

Nebraska Problem Gamblers Assistance Program

GAMBLER DISCHARGE DATA

2024–2025
Contract Year
Rev. May 2024

AGENCY NAME:

DATE: _____ / _____ / _____

CLIENT ID: H I

If your goal for GAP treatment was to quit gambling, were you successful in meeting your goal?			
If your goal for GAP treatment was to gamble without harm, were you successful in meeting your goal?			
What is the primary reason you are ending counseling? (SELECT ONE)	<input type="checkbox"/> I am not ready to change my gambling	<input type="checkbox"/> I met my goals	<input type="checkbox"/> I want to change my gambling on my own
How many hourly sessions did you complete before you knew counseling would help you?	<input type="checkbox"/> 1 - 6 <input type="checkbox"/> 7 - 12	<input type="checkbox"/> 13 - 21	<input type="checkbox"/> 21 +
Did you attend any self-help support groups for people with a gambling problem during counseling?			
Are you interested in finding a self-help support group to help you after counseling has ended?			
Did you request or participate in any telehealth counseling sessions with your counselor?			
Do you feel that your counseling met your needs?			
Will you return to counseling if gambling becomes a problem for you again?			

The following questions ask you to compare your life situation today to when you started counseling:

How would you describe your gambling today compared to when you started counseling?	<input type="checkbox"/> Lower <input type="checkbox"/> No change	<input type="checkbox"/> Higher	<input type="checkbox"/> Not gambling at all
How would you describe your financial status today compared to when you started counseling?	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	<input type="checkbox"/> Better
How would you describe the relationship with your family and friends today compared to when you started counseling?	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	<input type="checkbox"/> Better

Your answers are confidential. Thank you.

THIS SECTION COMPLETED BY COUNSELOR

End of counseling date: _____ / _____ / _____

Date last seen: _____ / _____ / _____

Client has had how many hourly counseling sessions? _____

Date client began long-term counseling: _____ / _____ / _____

End of counseling status:

<input type="checkbox"/> Counseling complete - agency decision	<input type="checkbox"/> Partial completion - agency decision
<input type="checkbox"/> Counseling complete - client decision	<input type="checkbox"/> Partial completion - client decision
<input type="checkbox"/> Counseling complete - agency and client decision	<input type="checkbox"/> Client inaccessible
<input type="checkbox"/> Referred to different counselor or agency. Client referred to:	

DSM 5 Score:	0	1	2	3	4	5	6	7	8	9
(DSM 5 score must match level of gambling severity)										

Counselor's rationale for client's status response:

DISCHARGE FORM REVIEWED BY COUNSELOR FOR COMPLETENESS:

Signature: _____

Date: ____ / ____ / ____