

# CHEMICAL HEALTH DATA BASE

## CLIENT INFORMATION

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Last Name:                      First Name:                      Middle Name:                      Birth date: \_\_\_\_\_

\_\_\_\_\_  
Address:                      (\_\_\_\_\_)                      (\_\_\_\_\_)                      \_\_\_\_\_  
Home Phone Number:                      Work Phone Number:

\_\_\_\_\_  
City:                      State:      Zip Code:                      (\_\_\_\_\_)                      \_\_\_\_\_  
Cell Phone Number:                      Social Security Number:

\_\_\_\_\_  
Health Insurance Coverage:                      Health Insurance Policy/ID Number: \_\_\_\_\_

\_\_\_\_\_  
Your Company/Organization:                      City:                      State: \_\_\_\_\_

\_\_\_\_\_  
Occupation/Department:                      Title:                      Current Job Status: \_\_\_\_\_

\_\_\_\_\_  
Referring Supervisor's Name:                      Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Referring Supervisor's Address                      City:                      State:                      Zip Code: \_\_\_\_\_

|   |  |  |
|---|--|--|
| <b>Tested Positive for:</b>                               | <input type="checkbox"/> Alcohol: Level _____      | <input type="checkbox"/> Drug: Type _____                |
| <b>Type of Test:</b><br>if you do not know<br>leave blank | <input type="checkbox"/> Pre-placement (Drug only) | <input type="checkbox"/> Federal Highway Administration  |
|   | <input type="checkbox"/> Post-accident             | <input type="checkbox"/> Federal Railroad Administration |
|   | <input type="checkbox"/> Random                    | <input type="checkbox"/> Federal Transit Administration  |
|   | <input type="checkbox"/> Reasonable suspicion      | <input type="checkbox"/> Federal Aviation Administration |
|   | <input type="checkbox"/> Return-to-duty            | <input type="checkbox"/> Research & Special Programs     |
|   | <input type="checkbox"/> Follow-up                 | <input type="checkbox"/> Coast Guard                     |

|                  |   |  |                              |  |
|------------------|---|--|------------------------------|--|
| <b>D   O   R</b> | Delivering<br>Organizational<br>Results | 1660 South Highway 100<br>Suite 430<br>Minneapolis, MN 55416 | 612-332-4805<br>800-367-3271 | Fax: 612-342-2422<br>www.doreap.com<br>doreap@doreap.com |
|------------------|---|--|------------------------------|--|

Place a check by the substances you have used :

| Ever in your life | within the last 12 months |   | Ever in your life | within the last 12 months |  |
|-------------------|---------------------------|---|-------------------|---------------------------|--|
| _____             | _____                     | <b>Alcohol</b>                          | _____             | _____                     | <b>Other</b>                             |
| _____             | _____                     | <b>Amphetamines</b>                     |                   |                           |  |
| _____             | _____                     | <b>Cocaine</b>                          | _____             | _____                     | <b>Other Stimulants</b>                  |
| _____             | _____                     | <b>Crack</b>                            | _____             | _____                     | <b>Over the Counter drugs</b>            |
| _____             | _____                     | <b>Codeine</b>                          | _____             | _____                     | <b>Benzodiazepines</b>                   |
| _____             | _____                     | <b>(Bennies)</b>                        |                   |                           |  |
| _____             | _____                     | <b>Heroin</b>                           |                   |                           |  |
| _____             | _____                     | <b>Non-prescrip Methadone</b>           | _____             | _____                     | <b>Other Tranquilizers</b>               |
| _____             | _____                     | <b>Other Opiates/Synthetics</b>         | _____             | _____                     | <b>Barbiturates (Downers)</b>            |
| _____             | _____                     | <b>Marijuana/Hash</b>                   | _____             | _____                     | <b>Other Sedatives</b>                   |
|                   |                           |   |                   |                           | <b>Inhalants (glue, paint, poppers)</b>  |
| _____             | _____                     | <b>PCP</b>                              | _____             | _____                     | <b>Nicotine/Tobacco</b>                  |
| _____             | _____                     | <b>LSD/ Acid</b>                        | _____             | _____                     | <b>Other (Special K, Extasy, etc...)</b> |
| _____             | _____                     | <b>Other Hallucinogens</b>              | _____             | _____                     | <b>Caffeine</b>                          |
| _____             | _____                     | <b>Metha-amphetimene (Crystal Meth)</b> |                   |                           |  |

1. Is there a history of chemical abuse, drug addiction, alcoholism in your family? Yes No (circle)  
 Please explain:

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2. Is there a history of mental illness in your family? (For example: "nervous breakdown" depression,) Yes No (circle)  
 Please explain:

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3. Please list any current medical problems.:

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4. Please list any medications you are currently taking:

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|              |                |                        |              |                   |
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|              |                |                        |              |                   |

