(b) The data identified in (a) above shall be filed with the Department on a quarterly basis, within 30 days of the close of each calendar quarter.

(c) Licensees shall report to the Department by telephone at (609) 588–7725 or at (609) 392–2020 after hours incidents in which a medical device is connected with the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990, 21 U.S.C. § 360.

8:43A–29.14 Provision of mobile or transportable services by licensed facility

(a) A licensed lithotripsy provider that uses a mobile or transportable lithotripter shall submit an amended license application and shall not provide service using the mobile or transportable lithotripter until the application is approved.

1. The licensed health care facility where the mobile or transportable lithotripsy services will be provided shall be inspected prior to the provision of those services to ensure that all applicable requirements of this chapter and subchapter are met by the licensed health care facility, the licensed lithotripsy provider, or a combination thereof.

(b) A fixed-site licensed lithotripsy facility, seeking licensure of mobile or transportable equipment, shall file an amended licensing application with the Department and provide documentation of the following:

1. The mobile or transportable services provided by the licensee's fixed site licensed lithotripsy facility is integrated with, subordinate to and accountable to the fixed lithotripsy facility in accordance with N.J.A.C. 8:43G–2.11. Where N.J.A.C. 8:43G–2.11 uses the term "hospital" or "hospital-based," that term shall mean the fixed-site licensed lithotripsy facility for purposes of this subchapter;

2. The fixed site licensed lithotripsy facility has written policies and procedures applicable to the mobile or transportable services assuring that the requirements of this subchapter are followed; and

3. The mobile or transportable lithotripter shall not be utilized prior to obtaining specific licensure by the Department. The general facility license shall not be sufficient. Every lithotripter shall be inspected and approved for licensure by the Department, prior to use.

8:43A–29.15 Physical plant; lithotripsy services

The lithotripsy suite of any facility which provides ESWL services shall conform with Chapter 9.1 B through H, of the Guidelines for Construction and Equipment of Hospital and Medical Facilities (The American Institute of Architects Press, 1996–1997 edition, 1735 New York Avenue, N.W., Washington, D.C. 20006) incorporated herein by reference, as amended and supplemented, all applicable equipment manufacturer specifications and shall also satisfy all applicable requirements of this subchapter.

SUBCHAPTER 30. RADIATION ONCOLOGY

8:43A–30.1 Radiation oncology policies and procedures

(a) The radiation oncology service shall have written policies and procedures that are reviewed at least once every three years, revised more frequently as needed, and implemented. These policies and procedures shall include at least:

1. Safety practices;
2. Emergencies;
3. Adverse reactions;
4. Management of the critically ill patient; and
5. Infection control.

(b) The radiation oncology facility's policies and procedures manual shall be available to staff.

(c) There shall be a written protocol for managing emergencies in the radiation oncology suite. All staff shall be instructed in this protocol and know their roles in the case of such an emergency.

(d) The facility shall have written policies and procedures to assure that the psychosocial needs of radiation oncology patients and their families are met.

8:43A–30.2 Radiology oncology continuous quality improvement methods

There shall be a program of continuous quality improvement for radiation oncology which includes regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data.

New Jersey State Library

APPENDIX A

ADA-6
Jan. 91

New Jersey State Department of Health

DRUG AND ALCOHOL ADMISSION RECORD

H-4152

Name of Client (First, Middle Initial, Last) | Social Security Number — — | Telephone Number ( )

Street Address | City | State | Zip Code

1. Provider Number	2. Case # (1st 3rd 1st 3rd)	3. Sex (M/F)	4. Birthdate (mmddyy)	5. In-House Case No. (optional)	6. Admission Date (mmddyy)

IMPORTANT: After completion of above, separate the Admission Record (Parts 1 and 2) from the Discharge Record (Parts 3 and 4)
USE BALL POINT PEN ONLY. All * fields require coded responses; see codes on the reverse side.

7. Client Type*	8. Treatment Setting at Intake*	9. Is use of methadone planned as part of treatment?	10. Resid. Code (Co. Municip)	11. Post Office Zip Code
		1 [ ] Yes 2 [ ] No		

12. Living Arrangements (Check ALL that apply)

A [ ] Alone
B [ ] With Children
C [ ] With Sibling(s)
D [ ] With Parent(s)
E [ ] With Spouse
F [ ] Living as Married
G [ ] With Foster Parent(s)
H [ ] With Other Relative(s)
I [ ] With Friend(s)
J [ ] In Group Quarters
K [ ] Homeless

13. Legal Status (Check ALL that apply)

A [ ] No Legal Problem
B [ ] Case Pending (Criminal)
C [ ] Probation
D [ ] Parole
E [ ] DWI License Suspension
F [ ] Jail/Prison Inmate
G [ ] DYFS/Family Court Case
H [ ] Other-Specify______

14. Household Income Per Year (Enter: 000 if None; 999 if unknown)	15. Household Size (No. of Persons)	16. Race*	17. Indicate Hispanic Origin* (5 if not applicable)
$ ___ ,000			

18. Marital Status*	19. Highest School Grade Completed	20. Is Client a Full-Time Student?	21. Employment Status*	22. Referral Source*
		1 [ ] Yes 2 [ ] No		

23. Number of Past Drug/Alcohol Treatment Episodes: ___ (Enter: 00 if None; 99 if unknown)

24. Self-Help Groups Ever Participated In (Check ALL That Apply)

A [ ] None
B [ ] Narcotics Anonymous
C [ ] Alcoholics Anonymous
D [ ] Other
Specify:______

