Oklahoma State Department of Health
Health Facility Systems
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SUBSTANCE ABUSE AND PSYCHIATRIC SERVICES MONTHLY REPORT

Month: _____ **Year:** _____

Date _____

Facility ID _____

_____ (___) ___-____
Name of Contact Person (Please print or type.) Contact Telephone

Facility Name

Street City State Zip

Contact email address: _____

0	Youth Psychiatric Beds	0	Youth Substance Abuse Beds
0	Adult Psychiatric Beds	0	Adult Substance Abuse Beds
0	Total Psychiatric Beds	0	Total Substance Abuse Beds

	Inpatient Days†	**(A) Psychiatric**	**(B) Substance Abuse**	**Total (A) + (B)**
	(1a) Youth	0	0	0
	(1b) Adult	0	0	0
2.	**Reserve Days‡**			
	(2a) Youth	0	0	0
	(2b) Adult	0	0	0
3.	**Total Days**			
	(1a+1b+2a+2b)	0	0	0

4. List semi-private rooms rented as private rooms by room number for the entire month. Indicate if the room is adult or youth and psychiatric or substance abuse.

NOTE: Do not report any patient days under contract with the Department of Corrections.

† Days of service excluding reserve days.
‡ Number of days a bed was held for a temporarily absent patient.