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BEHAVIORAL HEALTH & RECOVERY SERVICES ADULT INTIAL PLACEMENT SCREEN

This brief screening instrument is based on ASAM criteria, used for each treatment inquiry to:

1. Rule out necessity for Emergency intervention, and decide between:
2. Referral directly to Outpatient (OP) or Intensive Outpatient (IOP), or
3. Referral to the Residential Treatment Team (RTX team) for further Evaluation

How can we help you today?

_____

_____

(DEMOGRAPHICS)

Today's Date: _____

Client Name: _____

Gender: Male ☐ Female ☐ Trans/Other ☐

SSN #: _____

DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Ok to leave Voicemail? Yes ☐ No ☐

Email: _____

Ok to email? Yes ☐ No ☐

Are you currently pregnant: Yes ☐ No ☐ Unsure ☐

Are you parenting children 17 yrs. old or younger? Yes ☐ No ☐

Are you currently injecting drugs? Yes ☐ No ☐

Name of Insurance Provider: _____

ID# _____ Group# _____

Do you consent to releasing your information to providers we may refer you too today?

Yes ☐ No ☐

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DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

1. Are you experiencing any current severe withdrawal symptoms?

Yes ☐ No ☐

2. May I ask, are you under the influence of any substances right now?

Yes ☐ No ☐

3. If NO: Have you used any substances in the last 1-3 days?

Yes ☐ No ☐

Please describe Substances used / Amount / Frequency / Date of Last Use:

_____

_____

_____

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS

1. Are you having a medical emergency?

Yes ☐ No ☐

2. Do you require any special accommodation? (e.g., wheelchair, sensory impairment).

Yes ☐ No ☐

If YES, please specify:

_____

3. Are you currently taking any medication to treat medical concerns?

Yes ☐ No ☐

If YES, please specify:

_____

_____

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DIMENSION 3: EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS

1. Are you currently having thoughts of hurting yourself or others?

Yes ☐ No ☐

If YES, do you have a plan and the means to harm yourself or others?

Yes ☐ No ☐

2. Are you currently having any severe mental or emotional issues or distress?

Yes ☐ No ☐

If YES, please specify:

_____

_____

3. Are you currently being treated for any mental health conditions?

Yes ☐ No ☐

If YES, please specify:

_____

_____

4. Are you currently taking any mental health medications?

Yes ☐ No ☐

If YES, please specify:

_____

_____

DIMENSION 4: READINESS TO CHANGE

1. Have you been mandated or directed to enter OP/IOP/Residential Treatment?

Yes ☐ No ☐

2. Are you motivated to stop or cut back on your drinking/using?

Yes ☐ No ☐

If YES, please describe what is motivating you:

_____

_____

DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

1. In the last month, have you used substances more often than not?

Yes ☐ No ☐

a. Have you been, or are you currently, in a setting that prevents you from using substances? (e.g., jail, hospital, care facility, etc.)

Yes ☐ No ☐

2. Are you likely to continue to drink/use without treatment?

Yes ☐ No ☐

DIMENSION 6: RECOVERY/LIVING ENVIRONMENT

1. Is your current living situation unsafe or harmful to your recovery?

Yes ☐ No ☐

2. Do you struggle to care for yourself?

Yes ☐ No ☐

LEVEL OF CARE INQUIRY

1. Do you know what type of treatment you're interested in?

Outpatient ☐ Intensive Outpatient ☐ Residential treatment ☐

NRT (Methadone, Suboxone) ☐ Medication Assisted Treatment (Naltrexone, Vivitrol, etc.) ☐

Other: _____

2. Are you interested in learning about other Recovery Supports we have?

Yes ☐ No ☐

PROGRAM:

_____

Staff Printed Name:

_____

Staff Signature:

_____

Date:

_____

Client Printed Name:

_____

Client Signature:

_____

Date:

_____