Possible Admit

Prescreen Template

MOTS INFORMATION

Legal First Name:_____**Legal Middle Name or Initial:**_____

Legal Last Name:_____**Last Name at Birth:**_____

DOB: _____ **Zip Code:**_____**State:**_____ **County:** _____

Living Arrangements: ☐ Private residence ☐ Oxford House/Sober living ☐ Residential Facility ☐ Transient/Homeless ☐ Other

Primary language, other than English: ☐ None ☐ Other:_____**Need Interpreter?** Yes or No

Race: ☐ Alaska Native ☐ American Indian ☐ Black or African American ☐ White ☐ Asian ☐ Pacific Islander ☐ Other single race ☐ Two or more races:_____

Ethnicity: ☐ Cuban-Hispanic(no specific origin) ☐ Mexican ☐ Not of Hispanic origin ☐ Puerto Rican ☐ Hispanic (specific origin) ☐ Unknown

Gender: Male, Female or Other **Marital Status:** ☐ Divorced ☐ Married (or living as married) ☐ Never married ☐ Separated ☐ Unknown ☐ Widowed

Number of dependents (Client=1 dependent):_____ **Number of dependents under 18**:_____

Veteran: ☐ No ☐ No (current or former guard/reserve military) ☐ Unknown ☐ Yes (veteran and current/former guard/reserve military) ☐ Yes (veteran and current/former active duty military) ☐ Yes (veteran and unknown branch)

Highest Grade of School Completed:_____

Employment status ☐ Full time ☐ Part time ☐ Student ☐ Homemaker ☐ Retired ☐ Disabled ☐ Hospital patient ☐ Other ☐ Unemployed(looking for work) ☐ Not in labor force(not looking) ☐ Unknown

Most prominent form of income: ☐ SSDI/Disability ☐ None ☐ Other ☐ Public assistance ☐ Retirement/Pension/SSI ☐ Unknown ☐ Wages/Salary

Select all expected forms of payment: ☐ Self pay ☐ Medicare ☐ Medicaid/OHP ☐ AMH County financial assistance agreement ☐ Other government payment, other than AMH county FAA (Non-Medicaid) ☐ Workers compensation ☐ Private health insurance ☐ No charge (free, charity, special research or teaching) ☐ Other ☐ Unknown

Estimate Gross Monthly Income:_____ **Primary Insurance:** ☐ Medicaid/OHP ☐ Medicare ☐ None ☐ Other ☐ Private Insurance/managed care organization ☐ Unknown

Prime insurance ID:_____

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ENTER THE BELOW INFORMATION IN CLIENT PROFILE

Social security number: _____

Phone: _____ Msg.phone:_____

Address: _____

Are you looking for services? Yes/No
May I ask you a few questions that may be a little sensitive so it will allow me to better assist you? Yes/No
Are you thinking about hurting yourself or others? Yes/No
If yes:
1. Do you have a plan? Yes/No
2. Do you *a.* feel comfortable continuing with this prescreen for detox services, which might take 10 minutes or so, **OR** *b.* do you feel you need to talk to a crisis worker before we complete this prescreen?

If a, "Okay I will check in with you at the end of the prescreen as well, and you can be transferred then. Just in case we get disconnected, though, let me give you the Crisis Line phone number: **503-782-4499"**

Date offered of First Appt (today's date):

First type of Appt: Routine Assessment (in Credible)

****Are you a registered sex offender? Yes or No**
(If yes, notify client that we are unable to provide services, due to the location of our facility, and end prescreen)**

****Have you ever been convicted of arson as an adult? Yes or No**
(If yes, notify client that we are unable to provide services, due to insurance purposes, and end prescreen)**

Are you mandated? If so, by who? _____
Have you been in treatment before?_____Last date admitted:_____

