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)____