

RECORD CLOSEOUT SUPRT PDF for Adult Clients 18+

Substance Abuse and Mental Health Services Administration (SAMHSA) Unified Performance Reporting Tool (SUPRT)

June 2025

Public reporting burden for this collection of information is estimated to average 20 minutes per response. Send comments regarding this burden estimate, or any other aspect of this collection of information, to Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this project is 0930-0400.

RECORD MANAGEMENT

Provider email address: _____

Enter a unique client ID in the field below. *"Unique" means that the ID has not been assigned to any prior or current client served by this grant program.*

- Client IDs may contain letters and/or numbers and can include up to 9 characters.
- Client IDs should NOT contain special characters (e.g., dashes, slashes, hashtags, punctuation) or identifying information (e.g., do not use SSN or date of birth).
- Make sure to securely store the client ID; it must be used on all future SUPRT forms for this client.

Client ID: _ _ _ _ _

Which assessment type?

- ☐ Record closeout

Why are you closing out this client's record?

- ☐ Completed the program
- ☐ No contact
- ☐ Withdrew from/Refused treatment
- ☐ Referred out
- ☐ Transferred to a different grant program
- ☐ Incarceration
- ☐ Moved
- ☐ Death
- ☐ Other

[ONLY ANSWER IF "DEATH" IS SELECTED IN QUESTION ABOVE] What is the cause of death?

- ☐ Suicide
- ☐ Overdose
- ☐ Other behavioral health cause
- ☐ Other cause
- ☐ Not documented in record

SUPRT-A Staff Assessment Date:

What is the date of the staff-reported (SUPRT-A) assessment? You must enter the date in this format: yyyy/mm/dd.

Most Recent Service Date:

When did the client most recently receive services under this grant? You must enter the date in this format: yyyy/mm/dd.

SECTION E. SERVICES RECEIVED

Identify all the services your grant project provided to the client since their previous assessment.

BEHAVIORAL HEALTH SERVICES

E1. Since the previous administrative assessment, did the project provide or refer the client for one or more behavioral health services?

- ☐ Yes
☐ No
☐ Not documented in records or not documented in records using this standard

E1a. [ONLY ANSWER IF RESPONSE TO QUESTION E1 IS “YES”] Please indicate which.

Disorder	Yes – provided	Referred for service	No – not provided or referred	Not documented in records/ unknown
a. Case or care management or coordination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Person- or family-centered treatment planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Substance use psychoeducation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Mental health psychoeducation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Mental health therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Co-occurring therapy (substance use & mental health)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Group counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Individual counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Family counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Psychiatric rehabilitation services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Prescription medication for mental health disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Medication for substance use disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Intensive day treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Withdrawal management (whether in hospital, residential, or ambulatory)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. After care planning and referrals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. Co-occurring disorders (including developmental or neurologic)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
q. Intensive outpatient treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

E2. [ONLY ANSWER IF RESPONSE TO QUESTION E1a.I (“MEDICATION FOR SUBSTANCE USE DISORDER”) IS “YES – PROVIDED”] Indicate medication received:

	Yes – received	No – not received	Not documented in records/unknown
a. Naltrexone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Extended-release Naltrexone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Disulfiram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Acamprosate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Methadone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Buprenorphine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Nicotine cessation therapy (e.g. Nicotine patch, gum, lozenge)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Bupropion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Varenicline	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CRISIS SERVICES

E3. Since the previous administrative assessment, did the project provide or refer the client for one or more behavioral health services?

- ☐ Yes
☐ No
☐ Not documented in records or not documented in records using this standard

E3a. [ONLY ANSWER IF RESPONSE TO QUESTION E3 IS “YES”] Please indicate which:

Disorder	Yes – provided	Referred for service	No – not provided or referred	Not documented in records/unknown
a. Crisis response planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Crisis response	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Crisis stabilization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Crisis follow-up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

RECOVERY AND SUPPORT SERVICES

E4. Since the previous administrative assessment, did the project provide or refer the client for one or more recovery support services?

- ☐ Yes
☐ No
☐ Not documented in records or not documented in records using this standard

E4a. [ONLY ANSWER IF RESPONSE TO QUESTION E4 IS “YES”] Please indicate which:

Disorder	Yes – provided	Referred for service	No – not provided or referred	Not documented in records/unknown
a. Employment support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Family support services, including family peer support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Childcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Education support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Housing support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Recovery housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Spiritual, ceremonial, and/or traditional activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Mutual support groups	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Peer support specialist services, coaching or mentoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Respite care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Therapeutic foster care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Vocational services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Case management services to specifically support recovery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

E4b. [ONLY ANSWER IF RESPONSE TO QUESTION E4a.j (“PEER SUPPORT SPECIALIST SERVICES, COACHING OR MENTORING”) IS “YES – PROVIDED” OR RESPONSE TO E4a.n (“CASE MANAGEMENT SERVICES TO SPECIFICALLY SUPPORT RECOVERY”) IS “YES – PROVIDED”]
Identify the number of sessions provided to the client during the client’s course of treatment/recovery.

Service	Number of sessions
Peer coaching or mentoring	_____
Case management services to specifically support recovery	_____

INTEGRATED SERVICES

E5. Since the previous administrative assessment, did the project provide or refer the client for one or more integrated services?

- ☐ Yes
☐ No
☐ Not documented in records or not documented in records using this standard

E5a. [ONLY ANSWER IF RESPONSE TO QUESTION E5 IS “YES”] Please indicate which:

Disorder	Yes – provided	Referred for service	No – not provided or referred	Not documented in records/unknown
a. Primary health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Maternal health care or OB/GYN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. HIV testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Viral hepatitis testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. HIV treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. HIV pre-exposure prophylaxis (PrEP)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Viral hepatitis treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Other STI testing or treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Dental care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

E6. Has this client attended 60% or more of their planned services?

- ☐ Yes
☐ No
☐ Not documented in records or not documented in records using this standard

E7. Has this client previously been diagnosed with an opioid use disorder?

- ☐ Yes
☐ No
☐ Not documented in records or not documented in records using this standard

E7a. [ONLY ANSWER IF RESPONSE TO QUESTION E7 IS “YES”] In the past 30 days, which FDA-approved medication did the client receive for the treatment of this opioid use disorder?

CHECK ALL THAT APPLY

- ☐ Methadone
☐ Buprenorphine
☐ Naltrexone
☐ Extended-release Naltrexon
☐ Client did not receive an FDA-approved medication for a diagnosed opioid use disorder
☐ Not documented in records

E8. What was the date of the client's most recent toxicology screen? You must enter the date in this format: yyyy/mm/dd. _____

E9. What was the result of the client's most recent toxicology screen?

- ☐ Positive
- ☐ Negative
- ☐ Not documented in records or not documented in records using this standard
- ☐ Diluted
- ☐ Stalled
- ☐ Falsified
- ☐ Not documented in records or not documented in records using this standard

E9a. [ONLY ANSWER IF RESPONSE TO QUESTION E9 IS "POSITIVE"] If positive, select the drug(s) that the screen was positive for:

- ☐ Barbiturates
- ☐ Benzodiazepines
- ☐ Marijuana
- ☐ Cocaine
- ☐ Amphetamines
- ☐ Methamphetamines
- ☐ Opiates
- ☐ ETG/ETS (Alcohol)
- ☐ Tramadol
- ☐ Suboxone
- ☐ Other (Specify): _____

This is the end of the SUPRT form.