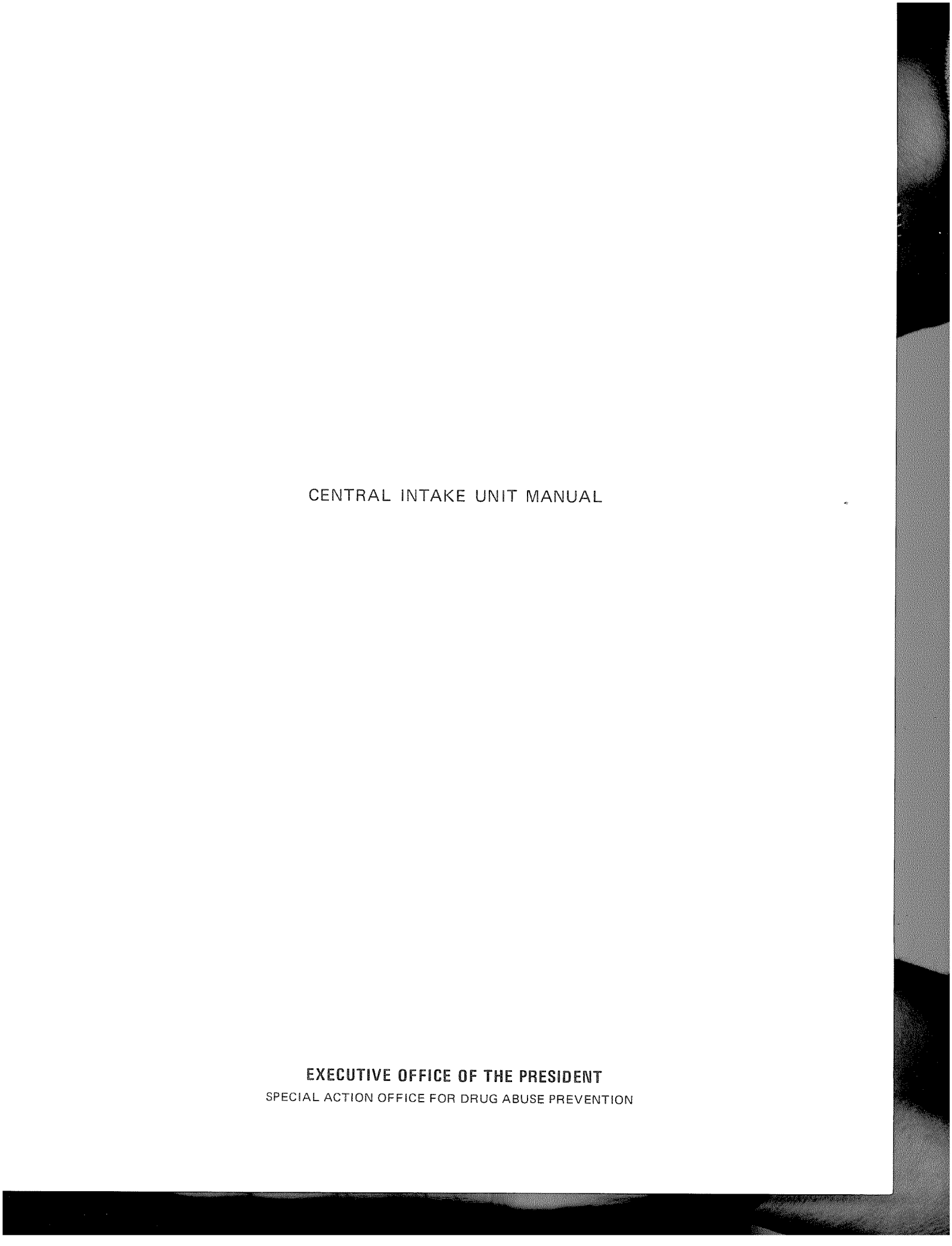

PREFACE

This is the first of several Monographs developed by the Special Action Office for Drug Abuse Prevention to help present ideas regarding efficient and effective ways of providing drug abuse treatment services.

A major concern of the Special Action Office has been upgrading the quality of the drug abuse treatment services. One element of that effort has been to encourage the introduction of central intake units (CIU's) in cities with multiple treatment programs.

It is our feeling that a central intake unit is helpful in managing a multi-unit city drug program. This CIU Monograph was designed to assist communities with multiple drug programs establish central intake units. We hope you find this CIU Monograph helpful and are able to tailor it to meet your specific managerial needs.

Robert L. DuPont, M.D.
Director

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I Introduction: Rationale and Goals of a Central Intake Unit

In many metropolitan areas with a high incidence of drug addiction and related crime, a new emphasis on providing treatment alternatives to arrest and incarceration has led to the development of a variety of drug treatment programs. These services have been variously organized under tightly structured municipal controls or loose-knit umbrella agencies, or have remained as autonomous and fiercely competitive units that vie for potential patients. Regardless of their organization, any city with multiple treatment programs has probably experienced problems in such areas as the random self-selection of programs by patients; haphazard referral policies; punitive admission requirements; spotty information collection; costly duplication or services; inefficient distribution of patients in any modality; the potential for double registration in methadone dispensing facilities; and enforcement of FDA regulations regarding methadone. One solution to these problems has been the development of centralized admission control within a Central Intake Unit.

A Central Intake Unit functions on two different levels. While its mandate is to establish uniform entrance requirements and expedite referral to treatment, it will also help define a community's attitude towards drug abuse rehabilitation through its admission policies. For example, by emphasizing the availability of treatment for all who seek it, whether opiate or polydrug users, the Intake Unit stresses inclusion. This policy encourages cooperation from the diverse elements which comprise the treatment community. Furthermore, once a measure of cooperation is achieved, the Central Intake Unit can establish two basic policies, the first being that clients will not be accepted directly into individual treatment service units and the second, that treatment service units must accept the clients referred to them. Not only does this stance serve to reduce competition among individual programs but, more importantly, it expresses a commitment to rapid and appropriate client placement which may increase the demand for services from previously disinterested segments of the abusing population.

The Central Intake Unit may serve another purpose as well. It offers an ideal opportunity to introduce the client to the full range of social services (health, welfare, education) available in the community. Suggested methods for incorporating this component into the Unit will be discussed in Section C7.

At this point, it should be noted that for the purposes of this manual, it has been assumed that the requisite inter-agency cooperation has been secured to support the establishment of a Central Intake Unit. Without this kind of agreement, it is difficult to implement a CIU since it may pose a threat to many program directors who do not want to lose control of their intake. When the CIU concept is being examined by a community, the issues of endorsement and support should be carefully considered so that if the program is launched, it has a realistic opportunity for impact.

For those cities with an estimated drug-dependent population over eight thousand and anticipated treatment capacity exceeding 2500 slots, the efficiency and effectiveness of opening a Central Intake Unit should be considered. These figures are based on the Federal Strategy which estimates that "during the course of a year, no more than a half of all active narcotics users and addicts will seek treatment",[1] and that the dynamic capacity of a treatment program is approximately 1.7 times the static capacity. Staff and budget for a Central Intake Unit that can screen from 15-30 patients a day or 5,000 per year will not substantially increase the total cost of treatment per patient year. If intake falls below an average of 15 per day, the unit may cease to be cost-effective in attempting to provide independent medical services. A modified plan to utilize the administrative, clerical and counseling functions of a CIU in conjunction with an ongoing health screening unit might be a realistic budgetary possibility. The overall additional costs per patient per year of a CIU must be weighed carefully against the many problems associated with random treatment selection.

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1. Federal Strategy for Drug Abuse and Drug Traffic Prevention, 1973, pp. 78,80.

The advantages of a Central Intake Unit include, but are not limited to, the following:

- standardized and quality medical evaluation of each patient. This includes multi-phasic screening for disease with appropriate referral as necessary; optional annual follow-up examinations when desired; consistent documentation of drug history and verification of records; professional observation of drug symptoms and application of clinical judgement; convenient central collection of laboratory specimens for testing that ensures patient cooperation and evaluation prior to treatment.
- rational, objective, and reviewable referral procedures that may also initiate planning processes. The population requesting treatment may be carefully studied and programs modified or developed to meet their needs on a timely basis, but controls on referrals may also be imposed to ensure that facilities are efficiently utilized.
- non-partisan orientation to the available treatment modalities. This allows objective selection of a program best-suited to the current needs of the patient, and provides for rational analysis of treatment failure, relapse, and re-entry. Patients may be referred both by treatment modality and geographic location, according to their specific situation at each admission.
- uniform record keeping and data collection on each patient that provides information to comply with all Federal and local reporting requirements as well as research and evaluation statistics for a variety of management, medical, social or legal studies.
- identification verification and current treatment status checks at admission for each patient to eliminate double registration in medication programs. Maintenance of an up-dated central registration system also avoids readmission of ineligible patients such as recently detoxified juveniles or behavioral suspensions.
- increased treatment demand as admission or readmission becomes readily available on a one-day basis, well-known to the target population, and acceptable to them. As unnecessary delays and admission hurdles are eliminated, and a variety of treatment programs are available, a larger percentage of the population that may benefit from drug-treatment will tend to seek it voluntarily.
- centralized assessment or referral to such ancillary services as temporary emergency medication, other immediately required social services, or transfer acceptance on a temporary or permanent basis from an out-of-town program.

This manual is designed to assist in the planning and operation of a Central Intake Unit and will be of primary interest to the manager of such a facility. It is organized to give an overview of the tasks and functions of the whole unit that will be necessary for the manager to understand in order to plan and implement daily operations. No single section of a CIU may function effectively without a cooperative relationship with the rest of the staff. It is the manager's primary responsibility to coordinate all functions, both internal and external, into an effective program. General information and suggestions are also given for acquiring and maintaining the physical plant, for designing data collection instruments, distributing and storing information, staffing, budgeting, and necessary equipment, supplies and ancillary services.

The operational suggestions have been tailored to comply with the Federal regulations and policy for drug abuse prevention and treatment. The following sources should be obtained and consulted for additional information and guidelines:

- Federal Register, Vol. 37, No. 242, Friday, December 15, 1972 Part III. Methadone
- Federal Register, Vol. 37, No. 223, Friday, November 17, 1972 Part III. Special Action Office for Drug Abuse Prevention. Confidentiality of Drug Abuse Patient Records
- Federal Central Intake Unit (CIU) Scope of Work, SAODAP September 17, 1973
- Client Oriented Data Acquisition Process, *National Management Handbook*, SAODAP, Washington, D.C. 20506 November, 1972, Revised 20 February, 1973

- Client Oriented Data Acquisition Process, *Client Management Handbook*, National Institute of Mental Health, Rockville, Maryland 20852, May, 1973
- Federal Strategy for Drug Abuse and Drug Traffic Prevention, 1973. Strategy Council on Drug Abuse, Washington, D.C., March, 1973
- *Prescriptive Package: Methadone Treatment Manual*, U.S. Department of Justice, Washington, D.C., June, 1973 (available mid-January, 1974).

II Tasks and Functions of a Central Intake Unit

In general, a Central Intake Unit is responsible for initial medical-social screening, evaluation, diagnosis, orientation and referral to appropriate treatment modality and facility of all new and readmitted patients in a defined drug-treatment system. It collects, documents and distributes necessary information on the patient to a variety of sources for purposes of identification, supervision, treatment planning, and reporting within the restrictions of confidentiality. Annual examination and evaluations are also performed for patients in ongoing treatment. Linkages are established and maintained with appropriate community resources such as treatment programs, social or medical services, and criminal justice systems. These functions may be broken down into a series of tasks performed by specific staff members in three organizational units: medical, counseling and administrative/clerical. Each task is described in some detail with suggested staffing assignments. Additional information about staffing patterns and the equipment, space and forms necessary for the performance of these tasks will be found in other sections.

A. Medical Unit Tasks: Staff Responsibility

1. Obtain complete medical history for each patient.

   Self-administered-
   by patient with assistance
   by medical technician

The form on which this information is collected should be developed or approved by the Medical Director. It should include a history of appropriate diseases with space for date and treatment notes if respondent is affirmative. A list of recently experienced symptoms will also help in confirming drug problems as well as indicating common diseases. A second section should contain questions about hospitalizations, recent medical/dental or optical examinations; insurance or medicaid status; name and address of clinics or physicians currently treating the patient; and the patient's own assessment of his health status or most compelling complaints. Females should fill in a special questionnaire on their menstrual and reproductive history with emphasis on suspected pregnancy. This form should also contain a consent for physical examination and appropriate laboratory tests with an explanation of the requirement to report some communicable diseases to the local Health Department.

Since many patients have reading difficulties and find medical terms most confusing, this form must be carefully administered to insure accurate responses. Some patients may be able to fill out their own histories with no difficulty, but others will require that each question be read or explained. Every form should be reviewed for completion and accuracy before it is accepted. The nurse and all medical technicians should be trained in both the forms content and suggested interview techniques to avoid embarrassment while eliciting correct information. A video-taped presentation of the questionnaire with brief explanations might be one way to short-cut staff involvement although CIU personnel should be on hand to answer questions or deal with any problems that might arise.

In some CIU's, patients who are being readmitted to the program within six months of their last admission may not be requested to repeat the entire history, but only to fill out an addendum of any new diseases, hospitalizations, examinations, current symptoms or treatment, and other changes. This addendum should, however, be attached to the previous history and presented to the physician before the physical examination along with the patient's complete CIU record.

2. Obtain specimens for laboratory tests, perform certain tests, prepare other specimens for outside analysis, document results on logs and in patient records, and prepare laboratory forms for filing in patient record and distributing to the clinic.

   Medical technician

The laboratory tests will require the observed collection of a urine specimen for routine and microscopic urinalysis and screening for drugs (toxicology). One sample can be used for both purposes as well as pregnancy testing for females. In most circumstances, all of these tests can be performed on site although confirmation or specificity of drug content may be sent through another system and microscopic testing contracted. If technicians are responsible for supervision of urine collection, an appropriate ratio of male/female employees will be necessary.

Daily logs of patients, ID numbers and test results with space for repeats should be kept as well as entered in the individual file. This provides a cross-reference if one set is inadvertently lost and also an accessible data base for research.

Technicians will also need to collect blood specimens adequate for CBC, SMA 12/60, serologic test for lues, Australian antigen, and sickle cell screening, if desired. All the specimens except CBC and the initial sickle cell screen will probably need to be centrifuged and separated, labeled, and refrigerated with appropriate transaction forms until delivery to outside laboratories. Some patients will be apprehensive about the number of tubes of blood necessary for these tests and will need reassurance. Proficiency and expertise in blood drawing techniques will also be required to find unscarred sites on some patients. Attention should again be given to maintaining a daily blood log of patients' names, ID numbers and test results as well as entering them in individual files. When results are returned from outside laboratories, individual forms can be checked for abnormalities, appropriately acted upon, filed in CIU patient records with copies sent to the receiving clinic. Laboratories usually also send a weekly or monthly report summary that substitutes for the logs on that particular test.

In most CIU's, a routine chest x-ray will also be taken and developed prior to the physical examination. It will be available to the physician for screening, but will be read later by a radiologist. Again, a daily log of patients and results should be kept with space for noting recommended follow-up tests and results. The x-ray slip containing the radiologist's reading should be filed in the individual medical record with a copy sent to the clinic. The film itself should be stored in an envelope and filed separately in a system that matches the one established for filing CIU patient records. Care should be taken to note possible pregnancy and avoid x-ray and also to establish proper guidelines to prohibit unnecessary and repeated x-ray exposure for readmitted patients.

Pap smears and gonorrhea cultures can be collected during the physical examination and properly prepared and stored prior to mailing or delivery for analysis. Lab slips with results should be noted for follow-up before filing at CIU and forwarding of duplicates to the clinics.

3. Review laboratory tests and x-ray results for abnormalities that require retesting or other referral.	Nurse under supervision of M.D., and radiologist.

Test results from outside laboratories will not be available to the physician at the time of examination. Guidelines for selecting ranges of abnormality that require repeated testing (perhaps with additional instructions such as fasting) or referral should be established by the Medical Director. The nurse, however, can review results as they are returned and notify clinics and patients of necessary procedures under the supervision of the doctor. Logs again must be kept to ensure that appropriate actions are taken.

4. Conduct physical examination with documentation of diagnosis, evaluation and recommendations.	M.D. licensed in CIU jurisdiction

The physical examination by the doctor is crucial to the quality of care that is given to the patient. It should be thorough and complete with an emphasis on addiction-related diseases (e.g. infectious diseases, liver and cardiac abnormalities, venous diseases, abscesses, etc.). Special attention should also be given to any other diseases associated with particular ethnic groups or geographic location that might be applicable. The drug history of the patient should be documented by the doctor along with observations of current physiological dependence including tracks and needle marks and early signs of withdrawal. Clinical judgement should be exercised to specify the duration and severity of addiction that determines the patient's eligibility for methadone treatment or detoxification rather than abstinence. All recommendations for further health care referrals should be carefully noted on the examination form. Some of the examination procedures such as temperature, pulse, weight, height, and blood pressure readings may be done by the nurse or technicians before the patient sees the physician. Tetanus injections, as directed, may also be given by the nurse.

5. Establish and maintain appropriate referral procedures to medical services for quality patient health care and arrange for appropriate emergency care on and off-site.	M.D. and nurse

The Medical Director should make appropriate contacts with necessary health services and clinics so that patients may be referred and receive care within a reasonable period of time for all non-drug problems. Primary arrangements will probably be necessary with cardiac and hypertension clinics, medical/surgical services, dermatology clinics and dental practices. The Medical Director should also arrange for the required emergency medical equipment to be present at CIU and negotiate a formal written agreement with a licensed hospital for provision of emergency in-patient and ambulatory hospital services. FDA regulations require ready access to a comprehensive range of medical services and suggest that formal arrangements be made with hospitals for general medical care for patients although neither the program nor the hospitals are required to assume financial responsibility for the patient's medical care.

Required communicable diseases must be reported promptly to public health authorities and close liaison should be established with the local V.D. and T.B. control units. Positive or suspected cases should be referred immediately for follow-up and assistance should be given to their staff in locating patients for treatment.

Once the initial contacts are made, it becomes the nurse's responsibility for carrying out the doctor's recommendations for health referrals including obtaining necessary patient release of information consent forms so that results of treatment or diagnoses are returned to CIU and the patient's clinic. The nurse may explain and clarify the necessity for treatment to the patient and/or his family and become the liaison between patient, medical service and drug treatment clinic. The nurse should note the kind of insurance coverage or other medical eligibility of the patient in determining the best referral. The nurse should also make arrangements for appropriate transportation to clinic or hospitals in emergency cases or to facilitate rapid treatment. Taxi script have been found to be convenient for transporting serious, but non-emergency cases.

6. Unit staff training and administrative functions	Nurse with assistance of M.D.

In many clinics, the nurse should assume direct administrative and supervisory responsibility for the medical unit including scheduling of personnel, leave approval, training related to unit procedures

(non-technical) and general staff training related to health problems and care such as nutrition, hypertension, sickle cell counseling, etc. She may use the physicians for consultation. She will also have responsibility for supervising the maintenance of equipment, inventorying supplies for the unit and initiating requests for repairs or requisitions.

7. Research — M.D. with Administrator

The use of medical data collected at CIU for research purposes should be approved by both the Medical Director and the Administrator in most instances. It should be controlled within the Federal guidelines for confidentiality of records. Requests to use the patient population for research purposes entailing additional testing beyond the standard intake procedures should be medically approved by the Medical Director and finally accepted and coordinated by the Administrator. The patient should always be given the option of refusing to participate in such projects. However, if he agrees to participate, an informed consent must be obtained.

B. Counseling Unit Tasks: Staff Responsibility

1. Pre-screening, identification registration, and routing of all patient/applicants. — Diagnostic counselor

All persons presenting themselves at CIU should be greeted by a diagnostic counselor and screened for admission eligibility or referred appropriately. This screening may consist of a formal or informal evaluation of drug use by a few simple questions and observations. Identification of the applicant is carefully checked by at least two approved documents preferably containing a photo, signature, date of birth and social security number. A list of suggested approved documents is contained in the Appendix. The applicant is then checked for previous registration with the CIU and current treatment status. If he is unknown, a new identification number is assigned and appropriately logged. If he has been previously known, his eligibility for readmission must be checked by the presence at CIU of a terminated file from his last treatment program, or by a telephone call to that clinic. If eligibility is verified, the original identification number is reissued. After eligibility and identification are established, a registration form is filled out and a patient record is initiated. The registration form may consist of identifying information and photo with a record section to be completed after CIU processing determines clinic and modality assignment. If the patient has been referred by a participating criminal justice agency, he may arrive with a partially completed registration form that must be returned to the referral source. The patient is logged in on the daily activity sheet and then routed to the medical unit to begin processing. Careful attention must be given to the date of birth so that juveniles under eighteen have parental consent before admission in states where this is necessary. The patient record that is initiated consists of the blank forms necessary for intake procedures plus whatever information is contained in the previous CIU files on this patient. Because the file may be bulky, an envelope may be preferred to a folder as a carrier. A routing slip is attached to the outside to be used as a check list in CIU processing.

Readmissions of patients who were examined at the CIU within six months may be abbreviated by eliminating certain portions of the intake process. Generally, addendums are added to physical exams and interviews to focus on current drug status and reasons for treatment termination. Urinalysis for drugs is also performed (see routing slip in the Appendix).

2. Obtain and document a personal/social and drug involvement history — Diagnostic counselor

The diagnostic counselor usually interviews the patient after medical diagnoses and referrals are completed. He reviews this information and any other contained in a previous available record before calling the patient. The interview instrument should conform to requirements in the CODAP *Client Management Handbook* and consist of modules for identification and demography, referral, personal history, education and employment, drug usage, current problems, and action taken. It is also suggested that information be collected on any previous treatment for drug abuse, any prior involvement with the criminal justice system on drug-related charges, and any friends or relatives whom the patient might wish to use to verify his drug involvement. With proper release of information request forms signed by the patient, documentary evidence of a history of addiction may then be obtained and entered into the patient's record.

There are many samples of intake interview forms that may be used as models for particular CIUs. An example of such a form is in the Appendix. The length of the interview should be kept in mind, however, when considering addition of other information. Many patients enter treatment in early withdrawal, or very "high" from street drugs. The rapport that may be maintained throughout a lengthy interview by even the most experienced counselor is notably diminished if the questionnaire itself takes more than 20-30 minutes. The diagnostic counselor must learn to use it as a point of departure for discussion with the patient and evaluation of his attitudes, experiences, and knowledge of treatment modalities and requirements. If an objective and rationalized system such as Pittel recommends for quantifying drug involvement and prognostic index is to be used, it should be smoothly incorporated into the interview structure. This will avoid duplication of questions which frequently antagonize patients.

The psychiatrist at the CIU may also wish to design a short screening instrument to be administered by the diagnostic counselor to determine which patients are in need of more extensive psychological evaluation. Training in necessary interview techniques and basic interpretation of the results should be conducted by the psychiatrist. Arrangements should also be made for a referral procedure and schedule since the psychiatrist will only be available part-time.

3. Orient patient to available treatment modalities and program requirements and negotiate treatment selection.	Diagnostic counselor

Drug dependent persons will often benefit from different treatment approaches at various stages in their drug involvement. Knowledge about different modalities is as important to the patient as to the clinician. Patient preferences and selections must be considered along with the doctor's recommendations and the counselor's judgements. Federal eligibility requirements as to age, duration of addiction, length of time for juveniles since last methadone medication, etc. will influence some decisions. Program requirements such as geographic catchment area, type of drugs used, sex, or current criminal status will determine other placements. The diagnostic counselor must be alert to *all* available resources and assist the patient in negotiating the best alternative. The doctor's judgement about length and severity of addiction with his recommendation of modality will be primarily considered, although a patient may be eligible, but not volunteer, for methadone treatment and thus in conjunction with the physician opt for a different modality. The reverse situation is not true however. That is, if the physician's judgement is that a patient is not eligible for maintenance, this decision cannot be overridden. Some factors that *must* be considered are:

1. age limitations for methadone treatment
2. documented two-year history of narcotic addiction before methadone treatment
3. elapsed time since detoxification completed for juveniles
4. pregnancy or other serious illness

Other factors to be considered include:

1. current employment and living situation
2. previous institutionalization
3. attitudes toward in– or out-patient programs
4. types, amounts and frequency of drugs being used
5. current criminal status
6. attitudes toward various treatment program requirements (daily attendance, group therapy, religious affiliation, etc.)
7. verbal and analytical abilities.

Various devices may be used in the counseling unit to visualize the treatment alternatives and make choices and decisions easier and more rapid. A handbook of programs should be available that lists necessary information about each one such as staff contact, address, phone, hours of operation, eligibility criteria, program requirements, staffing services, capacity and current patient load. A wall chart may capture the basic information organized by treatment modality. A large map with flagged programs will assist geographic choices. Catchment areas may also be clearly defined.

4. Obtain all necessary release of information and consent forms, make formal referrals, complete ID card, verify CIU check-out — Diagnostic counselor

The patient may also require immediate referral to other social agencies for emergency shelter, clothing or food needs. These should be initiated by the CIU. Less pressing issues such as public assistance or unemployment applications may be recommended to the receiving program.

Consent forms for release of information to be returned to CIU should be signed. If methadone is to be administered, a Federal Consent Form FD 2635 should be read and signed.

A photo-identification card may be made at this point. If the patient is to be using methadone, a photo-identification card is strongly recommended for his own protection. If he may receive take-home privileges, it should be required. Even for drug-free programs, photo-identification at intake is recommended. Copies may be kept in the program record and at the CIU. Even if the patient decides not to carry identification, a photo may be very helpful in eliminating double-registrations and, later, verifying identification. Most patients actually demand ID cards if they are available. The card should include the patient's name, signature, date of birth, social security number, or program ID number, date of issue, and sponsoring agency with emergency contact number.

Formal referral to the treatment program may necessitate a one-page intake summary for the patient to carry with him, or a telephone call to the program, or both. The CIU record which has been compiled will be received by the program not sooner than the next day. An alternative is to initiate detoxification or methadone maintenance before assignment to the permanent clinic and request drug-free patients to visit the program the day following CIU processing. It is not advisable to give the patient the full record to carry with him. Referral procedures should be as simple as possible and never entail a complete rescreening at the receiving program.

The routing sheet on the patient's CIU chart should be checked by the counselor before the patient is dismissed to make certain that the admission process has been completed. This form is useful for other units to request return for urine, incomplete health referrals, results of pregnancy test, etc.

5. Prepare CIU records for distribution.	Diagnostic counselor

After the patient completes processing, the diagnostic counselor separates all of the forms (usually prepared in duplicate), in the record, checks them for completion, and prepares them for distribution. The clerical section may have pre-labeled boxes or drawers to separate them. Each folder *must* be separated on the day of patient referral so that all units are promptly notified and receive necessary information. (Distribution is further discussed under information flow). The front desk daily activity log is also completed at this time so that daily statistical summaries may be prepared.