Does the client have any of the following medical conditions which may need attention?
Asthma Yes or No **Explain:**
Diabetes or insulin-dependence Yes or No **Explain:**
Epilepsy Yes or No **Explain:**
Broken Bones Yes or No **Explain:**
History of TB Yes or No **Explain:**
Chest or abdominal pain Yes or No **Explain:**
History of surgeries Yes or No **Explain:**
Shortness of breath Yes or No **Explain:**
Abscesses Yes or No **Explain:**
Liver problem Yes or No **Explain:**
Acute/possible infection Yes or No **Explain:**
Open wounds Yes or No **Explain:**
Recent injury or accident Yes or No **Explain:**

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Heart condition Yes or No **Explain:**
Recent hospitalization Yes or No **Explain:**
Other Yes or No **Explain:**

Are you experiencing or have you experienced any of the following symptoms:

Tremors: Yes No **Dts:** Yes No **Vomiting:** Yes No

Diarrhea: Yes No **Fever:** Yes No **Hallucinations:** Yes No

Seizures: Yes No

If yes to seizures and/or hallucinations **give dates of most recent and types of seizures/hallucinations** and whether seizures are withdrawal-related or seizure disorders: (type of hallucinations are audio, visual, and tactile):

_____

Special diet modifications/restrictions: (inform client we need medical note for accommodations)

_____

Currently pregnant? If yes, how far along and where are you receiving prenatal care?

_____

Do you have the ability/means to care for yourself? Yes No

Are you on any prescribed medications: Yes No **Are they in the bottles they came in:** Yes No

Notify client that they must bring in their medications with them on admit and they must be in their original bottles with their name, correct medication, and be current (not expired).

Notify client that if they do not meet these requirements that the medications will be disposed of on admit.

Name of Medication: Dose: Route: Frequency: Diagnosis:

_____

_____

_____

_____

_____

_____

_____

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Allergies and reaction *(Must be entered into Credible separately, or check "NKDA" box under allergies tab):*

_____

_____

Psychiatric Data

Do you have any history of mental health symptoms? (Depression, anxiety, bipolar, etc.)

_____

Have you ever experienced any psychotic symptoms (felt disconnected from reality); Yes No; If yes, describe thoughts/behaviors:

_____

Do you have a history of or current violent/homicidal thoughts or behaviors: Yes No; if yes, describe thought/behaviors

_____

Do you smoke or use tobacco products: Yes No **(Notify client facility is non-smoking)**

How many times in the past year have you had 5(for men) or 4 (for women and all adults older than 65 years) or more drinks in one day?

How long have you been using? _____

What is the longest time that you have been clean and sober, and when was that?_____

Substance Abuse History

Substance "What are you detoxing from?"	**Amount and Frequency** "How much/often do you use?"	**Age of first use** "When is the first time you remember using (substance)."	**Last use/amount** "When was the last time you used/drank (substance)? How much did you use/drink?"	**Route** "Do you smoke, use IV, drink?"

Are you taking Xanax, Valium, Ativan, Librium, Klonopin, or any other benzodiazepines? Yes No

If Yes: How much/often?_____ Is it prescribed?_____

******If client says "yes" notify them RN will discuss with them, if client says "no" you MUST let them know that if their urine tests positive for benzodiazepines, for their own safety, we will not admit them at that time.******

Are you taking methadone? Yes No

If Yes: How much/often?_____ Is it prescribed?_____

Are you taking Suboxone? Yes No

If Yes: How much/often?_____ Is it prescribed?_____

Legal Charges

Do you have any criminal charges that involve another person (assault, harassment, menacing…)? If yes, any current cases? Please describe._____

Do you have any other current legal issues? Please describe._____

Notify client of the following:

1. Client will be asked to complete a complete Drug and Alcohol assessment while in our care
2. We are a non-smoking facility, but nicotine-replacement products will be available
3. Our goal is to help our clients obtain sobriety in a quiet, relaxed environment

Did the client report suicidal ideation at the beginning of the prescreen? Yes or No

If yes, "We are now at the end of the prescreen. I just want to check back in with you and see if you would be interested in speaking with a crisis worker now?" If yes, transfer to **503-782-4499**