TRIUMPH

CareLogic Screening

BED DATE GIVEN: _____**Client #/Transportation:** _____

TTS Pre-admit Screening Information

***Name:** _____

Dob:** _____SS#** _____

Provider One #: _____*** Race & Ethnicity:** _____

- **Are you required to register as a sex offender?** **YES ☐ - STOP** **NO ☐**
- **Or/have you been convicted of arson?** **YES ☐ - STOP** **NO ☐**

Are you currently on any MAT/MOUD Services? ☐ No ☐ Yes, What & Where? _____

- **Spoken/Written Languages** _____
- **Military Experience?** _____
- **Highest level of Education:** _____
- **Have you attended school in the past 3 months:** _____
- **Employment Status:** _____
- **Place of Birth:** _____
- **Tabacco Use/History:** _____
- **Is Client Affiliated with a Tribe? ☐ NO ☐ YES -** If Yes, Name and/or Tribal Code: _____

Living Arrangements: _____

Mailing Address: _____
City/ Zip Code: _____

Phone Number: _____ **Message Number:** _____

Email Address: _____

Current Income Level/Funding $: _____**Monthly From:** _____

Gender Identity: ☐Female ☐Male **Sexual Orientation: ☐Heterosexual ☐Other:** _____

Marital Status: ☐Single ☐Divorced ☐Separated ☐Married/Committed Relation ☐Widowed ☐Uknown

Referent: Contact Name & Clinic: _____

Phone & Fax: _____

If assessed: Level of Care: PPW ☐ 3.3 IIP ☐ 3.5 - Date of Assessment: _____ **(please attach)**

Is Client Involved with the Department of Children, Youth, and Family Services? ☐ NO ☐ YES

If Yes, Name and Contact Info: _____

Is Client Involved with any Therapeutic Court? (Drug Court, Family Recovery, DUI, Mental Health) - ☐ NO ☐ YES

If Yes, Name and Contact Info: _____

Is the Client on Probation? ☐ YES ☐ NO

If Yes, Name and Contact Info: _____

Any Pending Court Dates? _____

Are There Any Active Court Orders (LRA, Protection/No Contact Orders)?

_____

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Any Family or Other Support? Describe:_____

- **Drugs Used:** _____
- **Last Use:** _____**IV History?** ☐ **YES** ☐ **NO**
- **Tobacco Use History:** _____

Describe Interim Services/Waitlist Management Plan/ <u>Detox needed?</u> ☐ **YES** ☐ **NO**

_____

Do you have chronic medical conditions? Are these medical conditions in a controlled state?

_____

Do you have any current medical needs that need to be addressed?

_____

Do you have any medical needs that would prevent you from sleeping on a top bunk (bunk bed): YES ☐ NO ☐

Are you prescribed any mental health medications: YES ☐ NO ☐

CURRENT MEDICATIONS (including medical, medication-assisted treatment (MAT), and mental health medications)
Please bring a 30 days supply.

_____

_____

Do you have a mental health diagnosis? ☐ YES ☐ NO, please list ALL below

_____

Are you interested in Mental Health Counseling or Mental Health Medication while at Triumph: YES ☐ NO ☐

History of Self-Harm or Suicidality? ☐ YES ☐ NO If Yes, What & When:

_____

History of assault/harm to others/homicidally ☐ YES ☐ NO If Yes, Explain:

_____

<u>PPW Program (complete below)</u>

Is Client Pregnant or Parenting a Child Under 6 Years Old: ☐ YES ☐ NO

Children Name, Gender & DOB:

1. _____ **☐ YES ☐ NO DOB:** _____

2. _____ **☐ YES ☐ NO DOB:** _____

Do you have any medical concerns for the child(ren)? Does the child(ren) have chronic medical conditions? Are medical conditions in a controlled state?

_____

Will you be coming with Child(ren): ☐ No ☐ Yes How many ? _____

Parental, right? ☐ YES If NO, who has custody? _____

Pregnant? ☐ NO, YES – Estimated Delivery Date: _____

Are you connected with the Parent Child Assistance Program (PCAP)? (Females Only) –

If Yes, Name and Contact Info: _____