West Slope Casa Residential Treatment Screening Form

DATE OF REFERRAL:______ _________________________________IV: ___________ PREGNANT: ___________

CLIENT NAME:____ CLIENT PHONE NUMBER: _______________________

CLIENT ADDRESS: ____
(CITY/STATE) (COUNTY)

AGE: _____ DOB: _________________ GENDER_______SSN: ____

REFERRED BY (AGENCY) : ____PHONE: ____________________

Required
CLINICIAN_______________________________________

Required
CLINICIAN E-MAIL ADDRESS______________________

DRUG USE HISTORY:

(Type) (Route) (Date first used) (Last use) (Amount)

1. ____
2. ____
3. ____

TREATMENT HISTORY **(Note: no prior treatment requires a written clinical justification on the ASAM sheet)**:

(Type) (Dates) (Completed?) (Followed recommendations?)

1. ____
2. ____
3. ____

COMMUNITY SUPPORT:

AA NA OTHER ______________________________ ATTENDANCE: Regular or Sporadic

*MEDICAL ISSUES: ***West Slope Casa Medical History Questionnaire must accompany referral.***

PSYCH ISSUES: YES *OR* NO

1. ____
2. ____

MEDICATION: YES *OR* NO 50-Day Supply? YES *OR* NO

(Type) (Dosage) (Prescribing Physician)

1. ____
2. ____

LEGAL ISSUES: YES *OR* NO (Attach court papers if court ordered)

1. ____
2. ____

RECOMMENDED LEVEL OF CARE AND LOCATION – check one - (*MUST ATTACH ASAM JUSTIFICATION SHEET*) :

INTENSIVE RESIDENTIAL CWRS Grand Junction______ *INTENSIVE RESIDENTIAL PEACEFUL SPIRIT_______*
HALFWAY HOUSE GWS___________