ADULT Initial Screening/Intake Instruction Form

REQUIRED FORM:

This form is required within the client file

WHEN: Form to be completed by Therapist/Counselor with the client, during the Screening/Intake Admission process for adult clients in SUD programs.

PURPOSE: To determine possible admission of a client into a SUD treatment program and appropriate level of care. Increased collaboration between Therapist/Counselor and client by use of Motivational Interviewing techniques will result in a more comprehensive and useful screen/intake.

REQUIRED ELEMENTS:

- **Client Name:** Enter "Client Name", hit tab to get to "Client ID #", *once you hit tab again to get to the next field, the client name and ID will populate on the rest of the pages.*
- **Client ID#:** Client ID number as determined by agency guidelines.
- **Staff Completing the Form:** Name of staff completing the screening/intake.
- **Place of Screening/Intake:** Location of screening/intake (jail, program, etc.)
- **Date of Screening/Intake:** Date of screening/intake.
- **Referral source:** Referral source name (Probation, CWS, Parole, etc.) and contact information (contact person, phone number, address, etc.).

PERSONAL INFORMATION

- **Name:** Client's first name, middle initial and last name. (Obtain copy of legal ID, if available)
- **Age:** Client's age.
- **Social Security Number:** Client's social security number (obtain a copy of card, if available). If client does not have a social security number, follow your agency guidelines.
- **Birth Date:** Client's month/day/year of birth.
- **Phone Number:** Client's phone number.
- **Ok to leave a message:** Check the appropriate box.
- **Preferred language:** Client's preferred language.
- **Address:** Client's current, physical address. If client is homeless, document "homeless" and address issue on ASAM Dimension 6: Recovery Environment.
- **What are the main reasons you are seeking help here today?** Write in clients own words, ask client to prioritize based upon importance/risk.
- **Gender Identity:** Check the appropriate box. If "OTHER", write in client's own words specifics.
- **Sexual Orientation:** Check the appropriate box. If "OTHER", write in client's own words specifics.
- **Veteran Status:** Check Yes or No.
- **Pregnant /Due date:** Client's pregnancy status.
    - If pregnant, complete due date. Inform client they may be asked to provide documentation such as proof of pregnancy.

- **Number of Children Under 18:** Complete client's number of children under the age of 18. Programs requiring additional information may refer to "Supplemental A: Minor Children Information Form."
- **Medi-Cal:** Check Yes or No.
    - If yes, complete Medi-Cal card number. Inform client they may be required to provide proof of Medi-Cal eligibility. Follow agency guidelines for Medi-Cal eligibility.
- **Health Insurance:** Check Yes or No.
    - If yes, complete Insurance Company's name. Inform client they may be required to provide proof of insurance. Follow agency guidelines for health insurance eligibility.
- **Medically Assisted Treatment:** Check Yes or No.
    - If yes, list medication(s) and name of program client receives the medication. (Note: Post COSD-ODS, services may become billable).
- **Have you ever been arrested/charged/convicted/registered for arson?** Check Yes or No.
- **Have you ever been arrested/charged/convicted/registered for a sex crime(s)?** Check Yes or No.
- **Emergency Contact Information:** Name, relationship, and contact number of designated emergency contact.

ALCOHOL AND/OR OTHER DRUG USE

- **Alcohol and/or other drug use:** Fill in *ALL* prompts within the boxes, document with N/A or "client denies" within boxes as appropriate. *DO NOT LEAVE ANY BOXES BLANK.*
- **Have you used needles in the Past 12 Months:** Check Yes, No, or decline to state.
    - If yes, specify date.
- **Date last used any drugs including alcohol:** Enter date.
- **Number of days in a Row using:** Complete the number of consecutive days the client has been using alcohol and/or other drugs, up to the last date used.
- **How long do you think you have had a problem with alcohol and/or other drugs?** Enter in clients own words.

