COUNTY OF SAN MATEO
HEALTH SYSTEM

BEHAVIORAL HEALTH & RECOVERY SERVICES
ADULT 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 decide between:
*(2) Referral directly to Outpatient (**OP**) or Intensive Outpatient (**IOP**), or*
*(3) Referral to the Residential Treatment Team (**RTX team**) for Evaluation*

How can I help you today? _____
I will be asking you some questions to figure out how we can meet your needs:

Client Name: _____ SSN #:_____

Date: _____ Time: _____ Call Duration: _____ DOB:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone:_____ VM ok: ☐ Yes ☐ No Medi-Cal: ☐ San Mateo ☐ None ☐ Other: _____

Gender: ☐ M ☐ F ☐ Trans/Other Are you currently pregnant: ☐ Yes ☐ No ☐ Unsure

Are you parenting children 17 yo or younger ☐ Yes ☐ No Are you currently injecting drugs ☐ Yes ☐ No

Do you consent to releasing your information to providers we refer you to today? ☐ Yes ☐ No

DIMENSION 1. WITHDRAWAL/DETOXIFICATION POTENTIAL

1. Are you experiencing any current severe withdrawal symptoms? ☐ Yes ☐ No
2. May I ask, are you under the influence of any substances right now? ☐ Yes ☐ No
   a. If NO: Have you used any substances in the last 1-3 days? ☐ Yes ☐ No

*If YES Q1, immediate referral to nearest Emergency Dept., **Stop Screen***
If YES Q2, consider Withdrawal Mgnt/Detox (medical clearance needed) or Sobering Station, cont. screen

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

1. Are you having a medical emergency? ☐ Yes ☐ No
2. Do you require any special accommodation (*e.g. wheelchair, sensory impairment*)? ☐ Yes ☐ No
   If YES, specify: _____

*If YES Q1, immediate referral to nearest Emergency Dept., **Stop Screen***
If NO, continue screen

DIMENSION 3. EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

1. Are you currently having thoughts of hurting yourself or others? ☐ Yes ☐ No
   If YES, do you have a plan and the means to harm yourself or others? _____
2. Are you 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. Have you been mandated or directed to enter Residential Treatment? ☐ Yes ☐ No
2. Are you motivated to stop or cut back your 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, have you used substances more often than not? ☐ Yes ☐ No
   a. Have you been, or are you currently, in a setting that prevents you from using substances? (e.g. jail, hospital, care facility, etc.) ☐ Yes ☐ No
2. Are you likely to continue to drink/use without treatment? ☐ 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 your current living situation unsafe or harmful to your recovery? ☐ Yes ☐ No
2. Do you struggle to care for yourself? ☐ Yes ☐ No

If YES Q1, or Q2 consider RTX or Shelter referral
If NO, consider if client can be safely managed in OP/IOP

Level of Care Inquiry:

Do you know what type of treatment you're interested in?

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

Are you interested in learning about other Recovery Supports we have? ☐ Yes ☐ No

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

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

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

*If no *(e.g.: inconsistent answers, poor insight, heavily 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: _____

_____

Printed Name: _____ **Program**: _____

Signature: _____ **Date**: _____