



Office of Alcoholism and Substance Abuse Services

CONTINUING CARE Per Service Report

*Provider Number

Provider Name

*Program Number

Program Name

*Provider Client ID

*Sex (at birth)

Male

Female

*Birth Date

*Last Name 2 Char

*Last 4 SSN

*Service Date

*Misuse of substance since last contact

Yes

No

*Frequency of Use in last 30 days

No use in last 30 days

1-3 times last 30 days

1-2 times per week

3-6 times per week

Daily

*Disposition

Continuing Care

Refer to Active Treatment

*Service (Check all that apply):

Individual Counseling Brief (G0396/90832)

Individual Counseling Normative (G0397/90834)

Group Counseling Normative (H0005/90853)

Peer Advocate Service (H0038)

Medication Administration Observation (H0033)

Medication Management (99211-99215)

Addiction Medication Induction/Withdrawal (H0014)

* REQUIRED FIELD