Montana Department of Public Health & Human Services
SUBSTANCE ABUSE MANAGEMENT SYSTEM

CLIENT ACT FORM

Name:			Account #:		
Program #			Facility		

ACT ADMIT / DEMOGRAPHICS

3.	Admission Date *(mmddyyyy)*		
4.	Act Facility		
5.	Admission Status *(check one)*		
	☐ *Admission*	☐ *Readmission - Same Offense*	
6.	Case Number		
11.	Employment Status		
	☐ *Employed Full Time*	☐ *Employed Part Time*	☐ *Public Assistance Benefits Depleted*
	☐ *Unemployed*	☐ *Not in Labor Force*	

ACT EDUCATION

12.	NON-DUI CLIENT			
	a. Dangerous Drug Misdemeanor Client:	☐ *Yes*	☐ *No*	
	b. Driving Related Reduced Charge Client:	☐ *Yes*	☐ *No*	
13.	Court Number			
14.	County of DUI Arrest			
15.	Blood Alcohol Level	.	☐ *Refused*	☐ *Unknown*
	(Valid values are 0.00 to 0.55, Refused, or Unknown)			
16.	Previous DUI/BAC Convictions:			
17.	Previous ACT Programs Attended:			
18.	Prior Treatment Episodes			
19.	Mandatory Monitoring Required:	☐ *Yes*	☐ *No*	

CLIENT ACT FORM

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ACT Discharge

Discharge Date: *(mmddyyyy)*

Reason for Discharge *(check one)*

- ☐ *Completed Program*
- ☐ *Did Not Complete Program*
- ☐ *Transferred*
- ☐ *Referred to Treatment*

Results of Assessment/Evaluation: *(check one)*

- ☐ *Misuse/No Problem*
- ☐ *Dependency*
- ☐ *Abuser*
- ☐ *Unidentified*

Treatment Recommendations: *(check one)*

- ☐ *None*
- ☐ *IOP*
- ☐ *Outpatient*
- ☐ *Inpatient*

Referral Program *(Use Program Table)*

Referral Agency *(Write Description)*

Comments: