

Assertive Community Treatment (ACT)

Referral Guide and Referral Form

Program Description

Assertive Community Treatment (ACT) is an evidence-based practice that provides community-based, multidisciplinary mental health treatment for individuals with severe and persistent mental illness. The goal of ACT is to lessen or eliminate the debilitating effects that the symptoms of mental illness can have on functioning and quality of life by providing the majority of treatment, rehabilitation, and support services that individuals need to achieve their goals and live independently in their community.

ACT services are tailored for each person and address their preferences and identified goals established through relationship building and individualized assessments. The teams work collaboratively to provide services in community locations that can be available 24 hours a day and 365 days a year. The services that the teams are required to provide include:

- Service coordination
- 24-hour crisis assessment and intervention
- Symptom assessment and management
- Medication prescription, administration, monitoring, and documentation
- Co-occurring substance use services
- Employment services
- Activities of daily living
- Social/interpersonal relationship and leisure-time skill training
- Peer support services
- Support services
- Education, support, and consultation to families

Admission Criteria

Patients **must meet all seven** of the admission criteria:

1. A primary diagnosis of schizophrenia or other psychotic disorders, such as schizoaffective disorder or bipolar disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM V or any subsequent revisions thereafter). Individuals with a primary diagnosis of substance use disorder, intellectual disability, or brain injury are not the intended consumer group.

2. Must be 18 years of age or older.
3. At least two or more acute episodes of psychiatric inpatient treatment within the past 12 months or 30 days or more on an acute psychiatric unit or State Hospital during the last 12 months, or three or more contacts with crisis intervention/emergency services within the past six months.
4. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless.
5. The individual does not have a primary diagnosis of a Personality Disorder, Traumatic Brain Injury, or Intellectual Disability.
6. Difficulty effectively utilizing traditional community-based services: outpatient, case management, etc.
7. History of inadequate follow through with elements of a treatment/service plan that resulted in member psychiatric or medically instability. OR 8. The individual does not meet all of the admission criteria described above, but is designated as appropriate to receive ACT services by a multidisciplinary team, which includes participation by representatives of CBH Clinical Management in consultation with an ACT provider, CBH physician advisor, or the county Office of Behavioral Health.

ACT Providers

There are two ACT providers: **CTT and Horizon House**. Contact information for each of these providers is listed below. If sending to CTT, please click directly on the link to complete the electronic referral. If sending to Horizon House, complete referral and email directly to email address indicated.

ACT Provider	Primary ACT Contact	Contact Email
CTT	cttadmissions@pmhcc.org	https://pmhcc.formstack.com/forms/act
Horizon House	Shanise Weatherbee	Shanise.Weatherbee@hhinc.org

For more information about ACT services, please contact Elisabeth Caba, BHCMU Supervisor at Elisabeth.Caba@Phila.gov.

Assertive Community Treatment (ACT)

Cover Sheet

Send this cover sheet as a scanned copy to Community Treatment Teams (CTT) OR Horizon House along with the complete Referral Form packet for all ACT applicants (Choose one)

Email the Completed Referral Form Packet to:

___ CTT: <https://pmhcc.formstack.com/forms/act>

<input type="checkbox"/>	Act 1 - Forensic	For participants with significant forensic involvement
<input type="checkbox"/>	Act 2 - Extended Care	For participants with a history of EAC Placement
<input type="checkbox"/>	Act 3 - Acute Care	For participants who are heavy utilizers of acute services
<input type="checkbox"/>	Act 4 - Young Adults	For younger participants

___ Horizon House: Shanise.Weatherbee@hhinc.org

<input type="checkbox"/>	Generic ACT	High Utilizers/ Unspecified Needs
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*** Mailed or faxed referrals will NOT be reviewed. ***

FROM:

Referring Agency/Program: _____

Referring Staff's Name/Person Completing Form: _____

Contact Phone: _____ Fax: _____

Referring Staff's Email: _____

Other Case Managers: _____ Contact Info: _____

ACT Referral is being requested for:

Applicant's Last Name: _____ First Name: _____

Applicant's D.O.B.: _____ SS#: _____

Consent to Release Information

I authorize the disclosure of the ACT Application and all related supporting documents, including confidential medical and mental health information, to Community Treatment Teams Philadelphia or Horizon House for the purposes of assessment for ACT services. I understand that I may revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.

