Montana Department of Public Health & Human Services

SUBSTANCE ABUSE MANAGEMENT SYSTEM

CLIENT ACT FORM

Page 1 of 1

Name:					Account #:				
Program #					Facility				

ACT ADMIT / DEMOGRAPHICS

3.	Admission Date *(mmddyyyy)*									

4.	Act Facility				

5. Admission Status *(check one)*

☐ *Admission* ☐ *Readmission - Same Offense*

6.	Case Number	

11. Employment Status

☐ *Employed Full Time* ☐ *Employed Part Time* ☐ *Public Assistance Benefits*

☐ *Unemployed* ☐ *Not in Labor Force* *Depleted*

ACT EDUCATION

12. NON-DUI CLIENT

    a. Dangerous Drug Misdemeanor Client: ☐ *Yes* ☐ *No*

    b. Driving Related Reduced Charge Client: ☐ *Yes* ☐ *No*

13.	Court Number							

14.	County of DUI Arrest			

15.	Blood Alcohol Level		**.**			☐ *Refused*	☐ *Unknown*

(Valid values are 0.00 to 0.55, Refused, or Unknown)

16.	Previous DUI/BAC Convictions:				
17.	Previous ACT Programs Attended:				
18.	Prior Treatment Episodes				

19. Mandatory Monitoring Required: ☐ *Yes* ☐ *No*

CLIENT ACT FORM

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Name:					Account #:				
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ACT Discharge

Discharge Date: *(mmddyyyy)*								

Reason for Discharge *(check one)*

☐ Completed Program   ☐ Did Not Complete Program

☐ Transferred   ☐ Referred to Treatment

Results of Assessment/Evaluation: *(check one)*

☐ Misuse/No Problem   ☐ Dependency

☐ Abuser   ☐ Unidentified

Treatment Recommendations: *(check one)*

☐ None   ☐ IOP

☐ Outpatient   ☐ Inpatient

Referral Program *(Use Program Table)*				
Referral Agency *(Write Description)*				

Comments: