

# SMART Tip Sheets TAP Assessment

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## Treatment Assignment Protocol (TAP)

TAP Assessment

TAP Narrative

This Tip Sheet outlines the steps required to complete each section of the TAP Assessment.

**Total Pages: 4**

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IGSR Technical Support: 301.405.4870

Updated: Jan 2012

## TAP Assessment

The TAP is the Treatment Assignment Protocol assessment instrument, required for all ADAA funded clients effective January 1, 2011.

1. **Entry Steps:** Login, select Facility, select Client List, select Client, select Activity List, select Assessments. A list of Assessments will appear on the menu tree.
2. Select **TAP**. This will generate the TAP List Screen. (The List Screen lists all the TAP's completed for this client.)
3. To enter a new **TAP Assessment**, click on the yellow link **Add New Intake TAP** if this is the first TAP Assessment for this client for this episode of care and is completed prior to the ADAA Admission. If the TAP Assessment is completed after the admission, it is a follow-up assessment. Choose **Add New Follow-up TAP**.
4. To review an existing TAP Assessment, on the List Screen click on **Review** under Actions.

SMART QA IGSR

Users: Black, Dovella  
Loc: Middle Earth Treatment Clinic, Gandalf Lane  
Client: Finch, Jeremy | M110355555F1 | Case #: 1

Diagnosics Print View Logout

per 2010

**Treatment Assignment Protocol List**

Date of Interview	Interviewed By	Interview Class	Actions
7/15/2009	Snaveley, Kathleen	Follow-up	Review

**Add New Intake TAP**  
**Add New Follow-up TAP**

**Review**

To enter a New Intake or Follow-up TAP Assessment, click the appropriate link.

To review an existing TAP Assessment, click **Review**.

## TAP Assessment Navigation

- The first screen is the **Client Profile**. This sub-module consist of one screen.
- Yellow highlighted areas must be completed on each screen to in order to save the record. The best way to ensure this is done is to click **Next** at the end of each screen. If all required fields on the screen are not completed the system will not allow you to proceed . You will either have to cancel or complete the highlighted areas . To save the current information and not continue click **Save**.
- All ADAA funded programs are required to complete all fields in the TAP Assessment.
- You can always refer to the menu on the left side of the screen to see the module or sub module for which you are currently entering information.
- Enter the response for each question by selecting the appropriate response from the drop-down box or typing in the text box.
- For certain questions throughout the TAP the system will populate a response based on a response to a previous questions or based on the type of TAP. For example, intake TAPS have an event type of “Placement screening.”

The screenshot displays the 'SMART QA IGSR' interface for a 'Treatment Assignment Protocol Assessment: Client Profile'. The user is identified as Black, Dovella, LSCC, Middle Earth Treatment Clinic, Gandalf Lane, Client: Finch, Jeremy | M110355555F1 | Case #: 1. The client information includes Intake ID: 370995, SSN: 123-77-5559, Client Name: Finch, Jeremy, Client ID: M110355555F1, and DOB: 11/3/1955. The form contains several sections with highlighted fields: 'Interview Date' (7/15/2009), 'Admission Date' (8/12/2007), and 'Event Type' (Admission). Other fields include 'Class' (Follow-up), 'How Long at Current Address', 'Is the Residence Owned by You or Family', 'County of Residence' (Baltimore City), 'Source of Referral' (Drug Court), 'Controlled Environment in Last 30 Days?', 'Primary Payment Source', 'Interviewer' (Snavely, Kathleen), 'Special Code', 'Days Attended AA/NA/Similar Meetings in Last 30 Days', 'Days on Wait List', 'Months Since Discharged from Last Admission', 'Pregnant' (No), 'Race' (Alaskan Native, White), 'Ethnicity' (Not of Hispanic Origin), 'Religious Preference', 'Is This a TAP for Concerned Person' (No), 'Crisis Intervention Date', and 'Placement Screening Date'. The form also features a navigation menu on the left and buttons for 'Cancel', 'Save', and 'Finish' at the bottom right.

## Summary/Narrative

- The **SUMMARY** is the last module of the TAP. It consists of **one screen**.
- When you have completed this screen click **Next**, you will be taken to the **Narrative Report** screen.
- The *Narrative* is produced by SMART using the responses entered in the preceding screens of the TAP. **You may review the narrative for accuracy, and then go back to change responses as needed on previous screens. You can not change the narrative directly.** After clicking “save” you may print the report by clicking “Print Report.”
- Click **Finish** to exit this module.

