

## Continuing Care Orientation Check List:

Client: \_\_\_\_\_

Session Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

Therapist: \_\_\_\_\_

### Check:

- Review the patient's Recovery Plan
- Complete Risk and Protective Factor data and enter it onto the Recovery Check-Up form;
- Review the Continuing Care Recovery Check-Up form;
- Complete the Continuing Care Emergency Safety Contract;
- Complete the Continuing Care Agreement;
- Review existing permissions for release of information and collateral contact and modify if indicated;
- Identify the Continuing Care collateral contact(s) and complete a consent form that permits the clinician to communicate with collateral contacts in the event that the patient cannot be reached; and
- Schedule the first phone session, ideally less than a week after the orientation.

## Continuing Care Agreement

I, \_(name) \_\_\_\_\_, agree to participate in Continuing Care with \_\_\_\_\_ (program) \_\_\_\_\_ for a period of three months, from \_\_\_\_ (date) \_\_\_\_\_ to \_\_\_\_ (date) \_\_\_\_\_, with the option of renewing my participation for additional three month periods, as long as I am benefiting from the services provided and complying with the requirements for contact.

I understand that I will initially be contacted \_\_\_\_ (frequency) \_\_\_\_\_, by telephone or email, to discuss my progress in recovery. Frequency of contact will be negotiated periodically.

I understand that I may decide to end my participation in Continuing Care at any time. If I do not maintain contact, I may be dis-enrolled from Continuing Care services.

I have received a copy of my Recovery Plan, my Continuing Care Agreement, Recovery Check-Up form, Emergency Safety Contract, and consent form.

Signed: \_\_\_\_\_

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

## Continuing Care Emergency Safety Contract

My primary care physician:

Phone number:

My local emergency room is at \_\_\_\_\_ Hospital.

Phone number:

In an emergency, the person I can most count on to assist me in obtaining help is

\_\_\_\_\_, whose phone number is \_\_\_\_\_.

My Continuing Care clinician is:

Phone number:

My psychiatrist is:

Phone number:

My sponsor is:

Phone number:

If I genuinely feel like hurting/killing myself or someone else, I will take the following steps. If needed, I will contact my emergency helper (identified in #3) and ask him/her to help me complete these steps:

- a. During daytime hours Monday thru Friday contact my Continuing Care clinician at the following number:
- b. If I have a psychiatrist treating me, I will contact his/her office and tell him/her that I am in crisis.
- c. If I cannot contact either of the above, I will contact the agency's 7 day, 24 hour Emergency Services at \_\_\_\_\_.
- d. If none of the above can be reached, I will go to my local emergency room and tell them I am in psychiatric crisis.
- e. If I am unable to get to an Emergency Room, I will dial 911, tell them I am in psychiatric crisis and ask for help.

If I am in any type of medical crisis, I will call my primary care physician. If he/she is unable to be reached, I will go to my local emergency room, urgent care facility, or call 911 and ask for help.

I have reviewed this emergency plan with my Continuing Care clinician and fully understand the steps I need to take in the event that I am in psychiatric or medical crisis. I agree to review this contract with my emergency helper.

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Participant Signature

Date

Clinician Signature

Date

## Continuing Care Risk and Protective Factor Data

(This information is gathered at Orientation Session. It will pre-populate the *Recovery Activities* and *High Risk Situations* sections of the Recovery Check-Up form)

Top four high-risk situations:

- In a bar
- In a crack house
- At an actively using (alcohol or other drugs) friend's house
- At an actively using (alcohol or other drugs) family member's house
- Hanging out with active drinkers/users
- With boyfriend/girlfriend/spouse while they are drinking/using
- With boyfriend/girlfriend/spouse, or ex-boyfriend/girlfriend/spouse
- Tricking/ picking up prostitutes
- At a corner store that sells beer
- At a party where there is alcohol/drugs
- Driving/riding through neighborhoods where I used/drank
- Other: \_\_\_\_\_

Top four ways to spend time with people who do not have an alcohol or drug problem:

- Brothers/sisters events
- Recreational/sports participation
- Activities with my children
- Activities with clean and sober family members
- Activities with clean and sober friends
- Church services
- Church social activities
- Classes (GED, college, etc.)
- Working out/going to the gym
- Other: \_\_\_\_\_

## Continuing Care Recovery Check-Up

**Question**

**Answer**

How have you been doing with your recovery?	
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**If recovery has been sustained:**

What has helped you sustain your recovery?	
Have there been specific things (stressors or triggers) that have been making it difficult to sustain your recovery? If so, what have they been? How have you been managing them?	