## SAP Statement of Understanding and Limits

1. The scope of your visit to a Substance Abuse Professional (SAP) is specifically defined by Department of Transportation (DOT) regulations. Basically a SAP will offer assistance in resolving problems associated with drug or chemical use. Your being here is the **first step** in compliance with those regulations. The Substance Abuse Professional will:
  - **conduct a substance abuse evaluation which will determine the level and the nature of any chemical health problem you may have.**
  - **make recommendations for that problem.**
  - **monitor your progress and compliance with any recommendations.**
2. The Substance Abuse Professional will also need to report to your employer the following information
  - **the date you attended the appointment.**
  - **the outcome of your evaluation.**
  - **any recommendations and referral information that were given to you.**
3. In addition the Substance Abuse Professional will continue to follow your progress and report your compliance to your employer
4. Please note that it is **up to your employer to determine your work status**. The Substance Abuse Professional **does not** determine your work status and will **only report** whether or not you fully **complied** with the **recommendations** that were made for you.
5. SAP services include the following:
  - **an evaluation (which includes a face to face interview and a standardized test)**
  - **recommendations and a treatment plan.**
  - **assistance in arranging for any recommended service.**
  - **regular contact with treatment providers to evaluate your progress.**
  - **a follow up interview to discuss your compliance and participation in treatment.**
  - **a written statement of compliance for your employer**
  - **any required consultation or report that needs to be made to your employer.**
6. For some employees, **ongoing monitoring** is required after that employee returns to work. **Ongoing monitoring** includes:
  - **providing a monthly face to face interview to review plans, progress and compliance with any recommendations.**
  - **assessing for any developing problems; recommendations will be made accordingly.**
  - **making necessary reports to your employer or anyone else on your care team, with your consent.**

*I have read the above statement. I understand and agree to all that it contains:*

\_\_\_\_\_  
**Client signature:**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Witness signature:**

\_\_\_\_\_  
**Date:**

**PROHIBITION ON REDISCLOSURE**

This information has been disclosed to you from records protected under Federal Law. Federal Regulations (42 CFR part 2) prohibits you from making further disclosure of this information without the specific consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**SAP EVALUATION & RECOMMENDATIONS**

**EMPLOYER:**

**ADDRESS:**

**CONTACT NAME:**

**TITLE:**

**EMPLOYEE:**

**DOT Operating Administration:**

**POSITION:**

**SOCIAL SECURITY:**

**VIOLATION:**

**DATE OF EVALUATION:**

**DATE OF FINAL EVALUATION:**

**SAP RECOMMENDATION:**

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\_\_\_\_\_  
**Substance Abuse Professional:**

\_\_\_\_\_  
**Date:**

|                  |                |                        |              |                   |
|------------------|----------------|------------------------|--------------|-------------------|
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**SAP Verification of Compliance with Assistance Plan and Recommendation for Follow-Up Testing**

**EMPLOYER:**

**CONTACT NAME:**

**TITLE:**

**EMPLOYEE:**

**DOT Operating Administration:**

**POSITION:**

**SOCIAL SECURITY:**

**VIOLATION:**

**DATE OF EVALUATION:**

**DATE OF FINAL EVALUATION:**

**TREATMENT PROVIDER/PROGRAM:**

**PHONE:**

**INCLUSIVE DATES OF TREATMENT:**

**Brief synopsis of treatment:**

**I recommend the following plan for follow-up testing:**

First \_\_\_months \_\_\_Alcohol \_\_\_Drugs Frequency: \_\_\_\_\_.

Next \_\_\_months \_\_\_Alcohol \_\_\_Drugs Frequency: \_\_\_\_\_.

Subsequent years \_\_\_Alcohol \_\_\_Drugs Frequency: \_\_\_\_\_.

I hereby certify that I am a qualified Substance Abuse Professional, and that I have knowledge of and clinical experience in the diagnosis and treatment of alcohol/substance use disorders and related disorders. I further verify that in my professional opinion the above named Employee, \_\_\_\_\_, has complied with my recommendations. I further certify that as a Substance Abuse Professional, I have complied with all DOT regulations regarding my evaluation, recommendation and monitoring of the above named Employee during this intervention.

\_\_\_\_\_  
**Substance Abuse Professional:**

\_\_\_\_\_  
**Date:**

|              |                        |                                    |              |                                     |
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# Affiliate Invoice

**Affiliate Name and Address:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Tax I.D. Number:** \_\_\_\_\_

**Month of:** \_\_\_\_\_ **20**\_\_

| Dates of Contact | Client Name | Company Name | Fee Charged |
|------------------|-------------|--------------|-------------|
|                  |             |              |             |
|                  |             |              |             |

With this invoice, we must receive the **client information sheet** and signed **S.A.P. statement of understanding and limits, SAP Evaluation & Recommendations** and **SAP Verification of Compliance with Assistance Plan and Recommendation for Follow-Up Testing**.  
 Submit the paperwork within 30 days of the last session.

02/03

|                  |                        |                                    |              |                                     |
|------------------|------------------------|------------------------------------|--------------|-------------------------------------|
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