GAP-3 SCREENING/BRIEF INTERVENTION DETAIL

Name of Counselor:

Month of Service billed:

Residence of client (city):

Client ID:

Client dob:

Client Gender (Check One)

☐ M ☐ F ☐ Other

Who asked for screening:

- ☐ Client
- ☐ Other therapist
- ☐ Judge
- ☐ State/local corrections
- ☐ Federal corrections

Client Type:

- ☐ Gambler
- ☐ Family Member

# of Intervention hours this month:

# of Intervention hours prior months:

Method of providing service:

- ☐ Person-to-person
- ☐ Telephone
- ☐ Telehealth

Results of Screening:

BBGS: **NODS-CLiP:**

Family Member GAM-ANON 20:

If the screen was positive and the client agreed to a Brief Intervention:

What was the primary gambling-related problem the client described?

What was the result of the intervention?

Dates and Times of interventions:

Date (mm/dd/yyyy)	Start (hh:mm)	End (hh:mm)

Signature of Counselor: