Call Screening Tool
Substance Use Disorder Services

Date: _________ Time: __________ Screener: ____

Client Name: ____ Date of Birth: __________________

Age: _______ Ethnicity: ____________________ Gender Identity: Male / Female / Transgender / Other

Phone # 1: ___________________________ Phone # 2: ____________________________

* What is most important to you, that you want help with, or that made you decide to call today? *(If caller is not seeking SUD Services provide appropriate referrals and end call & form ends here)* Referral Made: Yes / No

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Drug of Choice	Route of Administration	Frequency last 30 days	Frequency last 12 months	Continuous use at age:

Do you have Current Medical Coverage: Y / N If Yes: Insurance Provider: _______________________________

Primary Physician: ____ Phone #: _______________________

Current Medical Condition(s):____

Current Psychiatric Diagnosis/Condition(s):_____________________ Pharmacy: __________________________

If yes, is the Mental Health Professional *(MFT, MSW, PhD, MD, etc.)* Involvement: past / present or both past & present? If yes, Please provide the name of the Mental Health Professional _____________________________

Where are they located? ________________________Current Prescribed Medications: ____________________

Are you currently experiencing any mental health symptoms such as depression or anxiety for which you would also like a referral? Yes / No

Living Situation: Married / Living with a Partner / Living with Family / Other / Single

Female Clients Only; Are you pregnant? Yes / No

If yes, do you have custody of your children? Custody of Children: Yes / No / Unknown

Number of children: ______ Children(s) Ages: ______________

Are you: Employed / Attending School / Unemployed / Disability / Other _________________________________

If employed, do you work: Part Time / Full Time and Evenings / Days What are your hours per Week: ______

Name of Employer: ___________________________________ Location: ________________________________

Client Address/Place of Residence: ________________________City: ___________________ Zip: ___________

Social Security #: ________________________ Source of Income: ______________________________________

DIMENSION 1. Acute Intoxication and/or Withdrawal Potential

(a) Past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal? e.g., need for IV therapy; hospital for seizure control; psychosis with DT's; medication management with close nurse monitoring and medical management? ___No ___Yes; (b) Currently is having severe, life-threatening and/or similar withdrawal symptoms? ___No ___Yes

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Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

DIMENSION 2. Biomedical Conditions/Complications

(a) Does the client have any current severe physical health problems? e.g., bleeding from mouth/rectum in past 24 hours; recent, unstable hypertension; severe pain in chest, abdomen, head; significant problems in balance, gait, sensory/motor abilities not related to intoxication. ___No ___Yes; (b) Does or has the client had a history or recent episode of seizures/convulsions; diagnosed with TB, emphysema, hepatitis C, heart condition? ___No ___Yes

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Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

DIMENSION 3. Emotional/Behavioral/Cognitive Conditions/Complications

(a) Imminent danger of harming self or someone else? e.g., SI+ with intent, plan, means to succeed; HI+ or violent ideation, impulses, uncertainty about ability to control impulses, with means to act. ___No ___Yes; (b) Unable to function in ADL's, care for self with imminent, dangerous consequences? e.g., unable to bathe, feed, care for self-due to psychosis, organicity or uncontrolled intoxication with threat of imminent DTS/O as regards death or severe injury. ___No ___Yes; (c) Client will benefit from a co-occurring capable program as opposed to a co-occurring enhanced program? ___No ___Yes

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Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

DIMENSION 4. Readiness to Change

(a) Does the client appear to need SUD treatment/recovery and/or mental health treatment, but is ambivalent or feels it's unnecessary? e.g., severe addiction, but client feels controlled use is still OK; psychotic, but blames a conspiracy. ___No ___Yes;
(b) Client has been coerced or mandated to have assessment and/or treatment by Mental Health Court or CJ system, health or social services, work/school, or family/significant other? ___No ___Yes; (c) Client desires and is ready to change their current SUD behavior? ___No ___Yes

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Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

DIMENSION 5. Relapse/Continued Use/Continued Problem Potential

(a) Does the client understand relapse but needs structure to maintain therapeutic gains? ___No ____Yes; (b) Client is unwilling and/or ambivalent to create a continued use prevention plan? ___No ____Yes; (c) Is the client likely to continue to use or have active, acute symptoms in an imminently dangerous manner, without immediate containment? ___No ____Yes

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Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

DIMENSION 6. Recovery Environment

(a)Are there any dangerous family, significant others, living/work/school situations threatening the client's safety, immediate well-being, and/or sobriety? e.g., living with a drug dealer; someone with a Substance Use Disorder or using drugs or alcohol; client is experiencing abuse by a partner or significant other; homeless in freezing temperatures. ___No ___Yes; (b) Does the client have the life skills and/or support necessary to participate in day to day functions? ___No ___Yes

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Select one: No Risk/Stable (0) Mild (1) Moderate (2) Significant (3) Severe (4)

ASAM Clinical Placement Scoring Summary						
ASAM Dimensions: *2 – Biomedical Conditions and Complications; 3 –Emotional/Behavioral/Cognitive Conditions and Complications; 4 – Readiness to Change (including Desire to Change); 5 – Relapse/Continued Use/Continued Problem Potential; 6 – Recovery Environment*						
Risk Rating	Intensity of Service Needed	Dimensions				
		2	3	4	5	6
(0) No Risk or Stable – Current risk absent. Any acute or chronic problem mostly stabilized.	No immediate services needed.					
(1) Mild – Minimal, current difficulty or impairment. Minimal or mild signs and symptoms. Any acute or chronic problems soon able to be stabilized and functioning restored with minimal difficulty.	Low intensity of services needed for this dimension. Treatment strategies usually able to be delivered tin outpatient settings.					
(2) Moderate – Moderate difficulty or impairment. Moderate signs and symptoms. Some difficulty coping or understanding, but able to function with clinical and other support services and assistance	Moderate intensity of services, skills training or supports needed for this level of risk. Treatment strategies may require intensive levels of outpatient care.					
(3) Significant – Serious difficulties or impairment. Substantial difficulty coping or understanding and being able to function even with clinical support.	Moderately high intensity of services, skills training, or supports needed. May be in danger or near imminent danger.					
(4) Severe – Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate and cope with problems. Is in imminent danger.	High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services & frequency greater than daily.					

Key Findings Supporting Next Placement Decision:

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ASAM Level of Care to which referred (circle)	Program to which referred
- 1 Outpatient Services - 2.1 Intensive Outpatient Services - RR/OT Recovery Residence plus Outpatient - RR/IOT Recovery Residence plus Intensive Outpatient - 3.1 Low-Intensity Residential Services - 3.3 Population-Specific High-Intensity Residential Services - 3.5 High-Intensity Residential Services - 1-WM Ambulatory Withdrawal Mgmt. w/out Extended On-Site Monitoring - 3.2-WM Residential Withdrawal Management - NTP Narcotic Treatment Program	Is there other information regarding your treatment needs such as sexual orientation, gender identity, disability and accessibility of services, or any other needs that you would like to discuss? If yes, please explain: ____________ ____________ Program Referred to:____________ Contact Person: ____________ Intake Appointment Date: ________ Time: ________

Availability to admit into Care: Immediately / Delayed
If delayed, reason: Client Choice / Lack of Bed Availability
Interim Service Referral: Date _______ Time: _______ Where: _______ With: ____________

Do You consent to Releasing Your Information to the Provider(s) We Refer You To? Yes / No

Staff Printed Name & Signature (required)	**Date:**
Supervisor Printed Name & Signature (required)	**Date:**