Prescreening Form

Please complete ALL applicable sections MUST BE LEGIBLE

Please check the location for which you are applying to receive treatment

FULL Name: First, Middle, Last (If Incarcerated, Please Include Inmate ID, SID etc)			Date:
Address (If Incarcerated, Please list the Facility):			
City:	County:	State:	Zip Code:
Date of birth:	Male Female	Social Security # (Required to Process)	
Telephone #	List any urgent needs, such as currently needing detox services/referral, homelessness during winter/extreme conditions (cold or heat), lacking access to food or clothing, needing medical attention, gender expression concerns, or the need for assistive technology.		
Applying for outpatient treatment: Yes	We are an outpatient facility only	If currently in treatment, where:	
Counselor/Case worker contact info:	Do you give us permission to contact the Counselor/ Case Worker? Yes____No _____		
Military Veteran: Yes___NO____	Date available for admission:		
Current Forms of ID: State ID Card/Driver's License Birth Certificate Social Security Card			
Open Case with DSS for Food Stamps and/or TDAP: Yes No			
Insurance: 13 Yes D No Type: C] Medicaid Medicare Other Private Insurance Issue Date: Expiration Date: Name:__________________________Group#:_______________________Member#________________ Insurance Issuer:Self_________Other (person)_____________________			
PLEASE PROVIDE A COPY OF INSURANCE CARD WITH THIS PRESCREEN			

Current Legal Status

Do you have a valid driver's license: Yes_ No__ If no, why not?	
On Probation: Yes ___ No____ County:_____	Probation/Parole Officer:
Pending court dates: Yes___ No___ When?	What charges?
Court ordered to treatment: Yes__ No__ If yes, who ordered you? List court, judge or agency below:	
Legal History: Including outcome of ALL court appearances (Be honest, we will do a background search)	
1.	
2.	
3.	
Use reverse side, if necessary.	

Employment History

Income during this past year: $	Current monthly income: $
D Currently Employed VA Benefits Retirement SSDI (SS Disability) Ü SSI (Social Security) TEHMA/TANF/TCA O Unemployment Insurance Other Income Source (please list):	
Are you physically able to work: Yes O No If Unemployed, last employment date:	
Reason for leaving:	

Dimension 1: Acute Intoxication/Withdrawal Potential

Substances you have Used:	Frequency	How? Orally, Injection, Smoked, Inhaled	Date of last use: (Required)
1st.			
2nd.			
3rd.			
History of DT's or seizures: Yes No			

Dimension 2: Medical Conditions and Complications

IV Drug use (must answer): Yes No Pregnant: Yes No HIV: Yes__ No __ Hepatitis C: Yes __No__

Are you currently taking Methadone, Suboxone or Vivitrol: Yes No

Do you have any OTHER physical/medical problems? Yes C] No

If yes, describe (Use reverse side or Notes section on last page, if you need additional space):

Do you have any drug allergies? Yes __No___ Do you have any food allergies? Yes___ No___

Do you take medication for your physical/medical problems? Yes No

If yes, list Medications (Use reverse side or Notes section on last page, if you need additional space):

Are you able to take this medication by yourself? Yes___ No___

Are you receiving medical services from a physician for your somatic or medical issues: Yes___ No____

If yes, by whom (name of provider, contact information):

re you physically able to climb stairs? Yes___ No___

Do you have any other physical limitations that are important for us to know?

Dimension 3: Emotional/Behavioral Conditions and Complications

Do you have any mental health diagnosis? Yes___ No____ If yes, please describe:

Are you taking any medication for this condition? Yes___ No ____ If yes please list your medications:

Date you were Diagnosed with this condition:

Have you consistently taken this medication as prescribed? Yes___No____ If no, Why not?

Are you currently receiving psychiatric services for this condition? Yes___No___ If yes, by whom?

Do you have a history of suicidal or homicidal ideation or attempts? Yes__ No___ If yes, how many times, and when was the last attempt?
What effect has your mental health condition had on attempts to remain abstinent from alcohol & drugs?

