

**LITS – 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 Medication (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:

Consumer Name:

***Presenting Problem:**

Barriers Identified:

Consumer Name:

Team Recommendations: _____

Signature Page:

Name:

Title/Agency:
