Click here to submit form

SERENITY PLACE RESIDENTIAL SCREENING FORM

PRIORITY

☐ Code A (pregnant IV user) ☐ Code B (pregnant) ☐ Code C (IV user) ☐ Code D (all others)

DEMOGRAPHICS

Date Screen Completed: Referral Source:

Client Name: DOB: SS#:

Address: Phone #:

Incarcerated: ☐ No ☐ Yes Conditional Release: ☐ No ☐ Yes Release Date:

Individuals who are incarcerated without a release date will be place on the pending list until a date is given.

Are you willing to stay 4 - 6 months to successfully complete the program? ☐ No ☐ Yes

ADMISSION ELIGIBILITY
(must meet one of the following criteria)

☐ Pregnant # weeks: Date of last Period:

Due Date: Prenatal Care: ☐ No ☐ Yes, if so where:

☐ Non-Pregnant (must have a child age 6 years or under who can enter treatment with mother)

Total # children: Ages:

Complete the information below for children attending treatment with mother.

Name of Child	DOB	SS#	Gender	Immunization	Special Needs/ Conditions	Custody

PREVIOUS AOD HISTORY

Admission Criteria: Use within 30 days if non-pregnant and use within 60 days if pregnant.

Substance(s) Used	Date Last Use	Amount & Frequency last 30 days	IV

Inpatient/Outpatient Facility Name	Year	Successful Completed
		☐ No ☐ Yes
		☐ No ☐ Yes

MENTAL HEALTH HISTORY

Mental Health Diagnosis:

Physician Name: Date of Last Appointment:

History of suicidal attempts: ☐ No ☐ Yes Hospitalized: ☐ No ☐ Yes

Explain:

CRIMINAL HISTORY

Currently on Probation? ☐ No ☐ Yes, Agent Name: Phone Number:

Do you currently wear any type of electronic monitoring device? ☐ No ☐ Yes

Any pending charges? ☐ No ☐ Yes, if so explain:

History of Violence: ☐ No ☐ Yes, if so explain (charge & date):

MEDICAL HISTORY

Do you have any medical needs? ☐ No ☐ Yes

Explain:

Name of Medication	Dosage	Frequency	Date Last Dose

Do you smoke or use tobacco products? ☐ No ☐ Yes ***(explain smoking policy)***

Smoking Policy: Clients are permitted to smoke on premises during specified times. Due to safety concerns of unborn children, pregnant women are unable to participate in this privilege. Clients are permitted to smoke off premises except when out with the children or locations that are smoke-free. Clients will be provided assistance in abstaining from and quitting smoking if desired.

Tuberculosis Risk Assessment	YES	NO
Have you ever been diagnosed with or treated for TB?	☐	☐
Within the past 6 months, have you been around someone who has been diagnosed with or treated for TB?	☐	☐
Within the past 6 months, have you traveled to or lived in any of the following countries: Latin America, the Caribbean, Africa, Asia, Eastern Europe, or Russia?	☐	☐
Within the past 6 months, have you lived or worked in any of the following places: homeless shelter, jail, prison, or nursing home?	☐	☐
Do you currently have any condition that weakens your immunity or ability to fight disease?	☐	☐
Within the past 6 months, have you injected illegal or other drugs into your body which were not recommended by your doctor?	☐	☐

Tuberculosis Current Symptom Survey	YES	NO
Have you had a cough for 3 weeks or longer which is much worse than a regular cough when you have a cold?	☐	☐
Have you lost more than 5 pounds for no known reason?	☐	☐
Have you coughed up blood?	☐	☐
Have you experienced frequent, unexplained fever lasting for 2 weeks or more?	☐	☐
Have you had unusual or heavy sweating, especially at night?	☐	☐
Have you experienced weakness or extreme fatigue?	☐	☐

MEDICAID/INSURANCE

Medicaid: Type: ☐ MCO ☐ FFS ☐ FPO

Applied (date):

Other Insurance Company Name:

REFERRING AGENCIES

Agency	Case Worker	Phone Number	Approval for Admission
			☐ No ☐ Yes
			☐ No ☐ Yes

HIGH RISK - INFORMATION PROVIDED

☐ **All IV/IV Pregnant Users:** Counseling and education about HIV and tuberculosis; Counseling and education about the risk of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and tuberculosis transmission does not occur; Referral for HIV or tuberculosis treatment services if necessary.
Packet mailed: _____ ☐ **Refused**

☐ **All Pregnant Clients:** Interim services offered to include counseling on the effects of alcohol and drug abuse on the fetus, as well as referral for prenatal care. **Packet mailed:** _____

Outpatient Appointment: _____ ☐ **Refused**

Prenatal Care Referral: _____ ☐ **Refused**

ADDITIONAL INFORMATION

PHOENIX CENTER STAFF USE ONLY
Medical Director Approval Obtained ☐ No ☐ Yes, if so date: Clinical Manager Approval: ☐ No ☐ Yes, if so date: Comments: Reason for Non-Admission:
Will client need assistance with applying for Medicaid? ☐ No ☐ Yes Will client need assistance with applying for Medicaid for her children? ☐ No ☐ Yes
Sex Offender Registry checked? ☐ No ☐ Yes Cleared? ☐ No ☐ Yes
Previous Client: ☐ No ☐ Yes Phoenix Center Status: ☐ Active ☐ Discharged

DODUMENTATION NEEDED UPON ADMISSION	
Mother	**Child**
• Picture ID • Social Security Card • Medicaid/Insurance Card • Proof of Pregnancy	• Social Security Card • Medicaid/Insurance Card • Immunization Record
CONTRABAND LIST	
• Alcohol or Illegal Drugs • Items Containing Alcohol • Cameras (except disposable) • Candles/No Incense of any type • Video Games/DVDs	• Knives or Any Other Weapon • Personal Computers • Portable DVD Players/iPods/iPads • Rubber Balloons • Televisions

- Bedding will be provided by Serenity Place upon admission.

*** Upon admission to Serenity Place, you are required to submit to a bodily search. In addition, all personal items will be searched.**

Click here to submit form