

**LITS (ITTS) TEAM
CASE REVIEW STAFFING**

Date of Staffing: _____

Consumer Name: _____ **Age:** _____ **Sex/Race:** _____

Occupation/Income Source: _____

Significant Other: _____ **Relationship:** _____

Level of Involvement: _____

Primary Referring Clinician: _____ **Agency:** _____

Collateral Clinician: _____ **Agency:** _____

Date of Admission: _____

Diagnosis: _____

By Who: _____

Current Medication:

_____ **Dosage/Frequency:** _____

_____ **Dosage/Frequency:** _____

_____ **Dosage/Frequency:** _____

_____ **Dosage/Frequency:** _____

Any previous medications (now dc'd): _____

Current Treatment Plan: Please Attach

Previous Treatment/Interventions: _____

Current Usage of Substances of Abuse/Dependence: See Page 2

ALCOHOL AND DRUG HISTORY FORM

		FREQUENCY	AVG AMT OF USE	AGE AT 1ST USE	LAST USE
Alcohol					
THC					
Crack					
Cocaine Powder					
IV Usage	Drug:				
Hallucinogens	Drug:				
Inhalants	Drug:				
Other:					
Other:					
Other:					
Other:					

COMMENTS:
