



Gambling Outpatient Treatment Discharge Form

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AGENCY/ PROVIDER NAME: _____

CONTRACT #: _____ **CLIENT ID #:** _____

SAP VENDOR#: _____ **GENDER:** Man Woman Other _____

IS CLIENT A SIGNIFICANT OTHER OF A GAMBLER? Yes No

DISCHARGE DATE: _____ **ADMISSION DATE:** _____

TYPE OF RESIDENCE AT DISCHARGE: *(Check one)*

- | | | | |
|---|--|--|----------------------------------|
| <input type="checkbox"/> Private Residence | <input type="checkbox"/> Homeless | <input type="checkbox"/> Other Group Residential Setting | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Child in Placement | <input type="checkbox"/> Institution <i>(e.g., hospital, jail)</i> | <input type="checkbox"/> Other <i>(specify)</i> _____ | |

EMPLOYMENT STATUS: *(Check all that apply)*

- | | | | |
|--|-------------------------------------|--|---------|
| <input type="checkbox"/> Active Military | <input type="checkbox"/> Disabled | <input type="checkbox"/> Full-Time | Unknown |
| <input type="checkbox"/> Part-Time or Seasonal | <input type="checkbox"/> Retired | <input type="checkbox"/> Self-employed | |
| <input type="checkbox"/> Student | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Other | |

DISCHARGE STATUS: *(Check one)*

- Completed Treatment: All Goals Met
- Completed Treatment: Half or More Goals Met
- Treatment Not Completed: Some Goals Met
- Treatment Not Completed: No Goals Met

DISCHARGE DISPOSITION: *(Check one)*

- Successfully completed treatment
- Left against clinical advice
- Client Relocated
- Dismissed due to non-compliance with program rules
- Client arrested/incarcerated
- Client's health prohibits attendance in treatment
- Client death
- Client no longer needs DDAP funding (remains in treatment)

REFERRALS: *(check all that apply)*

- | | | |
|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Gambling Inpatient/Residential Provider | <input type="checkbox"/> Financial counseling |
| <input type="checkbox"/> Int/Dev Disabilities Provider | <input type="checkbox"/> Gambling Outpatient Provider | <input type="checkbox"/> SAP/ EAP |
| <input type="checkbox"/> Other Health Care Provider | <input type="checkbox"/> Other Community Referral | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> GA/Gam-Anon | <input type="checkbox"/> D&A provider | |

NUMBER OF COUNSELING SESSIONS: Individual Sessions: _____ Group Sessions: _____

DURING THE PAST 30 DAYS:

- **What amount of money did you spend on a typical day of gambling?** \$ _____ n/a or unknown
- **How much time did you usually spend on a typical day of gambling?** _____ hours _____ minutes n/a or unknown
- **On how many days did you gamble?** _____ days n/a or unknown

HOW DOES THE CLIENT'S CURRENT GAMBLING PROBLEM COMPARE TO THE LEVEL OF GAMBLING AT ADMISSION?

- No Longer Gambling Reduced Same Worse Don't Know n/a
(family member)