SCREENING TOOL FOR INPATIENT AND SUBSTANCE WITHDRAWAL MANAGEMENT (DETOX)

DATE	TIME	SERVICES YOU'RE SEEKING	
		☐ DETOX	☐ INPATIENT

DEMOGRAPHIC INFORMATION

LEGAL NAME:	PREFERRED NAME:
BIRTHDATE:	SOCIAL SECURITY NUMBER:
PHONE:	SECONDARY PHONE:
	GENDER IDENTITY:

WHAT IS YOUR LIVING SITUATION?

ALONE: ☐	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 ATTEST THAT I AM ABLE TO MOVE ABOUT, BATHE, DRESS, TRANSFER AND TOILET MYSELF WITHOUT ASSISTANCE.

SUBSTANCES

DRUG TYPE	AMOUNT	FREQUENCY	DURATION	METHOD	LAST USE
What kind?	*How much?*	*How often?*	*How long (days weeks/months)?*	*How do you use it?*	*When was it last used?*
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 of being 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, 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 currently experiencing hallucinations?	☐ No	☐ Yes, describe:
Do you have diabetes?	☐ No	☐ Yes, what meds do you take:
Have you had head trauma/brain injury?	☐ No	☐ Yes, describe:
Any other medical issues?	☐ No	☐ Yes, describe:
Do you require medical supplies and are able to bring them with you? (ex: CPAP, wheelchair, walker, cane, etc)	☐ No	☐ Yes, list:
Do you need supplemental oxygen?	☐ 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 *Name of medication.*	**INDICATION** *What condition does it treat?*	**DOSAGE** *Strength (mg)*	**FREQUENCY** *How many times do you take it a day?*	**AMOUNT** *How many days supply is being brought to RPS?*	**RX/REFILL** *Do you have a written prescription or refill?*
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

SUBSTANCE USE DISORDER TREATMENT HISTORY		
DATE *When were you in treatment?*	**TYPE** *What kind of treatment? (Inpatient, Detox, Outpatient, IOP, PHP, etc.)*	**WHERE** *Facility name where you were treated.*

LEGAL HISTORY

Do you have past/pending convictions for **arson, sex offense or assault?**	☐ No	☐ Yes (Provide information below.)

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

ACKNOWLEDGEMENTS

☐ I understand that the Inpatient Program at Recovery Place Seattle does not have a dedicated medical provider. All medications that I require while in treatment must be brought with me and inventoried upon arrival

☐ I understand that deliberate falsification or omission of information on this screening tool may 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 Indicate arrest date: _____ Indicate earliest possible release date: _____	Please fax this screening and relevant clinical to: **Recovery Place Seattle** **Intake Department** **206-325-6649**