

SCREENING FORM

VENANGO COUNTY SUBSTANCE ABUSE PROGRAM

Screener Name: _____
Date: _____ Time: _____ Type of Screening: Telephone Face To Face

DEMOGRAPHICS

Name: _____
SSN: _____ DOB: _____
Birth/Maiden name: _____ Phone: _____
Address: _____
Referral source: _____ Phone: _____
Why Referred: _____
Marital Status: Married Never Married Separated Divorced Widowed
 Other: (specify) _____
Sex: M F Race: White Black Alaskan Native
 American Indian Asian or Pacific Islander Puerto Rican Mexican Cuban
 Other Hispanic Other: (specify) _____

ACCESS / ASSESSMENT

Type of access: Emergent (referred for emergent care)
 Urgent (scheduled within two business days)
 Routine (scheduled within five business days)
Date of Assessment: _____ Time: _____
Assessor: _____ Location: SAP office
Rescheduled due to NO SHOW or CANCELLATION (circle one): by CLIENT OR STAFF
No Show Date:
Rescheduled Date: _____ Time _____ Assessor _____
Rescheduled Date: _____ Time _____ Assessor _____
If the assessment cannot be scheduled within the required timeframe, why:
 Client choice SCA/Provider schedule will not permit
Other (specify) _____

DRUG & ALCOHOL

What are you currently using (alcohol/drug)? _____

Last use? _____

How much/how often are you drinking/using? _____

Have you ever used IV drugs? Y N

If yes, when? _____

Are you experiencing any of the following withdrawal symptoms currently? (If the client answers "yes" to this question, he/she must be transferred to a clinical staff person.)

Uncontrollable shaking Hallucinations Seizures Nausea/Vomiting Severe cramps

Other: (specify) _____

Have you ever experienced any of the above symptoms? If so, explain: _____

Have you ever received drug/alcohol treatment or services? Y N

If yes, most recent? _____

Type: Outpatient Intensive Outpatient Partial Halfway House Detox

Inpatient Hospital-based Long-term Methadone/LAAM/Buprenorphine

Community Support Groups

Other (specify): _____

PSYCHIATRIC

Are you having any thoughts of harming yourself or others currently? Y N (If the client answers "yes" to this question, he/she must be transferred to a clinical staff person.)

Suicide plan: _____

Ability to contract for safety: _____

Thoughts to harm others: _____

Plan to harm others (*note: there is no "duty to warn" as per D&A regulations*): _____

Have you ever received mental health services? Y N

If yes, most recent? _____

Type: Inpatient Outpatient

Other: (specify) _____

Was medication prescribed? Y N If yes, specify: _____

If yes to these questions, refer to **Mental Health Base Service Unit: 677-1336** or
Protective Service Unit: 676-4545

MEDICAL

Do you currently have any medical issues? Y N

If yes, describe: _____

Are you currently taking any prescribed medications? Y N

If yes, what? _____

Are you currently experiencing any medical problems that you feel may require emergency care? Y N (*If the client answers "yes" to this question, he/she must be referred to a clinical staff person.*)

If yes describe: _____

PRENATAL/PERINATAL

Not Applicable

Are you pregnant? Yes No If yes, how far along? _____

Are you receiving prenatal care? Yes No

Have you given birth within the last twenty-eight days? Yes No

Are you experiencing any complications that you feel may require emergency care?

Yes No

(*If the client answers "yes" to this question, she must be transferred to a clinical staff person.*)

If yes, explain: _____

EMPLOYMENT / FUNDING / LEGAL

Are you employed? Yes No Employer ? _____

Do you receive SSI or SSDI ? (circle one)

Do you have Medical Assistance? Yes No

Do you have health insurance? Yes No Specify: _____

Are you a veteran? Yes No Other funding sources? (specify) _____

Are you involved with the criminal/juvenile justice system? Yes No

If yes, what is your status? _____

Do you have any pending charges? Yes No If yes, specify: _____

REFERRAL FOR EMERGENT CARE SERVICES

****SCREENER****

Is there a need for a referral for emergent care services? Yes No Reason: _____

If yes, where? _____

PRIORITY POPULATIONS / SPECIAL NEEDS

Pregnant IVDU Pregnant substance abuser IVDU

Do you have any special needs? Yes No If yes, explain: _____ Woman w/ children

→ _____ Number of children under 18 _____ Number living with you _____

Adolescent – will parent/caregiver be coming with you? Yes No

Parent/caregiver name: _____

INSTRUCTIONS TO CLIENT:

PLEASE MAKE SURE TO BRING YOUR INCOME VERIFICATION TO YOUR INTAKE APPOINTMENT. THE INFORMATION INCLUDES EITHER 3 CONSECUTIVE PAY STUBS, 2 WOULD BE ALL RIGHT EVEN 1 IF THAT IS ALL YOU HAVE OR YOUR MOST RECENT TAX RETURN. IF YOU ARE ON MEDICAL ASSISTANCE OF MEDICARE MAKE SURE YOU BRING YOUR CURRENT CARD. IF YOU HAVE PRIVATE INSURANCE PLEASE BRING IN A SIGNED INSURANCE FORM AND YOUR CARD. IF YOU ARE ON SSI OR SSDI, THE SSI OR SSDI FORM OR COPY OF THE INSURANCE CARD IS NEEDED. IF YOU DO NOT HAVE ANY INCOME OR INSURANCE AND DO NOT HAVE YOUR MEDICAL ASSISTANCE CARD, YOU MUST GO TO THE WELFARE OFFICE AND APPLY FOR IT BEFORE YOU HAVE YOUR ASSESSMENT.

VERIFICATION OF RESIDENCY: DRIVER'S LICENSE, INCOME TAX RETURN, UTILITY BILL, NO PERSONAL CORRESPONDENCE, ETC.

- WE ARE LOCATED IN THE COUNTY EXCHANGE BUILDING ON THE THIRD FLOOR. OUR ADDRESS IS 1283 LIBERTY STREET, FRANKLIN, PA.**
- IF AN EMERGENCY SHOULD ARISE OR YOU NEED SOMEONE TO TALK WITH, FEEL FREE TO CALL EMERGENCY SERVICES. THEY ARE THERE FOR YOU 24 HOURS A DAY. TO REACH THEM, YOU MAY CALL (814)-676-4545.**
- EVERYTHING HERE IS CONFIDENTIAL. WE DO NOT RELEASE ANY INFORMATION TO ANY ORGANIZATION OR OTHER PERSONS UNLESS A RELEASE FORM IS SIGNED. WE DO NOT REVEAL OUR AGENCY NAME UNLESS WE TALK DIRECTLY TO YOU. ALL RECORDS ARE KEPT LOCKED.**

ASSESSOR: **NEW** **OLD** **FILE**

INTAKE PERSON:

- 1.) PUT IN CAMSOFT
- 2.) COPY OF FACE SHEET FOR CLERICAL
- 3.) SEND LETTER TO CLIENT YES
 NO, NOT ENOUGH TIME