Dimension 4: Readiness to Change

Are you currently in treatment: Yes__ No__ If yes, list facility:___________________________ Is this your first treatment attempt? Yes__ No___ If no, How many times before? Detox only: _____Inpatient:_______Outpatient:_______ Have you ever been in treatment? Yes___ No___ if yes, when?___________________________ Did you
Did you decide to admit yourself into treatment or were others involved (Not including legal system)
life consequences have you experienced as a result of your use?
How ready do you feel to reduce your use of drugs and/or alcohol?

3

Dimension 5: Relapse/Continued Use Potential

What relapse prevention tools, if any, have you learned in your current treatment or from previous treatment episodes?
What are your biggest relapse triggers?
What are your plans if a treatment slot is not available?

How do you resist temptation?
How do you resist frustrations?
How do you resist urges?
Have you had a period of sobriety in the past year? Yes____ No____ How long?_____________ If yes, what did you do to maintain your sobriety and why did you relapse?
Do you sometimes wonder if you can control your use of alcohol?
Do you sometimes wonder if you can control your use of drugs?
Do you sometimes wonder if your substance use is hurting others?
What are the reasons you believe you have not been able to stay clean and sober on your own?

Are you currently experiencing any Cravings or Withdrawal Symptoms? Yes___ No___. If yes what?

NOTES:

Has patient been tested for TB? Has patient signed declination form if not desiring?	
IV Drug user: Yes No	HIV: Yes No Hepatitis C Yes C] No O

Dimension 6: Recovery Environment

Current Relationship: Never Married Married Divorced Separated Widowed Partner
Describe your CURRENT living situation prior to entering treatment:
What about your current living situation helps or hurt your recovery efforts? Describe:
Do you have a significant other? Yes C] No If yes what is the status of this relationship:
Number of children (under 18)? Names/Ages: Who has legal custody?____________________ Who has physical custody? ____________________ Where do they reside? ____________________

I HEREBY GIVE MY CONSENT TO Continuum Recovery, INC TO COMMUNICATE WITH MY REFERRAL SOURCE OR ANY CONTACTS LISTED ABOVE TO OBTAIN ANY INFORMATION AND/OR DOCUMENTS NEEDED TO CONSIDER MY APPLICATION FOR ADMISSION TO CONTINUUM RECOVERY'S OUTPATIENT PROGRAM.

______________________________ ________________

Applicant's Signature Date

IF THE APPLICANT WISHES TO PROVIDE ADDITIONAL INFORMATION TO CONTINUUM RECOVERY NOT COVERED ABOVE, USE THE REVERSE SIDE OR NOTE SECTION ON LAST PAGE!

OTHERWISE PLEASE STOP HERE!

NEXT PAGE TO BE COMPLETED BY CURRENT TREATMENT PROVIDER OR REFERRAL SOURCE

TO BE COMPLETED BY CURRENT TREATMENT PROVIDER OR REFERRAL SOURCE

Documentation from Referral Source

Pregnant: Yes No	Other:
Military Veteran: Yes No When/What tour:	
DSM 5 Diagnosis:	

Referral Source Signature   Date

Referral Source Name and Title

Continuum Recovery MUST RECEIVE THE FOLLOWING

☐ Psychosocial Assessment   Discharge Summary   TB Test Results Ü Copy of Insurance Card

CONTINUUM USE ONLY
Date received by Continuum Recovery:
Date Placed on Waiting List:
Scheduled Admission Date:
Date TB Test Results Received:
Transportation Needed:
Phone screen completed by:
Clinical supervisor signature:

NOTES:

- ○ Approved
- ○ Denied

Clinical Supervisor signature: ____

ASAM Dimensions

Dimension 1 (Acute intoxication and/or withdrawal potential): Low, Medium, High

Dimension 2 (Biomedical conditions and complications): Low, Medium, High

Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications): Low, Medium, High

Dimension 4 (Readiness to Change): Low, Medium, High

Dimension 5 (Relapse, Continued Use or Continued Problem Potential): Low, Medium, High

Dimension 6 (Recovery/Living Environment): Low, Medium, High

Recommended Level of Care: