COUNTY OF SAN MATEO
HEALTH SYSTEM

BEHAVIORAL HEALTH & RECOVERY SERVICES
ADOLESCENT INITIAL PLACEMENT SCREEN

This brief screening instrument is based on ASAM criteria, used for each treatment inquiry to:
(1) Rule out necessity for Emergency intervention, and helps decide between:
*(2) Referral directly to Outpatient (**OP**) or Intensive Outpatient (**IOP**), or*
*(3) Referral to the Residential Treatment Team (**RTX team**) for Evaluation*

I will be asking you some questions so I can figure out the best way to help you.

Are you calling for yourself, or as a parent/guardian (or other adult) on behalf of a minor? ☐ Self* ☐ Other

**If calling for self, please adjust questions accordingly (e.g.: from "minor" – "you")*

Has the minor been referred to treatment by a 3rd party? ☐ Yes ☐ No If yes, by whom?__________

How can I help you today? ____

Client Name: ____ SSN #:____________________________

Date: _______________ Time: _____________ Call Duration: _____________ DOB:____________________

Address: ______________________________ City: ____________________ State: _______ Zip: ________

Phone:___________________ VM/text ok: ☐ Yes ☐ No Medi-Cal: ☐ San Mateo ☐ None ☐ Other: ____________

Gender: ☐ M ☐ F ☐ Trans/Other If female, is minor currently pregnant: ☐ Yes ☐ No ☐ Unsure

Do you consent to releasing the minor's information to providers we refer you to today? ☐ Yes ☐ No

DIMENSION 1. WITHDRAWAL/DETOXIFICATION POTENTIAL

1. Is the minor experiencing any current severe withdrawal symptoms? ☐ Yes ☐ No
   a. What substances does the minor use to get high?
      Please describe: ____
2. May I ask, is the minor under the influence of substances right now? ☐ Yes ☐ No
   a. If NO: Has minor used any substances in the last 1-3 days? ☐ Yes ☐ No

*If YES Q1, immediate referral to nearest Emergency Dept., **Stop Screen***

DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS (not related to withdrawal):

1. Is the minor having a medical emergency? ☐ Yes ☐ No
2. Does the minor require special accommodation (*e.g. wheelchair, sensory impairment*)? ☐ Yes ☐ No
   If YES, specify: ____

*If YES Q1, immediate referral to nearest Emergency Dept., **Stop Screen***

DIMENSION 3. EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

1. Is the minor currently having thoughts of hurting self or others? ☐ Yes ☐ No
   a. If YES, does minor have a plan and means to harm self or others? ☐ Yes ☐ No
      If YES: describe: ____
2. Is minor currently having any severe mental or emotional issues or distress? ☐ Yes ☐ No
   If YES, specify: ____

*If YES Q1 or Q2, refer to nearest Psychiatric Emergency facility, **Stop Screen***
If NO, consider referral to ACCESS Call Center or OP/ IOP, continue screen

DIMENSION 4. READINESS TO CHANGE

1. Has minor been mandated/directed to enter Residential Substance Use Treatment? ☐ Yes ☐ No
2. Is minor motivated to stop or cut back their drinking/using? ☐ Yes ☐ No

If YES Q1, RTX referral
If NO Q2, consider OP / IOP for Motivational Interviewing / Enhancement

DIMENSION 5. RELAPSE/CONTINUED USE POTENTIAL

1. In the last month, has the minor used substances more often than not? ☐ Yes ☐ No
   a. Has / or is minor currently in a setting that prevents them from using substances? (e.g. jail, hospital, care facility, etc.) ☐ Yes ☐ No
2. Is the minor likely to continue to drink/use without treatment? ☐ Yes ☐ No
3. Do minor's family/friends state the minor should cut down on his/her drinking or drug use? ☐ Yes ☐ No

If YES Q1 or Q2, consider RTX referral and/or NRT
If NO, consider OP/IOP and/or recovery support referrals

DIMENSION 6. RECOVERY ENVIRONMENT

1. Is the minor's current living situation unsafe or harmful to their recovery? ☐ Yes ☐ No
   a. If YES, specify: ____
2. Does the minor feel supported at home? ☐ Yes ☐ No
3. Does anyone else at home use drugs or alcohol? ☐ Yes ☐ No

If YES Q1 consider RTX referral
If NO Q1 consider if client can be safely managed in OP/IOP

Level of Care Inquiry:

Does the minor know what type of treatment they are interested in?

☐ Outpatient ☐ Intensive Outpatient ☐ Residential treatment ☐ Other: _____________
☐ Medication Assisted Treatment (Naltrexone, Vivitrol, etc.) ☐ NRT (Methadone, Suboxone)

Are you/the minor interested in learning about other Recovery Supports? ☐ Yes ☐ No

If caller not ready for abstinence, consider OP/ IOP and/or Recovery Support referrals.

Level of Care Disposition: referrals: fax 650-802-6440 GRP_HS_BHRS_RTXTEAM@smcgov.onmicrosoft.com

Do you have confidence the information presented is reliable and accurate? ☐ Yes ☐ No

*If no *(e.g.: Unsure about minor's use, poor insight, intoxicated, etc.)*, refer to RTX team for further evaluation

Indicated Level of Care *based on screen results)*

☐ Outpatient / Intensive Outpatient
☐ Residential Evaluation
☐ Urgent / Crisis Services

Actual Level of Care Offered:

☐ Outpatient / Intensive Outpatient
☐ Residential Evaluation
☐ Urgent / Crisis Services

Reason for Difference (if any): ____

☐ N/A, no difference ☐ Client preference ☐ Family Responsibility
☐ Service not available ☐ Provider Judgment ☐ Geographic accessibility
☐ Language Needs ☐ Ct on waiting list for indicated level ☐ Other____________________

Program Referral(s): ____

What Recovery Supports/Resources were provided:

☐ Access Call Center ☐ Medication Assisted Treatment ☐ Narcotic Replacement Tx
☐ Shelter Referral ☐ Voices of Recovery ☐ 12 Step ☐ Other: ___________________

How did you attempt to link the caller and do a warm hand off: ______________________________________

Signature: ____ **Date**: ____________________