

## 11.01 APPENDIX A

### BDAP SCREENING TOOL

Type of Screening:  Telephone  Face To Face

#### DEMOGRAPHICS

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Birth/Maiden name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referral source: \_\_\_\_\_ Phone: \_\_\_\_\_  
Marital Status:  Married  Never Married  Separated  Divorced  Widowed  
 Other: (specify) \_\_\_\_\_  
Sex:  M  F  
Race:  White  Black  Alaskan Native  American Indian  Asian or Pacific Islander  
 Puerto Rican  Mexican  Cuban  Other Hispanic  Other: (specify) \_\_\_\_\_

#### DRUG & ALCOHOL

What are you currently using (alcohol/drug)? \_\_\_\_\_

Last use? \_\_\_\_\_

How much/how often are you drinking/using? \_\_\_\_\_

Have you ever used IV drugs?  Y  N

If yes, when? \_\_\_\_\_

Are you experiencing any of the following withdrawal symptoms? (If the client answers "yes" to this question, he/she must be transferred to a clinical staff person.)

Uncontrollable shaking  Hallucinations  Seizures  Nausea/Vomiting  Severe cramps

Other: (specify) \_\_\_\_\_

Have you ever experienced any of the above symptoms? If so, explain:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever received drug/alcohol treatment or services?  Y  N

If yes, most recent? \_\_\_\_\_

Type:  Outpatient  Intensive Outpatient  Partial  Halfway House  Detox  Inpatient  Hospital-based

Long-term  Methadone/LAAM/Buprenorphine  Community Support Groups

Other (specify): \_\_\_\_\_

**PSYCHIATRIC**

**Are you having any thoughts of harming yourself or others?**  Y  N *(If the client answers "yes" to this question, he/she must be transferred to a clinical staff person.)*

Suicide plan: \_\_\_\_\_

Ability to contract for safety: \_\_\_\_\_

Thoughts to harm others: \_\_\_\_\_

Plan to harm others: \_\_\_\_\_

**Have you ever received mental health services?**  Y  N

**If yes, most recent?** \_\_\_\_\_

**Type:**  Inpatient  Outpatient  Other: (specify) \_\_\_\_\_

**Was medication prescribed?**  Y  N **If yes, specify:** \_\_\_\_\_

**PRENATAL/PERINATAL**

**Are you pregnant?**  Y  N **If yes, how far along?** \_\_\_\_\_

**Are you receiving prenatal care?** \_\_\_\_\_

**Have you given birth within the last twenty-eight days?**  Y  N

**Are you experiencing any complications that you feel may require emergency care?**  Y  N

*(If the client answers "yes" to this question, she must be transferred to a clinical staff person.)*

**If yes, explain:** \_\_\_\_\_

**REFERRAL FOR EMERGENT CARE SERVICES**

**\*\*SCREENER\*\***

**Is there a need for a referral for emergent care services?**  Y  N

**Reason:** \_\_\_\_\_

**If yes, where?** \_\_\_\_\_

**EMPLOYMENT / FUNDING / LEGAL**

**Are you employed?**  Y  N **Employer ?** \_\_\_\_\_

**Do you have health insurance or Medical Assistance?**  Y  N **Specify:** \_\_\_\_\_

**Are you a veteran?**  Y  N **Other funding sources?** (specify) \_\_\_\_\_

**Are you involved with the criminal/juvenile justice system?**  Y  N

**If yes, what is your status?** \_\_\_\_\_

**Do you have any pending charges?**  Y  N **If yes, specify:** \_\_\_\_\_

**PRIORITY POPULATIONS / SPECIAL NEEDS**

Pregnant IDU       Pregnant substance abuser       IDU  
 Woman w/ children →  Number of children under 18       Number living with client  
 Other (specify) \_\_\_\_\_

Do you have any special needs?  Y  N      If yes, explain: \_\_\_\_\_

**ACCESS / ASSESSMENT**

Screener Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Date of Assessment: \_\_\_\_\_ Time: \_\_\_\_\_

Location: \_\_\_\_\_

Assessor: \_\_\_\_\_

If the assessment cannot be scheduled within the required timeframe, why:

- Client choice
- SCA/Provider schedule will not permit
- Other (specify) \_\_\_\_\_