

# PART 822 CHEMICAL DEPENDENCE OUTPATIENT SERVICES SCREENING FORM

<b>Patient Name:</b>		<b>Patient ID #:</b>
<b>Date of Screening:</b>		<b>Duration of Screening:</b>
<b>Referral Source:</b> <input type="checkbox"/> Self <input type="checkbox"/> Probation/Parole <input type="checkbox"/> DSS/CPS <input type="checkbox"/> DWI/DPP <input type="checkbox"/> Other treatment provider <input type="checkbox"/> Other		
Name/Title:		
Agency:		
Address:		
Phone #:		
Signed consent(s) for release? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Screening Tool:</b>		
<input type="checkbox"/> ASSIST	<input type="checkbox"/> CAGEAID	<input type="checkbox"/> DPP/DWI
<input type="checkbox"/> AUDIT	<input type="checkbox"/> CRAFFT (adolescents)	<input type="checkbox"/> GAIN Quick
<input type="checkbox"/> CAGE	<input type="checkbox"/> DAST	<input type="checkbox"/> MAST
<input type="checkbox"/> RIASI	<input type="checkbox"/> Simple Screen	<input type="checkbox"/> Other
<b>Results of Screening:</b>		
Score from Screening Tool:		
1. From results of Screening Tool, on a scale of 1 – 10 (with 1 being not likely and 10 being highly likely) how would you rate the likelihood that the patient has a Substance Abuse Problem?		□
2. Counselor assessment, on a scale of 1 – 10 (with 1 being not likely and 10 being highly likely) how would you rate the likelihood that the patient has a Substance Abuse Problem?		□
Recommendations: <input type="checkbox"/> Pre-admission Assessment <input type="checkbox"/> Brief Intervention <input type="checkbox"/> No further assessment needed		
<input type="checkbox"/> Referral to different type or level of care; referral information		
<b>Summary of Feedback given to the Patient Based on the Results of the Screening:</b>		
<b>Clinical Staff Member's Signature</b>		<b>Date</b>
By my signature I acknowledge that the results and recommendations of this screening have been shared with me:		
<b>Patient's Signature</b>		<b>Date</b>