



Health Resources
Development Service
Oklahoma State
Department of Health

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SUBSTANCE ABUSE AND PSYCHIATRIC SERVICES MONTHLY REPORT

_____ 2009
Month

Date _____

Facility ID _____

Name of Contact Person (Please print or type.) (_____) _____
Telephone

Facility Name

Street City State Zip

_____ Youth Psychiatric _____ Adult Psychiatric _____ Total Psychiatric	_____ Youth Substance Abuse _____ Adult Substance Abuse _____ Total Substance Abuse
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1. Inpatient Days [†]	(A) Psychiatric	(B) Substance Abuse	Total (A) + (B)
(1a) Youth	_____	_____	_____
(1b) Adult	_____	_____	_____
2. Reserve Days [‡]			
(2a) Youth	_____	_____	_____
(2b) Adult	_____	_____	_____
3. Total Days			
(1a+1b+2a+2b)	_____	_____	_____

4. List semi-private rooms rented as private rooms by room number for the entire month. Indicate if the room is adult or youth and psychiatric or substance abuse.

NOTE: Do not report any patient days under contract with the Department of Corrections.

[†] Days of service excluding reserve days.
[‡] Number of days a bed was held for a temporarily absent patient.