Date: / / Name: Phone Number:

Emergency Contact/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to Contact Y/N

Homeless? Y/N Address (if homeless, last known address):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: / / **Age:** Male/ Female/Other Social Security Number:

Current/former FLACRA Client? Y/N When/where: Own transportation available: Y/N

Who is referring you? VA Preference Program: Y/N

Have you ever served in the military? Y/N If Yes, Do you have a DD-214 or NGB-22 Document? Y/N

|  |  |  |
| --- | --- | --- |
| **High priority** | Y | N |
| Pregnant |  |  |
| IV user |  |  |
| Homeless |  |  |

**Insurance/Fundi \*Please bring insurance card(s) and ID\***

* No Insurance Have you applied for Medicaid? Date applied:
* Medicaid/ CIN Number:

 Managed Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Other Insurance: ID Number:
* Have you applied for DSS? County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* SSD/SSI

**Drug of Choice:** Route:

Age of first use:

Pattern of use - How much (mgs, oz, bags, $):

How often:

How long using AT THIS RATE:

Pattern of use in the past 30 days:

Most recent use: Date / / how much:

Longest period of abstinence and date of abstinence:

**Other Drug:** Route:

Age of first use:

Pattern of use - How much:

How often:

How long using at this rate:

Pattern of use in the past 30 days:

Most recent use: Date / / how much:

Longest period of abstinence and date of abstinence:

**Other Drug:** Route:

Age of first use:

Pattern of use - How much:

How often:

How long using at this rate:

Pattern of use in the past 30 days:

Most recent use: Date / / how much:

Longest period of abstinence and date of abstinence:

**Nicotine:** Route:

Age of first use:

Pattern of use - How much:

How often:

How long using at this rate:

Pattern of use in the past 30 days:

Most recent use: Date / / how much:

Longest period of abstinence and date of abstinence:

**Withdrawal Symptoms**

Currently Experiencing:

History of other withdrawal symptoms:

**Medical History**

Able to complete activities of daily living independently? (Shower, dress, ability to walk, etc.) Y/N

History of Seizures? Last seizure: Seizure Disorder or due to withdrawal?

Hallucinations? Audio/ Visual/Both Last episode:

Medical Detox? Complications? If yes, explain:

Current medical conditions: Upcoming Medical Appts:

Past medical/surgical history:

Hospitalization or Emergency room visits in the past 6 months (when and reason for visit):

Recent blood testing? If yes, when and location:

Tested positive for HIV/AIDS/TB/Hep C or any other communicable disease?

 Are you experiencing chronic pain? Y/N If yes, are you receiving treatment for pain management? Y/N

Food/Drug Allergies: **Currently Pregnant?**   **If Yes, Due Date?**

**Current Prescribed Medication Last day took medicat**ion Used for / mgs / how often Bringing medication

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | Y/N |
|  |  |  | Y/N |
|  |  |  | Y/N |
|  |  |  | Y/N |
|  |  |  | Y/N |
|  |  |  | Y/N |
|  |  |  | Y/N |

Who prescribes these medications:

 ***\*Must bring a 30-day supply of medications or obtain their refill prior to admission\****

**Mental Health History**

Current mental health conditions:

Past mental health history/hospitalizations:

Mental Health Provider: Upcoming Mental Health Appts:

Current suicidal thoughts: \*If yes -Do you have a plan?

***\*If yes, ask the client to hold and have another staff call 911. Keep the client on the phone until Emergency Responders arrive at the client’s location. Document everything. \****

History of suicide attempts: Last attempt: Method:

**Social Factors**

Current living situation: Is this a safe place?

Do you have children? Are you in jeopardy of losing them?

Do you have Friend or Loved one who has been affected by your SUD? Y N

If yes, whom? Can our Family Navigators contact them? Y N

Contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Probation/Parole/Drug Court (type/county/PO Name):

Current legal issues: Upcoming court dates?

**Registered sex offender? If yes, what level?**

In their own words, what is their crisis?

**Completed By:**  **Date:**

**Staff Review**

❒820/Stabilization ❒Medically Supervised ACC

❒Not Approved/Reason:

❒Community Residence ❒ Supportive Living

**Referred to:**

❒Loyola ❒SBH Eval Center Syracuse ❒Binghamton ACC ❒ Highland Hospital ❒Utica ACC

❒SBH Eval Center Rochester ❒Lifeline ❒Nearest Emergency Dept. ❒FLACRA Care Management ❒Navigator Valorie Woodside 585-526-6215 ❒Other

**Reviewed by: Date:**

***Please Bring: Limited drop offs allowed***

3-5 Days’ Worth of Weather Appropriate Clothing

Medications in Original Containers

Up to $20 dollars (quarters or dollars )

***Items Not Allowed:***

Aerosol Cans (Hairspray, Body Spray, Etc.)

Baby Powder

Blankets, Pillows, Towels, Stuffed Animals

Cell Phones, Chargers, Cameras, Pagers

Clippers, Razors, Shavers

Earphones

Food or Beverages

Hats (cannot wear hoods up)

iPod, MP3 Players, CDs, iPad and Tablets

Nail Clippers, Tweezers

Nail Polish or Remover

Shower Shoes/ Flip Flops

Insurance Card/ID

**\*\*\*All Clothing will be run through a dryer on HIGH HEAT for 40 MINUTES\*\*\***

***Items that will be Destroyed upon Admission:***

Cigarettes

Tobacco

Lighters/Matches

E-Cigarettes

E-Cig Batteries

E-Juice

Drug Paraphernalia

Drugs

Loose Medication

Non-prescribed Medications

Q-Tips and Cotton Balls

Revealing clothing

Scissors, Weapons, Knives

Products Containing Alcohol

Pornographic Materials

Perfume, Cologne, Scented Oils, Patchouli, Etc.

Personal Hygiene Products – These will be provided.



Coronavirus Screening Assessment

(Please give to staff prior to entering the building.)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle yes or no:

1. Are you experiencing shortness of breath, a cough, or sore throat?

YES NO

1. Do you have a fever?

YES NO

1. Have you traveled outside the United States in the past 14 days? (Specifically, Italy, South Korea, Iran or China)

YES NO

1. Have you been in contact with anyone who has traveled outside the United States within the last 14 days?

YES NO

Staff/Visitor/Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_