EMERGENCY ROOM ENHANCEMENT

Data Dictionary

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MISSOURI DEPARTMENT OF MENTAL HEALTH

MISSOURI COALITION FOR COMMUNITY BEHAVIORAL HEALTHCARE

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Data Collection and Uploading Reports

Data Collection Process:

- The Referral Form, Individual History & Needs Assessment (IHNA), Three Month Follow-Up, Six Month Follow-Up, and Individual Transition Form will each be used at the necessary collection stages.
- To fill out and save the forms, basic Adobe Reader is required.
- When saving each individual's form, they should be named as: first four letters of the individual's last name and first initial of their first name followed by the date of referral. For example, John Smith (referral taken on July 5, 2016) should be saved as **smitj07052016**. Please include leading zeros with single digit months and single digit dates.
- Each site has a designated person(s) to convert these forms to excel at the end of each month and upload them to Citrix ShareFile by the 7th of the following month.
- The monthly excel file to be uploaded should be named **ERE Monthly Report {Region} 2016 {Month}.xlsx**, so the Springfield region's first report for example would be named *ERE Monthly Report Springfield 2016 August.xlsx.*
- The quarterly excel file to be uploaded should be named **Q{ } 2016 {Region}.doc**, so the Springfield region's first report for example would be named *Q2 2016 Springfield.doc.*
- Once they have been uploaded, the Coalition will download the reports from ShareFile for analysis.

To Upload Reports to Citrix ShareFile:

- Login to Citrix ShareFile >> you should receive a "Welcome" email with a link and your login information shortly.
- Your homepage will display your Shared Folders which will include your region folder where both your monthly and quarterly files will be uploaded.
- Upon clicking on your region's folder, you will see the two subfolders: Monthly & Quarterly. By clicking on the desired subfolder, you will then have three different upload options:
    1. Drag and place the file(s) you want to upload over the picture of the folder,
    2. Click on the "Browse Files" link below the picture of the folder in the center of the page and attach your reports you would any other document (such as you do with emails, etc.),
    3. Or click on the "Upload Files" button in the upper right-hand corner of the screen and browse/select the file(s) you would like to upload.

Notes regarding ShareFile:

- Each region has its own folder for these reports that no one else can utilize or view outside of the Coalition and DBH.
- Chrome would be the recommended browser for this tool, if possible. However, some versions of Internet Explorer should work as well.

Referral Form

The Referral Form should be completed for ALL individuals referred for ERE services regardless of eligibility or program retention. Each occurrence for referral for an individual should be documented as a separate referral.

Region: This field will have a drop down prefilled with all regions. This field will autofill into subsequent forms.

- Columbia
- Hannibal
- Kansas City
- Poplar Bluff
- Rolla
- Springfield
- St. Louis

Date of Referral: This field should be the date the referral was made. This field will auto-format to MM/DD/YYYY

Individual Name: This field should be filled with individual's last name, first name, middle initial. This field will autofill into subsequent forms.

DOB: Enter the individual's date of birth. This field will auto-format to MM/DD/YYYY. This field will autofill into subsequent forms.

SSN: This information is used to identify individuals. This information may also be used to identify the correct person when two or more individuals share the same name. This field will auto-format to ###-##-####. This field will auto-format to include dashes. This field will autofill into subsequent forms.

DCN: This information is collected when the individual has been enrolled in Mo HealthNet or CIMOR. If you do not know the DCN or the individual does not have a DCN, please leave blank. This field will require exactly eight characters. If necessary, be sure to add the leading zero. This field will autofill into subsequent forms.

Street Address, City/State/Zip: List the address of the individual. If the individual is homeless, ask them where they receive their mail. This information is used to contact the individual for service coordination.

Phone: Enter the individual's primary phone number, including area code.

Email: Enter the individual's primary email address.

Referred From (optional): The intent of this field is to allow each region to record and track from where each referral was received. This information is for provider use only and is optional.

Referred To (optional): The intent of this field is to allow each region to record and track where referrals are made. This information is for provider use only and is optional.

Sex: The intent of this field is to record the individual's stated sex. This field will autofill into subsequent forms but can be amended on later forms, if necessary.

- Male
- Female
- Intersex (male and female)
- Male to Female
- Female to Male
- Unknown/Refused

Ethnicity: The intent is to ascertain if the individual is Hispanic or Latino. Ethnicity is different from race. For example, an individual can be both Hispanic and African American. This field will autofill into subsequent forms but can be amended on later forms, if necessary.

