LOUISIANA INTEGRATED TREATMENT SERVICES
ITTS 90-DAYTREATMENT 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: _____