

NC-TOPPS

TASC CJM Episode Completion 2024

****Use this form for backup only. Enter data into web-based system. (<https://nctopps.ncdmh.net/tasc.htm>)**

Clinician First Initial & Last Name

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Please provide the following information about the consumer:

Consumer ID

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender Assigned at Birth

☐ Male ☐ Female

1. Date Consumer Discharged from TASC:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2. Date Consumer Admitted to TASC (this episode):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

3. County of TASC Management: _____

4. Did the consumer complete TASC services?

☐ Yes -> (skip to 5)

☐ No

b. Reason for not completing TASC services:

☐ Probation non-compliance/revocation -> (answer c)

☐ Consumer deceased -> (skip to 5)

☐ Consumer moved/relocated -> (skip to 5)

☐ TASC non-compliance/no-show -> (answer d)

☐ No longer required to attend treatment -> (skip to 5)

c. Reason for probation non-compliance/revocation:

☐ Technical

☐ New Crime

☐ Absconder -> (skip questions 9-15)

d. Reason for TASC non-compliance/no-show:

☐ Client fails to comply with requirements of jeopardy staffings

☐ Client is arrested or convicted of a charge, which precludes his/her continued participation in TASC

☐ Client acts violently or threatens violence against TASC staff, treatment staff, or another client

☐ Client is in possession of a weapon at TASC or treatment program sites

☐ Client is in possession of drugs or alcohol at TASC or treatment program sites

☐ No contact with TASC in 30 calendar days (requires a minimum of two attempts to contact the client and supervisory review)

☐ Refusal of services

5. Is the consumer or a member of the consumer's immediate family or household currently serving in or has served in the Military, Military Reserve or National Guard?

☐ Yes, active Military, Military Reserve or National Guard

☐ Yes, veteran or prior service member

☐ Yes, family member

☐ No

6. At any time in the past, has the consumer been suspected of having a head or brain injury?

☐ Yes ☐ No

7. NC Docket Number (current, most serious): (Skip to question 8 if state of arrest for this episode was *not* in North Carolina)

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8. Primary Diagnosis: (Select one or enter primary diagnosis below)

☐ F10.10 - Alcohol Use Disorder, Mild

☐ F10.20 - Alcohol Use Disorder, Moderate

☐ F10.20 - Alcohol Use Disorder, Severe

☐ F12.10 - Cannabis Use Disorder, Mild

☐ F12.20 - Cannabis Use Disorder, Moderate

☐ F12.20 - Cannabis Use Disorder, Severe

☐ F14.10 - Cocaine Use Disorder, Mild

☐ F14.20 - Cocaine Use Disorder, Moderate

☐ F14.20 - Cocaine Use Disorder, Severe

☐ F11.10 - Opioid Use Disorder, Mild

☐ F11.20 - Opioid Use Disorder, Moderate

☐ F11.20 - Opioid Use Disorder, Severe

☐ F15.10 - Amphetamine or Other or Unspecified Stimulant Use Disorder, Mild

☐ F15.20 - Amphetamine or Other or Unspecified Stimulant Use Disorder, Moderate

☐ F15.20 - Amphetamine or Other or Unspecified Stimulant Use Disorder, Severe

☐ F18.10 - Inhalant Use Disorder, Mild

☐ F18.20 - Inhalant Use Disorder, Moderate

☐ F18.20 - Inhalant Use Disorder, Severe

☐ F13.10 - Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild

☐ F13.20 - Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate

☐ F13.20 - Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe

☐ F16.10 - Phencyclidine or Other Hallucinogen Use Disorder, Mild

☐ F16.20 - Phencyclidine or Other Hallucinogen Use Disorder, Moderate

☐ F16.20 - Phencyclidine or Other Hallucinogen Use Disorder, Severe

Primary diagnosis if not listed above:

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☐ No diagnosis

☐ MH Only diagnosis -> (skip questions 16-18)

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9. Currently, where does the consumer live most of the time?

- ☐ Homeless → (answer b)
- ☐ Temporary housing → (answer c)
- ☐ Private or permanent residence → (answer d if adult, skip to 10 if adolescent)
- ☐ Residential program → (answer e if adult, answer f if adolescent)
- ☐ Facility/institution → (answer g)
- ☐ Other → (skip to 10)

b. If *homeless*, please specify the consumer's living situation currently.

- ☐ Sheltered (homeless shelter)
- ☐ Unsheltered (on the street, in a car, camp)

c. If *temporary housing*, please specify the type of temporary housing the consumer currently lives in.

- ☐ Transitional housing (time-limited stay)
- ☐ Living temporarily with other(s)

d. **For Adult TASC consumer only:** If *private residence*, please specify the type of residence the consumer currently lives in.

- ☐ Self-owned
- ☐ Rent with rental assistance
- ☐ Rent without rental assistance
- ☐ Other

e. **For Adult TASC consumer only:** If *residential program*, please specify the type of residential program the consumer currently lives in.

- ☐ Alternative family living ☐ Licensed supervised apartment
- ☐ Group home ☐ Family care home
- ☐ Residential treatment center ☐ Halfway house

f. **For Adolescent TASC consumer only:** If *residential program*, please specify the type of residential program the consumer currently lives in.

- ☐ Foster home
- ☐ Therapeutic foster home
- ☐ Level III group home
- ☐ Level IV group home
- ☐ State-operated residential treatment center
- ☐ Substance abuse residential treatment facility
- ☐ Halfway house

g. If *facility/institution*, please specify the type of facility the consumer currently lives in.

- ☐ PRTF (adolescent only)
- ☐ Public institution
- ☐ Private institution
- ☐ Adult care home/assisted living (adult only)
- ☐ Nursing facility (adult only)
- ☐ Correctional facility

10. What is the highest grade the consumer completed or degree s/he received in school?

- ☐ Grade K, 1, 2, 3, 4, or 5 ☐ Some college or technical/vocational school
- ☐ Grade 6, 7, or 8 ☐ 2-year college/assoc. degree
- ☐ Grade 9, 10, 11, or 12 (no diploma) ☐ 4-year college degree
- ☐ GED ☐ Graduate work, no degree
- ☐ High school diploma ☐ Professional degree or more

11. Was a GED or other degree(s) completed during TASC?

- ☐ Yes ☐ No

12. Is the consumer currently enrolled in school or courses that satisfy requirements for a certification, diploma or degree? ☐ Yes ☐ No → (skip to 13)

b. If **yes**, mark all that apply:

- ☐ High School ☐ Technical/Vocational school
- ☐ GED Program, Adult literacy ☐ Other
- ☐ College

13. What best describes the consumer's employment status at Episode Completion? (mark only one)

- ☐ Full-time work (working 35 hours or more a week) → (skip to 14)
- ☐ Part-time work (working less than 35 hours a week) → (skip to 14)
- ☐ Unemployed (seeking work or on layoff from a job) → (skip to 14)
- ☐ Not in labor force (not seeking work)
- b. If *not seeking work*, what best describes the consumer's current status?
- ☐ Homemaker ☐ Chronic medical condition which prevents employment
- ☐ Student ☐ Retired ☐ None of the above

14. In the past 3 months, how often did the consumer participate in ...

- a. positive community/leisure (extracurricular) activities?
- ☐ Never ☐ A few times ☐ More than a few times
- b. recovery-related support or self-help groups?
- ☐ Never → (answer c)
- ☐ A few times
- ☐ More than a few times
- b-1. In the past month, how many times did the consumer attend recovery-related support or self-help groups?
- ☐ Did not attend in past month
- ☐ 1-3 times (less than once per week)
- ☐ 4-7 times (about once per week)
- ☐ 8-15 times (2 or 3 times per week)
- ☐ 16-30 times (4 or more times per week)
- ☐ some attendance, but frequency unknown
- c. organized religious activities?
- ☐ Never ☐ A few times ☐ More than a few times

15. Does the consumer have a sponsor?

- ☐ Yes ☐ No → (skip to 16)
- b. In the past month, how often did the consumer have contact with his/her sponsor?
- ☐ Never ☐ A few times ☐ More than a few times

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16. If Primary Diagnosis is not MH Only, please indicate the consumer's Primary (required), Secondary (if applicable), and Tertiary (if applicable) substance problems by entering a "1" for Primary, "2" for Secondary, and "3" for Tertiary.

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Marijuana/Hashish	<input type="checkbox"/> Cocaine/Crack	<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Heroin
<input type="checkbox"/> Fentanyl	<input type="checkbox"/> Other Opiates/Opioids	<input type="checkbox"/> Non-Prescription Methadone	<input type="checkbox"/> PCP-Phencyclidine	<input type="checkbox"/> Other Hallucinogen
<input type="checkbox"/> Other Amphetamine	<input type="checkbox"/> Other Stimulant	<input type="checkbox"/> Benzodiazepine	<input type="checkbox"/> Other Non-Benzodiazepine Tranquilizer	<input type="checkbox"/> Barbiturate
<input type="checkbox"/> Other Non-Barbiturate Sedative or Hypnotic	<input type="checkbox"/> Inhalants	<input type="checkbox"/> Over-the-Counter	<input type="checkbox"/> Oxycodone (OxyContin, Percocet, Percodan)	<input type="checkbox"/> MDMA (Ecstasy)
<input type="checkbox"/> Prescription Drug	<input type="checkbox"/> Ketamine	<input type="checkbox"/> Spice	<input type="checkbox"/> Dilantin	<input type="checkbox"/> GHB/GBL
<input type="checkbox"/> Cannabinoids, Delta THC/Other Synthetic	<input type="checkbox"/> Other Drug			

17. If Primary Diagnosis is not MH Only, please indicate the consumer's age at first use/intoxication and how each substance was taken (if applicable) for the Primary, Secondary (if applicable), and Tertiary (if applicable) substance(s).

Substance	Age of First Use/ Intoxication	How usually taken (mark only one)	Substance	Age of First Use/ Intoxication	How usually taken (mark only one)
Alcohol	<input type="text"/> <input type="text"/>	N/A	Barbiturate	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Marijuana/Hashish	<input type="text"/> <input type="text"/>	N/A	Other Non-Barbiturate Sedative or Hypnotic	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Cocaine/Crack	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other	Inhalant	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Methamphetamine	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other	Over-the-Counter	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Heroin	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other	Oxycodone (OxyContin, Percocet, Percodan)	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Fentanyl	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other	MDMA (Ecstasy)	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Opiates/Opioids	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other	Prescription Drug	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Non-Prescription Methadone	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other	Ketamine	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
PCP-phencyclidine	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other	Spice	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Hallucinogen	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other	Dilantin	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Amphetamine	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other	GHB/GBL	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Stimulant	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other	Cannabinoids, Delta THC/Other Synthetic	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Benzodiazepine	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other	Other Drug	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Non-Benzodiazepine Tranquilizer	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other			

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18. If Primary Diagnosis is not MH Only, have any substances been used in the past month?

☐ Yes ☐ No -> (skip to 20) ☐ Unknown -> (skip to 20)

19. If Primary Diagnosis is not MH Only, please mark the frequency of use for each substance in the past month.

Substance	Past Month - Frequency of Use				
	Not Used	1-3 times monthly	1-2 times weekly	3-6 times weekly	Daily
Tobacco/vaping use (any tobacco/vaping products)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy alcohol use (>=5(4) drinks per sitting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than heavy alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana or hashish use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine or crack use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentanyl use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other opiates/opioids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Drug Use <input type="text"/> <input type="text"/> (enter code from list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Drug Codes

5=Non-prescription Methadone	13=Other Tranquilizer	46=Ketamine
7=PCP-Phencyclidine	14=Barbiturate	57=Prescription Drug
8=Other Hallucinogen	15=Other Sedative or Hypnotic	58=Spice
9=Methamphetamine	16=Inhalant	59=Dilantin
10=Other Amphetamine	17=Over-the-Counter	61=GHB/GBL
11=Other Stimulant	22=Oxycodone (OxyContin, Percocet, Percodan)	62=Cannabinoids
12=Benzodiazepine	29=MDMA (Ecstasy)	

20. Drug test results from all sources in the past 3 months (or since admission if consumer was not in TASC for 3 months):

a. Number Conducted b. Number Positive enter 0, if none and skip to 20

b-1. Date of last positive screening:

/ /

b-2. How often did each substance appear for all tests conducted?

Alcohol	THC	Opiates	Benzo.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Cocaine	Amphetamines	Barbiturates	Other
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

21. In the past month, how many times has the consumer been arrested (or had a petition filed for adjudication) for any offense including DWI?

-> (enter 0, if none); answer b if greater than zero)

b. Indicate the type(s) of crime from arrest(s) in the past month: (mark all that apply)

<input type="checkbox"/> Violent felony	<input type="checkbox"/> Violent misdemeanor
<input type="checkbox"/> Property felony	<input type="checkbox"/> Property misdemeanor
<input type="checkbox"/> Drug felony	<input type="checkbox"/> Drug misdemeanor
<input type="checkbox"/> Other felony	<input type="checkbox"/> Other misdemeanor

22. Please indicate the consumer's DAC Supervision Level.

☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4 ☐ Level 5

23. Please indicate the consumer's DAC Need Level.

☐ Extreme (L1) ☐ Low (L4)
☐ High (L2) ☐ Minimal (L5)
☐ Moderate (L3)

24. Date of Last Face-to-Face Contact with Consumer:

/ /

25. Level of Care Management prior to Episode Completion:

☐ Level I ☐ Level II ☐ Level III

26. Does the consumer have a need for any of the following? (mark all that apply)

<input type="checkbox"/> Wheelchair/Mobility equipment or services	<input type="checkbox"/> Equipment or services due to being visually impaired
<input type="checkbox"/> Equipment or services due to a physical disability	<input type="checkbox"/> Child care
<input type="checkbox"/> Equipment or services due to being deaf/hard of hearing	<input type="checkbox"/> Equipment or services due to being a frail senior
<input type="checkbox"/> Sign language interpreter	<input type="checkbox"/> Other
<input type="checkbox"/> Foreign language interpreter	<input type="checkbox"/> None of the above/NA

27. Services and Supports Received: (mark all that apply)

<input type="checkbox"/> Peer support services	<input type="checkbox"/> Pre-treatment education
<input type="checkbox"/> Family/Parenting classes	<input type="checkbox"/> SA outpatient -> (answer b)
<input type="checkbox"/> Faith-based services	<input type="checkbox"/> SA Intensive Outpatient (IOP) -> (answer c)
<input type="checkbox"/> Self-care/Wellness activities (ex. Yoga, Guided Meditation, Exercise)	<input type="checkbox"/> SA Day Treatment
<input type="checkbox"/> Transportation services	<input type="checkbox"/> Residential
<input type="checkbox"/> Housing services	<input type="checkbox"/> Therapeutic community
<input type="checkbox"/> Financial wellness/Education programs	<input type="checkbox"/> AA/NA/Self help
<input type="checkbox"/> Harm reduction services	<input type="checkbox"/> Specialty courts
<input type="checkbox"/> Syringe Services Programs (SSPs)	<input type="checkbox"/> DART Center
<input type="checkbox"/> Primary care/Medical services	<input type="checkbox"/> Black Mountain
<input type="checkbox"/> Drug and other education classes	<input type="checkbox"/> Crisis Services
<input type="checkbox"/> CBI -> (answer a)	<input type="checkbox"/> Medication Management
<input type="checkbox"/> Mental health services	<input type="checkbox"/> Other
<input type="checkbox"/> Detox	<input type="checkbox"/> None

*****If any of the services are received above, please indicate the status of the service(s) received?**

☐ Completed ☐ Not Completed ☐ Ongoing

a. If CBI, who is funding/paying for CBI services?

☐ TECS ☐ Non-TECS

b. If SA Outpatient, who is funding/paying for SA Outpatient services?

☐ TECS ☐ Non-TECS

c. If SA Intensive Outpatient (IOP), who is funding/paying for SA Intensive Outpatient (IOP) services?

☐ TECS ☐ Non-TECS