Applicant

Print Name

Signature

Date

Witness

Print Name

Signature

Date

ACT Application Packet Instructions

The ACT Application Packet consists of 2 forms as well as supporting documentation. A completed application must include the following (check all boxes to indicate paperwork is attached):

<input type="checkbox"/>	The ACT Cover Sheet with signed consent to release information.
<input type="checkbox"/>	A completed ACT Referral Form. Please answer all questions; type answers when possible or write legibly.
<input type="checkbox"/>	A Comprehensive Biopsychosocial Evaluation (CBE) or ADAPT Assessment completed within the last year for cases directly referred from Extended Acute Care service (EAC).
<input type="checkbox"/>	A Comprehensive Psychiatric Evaluation signed by a Psychiatrist or a Psychiatric Nurse Practitioner and completed within the last 30 days for acute inpatient or EAC referrals.

4. Does the applicant have significant difficulty meeting survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless? * Yes No Unknown
If “Yes” please describe.

5. Does the applicant have a previous or current diagnosis of a Personality Disorder, Traumatic Brain Injury or Intellectual Disability? * Yes No Unknown
Is this considered a primary diagnosis? Yes No
What factors (for example, behaviors, functional deficits, etc.) led to this diagnosis?

6. Has the applicant had difficulty effectively utilizing community-based services: PCP appointments, outpatient therapy, medication management, medication adherence / non-adherence and consequences, case management, drug and alcohol services, etc.?*
 Yes No Unknown

If “Yes”, please describe these difficulties (e.g. engaged, rarely attended, never attended, or refused services).

7. What community-based supports and interventions/strategies (e.g. Outpatient, Inpatient Rehab, IOP, etc ...) have been attempted within the last 12 months to engage and/or link the applicant to community behavioral health services?
8. Has the applicant had a history of inadequate follow through with elements of a treatment/service plan that resulted in member psychiatric or medical instability? * Yes No Unknown
If “Yes”, please describe applicant’s typical obstacles to following through with treatment/service planning.
9. Please describe the applicant’s health/medical status, including conditions, adherence with medication and medical treatments, and impact on applicant’s overall day to day function and may put applicant at risk in the community.

Print Name: _____ Title: _____

Signature: _____ Date: _____

Email address: _____ Phone #: _____

ACT Referral Form

Date of Referral Form: _____ Person Completing Form: _____

Section A: Demographics

1.	First Name:		Last Name:	
2.	DOB:		SS#:	
3.	Applicant Address: _____ _____ _____ *If the applicant is homeless please note the shelter/drop in center or location where they may be contacted. *Determination cannot be made without an address to locate the participant			
4.	Participant Telephone #:			
5.	Emergency Contact:		EC Phone:	
6.	Relationship to EC:			
7.	CIS#:	BSU#:	Medicaid #	
8.	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other		
9.	US Veteran:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, branch of service: _____		
10.	Available forms of government issued ID: <input type="checkbox"/> Photo ID <input type="checkbox"/> Social Security Card <input type="checkbox"/> None <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Permanent Resident Card <input type="checkbox"/> Other: _____			
11.	PP# (Philadelphia County Jail Police Photo #):			
12.	Applicant's Race (check all that apply): <input type="checkbox"/> Black / African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Other/Unknown: _____			
13.	Applicant's Ethnicity (check all that apply): <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non-hispanic / Latino <input type="checkbox"/> Unknown			

14.	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Mandarin <input type="checkbox"/> Cantonese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hindi <input type="checkbox"/> Cambodian (Khmer) <input type="checkbox"/> ASL <input type="checkbox"/> No language <input type="checkbox"/> Other: _____
15.	Participant's English Proficiency: <input type="checkbox"/> Does not speak <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent
16.	Highest level of education completed: _____

