LOUISIANA INTEGRATED TREATMENT SERVICES
ITTS POST-TREATMENT EVALUATION

A. RECORD MANAGEMENT

1. Client ID# (SS#): |__|__|__|__|__|__|__|__|__|__|__|__|
2. Evaluation Date: |__|__|-|__|__|-|__|__|
3. Facility/Clinician: OMH Clinician _____OAD Clinician _____
4. Psychiatric Diagnosis: _____ Primary Substance _____

B. CLINICAL EVALUATION

	NUMBER
1. During the past 30 days, how many sessions was the client scheduled for	
a. Group Sessions	|__|__|
b. Individual Sessions	|__|__|
2. During the past 30 days, how many scheduled sessions did the client miss?	|__|__|
3. How many urine screens were given in the past 30 days?	|__|__|
a. How many were positive?	|__|__|
4. To your knowledge, please indicate the extent to which you think the client has been medication compliant in the last 30 days.	|__|__|
0-non-compliant 1-Somewhat compliant 2-Moderately compliant 3-Largely compliant 4-Very compliant, or N/A	
5. Please rate the extent to which the client is complaint with his/her treatment plan:	|__|__|
0-non-compliant 1-Somewhat compliant 2-Moderately compliant 3-Largely compliant 4-Very compliant, or N/A	
6. In your clinical judgment, how responsive is this client to treatment?	|__|__|
0-non-responsive 1-Somewhat responsive 2-Moderately responsive 3-Largely responsive 4-Very responsive	
7. In your clinical judgment, please indicate the level of readiness for change in substance use for this client	|__|__|
1-Precontemplative 2-Relapse 3-Contemplative 4-Determination 5-Action 6-Maintenance	
8. In your clinical judgment, please indicate the level of readiness for change in mental illness for this client	|__|__|
1-Precontemplative 2-Relapse 3-Contemplative 4-Determination 5-Action 6-Maintenance	

C. ITTS TREATMENT RECOMENTATIONS	COMPLETION DATE
1. _____	|__|__|__|
2. _____	|__|__|__|
3. _____	|__|__|__|
4. _____	|__|__|__|

Submitted by: _____