PLEASE EMAIL OR FAX TO: Heather Hershberger
FAX: 319-335-4484 heather-hershberger@uiowa.edu

State Youth Treatment – Implementation (SYT-I)
Client Intake Form

***** Please complete and send within 7 days of the GPRA intake. *****

Date Client Intake Form Completed: **(Date format 01/01/16)**	
Staff Member Completing Form:	
Agency:	
Assigned Therapist:	
GPRA Client ID: **(include special agency letters)**	
GPRA Intake Date: **(This date should match the Intake Date (Interview Date) entered in the GPRA record.)**	
Unique Client Number: **(10 digit number)**	
Admission Date: **(This date should match the Admission Date entered in the treatment admission record.)**	
Treatment Plan (check all that apply)	**MDFT** ☐ **MET/CBT** ☐
Family Member(s) or Other Adult Participating in Treatment (check all that apply):	
Please specify the relationship of "other" to the client (if there is more than one other, please document in an email):	**Mom** ☐ **Dad** ☐ **Sibling** ☐ **Grandparent** ☐ **Other** ☐

THE IOWA CONSORTIUM
FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

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State Youth Treatment – Implementation (SYT-I)
Client Discharge Notification Form

Please complete and send within 7 days of discharge from the SYT-I grant.*

Date Discharged Intake Form Completed:

(Date format 01/01/16)

Staff Member Completing Form:

Agency:

Assigned Therapist:

GPRA Client ID:

(include special agency letters)

GPRA Discharge Date:

(This date should match **Question #1, Discharge Date, in Section J of the GPRA**.)

Unique Client Number:

(10 digit number)

Discharge Date:

(This date should match the **Discharge Date** entered in the treatment discharge record. If still in treatment, write that instead of the date.)

Completion of Treatment (check one):

Completion/Graduate ☐ Termination ☐

Treatment Plan (check all that apply) MDFT ☐ MET/CBT ☐

CASI Assessment: Yes ☐ No ☐

Screened for Co-occurring Diagnosis: Yes ☐ No ☐

Co-occurring Diagnosis: Yes ☐ No ☐

Number of Sessions Client Attended MDFT _____ MET/CBT _____

Parents, Siblings, Grandparents, and Other Adults participating in treatment:

Relationship to the Client	# of MDFT sessions attended	Age	Gender (circle gender)	Race (circle race)	Ethnicity (circle ethnicity)
Mom			F M	White/Caucasian African American/Black American Indian Other	Not Hispanic or Latino Puerto Rican Mexican Other Hispanic or Latino
Dad			F M	White/Caucasian African American/Black American Indian Other	Not Hispanic or Latino Puerto Rican Mexican Other Hispanic or Latino
Sibling			F M	White/Caucasian African American/Black American Indian Other	Not Hispanic or Latino Puerto Rican Mexican Other Hispanic or Latino
Grandparent			F M	White/Caucasian African American/Black American Indian Other	Not Hispanic or Latino Puerto Rican Mexican Other Hispanic or Latino
Other (specify relationship):			F M	White/Caucasian African American/Black American Indian Other	Not Hispanic or Latino Puerto Rican Mexican Other Hispanic or Latino

Please include only the total number of sessions that family members and/or other adults attended: _____