

**PREVENTION COUNSELING & TEEN INTERVENE  
COMPLETION/DISCHARGE FORM  
2022-2023**

**Directions:** 1. Complete page 1 and 2. 2. Submit a copy of page 1 with monthly stats (by the 3<sup>rd</sup> of the month following the date of discharge) 3. Place original in case/Ten Intervene file.

Month \_\_\_\_\_ Year \_\_\_\_\_ Counselor \_\_\_\_\_

<b>Location:</b>	<b>Participant Identifier Code:</b> _____
<b>1. Date of 1<sup>st</sup> Session Following Admission:</b> ____--____--____	
<b>2. Date of Discharge or Completion:</b> ____--____--____ (Last face to face contact, or date <i>within 30 calendar days of last face to face contact</i> )	
<b>3. Total # Individual Sessions:</b> _____ <b>Total # Group Sessions:</b> _____ <b>Total # Family Sessions:</b> _____	

<b>4. Completion/Discharge Reason: (Select one)</b>			
<input type="checkbox"/> Services Completed (Achieved all/majority of objectives)	<input type="checkbox"/> Non-Compliance		
<input type="checkbox"/> Services Achieved Maximum Benefit	<input type="checkbox"/> No Contact Due to COVID-19		
<input type="checkbox"/> School Year Ended	<input type="checkbox"/> Refuses Counseling or Early Intervention Service		
<input type="checkbox"/> Extended Illness or transfer out of building/district	<input type="checkbox"/> No Face-to-Face Contact		
<b>5. Referral to Service at Completion: (Select the most significant)</b>			
<input type="checkbox"/> None	<input type="checkbox"/> Family Counseling Services		
<input type="checkbox"/> Crisis Services	<input type="checkbox"/> Mental Health Services		
<input type="checkbox"/> Substance Abuse Treatment	<input type="checkbox"/> Developmental Disability Services		
<input type="checkbox"/> Other Substance Abuse Early Intervention	<input type="checkbox"/> Health Care Service		
<input type="checkbox"/> Problem Gambling Services	<input type="checkbox"/> Vocational and/or Educational Services		
<input type="checkbox"/> Provider-Developed Intervention	<input type="checkbox"/> HIV Education and Risk Assessment		
<b>6. 30-Day Use at Discharge: (Check substances reported in past 30 days, or since Admission if less than 30 days &amp; # of days used)</b>			
<input type="checkbox"/> None Reported _____	<input type="checkbox"/> Crack _____	<input type="checkbox"/> Marijuana/hashish _____	<input type="checkbox"/> LSD/Hallucinogens _____
<input type="checkbox"/> Alcohol _____	<input type="checkbox"/> Ecstasy (MDMA) _____	<input type="checkbox"/> Tobacco/Nicotine _____	<input type="checkbox"/> Other Drug Use _____
<input type="checkbox"/> Binge Drinking _____	<input type="checkbox"/> Heroin/other Opiates _____	<input type="checkbox"/> Smoking (vaping-cig) _____	<input type="checkbox"/> OTC Stimulants _____
<input type="checkbox"/> Cocaine _____	<input type="checkbox"/> Inhalants _____	<input type="checkbox"/> Prescription Pain Meds _____	<input type="checkbox"/> Problem Gambling _____
<input type="checkbox"/> OTC Cough/Cold medicine _____			

**Data Entry Signature:** \_\_\_\_\_ **Date Entered:** \_\_\_\_\_

