VALLEY | CITIES
Behavioral Health Care

SCREENING TOOL FOR DETOX & INPATIENT			
Date	**Time**	**Services You are Seeking**	
		☐ Detox (3-5 Days)	☐ Inpatient (28 Days)

Demographic Information			
Legal Name:		Preferred Name:	
Birthdate:		Social Security Number:	
Phone Number:		Secondary Phone:	
What is your living situation?			
☐ Lives alone	☐ Lives with others	☐ Unhoused	☐ Other:
Home Address:		City/State/Zip:	
Mailing Address (If different):		City/State/Zip:	
Insurance			
☐ Medicaid, County:	☐ Commercial, Company:	☐ None	
Referral Source			
Organization:	Name:	Phone:	
☐ I agree to always wear a mask in common areas for the duration of my stay at Recovery Place Seattle.			
☐ I attest that I am able to move about, bathe, dress, transfer, and toilet myself without any assistance.			

Substances					
Category	**Type**	**Amount**	**Frequency**	**Method**	**Last Use**
Type of Drug	What Kind?	How Much Do You Normally Use?	How Often Do You Use This Drug?	How Do You Use It? (Drink, Snort, Smoke, IV)	When Did You Last Use It?
ALCOHOL					
AMPHETAMINES					
BENZODIAZEPINES					
COCAINE					
OPIATES					
OTHER					

Mental Health		
Have you ever assaulted a health care worker?	☐ No	☐ Yes, describe:
Have you ever been admitted to a psychiatric facility?	☐ No	☐ Yes, when/reason:
Do you have any psychiatric diagnoses?	☐ No	☐ Yes, list:
Are you experiencing suicidal thoughts?	☐ No	☐ Yes
Do you have a suicide plan?	☐ No	☐ Yes, describe:
Do you intend to carry out this plan?	☐ No	☐ Yes

Medical

Do you require a special diet?	☐ No	☐ Yes, describe:
Are you taking antibiotics?	☐ No	☐ Yes, reason:
Do you have lice or scabies>	☐ No	☐ Yes, when was it treated:
Are you pregnant or suspected to be pregnant?	☐ No	☐ Yes, how many weeks:
Have you had a heart attack?	☐ No	☐ Yes, date:
Have you had a stroke?	☐ No	☐ Yes, date:
Have you had a seizure?	☐ No	☐ Yes, last seizure date:
Do you have a seizure disorder?	☐ No	☐ Yes, how do you manage it:
Do you have abscesses or open wounds?	☐ No	☐ Yes, describe:
Are you experiencing hallucinations?	☐ No	☐ Yes, describe:
Do you have hypertension or blood clots?	☐ No	☐ Yes, explain:
Do you have diabetes?	☐ No	☐ Yes, what meds do you take:
Do you have hepatitis, liver problems, jaundice?	☐ No	☐ Yes, describe:
Do you have asthma, COPD, sleep apnea?	☐ No	☐ Yes, describe:
Do you have other lung or kidney problems?	☐ No	☐ Yes, describe:
Have you had a head trauma/brain injury?	☐ No	☐ Yes, describe:
Any other medical problems?	☐ No	☐ Yes, describe:
Do you need medical supplies? (CPAP, wheelchair, walker, cane, crutch, O2, etc.)	☐ No	☐ Yes, list:
Have you been hospitalized in the last 6 mo.?	☐ No	☐ Yes, explain:
(Inpatient Only) Do you have any medical or dental appointments scheduled?	☐ No	☐ Yes, when:
(Inpatient Only) If you have appointments, can they be postponed by 30 days?	☐ No	☐ Yes

Medications

Name	Indication	Dosage	Frequency	Amount	Rx or Refill	
Name of medication	What condition does this medication treat?	Strength (mg)	How many times per day do you take it?	How many days' supply will you bring to RPS?	Do you have a written prescription or a refill?	
					☐ Yes	☐ No
					☐ Yes	☐ No
					☐ Yes	☐ No
					☐ Yes	☐ No
					☐ Yes	☐ No
					☐ Yes	☐ No
					☐ Yes	☐ No
					☐ Yes	☐ No

VALLEY | CITIES
Behavioral Health Care

ONLY COMPLETE THIS PAGE IF YOU ARE INTERESTED IN THE 28-DAY INPATIENT TREATMENT PROGRAM.

Substance Use Disorder Treatment History

Date	Type	Where
When where you in treatment?	What kind of treatment? (Inpatient, Detox, Outpatient, PHP, IOP, etc.)	Name of facility where you receive treatment.

Legal History

Do you have pending/past convictions for **arson, sex offense** or **assault?** ☐ No ☐ Yes, provide info below

Charge (Arson, Sex Offense, Assault)	Offense Level	Pending or Convicted		Date
		☐ Pending	☐ Convicted	
		☐ Pending	☐ Convicted	
		☐ Pending	☐ Convicted	
		☐ Pending	☐ Convicted	
		☐ Pending	☐ Convicted	
		☐ Pending	☐ Convicted	

Acknowledgements

☐ I understand that the Inpatient Program at Recovery Place Seattle does not prescribe any medications. All medications that I need while at Recovery Place Seattle must be provided by me upon arrival.

☐ I understand that deliberate falsification or omission of information on this screening tool will result in termination of services with Recovery Place Seattle.

Information for Professionals Referring a Client

If you are referring a patient that is ***currently incarcerated***, please attach the following documents to this screening:

- MAR
- Record of past convictions & current charges

Please fax this screening and relevant clinical to:
Recovery Place Seattle
Intake Department
206-325-6649

Please include your name and the best phone number to reach you.