6. Arrange patient transfers between programs or out-of town on temporary or permanent basis.	Treatment program staff or Diagnostic counselor

The patient population is in a continual state of flux and changes are constantly requested. Guidelines for expediting them should be clearly understood. In general, all treatment programs should undertake arrangements for satisfactory patients to make changes within the same modality to another geographic location either in the same jurisdiction or out-of-town. If, for instance, a maintenance patient in good standing moves or changes jobs, efforts should be made to find a more convenient clinic with notification of the transfer to the CIU. If a similar patient needs to travel or move out-of-town – assistance is offered on a national basis from TRIPS (202-466-2310) and may be requested by the local clinic.

Patients, however, who are failing in one modality and need reassessment for another should be returned to CIU for reinterview and transfer. If a physical has been given within six months, there may be no requirement for this portion of the intake except for drug use verification and examination for drugs. Such patients can be handled similarly to readmissions.

TRIPS will contact clinics individually to arrange temporary transfers from out of town locations. For most programs, it would be wise to request that individual clinics then notify the CIU. Other jurisdictions may also contact programs individually, and should be referred to CIU in order to avoid possible duplication of treatment arrangements and to ensure use of the most appropriate facility. A certain number of patients from other jurisdictions will simply arrive in town and should be referred to CIU for processing just as any other new patient. The CIU may call TRIPS for assistance in verifying the treatment status of these patients. Dosage information can then be verified by CIU and appropriate arrangements made for return of the patient to his original program or for a formal transfer.

7. Monitor patient behavior	Chief counselor or Diagnostic counselor

Every effort should be made at a CIU to create and maintain a cordial, professional, and efficient atmosphere and to understand the ambivalent feelings of patients and their families about seeking help. Negative attitudes of staff toward patients should be promptly discussed and discouraged. However, despite the best staff training and intentions, there will be disruptive patients with overt behavioral problems that require immediate attention. The chief counselor with mental health training is usually the best CIU resource for handling these situations. He should be alerted whenever a situation is getting out of hand so that the patient can be isolated, if possible, and the problem resolved. Quiet discussion and explanation of procedures or requirements usually persuade a patient of their necessity. The counselor should understand and have experience in dealing with patients under the influence of a variety of drugs so that he recognizes when medical intervention may be necessary and when verbal explanations are wasted. Ground rules for different situations should be developed through experience and staff discussion. Particularly

explosive confrontations should be analyzed later as part of general staff training, and consultation requested from the psychiatrist or other experts. Learning to intercept violence and hostility and deflect it before the whole facility is involved should be the goal of such training.

8. Consultation with families and social agencies about drug treatment. — Chief counselor

Inquiries about treatment and motivating a potential patient to come to CIU are often received and should generally be directed to the chief counselor. He can also be available to families etc. who may accompany the patient to CIU and desire an explanation of treatment. This applies particularly to parents of juveniles who must sign treatment consent forms.

9. Maintain daily logs and statistics, review patient folders, train unit staff in diagnostic judgements and administrative supervision of unit — Chief counselor

Certain information should be compiled daily at the CIU from the logs in preparation of statistical summaries. This will include the referral source statistics necessary for the National Management Census Report (voluntary and type of involuntary admissions), and numbers and kinds of services, and treatment referrals by modality and clinic. This information may not have to be hand tabulated if a computerized information system exists, but it is likely that there will be many reports prepared from available data that are not programmed in the computer.

The chief counselor will have responsibility for reviewing the patient folders prepared at CIU and using them as a basis for training unit staff in diagnostic skills, interview techniques, and other problem areas that may be discovered. He will ensure that the daily distribution is completed and that the number of folders tallies with the log of admissions.

Overall supervisory responsibility for the unit in schedules, inventories, leave approval, etc. also falls on the chief counselor.

C. Administrative/Clerical Unit Tasks: Staff Responsibility

1. File, maintain and retrieve all patient records in central CIU files within Federal guidelines for confidentiality — File clerk

The file clerks will have primary responsibility for actual filing and retrieval of CIU patient records. This will include the information contained in the admission records, the incoming laboratory reports received later, any additional treatment or arrest documentations, status change reports, or terminated files returned from the treatment program. If the file system is set up by ID number (a terminal digit system is suggested which organizes ID numbers by their last two digits and groups them in blocks from 1 to 99), file clerks should also maintain an alphabetical-photo cross index in a separate system and retain the daily activity logs from the front desk that record admission by date. File clerks will be responsible for stamping all files appropriately for confidentiality of information and securing them in locked file cabinets. They will also maintain a system for checking out files to approved persons (CIU staff and other authorized personnel).

and retrieving them on a daily basis. All patient information must be locked each night in marked file cabinets. Every staff person with access to them should sign an understanding of confidentiality.

2. Prepare mail for daily messenger distribution to treatment programs, central registration, and criminal justice systems.	File clerks
3. Deliver mail on daily basis to treatment programs, central registration and criminal justice system. Pick-up status change reports and terminated files; deliver laboratory specimens and pick-up laboratory results	Clerk/Messenger

A regular distribution system for patient files and laboratory services is crucial to the acceptance of a CIU. One clerk/messenger can usually cover all delivery points in a half-day.

4. Telephone Regular mail Typing Office files	Secretary with assistance from clerks.
5. Maintain supply inventory and order and receive expendable items as necessary	Secretary
6. Duplicating by photocopy and mimeograph	Secretary and file clerks

A photocopy machine is useful if records must be duplicated and released from CIU to other treatment programs, hospitals, vocational rehabilitation services, etc. The mimeograph is used for reproducing those forms that are not economical to print, such as logs, route slips, report forms, information release consents, etc.

7. Establish and maintain liaison with treatment programs, community services and resources (non-medical) and the criminal justice system.	Administrator

The administrator has primary responsibility for making all non-medical community linkages. Drug treatment programs may already be organized under one agency or federation or may require new coordination under a revised system such as a nonprofit corporation. The administrator will participate in regular meetings with representatives from cooperating programs and should initiate these meetings if necessary. The handbook of referral resources may be developed in this group and continuously updated as programs change. Problems of referral, treatment policies, reporting requirements, records documentation, etc. should be resolved in these exchanges.

Contacts with appropriate community agencies such as shelter homes, crisis assistance, hot lines, etc. should also be made on a regular, formalized basis in order to improve the quality of services offered by the CIU and to refer clients to all available community resources as part of an active CIU outreach component. Local merchants, particularly fast-food chains, are often generous in their assistance to CIU's and can be approached for emergency support.

The administrator should also be involved in whatever local criminal justice system referral schemes, such as TASC, that are developed. The reporting requirements to various agencies such as probation, parole and courts should be simplified or centralized as much as possible to conserve both staff and patient time. A scheme for identification of the referral source at intake should also be developed so that non-voluntary patients are immediately and correctly flagged.

8. Collect statistics and prepare reports — Administrator

Local reporting requirements and the sophistication of any computer information system will probably determine how much time is spent on this task by the administrator. The one National Management Census Report on intake is relatively straightforward and can be compiled from the daily admission activity log. The CODAP Case Sample reports should be prepared at the treatment program from the information at admission.

9. Supervise patient and information flow, develop and modify forms, procedures, or facility to comply with all Federal, State, and local policies and regulations. — Administrator

The administrator will develop the operational scheme for CIU and assign staff functions. He will be responsible for compliance with regulations such as building or occupancy ordinances, safety and security precautions, occupational requirements and directives from Federal and State agencies regarding drug treatment. All operations must be reviewed periodically for efficiency, effectiveness, and compliance.

10. Prepare, submit and control budget. — Administrator
11. Change physical plant and space utilization of facility as necessary to improve quality of services; arrange for building maintenance, inspection and security. — Administrator
12. Recommends and acquires new equipment or replacement equipment and expendable supplies; arranges repairs on equipment. — Administrator
13. Recruits new and replacement personnel; supervises, rates performances, recommends promotions, approves leave, determines performance standards and disciplines staff. — Administrator

14.	Conducts tours of facility; gives speeches to outside groups and organizations to explain CIU; participates in appropriate conferences, or meetings relating to CIU.	Administrator
15.	Approves all use of the facility or data by outside staff for research purposes consistent with CIU objectives and within restrictions of confidentiality.	Administrator

The administrator considers all requests to conduct research for consistency with stated objectives and relation to other drug-treatment research. He ensures that no improper disclosure of patient identity will be made and that the conditions or time required will not interfere with, or substantially change, the intake process. If necessary, he schedules research projects in the unit to minimize the inconvenience to patients.

16.	Plans, arranges and holds regular staff meetings and training sessions to improve the quality of service, and augment staff career mobility.	Administrator

Several hours a week should be devoted to ongoing staff training in areas related to the CIU. Some of the training may be in other facilities or within the smaller organizational units of the facility, but a regular time should be set aside in the operational schedule. A mid-week morning is suggested. The focus or agenda of the meetings may be rotated so that all staff understand the importance of each organizational function. Internal procedural problems may be handled one week, interview techniques another, interpretation of SMA 12/60 results in a third, and consultation and discussion with representatives from a cooperating treatment program on still another. Various techniques such as videotapes of interviews, tours of other facilities, guest speakers, role playing, or pop quizzes can be used in order to maintain interest in these sessions. Good staff morale is a crucial element in a CIU, and training, discussion and communication are key methods to maintain it. The administrator should be responsible for directing or coordinating all training.

III Facility

The site selection, building utilization and maintenance and operational schedule of a Central Intake Unit will all impact on the availability and acceptability of treatment referral by patients. The environment should be carefully chosen and controlled to enhance program objectives and staff-patient rapport and morale.

A. Site and Building Selection

There are several important factors to weigh in choosing the building location:

1. It should be in the central city, preferably in the heart of the narcotics section so that it is easily found and approached.
2. Good public transportation to other treatment programs should be readily available or arrangements made with out-lying facilities for a pick-up service. Some parking space should also be available for patients who drive.
3. Consideration should be given to a location close to a methadone maintenance or detoxification unit so that clients may receive medication before permanent clinic assignment. There are a few clients, however, who do present themselves in severe withdrawal and cannot be processed in that condition. Practical arrangements need to be made to provide immediate treatment, particularly if the complete intake process may be delayed for a day or a weekend.
4. Attention should also be directed to locations close to hospitals or health clinics that could provide ancillary services speedily and readily.
5. Zoning in the selected area will probably be commercial, but community attitudes and possible opposition should be considered. Since the CIU is only used for intake, there is seldom a problem with loitering around the building. Restaurants should be available in the area as patients often spend most of a day at CIU and will want food. In a heavy-traffic area the presence of a discrete number of drug dependent persons will not be noticed or feared. Generally, there is less neighborhood opposition to the CIU than to a treatment clinic.

The building itself must have adequate space for the operations in it and also for the estimated daily flow of patients. The required square footage to meet local ordinances should be carefully checked along with the power supply, hot water availability (especially for x-ray processor), and heat and air conditioning. The building should also have adequate ventilation, be structurally sound, and easily cleaned.

B. Cleaning and Security

If the building is leased, it may include janitorial arrangements. These should be carefully investigated and upgraded to a level of "clinical cleaning". Patient traffic through the building will be heavy and the tasks performed such as urine collection and analysis and blood-drawing and separation require stringent standards of cleanliness. The refuse from these operations is also considerable and becomes a public health menace if not promptly and properly disposed of.

Another arrangement that might be considered in the lease is security. Some buildings are covered by regular inspections, or have electronic systems installed. Although a CIU is not as vulnerable to burglary attempts as a dispensing clinic, there are valuable pieces of equipment and pilferable supplies. They should be locked up within the building at night if there are no other security precautions.

C. Space Needs and Client Flow for CIU to Handle 20 Patients per day

1. Reception Area: Patients should enter the building through a large and cheerful reception area with adequate chairs, ashtrays, literature racks, etc. to keep them and their friends or families comfortable for several hours.

Patients will be identified and registered at a desk in a semi-screened section of the room that should allow for adequate privacy. The exits from this room to the rest of the building should be controlled by dutch doors or other devices so that only staff and patients can proceed to other areas. Families and friends should remain in the reception area and patients will return to it if there is any delay in their routing process. Various techniques may be used to keep this room comfortable and mildly entertaining. Toys for small children and coloring books, etc. should be available. Reading material may consist of magazines or drug and health information. Art exhibits on the walls or videotaped lectures, movies, or T.V. shows may be experimented with from time to time. Fliers for entertainment or vocational and educational opportunities can be posted. Nutrition demonstrations were popular in one CIU because the food was distributed for consumption. Care should be exercised to see that the room is not used for political, religious or commercial purposes although a vending machine for soft drinks or candy is usually appreciated.

2. Medical Unit: Patients are usually routed to the Medical Unit first. It should be self-contained and consist of at least enough space for two examining rooms with sinks (both may double as M.D. offices).

- nurses' offices which may also be used as the unit registration point and for medical history
- two bathrooms (one male and one female, if possible)
- blood collection room with sink
- x-ray and processor space with adjoining area for disrobing
- laboratory space for analysis of urines and centrifuging of blood specimens and refrigerated storage.

Exact patient routing will probably depend on the layout of this area.

3. Counseling Unit: Diagnostic counselors do not necessarily need private offices but should have at least a booth in which to conduct interviews. Four will be adequate for five counselors, as one will always be stationed at the front desk in the reception area. The chief counselor will need a private office available to the unit for family conferences, etc. The psychiatrist should also have an office available to him though it may be possible to share with the chief counselor. A small room can be used for photo-ID equipment.

4. Administrative/Clerical Unit: The clerks will need desk space which can be located in the secretary's office so that phone assistance can be given on the call-director. The administrator will need a private office. A large room away from the patient flow should be designated for file storage and a smaller one for supplies, mimeograph and Xerox.

5. Staff Room: If possible, a separate bathroom and rest space should be provided for staff. Those who are at duty stations with patients all day need a place to lock personal effects, hang coats, and relax for brief breaks.

D. Hours of Operation

The services of a CIU can be provided readily in a forty hour week: eight hours per day, five days a week. Experience suggests that there will probably be a concentration of patients on Mondays and Fridays, so that staff meetings should be scheduled for a mid-week morning. The hours should be selected to tie in

smoothly with other treatment program operations. Patients should be able to receive treatment on the same day that they complete admission. If most medication clinics are open until 8:00 P.M., a CIU might have hours from 10:00 A.M. - 6:00 P.M., but elect earlier ones if clinics close at 6:00 P.M. or 7:00 P.M.

CIU services will take a minimum of 2-3 hours per patient and frequently much longer. New admissions should not ordinarily be accepted three hours prior to closing time if one day service is the objective. Patients who appear in the late afternoon may be requested to return the next day and processed for emergency medication at a nearby clinic if required. It is, of course, possible to accept new admissions up to an hour before closing time (sufficient time to complete blood and urine analysis and preparation for laboratory delivery), but the number who fail to return the next day is often high and incomplete or repeated testing is expensive. One day admission processing is preferable and allows exceptional patients to be held-over for completion the second day if they are too "sick" or "high" or have complicated social, legal or medical problems. They will still be referred within the 48 hour period prescribed by the scopes of work.

It may be desirable to stagger some staff duty hours at CIU in order to process patients during the full eight hours. Several medical technicians may come in early to set up the laboratory and be dismissed before closing time. Some counselors, on the other hand, should be scheduled to remain after hours to finish the paper work and lock files. Lunch hours can be staggered so that each unit remains open all day. The proposed staffing pattern is adequate for ample coverage of all stations.

IV Information Flow, Forms and Central File Systems

A. Information Distribution

The information collection and distribution system for the Central Intake Unit parallels the client flow within the facility and relates to all cooperating programs and services outside the unit. The compiled records are stored at several stations within CIU, but primarily in the central patient file system that duplicates the individual patient record that is forwarded to the treatment program. The treatment record from any one program is returned to the CIU system if the patient is terminated from treatment. A subsequent readmission may then utilize that record in diagnostic interviews and forward the old treatment record with the readmission data to the new program while retaining copies of all processing that is performed at CIU. Notices of transfers between clinics should also be sent to CIU for recording in the registry and filing in the patient file if the patient himself does not return to CIU (see counseling tasks). Files that remain inactive at CIU for some pre-determined length of time (probably a two-year period) may be culled for storage elsewhere.

The intake process and information flow is visualized in Figure 1. It details the parallel flow of the client through CIU and the simultaneous creation of a patient file. Those tests or referrals that require outside analysis or processing and yield reports that are returned to CIU are indicated as terminating at B. The breakdown of this process is then detailed in Figure 1a. This diagram also shows the generation of the various CIU and treatment program files as well as the reports that are derived from them. The functional responsibilities for the collating and sorting process are explained under Task and Functions. Figure 2 explains the process by which the CIU patient files and registry are updated. Notifications of transfers or records of terminated patients are returned to CIU and noted on the registry before filing.

It must be reiterated that cooperative relations between a Central Intake Unit and various treatment programs strongly depend on the accurate collection and rapid dissemination of patient information. Programs must receive patient files the day following intake to avoid duplicating the interview process in making treatment plans. A CIU clerk can serve as a messenger if there is no other established system for communication between programs and CIU.

Programs need to agree on a definition of "inactive" and "terminated" patients so that records will revert promptly to CIU if patients drop-out of the program. Methadone treatment programs may use a two-week cut-off which must be documented in the record according to Federal guidelines, or may prefer a longer interval such as a month, which is also acceptable to drug-free programs. Reporting may, however, become complicated if procedures are not uniform for all participating programs. The confusion about admission eligibility status at CIU is most frustrating to patients and staff if all programs do not comply promptly with notification and record return procedures and if the central registry system is not accurate and up-to-date.

B. Forms

The various data elements for inclusion in the forms for each unit were discussed in the section on tasks and functions. A listing of suggested forms for each section is provided here with some additional commentary. Asterisks indicate where examples have been included in the Appendix.

1. *Reception Unit* (counselor function)

*a. Daily Activity Log records all contacts with the Central Intake Unit even when processing is refused or referral is made to a service that is not a cooperating treatment program. The name and DOB is recorded and the reason for refusal of service is noted (i.e. no drug problem, insufficient ID, etc.). If a

Figure 1 INTAKE PROCESS AND INFORMATION FLOW

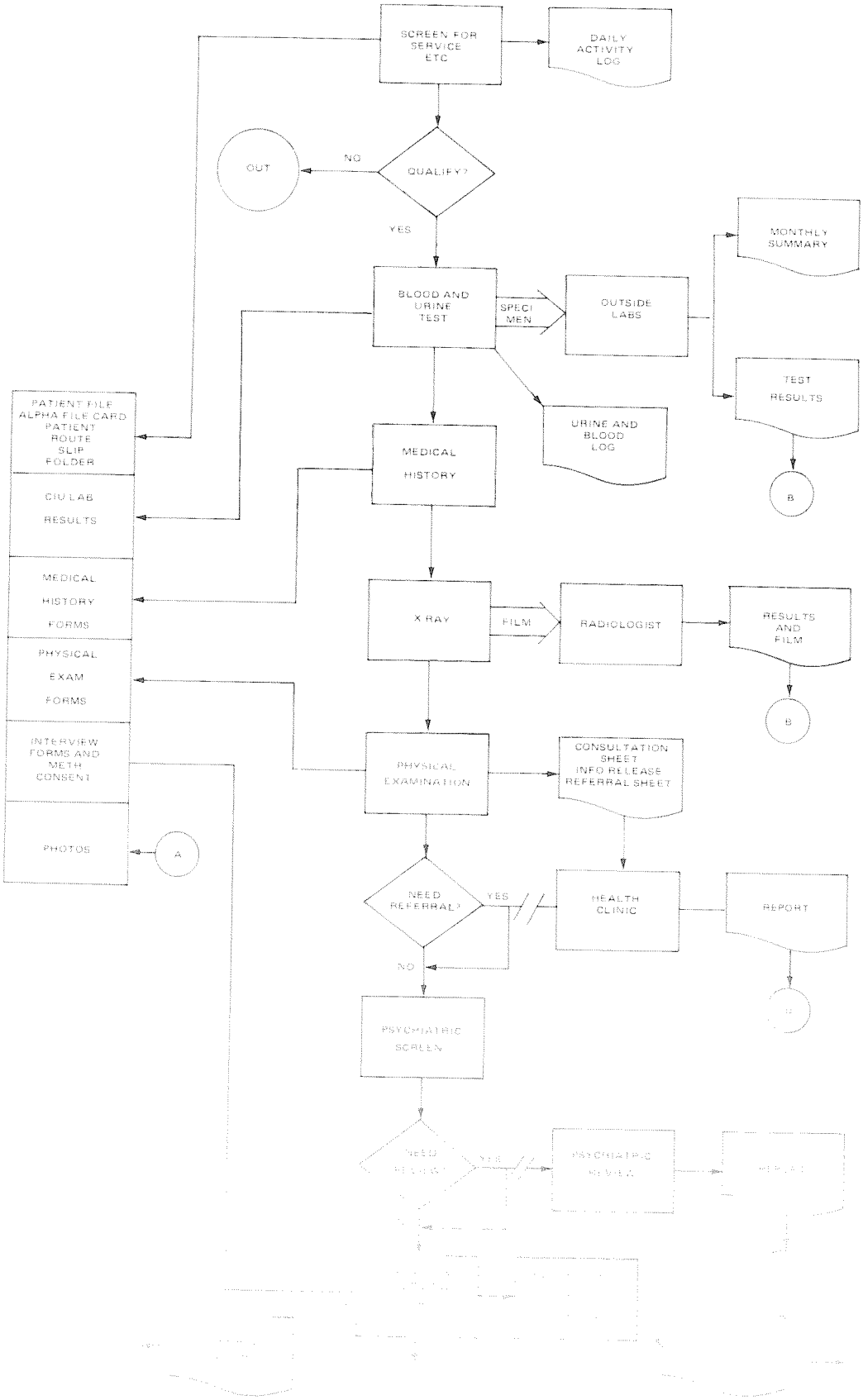


Figure 1. Continued

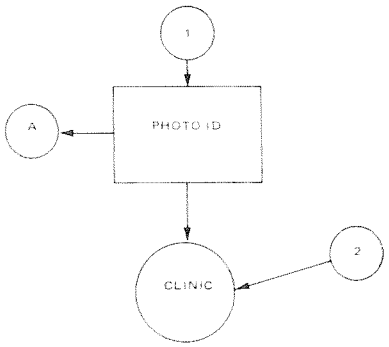


Figure 1a.

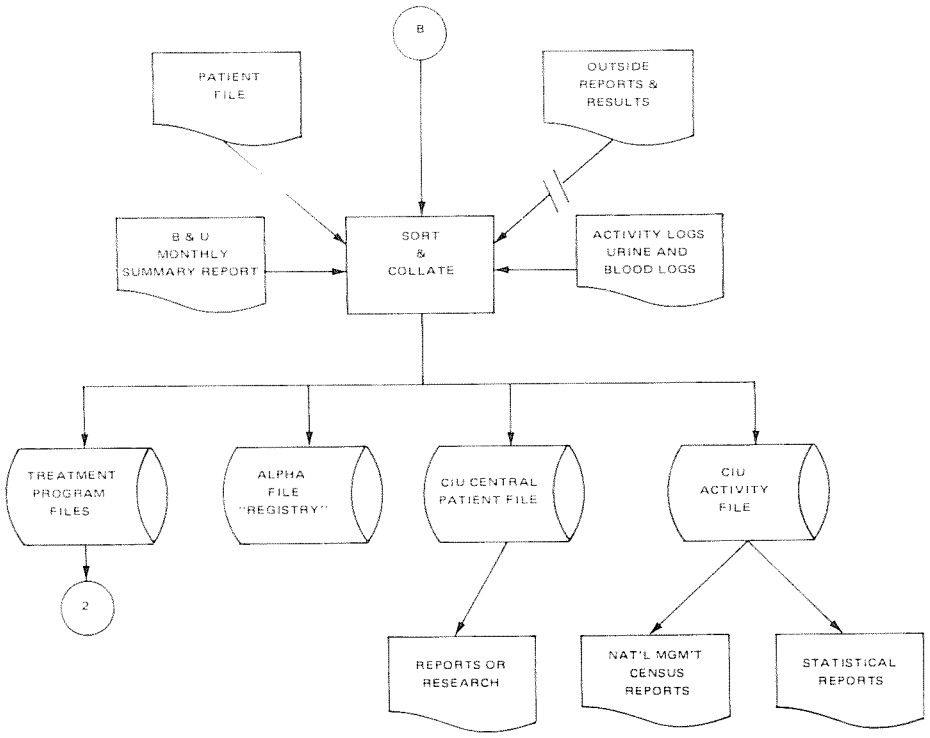
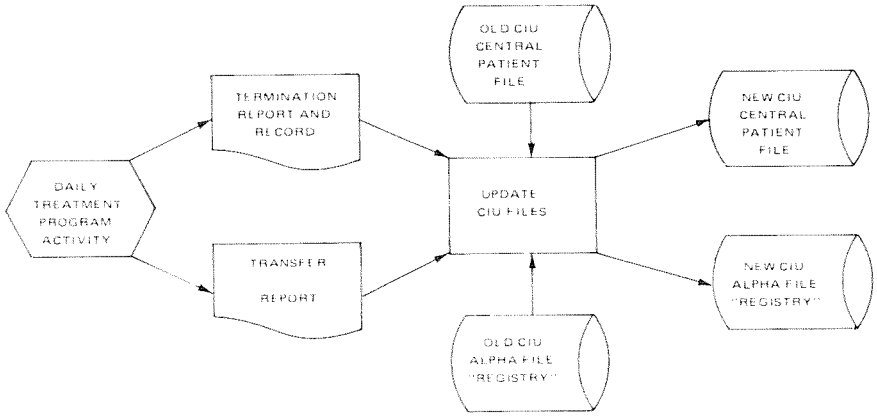


Figure 2. FILE UPDATE AND MAINTENANCE



formal referral is made to another service after evaluation, the notation is made under treatment clinic code (i.e. St. Francis Psychiatric Hospital, Emergency Room, City Hospital). The referral source may be coded or initialed to correspond with NM Census Report requirements (i.e. Vol., TASC, NARA I, etc. as applicable). "Action" indicates the service required at CIU (new, readmit, transfer, physical exam, repeat blood test, etc.). The program and modality to which a patient is referred are entered by the counselor at checkout. Daily statistics are derived from this log.

*b. Routing Card
*c. Approved Identification List
*d. Photo-Alpha File Card which may be used as a Central registration system maintained at CIU in lieu of a computer print out. If an information system exists, a file card for tabulation may be used instead. The photo-alpha card is initiated on new patients only. Readmissions have the card pulled from the file at the reception desk and the CIU action noted on the back by the diagnostic counselor before the card returns to the file. Terminations and transfers are also noted on this card by a clerk as information or files are received from the clinics. Each readmission should have address etc. verified for current accuracy and a new photo may be added if hair-style, weight, etc. change. This file serves also as a cross index to the patient files which may be stored by identification number.

2. *Medical Unit*

*e. Medical History Forms with Addendum
*f. Laboratory Results for tests performed at CIU that can be immediately entered in the patient record and forwarded to the clinic.
*g. Laboratory Request and Report Forms for Serological Test for Syphilis, SMA 12/60 and x-ray.
h. Physical Examination Form with Addendum.
*i. Consultation Sheet
*j . Referral for Health Services
k. Logs for various stations in this unit: blood, urine, p.e., x-ray.
l. Labels for blood, urine, V.D. specimens that are sent out for analysis.

3. *Counseling Unit*

*m. Diagnostic Interview Form may be developed from the CODAP *Client Management Handbook*.
*n. Documentation of Addiction History which may be used to request release of records.
o. Request for release of information to the CIU.
*p. FDA Methadone Consent Form
*q. Readmission Summary Interview
*r. Intake Summary and Referral
s. ID card
t. Psychiatric Screening Interview which should be developed by the psychiatrist.

C. Central File System

Each new patient will be assigned an identification number at intake that will remain with him whenever he re-enters the system. CODAP forms require a ten digit code but do not specify how it is to be made up. They suggest a combination of date of birth, sex code, group code, mother's maiden name initials and perhaps one digit number. This will be unique, but difficult to file, except alphabetically by patient name.

Four initials of the mother's maiden name with sex letter plus a five digit number might also be used, and the files organized by terminal digits. This is an easily used system with even distribution for storage. The five digits can be assigned by a non-duplicating numbering machine and a log — or by pre-numbering printed intake sheets.

The patient record at CIU will consist of the forms collected at intake plus the various reports and test results that are later returned. All forms must be in duplicate as one copy is sent to the treatment program. The CIU patient forms should be *attached* to the patient folder which is labeled *confidential* and identified by name and number on the outside for filing. If clinic records are kept in smaller folders, there will be no difficulty in simply inserting them temporarily into the CIU folder awaiting readmission.

Information cannot be released from any patient record without the signed written consent of the patient except by medical personnel to meet a medical emergency and to qualified personnel for research, audits, etc. when no patient identity is disclosed. Federal regulations on confidentiality also require that written consent releases be directed to a specific person or organization and state the type of information to be disclosed and the purposes or needs for such disclosure. The limitations for release of information are covered by Federal Statute in section 408 of Public Law 92-255 and should be referred to.

V Staffing Pattern and Budget

A. Personnel

Administrator	$ 15,000	
Medical Director (full-time)	$ 28,000	
Physician (half-time)	$ 13,000	
Psychiatrist (one-quarter time)	$ 7,000	
Radiologist (one-quarter time)	$ 7,000	
Secretary	$ 8,000	
Two clerks	$ 13,000	
Chief Counselor	$ 13,000	
Five Diagnostic and Referral Counselors	$ 45,000	
One Nurse	$ 12,000	
Four Medical Technicians	$ 34,000	
Total	$195,000	
Employee benefits @ 10%	$ 19,500	
Total Personnel Budget	$214,500	$214,500

B. Travel

Local staff	$ 2,000	
Local patients	$ 2,000	
Out of state	$ 1,000	
Total	$ 5,000	$ 5,000

C. Equipment

Office	$ 4,000	
X-ray	$ 25,000	
Other medical	$ 6,000	
Urinalysis	$ 6,000	
Total	$ 41,000	$ 41,000

D. Training	$ 5,000	$ 5,000
E. Rent and Renovations	$ 30,000	$ 30,000
F. Supplies and Materials	$ 20,000	$ 20,000

G. Other

Printing	$ 1,000	
Utilities and Communications	$ 1,800	
Laboratory Services Contract	$ 26,000	
Total	$ 28,800	$ 28,800
GRAND TOTAL FOR CENTRAL INTAKE UNIT	$344,300	$344,300

This staffing pattern should provide enough flexibility to service between 15 and 30 patients per day. If intake increases beyond 35 for a significant length of time, the staff can be increased by another clerk, counselor, and medical technician. The part-time M.D. may also have to increase his hours.

Similarly, if intake drops below 20 per day, the part-time physician may be transferred to a clinic, the psychiatrist shared with a clinic, and at least one of the counselors transferred. The medical unit will probably require the full staff complement to keep all of the laboratory testing functional, although the nurse might be shared with a clinic.

If intake falls below 10 per day, consideration might be given to contracting medical examinations and laboratory testing and attaching a portion of the administrative/ clerical and counseling staff to another clinic to continue a modified central intake process and central file system. Another option at some point may be to use the facility and staff for other types of non-drug dependent clients needing medical screening.

The budget also reflects the high costs of medical equipment and supplies. It provides for on-site testing of urine for drugs by a process such as rapid screening, x-ray equipment at the facility (including building renovations and installation), and contracted laboratory services. Different localities may be able to negotiate other arrangements for these services at considerable savings. Health Department and hospital laboratories and facilities should be explored for all possibilities.

VI Contract Services, Equipment, Supplies, and Printing

The following lists are groupings of equipment, services, supplies, and printed forms which are suggested for the Central Intake Unit.

A. Services and Contracts

Test	Recommended Site of Analysis
CBC (except for hematocrit)	Contracted laboratory
Serologic test for lues	Health Department
Urinalysis (routine and microscopic)	CIU
SMA 12/60	Contracted laboratory
*Chest x-ray	CIU
Pap smear and gonorrhea	Health Department
Tetanus toxoid (optional)	CIU
Sickle Cell screening (optional)	CIU
Pregnancy test (optional)	CIU
Australian Antigen	Contracted laboratory
*Urine test for drugs (toxicology)	CIU and contracted laboratory

*The equipment, supplies and maintenance to perform these two tests at the CIU are quite expensive. It is generally conceded that both are necessary for health screen and drug use confirmation. The x-ray equipment, particularly the film processor, should be under a repair service contract to ensure proper care and optimal functioning. A similar service is being developed for the rapid screening machine if it is selected for use. The advantages of immediate drug testing results over delayed ones are obvious and the use of objective data with the patient is also very helpful in conducting the diagnostic interview. Any dubious results can be rechecked by thin layer chromotography or gas liquid chromotography (these are analytical methods geared towards precise identification of the presence of unknown substances rather than screening procedures), through a treatment program contract laboratory.

B. Equipment/Supplies

1. Medical Unit

Standard Equipment

Examining tables with stirrups
Stools
Stethescopes
Small flashlights
Otoscopes
Pressure cuffs
Sphygnomenometers
Ophthalmascope
Speculums (disposable if possible)
Refrigerator freezer
Storage cabinets
X-ray machinery
X-ray view box
Percussion hammers
Autoclave (if necessary)
Tuning forks
Tape measures
Scales
Thermometers with holders
Forceps
Incubator (if necessary)
Centrifuges
Floor lamps
Microscopes
X-ray developer
Exam screens

Resuscitator
Airways
Swivel chairs
Medical supply cabinets
Tables

Aspirator
Desks
Chairs
Bookcases
Rapid urine screening machine with calculator

Expendable Supplies

Paper sheeting, examining tables; 5-6 ft. per pt.
Capes, disposable; 1 per female pt.
Gloves, examining, non-sterile, disposable; 1-2 per pt.
Tongue depressors, wood, regular; 1 per pt.
Isopropyl alcohol; 2 pints monthly
Gauze squares, 4 x 4, 12 ply (cleaning instruments)
Gauze squares, 2 x 2, 12 play (drawing blood)
Multiple sample vacutainer needles, 1 1/2 inch, 20 gauge
Vacutainer holders, plastic
Band-aids
Alcohol swabs
Culture swabs
Pipette capillary dispenser (pasteur) 5 3/4 inch
Rubber bulbs (for aspiration of serum)
Tourniquets, rubber
Urine cups
Syringes, disposable
Needles
X-ray film, RP/L14
X-ray envelopes
Tubes, blood collecting – 5 m1., 7 m1., 10 m1.
Test tubes, culture type
Reagent strip labstix
Tubes, capillary blood sample
Prognostican slide and accusphere tests
Distilled water
Lense paper
Rapid urine screening reagents, supply kits and calibrators
Emergency kit – naloxone, epinephrine
Glass slides and cover slips
Wax pencils

Supplies for Specific Laboratory Tests

Test: CBC (hematocrit)

Supplies: Tubes, blood collecting, lavender top, 5 m1.; 1 per pt.
Standardized lab slip with pt. identification and test requested; 1 per pt.
Gum labels (pasted on individual tubes with pt. identification)
Rubber bands (secure standardized slip to blood tube)

Test: Serologic test for lues

Supplies: Vacutainer tubes, blood collecting, 2 red, 10 m1., for blood drawing, 1 red top, 7 m1., for serum
Standardized lap slip with pt. identification and test required, 1 per pt.
Gum labels
Rubber bands

Test: Urinalysis, routine and microscopic

Supplies: Bilistix or Labstix
Note: Both are "dip sticks" providing color coded readings. Bilistix include readings for blood, glucose, ketones, protein, pH, and bilirubin. Labstix includes no bilirubin reading
Slides, disposable
Cover slips
Tubes, blood collecting, 10 cc.
Urometer

Test: SMA 12/60 (includes blood levels of calcium, inorganic phosphorus, uric acid, cholesterol, BUN, Total Protein, albumin, total bilirubin, SGOT, alkaline phosphatase, LDH, and glucose).

Supplies: Vacutainer tubes, 2 red top, 10 cc. for blood drawing; 1 red top, 10 m1., for serum;
Standardized lab slips with pt. identification and test requested; 1 per pt.
Gum labels
Rubber bands

Test: Chest x-ray

Supplies: Cassette
Film, x-ray RP/L14
Disposable gowns (or sheets)
X-ray envelopes

*Test: Sickle cell screen (pos.-neg.)

Supplies: Sickle Dex Test kits with solution (available from Ortho-Diagnostic Labs, New Jersey)
Sickle Dex test racks
Test tubes, culture with lip, 12 mm. x 75 mm.
Kimble pipette, automatic, 20 microliters; 1-2 per pt.
Kimble tips, disposable; 1 per test

*If test is positive, electrophoresis is required and probably can be arranged with Health Department Lab.

Test: Pap smear and gonorrhea culture

Supplies: Available from Public Health

Test: Pregnancy screening

Supplies: Pregnosticon slide test (2 min. screening) Pregnosticon accusphere (2 hr. test) Used if slide test is positive. Particularly accurate with addicts. Both are available with complete kits.

Test: Immunoassay drug urinalysis (toxicology)

Supplies: Conical cups 1.8 ml. (disposable)
Lense paper
Distilled water
Testing bacteria
Reagents – A & B for each test
- opiates
- barbiturates
- amphetamines
- methadone
- cocaine (optional)

Negative and low calibrators (medium and high available for quantitative analysis)
Buffer concentrate

2. Counseling Unit

Standard Equipment

Tables (one drawer) for interview
Arm chairs
Desks (single pedestal)
Chairs (without arms)
Magazine racks
Polaroid ID camera
Pouch laminator
Swivel desk chairs
Reception desk (double pedestal)
File cabinets (two drawer)
Bookcases
Ashtrays
Photo die cutter
Typewriter

Expendable Supplies

ID card inserts
Photo tacs
Manilla folders
Usual pens, pencils, paper clips, rubber bands, staplers, etc.
Plastic pouches
Polaroid film #108
Envelopes

3. Administrative/Clerical Unit

Standard Equipment

Desks, double pedestal
Desks, single pedestal
Arm chairs
Bookcases
X-ray file cabinet
Supply cabinets
Photocopy machine (rental)
Calculator
Desks, secretarial
Swivel chairs
Chairs
File cabinets (5 drawer)
File cabinet (10 drawer)
Typewriters
Mimeograph

Expendable Supplies

Photocopy paper
Carbons
Binders
Mimeograph paper
General office supplies
Polyetheline bag liners (garbage)

C. Printing – Contract Order

Intake interview forms
Medical history forms
Physical examination forms
ID card inserts
Photo-Alpha Registration Cards
Standard laboratory test requests for:
- syphilis
- pap
- gonorrhea
- SMA 12/60
- CBC
- X-ray

Consultation sheets
FDA consent for methadone

VII APPENDIX: Forms for Central Intake Unit

Page No. _____

CENTRAL MEDICAL INTAKE
DAILY PATIENT LOG

Date _____

Desk Clerk _____

NO.	NAME *(Last, First, Initial)*	DOB	ID NUMBER	REF. SOURCE	TIME-IN	ACTION	CURRENT CTR. CODE	TREATMENT MODALITY		TIME-OUT	CMI DIAGNOSTIC COUNSEL
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
11.											
12.											
13.											
14.											
15.											
16.											
17.											
18.											

B

CENTRAL MEDICAL INTAKE FORM I
Patient Routing Card

Patient name: _____ I.D. # _____

CMI Counselor _____ CMI Date _____

☐ voluntary ☐ CJC ☐ Transfer _____

☐ Complete New or Re
☐ Clerk
☐ Blood
☐ Urine (Complete)
☐ Medical Hx
☐ Chest X-ray
☐ Physical exam
☐ Footprint
☐ Interview
☐ I.D. Card

Rec. Rx _____

Center _____

Time Out _____

☐ Partial Re
☐ Clerk
☐ Urine (drugs)
☐ Hx update
☐ P.E. update
☐ Other _____

_____

_____

☐ Interview
☐ I.D. File

Rec. Rx _____

Center _____

Time Out _____

☐ Annual P.E.
☐ Clerk
☐ Blood
☐ Urine (Medical)
☐ Medical Hx
☐ Chest X-ray
☐ Physical exam
☐ Footprint
☐ Interview
☐ I.D. File

Center _____

Time Out _____

Comments _____

_____

IDENTIFIER AND SUBSTANTIATOR LIST

C

These lists are a guide to what documents constitute acceptable identification and substantiation. Identification documents will be documents issued by a government agency, employer, or other institution, which contain the person's name. Substantiators are documents not ordinarily found in a wallet that also contain the applicant's name.