**If recovery has not been sustained:**

When did you relapse?	Date:
What triggered the relapse?	
What have you been using?	
How often have you used?	
How much have you been using?	
What has worked well for you in the past when you have relapsed? What might you do this time to get back into recovery?	
Can I help you access treatment or other recovery support services? If yes, specify date and time for appointment.	Date: Time:

### Risk Assessment

Risk Factor	Lowest Risk			Highest Risk
<b>Mood</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How would you describe your mood in the past week? (Sad, depressed, angry, worried, anxious, hopeless, etc) Has your mood been steady or changed often?	<1 day/ Wk	1-2 days/ wk	3 days/ wk	4 + days/ wk
<b>Suicidality/ Homicidality</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Have you had any thoughts of hurting yourself? or someone else? If yes, how frequent are the thoughts? Do you have a plan? Do you have what is needed to carry out the plan?	No	Infrequent Thoughts	Frequent Thoughts	Thoughts with Intent/Plan and/or Means
<b>Medication Adherence</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>

Have you had any changes in prescribed medication?	No			Yes
If currently taking medication, have you taken medication as prescribed this week?	Yes/NA	Most of the time	Some of the time	Rarely or never
<b>Concern</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How concerned are you right now about your ability to stay clean and sober until our next phone call?	Not at all concerned	A little concerned	Moderately concerned	Very concerned
<b>Time Alone</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How have you been spending your free time? (outside of work or other obligations) How much time are you spending alone or with strangers? Are you happy with the amount of time you spend alone?	None	1 day/wk	2-3 days/wk	4 days/ wk
<b>High Risk Situations</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
The four riskiest situations you have identified were: XXXX Have you been in any of those in the past week?	None	1 time/ wk	2 times/ wk	3 or more times/ wk
<b>Craving</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Have you experienced cravings, dreams, thoughts or desires to drink or use drugs?	None	1-2 days/ Wk	3 days/ Wk	4 or more days/ wk
<b>Craving</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
If so, how strong?	Just a passing thought	Mild	Moderate	Strong
<b>Craving</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
What did you do when you had a craving?	Moved out of a risky situation <b>or</b> Did not seek a risky situation	Called sponsor or other positive support, attended a mtg., or a grp. sober activity	Participated in an individual sober activity (for ex - read, shower, exercise, journal writing)	Did nothing, but did not use
<b>Risk Factor Total</b>				

<b>Protective Factor</b>	<b>Lowest Protection</b>			<b>Highest Protection</b>
<b>Living Environment</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Are you currently living in a safe environment that supports your recovery?	No, living with active users			Yes
<b>Recovery Activities</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How many times have you participated in a recovery activity other than an AA/NA meeting with people who are sober or who have no alcohol/drug problem? The four activities you chose to involve yourself in were XXXX	None	1 time/ wk	2-3 times/ wk	4 or more times/ wk
<b>Meetings</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How many AA/NA meetings have you attended this past week?	None	1 time/ wk	2-3 times/ wk	4 or more times/ wk
Did you participate actively at any of these meetings?	No			Yes
<b>Sponsor</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How many times have you talked with your sponsor outside of meetings this past week?	None or no sponsor	1 time/ wk	2-3 times/ wk	4 or more times/ wk
<b>Treatment Involvement</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Are you involved in any other kind of services? (medical, psychiatric, etc.)?	Services needed but has not made/kept appt			Yes, or No additional services needed
<b>Progress toward Goals</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Have you been making any progress toward your goals?	No, I have had setbacks	I have not been progressing, but have not had setbacks	Yes, I have been making some progress	Yes, I have made considerable progress
<b>Protective Factor Total</b>				

<b>Overall Risk Total (Protective Factor Total – Risk Factor Total )</b>	
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If Overall Risk Total is positive, the patient has more protective factors than risks. If Overall Risk Total is negative, the patient has more risk factors than protective factors.

<b>Case Management/ Other Service Needs</b>	<b>No</b>	<b>Yes</b>
Do you have needs that are a major source of stress in any other part of your life?		
Transportation		
Employment		
Housing		
Childcare		
Family/ marriage concerns		
Problems with peer relationships		
Education		
Parenting		
Basic Needs (e.g., food, clothing, personal care)		
Medical		
Financial Issues		
Legal Issues		
Other: _____		

<b>Activity</b>	<b>Response</b>
Review risk level	
Review progress since last contact	
Problem solve issues raised by risk assessment	
Anticipate upcoming high-risk situations	
Set goals for coming week	
Offer referrals to outside services	
Schedule next contact	Date: Time:

## Consent to Collateral Contact

I agree to allow \_\_\_\_\_  
to contact the individuals listed below to confirm my whereabouts. I understand that no confidential information will be provided to persons on the contact page unless I have authorized it through a separate consent to disclose information.

The best times to reach me are:

Sunday	8AM – 10 AM	10 AM – 2 PM	2PM – 6PM	6 PM- 8 PM
Monday	8AM – 10 AM	10 AM – 2 PM	2PM – 6PM	6 PM- 8 PM
Tuesday	8AM – 10 AM	10 AM – 2 PM	2PM – 6PM	6 PM- 8 PM
Wednesday	8AM – 10 AM	10 AM – 2 PM	2PM – 6PM	6 PM- 8 PM
Thursday	8AM – 10 AM	10 AM – 2 PM	2PM – 6PM	6 PM- 8 PM
Friday	8AM – 10 AM	10 AM – 2 PM	2PM – 6PM	6 PM- 8 PM
Saturday	8AM – 10 AM	10 AM – 2 PM	2PM – 6PM	6 PM- 8 PM

I agree to be contacted by email. My email address is:

\_\_\_\_\_

If I cannot be reached through my current contact information, you may contact the following persons for information regarding how to reach me, or to leave a message for me:

**Primary Contact.** Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Apt./Room/Floor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Additional Contact.** Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Apt./Room/Floor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**This consent will expire on** \_\_\_\_\_.

**Signed:** \_\_\_\_\_

(date)