ALCOHOL AND/OR OTHER DRUG TREATMENT HISTORY

- **Have you received treatment for alcohol and/or other drugs in the past?** Check Yes or No.
    - If yes, specify in the boxes below; Type of Treatment, Name of Treatment Facility, Dates of Treatment, and if treatment was completed. *DO NOT LEAVE ANY FIELDS BLANK.*

ASAM DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

- **History of serious withdrawal, seizures, or life-threatening symptoms during last withdrawal:** Check Yes or No.
    - If yes, describe in detail using clients own words.
- **Are you currently experiencing withdrawal symptoms, tremors, excessive sweating, rapid heart rate, blackouts, anxiety, vomiting:** Check Yes or No.
    - *If yes, immediately follow agency policy and procedure for further medical evaluation of client.*
- **Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, and Withdrawal Potential):** Follow the prompts and check the current, assessed level of risk.

ASAM DIMENSION 2: BIOMEDICAL CONDITIONS/COMPLICATIONS

(Therapist/Counselor to review the Health Questionnaire and TB Questionnaire in your determination below)

- **Are you currently taking prescription medications for any medical conditions:** Check Yes or No.
  - If yes, describe in detail.
- **Severity Rating – Dimension 2 (Biomedical Conditions and Complications):** Follow the prompts and check the current, assessed level of risk. (Include review of Health Questionnaire and TB Questionnaire in your determination).

ASAM DIMENSION 3: EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS/COMPLICATIONS

(Review Risk Assessment and Co-Occurring Screening from for historical information relevant to this dimension include as a part of your assessment of severity below)

- **Do you have current thoughts of hurting yourself or others?** Check Yes or No.
  - *If yes continue questions per your agency policy and procedures to include additional screens, and assessment if client has a plan or means to harm self or others. Document client responses and respond according to your agency policy and procedure.*
- **Are you currently being treated or sought help in the past for a mental health condition (Depression, Anxiety, PTSD, Bipolar, other mental health condition):** Check Yes or No.
  - If yes, describe in detail. (Include as much information as possible; who, what for, where, when, was treatment helpful or not, was treatment completed or not.
  - If yes to above, are you currently prescribed medications**:** Check Yes or No.
  - If yes, describe in detail.
- **Do you feel like you are unable to care for yourself (hygiene, food, clothing, shelter, etc.)?** Check Yes or No.
  - If yes, describe in detail.
- **Do you currently have a Therapist and/or Psychiatrist?** Check Yes or No.
  - If yes, provide contact information to include; name, agency, address, and contact number/email.
- **Over the past 2 weeks, how often have you been bothered by any of the following problems:** Check *ALL* the following six questions with either: Not at all, Several Days, More Than Half the Days, Nearly Every Day. *DO NOT LEAVE ANY QUESTIONS BLANK*.
- **Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications):** Follow the prompts and check the current, assessed level of risk. (Review Co-Occurring Conditions Screening Form for historical information relevant to this dimension)

ASAM DIMENSION 4: READINESS TO CHANGE

- **How long do you think you have had a problem with alcohol and/or other drugs?** Document client self-report in as much detail as possible, in client's own words.
- **Have you tried to stop drinking/using before? If so, what interfered with your success with that goal?** Document client self-report in as much detail as possible in client's own words.
- **Do you intend to reduce or quit drinking/using in the next 2 weeks?** Check appropriate box.
- **What substance(s) are you willing to stop using?** Document client self-report in as much detail as possible.
- **What would be helpful for you now in order to change your drinking/using?** Document client self-report in as much detail as possible using client's own words.
- **What is the possibility that 12 months from now, you will not have a problem with alcohol and/or other drugs?** Check the appropriate box.

- **How important is it for you to receive treatment for Alcohol Problems:** Check the appropriate box.
- **How important is it for you to receive treatment for Drug Problems:** Check the appropriate box.
- **Severity Rating – Dimension 4 (Readiness to Change):** Follow the prompts and check the current, assessed level of risk.

