Universal Screening Questionnaire

ALL QUESTIONS MUST BE ANSWERED. NO BLANKS

All documentation regarding recent evaluation(s), PPD results and recent physical must be included with screen in order to be processed.

Check One: ☐ ACC ☐ Stabilization/ Rehabilitation ☐ Reintegration

Date: Name:_____ Phone Number:

Emergency Contact/Phone: _____ Permission to Contact:

Homeless? Address (if homeless, last known address): _____

DOB: / / Age: Male/ Female/Other Social Security Number:

Current/Former FLACRA Client? When/Where: Own transportation available:

verified in 10e11 ☐

Who is referring you? Are you a Veteran or Currently Service in the Military?

If yes, do you have a DD-214 or NGB-22 Document?

High Priority (Y or N)			
Pregnant	IV User	Homeless	Losing Children

If Pregnant, due date: _____

Insurance (Check all that apply)

____No Insurance
____ Medicaid CIN # _____
____ Managed Care Provider_____
____ Medicare
____ Private Provider_____

Funding (Check all that apply)

____DSS County _____ _____Cash Assistance/Section 8 _____Food Stamps
_____SSD/SSI Monthly Award _____
_____Unemployment Weekly Income _____

Current Client Information
Social Factors

Current living situation (w/ friends/family, alone, bed to bed, car, etc.): Is it a safe place?

Do you have Friend or Loved one who has been affected by your SUD?

Can our Family Navigators contact them? Contact information: _____

Probation/Parole/Drug Court (type/county/PO Name):

Current legal issues: Upcoming court dates?

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Registered sex offender? ***If yes, what level?**

Verified status via National Sex Offender Website @ https://www.nsopw.gov/ ☐ **Yes** ☐ **No**

*** Status must be verified before acceptance of referral packet. If website indicates a different status, then what client reported please indicate clients SO status (level) _____.**

*** If yes, program will need documentation regarding restrictions attached to this form.**

Current Usage

(If substance is prescribed, please specify)

Drug of Choice:

Route:

Age of first use:
Pattern of use - How much (mgs, oz, bags, $):
How often:
How long using AT THIS RATE:
Pattern of use in the past 30 days:
Most recent use: Date / / how much:
Longest period of abstinence and date of abstinence:

Other Drug:

Route:

Age of first use:
Pattern of use - How much:
How often:
How long using at this rate:
Pattern of use in the past 30 days:
Most recent use: Date / / how much:
Longest period of abstinence and date of abstinence:

Other Drug:

Route:

Age of first use:
Pattern of use - How much:
How often:
How long using at this rate:
Pattern of use in the past 30 days:
Most recent use: Date / / how much:
Longest period of abstinence and date of abstinence:

Nicotine (Specify type):

Age of first use:
Pattern of use - How much:
How often:

Withdrawal Symptoms

Currently Experiencing:

History of other withdrawal symptoms:

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Current Medical Information

Do you use a cane, walker, or wheelchair? If yes, which?

Do you have any medical equipment (Oxygen, CPAP Machine, etc.)?

Able to complete activities of daily living independently? (Shower, dress, ability to walk, etc.):

Seizures? Last seizure: Seizure Disorder or due to withdrawal?

Current Hallucinations? Audio/ Visual/Both Last episode:

Medical Detox? Complications? If yes, explain:

Current medical conditions (Diabetes, Hep C, COPD, etc.):

Hospitalization or Emergency room visits in the past 6 months (when and reason for visit):

Recent blood testing? If yes, when and location:

Have you recently been tested for communicable disease?

Are you experiencing chronic pain? If yes, are you receiving treatment for pain management?

Food/Drug Allergies:

Current Prescribed Medication	**Last day took medication**	Used for / mgs / how often	Bringing medication

**If on Methadone, what clinic prescribes it?

**Explain to client that we will need them to go to their clinic and sign a consent in order for FLACRA to speak with the provider to coordinate medication and admission.

Current Mental Health Status

Current mental health conditions:

Any recent hospitalizations: Do you have a Mental Health Provider:

Current suicidal thoughts: *If yes -Do you have a plan?

If yes, ask the client to hold and have another staff call 911. Keep the client on the phone until Emergency Responders arrive at the client's location. Document everything.

Any recent suicide attempts: Date of attempt: Method:

Why would you like to come to our program?

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Historical Information

Past Drug Use –

Past Medical/ Surgical History –

History of Medical Conditions –

History of Hospitalizations –

History of MH/ Aggression –

History of Suicidal Thoughts/ Attempts –
Have you been previously hospitalized?

Completed By: **Date:**

COVID-19 Questionnaire

1. Have you traveled outside of NYS or near a Red Zone in the last 14 days?

☐ **YES** ☐ **NO**

2. Have you had contact with any Persons Under Investigation (PUIs) for COVID-19 within the last 14 days, OR with anyone with known COVID-19?

☐ **YES** ☐ **NO**

3. Do you have any symptoms of COVID-19 (e.g., cough, sore throat, fever, shortness of breath, unexplained nausea, vomiting or diarrhea)?

☐ **YES** ☐ **NO**

Client's name: _____

Staff Signature: _____ Date: _____

Authorized Items Allowed During Treatment –

Please Bring: Limited drop offs allowed.

3-5 Days' Worth of Weather Appropriate Clothing, if admitting to detox. If admitting to stabilization/ rehabilitation, make sure you have at least 2 weeks' worth of clothes (we have laundry on site). Anything that does not fit into the space provided in the clients' room, will be brought to storage.

No more than 1 suitcase will be stored on FLACRA property during your treatment stay.

Medications in Original Containers
Hard Candy (Individually wrapped) – unopened in original packaging
Nail Polish or Remover – these items will be stored in BHT office when not in use
Clippers, Razors, Shavers – these items will be kept in the safe on the unit when not in use.
Shower Shoes/ Flip Flops
Nail Clippers, Tweezers
Insurance Card/ID
*****All Clothing will be run through a dryer on HIGH HEAT for 40 MINUTES*****

Items Not Allowed During Treatment:

Aerosol Cans (Hairspray, Body Spray, Etc.)
Baby Powder
Blankets, Pillows, Towels, Stuffed Animals
Cell Phones, Chargers, Cameras, Pagers
Earphones
Food or Beverages
Hats (cannot wear hoods up)
iPod, MP3 Players, CDs, iPad, and Tablets
Q-Tips and Cotton Balls
Revealing clothing
Dumbbells/ free weights/ exercise equipment

Items that will be Destroyed upon Admission:

Cigarettes
Tobacco
Lighters/Matches
E-Cigarettes
E-Cig Batteries
E-Juice
Drug Paraphernalia
Drugs
Loose Medication
Non-Prescribed Medication
Scissors, Weapons, Knives
Products Containing Alcohol
Pornographic Materials
Perfume, Cologne, Scented Oils, Patchouli, Etc.
Personal Hygiene Products – These will be provided.