Organization of American States

Inter-American Drug Abuse Control Commission

STANDARD DRUG TREATMENT REGISTRATION FORM

This information is being collected for research purposes only. Your confidentiality will be respected.

Form Number

1. Country

2. Reporting Center Code (Numerical code only)

3.1 Date of Interview Day / Month / Year

3.2 Date of Admission (If Applicable) Day / Month / Year

4. Patient code (for internal use only) Optional

5. Sex 1. Male 2. Female

6. Age

7. Residence (last 30 days) and Nationality

7a. Residence

City, Region or Parish where you currently live

No Fixed Place of Abode **(check this box ONLY if the client does not have a specific place to live)**

7b. Nationality

8a. Where have you lived the most/longest for the last 30 days?

Family home		Shelter/refuge	
Own home		Squatting	
Rental house, flat, apartment		Homeless	
Rooming/boarding house		No response	
Prison			
Other (specify)			

8b. Have you ever been deported?

Yes	
No	

9. Ethnic group

African Origin/Black		Garifuna	
Indigenous People		Maya(Ketchi, Mopan,Yucatec)	
East Indian		Mennonite	
Chinese		Mestizo/Spanish	
Portuguese		Javanese	
White		Maroon	
Mixed		No Response	
Syrian/Lebanese/Arab			
Creole			

9a. Other(Specify)

10. With whom do you live? (You may tick as many options as necessary).

Father		Mother	
Brother/ sister		Stepmother	
Stepfather		Wife/Husband	
Girlfriend/Boyfriend		Friend	
Alone		No response/DNK	
Child/Children			
Other			
Prison			

11. Marital status

Single		Living together/ Common-law	
Married		Widow/widower	
Divorced		No response	
Separated			

12. Educational level (highest level achieved)

Level achieved:

Never attended school	
Incomplete Primary	
Complete Primary	
Incomplete Secondary	
Complete Secondary	
Incomplete University/Tertiary	
Complete University/Tertiary	
Vocational (**Specify in 12a below**)	
No response	
DNK	

12a. Please specify the type of vocational

education.

13. Current employment (last 30 days) **(if in prison, select "not working other and specify prison)**

Working/self-employed	
Working and Studying	
Unemployed *(looking for work)*	
Not working/student	
Homemaker/Housewife	
Not working/ retired (retiree, disabled)	
Not working other(**Please specify in 13a below**)	
No response	

13a. Please specify the other 'not working' status.

14. How did you come here seeking treatment? (select only 1 response)

Referral from another drug treatment program	
Referral from a general health center (hospital, ER, medical referral, etc.)	
Referral from Social Services or others (churches, community services)	
Referral from National Drug Councils	
Referral from prison or juvenile detention center	
Referral from the justice system or police department	
Referral from employer	
Encouragement from friend(s) or family member(s)	
Voluntarily (self-referral)	
Referral from the school system	
Referral from Drug Treatment Court	
Other.(**Please specify in 14a below**):	
No response	

14a.Please specify the other source of referral

TREATMENT HISTORY

15. Have you ever been treated for drug or alcohol misuse?

YES: _____ NO: ____ (if no, skip to Q17)

15a. If yes, how many times did you receive treatment? (do not include this current registration)

I have been treated _____ times

15b. Have you registered with this or another treatment facility (whether in-patient or out-patient) DURING THIS CALENDAR YEAR) (do not include this registration)

YES:_____ NO:_____ (if no, skip to Q16)

15c. If YES, how many times were you registered with year? (do not include this current registration)

I have been admitted _____ times

16. Most recent type of treatment received for drug abuse (only if response to Q15 was "YES")

Outpatient	
Residential	
Day clinic	
Detoxification	
Psychiatric Counseling	
No response	
DNK	

16a. Did you Complete Treatment? (only if response to Q15 was "YES")

Yes	
No	
DNK	
No Response	

17a. What is the main substance for which you are seeking treatment? (enter only 1 substance)

17b. What is the secondary substance for which you are seeking treatment, if any? (enter only 1 substance, if any)

18. What is the most frequent route of administration for the main substance (identified in Q17a)?

Oral	
Smoked	
Inhaled	
Injected (intravenous or intramuscular)	
Other, *(please specify in 18a below)*	
No response	

18a. Please specify the other route of administration

19. Age when you first started to use the main substance (Identified in 17a)?

20. TYPES OF SUBSTANCES YOU HAVE USED IN THE LAST 30 DAYS

Have you used any of the following drugs within the last 30 days? If **YES**= Please check in the space
If **NO**= Leave it blank

1. Alcohol (rum, beer, wine, whisky, vodka, etc)	
2. Tobacco	
3. Cannabis/marijuana/ganja	
4. Cocaine	
4.1 Cocaine (powder)	
4.2 Coca paste (basuco, paco)	
4.3 Crack	
5. Abuse of prescribed medication	
6. Other Drug **(Please specify)**:	
7. Opioids	
7.1 Heroin	
7.2 Methadone*	
7.3 Other opioids* **(Please specify)**:	
8. Stimulants	
8.1 Amphetamines*	
8.2 Methamphetamines (MDMA) and other derivate	
8.3 Other Stimulants **(Please specify)**:	
9. Hypnotics and Sedatives	
9.1 Barbiturates*	
9.2 Benzodiazepines*	
10. Inhalants	
11. Anabolic steroids*	
12. Hallucinogens	
12.1. LSD	
12.2. Others Hallucinogens **(Please specify)**:	

***without prescription**

Adapted from the Inter-American Uniform Drug Use Data System (SIDUC), Inter-American Drug Abuse Control Commission (CICAD), Organization of American States

21. Judicial information

21.1 Have you ever been arrested? (**if the answer is NO, go to question 22**)	**YES**		**NO**	
21.2 Have you been arrested in the last year?(**if NO, then go to question 22**)	**YES**		**NO**	
21.3 How many times were you arrested in the last year?				

22. History of treatment for psychiatric conditions

22.1. Have you ever been diagnosed with a psychiatric condition? (**If the answer is NO or No response, go to question 23)**	**YES**		**NO**		**No Response**	

22.2**. If YES, please indicate the Condition(s)**

01. Depression	
02. Bipolar Affective Disorder	
03. Schizophrenia and Other Psychoses	
04. Dementia	
05. Developmental Disorders (including Autism)	
06. Do not remember	
07. Do not know the name of the condition	
08. Does not Wish to respond	

23. Contagious disease history: Have you ever been tested for any of the following?

Disease	**YES**	**NO**	**DON´T KNOW**	**DOES NOT WISH TO RESPOND (no response)**	**Result**				**Are you currently receiving treatment for this condition?**	
					Positive +	**Negative -**	**DON'T KNOW**	**DNR**	**Yes**	**No**
HIV/AIDS										
SEXUALLY TRANSMITTED DISEASES										
HEPATITIS B										
HEPATITIS C										
TUBERCULOSIS										

24. Recommended patient placement after assessment
(Please check more than one answer, if applicable)

Placement Options	
24.1 Outpatient	
24.2 Residential	
24.3 Day clinic	
24.4 Self-help group (e.g., AA, NA)	
24.5 Detox Unit	
24.6 Psychiatric Unit	
24.7 Referred to other facility *(Please specify in 24.7a below):*	
24.8 Other (*Please specify in 24.8a below*):	
24.9 No response	

24.7a Please specify the **other facility**.

24.8a. Please specify the **other placement option**.