

West Slope Recovery, Inc. MENS' RESIDENTIAL

CLIENT SCREENING & INFORMATION

FIRST _____ LAST _____ DATE OF BIRTH ____/____/____ AGE ____ VET: _____
ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
COUNTY _____ # OF YEARS _____ (____) _____ - _____ (____) _____ - _____
SOCIAL SECURITY NUMBER _____ DRIVERS LICENSE # _____ DL STATE _____ MARITAL STATUS _____ PARTNERS NAME _____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____ (____) _____ - _____
ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ CELL - WORK - MESSAGE _____

AGENCY/REPRESENTATIVE, AND/OR PERSON, COORDINATING SERVICES OR REFERRAL SOURCE

AGENCY NAME _____ CONTACT PERSON _____ COUNTY _____ (____) _____ - _____
ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ CELL PHONE _____

LEGAL INFORMATION

Jail / Prison last 30 Days: _____ On Parole / Probation: _____ Why: _____

NAME of PAROLE/PROBATION OFFICER _____ ADDRESS _____ (____) _____ - _____

PHYSICAL & MENTAL HEALTH

Physical Hospitalization in the past 30 days: _____ Why: _____

Mental Health Hospitalization past 30 days : _____ Why: _____

SUBSTANCE	Date of Last Use	FREQUENCY	AMOUNT of USE	METHOD

IV USE IN THE LAST 12 MONTHS: _____ PRIOR TREATMENT / PROGRAMS: _____ HOW MANY: _____

WHERE AND WHEN: _____

****** STOP **** AND COMPLETE ASAM PAGE TWO OF CLIENT INFORMATION******

To the best of my knowledge, the above is true and correct.

Client Signature _____ Admission Date ____/____/____ Staff Signature _____ Admission Date ____/____/____

CLIENT LOG # _____

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Screening, Placement and Referral

Have you ever been convicted of a sexual crime? _____ Have you ever been convicted of arson? _____

If YES to either question * STOP****Inform individual of Policy and provide Referrals***

Note referrals given: _____

ASAM QUESTIONS

1. Complete ASAM, if YES ANSWERS to questions, 1a, and 1b, or 2, or 3, requires that the caller/client immediately receive medical or psychiatric care. NOTE ACTION TAKEN.

2. If YES to 4a and/or 1b alone, requires caller/client be seen for an assessment within 48 hours preferably earlier. NOTE ACTION TAKEN.

3. If YES TO 5a alone requires referral to 24-hour facility or as per agency procedure within 48 hours or preferably earlier. NOTE ACTION TAKEN.

4. If YES in question 5b and/or 6, without any yes in question 1, 2, and/or 3, requires that the client be referred to a safe or supervised environment. NOTE ANY ACTION TAKEN.

Do you have any Physical limitations that may require assistance? (Wheelchair/walker) Y/N _____

If yes describe: _____

LIST CURRENT PERSCRIPTIONS

DIAGNOSIS	NAME of MEDICATION	DOSAGE and FREQUENCY

If client is approved for admission, the client will be scheduled an Intake appointment as requires by ASAM or next available opening. The client will be informed that they will have to have a copy of TB test results that are current and clear, (negative results), at time of intake. Staff will advise client on what to bring, such as, seven days of clothing only, three pair of shoes, hand soap, shampoo, razor & shaving cream, tooth brush & tooth paste. Client is informed not to bring Lap top computer, i-book, i-pod or any other internet accessible devices these are not allowed. Client will be informed that cell Phones are not allow in the client's possessions and will be placed in safe keeping. The agency provides laundry detergent, and washing machine. The agency also provides blankets, bed linens, towels, food and drinks. Client may bring a small amount of personal bottled water, soda and snacks.

CLIENT LOG # _____

Staff Signature

_____/_____/_____
Screening Date