

**NEBRASKA GAMBLER ASSISTANCE PROGRAM
GAP-3 URGENT CARE DETAIL**

NAME OF CONTRACTOR: _____

DATE(S) OF SERVICES BILLED: _____

CLIENT DOB:	____/____/____	RESIDENCE OF CLIENT:	YOUR ID FOR THIS CLIENT:	
Client Gender (Check <u>one</u>)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Client Type:	<input type="checkbox"/> Gambler <input type="checkbox"/> Family member
How did this person get your phone number or other contact information? (Check <u>one</u>)	<input type="checkbox"/> Online prevention ads, such as Bear Trap, Snake, or Deck of Cards (BetCareful.com) or online Lifeafterbet ads, such as 'bet, lie . . . bet, bet, bet, lie. . . .'		#Urgent Care hours this month:	_____
	<input type="checkbox"/> GAP Helpline 833-BETOVER (238-6837)		#Urgent Care hours prior months:	_____
	<input type="checkbox"/> Nebraska Council 800-522-4700		Date of conversion to long-term treatment:	____/____/____
	<input type="checkbox"/> Internet search		GAMBLER'S STAGE OF CHANGE	
	<input type="checkbox"/> Family		<input type="checkbox"/> PRE-CONTEMPLATION	
	<input type="checkbox"/> Professional		<input type="checkbox"/> CONTEMPLATION	
	<input type="checkbox"/> This counselor helpline		<input type="checkbox"/> PREPARATION	
	<input type="checkbox"/> Previous client		<input type="checkbox"/> ACTION	
<input type="checkbox"/> Other:		BBGS Score:	_____	

METHOD FOR PROVIDING THIS SERVICE	WHO ASKED FOR THIS SERVICE	
<input type="checkbox"/> In person face-to-face	<input type="checkbox"/> The gambler	<input type="checkbox"/> Intimate domestic partner
<input type="checkbox"/> By telephone	<input type="checkbox"/> Gambler's spouse	<input type="checkbox"/> Other family member
<input type="checkbox"/> By telehealth audio-visual	<input type="checkbox"/> Employer	<input type="checkbox"/> Friend/Co-worker

NATURE OF THE PROBLEMS			
Suicide ideation/Gestures?	Y/N	Risk of criminal action?	Y/N
Financial?	Y/N	Bankruptcy/Foreclosure?	Y/N
Family/Marriage at risk?	Y/N	Danger to others?	Y/N
Employment at risk?	Y/N	In danger from others?	Y/N

RESOLUTION OF THE CONSUMER'S NEEDS			
Referral to emergency services?	Y/N	GAP services explained?	Y/N
Referral to medical care?	Y/N	Referred to other GAP counselor?	Y/N
Will talk again another time?	Y/N	Wait for client to call?	Y/N
Counselor will call to check in?	Y/N	Appointment for assessment?	Y/N

URGENT CARE FORM REVIEWED BY COUNSELOR FOR COMPLETENESS:

Signature: _____

Date: ____/____/____