

## 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:
<i>Individuals who are incarcerated without a release date will be place on the pending list until a date is given.</i>						
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						
<b><i>Admission Criteria: Use within 30 days if non-pregnant and use within 60 days if pregnant.</i></b>						
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 ( <i>explain smoking policy</i> )				
<b>Smoking Policy:</b> 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			
<p><b>All IV/IV Pregnant Users:</b> 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.</p> <p><b>Packet mailed:</b> _____ <b>Refused</b></p> <p><b>All Pregnant Clients:</b> Interim services offered to include counseling on the effects of alcohol and drug abuse on the fetus, as well as referral for prenatal care. <b>Packet mailed:</b> _____</p> <p>Outpatient Appointment: _____ <b>Refused</b></p> <p>Prenatal Care Referral: _____ <b>Refused</b></p>			
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
<ul style="list-style-type: none"> <li>• Picture ID</li> <li>• Social Security Card</li> <li>• Medicaid/Insurance Card</li> <li>• Proof of Pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>• Social Security Card</li> <li>• Medicaid/Insurance Card</li> <li>• Immunization Record</li> </ul>
CONTRABAND LIST	
<ul style="list-style-type: none"> <li>• Alcohol or Illegal Drugs</li> <li>• Items Containing Alcohol</li> <li>• Cameras (except disposable)</li> <li>• Candles/No Incense of any type</li> <li>• Video Games/DVDs</li> </ul>	<ul style="list-style-type: none"> <li>• Knives or Any Other Weapon</li> <li>• Personal Computers</li> <li>• Portable DVD Players/iPods/iPads</li> <li>• Rubber Balloons</li> <li>• Televisions</li> </ul>

- 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.**