IDENTIFICATION DOCUMENTS	SUBSTANTIATING DOCUMENTS
Social Security Card	Utility receipt
Employee identification card	Rent receipt
Driver's license	Apartment lease
Automobile registration	Marriage certificate
Voter registration	Birth certificate
Blue Cross identification	Baptismal certificate
Draft registration	Bank book
Welfare card	Military discharge papers
Medicaid card	Unemployment book
Food stamp card	Large purchase receipt
Union identification	Mailed envelope
Library card	

NOTE: Other forms submitted for identification and substantiation should be cleared with the Central Office.

Applicants must submit one identification document and one substantiation document prior to physical examination. These documents must be submitted when signing medication card.

D

Front

PHOTO – ALPHA FILE REGISTRATION

LAST NAME | FIRST | M.I.

ID NUMBER

AFFIX PHOTO | AFFIX PHOTO | AFFIX PHOTO | AFFIX PHOTO | AFFIX PHOTO

SOCIAL SECURITY | BIRTHDATE | SEX | RACE | INITIALS-MOTHER'S MAIDEN NAME

PATIENT'S ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE | EMERGENCY CONTACT | RELATIONSHIP

ADDRESS *(emergency)* | TELEPHONE

Back

PATIENT RECORD

DATE	AT PROGRAM	ACTION	STATUS	TO PROGRAM	TREATMENT	COMMENT

CENTRAL MEDICAL INTAKE REPORT FORM III
MEDICAL HISTORY REPORT FORM

Patient Name:_____ Client No._____

YES	NO	HAVE YOU EVER HAD:
____	____	Anemia or Blood Disease (Sickle Cell Disease)
____	____	Cancers or Tumors
____	____	Rheumatic Fever
____	____	Heart Disease
____	____	Varicose Veins
____	____	Phlebitis or Infected Veins
____	____	Tuberculosis
____	____	Pneumonia or Pleurisy
____	____	Asthma
____	____	Hay Fever
____	____	Sinus Trouble
____	____	Allergy to Drugs or Foods
____	____	Hives
____	____	Dermatitis or Skin Disease
____	____	Eye Infection
____	____	Blindness
____	____	Color Blindness
____	____	Deafness or hearing loss
____	____	Seizure disorders or epilepsy
____	____	Severe back disease
____	____	Arthritis or Joint Disease
____	____	Stomach ulcers a ulcer disease
____	____	Gall bladder disease
____	____	Diabetes
____	____	Thyroid disease
____	____	Syphilis - date _____ Where treated _____
____	____	Gonorrhea
____	____	Hepatitis
____	____	Hypertension or High Blood Pressure
____	____	Malaria
____	____	Kidney disease
____	____	Typhoid fever
____	____	Gout
____	____	Hemorrhoid

What other diseases not on this list have you had;

1. _____
2. _____
3. _____
4. _____

When did you have your last regular physical examination _____
When did you last see your dentist _____
Where are your most recent medical records _____
Are your teeth in good repair currently _____
Do you wear eye glasses or contact lenses _____
Do you need new eye glasses _____

Patient Name _____ Client No. _____

How many times have you been hospitalized _____

For more than 24 hours (include all operation, OB & GYN) _____

Name Hospital _____ Date _____ Disease _____
Name Hospital _____ Date _____ Disease _____
Name Hospital _____ Date _____ Disease _____
Name Hospital _____ Date _____ Disease _____

Indicate Health Status: Excellent _____ Good _____ Fair _____ Poor _____

Name of personal physician or clinic _____
Address _____ Telephone _____
Medicaid No. _____ Card Color _____
Hospitalization No. _____

Have You Recently:

Yes	No	
____	____	Had a sore tongue
____	____	Had "fever sores"
____	____	Had difficulty swallowing
____	____	Had excessive gas
____	____	Had abdominal pain
____	____	Been constipated often
____	____	Had diarrhea frequently-
____	____	Had blood in your bowel movements
____	____	Had black bowel movements
____	____	Had light gray or white bowel movements
____	____	Had burning or discomfort when you urinate
____	____	Had very dark (green-brown) urine
____	____	Had stiffness, swelling or pain in your joints
____	____	Had frequent or severe headaches
____	____	Had persistent numbness or weakness any place in your body
____	____	Had dizziness or light headedness
____	____	Had unsteadiness in walking or balance
____	____	Had difficulty falling or staying asleep
____	____	Felt tired after having enough sleep
____	____	Had difficulty trying to remember things
____	____	Had difficulty remaining awake during usual waking hours
____	____	Felt excessively tired, or weak
____	____	Had any trouble with skin sores
____	____	Had excessive itching
____	____	Gained or lost 5 pounds of weight or more
____	____	Had any chills or fever
____	____	Had any difficulty with your vision
____	____	Been troubled with double vision

Yes	No	
____	____	Had a buzzing or ringing in your ears
____	____	Had severe nose bleeds
____	____	Had difficulty breathing through either side of your nose
____	____	Had any hoarseness
____	____	Had a bad cough
____	____	Had night sweats
____	____	Felt short of breath easily
____	____	Noticed anything unusual about your heart beat
____	____	Had pain in your chest
____	____	Had hand swell
____	____	Had cramps while walking
____	____	Had a loss of appetite
____	____	Had nausea or vomiting
____	____	Had bleeding gums
____	____	Do you have unusual thirst or hunger
____	____	Had feet or ankles swell

Yes	No	Don't Know	
____	____	_____	Are you very shy or sensitive
____	____	_____	Are your feelings easily hurt
____	____	_____	Are you easily restless
____	____	_____	Are you nervous or "keyed up" most of the time
____	____	_____	Is it difficult for you to relax
____	____	_____	Are you easily irritated and upset
____	____	_____	Are you often depressed or blue
____	____	_____	Do you cry easily
____	____	_____	Do you have any unusual fears
____	____	_____	Have you had nightmare
____	____	_____	Do you worry very much
____	____	_____	Do you regard yourself as being nervous
____	____	_____	Have you ever been examined or treated for a nervous illness
____	____	_____	Have you ever had a nervous breakdown
____	____	_____	Are there any sexual matters of difficulties you would like to discuss
____	____	_____	Have you been married more than once
____	____	_____	Do you have any work problems which produce emotional stress
____	____	_____	Do you enjoy school work
____	____	_____	Do you enjoy on-job-training

I hereby give my consent for the following:

1. A physical examination
2. A blood test for blood chemistries and syphilis
3. Urinalysis to screen for abnormalities and drug content
4. Chest X-ray
5. Pregnancy test (female only)

I also understand that if my syphilis test or X-ray indicate the presence of communicable disease, the results will be released to the Department of Public Health for further confidential follow-up.

_____

Signature and Date

FOR FEMALES ONLY

Patient Name: _____ Client No. _____

Age of your first period _____
Is your period regular _____
Period occur every _____
Usual flow: Normal _____ Heavy _____ Light _____
Has there been an: Increase ( ) Decrease ( ) in flow recently _____
Date of last normal period _____
Are you tensed or irritable before or during periods _____
Have you, within the past year, had vaginal bleeding other than at the time of your period _____
Are you or do you think you are pregnant _____
Age of first pregnancy _____ Number of living children _____
Date of birth _____
How many abortions_____ Dates _____ Miscarriages _____ Dates _____
Stillbirth _____ Dates _____
Do you feel you have an unusual amount of vaginal discharge or itching _____
Note: If you have ever been treated for a female disorder or been told you had any trouble with your female organs list here _____
Do you have hot flashes _____
Have your breasts recently changed in size _____
Have you recently changed breast discharge _____
When was your last pelvic (GYN or Vaginal) examination _____
Are you on birth control pills _____
What kind of pill _____ How long _____

PROGRAM ON METHADONE IN MOTHERS AND INFANTS

Patient Name: _____ Referred by _____
ID No. _____ Date of Referral_____
Date of Birth _____ Marital status ( ) M ( ) D ( ) Sep. ( ) W ( ) S
Address: _____ with whom living _____
Telephone: Home _____ Work: _____
For Emergency Contact_____
Name Phone
Employment current ( ) Yes ( ) No Date begun _____
Highest grade completed _____ Medicaid ( ) Yes ( ) No ( ) Eligible
Other Insurance _____
Length Heroin use _____Length present habit _____ other drug abuse _____
_____
clinic patient attends _____
Counselor _____ Nurse _____
Treatment received: Meth. Maint. _____ Detox _____ Other _____
Date Rx begun _____ ended _____
Prenatal care at clinic _____ Hospital _____ Private _____
Name
None _____ Date begun _____
Patient to deliver at _____ Hospital
Expected date of confinement _____ Patient requests abortion _____
Referred to _____

CENTRAL PATIENT INTAKE REPORT FORM III-A
MEDICAL HISTORY REPORT FORM
ANNUAL FOLLOW-UP

Patient Name: _____ Client No. _____
Last First Middle Initial

1. Have you had any significant illnesses since your last physical exam at CPI? _____

2. Have you seen a doctor or been treated at a clinic for health reasons since your last physical at CPI? _____

3. Have you been hospitalized for any reason since your last physical at CPI? _____

4. Have you recently felt ill or had any symptoms you would like to discuss with the doctor? _____

5. Do you think treatment has affected your health? _____

   Explain: _____

6. Have you discussed the above problem(s) with the medical staff at your clinic? _____

7. Do you feel you have received adequate medical attention from your clinic? _____

CENTRAL MEDICAL INTAKE FORM V
LABORATORY RESULTS

Patient Name _____ I.D. No. _____
Last First Middle

CMI Date _____ Lab Log # _____

Dipstick Urinalysis

Blood _____
Ketones _____
Glucose _____
Protein _____
PH _____

Blood

Hematocrit _____

EMIT URINE SCREENING

	opiates	meth.	barbs.	amp.	cocaine	other
positive:	☐	☐	☐	☐	☐	☐
negative:	☐	☐	☐	☐	☐	☐
borderline:	☐	☐	☐	☐	☐	☐

Analysis _____

Pregnancy Test (Female only)

Slide Test pos. ☐ neg. ☐

Accusphere pos. ☐ neg. ☐

SEROLOGICAL TESTS FOR SYPHILIS

Last Patient's Name First

Do not write in this block

Address

Birthdate	Race	Sex

[ ] Blood [ ] Serum [ ] Spinal fluid

[ ] Premarital (Specify State) _____

[ ] Prenatal

Test requested other than VDRL slide,

Specify: _____

VDRL SLIDE TEST

Titer dilutions

_____
date collected

N=Nonreactive, WR=Weakly reactive, R=Reactive

Date completed

Dr. _____

_____
SEROLOGIST

Address _____

G

mg%	CA++	8.5 - 10.5	
mg%	I-PH	2.50 - 4.50	
mg%	GLU	65 - 120	
mg%	B.U.N.	9.0 - 24.0	
mg%	U-AC	2.5 - 8.0	
mg%	CHOL	150 - 300.	
gm%	T.P.	6.00 - 8.00	
gm%	ALB	3.50 - 5.00	
mg%	T-BIL	0.10 - 1.00	
mu/ml	A-PH	30. - 85.	
mu/ml	L.D.H.	100 - 225	
mu/ml	SGOT	7.0 - 40.	

RESULTS	UNITS	TEST	NORMALS
	Ug%	PBI	4.1 - 8.2
	MEQ/L	Na	135 - 145.
	MEQ/L	K	3.3 - 5.2
	MEQ/L	CL	95. - 105.
	MEQ/L	CO_2	24. - 32.
	MG%	CREAT	0.5 - 1.6
	MG%	GLU (GREY)	65. - 120.

RESULTS	UNITS	TEST	NORMALS

NOTES _____

PATIENT'S LAST NAME-FIRST NAME-MIDDLE NAME | REGISTER NO. | WARD NO.

AGE | SEX | *(Check one)* ☐ Bedside Wheelchair or Stretcher ☐ Bed Patient ☐ Ambulatory

EXAMINATION REQUESTED

(Above space for mechanical imprinting, if used)

PERTINENT CLINICAL HISTORY, OPERATIONS, PHYSICAL FINDINGS, AND PROVISIONAL DIAGNOSIS

FILM NO. | DATE OF REQUEST | REQUESTED BY

RADIOGRAPHIC REPORT

SIGNATURE: *(Specify location of laboratory if not part of requesting facility)*

DATE OF REPORT:

(NAME OF HOSPITAL OR OTHER MEDICAL FACILITY)

Standard Form 519A Rev. Aug. 1954
Promulgated by Bureau of the Budget
Circular A–32 Rev.
RADIOGRAPHIC REPORT
519-207

Standard Form 513
Rev. August 1954
Bureau of the Budget
Circular A–32

CLINICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: *(Requesting ward, unit, or activity)*	DATE OF REQUEST

REASON FOR REQUEST *(Complaints and findings)*

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL	☐ EMERGENCY ☐ ROUTINE

CONSULTATION REPORT

(Continued on reverse side)

SIGNATURE AND TITLE	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name–last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

CONSULTATION SHEET
Standard Form 513
513–104

J

NAME

P F NO. | BIRTHDATE | SEX M F

SOURCE OF REFERRAL AND ADDRESS

PATIENT'S ADDRESS ZIP

APT. NO. | CT | TELEPHONE NO.

REASON FOR REFERRAL CONTROL NO.

REFERRAL

Important – Take this with you. Report to the following address at the time indicated below.

FACILITY

ADDRESS

DATE HOUR

SIGNATURE | TITLE | TELEPHONE NO. | DATE

☐ I HEREBY GIVE MY PERMISSION TO RELEASE MEDICAL INFORMATION FOR USE BY D.C. DEPARTMENT OF HUMAN RESOURCES.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN | DATE

INSTRUCTIONS: PLEASE REPORT DIAGNOSIS AND TREATMENT BELOW AND RETURN ONE COPY TO THE FACILITY WHICH MADE THE REFERRAL.

DIAGNOSIS AND TREATMENT:

TREATMENT: ☐ COMPLETED, ☐ UNCOMPLETED, ☐ NOT INDICATED.

SIGNATURE TITLE DATE

UNIFORM DATA COLLECTION SYSTEM

M

CLINIC IDENTIFIER [1] CLIENT CODE [2]

CLIENT INTAKE

A. IDENT. & DEMOGRAPHY

DATE INTAKE PREPARED [3]

STAFF IDENTIFIER [4]

INFORMATION SOURCE [5]
1 - CLIENT 3 - CHILDREN
2 - SPOUSE 9 - OTHER (SPECIFY)

YEAR OF BIRTH [6]

SEX 1 - MALE 2 - FEMALE [7]

CLIENT ZIP CODE (LATEST ADDRESS) [8]

RACE 1 - WHITE 2 - BLACK 9 - OTHER [9]

ETHNIC [10]
1 - PUERTO RICAN 4 - AMERICAN INDIAN
2 - MEXICAN AMERICAN
3 - ASIAN 9 - OTHER

B. REFERRAL

CLIENT REFERRED BY [11]
1 - SELF 4 - PHYSICIAN 7 - AA
2 - RELATIVE 5 - SCHOOL 8 - EMPLOYER
3 - FRIEND 6 - COURT 9 - OTHER

ENTER THE NUMBER OF TIMES CLIENT HAS BEEN ADMITTED FOR TREATMENT IN DRUG, ALCOHOL OR MENTAL HEALTH PROGRAMS.
THIS PROGRAM [12]
OTHER PROGRAMS [13]

C. PERSONAL HISTORY

CLIENTS CURRENT MARITAL STATUS [14]
1 - NEVER MARRIED 5 - SEPARATED
2 - MARRIED (NOT COMMON LAW) 6 - DIVORCED
3 - COMMON LAW 7 - WIDOWED
4 - LIVING TOGETHER 8 - UNKNOWN

CLIENTS CURRENT LIVING ARRANGEMENTS (ENTER ALL THAT APPLY) [15]
1 - ALONE 5 - WITH FRIEND(S)
2 - WITH SPOUSE(S) 6 - WITH CHILD/CHILDREN
3 - WITH RELATIVE(S) 7 - INSTITUTIONAL
4 - WITH PARENT(S) 8 - NO STABLE ARRANGEMENTS

WHO OF THE FOLLOWING HAVE USED EXCESSIVELY EITHER:
1 - NONE 5 - SISTER(S)
2 - MOTHER 6 - SPOUSE
3 - FATHER 7 - CHILDREN
4 - BROTHER(S)
DRUGS [16]
ALCOHOL [17]

HAVE ANY MEMBER(S) OF CLIENT'S FAMILY EVER SOUGHT TREATMENT OR COUNSELING FOR PROBLEMS RELATED TO THE USE OF:
DRUGS [18]
ALCOHOL [19]
1 - YES 2 - NO

(C. PERSONAL HISTORY CONTINUED)
PREVIOUS TREATMENT CONTACTS (ENTER ALL THAT APPLY)
1 - NONE
2 - AA
3 - PRIVATE PHYSICIAN OR PSYCHIATRIST
4 - HOSPITAL (GENERAL, VA, STATE MENTAL)
5 - MH/MR
6 - SOCIAL OR COMMUNITY SERVICE
7 - CLERGYMAN
9 - OTHER (SPECIFY)
DRUGS [20]
ALCOHOL [21]

IF A CLIENT HAS SPENT MORE THAN 2 WEEKS IN AN INSTITUTION ENTER THE TYPE, NO. OF STAYS, AND AGE OF FIRST STAY.

	TYPE	NO. OF STAYS	AGE
	[22]	[27]	[32]
	[23]	[28]	[33]
	[24]	[29]	[34]
	[25]	[30]	[35]
	[26]	[31]	[36]

1 - NONE
2 - PRISON
3 - MEDICAL HOSPITALIZATION
4 - PSYCHIATRIC HOSPITALIZATION
5 - RESIDENTIAL DRUG OR ALCOHOL PROGRAM
6 - JUVENILE CORRECTION
9 - OTHER

D. ARRESTS AND CHARGES

IS CLIENT UNDER LEGAL PRESSURE TO ENTER TREATMENT? [37]
1 - YES 2 - NO

ENTER THE TOTAL NUMBER OF ARRESTS [38]

ENTER NO. OF CHARGES
CRIMES AGAINST INDIVIDUALS [39]
PROPERTY CRIMES [40]
SERIOUS MOTOR VEHICLE VIOLATIONS [41]
MINOR CRIMES [42]
SALE OF DRUGS [43]
OTHER (SPECIFY)

ENTER TOTAL NUMBER OF CONVICTIONS [44]

E. MILITARY HISTORY

IF CLIENT HAS SERVED IN ARMED SERVICES:

ENTER SEPARATION YEAR [45]

TOTAL NUMBER OF MONTHS IN SERVICE [46]

F. FINANCIAL SUPPORT

ENTER ALL RECEIVED BY CLIENT [47] [48] [49]
1 - NONE 5 - WORKMENS COMP
2 - MEDICAL ASST. ONLY 6 - UNEMPLOYMENT COMP.
3 - DPA
4 - PENSION 9 - OTHER (SPECIFY)

UNIFORM DATA COLLECTION SYSTEM

M

CLINIC IDENTIFIER [50] CLIENT CODE [51]

CLIENT INTAKE [ ]

G. EDUC. & EMPLOYMENT

ENTER CLIENTS EDUCATIONAL LEVEL

1 - NONE
2 - GRADES 1-4
3 - GRADES 5-8
4 - GRADES 9-12
5 - HIGH SCHOOL (OR GED)
6 - SOME COLLEGE
7 - COLLEGE GRADUATE
8 - POST GRADUATE

[52]

ENTER ALL OF THE FOLLOWING TRAINING SCHOOLS ATTENDED

1 - NONE
2 - VOCATIONAL
3 - BUSINESS
4 - TECHNICAL
9 - OTHER (SPECIFY)

[53]

IS CLIENT CURRENTLY IN A TRAINING PROGRAM? [54]

IS CLIENT CURRENTLY IN AN EDUCATIONAL PROGRAM? [55]

1 - YES 2 - NO

IS CLIENT CURRENTLY EMPLOYED? [56]

1 - YES 2 - NO 3 - RETIRED 4 - UNKNOWN

AVERAGE NET WEEKLY INCOME UPON ENTRY INTO PROGRAM (DOLLARS ONLY) [57]

ENTER CLIENTS TRADE OR PROFESSION [58]

CLIENT'S USUAL OCCUPATION WHEN EMPLOYED [59]

SPECIFY USUAL OCCUPATION

01 - NONE
02 - OFFICIAL OR MANAGER
03 - PROFESSIONAL
04 - TECHNICAL
05 - SALES
06 - OFFICE/CLERICAL
07 - CRAFTSMAN (SKILLED)
08 - OPERATIVE (SEMI-SKILLED)
09 - LABORER (UNSKILLED)
10 - SERVICE WORKER
11 - STUDENT
12 - HOUSEWIFE
99 - OTHER TRADE OR PROFESSION (SPECIFY)

ENTER THE NUMBER OF JOBS THE CLIENT HAS HELD (LAST TWO YEARS) [60]

ENTER THE NUMBER OF MONTHS OF EMPLOYMENT (LAST TWO YEARS [61]

ENTER THE NUMBER OF MONTHS OF THE LONGEST SINGLE JOB HELD BY THE CLIENT (LAST TWO YEARS) [62]

H. DRUG AND ALCOHOL HISTORY

ENTER ALL DRUGS PRESENTLY USED (LAST TWO MONTHS)
LIST IN ORDER OF MOST USED.
PRIMARY DRUG IS THE ONE FOR WHICH CLIENT ENTERED TREATMENT

(CODES LISTED BELOW)

	DRUGS MOST USED	USE CODE	AGE OF FIRST CONTINUED USE
PRIMARY	[63]	[66]	[69]
SECONDARY	[64]	[67]	[70]
TERTIARY	[65]	[68]	[71]

DOES CLIENT HAVE MORE THAN THREE DRUG PROBLEMS? [72]

1 - YES 2 - NO

ENTER ALL DRUGS EVER USED BY CLIENT IN ORDER OF MOST USED
(PRESENT PRIMARY DRUGS MUST BE INCLUDED)
(CODES LISTED BELOW)

DRUGS MOST USED	USE CODE	AGE OF FIRST USE	AGE OF FIRST CONTINUED USE	TYPE CODE
[73]	[80]	[87]	[94]	[101]
[74]	[81]	[88]	[95]	[102]
[75]	[82]	[89]	[96]	[103]
[76]	[83]	[90]	[97]	[104]
[77]	[84]	[91]	[98]	[105]
[78]	[85]	[92]	[99]	[106]
[79]	[86]	[93]	[100]	[107]

DRUG CODE

01 - NONE
02 - HEROIN
03 - METHADONE (ILLEGAL)
04 - METHADONE (LEGAL)
05 - OTHER OPIATES AND SYNTHETICS
06 - ALCOHOL
07 - BARBITURATES AND OTHER SEDATIVES
08 - METHAQUALONE (QUAALUDE, SOPOR)
09 - AMPHETAMINES
10 - COCAINE
11 - MARIJUANA (HASHISH)
12 - HALLUCINOGENS (PSYCHEDELICS)
13 - PSYCHOTROPICS (LIBRIUM, VALIUM, ETC.)
14 - INHALANTS
15 - NON-PRESCRIPTION, OVER THE COUNTER DRUGS (COUGH MEDICINE, ETC.)
99 - OTHER

USE CODE

1 - DAILY
2 - SEVERAL TIMES PER WEEK
3 - ONCE PER WEEK
4 - LESS OFTEN THAN ONCE PER WEEK
5 - NO PRESENT USE

TYPE CODE

1 - PRESCRIPTION (USED AS PRESCRIBED)
2 - PRESCRIPTION (USED IN EXCESS)
3 - NON-PRESCRIPTION USE
4 - ILLEGALLY OBTAINED AND USED

M

UNIFORM DATA COLLECTION SYSTEM

CLIENT INTAKE

CLINIC IDENTIFIER [102] [ ][ ][ ][ ][ ][ ][ ][ ][ ]

CLIENT CODE [109] [ ][ ][ ][ ][ ][ ][ ][ ][ ]

I. ALCOHOL USAGE

IF ALCOHOL IS THE PRIMARY, SECONDARY OR TERTIARY DRUG PRESENTLY USED (CODES 63-65), ENTER ALL OF THE FOLLOWING THAT APPLY:

LIQUOR				WINE				BEER			(ENTER ALL THAT APPLY)
TYPE [110]	FREQ. [111]	DRINKS [112]	PINTS [113]	TYPE [114]	FREQ. [115]	DRINKS [116]	BOTTLES [117]	TYPE [118]	FREQ. [119]	CANS [120]	[121]
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ][ ][ ][ ][ ][ ][ ][ ]

TYPE OF DRINKING	FREQUENCY (ON THE AVERAGE)	DRINKS (AVERAGE PER OCCASION)	–OR– ENTER THE NUMBER OF:	BEHAVIORAL INDICATORS
1 - SOCIAL	1 - LESS THAN ONCE MONTH	1 - 1 DRINK	PINTS - LIQUOR	1 - DELIRIUM TREMENS
2 - ALONE	2 - ONCE MONTH	2 - 2 DRINKS	BOTTLES - WINE	2 - MEMORY LAPSES OR BLACKOUTS
3 - WEEKEND BINGE	3 - 2 OR 3 TIMES MONTH	3 - 3 DRINKS	CANS - BEER	3 - SHAKES
4 - PROBLEM DRINKING ON SPREES	4 - 1 OR 2 TIMES WEEK	4 - 4 DRINKS		4 - TREMOR OF HANDS
5 - STEADY PROBLEM DRINKING	5 - 3 OR 4 TIMES WEEK	5 - 5 OR MORE DRINKS		5 - DIFFICULTY SLEEPING
6 - COMBINATION OF ABOVE	6 - 5 OR 6 TIMES WEEK			6 - MEALS MISSED
	7 - ONCE DAY			7 - WORK MISSED
	8 - 2 OR MORE TIMES DAY			8 - QUARRELS WITH OTHERS
	9 - ALL DAY			9 - OTHER

IS CLIENT A RESIDENT OF SKID ROW? 1 - YES 2 - NO [122] [ ]

J. TOBACCO CONSUMPTION

DOES CLIENT SMOKE:

1 - HEAVILY
2 - REGULARLY
3 - OCCASIONALLY
4 - NEVER

[123] [ ]

ENTER AGE CLIENT STARTED SMOKING [124] [ ][ ]

K. CURRENT PROBLEMS

(PLACE AN X IN THE APPROPRIATE BOX)

HOW WORRIED IS THE CLIENT ABOUT:

	VERY WORRIED	SOMEWHAT WORRIED	NOT WORRIED	UNCERTAIN
TROUBLE WITH THE LAW	[125] [ ]	[126] [ ]	[127] [ ]	[128] [ ]
HAVING ENOUGH MONEY TO LIVE ON	[129] [ ]	[130] [ ]	[131] [ ]	[132] [ ]
GETTING AND KEEPING A LIKEABLE JOB	[133] [ ]	[134] [ ]	[135] [ ]	[136] [ ]
FINDING THE RIGHT KIND OF FRIENDS	[137] [ ]	[138] [ ]	[139] [ ]	[140] [ ]
GETTING ALONG WITH PEOPLE	[141] [ ]	[142] [ ]	[143] [ ]	[144] [ ]
GETTING ALONG WITH FAMILY	[145] [ ]	[146] [ ]	[147] [ ]	[148] [ ]
FINDING A GOOD PLACE TO LIVE	[149] [ ]	[150] [ ]	[151] [ ]	[152] [ ]
PERSONAL HEALTH	[153] [ ]	[154] [ ]	[155] [ ]	[156] [ ]
FINDING THINGS TO DO IN SPARE TIME	[157] [ ]	[158] [ ]	[159] [ ]	[160] [ ]
DEALING WITH HIS/HER EMOTIONS	[161] [ ]	[162] [ ]	[163] [ ]	[164] [ ]
LEADING A SATISFYING LIFE	[165] [ ]	[166] [ ]	[167] [ ]	[168] [ ]

DATE CURRENT PROBLEMS FILLED OUT [169] MONTH [ ][ ] DAY [ ][ ] YEAR [ ][ ]

M

UNIFORM DATA COLLECTION SYSTEM

CLIENT INTAKE

CLINIC IDENTIFIER 170

CLIENT CODE 171

L. ACTION TAKEN

ENTER ACTION TAKEN

1 - ADMITTED TO PROGRAM
2 - REFERRED (OUT OF PROGRAM)
3 - REFERRED (WITHIN PROGRAM)
4 - REJECTED
5 - WAITING LIST
6 - CLIENT SPLIT

172 DATE OF FIRST ACTION TAKEN (MONTH DAY YEAR) 174

DATE CLIENT SPLIT 175

DUAL CLINIC ASSIGNMENT NUMBER 176

IF CLIENT IS REFERRED, LIST NEW CLINIC IDENTIFIER 173

ADDITIONAL CLINIC ASSIGNMENT NUMBER 177

IF CLIENT IS REFERRED (OUT OF PROGRAM AFTER INTAKE), CLINIC DOING SECOND INTERVIEW SHOULD COMPLETE THE FOLLOWING:

CLINIC IDENTIFIER 178

DATE OF INTERVIEW (MONTH DAY YEAR) 182

CLIENT CODE 179

DATE CLIENT SPLIT 183

ENTER ACTION TAKEN

1 - ADMITTED TO PROGRAM
2 - REFERRED (OUT OF PROGRAM)
3 - REFERRED (WITHIN PROGRAM)
4 - REJECTED
5 - WAITING LIST
6 - CLIENT SPLIT

180 DUAL CLINIC ASSIGNMENT NUMBER 184

ADDITIONAL CLINIC ASSIGNMENT NUMBER 185

IF CLINIC IS REFERRED LIST NEW CLINIC IDENTIFIER 181

IF CLIENT IS AGAIN REFERRED (OUT OF PROGRAM) CLINIC DOING THIRD INTERVIEW SHOULD ENTER X HERE AND FILL IN ABOVE SECTION 186

M. PROGRAM ASSIGNMENT

IF CLIENT IS ADMITTED, ENTER INITIAL PROGRAM ASSIGNMENT:

187 188 189 LEGAL STATUS

01 - DOES NOT APPLY
02 - T.A.S.C. OR EQUIVALENT
03 - BAIL OR R.O.R.
04 - PROBATION
05 - NARA I
06 - NARA III
07 - CIVIL COMMITMENT IN LIEU OF PROSECUTION
08 - SENTENCED TO COMMITMENT
09 - CIVIL COMMITMENT
10 - BUREAU OF PRISONS
11 - OTHER PRISON PROGRAMS
12 - PAROLE
13 - WORK RELEASE
14 - VOLUNTARY COMMITMENT (403)
15 - JUVENILE COURT
16 - CHARGES PENDING
99 - OTHER (SPECIFY)

190 CLIENT RELATIONSHIP

01 - CASUAL DROP-IN
02 - IN PATIENT
03 - RESIDENTIAL
04 - OUT PATIENT
05 - PRISON
06 - PROBATIONARY
07 - OUTREACH

191 ENVIRONMENT

01 - CONTACT ONLY
02 - MEDICAL WARD (HOSPITAL)
03 - PSYCHIATRIC WARD (HOSPITAL)
04 - LIVE IN/WORK IN (NON-HOSPITAL RESIDENCE; OPTION TO LEAVE)
05 - LIVE IN/WORK IN (NON-HOSPITAL CORRECTIONAL INSTITUTION)
06 - LIVE IN/WORK IN (HOSPITAL)
07 - LIVE IN/WORK OUT
08 - LIVE OUT/WORK IN (DAY CARE CENTER)
09 - LIVE OUT/WORK OUT
- OTHER (SPECIFY)

192 PRIMARY APPROACH

01 - DETOXIFICATION
02 - MAINTENANCE (METHADONE, ETC.)
03 - SLOW METHADONE WITHDRAWAL
04 - OTHER CHEMOTHERAPY
05 - PSYCHOLOGICAL PSYCHIATRIC (PRIMARY)
06 - MEDICAL/SURGICAL (PRIMARY)
07 - ABSTINENT CHARACTER RESTRUCTURING
08 - SUPERVISORY COUNSELING
99 - OTHER (SPECIFY)

193 MEDICATION

01 - NONE
METHADONE (USE SPECIFIC CODE)
11 - LIQUID METHADONE
12 - DISPERSABLE TABLETS
13 - L-ALPHA ACETYMETHADOL (LAAM)
19 - OTHER FORMS
ANTAGONISTS (USE SPECIFIC CODE)
21 - NALAXONE
22 - CYCLAZOCINE
23 - ANTABUSE
29 - OTHER FORMS
31 - MAJOR TRANQUILIZERS (SPECIFY)

32 - MINOR TRANQUILIZERS (SPECIFY)

99 - OTHER CHEMOTHERAPY

Part II — Intake Questionnaire

1. HAVE YOU EVER RECEIVED INSTITUTIONAL OR AMBULATORY TREATMENT FOR YOUR DRUG PROBLEM OR PROBLEMS RELATED TO DRUG USE (e.g. Hepatitis)? _____

2. IF YES, PLEASE GIVE DETAILS:

NAME OF AGENCY OR INSTITUTION	DATE(S)	TREATMENT	TYPE OF DRUG

3. HAVE YOU EVER BEEN ARRESTED ON DRUG CHARGES OR DRUG-RELATED CHARGES? _____

4. IF YES, PLEASE GIVE DETAILS:

CHARGE	DATE	LOCATION

5. DO YOU KNOW OF ANYONE WHO COULD VERIFY YOUR DRUG USE OVER THE LAST TWO YEARS OR LONGER? _____

IF YES, PLEASE SPECIFY:

NAME	ADDRESS	RELATIONSHIP, IF ANY

P

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
FOOD AND DRUG ADMINISTRATION

Form Approved
OMB No. 057R 0098

DATE

CONSENT TO METHADONE TREATMENT

(Provisions of this form may be modified to conform to any applicable State law)

NAME OF PATIENT

NAME OF PRACTITIONER EXPLAINING PROCEDURES

NAME OF PROGRAM MEDICAL DIRECTOR

I hereby authorize and give my voluntary consent to the above named Program Medical Director and/or any appropriately authorized assistants he may select, to administer or prescribe the drug methadone as an element in the treatment for my dependence on heroin or other narcotic drugs.

The procedures necessary to treat my condition have been explained to me and I understand that it will involve my taking daily dosages of methadone, or other drugs, which will help control my dependence on heroin or other narcotic drugs.

It has been explained to me that methadone is a narcotic drug which can be harmful if taken without medical supervision. I further understand that methadone is an addictive medication and may, like other drugs used in medical practice, produce adverse results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, but I still desire to receive methadone due to the risk of my return to the use of heroin or other drugs.

The goal of methadone treatment is total rehabilitation of the patient. Eventual withdrawal from the use of all drugs, including methadone, is an appropriate treatment goal. I realize that for some patients methadone treatment may continue for relatively long periods of time but that periodic consideration shall be given concerning my complete withdrawal from methadone use.

I understand that I may withdraw from this treatment program and discontinue the use of the drug at any time and I shall be afforded detoxification under medical supervision.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a methadone treatment program, since the use of other drugs in conjunction with methadone may cause me harm.

I also understand that during the course of treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me. I understand that these alternate procedures shall be used when in the Program or Medical Director's professional judgment it is considered advisable.

(See reverse of this sheet for additional consent elements)

FORM FD 2635 (12/72)

FEMALE PATIENTS OF CHILD-BEARING AGE	PATIENTS UNDER 18 YEARS OF AGE
To the best of my knowledge, I ☐ am ☐ am not pregnant at this time. Besides the possible risks involved with the long-term use of methadone, I further understand that, like heroin and other narcotic drugs, information on its effects on pregnant women and on their unborn children is at present inadequate to guarantee that it may not produce significant or serious side effects. It has been explained to me and I understand that methadone is transmitted to the unborn child and will cause physical dependence. Thus, if I am pregnant and suddenly stop taking methadone, I or the unborn child may show signs of withdrawal which may adversely affect my pregnancy or the child. I shall use no other drugs without the Medical Director or his assistants' approval, since these drugs, particularly as they might interact with methadone, may harm me or my unborn child. I shall inform any other doctor who sees me during my present or any future pregnancy or who sees the child after birth, of my current or past participation in a methadone treatment program in order that he may properly care for my child and me. It has been explained to me that after the birth of my child I should not nurse the baby because methadone is transmitted through the milk to the baby and this may cause physical dependence on methadone in the child. I understand that for a brief period following birth, the child may show temporary irritability or other ill effects due to my use of methadone. It is essential for the child's physician to know of my participation in a methadone treatment program so that he may provide appropriate medical treatment for the child. All the above possible effects of methadone have been fully explained to me and I understand that at present, there have not been enough studies conducted on the long term use of the drug to assure complete safety to my child. With full knowledge of this, I consent to its use and promise to inform the Medical Director or one of his assistants immediately if I become pregnant in the future.	The patient is a minor, ____ years of age, born, _____, The risks of the use of methadone have been explained to (me/us) and (I/we) understand that methadone is a drug on which long-term studies are still being conducted and that information on its effects in adolescents is incomplete. It has been explained to (me/us) that methadone is being used in the minor's treatment only because the risk of (his/her) return to the use of heroin is sufficiently great to justify this treatment. (I/We) declare that participation in the methadone treatment program is wholly voluntary on the part of both the (parent(s)/guardian(s)) and the patient and that methadone treatment may be stopped at any time on (my/our) request or that of the patient. With full knowledge of the potential benefits and possible risks involved with the use of methadone in the treatment of an adolescent, (I/we) consent to its use upon the minor, since (I/we) realize that otherwise (he/she) shall continue to be dependent upon heroin or other narcotic drugs.

I certify that no guarantee or assurance has been made as to the results that may be obtained from methadone treatment. With full knowledge of the potential benefits and possible risks involved, I consent to methadone treatment, since I realize that I would otherwise continue to be dependent on heroin or other narcotic drugs.

SIGNATURE OF PATIENT	DATE OF BIRTH	DATE
SIGNATURE OF PARENT(S) OR GUARDIAN(S)	RELATIONSHIP	DATE
SIGNATURE OF WITNESS		DATE

Q

Part III - Readmissions Questionnaire

1. WHEN DID YOU LEAVE TREATMENT? _____

2. WHY DID YOU LEAVE TREATMENT AT THAT TIME?

_____

_____

_____

3. WHEN DID YOU RESUME USING DRUGS? _____

4. HAVE YOU BEEN INSTITUTIONALIZED (e.g. incarcerated, hospitalized, etc.) SINCE LEAVING TREATMENT FOR DRUG RELATED REASONS? _____

(IF YES, EXPLAIN WHERE AND WHEN) _____

_____

5. WHAT DO YOU EXPECT TO DO DIFFERENTLY THIS TIME TO AVOID A RELAPSE? _____

_____

_____

_____

R

CENTRAL MEDICAL INTAKE FORM VI
Final Patient Assessment and Referral

CMI Counselor: _____
CMI Date: _____

Patient name: _____ I.D. # _____
Address: _____ Phone # _____
DOB _____ Age ___ Race ____ Sex____ I.D. Verified _____
Status: ___ New ___ Readmit ___Vol ___CJS: _____
Drug Hx and duration (incl. Alcohol) _____
_____
Present dailu use _____ Current run _____
Drugs used last 24 hours: _____
(Date, Time, Drugs, Amt., Admin) _____
Urine results: (Circle all that apply) date taken: _____
Heg., Quin., Mor., Opiates, Meth., Amp., Barb., Coc., Other: _____
Previous Rx: program, dates, Rx, and why left.
_____
_____
_____
Addiction observations & diagnosis _____
_____
Last complete physical exam: _____ Medical referrals: _____
_____
Did patient receive emergency med. ___No ___Yes_____
(date, time, center)
Social Summary (incl. attitude, family, empl./ed., CJS dates etc.
_____
_____
_____
Recommend Rx: ___ abst. ___FDA Detox. ___Long term detox ___Meth. Stabilization

Center assignment: Name/Code _____
Contact _____

GPO 891-253

UNIVERSITY OF MINNESOTA
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