- Cuban
- Mexican
- Not of Hispanic Origin
- Puerto Rican
- Other Hispanic
- Unknown/Refused

Race: The intent is to determine what race the individual considers themselves. Record the response given by the individual if possible and not your opinion. This field will autofill into subsequent forms but can be amended on later forms, if necessary.

- African American/Black
- Asian
- Caucasian
- Native American
- Other
- Unknown/Refused

Military Status: The intent is to determine whether the individual is currently or has ever served in the U.S. Armed Forces (any branch). Did the individual ever wear the uniform? This field will autofill into subsequent forms but can be amended on later forms, if necessary.

- Currently in Military
- Never in Military
- Veteran
- Unknown/Refused

Housing Status: The intent is to record information about the individual's current living situation.

- Homeless
- Not Homeless
- Shelter Housing
- Transitional Housing
- Unknown

Employment Status: The intent is to determine the individual's current employment status.

- Full time (>35 hours per week, all jobs combined)
- Not in workforce (homemaker, student, retired, disabled, sheltered/non-competitive employment)
- Part time (< 35 hours/week)
- Supported Employment (engaged in an agencies supported employment program)
- Unemployed
- Unknown/Refused

Payer Source: The intent is to determine if the individual has any sort of healthcare insurance coverage.

- DMH (Place of Service funding through DMH)
- Medicaid
- Medicare
- Medicaid and Medicare
- Private Insurance
- Uninsured
- Other
- Unknown/Refused

Law Enforcement Involvement: The intent is to determine if law enforcement made the initial referral to services or was involved in transporting or escorting the individual (only at the time of referral). This does include probation and parole violations. It should only pertain to this encounter.

- Law Enforcement Involvement
- No Law Enforcement Involvement
- Unknown

Reason for Referral: The intent is to capture the main reason for the referral. Examples of each are listed in ( ) and are not all inclusive.

- Chronically Homeless (seeking basic necessities of survival i.e., food, water, shelter, safety, etc.)
- Frequent ER use (non-emergent issues such as seeking medications, primary care issues like cold symptoms, aches and pains, non-descript symptoms)
- Mental Health Crisis (severe depression, anxiety, paranoia, etc.)
- Physical Health Crisis (high blood sugar, blood pressure, exacerbation of COPD/asthma, etc.)
- Substance Use Crisis (substance reaction, unintentional overdose, withdrawal)
- Suicide Attempt/Ideation (suicidal thoughts, planning, or attempt)
- Other

Mental Health Concern at Referral: The intent is to record the individual's primary mental health issue they are currently experiencing, if any. This is not necessarily a diagnosis but a snap shot at the time of referral. If the individual is not displaying symptoms of a mental health issue select "No Mental Health Concern."

- ADD/ADHD
- Alzheimer's
- Antisocial Personality Disorder
- Autism Spectrum Disorder
- Bipolar Disorder
- Borderline Personality Disorder
- DD/Intellectual Disability
- Delusional
- Dementia
- Depression
- Eating Disorder
- OCD
- Panic/Anxiety
- PTSD
- Schizophrenia/Schizoaffective Disorder
- Sleep Disorder
- Other-Psychotic Disorder
- Other
- Unknown
- No Mental Health Concern

Substance Use Concern at Referral: The intent is to record the individual's primary substance use issue they are currently experiencing, if any. This is not necessarily a diagnosis but a snap shot at the time of referral. If the individual is not displaying symptoms of a substance use issue select "No Substance Use Concern."

- Alcohol
- Cocaine
- Hallucinogens
- Heroine
- Inhalants
- Marijuana
- Methamphetamine
- Prescription Opioids
- Prescription Sedatives
- Prescription Stimulants
- Synthetic Drugs
- Other
- Unknown Substance (s)
- No Substance Use Concern

Primary Physical Health Concert at Referral: The intent here is to record the individual's primary physical health issue they are currently experiencing, if any. This is not necessarily a diagnosis but a snap shot at the time of referral. If the individual is not displaying symptoms of a physical health issue select "No Physical Health Concern."

