

CLIENT DRUG MATRIX FORM

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Name:				Account #:			
Program #				Facility			

<input type="checkbox"/> Admission	<input type="checkbox"/> Discharge
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Drug Matrix (Primary)			
Primary Drug of Choice:			
Drug Details:			
Frequency of Use:			
<input type="checkbox"/> No Use in Past Month	<input type="checkbox"/> 1-2 Times Per Week	<input type="checkbox"/> Daily	
<input type="checkbox"/> 1-3 Times in Past Month	<input type="checkbox"/> 3-6 Times Per Week		
Age of First Use (in years)			
Usual Route of Administration:			
<input type="checkbox"/> Oral	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Other	
<input type="checkbox"/> Smoking	<input type="checkbox"/> Injection		
Route Details:			

Drug Matrix (Secondary)			
Secondary Drug of Choice:			
Drug Details:			
Frequency of Use:			
<input type="checkbox"/> No Use in Past Month	<input type="checkbox"/> 1-2 Times Per Week	<input type="checkbox"/> Daily	
<input type="checkbox"/> 1-3 Times in Past Month	<input type="checkbox"/> 3-6 Times Per Week		
Age of First Use (in years)			
Usual Route of Administration:			
<input type="checkbox"/> Oral	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Other	
<input type="checkbox"/> Smoking	<input type="checkbox"/> Injection		
Route Details:			

CLIENT DRUG MATRIX FORM

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Drug Matrix (Tertiary)			
Tertiary Drug of Choice:			
Drug Details:			
Frequency of Use:			
<input type="checkbox"/> <i>No Use in Past Month</i> <input type="checkbox"/> <i>1-2 Times Per Week</i> <input type="checkbox"/> <i>Daily</i>			
<input type="checkbox"/> <i>1-3 Times in Past Month</i> <input type="checkbox"/> <i>3-6 Times Per Week</i>			
Age of First Use (<i>in years</i>)			
Usual Route of Administration:			
<input type="checkbox"/> <i>Oral</i> <input type="checkbox"/> <i>Inhalation</i> <input type="checkbox"/> <i>Other</i>			
<input type="checkbox"/> <i>Smoking</i> <input type="checkbox"/> <i>Injection</i>			
Route Details:			