

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 *(note: there is no "duty to warn" as per D&A regulations):* _____

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 IVDU Pregnant substance abuser IVDU

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) _____