Universal Screening Assessment

Please answer all questions. If faxing, 315-462-6960.

If possible, please include documentation of recent evaluation(s), PPD results and recent physical.

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:

Who is referring you? Have you ever served in the military?

Prefer VA program? 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 _____

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?

Registered sex offender? If yes, what level? Still on parole/ probation?
***Will need documentation regarding restrictions.**

Finger Lakes Area Counseling & Recovery Agency FLACRA Together We Will

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Usage History

(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:

Medical History

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

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

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

Hallucinations? Audio/ Visual/Both Last episode:

Medical Detox? Complications? If yes, explain:

Current medical conditions:

Past medical/surgical history:

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

Recent blood testing? If yes, when and location:

Tested positive for HIV/AIDS/TB/Hep C or any other 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
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N

**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.

Mental Health History

Current mental health conditions:

Past mental health history/hospitalizations: 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.*

History of suicide attempts: Last attempt: Method:

Why would you like to come to our program?

Completed By: **Date:**

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Please Bring: Limited drop offs allowed.

3-5 Days' Worth of Weather Appropriate Clothing

Medications in Original Containers

Hard Candy (Individually wrapped)

Items Not Allowed:

Aerosol Cans (Hairspray, Body Spray, Etc.)

Baby Powder

Blankets, Pillows, Towels, Stuffed Animals

Cell Phones, Chargers, Cameras, Pagers

Clippers, Razors, Shavers

Earphones

Food or Beverages

Hats (cannot wear hoods up)

iPod, MP3 Players, CDs, iPad, and Tablets

Nail Clippers, Tweezers

Q-Tips and Cotton Balls

Revealing clothing

Scissors, Weapons, Knives

Products Containing Alcohol

Pornographic Materials

Perfume, Cologne, Scented Oils, Patchouli, Etc.

Personal Hygiene Products – These will be provided.

Nail Polish or Remover

Shower Shoes/ Flip Flops

Insurance Card/ID

*****All Clothing will be run through a dryer on HIGH HEAT for 40 MINUTES*****

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

Last revised – April 2021 CC

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: _____