INTAKE PHONE SCREENING M_____

Name:_____		Date:**3/25/11**
Address:_____		SS#:_____
Phone:_____	DOB:_____	Age:_____ (if under 18 y/o = FDA 30 day detox)

OK to leave a message? Yes ☐ No ☐ OK to say Cap? Yes ☐ No ☐

1. How long does it take you to travel to Westbrook? *(Explain need for daily attendance and how distance traveled does not qualify for early take homes.)*	_____
2. A) Have you been in MMT before? B) Have you been in treatment for substance abuse anywhere else?	Yes ☐ No ☐ (*If yes ask questions 3 & 4*) Yes ☐ No ☐ (*Detox, out patient or residential treatment*)_____
3. **Are you a previous CAP patient?** ***If yes, check balance*** ____ Did you complete the medical withdrawal schedule?	Yes ☐ No ☐ *If yes …* Dates: _____CAP # :***M***_____ Yes ☐ No ☐ *Why did you leave treatment?*_____
4. MMT at another facility? Did you complete a medical withdrawal schedule from that facility?	Yes ☐ No ☐ *If yes …* Dates: _____ Yes ☐ No ☐ *Why did you leave treatment?*_____

Mercy Referrals --- **Mercy Contact Name: _____Mercy Contact Phone:_____**

5A) What drugs are you currently using? 5B) Have you used IV Drugs? Yes ☐ No ☐ If yes, specify if • Past or current _____ • Injected in what part of body _____ • Shared needles _____ • Etc _____ *Refer IV drug users to public health service for HIV testing:* ***Positive Health Care 874-8791*** ***Referral made:*** Yes ☐ No ☐	***RX Drug***	***Amount***	***Frequency***	***Method***
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	Illicit Drug	***Amount***	***Frequency***	***Method***
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
5C) Are you currently using ***benzodiazipines***? (*Valium, Klonopin, Ativan, Lorazepam, Xanax, Diazepam, etc.*)	***RX Drug***	***Amount***	***Frequency***	***Method***
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	Illicit Drug	***Amount***	***Frequency***	***Method***
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
5D) Are you currently using ***Suboxone or Subutex*** or other buprenorphine such as ***Temgesic or Buprenex?***	***RX Drug***	***Amount***	***Frequency***	***Method***
	_____	_____	_____	_____
	Illicit Drug	***Amount***	***Frequency***	***Method***
	_____	_____	_____	_____
	_____	_____	_____	_____
5E) Do you get sick when you don't use any type of drug?	Yes ☐ No ☐ *If no, why not?*_____			

5.) Do you drink alcohol? *If yes, explain **CAP Alcohol Policy** and interactions between alcohol and methadone.* Will it be difficult for you to quit alcohol on your own?	Yes ☐ No ☐ If yes: *Amount_____ Frequency_____* Yes ☐ No ☐ *If yes, give referrals for ETOH detox/treatment, if needed.*
6. How long have you been using opiates on a daily basis?	____
7. Are you Pregnant? If patient reports no provider patient must call and schedule an appointment **BEFORE** Cap's intake appointment: **MMC OBGYN Clinic 662-2911 or CMMC OBGYN 795-5770**.	Yes ☐ No ☐ If yes, **documentation of High Risk Pre-natal care is needed for Intake appointment.** **Informed** **Yes ☐ No ☐**
8. Have you recently been hospitalized?	Yes ☐ No ☐ If yes, where and what for? ____
9. A) Do you have any thought of hurting or killing yourself? B) Do you have any thought of hurting or killing someone else? C) Are you currently receiving counseling?	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ If yes, inform the patient that documentation of counseling is required at intake
10. Are you legally mentally incapacitated? Documentation and the legal guardian **must be present** for the CAP intake appointment.	Yes ☐ No ☐ If yes, who is your guardian? ____
11. What is going on in your life that is making you seek treatment at this time?	____

Inform the Patient of the following:	**Informed**
• **Do not take/use any substances 24 hours prior to your intake appointment.**	**Yes No** ☐ ☐
• **Patient must provide documentation for previous treatment with opioid dependence diagnosis.**	☐ ☐
• **If appropriate for MMT, patient will need the following:** ☐ **$90** (per week) in cash or money order and ☐ a portion of the back bill (*if applicable*) Amount of balance due: ____ or ☐ a current Medicaid (Maine Care) plus a $2 co-pay (*if applicable*)	☐ ☐
• **2 ID's** 1. Valid Photo ID (*DL, State ID, IDPA Card, or Passport*) 2. Valid ID (*SS Card, Birth Certificate, Voter Registration Card, Work/School ID*)	☐ ☐ ☐ ☐
• Must bring copies of all currently prescribed medications and/or pharmacy printout. **(No Bottles!)**	☐ ☐
• Be prepared to provide a urine sample. (This will happen near the beginning of the intake process.)	☐ ☐
• **If pregnant** must provide documentation of **"High Risk Pre-Natal Care."**	☐ ☐
• Be prepared to have this intake process last to about 12 o'clock, noon.	☐ ☐
• Have reliable transportation for lab work on intake day. **Lab work is required to be completed on intake day at an off-premise lab**.	☐ ☐
• We strongly encourage you to **NOT** bring children, S/O, or anyone else to your intake appointment in order to avoid distractions and issues with confidentiality. **This clinic does NOT provide childcare.**	☐ ☐
• Stress the importance of being **ON TIME.** ▪ You must arrive on intake day no later than **6:00 am.** ▪ If you are late, you will not be considered for an intake on that day. ▪ You will have to come back on the next scheduled intake day.	☐ ☐
• Emphasize that the intake appointment is **ONLY A SCREENING** and **DOES NOT GUARANTEE ADMISSION to CAP Quality Care.**	☐ ☐

Comments and Referrals: ____

Intake Appointment: ____ **Walk-in Appointment:** ☐

Staff Member: ____

Staff Signature: _____ Date:3/25/11