The screenshot displays the SMART QA ICSR software interface. The top navigation bar includes the user name 'Black, Dovella', location 'Middle Earth Treatment Clinic, Gandalf Lane', and client information 'Finch, Jeremy | M110355555F1 | Case #: 1'. The date is 'October 2010'. The main content area is titled 'Summary/Narrative' and shows the following information:

**Intake ID:** 370996 **Client Name:** Finch, Jeremy **Client ID:** M110355555F1  
**SSN:** 123-77-5559 **DOB:** 11/3/1955 **Gender:** Male

On 10/27/2008 2:00:21 PM client was referred by Drug Court for services as a result of use cocaine.

**Withdrawal**

Client reports no periods of abstinence from alcohol/drug use in the 30 days prior to the Assessment. Client reports no periods of abstinence from alcohol/drug use in the last 6 months prior to the Assessment. Client reports and/or exhibits the following withdrawal symptoms ( Agitation ). Client reports 0 lifetime treatments for alcohol abuse and 0 treatments for drug abuse. During the past 30 days, client reports using alcohol More Than 3 Times Daily. During the past 30 days, client reports using drugs 2-3 Times Daily. Client reports experiencing both alcohol and drug problems in the 30 days prior to the assessment. Client acknowledges a history of alcohol DTs. Client acknowledges a history of drug overdose Client reports sometimes using prescription, over the counter medicines, or alcohol or an illicit drug to relieve withdrawal symptoms. The client reports an increase in tolerance She/he acknowledges having used more of a substance than she/he has intended. She/he reports having experienced a preoccupation with substance use. Client denies a past history of IV drug use. She/he denies using tobacco. Client denies there would be adequate support at home if he/she needed help while detoxifying. She acknowledges other possible addictions detailed further in the Comments section. This interviewer rates the client's need for detoxification services as High.

**Medical**

Client reports 2 hospitalizations for medical problems during her/his lifetime. Client reports last hospitalization for a physical problem as 2 year(s) and 2 month(s) ago. She reports a history or current diagnosis of the following: ( Abscess ). Client reports any chronic medical problems that continue to interfere with her/his life. He/she denies taking prescription medication on a regular basis for a physical problem. Client reports experiencing medical problems in the past 30 days. Client reports ever being diagnosed with Tuberculosis. Client reports 1 hospitalizations in the past 6 months due to an alcohol or drug related problem. This interviewer rates the client's need for medical treatment as being Moderate.

**Co-occurring**

Client reports 1 treatments in a hospital/inpatient setting for psychological or emotional problems. Client denies experiencing serious depression, sadness, hopelessness, loss of interest, or difficulty with daily function during his/her lifetime. Client denies experiencing serious unreasonable worry, or feel relaxed during his/her lifetime. Client denies experiencing hallucinations or saw/heard things that did not exist during his/her lifetime. Client acknowledges experiencing trouble understanding, concentrating, remembering in the past 30 days. Client acknowledges experiencing trouble controlling violent behavior including rage or violence in the past 30 days. Client acknowledges experiencing serious thoughts of suicide in the past 30 days. Client reports attempting suicide in the past 30 days. He/she reports having been prescribed medication for psychological or emotional problems within the past 30 days. Client acknowledges experiencing psychological or emotional problems in the past 30 days. The interviewer finds that the client does not appear to have a psychiatric problem in addition to possible alcohol/drug problem. At the time of the interview, the client did not seem obviously depressed/withdrawn; did not appear obviously hostile; was obviously anxious/nervous. The interviewer noted indicators that the client was having trouble with reality testing, thought disorders and/or paranoid thinking. The client appeared to be having trouble comprehending, concentrating, remembering; She denied suicidal thoughts at present. The interviewer rates the client's level of needs for mental health treatment as being High.

**Alcohol/Drug Usage**

The assessment information suggests that the client's primary problem substance is Alcohol. The client reports his/her age of first use of the primary substance as 12. The interviewer has assessed the client's severity of use as being Moderate Problem/Dysfnc. The client reported her/his frequency of use of the primary substance as 3-6 times per week. Method of administration is reported as Oral. The client reports no evidence of other addictions. She denies having been admitted to substance abuse treatment.

**Employment**

The Client states that his/her education level is 9.

**Legal**

Client denies any history of arrests. The client has been arrested 4 times in the last 12 months. The client has been arrested 3 times in the last 30 days.

**ASAM Level of Care**