25. Health Coverage*
A ___
B ___

26. Reimbursement Source*
A ___
B ___
[Agencies receiving public funds should note instructions]

27. Check all drugs USED within the past 6 months

___ A. Alcohol
___ B. Heroin
___ C. Non-Prescription Methadone
___ D. Other Opiates or Synthetics
___ E. Cocaine/Crack
___ F. Marijuana/Hashish
___ G. Methamphetamine
___ H. Other Amphetamines
___ I. Other Stimulants
___ J. Benzodiazepines
___ K. Other Tranquilizers
___ L. Barbiturates
___ M. Other Sedatives or Hypnotics
___ N. PCP
___ O. Other Hallucinogens
___ P. Inhalants
___ Q. Over-the-Counter
___ R. Other

27a. Drugs ABUSED	Primary	Secondary	Tertiary
Drug* (Use code letters at left)			
Route of Administration* (see codes below)			
Frequency* (see codes below)			
Age at First Use (99 if unknown)			

ROUTE CODES:	FREQUENCY CODES:
1 - Oral	1 - Not Used In Past Month
2 - Smoking	2 - Less Than Weekly
3 - Inhalation	3 - 1-2 Times Per Week
4 - Intramuscular/ Sub-Cutaneous	4 - 3 to 6 Times Per Week
	5 - Daily
5 - Intravenous	6 - 2 or More Times Per Day

28. Does Client Smoke Tobacco?
1 [ ] Yes 2 [ ] No

If yes, How many cigarettes per day? ___
No. = (Packs X 20)
Pipe = PP
Cigar = CC

29. SPECIAL USE 5 10 15 20 25 30 35

Name of Agency | Name of Worker

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Jan. 91

New Jersey State Department of Health

DRUG AND ALCOHOL DISCHARGE RECORD

Name of Client (First, Middle Initial, Last)	Social Security Number	Telephone Number
	— —	( )

Street Address	City	State	Zip Code

1. Provider Number	2. Case # (1st 3rd 1st 3rd)	3. Sex (M/F)	4. Birthdate (mmddyy)	5. In-House Case No. (optional)	6. Admission Date (mmddyy)

STOP! - Before continuing, remove tissue carbon which extends at bottom. Use Ball Point Pen ONLY. Press firmly. All * fields require coded responses; see code list on the reverse side.

7. Treatment Setting at Discharge*	8. Date of Admission to Discharge Setting (mmddyy)	9. Date of Discharge (mmddyy)

10. Units of Service (non-residential)

(Days/Sessions) [ ]

11. Units of Service for Codependents Not Reported Separately (0 if None)

(Sessions) [ ]

12. Reason for Termination (Check One)

1 [ ] Treatment Plan Completed
2 [ ] Client Dropped Out
3 [ ] Administrative/Therapeutic Discharge
4 [ ] Deceased
5 [ ] Hospitalized (Medical)
6 [ ] Hospitalized (Psychiatric)
7 [ ] Incarcerated
8 [ ] Other (Specify): ____________

13. Significant Problems and Conditions Present at Admission or Identified During Treatment (Check ALL that apply)

[ ] Not Applicable
A [ ] Mental Health Problem
B [ ] Compulsive Gambling
C [ ] Physical Disability/Handicap
D [ ] Victim of Physical Abuse/Neglect
E [ ] Victim of Sexual Abuse
F [ ] Pregnancy
G [ ] Suicide Attempt
H [ ] Runaway Behavior
I [ ] Neglect/Abuse of Clients' Children
J [ ] Child of Substance Abuser
K [ ] Batterer
L [ ] Criminal Activity
M [ ] Other: ____________

14. Referrals for Alcohol/Drug Treatment at Discharge* (99 if None)

Setting Code [ ]

Non-Agency Referrals (Check ALL that apply)

1 [ ] Employee/Student Assistance Program
2 [ ] Alcoholics Anonymous
3 [ ] Narcotics Anonymous
4 [ ] Family-Oriented Self Help Program
5 [ ] Other Self-Help Program, Specify: ____________

15. Psychiatric Diagnoses (Excluding Drug and Alcohol)
[Required for Mental Health Agencies. Optional for Others.]

A [ ].[ ]

B [ ].[ ]

16. Referrals for Supportive Services (Check ALL that apply)

A [ ] None
B [ ] Clergy
C [ ] Educational
D [ ] Legal
E [ ] Medical
F [ ] Mental Health
G [ ] Public Welfare
H [ ] Pre-Natal
I [ ] Family Services
J [ ] Vocational Rehab.
K [ ] Housing
L [ ] Social Services
M [ ] Employment
N [ ] Food Stamps/Food
O [ ] Women's Center
P [ ] Other ____________

17. Evaluation of Client Goal Achievement* (Each item must be answered)
(Enter Code: A-Achieved, B-Partially Achieved, C- Not Achieved, D-Not Applicable)

1 [ ] Alcohol/Drug Problem
2 [ ] Educational
3 [ ] Psycho/Social
4 [ ] Employment/Vocational
5 [ ] Family Situation
6 [ ] Health
7 [ ] Legal

18. Is Client Using at Discharge:

A [ ] No B [ ] Alcohol? C [ ] Other Drugs?

19. Employment Status* [ ]

20. SPECIAL USE 5 10 15 20 25 30 35

Name of Agency	Name of Worker