

Click _____ to save form

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RCED Section

Name of Recovery Coach filling out this form: _____

Hospital: BMH CVMC MAH NVRH PMC RPMC SMCS Copley
 SVMC UVMC NCH Gifford Other

If other, please specify: _____

Date and Time Recovery Coach was called: _____

Referring Physician: _____

Date & Time of ED Visit Start Date and Time: _____ End Date & Time: _____

All other Recovery Services Section

Name of Recovery Coach filling out this form: _____

Which Recovery Center are you reporting on? TPCR JRCC KRC NCVRC SWF
 TPCA TPCB TPCCV TPCC TPFC TPCS TPCW

Administrative Section

*Which GPRA Interview are you performing:

Intake/Baseline 6-month follow up Discharge

*Informed consent given for GPRA collection? Yes No *If no, submit only the Administrative Section

*Date of Interview: _____

Participant Report Section

How many times in the last 12 months have you visited the ER for Substance Use related causes? _____

Reason for ED Visit (check all that apply)

Alcohol Cocaine Methadone
 Amphetamines Hallucinogens Opiates
 Barbiturates Inhalants Other, specify here: _____
 Benzodiazepines Marijuana/Cannabis
 Buprenorphine Methamphetamines

Participant Name: First Name: _____ Last Name: _____

*Participant Date of Birth (mm/dd/yyyy): _____

Participant Address:

Address 1: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Participant Contact Info:

Cell Phone: _____ Home Phone: _____ Other: _____

Email address: _____

*What is your gender?

Male Transgender Other, specify here: _____ Refused
 Female Unknown

***Are you Hispanic or Latino?**

- Yes No Refused Unknown

If "Yes," specify below by checking all that apply.

- Central American Mexican Other: _____
 Cuban Puerto Rican Unknown
 Dominican South American Refused

***What is your race (you may select more than one)?**

- Black or African American White Native Hawaiian or Other Pacific
 Asian American Indian Islander
 Alaska Native Refused Unknown

***Preferred Language:**

- English Spanish Other: _____

***Have you ever served in the Armed Forces, in the Reserves, or in the National Guard?**

- No Yes, in the Reserves Refused
 Yes, in the Armed Forces Yes, in the National Guard Unknown

***If yes to the above, are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard?**

- No, separated or retired Yes, in the Reserves Refused
 Yes, in the Armed Forces Yes, in the National Guard Unknown

***Are you receiving any of the following Substance Use Disorder/Mental Health treatment(s) (check all that apply)?**

- Detox Primary care
 Intensive Outpatient Program (IOP) Outpatient services
 Medication Assisted Treatment (MAT) Telephone Recovery Support
 Psychiatric care Other: _____
 Counseling None/not applicable

[RCED ONLY] Did the patient agree to a referral? Yes No

If yes, to whom/where:

[RCED ONLY] Family referral(s) requested? Yes No

[RCED ONLY] Emergency Contact:

Name

Phone Number

Relationship to patient (check one):

- Spouse Sibling Colleague
 Significant Other Friend Other, specify: _____
 Partner Neighbor

***In the past 30 days, were you diagnosed with either of the following (choose all that apply but choose at least one):**

- Opiate Use Disorder (OUD) Neither Unknown
 Alcohol Use Disorder (AUD) Refused

***If you answered AUD or OUD in the above question, what medication, if any, was given for treatment:**

- | | | | |
|---|--|----------------------------------|----------------------------------|
| <input type="checkbox"/> Methadone (if yes, how many days: _____) | <input type="checkbox"/> Extended-release Naltrexone (if yes, how many days: _____) | | |
| <input type="checkbox"/> Buprenorphine (if yes, how many days: _____.) | <input type="checkbox"/> Disulfiram (if yes, how many days: _____.) | | |
| <input type="checkbox"/> Naltrexone (if yes, how many days: _____.) | <input type="checkbox"/> Acamprostate (if yes, how many days: _____.) | | |
| <input type="checkbox"/> Diagnosed but DID NOT receive medication | <input type="checkbox"/> NOT diagnosed AND did not receive medication | <input type="checkbox"/> Unknown | <input type="checkbox"/> Refused |

***In the past 30 days, where have you been living most of the time (check one)?**

- | | | |
|---|--|----------------------------------|
| <input type="checkbox"/> Shelter | <input type="checkbox"/> Street/Outdoors | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Housed (specify below) | <input type="checkbox"/> Institution | <input type="checkbox"/> Unknown |
| *If housed is chosen, you must choose one : | | |
| <input type="checkbox"/> Own/Rent | <input type="checkbox"/> Dorm | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Someone else's apt/home/room | <input type="checkbox"/> Halfway House | <input type="checkbox"/> Unknown |
| | <input type="checkbox"/> Residential Treatment | |
| | <input type="checkbox"/> Other | |

***How satisfied are you with your living situation (check one)?**

- | | | | |
|---|---|--|----------------------------------|
| <input type="checkbox"/> Very Satisfied | <input type="checkbox"/> Neither Satisfied nor Dissatisfied | <input type="checkbox"/> Dissatisfied | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Satisfied | | <input type="checkbox"/> Very Dissatisfied | <input type="checkbox"/> Unknown |

***Are you pregnant (check one)?** Yes No Refused Unknown

***Do you have children (check one)?** Yes No Refused Unknown

If yes:

- **How many children do you have?** _____ Refused Unknown
- **Are any of your children living with someone else due to a child protection court order?**
 Yes No Refused Unknown
- **How many of your children live with others due to a child protection order (if zero, enter 0)?** _____
- **For how many of your children have you lost parental rights (if zero, enter 0)?** _____

***Are you enrolled in school (check one)?**

- | | | |
|--|--|----------------------------------|
| <input type="checkbox"/> Not enrolled | <input type="checkbox"/> Enrolled, part time | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Enrolled, full time | <input type="checkbox"/> Other, specify: _____ | <input type="checkbox"/> Unknown |

***Are you currently employed (check one)?**

- | | | |
|--|---|--|
| <input type="checkbox"/> Employed, full time (35+ hours) | <input type="checkbox"/> Unemployed, volunteer work | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Employed, part time | <input type="checkbox"/> Unemployed, retired | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Unemployed, looking for work | <input type="checkbox"/> Unemployed, not looking for work | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Unemployed, disabled | | |

[RCED ONLY] What type of insurance do you have?

- | | | |
|-----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare | <input type="checkbox"/> Private: _____ |
|-----------------------------------|-----------------------------------|---|

[RCED ONLY] Do you have a Primary Care Provider? Yes No
If yes, who: _____

[RCED ONLY] Was Narcan administered to the patient? Yes No
If yes, where was it administered? _____

Was Narcan training provided to the patient? Yes No Refused Unknown

***In the past 30 days:**

- **How many times have you been arrested (if zero, enter 0)?** ____ Refused Unknown
- **How many times have you been arrested for a drug-related offense (if zero, enter 0)?** ____ Refused Unknown
- **When was your last release date?** _____ Refused Unknown

***In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization (check one)?** Yes No Refused Unknown

***In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery (check one)?** Yes No Refused Unknown

***How satisfied are you with your personal relationships (check one)?**

- Very Satisfied Neither Satisfied nor Dissatisfied Refused
 Satisfied Dissatisfied Very Dissatisfied Unknown

***To whom do you turn when you are having trouble (check one)?**

- No one Friends Refused
 Clergy member Other, specify: _____ Unknown
 Family member

[RCED ONLY] Would you like to receive 10 day follow up calls? Yes No

Would you like to be referred to a Recovery Coach at our center? Yes No

6-MONTH FOLLOW UP Section

This section is to be completed within the window of one month prior and two months after the 6-month 'anniversary' of the intake interview, in addition to the sections above.

***What is the follow-up status of the participant?**

- | | |
|---|---|
| <input type="checkbox"/> Deceased at time of due date | <input type="checkbox"/> Located, but otherwise unable to gain access |
| <input type="checkbox"/> Completed interview within specified window | <input type="checkbox"/> Located, but withdrawn from project |
| <input type="checkbox"/> Completed interview outside specified window | <input type="checkbox"/> Unable to locate, moved |
| <input type="checkbox"/> Located, but refused, unspecified | <input type="checkbox"/> Unable to locate, other: _____ |
| <input type="checkbox"/> Located, but unable to gain institutional access | |

***Is the participant still receiving services from your program?** Yes No

DISCHARGE Section

This section is to be completed on the day of discharge if the participant completes the program, or within 14 days of the day the client is terminated from the program, in addition to the sections above (except the 6-month follow

***On what date was the participant discharged?** _____

***What is the participant's discharge status?** Completed Terminated

***If the participant was terminated, what was the reason for termination (select one)?**

- Left on own against staff advice with satisfactory progress
- Left on own against staff advice without satisfactory progress
- Involuntarily discharged due to nonparticipation
- Involuntarily discharged due to violation of rules
- Referred to another program or other services with satisfactory progress
- Referred to another program or other services with unsatisfactory progress
- Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
- Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
- Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
- Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
- Transferred to another facility for health reasons
- Death
- Other: _____

***Identify the number of days each of these services was provided to the participant:**

- Peer coaching or mentoring: _____
Housing support: _____
Sober social activities: _____
Information & referral: _____

SIGNATURES	
Person completing this form:	
First name: _____	Last name: _____
Signature: _____	
Person entering data into RDP:	
First name: _____	Last name: _____
Signature: _____	
Once this form is complete and information is entered into the Recovery Data Platform, please secure form in a locked filing cabinet.	
<p>***GPRA Requirements*** In accordance with the draft from the Vermont Department of Health, this form must be submitted through Survey Gizmo link located at www.healthvermont.gov or faxed to (802) 652-2019 within 48 hours after intake, follow up or discharge. All questions relating to GPRA data are required, but any question can be refused by participant. Click _____ to submit form.</p>	
<p>As a last resort, this form can be mailed to: Vermont Department of Health Division of Alcohol and Drug Abuse Programs Attn: GPRA Coordinator 108 Cherry St, Suite 207 Burlington, VT 05401</p>	

GPRA Participant ID Key		
Program Name	Center Name	Center Abbreviation
MOMS, RCED or COVID	Turning Point Center of Rutland	TPCR
MOMS, RCED or COVID	Journey to Recovery Community Center	JRCC
MOMS, RCED or COVID	Kingdom Recovery Center	KRC
MOMS, RCED or COVID	North Central VT Recovery Center	NCVRC
MOMS, RCED or COVID	SecondWind Foundation	SWF
MOMS, RCED or COVID	Turning Point Center of Addison	TPCA
MOMS, RCED or COVID	Turning Point Center of Bennington	TPCB
MOMS, RCED or COVID	Turning Point Center of Central VT	TPCCV
MOMS, RCED or COVID	Turning Point Center of Chittenden	TPCCC
MOMS, RCED or COVID	Turning Point of Franklin County	TPFC
MOMS, RCED or COVID	Turning Point Center of Springfield	TPCS
MOMS, RCED or COVID	Turning Point Center of Windham	TPCW
GPRA ID Example #1	MOMSTPCCC1	
GPRA ID Example #2	RCEDTPCR1	
GPRA ID Example #3	COVIDSWF1	

Notes Section

[Empty box for notes]