NEBRASKA STANDARD REPORTING FORMAT FOR SUBSTANCE USE AND CO-OCCURRING EVALUATIONS FOR ALL JUSTICE REFERRALS

A. DEMOGRAPHICS

B. PRESENTING PROBLEM / PRIMARY COMPLAINT

1. External leverage to seek evaluation
2. When was client first recommended to obtain an evaluation
3. Synopsis of what led client to schedule this evaluation

C. MEDICAL HISTORY

1. Most Recent Appointments (primary care, medical, dental)
2. Hospitalizations-physical and mental health
3. Current Medications
4. Ongoing medical or chronic medical conditions
5. Potential history of head trauma

D. WORK / SCHOOL / MILITARY HISTORY

1. Education Completed
2. Training or Technical education completed
3. Profession/Trade/Specific Skills
4. How long was your longest job
5. Usual or last occupation
6. Employment pattern over the past 3 years
    a. Full time
    b. Part time
    c. Student
    d. Service
    e. Retired/disabled
    f. Unemployed

E. ALCOHOL / DRUG HISTORY SUMMARY

1. Frequency and amount
2. Most recent use-substance and administration
3. Drug and/or alcohol of choice including tobacco use and vaping
4. History of substance-induced/use/disorder (identify the following for each substance used)
   a. Use patterns
   b. Consequences of use (physiological, legal, interpersonal, familial, vocational, etc.)
   c. Periods of abstinence / when and why
   d. Tolerance level
   e. Withdrawal history and potential
   f. Influence of living situation on use
   g. Other addictive behaviors (e.g., gambling)
   h. IV drug use
5. Prior substance use evaluations and findings
6. Prior substance use disorder treatment

F. LEGAL HISTORY (Information from Criminal Justice System)

1. Criminal History and other information (including current legal and pending charges)
2. Next court appearance
3. Substance testing results
4. Risk assessments and results
5. Identify any treatment exclusionary factors (sex offender, criminal behavior, history of aggression)

G. FAMILY / SOCIAL PEER HISTORY

1. Identification of legal guardianship
2. Pro-social resources/connections/activities/recovery supports
3. Family history (legal, substance use, generational trauma, juvenile/adult/protective custody)
4. Current family status-living environment, stability, access to resources

H. BEHAVIORAL HEALTH HISTORY

1. Suicide risk-past/present
2. Previous/current mental health diagnosis
3. Mental Status Exam
4. Symptom and symptom management
5. Mental health medication, compliance indicators, access and resources

Nebraska Standardized Reporting Format

I. COLLATERAL INFORMATION (Information from Family/Friends/Criminal Justice/Other 2 are required or documentation of attempts/barriers)

1. Report any information about the client's use history, pattern, and/or consequences learned from other sources.
2. Identify any indicators from collateral report that may present as individual's agenda, etc.

II. OTHER DIAGNOSTIC / SCREENING TOOLS - SCORE AND RESULTS

1. Report the results and score from any other substance use assessment tool
2. Assessments specific to Diagnostic Criteria (JSH, SO, etc.)

III. ASAM MULTIDIMENSIONAL ASSESSMENT

1. Dimension 1: Intoxications, Withdrawal, and Addiction Medications
   a. Intoxication and associated withdrawal
   b. Withdrawal and associated risks
   c. Addiction medication needs
2. Dimension 2: Biomedical Conditions
   a. Physical health concerns
   b. Pregnancy related concerns
   c. Sleep concerns
3. Dimension 3: Psychiatric and Cognitive Conditions
   a. Active psychiatric symptoms
   b. Persistent disability
   c. Cognitive functioning
   d. Trauma-related needs
   e. Psychiatric and cognitive history
4. Dimension 4: Substance Use-Related Risks
   a. Likelihood of engaging in risky substance use
   b. Likelihood of engaging in risky SUD related behaviors
5. Dimension 5: Recovery Environment Interactions
   c. Ability to function effectively in current environment
   d. Safety in current environment
   e. Support in current environment
   f. Cultural perceptions of substance use and addiction
6. Dimension 6: Person-Centered Conditions
   a. Barriers to care
   b. Patient preferences
   c. Need for motivational enhancement

L. CLINICAL IMPRESSION

1. Summary of evaluation
   a. Behavior during evaluation (agitated, mood, level of cooperation)
   b. Motivation to change
   c. Level of engagement or defensiveness
   d. Personal agenda
   e. Discrepancies of information provided
2. Substance use or substance use disorder diagnostic impression
   a. Justification and specific criteria
   b. Identify the substance use and substance use disorder diagnostic impression
3. Strengths, needs, and preferences identified (for the client and the family)
4. Targeted treatment priorities

M. RECOMMENDATIONS

1. Primary / ideal level of care recommendation
   a. Identify the substance use or substance use disorder level of care and service(s) that would best meet the need of the client.
2. Available level of care / barriers to ideal recommendation
   a. If the substance use or substance use disorder level of care and service(s) are not available or there is some other reason the client cannot receive that service, identify those reasons. Include the next best substance use level of care and service that the client can be referred to
3. Client / family response to recommendation
   a. Document the individual's response to the level of care and service recommendation.
   b. Include the family's response to the level of care and service recommendation.
4. Additional recommendations or referrals made based on identified needs-health care, employment, support.