- BMI>25
- Chronic Pain
- Congestive Heart Failure
- COPD/Asthma
- Dental Pain
- Diabetes
- Hepatitis C
- Tobacco Use
- Other
- No Physical Health Concern

Is Individual Deaf/Hard of Hearing:

- No
- Yes
- Unknown/Refused

Program Participation: This field is to capture if the individual *appears* to be eligible or ineligible for ERE services.

- Eligible for ERE services
- Already in ERE services, ineligible (erroneously referred)
- Region specific, ineligible (does not qualify for agency specific program criteria)
- Services unavailable, ineligible (long agency waitlist, staff shortages or funding availably)
- Refused ERE services

Program Participation Notes

MHCPP (1115 Waiver) Referral: This field is to capture if the individual *appears* to be an appropriate referral to the MHCPP.

- Yes
- No
- Unknown

MHCPP Referral Notes (optional)

Notes from Referral Source (optional)

Individual History and Needs Assessment (IHNA)

The Individual History and Needs Assessment (IHNA) should be completed for any individual who wishes and is eligible to receive ERE services. This form may be completed as soon as the individual is found to be eligible – this is an assessment of prior and existing conditions and serves as initial referrals for needed resources.

Region: This field will have a drop down prefilled with all regions. This field will autofill into subsequent forms.

- Columbia
- Hannibal
- Kansas City
- Poplar Bluff
- Rolla
- Springfield
- St. Louis

Date of Assessment: This field should be the date the assessment was made.

Individual Name: This field should be filled with individual's last name, first name, middle initial. This field will autofill into subsequent forms.

DOB: Enter the individual's date of birth. This field will auto-format to MM/DD/YYYY. This field will autofill into subsequent forms.

SSN: This information is used to identify individuals. This information may also be used to identify the correct person when two or more individuals share the same name. This field will auto-format to ###-##-####. This field will auto-format to include dashes. This field will autofill into subsequent forms.

DCN: This information is collected when the individual has been enrolled in Mo HealthNet or CIMOR. If you do not know the DCN or the individual does not have a DCN, please leave blank. This field will require exactly eight characters. If necessary, be sure to add the leading zero. This field will autofill into subsequent forms.

Sex: The intent of this field is to record the individual's stated sex. This field will autofill into subsequent forms but can be amended on later forms, if necessary.

- Female
- Male
- Male and Female (intersex)

- Male to Female
- Female to Male
- Unknown/Not Specified

Ethnicity: The intent is to ascertain if the individual is Hispanic or Latino. Ethnicity is different from race. For example, an individual can be both Hispanic and African American. This field will autofill into subsequent forms but can be amended on later forms, if necessary.

- Cuban
- Mexican
- Not of Hispanic Origin
- Puerto Rican
- Other Hispanic
- Unknown/Refused

Race: The intent is to determine what race the individual considers themselves. Record the response given by the individual if possible and not your opinion. This field will autofill into subsequent forms but can be amended on later forms, if necessary.

- African American/Black
- Asian
- Caucasian
- Native American
- Other
- Unknown/Refused

Military Status: The intent is to determine whether the individual is currently or has ever served in the U.S. Armed Forces (any branch). Did the individual ever wear the uniform? This field will autofill into subsequent forms but can be amended on later forms, if necessary.

- Currently in Military
- Never in Military
- Veteran
- Unknown/Refused

Housing Status: The intent is to record information about the individual's current living situation.

- Homeless
- Not Homeless
- Shelter Housing
- Transitional Housing
- Unknown

Employment Status: The intent is to determine the individual's current employment status.

- Full time (>35 hours per week, all jobs combined)
- Not in workforce (homemaker, student, retired, disabled, sheltered/non-competitive employment)
- Part time (< 35 hours/week)

- Supported Employment (engaged in an agencies supported employment program)
- Unemployed
- Unknown/Refused

Payer Source: The intent is to determine if the individual has any sort of healthcare insurance coverage.

- DMH (Place of Service funding through DMH)
- Medicaid
- Medicare
- Medicaid and Medicare
- Private Insurance
- Uninsured
- Other
- Unknown/Refused

Is individual currently on probation or parole: The intent is to determine if the individual is on probation or parole at the time of referral. We do not expect you to call P & P to obtain this information. If individual refuses to answer, select unknown.

- No
- Yes, Parole
- Yes, Probation
- Unknown/Refused

Mental Health History – check all that apply: The intent is to record all of the individual's mental health diagnoses

- ADD/ADHD
- Alzheimer's
- Antisocial Personality Disorder
- Autism Spectrum Disorder
- Bipolar Disorder
- Borderline Personality Disorder
- DD/Intellectual Disability
- Delusional
- Dementia
- Depression
- Eating Disorder
- OCD
- Panic/Anxiety
- PTSD
- Schizophrenia/Schizoaffective Disorder
- Sleep Disorder
- Other-Psychotic Disorder
- Other
- Unknown

- No Mental Health Concern

Substance Use History – check all that apply: The intent is to determine if the individual has a substance use disorder diagnosis and what substances have been used.

- Alcohol
- Cocaine
- Hallucinogens
- Heroine
- Inhalants
- Marijuana
- Methamphetamine
- Prescription Opioids
- Prescription Sedatives
- Prescription Stimulants
- Synthetic Drugs
- Other
- Unknown Substances
- No Substance Use Concern

Physical Health History – check all that apply: The intent is to record all of the individual's physical health diagnoses

- BMI>25
- Chronic Pain
- Congestive Heart Failure
- COPD/Asthma
- Dental Pain
- Diabetes
- Hepatitis C
- Tobacco Use
- Other
- Unknown
- No Physical Health Concern

Program Need at IHNA: The intent is to document if a referral has been made for this individual to any of the following programs. Examples of each are listed in ( ) and are not all inclusive.

- Community Based Assistance (support groups, religious groups/counseling)
- Crisis Stabilization Services (In-agency crisis centers or housed crisis bed)
- Dental Care
- Developmental Disabilities Services (Independent Living Resource Center, Sheltered workshop)
- Employment Services (Supported or vocational rehabilitation and employment agencies)
- Food Assistance (Food bank/pantry, application for food stamps or grocery budget assistance)
- Housing (Shelters, transitional housing, additional housing resources or financial assistance)
- Mental Health Services (CPRP, any agency or CMHC referrals, individual or group therapy)

- Payer Assistance (assistance with Medicaid/disability/charity application)
- Primary Care (Primary care physicians, Community Health Center, FQHC, rural health clinics, county health department, family planning)
- Psychiatry Services (psychiatrist or psychiatric pharmacist)
- Substance Use Services (CSTAR, Access to Recovery, medication assisted treatment, medically modified detox)
- Transportation Assistance (Public transportation, bus passes, non-emergent medical transportation)

Individual has visited the Emergency Room in the past 3 months: The intent is to determine if the individual has been to the emergency room in the past 3 months for either a mental health, physical health or substance use issue.

Individual has been hospitalized in the past 3 months: The intent is to determine if the individual has been hospitalized in the past 3 months for either a mental health, physical health or substance use issue.

Individual has had law enforcement contact in the past 3 months: The intent is to determine if the individual has had contact with law enforcement in the past 3 months.

Individual's DLA-20© GAF/mGAF score at time of IHNA: The intent is to document the individual's current DLA-20© GAF/mGAf score at the time of the assessment.

Program Eligibility after IHNA: This field is to capture if the individual ***appears*** to be eligible or ineligible for ERE services.

- Eligible for ERE services
- Already in ERE services, ineligible (erroneously referred)
- Region specific, ineligible (does not qualify for agency specific program criteria)
- Services unavailable, ineligible (long agency waitlist, staff shortages or funding availably)
- Refused ERE services

MHCPP (1115 Waiver) Referral after IHNA: This field is to capture if the individual ***appears*** to be an appropriate referral to the MHCPP.
MHCPP has been put on hold temporarily. Please do not fill out this field until further notice*

- Yes
- No
- Unknown

MHCPP Referral Notes (optional)

Notes from Referral Source (optional)

Three Month Follow-Up

The Three Month Follow-Up Form should be completed for any individual who received an IHNA 3 months prior. If the participant is no longer actively engaged in the ERE program, attempts to contact the individual should be made.

Region: This field will have a drop down prefilled with all regions.

- Columbia
- Hannibal
- Kansas City
- Poplar Bluff
- Rolla
- Springfield
- St. Louis

Date of three month follow up: This field should be the date the follow up was made.

Individual Name: This field should be filled with individual's last name, first name, middle initial. This field will autofill into subsequent forms.

DOB: Enter the individual's date of birth. This field will auto-format to MM/DD/YYYY. This field will autofill into subsequent forms.

SSN: This information is used to identify individuals. This information may also be used to identify the correct person when two or more individuals share the same name. This field will auto-format to ###-##-####. This field will auto-format to include dashes. This field will autofill into subsequent forms.

DCN: This information is collected when the individual has been enrolled in Mo HealthNet or CIMOR. If you do not know the DCN or the individual does not have a DCN, please leave blank. This field will require exactly eight characters. If necessary, be sure to add the leading zero. This field will autofill into subsequent forms.

Is individual still actively engaged in ERE services:

- Yes
- No

Housing Status at Follow up: The intent is to determine housing status at the time of follow up.

- Homeless
- Not Homeless
- Shelter Housing

- Transitional Housing
- Unknown

Employment Status: The intent is to determine the individual's employment status at the time of follow up.

- Full time (>35 hours per week, all jobs combined)
- Not in workforce (homemaker, student, retired, disabled, sheltered/non-competitive employment)
- Part time (< 35 hours/week)
- Supported Employment (engaged in an agencies supported employment program)
- Unemployed
- Unknown/Refused

Payer Source: The intent is to determine if the individual has healthcare insurance coverage at the time of follow up.

- DMH (Place of Service funding through DMH)
- Medicaid
- Medicare/Medicaid
- Medicare
- Other
- Private Insurance
- Uninsured
- Unknown/Refused

Was the need identified for any of the following programs *at the time* of the initial history and needs assessment? This column will autofill based on the needs identified when the IHNA was completed.

Was the need identified for any of the following programs *after* the initial history and needs assessment? This column is for any new needs identified between the IHNA and 3 month follow up.

Is the individual currently engaged with any of the following programs? This column is to reflect any resources with which the individual is engaged to meet the corresponding need.

Is the individual's need currently met or stabilized? This column is to reflect any need that was previously identified and now has been met and/or stabilized.

Number of Emergency Room in the past 3 months: The intent is to determine how many visits the individual has had to the emergency room in the past 3 months for a mental health, physical health or substance use issue.

Number of Hospitalizations in the past 3 months: The intent is to determine how many hospitalizations the individual has had in the past 3 months for either a mental health, physical health or substance use issue.

Number of Law enforcement contact in the past 3 months: The intent is to determine how many contacts the individual has had with law enforcement in the past 3 months.

Individual's DLA-20© GAF/mGAF score at 3 months

Notes (optional)

Six Month Follow-Up

The Six Month Follow-Up Form should be completed for any individual who received an IHNA 6 months prior. If the participant is no longer actively engaged in the ERE program, attempts to contact the individual should be made.

Region: This field will have a drop down prefilled with all regions.

- Columbia
- Hannibal
- Kansas City
- Poplar Bluff
- Rolla
- Springfield
- St. Louis

Date of six month follow up: This field should be the date the follow up was made.

Individual Name: This field should be filled with individual's last name, first name, middle initial. This field will autofill into subsequent forms.

DOB: Enter the individual's date of birth in MM/DD/YYYY format.

SSN: This information is used to identify individuals. This information may also be used to identify the correct person when two or more individuals share the same name. This field will auto-format to ###-##-####. This field will auto-format to include dashes. This field will autofill into subsequent forms.

DCN: This information is collected when the individual has been enrolled in Mo HealthNet or CIMOR. If you do not know the DCN or the individual does not have a DCN, please leave blank. This field will require exactly eight characters. If necessary, be sure to add the leading zero. This field will autofill into subsequent forms.

Is individual still actively engaged in ERE services:

- Yes
- No

Housing Status at Follow up: The intent is to determine housing status at the time of follow up.

- Homeless
- Not Homeless
- Shelter Housing

- Transitional Housing
- Unknown

Employment Status: The intent is to determine the individual's employment status at the time of follow up.

- Full time (>35 hours per week, all jobs combined)
- Not in workforce (homemaker, student, retired, disabled, sheltered/non-competitive employment)
- Part time (< 35 hours/week)
- Supported Employment (engaged in an agencies supported employment program)
- Unemployed, actively looking
- Unknown/Refused

Payer Source: The intent is to determine if the individual has healthcare insurance coverage at the time of follow up.

- DMH (Place of Service funding through DMH)
- Medicaid
- Medicare/Medicaid
- Medicare
- Other
- Private Insurance
- Uninsured
- Unknown/Refused

Was the individual engaged with any of the following programs at the 3 month follow up? This column will autofill based on the programs identified as engaged in when the 3 months follow up was completed.

Was the need identified for any of the following programs *after* the 3 month follow up? This column is for any new needs identified between the 3 month and 6 month follow up.

Is the individual currently engaged with any of the following programs? This column is to reflect any resources with which the individual is engaged to meet the corresponding need.

Is the individual's need currently met or stabilized? This column is to reflect any need that was previously identified and now has been met and/or stabilized.

Number of Emergency Room in the past 3 months: The intent is to determine how many visits the individual has had to the emergency room in the past 3 months for either a mental health, physical health or substance use issue.

Number of Hospitalizations in the past 3 months: The intent is to determine how many hospitalizations the individual has had in the past 3 months for either a mental health, physical health or substance use issue.

Number of Law enforcement contact in the past 3 months: The intent is to determine how many contacts the individual has had with law enforcement in the past 3 months.

Individual's DLA-20© GAF/mGAF score at 6 months

Notes (optional)

Individual Transition Form

The Individual Transition Form should be completed when an individual no longer needs or is no longer engaged in ERE services and should reflect the state of the participant at last point of contact. If this form is completed because the individual no longer requires ERE services, attempts for follow up at 3 and 6 months should still be made.

Region: This field will have a drop down prefilled with all regions.

- Columbia
- Hannibal
- Kansas City
- Poplar Bluff
- Rolla
- Springfield
- St. Louis

Date of transition: This field should be the date the follow up was made.

Individual Name: This field should be filled with individual's last name, first name, middle initial.

DOB: Enter the individual's date of birth in MM/DD/YYYY format.

SSN: This information is used to identify individuals. This information may also be used to identify the correct person when two or more individuals share the same name. This field will auto-format to ###-##-####. This field will auto-format to include dashes. This field will autofill into subsequent forms.

DCN: This information is collected when the individual has been enrolled in Mo HealthNet or CIMOR. If you do not know the DCN or the individual does not have a DCN, please leave blank. This field will require exactly eight characters. If necessary, be sure to add the leading zero. This field will autofill into subsequent forms.

Is individual still actively engaged in ERE services:

- Yes
- No

Housing Status at Follow up: The intent is to determine status at the time of follow up.

- Homeless
- Not Homeless
- Shelter Housing

- Transitional Housing
- Unknown

Employment Status: The intent is to determine the individual's employment status at the time of follow up.

- Full time (>35 hours per week, all jobs combined)
- Not in workforce (homemaker, student, retired, disabled, sheltered/non-competitive employment)
- Part time (< 35 hours/week)
- Supported Employment (engaged in an agencies supported employment program)
- Unemployed
- Unknown/Refused

Payer Source: The intent is to determine if the individual has healthcare insurance coverage at the time of follow up.

- DMH (Place of Service funding through DMH)
- Medicaid
- Medicare/Medicaid
- Medicare
- Other
- Private Insurance
- Uninsured
- Unknown/Refused

Reason for completing transition: The intent is to capture the reason this individual no longer is receiving ERE services.

- Can no longer contact individual
- No longer requires services
- No longer primarily ERE services
- Refuses ERE services
- Deceased

Was the individual referred to any of the following resources at the time of the initial history and needs assessment?

Was the individual referred to any of the following resources after the initial history and needs assessment?

Is the individual currently engaged with any of the following resources?

Is the individual's need currently met or stabilized?

- Community based Assistance
- Crisis Services
- Dental Care

- Developmental Disabilities Services
- Employment Services
- Food Assistance
- Housing
- Mental Health Services
- Payer Assistance
- Primary Care
- Substance Use Services
- Transportation Assistance

Number of Emergency Room visits since last contact: The intent is to determine how many visits the individual has had to the emergency room since last contact for either a mental health, physical health or substance use issue.

Number of Hospitalizations since last contact: The intent is to determine how many hospitalizations the individual has had since last contact for either a mental health, physical health or substance use issue.

Number of Law enforcement contact since last contact: The intent is to determine how many law enforcement encounters the individual has had since last contact.

Individual's DLA-20© GAF/mGAF score at time of this follow up

Date of last DLA-20© GAF/mGAF score

Notes (optional)