Connecticut Department of Mental Health and Addiction Services

PRE-TRIAL INTERVENTION PROGRAM ASSESSMENT FORM - DDaP

DEMOGRAPHIC INFORMATION

PROVIDER CLIENT ID: ______________________

CLIENT NAME: ______________________

***CLIENT TRANSFERRED FROM OTHER AGENCY:** ☐ YES ☐ NO

*Check if the client had Evaluation at another agency and transferred to this agency for Intervention.

DRIVER'S LICENSE NUMBER: ______________________ **STATE:** __________

DATE ARRESTED: ________ / ______ / ________

STATE OF ARREST: ______________________

BLOOD ALCHOHOL LEVEL: **BAL 1:** ________ **BAL 2:** ________

IF NO BAC FOR PAEP, WHY?:			
☐ Refused	☐ Not Reported	☐ PAEP Drugs Alleged, Not Alcohol	☐ PDEP, Not Applicable

CT COURT REFERRAL: *(check one box below)*

GA 18	☐	BANTAM	GA 22	☐	MILFORD
GA 2	☐	BRIDGEPORT	GA 15	☐	NEW BRITAIN
GA 17	☐	BRISTOL	GA 23	☐	NEW HAVEN
GA 3	☐	DANBURY	GA 10	☐	NEW LONDON
GA 11	☐	DANIELSON	GA 20	☐	NORWALK
GA 5	☐	DERBY	GA 21	☐	NORWICH
GA 13	☐	ENFIELD	GA 19	☐	ROCKVILLE
GA 14	☐	HARTFORD	GA 1	☐	STAMFORD
GA 12	☐	MANCHESTER	GA 4	☐	WATERBURY
GA 7	☐	MERIDEN		☐	NOT APPLICABLE/OTHER
GA 9	☐	MIDDLETOWN			

SERVICE REFERRED: ☐ PAEP EVALUATION ☐ PDEP EVALUATION

ASSESSMENT INFORMATION

REFERRAL DATE: (*Date the order was received by the provider.*) ____________ / __________ / _____________

ASSESSMENT DATE: ________ / ______ / ______________

CONTINUANCE DATE: ________ / ______ / ______________

EVALUATION TOOLS USED: ☐ **RIASI**

EVALUATION FULL SCORE: **(ENTER 0 – 49)** ☐

(The Evaluation Sub Scale Score must be less than or equal to the Evaluation Full Score.)

EVALUATION SUB SCALE SCORE: **(ENTER 0 – 15)** ☐

OVERALL ASSESSED SEVERITY:			
☐ **MINIMAL**	☐ **LOW**	☐ **MEDIUM**	☐ **HIGH**

PAST TREATMENT: ☐ **YES** ☐ **NO** ☐ **UNSPECIFIED**

INTERVENTION RECOMMENDATION: ***(check one box)***		
☐ **PAEP LEVEL ONE**	☐ **PDEP LEVEL ONE**	☐ **OTHER**
☐ **PAEP LEVEL TWO**	☐ **PDEP LEVEL TWO**	
☐ **PAEP TREATMENT***	☐ **PDEP TREATMENT***	

LEVEL OF CARE: ***(*check one box below if Intervention Recommendation = PAEP or PDEP Treatment)***			
☐	**I.1 SA OP: Outpatient Substance Abuse**	☐	**III.7/IV.2 SA: Inpatient Detox**
☐	**I.D/II.D SA: Ambulatory/Methadone Detox or Maint**	☐	**III.7D/E SA: Intensive Residential for Substance Abuse**
☐	**II.1 SA: Substance Abuse Intensive Outpatient**	☐	**Any Mental Health Level of Care**
☐	**II.5 PART HOSP SA: SA Partial Hospitalization**	☐	**Any Co-Occurring Disorder Level of Care**

NOTE: If CLIENT TRANSFERRED FROM OTHER AGENCY is '**Yes**', please enter the **Agency where the Evaluation was completed** in the **EVALUATOR LAST NAME field below.**

EVALUATOR LAST NAME: ____

EVALUATOR FIRST NAME: ____

INTERVENTION INFORMATION

PROGRAM ORDERED: ***(check one box)***

☐ **PAEP LEVEL ONE** ☐ **PAEP LEVEL TWO** ☐ **PDEP LEVEL ONE** ☐ **PDEP LEVEL TWO**

REFERRED DATE: *(Date the order was received by the provider.)* ________ / ________ / __________

AVAILABLE DATE: *(Date of court order for PTIP intervention or date granted for delay.)* ________ / ______ / _________

NEXT COURT DATE: ______ / ______ / __________

GROUPS

INITIAL GROUP:

START DATE: ______ / ______ / __________

GROUP NUMBER: ____________ **COMPLETED**: ☐ YES ☐ NO

REINSTATEMENT 1:

START DATE: ______ / ______ / __________

GROUP NUMBER: ____________ **COMPLETED**: ☐ YES ☐ NO

REINSTATEMENT 2:

START DATE: ______ / ______ / __________

GROUP NUMBER: ____________ **COMPLETED**: ☐ YES ☐ NO

REINSTATEMENT 3:

START DATE: ______ / ______ / __________

GROUP NUMBER: ____________ **COMPLETED**: ☐ YES ☐ NO

REINSTATEMENT 4:

START DATE: ______ / ______ / __________

GROUP NUMBER: ____________ **COMPLETED**: ☐ YES ☐ NO

COMMENTS: ____

PRE-TEST SCORE: (0-100) ☐ **POST-TEST SCORE: (0-100)** ☐

COMPLETION DATE: _______ / _______ / _______

REASON NOT COMPLETED: *(check one box)*		
☐ ABSENTEEISM	☐ DIED	☐ REMOVED BY THE COURT
☐ ASKED TO RETURN TO COURT	☐ DISRUPTIVE/THREATENING/ VIOLENT	☐ SUBSTANCE USE (TIME OF SESSION)
☐ ATTENDED BUT NON-COOPERATIVE	☐ MOVED OUT-OF-STATE	☐ OTHER

FACILITATOR ASSESSMENT:			
☐ MINIMAL	☐ LOW	☐ MEDIUM	☐ HIGH

FACILITATOR RECOMMENED LEVEL OF CARE:			
☐	I.1 SA OP: Outpatient Substance Abuse	☐	III.7/IV.2 SA: Inpatient Detox
☐	I.D/II.D SA: Ambulatory/Methadone Detox or Maint	☐	III.7D/E SA: Intensive Residential for Substance Abuse
☐	II.1 SA: Substance Abuse Intensive Outpatient	☐	Any Mental Health Level of Care
☐	II.5 PART HOSP SA: SA Partial Hospitalization	☐	Any Co-Occurring Disorder Level of Care

FACILITATOR LAST NAME: ______________________________

FACILITATOR FIRST NAME: ______________________________

TREATMENT RECOMMENDATION INFORMATION:

TREATMENT RECOMMENDATION GRANTED: ☐ YES ☐ NO ☐ UNSPECIFIED

DATE OF ORDER: _______ / _______ / _______

DATE RECEIVED BY OPI: _______ / _______ / _______

CLIENT INDIGENT: ☐ YES ☐ NO

DATE ASO CONTACTED: _______ / _______ / _______

LEVEL OF CARE ORDERED:			
☐	I.1 SA OP: Outpatient Substance Abuse	☐	III.7/IV.2 SA: Inpatient Detox
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☐	II.5 PART HOSP SA: SA Partial Hospitalization	☐	Any Co-Occurring Disorder Level of Care

ASSIGNED PROGRAM: ______________________________