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

- **What's the longest period of time that you have gone without using alcohol and/or other drugs?** Document client self-report.
- **If you previously stopped using alcohol and/or other drugs, what are the reasons you started using again?** Document client self-report in as much detail as possible using clients own words.
- **Are you aware of your triggers to use alcohol and/or other drugs?** Check Yes or No.
    - If yes, list triggers.
- **What are some coping tools you have used in the past to avoid using?** Document client self-report in as much detail as possible.
- **Severity Rating – Dimension 5 (Relapse, continued Use, or Continued problem Potential):** Follow the prompts and check the current, assessed level of risk.

ASAM DIMENSION 6: RECOVERY ENVIRONMENT

- **Are you homeless or at risk?** Check Yes or No.
    - If yes, obtain additional information; how long, do you have a caseworker, would you be interested in a referral and linkage with housing services, has this/will this be a barrier to your receiving/continuing with services? Enter living situation.
- **Are you currently employed?** Check Yes or No.
- **Vocational/Educational Achievements (Highest grade level completed, training or technical education, etc.):** List and attempt to make the list all inclusive.
- **Do you have friends and/or family that are supportive of your seeking treatment for problems related to substance use?** Check Yes or No.
    - If yes, describe: what do the friends/family of the client do that he/she feels is supportive? Are they currently involved in the client's life?
- **Do you have friends and/or family that might interfere with your treatment for problems related to substance use?** Check Yes or No.
    - If yes, describe how might they interfere in your treatment; has this happened in the past?
- **PO Contact Name and Phone Number:** Enter information or N/A
- **Pending Court Date(s):** Check Yes or No.
    - If yes, enter reason and date(s).
- **Are there any transportation, child care, housing or employment issues that could interfere with your treatment for problems related to substance use?** Check Yes or No.
    - If yes, describe: is the client able to problem solve these issues so they are not a barrier to treatment.
- **Severity Rating – Dimension 6 (Recovery Environment):** Follow the prompts and check the current, assessed level of risk.

PROVISIONAL DIAGNOSIS

(Residential Programs must provide a provisional diagnosis to obtain authorization. Outpatient Programs may provide a provisional diagnosis. All modalities must complete the rest of this page).

- **Enter DSM-5 Diagnostic Label(s):** Ensure to utilize label and code; a diagnosis of Substance Use will be the primary and listed first. There can be additional DSM-5 Diagnostic Labels listed as well, but will need to follow the SUD label if appropriate.
- **READ LEVEL OF CARE DEETERMINATION INSTRUCTIONS ON THE FORM.**
- ***Optional Risk Rating Summary****: (provided to the left of the Level of Care Determination Instructions) Optional to enter risk ratings for each of the 6 dimensions here.*
- **Recommended Level of Care: Enter ASAM LOC that offers the most appropriate treatment setting given the client's current severity and functioning:** Read "Level of Care Determination Instructions" above. Based on the ASAM risk ratings, enter client's recommended level of care.
- **Actual Level of Care:** Enter next appropriate level of care if a level of care other than the recommended level of care above is provided.
- **Reason for Discrepancy (Clinical Override):** Check reasons for discrepancy between level of care recommendation and level of care provided. Document an explanation of the reason(s) on the line provided. Put N/A if not applicable.
- **Designated Treatment Provider Name/Location:** Enter information of where client will receive services.
- **A Face to Face interaction occurred between both AOD and LPHA to validate medical necessity:** Enter the date of the face to face interaction, if applicable.
  Note: If a LPHA does not conduct the screening, a face-to-face interaction must take place, at a minimum, between the AOD counselor who has completed the screening for the client and the medical director, licensed physician, or LPHA. The medical director, licensed physician, or LPHA must document the date when the face-to-face interaction took place and then sign and date the screening form.
- **AOD Therapist/Counselor Name:** Print name, signature, credentials, and date, if applicable.
- ***LPHA Name:** Print name, signature, credentials, and date.

**Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LPC), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.*