



Health Resources
Development Service
Oklahoma State
Department of Health

Health Facility Systems
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SUBSTANCE ABUSE AND PSYCHIATRIC SERVICES MONTHLY REPORT

Month: _____ Year: _____

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 |
|---|---|

| 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.