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| **Person Served Information** | |
| **Person Served Name:** | **Person Served DOB:** Enter Person Served DOB |
| **Preferred Name:** | **Preferred Pronoun:** Choose pronouns |
| **Person Served Address:** | **Person Served Phone #:** |
| **Preferred Language:** Enter Language | **Interpreter Utilized?** Choose answer |
| **Avatar ID Number:** | **Insurance:** Choose answer |
| **Person Served Social Security #:** | **Person Served Medi-Cal # (optional):** |
| **Explanation of why the person served is currently seeking treatment:** | |

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| **Provider Information** | | |
| **Program Name:** Enter Program Name | **Counselor/LPHA Name:** Enter Counselor/LPHA Name | |
| **Date:** Enter Service Date | **Start Time:** Start Time | **End Time:** End Time |
| **Total Time:** Total Minutes for Service including Documentation time | | |

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| **Dimension 1 – Acute Intoxication and/or Withdrawal Potential** |

1. Are you currently experiencing any severe withdrawal symptoms? Choose answer

If yes, please explain: Please explain

2. Are you currently under the influence of any substances? Choose answer

3. What substances do you primarily use? Enter substances

If Yes to Q1, immediate referral to nearest Emergency Dept. for medical treatment/clearance, **Stop Screening**

If Yes to Q2, consider WM 3.2 (medical clearance may be needed). For adolescents refer to Emergency Dept.

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| **Dimension 2 – Biomedical Conditions and Complications** |

1. Are you having any serious medical concerns that need immediate attention? Choose answer

If yes, please explain: Please explain

2. Do you have any medical problems or conditions that require special accommodations? Please explain

3. Are you pregnant? Choose answer If yes, when is your due date? Please explain

If Yes to Q1, immediate referral to nearest Emergency Dept. for medical treatment/clearance, **Stop Screening**

If Yes to Q3, refer to a program with perinatal services.

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| **Dimension 3 – Emotional, Behavioral or Cognitive Conditions and Complications** |

1. Are you currently having thoughts of causing physical harm to yourself or others? Choose answer

If Yes, do you have a plan and the means to harm yourself or others? Please explain

2. Are you currently experiencing any severe emotional, behavioral or cognitive issues? Choose answer

If Yes, document additional information in detail: Please explain

3. Have you been diagnosed with an emotional, behavioral or cognitive condition? Choose answer

If Yes, does it have an impact on your daily life or functioning? Choose answer

If Yes to Q1, ask additional questions to further assess for Tarasoff. **If a Tarasoff incident, follow your current policies.**

**Also,** refer to Exodus Recovery Crisis Center at 559-453-1008 or Emergency Dept., **Stop Screening**

If Yes to Q2, consider referral to DBH UCWC (adults) at 559-600-9171 or YWC (adolescents) at 559-600-8918, continue screening.

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| **Dimension 4 – Readiness to Change** |

1. Have you been mandated or directed to receive substance use disorder treatment? Choose answer

If Yes, please describe mandate or direction. Please explain

2. How willing are you to engage in substance use treatment? Please explain

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| **Dimension 5 – Relapse, Continued Use or Continued Problem Potential** |

1. How many days have you used in the past 30 days? Please explain

2. Are you likely to continue to use substances without treatment? Choose answer

3. On a scale of 0 to 4 with “0” being none and “4” being severe, describe your desire/urge to use substances? Choose answer

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| **Dimension 6 – Recovery Environment** |

1. Is your current living situation unsafe or harmful to your recovery? Choose answer

2. Do you have relationships (family, friends, peers) that are supportive of you and your recovery? Choose answer

If Yes to Q1, consider Residential Treatment or Emergency Housing referral.

If No, consider if person served can be safely managed in Outpatient or Intensive Outpatient.

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| **Level of Care Scoring Guide** | | | | | |
| **Dimension 1**  Choose answer | **Dimension 2**  Choose answer | **Dimension 3**  Choose answer | **Dimension 4**  Choose answer | **Dimension 5**  Choose answer | **Dimension 6**  Choose answer |
| **Level of Care Inquiry:**  What type of treatment services are you willing to participate in? Choose Level of Care  Are you interested in learning more about the Recovery Supports we have to offer? Choose answer  If interested, what information was given? Please explain | | | | | |
| **Level(s) of Care Disposition:**  Indicated Level of Care: Choose Level of Care  Additional Level of Care (if applicable): Choose Level of Care  Additional Treatment Services (Recovery Residence, MAT): Please explain | | | | | |
| Program Referral(s): Please explain | | | | | |
| How did you link the person served to program indicated along with any additional services? Please explain | | | | | |

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| **Counselor/LPHA Name Printed:** | **Counselor/LPHA Signature:** | **Date:** |
| **Clinical Supervisor Name Printed (Optional):** | **Clinical Supervisor Signature (Optional):** | **Date:** |