If applicant is hospitalized and being discharged to a different address or if the applicant is homeless and moving into housing, please indicate the address/contact information they will be transferred to:

Telephone #: _____

Section B: Family Contacts

1.	Marital Status: <input type="checkbox"/> Single, never married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Cohabiting <input type="checkbox"/> Divorced / Separated <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____
2.	Status of Applicant's Parents / Family (select all that apply): <input type="checkbox"/> Active Parental / Family Involvement <input type="checkbox"/> Parent / Family Uninvolved <input type="checkbox"/> Applicant has a history of exploitation by Parent / Family <input type="checkbox"/> Applicant does not want family involved <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____
3.	Status of Applicant's Offspring (select all that apply): <input type="checkbox"/> Children <input type="checkbox"/> No children <input type="checkbox"/> Unknown <input type="checkbox"/> Pregnant <input type="checkbox"/> # of Male children: _____ <input type="checkbox"/> # of Female children: _____ <input type="checkbox"/> # of Custodial children: _____ <input type="checkbox"/> Open Case with DHS? Provide DHS Contact Name & Phone #: _____

4. Family/Friend/Emergency contact(s): (Include name, telephone number and relationship)

Name:		Phone:		Relationship:	
Name:		Phone:		Relationship:	
Name:		Phone:		Relationship:	
Name:		Phone:		Relationship:	

Section C: Characteristics

1. Current Living Situation: (Check One) Where does the applicant live currently?

<input type="checkbox"/> State Hospital (NSH / other)	<input type="checkbox"/> Hospital – Psychiatric	<input type="checkbox"/> Hospital – Medical	<input type="checkbox"/> Hospital – detox or rehab
<input type="checkbox"/> Correctional Facility – Prison	<input type="checkbox"/> Correctional Facility – Jail	<input type="checkbox"/> LTSR	<input type="checkbox"/> MH Residence (other than LTSR)
<input type="checkbox"/> Nursing Home	<input type="checkbox"/> IDS / CLA	<input type="checkbox"/> Recovery House	<input type="checkbox"/> PCBH
<input type="checkbox"/> Family Home	<input type="checkbox"/> Independent Living	<input type="checkbox"/> Homeless / Shelter	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other: _____			

Facility Name (if applicable): _____

Address: _____

Length of occupancy (in months): _____

2. Previous Living Situation: (Check One) Where did the applicant live prior to their current living situation?

<input type="checkbox"/> State Hospital (NSH / other)	<input type="checkbox"/> Hospital – Psychiatric	<input type="checkbox"/> Hospital – Medical	<input type="checkbox"/> Hospital – detox or rehab
<input type="checkbox"/> Correctional Facility – Prison	<input type="checkbox"/> Correctional Facility – Jail	<input type="checkbox"/> LTSR	<input type="checkbox"/> MH Residence (other than LTSR)
<input type="checkbox"/> Nursing Home	<input type="checkbox"/> IDS / CLA	<input type="checkbox"/> Recovery House	<input type="checkbox"/> PCBH
<input type="checkbox"/> Family Home	<input type="checkbox"/> Independent Living	<input type="checkbox"/> Homeless / Shelter	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other: _____			

Facility Name (if applicable): _____

Address: _____

Length of occupancy (in months): _____

3. Has the applicant ever been homeless? Yes No

If you answered “Yes” to Question 3, complete the following. (Include dates of the most recent episode of homelessness, provide name of shelter, drop-in center, street, etc., under “Location.” List the most recent locations first)

Date:		Location:	
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Date:		Location:	
Date:		Location:	
Date:		Location:	

