

## APPENDIX B

### Discharge Checklist

Code: \_\_\_\_\_

# Department of Veterans Affairs Primary Care/Substance Abuse Clinic Evaluation

## Discharge Checklist

Please complete this checklist just before the patient is discharged.

### HOME ADDRESS AFTER DISCHARGE

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Street Address or P.O. Box

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

( \_\_\_\_\_ ) - \_\_\_\_\_  
Telephone Number

### PERMANENT MAILING ADDRESS IF DIFFERENT FROM ABOVE

\_\_\_\_\_  
Street Address or P.O. Box

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

( \_\_\_\_\_ ) - \_\_\_\_\_  
Telephone Number

Program Evaluation and Resource Center  
Department of Veterans Affairs Medical Center (152)  
3801 Miranda Avenue  
Palo Alto, CA 94304

Code: \_\_\_\_\_

Part I. Life Situation After Discharge

1. Where will the patient be living after discharge?  
Please check one response only

- a house or apartment . . . . . 1
- a rooming house or hotel . . . . . 2
- a halfway house or group home . . . . . 3
- a hospital or other inpatient treatment program . . . . . 4
- in jail . . . . . 5
- a shelter or domiciliary . . . . . 6
- on the street (no regular place) . . . . . 7

2. Is this housing managed by the program? 1  yes 2  no

If yes, how long is the patient likely to stay in housing managed by the program? \_\_\_\_\_ weeks

3. After discharge, which of the following do you think the patient will be doing on a regular basis?

- |  | Yes<br><u>1</u>          | No<br><u>2</u>           |
|--|--------------------------|--------------------------|
| a. Meeting with a counselor or therapist . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Participating in skills training groups . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Attending a job training or degree program . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Meeting with AA, NA, or CA sponsor . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Attending AA, NA, or CA meetings . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Attending other self-help recovery groups<br>(Secular Organization for Sobriety; Rational Recovery)                     | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Participating in clubs or other common interest groups . .<br>(for example, church group, veterans group, bowling team) | <input type="checkbox"/> | <input type="checkbox"/> |

4. Is the patient employed? . . . . .

4a. If yes, how many hours per week is the patient working? \_\_\_\_\_ hours



5. How often did the patient use the following services while in the program. If your program does not have the service, check "not at all."

	Not at all 1	1-5 times 2	6-10 times 3	11+ times 4	
a. Help with medications . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43
b. Legal advice or counseling . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Vocational counseling . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Nutrition counseling . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Help with finances . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Help with cleaning room . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48

6. How often did the patient participate in the following activities while in the program. If your program does not have the activity, check "not at all."

	Not at all 1	1-5 times 2	6-10 times 3	11+ times 4	
a. Exercise, physical fitness . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49
b. Classes or lectures . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Club or social group . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Discussion groups (other than those held as part of therapy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Cards or other games . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Arts and crafts . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Films or lectures . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	55
h. Religious services . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
i. House meetings . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
j. Outpatient mental health treatment (other than at a VA hospital or clinic) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
k. AA or 12-Step meetings outside this program . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	59

Part III. Characteristics of Patient's Stay

1. What was the main reason the patient left?

- Completed the program . . . . . 1
- Quit or left against staff advice . . . . . 2
- Discharged for using alcohol or drugs . . . . . 3
- Discharged for other problem behaviors . . . . . 4
- Admitted to an inpatient substance abuse or  
psychiatric program . . . . . 5
- Admitted to an inpatient medical or surgical unit . . . . . 6
- Put in prison or jail . . . . . 7

1

2. Did the patient use alcohol during his or her stay in the program?

- <sub>1</sub>  No      <sub>2</sub>  Yes, occasionally      <sub>3</sub>  Yes, frequently

2

3. Did the patient use drugs during his or her stay in the program?

- <sub>1</sub>  No      <sub>2</sub>  Yes, occasionally      <sub>3</sub>  Yes, frequently

3

4. How confident are you that this patient will be recovered one year from now?  
(Please circle one number on the scale)

- |                         |   |   |                       |   |   |                         |   |                        |    |
|-------------------------|---|---|-----------------------|---|---|-------------------------|---|------------------------|----|
| 1                       | 2 | 3 | 4                     | 5 | 6 | 7                       | 8 | 9                      | 10 |
| not at all<br>confident |   |   | somewhat<br>confident |   |   | moderately<br>confident |   | extremely<br>confident |    |

4-5

Part IV. Relationships with Other Patients

1. For each of the following items, please check the box that best describes the patient's relationships with other patients while at the program.

	<u>Never</u>	<u>Seldom</u>	<u>Some</u> <u>times</u>	<u>Fairly</u> <u>Often</u>	<u>Often</u>	
	1	2	3	4	5	
a. Could this patient count on other patients for help when needed? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6
b. Did other patients cheer this patient up when he or she was sad or worried? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Did this patient confide in any of the other patients? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Did this patient share mutual interests or activities with other patients? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Did any of the other patients disagree with this patient about important things? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
f. Were any other patients critical or disapproving of this patient? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Did other patients really understand how this patient felt about things? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
h. Did any other patients get on this patient's nerves? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
i. Did any other patient get angry or lose their temper with this patient? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
j. Did the other patients respect this patient's opinion? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
k. Did the other patients expect too much of this patient? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16

2. What is today's date? \_\_\_\_\_  
month      day      year