LOUISIANA INTEGRATED TREATMENT SERVICES
ITTS PRE-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

1. During the past 30 days, how many sessions was the client scheduled for **NUMBER**

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 compliant with his/her treatment plan: |___|___|
0-non-complaint 1-Somewhat Complaint 2-Moderately Compliant 3-Largely Compliant 4-Very Compliant

6. In your clinical judgement, how responsive is this client to treatment? |___|___|
0-non-responsive 2-Somewhat Responsive 3-Moderately Responsive 4-Very Responsive

7. In your clinical judgement please indicate the level of readiness for change in substance use for this client . |___|___|
1-Pre-contemplative 2-Relapse 3-Contemplative 4-Determination 5-Action 6-Maintanence

8. In your clinical judgement please indicate the level of readiness for change in mental illness for this client. |___|___|
1-Pre-contemplative 2-relapse 3-Contemplative 4-Determination 5-Action 6-Maintenance

Submitted By:_____