4.	Current Employment Status (check one): <input type="checkbox"/> Competitive Employment <input type="checkbox"/> Unknown <input type="checkbox"/> No Employment of any kind <input type="checkbox"/> Other: _____
5.	Income or benefits currently receiving: (check all that apply) <input type="checkbox"/> Wages, salary or self-employed <input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Social Security Retirement, survivor's benefits <input type="checkbox"/> Veteran's Benefits <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Cash Assistance / Food Stamps <input type="checkbox"/> Private Insurance <input type="checkbox"/> Ineligible <input type="checkbox"/> None <input type="checkbox"/> Other: _____
6.	Do you have a representative payee? <input type="checkbox"/> Yes <input type="checkbox"/> No Representative Payee Name: _____ Representative Payee Contact Information: _____

Section D: Criminal Justice Involvement

1.	Criminal Justice Status (check all that apply): <input type="checkbox"/> No criminal history <input type="checkbox"/> No history of probation / parole <input type="checkbox"/> Under supervision of MH court <input type="checkbox"/> Under supervision of probation / parole <input type="checkbox"/> State Incarceration <input type="checkbox"/> County Detention <input type="checkbox"/> NSH - Building 51 <input type="checkbox"/> Megan's Law Registrant
2.	Any prior felony convictions? <input type="checkbox"/> Yes <input type="checkbox"/> No

If "yes" to Question 2, list prior convictions:

Conviction (e.g. Aggravated Assault)	Year (e.g. 1999)

If “yes” to Question 2, what is the approximate total years held in detention / incarcerated? _____

Section E: Clinical

1. Clinical Disorders and other conditions that are a focus of clinical attention.

ICD 10/DSM-V Code	Diagnosis (if none, please indicate)

2. General Medical Conditions:

ICD 10 Code	Diagnosis

3. Life Stressors

ICD Definition of Code /DBHIDS Inclusion Criteria - Social Determinants of Health (SDOH)			
<input type="checkbox"/>	Inadequate housing	<input type="checkbox"/>	Homelessness
<input type="checkbox"/>	Lack of adequate food or safe drinking water	<input type="checkbox"/>	Problem living in a residential institution

<input type="checkbox"/>	Extreme poverty	<input type="checkbox"/>	Victim of crime
<input type="checkbox"/>	Target of (actual or perceived) adverse discrimination or persecution	<input type="checkbox"/>	Imprisonment or other incarceration including arrest and/or conviction
<input type="checkbox"/>	Academic or educational problem	<input type="checkbox"/>	Social exclusion or rejection
<input type="checkbox"/>	Insufficient social insurance or welfare support	<input type="checkbox"/>	Disruption of family by separation or divorce
<input type="checkbox"/>	Unavailability of inaccessibility of healthcare facilities	<input type="checkbox"/>	Unavailability of inaccessibility of other helping agencies
<input type="checkbox"/>	Personal history (past history) of abuse experienced in childhood - includes physical, sexual and neglect	<input type="checkbox"/>	Personal history (past history) of experiencing violence perpetrated by spouse or partner - includes any history or current abuse that is physical, sexual or psychological in nature
<input type="checkbox"/>	Discord with social service providers including probation officer, case manager or social services worker		

3. Current Psychotropic Medications: None prescribed

Name	Dosage	Schedule

4. Current Physical Medications: None prescribed

Name	Dosage	Schedule

5. Adherence to Medication Regimen: (check one)

<input type="checkbox"/>	Takes Medications as prescribed	<input type="checkbox"/>	Participant refuses medication
<input type="checkbox"/>	Takes Medications as prescribed most of the time	<input type="checkbox"/>	Medication not prescribed
<input type="checkbox"/>	Sometimes takes medications	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Rarely takes medications	<input type="checkbox"/>	Unknown

6. List all allergies including drug allergies, environment, food, etc. No Known Allergies

7. What level of support is required for compliance with medication regimen? (check one)

<input type="checkbox"/>	Independent	<input type="checkbox"/>	Reminders	<input type="checkbox"/>	Supervision	<input type="checkbox"/>	Dispensing	<input type="checkbox"/>	N/A
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8. Does the applicant have a medical condition that requires special services such as special medical equipment, medical supplies, ongoing physician support and / or a therapeutic diet? Yes No

If yes describe: _____

9. Name of PCP / Facility: _____ Phone: _____

10. Pharmacy: _____ Phone: _____

11. Medical Tests:

Has Applicant been tested for TB in the past year? Yes No Unknown

Result: Positive Negative

COVID Testing (most recent if multiple testing occurred)? Yes No

Date: _____ Result: Positive Negative

COVID Vaccination? Yes No Date (s): _____/_____/_____

12.	Physical Functioning Level (Check all that apply): <input type="checkbox"/> Fully ambulatory <input type="checkbox"/> Can climb one flight of stairs <input type="checkbox"/> Can bathe self <input type="checkbox"/> Can feed self <input type="checkbox"/> Can dress self <input type="checkbox"/> Needs help toileting
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Section F: Utilization

1. Applicant Services within the last 12 months: (Check all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> CRC
<input type="checkbox"/> State Psychiatric Hospital	<input type="checkbox"/> Detention / Jail / Prison
<input type="checkbox"/> Medical Hospital	<input type="checkbox"/> County Psychiatric Hospital
<input type="checkbox"/> Behavioral Health Residential Placement	<input type="checkbox"/> ACT / Blended Enhanced Services / CM
<input type="checkbox"/> Drug and Alcohol IOP	<input type="checkbox"/> Drug and Alcohol Inpatient Rehab
<input type="checkbox"/> Mental Health Outpatient Therapy	<input type="checkbox"/> Other:

2. Institutional Services utilization including current hospitalization if applicable. (Indicate the number of utilizations for each. Include “0” if none. “UNK” if unknown.)

	Psychiatric Hospitalizations in past 12 months		Psychiatric Hospitalizations - past 24 months
	CRC Visits in past 12 months		CRC Visits in past 24 months
	Arrests in past 12 months		Arrests past 24 months

3. List all psychiatric hospitalizations (including current) and CRC visits within the last two years (This information is required to determine eligibility for service).

Hospital / CRC	Admission / Contact Date	Discharge Date

4. Indicate any mental health or substance use programs the participant attends, had previously attended in the last 24 months, and/or if the program is part of the discharge plan. Indicate whether program is: C = Currently attending or P = Previously attended

Type	Name	Status
Behavioral Health Program		
Substance Use Treatment		
Day Program		
Vocational Program		

Section G: Well Being

1. Co-occurring disabilities: (Check all that apply)

<input type="checkbox"/>	None	<input type="checkbox"/>	Impaired ability to walk	<input type="checkbox"/>	Deaf
<input type="checkbox"/>	TBI / Cognitive disorder	<input type="checkbox"/>	Wheelchair required	<input type="checkbox"/>	Amputee
<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	Blindness	<input type="checkbox"/>	Speech Impairment	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Intellectual Disability *Please indicate source of information regarding status of ID*				

2. Indicate the applicant’s status regarding high risk behaviors. (Check one response for each).

- 0= no known history
- 1= not at all in the past 6 months
- 2= one or more times in the past 6 months, but not in the past 3 months
- 3= one or more times in the past 3 months but not in the past month
- 4= one or more times in the past month but not in the past week
- 5= one or more times in the past week
- U= Unknown

High Risk Behaviors	0	1	2	3	4	5	U
Physical harm to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cutting / self-injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically abused another	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assaulted another	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a victim of sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a victim of physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaged in arson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaged in accidental fire-setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaged in a Homicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experienced Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaged in Disruptive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Does the applicant have a history of substance use? Yes No

Indicate applicant’s status in regard to substance use. (Check one response for each)

0=no known history

1=not at all in the past 6 months

2=one or more times in the past 6 months, but not in the past 3 months

3=one or more times in the past 3 months but not in the past month

4=one or more times in the past month but not in the past week

5=one or more times in the past week

6=daily

U=unknown

Substances	0	1	2	3	4	5	6	U
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana / Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Synthetic Marijuana (K2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin / Opiates / Opioids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack / Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives/hypnotics/anxiolytics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other prescription drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>