Initial Screening Note

## *Demographic Info*

**How did you hear about the clinic?**

☐ 1 = Spouse/partner ☐ 2 = Friend ☐ 3 = Healthcare Provider
☐ 4 = Flyer ☐ 5 = Parent/guardian ☐ 6 = Hotline
☐ 7 = Treatment Locator ☐ 8 = Other: ____________

**What is your preferred name and pronouns? (e.g., he/him/his, she/her/hers, they/their/theirs): ______________________________________________**

**Are you currently pregnant?**

☐ 1 = Yes
☐ 2 = No
☐ 3 = Don't Know
☐ 4 =Other___________________

**Current Address__________________________________________________**
**Address confirmed/updated within the EMR to be correct** ☐

**Phone Number________________________Is it OK to leave a message?** ☐ 1= Yes ☐ 2 =No

**Alternative Contact Information:_____________Is it OK to leave a message?** ☐ 1= Yes ☐ 2 =No

**Emergency Contact_____________________ Phone Number _________________**

**Is the Emergency Contact aware of your addiction?** ☐ 1= Yes ☐ 2 = No

**Do you have a valid form of government issued identification?** ☐ 1 = Yes ☐ 2 = No

## *Transportation*

**How would you get to the OBAT program if you needed to get here?**
☐ 1 = I would drive
☐ 2 = I would use public transportation
☐ 3 = I would use a ride share/taxi
☐ 4 = I would walk
☐ 5 = I would get a ride from a family/friend

☐ 6 = I would use medical transportation
☐ 7 = I would need a PT1
☐ 8 = Other ______________________
☐ 9 = Unable to travel to clinic. Explain: ______________________

## *Housing*

**Have you spent one or more weeks on the street or in a shelter in the last three months?**
☐ 1=Yes ☐ 2=No

**What type of place are you living in now?**
☐ 1 = In a house or apartment I own or rent
☐ 3 = In a house or apartment owned or rented by family or friends
☐ 4 = Hotel
☐ 5 = Alcohol or substance use treatment program
☐ 6 = Shelter
☐ 7 = Street or car
☐ 8 = Sober Home
☐ 9 = Other: ______________________________
☐ 10 = Prefer not to say

**Who do you live with at this time?**
☐ 1 = I live alone.
☐ 2 = I live with my partner/significant other.
☐ 3 = I live with family members.
☐ 4 = I live with friends/acquaintances.
☐ 5 = Other: _________________________

## *Substance Use History*

| | *Age of Initiation* | *Date of Most Recent Use* | *Frequency* | *Route of administration* | *Amounts Used* | *Currently Using?* |
|---|---|---|---|---|---|---|
| *Opioid*<br>*__Heroin*<br>*__Fentanyl*<br>*__Oxycodone product*<br>*__Buprenorphine*<br>*__Methadone*<br>*__Other opioid* | | | | | | |
| *Benzodiazepine* | | | | | | |
| *Alcohol* | | | | | | |
| *Cocaine (including crack cocaine)* | | | | | | |
| *Amphetamines (including methamphetamine)* | | | | | | |
| *Tobacco/nicotine*<br>*Vaping* | | | | | | |
| *Cannabis* | | | | | | |
| *Other (e.g., Kratom, K2, synthetic cannabinoid, PCP)* | | | | | | |

**Have you ever shared injection or other substance use supplies?** ☐ 1= Yes ☐ 2 = No

**Have you ever belonged to a syringe service program?** ☐ 1= Yes ☐ 2 = No

**Do you have access to clean/new injection supplies?** ☐ 1= Yes ☐ 2 = No

**Do you have naloxone?** ☐ 1= Yes ☐ 2 = No

**Are you willing to carry naloxone?** ☐ 1= Yes ☐ 2 = No

**Have you ever overdosed?** ☐ 1= Yes ☐ 2 = No

**Number of lifetime overdoses:** ______

**Was naloxone administered?** ☐ 1= Yes ☐ 2 = No

**Have you ever been hospitalized due to an overdose?** ☐ 1= Yes ☐ 2 = No

## *Recovery History*

**What was the longest period of time that you have been in recovery?**

______________________________________________________________________

**When was this?** ________________________

**What were you doing at that time for your recovery?**

______________________________________________________________________

## *Addiction Treatment History*

**Have you ever engaged in treatment for a substance use disorder?** ☐ 1= Yes ☐ 2 = No

**If yes, how many times to each type?**

_____ Detoxification Program
_____ Methadone Maintenance
_____ Buprenorphine Maintenance
_____ Naltrexone (oral or injectable)
_____ Injectable Buprenorphine (Sublocade® or Brixadi®)
_____ Residential (e.g., Halfway House)
_____ Section to Treatment
_____ Intensive Outpatient Program
_____ MOUD while incarcerated

**Do you attend peer support meetings? (Check all that apply)**

☐ 1 = AA
☐ 2 = NA
☐ 3 = Smart Recovery
☐ 4 = Other: ________________
☐ 5 = None

**How many meetings do you attend each week?**

☐ 1 = 1-2 week
☐ 2 = 3-4 week
☐ 3 = 5-6 week
☐ 4 = None
☐ 5 = Other: _______________

**Do you have a sponsor?** ☐ 1= Yes ☐ 2 = No

**Do you have any history of a process addiction?**

☐ 1 = Gambling
☐ 2 = Sex
☐ 3 = Shopping
☐ 4 = Eating disorder (overeating, bulimia, anorexia)
☐ 5 = Other: _______________
☐ 6 = No

**Comments:** _______________________________________________

## *Treatment History*

**Have you ever engaged in a Methadone Maintenance program?** ☐ 1 = Yes ☐ 2 = No

**Where and when did you engage in Methadone Maintenance?**

_______________________________

**How long were you on Methadone Maintenance?** ____________________________

**What was your dose?** ______

**Did you ever earn take-homes?** ☐ **1 = Yes** ☐ **2 = No**

**If you are no longer on methadone treatment, why did you stop?**

_______________________________

**If currently engaged in methadone treatment, who is the primary contact person?**

_____________________________________________________________________

**Are you willing to sign a consent for release of information so that we can communicate with your opioid treatment program about your treatment plan?**

☐ 1 = Yes ☐ 2 = No

## *Buprenorphine History*

**Have you ever been prescribed buprenorphine before?**
☐ 1 = Yes ☐ 2 = No
**If yes:**

**Where and when you prescribed buprenorphine? ________________________**

**What was your dose? ________________**

**Did you ever receive an extended-release buprenorphine injection? If yes, please provide details:**

_______________________________________________________________________

**Why did you stop taking buprenorphine? __________________________________**

## *Naltrexone History*

**Have you ever been prescribed naltrexone before?**
☐ 1= Yes ☐ 2 = No

**If yes:**

**Where and prescribed naltrexone: ____________________________________**

**Did you ever receive an extended-release naltrexone injection? If yes, please provide details:**

_______________________________________________________________________

**Why did you stop naltrexone treatment? __________________________________**

## *Mental Health History*

**Are you currently seeing a psychiatrist, psychologist, or counselor for a mental health condition?**
☐ 1 = Yes ☐ 2 = No

**Where do you see your psychiatrist, psychologist, or counselor? ________________**

**What is their name? _____________________**

**How often do you see them? ____________________**

**Are you currently taking any medication for this/these conditions(s)?**
☐ 1 = Yes ☐ 2 = No

**If yes, what medications are you taking? __________________________________________**

**Are you willing to sign a consent for release of information so that we can communicate with your psychiatrist, psychologist, or counselor about your treatment plan?**
☐ 1 = Yes ☐ 2 = No

**Have you ever been hospitalized for a mental health condition?**
☐ 1 = Yes ☐ 2 = No

**Have you ever attempted to end your life or to hurt yourself?**
☐ 1 = Yes ☐ 2 = No

**How many times did you try to end your life or to hurt yourself?** _________

**Do you currently have thoughts about hurting yourself or ending your life?**
☐ 1 = Yes ☐ 2 = No *(If no, skip to homicide question)*

***If yes:***
***Do you currently have a plan for how you would hurt yourself or end your life?***
*☐ 1 = Yes ☐ 2 = No*

***Do you have the means to carry out your plan?***
*☐ 1 = Yes ☐ 2 = No*

***Have you ever attempted or thought about homicide (killing someone else)?***
*☐ 1 = Yes ☐ 2 = No (If no, skip to health status)*

***If yes:***
***Are you presently thinking about killing someone?***
*☐ 1 = Yes ☐ 2 = No*

***Do you have the means to carry this out?***
*☐ 1 = Yes ☐ 2 = No*

***If patient screens positive to any of the above italicized questions, staff member conducting the screener must implement institutional protocols regarding acute suicidal ideation or homicidal ideation.***

## *Health Status*

**Have you ever been diagnosed with any of the following medical conditions? Mark all that apply.**

☐ 1 = Head Trauma/Brain Injury (specify type): ____________________________________
☐ 2 = HIV ➔ If yes, are you currently in care? ☐ 1 = Yes ☐ 2 = No
☐ 3 = Hepatitis C ➔ If yes, have you been treated? ☐ 1 = Yes ☐ 2 = No
☐ 4 = Severe Liver or Kidney Disease ➔ If yes, are you currently in care? ☐ 1= Yes ☐ 2 = No
☐ 5 = Chronic Pain Syndrome (specify type): ____________________________________

☐ 6 = Other (specify type): ______________________________
☐ 7 = None

## *Health Care Provider Information*

**Where do you access most of your healthcare?**
☐ 1 = Emergency department
☐ 2 = Primary care clinic
☐ 3 = Walk-in clinic (e.g., Minute Clinic, urgent care setting)
☐ 4 = Shelter-based clinic or street outreach team
☐ 5 = Community program (e.g., Engagement center for persons experiencing homelessness)
☐ 6 = Criminal-legal setting (e.g., jail or prison)
☐ 7 = Other (specify type): ______________________________
☐ 8 = None

**Do you have a primary care provider?** ☐ 1 = Yes ☐ 2 = No
**If yes, can you tell us their name and where they are located?**

______________________________________________________________

## *Social History*

**Are you currently employed?** ☐ 1 = Yes ☐ 2 = No

**If yes, what do you do for work?** ______________________________

**What is a typical work schedule (in terms of days and hours working per week)?**

______________________________________________________________

**Have you ever spent any time in jail/prison?** ☐ 1 = Yes ☐ 2 = No

**If yes, what is the longest period of time you spent in jail/prison?** __________

**When was your most recent incarceration?** ______________________

**Are you on probation or parole?** ☐ 1 = Yes ☐ 2 = No

**Do you have any outstanding legal issues?** ☐ 1 = Yes ☐ 2 = No

## *Social Support*

**Do you have any support persons in your life?** ☐ 1 = Yes ☐ 2 = No

**If yes, who would you say are you support persons?**

☐ 1 = Significant other/partner
☐ 2 = Parent
☐ 3 = Friend/acquaintance
☐ 4 = Employer/supervisor
☐ 5 = Other: ____________________

**If you are in a relationship, do you feel safe (emotionally, physically, and mentally) with your partner?**
☐ 1 = Yes ☐ 2 = No

**Does your support person(s) know about your substance use disorder?** ☐ 1 = Yes ☐ 2 = No

**Do any other family members have a history of substance use disorder?**
☐ 1 = Yes ☐ 2 = No

## *Treatment Goals*

**Can you tell me what your goals are for treatment?**

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

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