7902 Fingerboard Rd
Frederick, MD 21704
Phone: 301-874-4701 X106 Secure Fax: 888-965-0597

Prescreening Form
Please complete ALL applicable sections – MUST BE LEGIBLE

Please check the program you are applying for to receive treatment at

☐ **Residential and OP** ☐ **OP Only**

FULL Name: First, Middle, Last (if incarcerated include inmate ID, SID etc.)			Date:
Address (If incarcerated list the facility):			
City:	County:	State:	Zip Code:
Age: Date of birth:	Client Telephone #	Social Security # (Cannot process without)	
If previously in treatment, when and where:	If currently in treatment, where: Current Level of Care:	Counselor/Case worker contact info:	
Do you use Tobacco? What Type? __ Smoke? ___ Chew? Race:	Preferred language? Any special communication needs?	Do you give us permission to contact the above contact person? Yes ☐ No ☐	
Military Veteran: Yes ☐ No ☐			
Date available for admission:			
Current Forms of ID: ☐ Birth Certificate ☐ Social Security Card ☐ Driver's License or ID			
Is your Driver's license valid? Yes ☐ No ☐ If not why?			
Insurance: ☐ Yes ☐ No Type: ☐ Medicaid MA# Insurer: ☐ Other Name: Group#: Member# Insurance issuer: ☐ Self ☐ Other (person)			

Current Legal Status

On Probation: Yes ☐ No ☐ County:	Probation/Parole Officer:
Pending court dates: Yes ☐ No ☐ When?	What charges?
Court ordered to treatment: Yes ☐ No ☐ If yes, who ordered you? (list court, judge or agency below: When was your last arrest? _____ Number of Arrests in the last year? _____ Do you have any Violent or Sexual Offenses? ___Yes ___ No Do you have any gang affiliations? ___Yes ___ No	
Legal History: Including outcome of ALL court appearances (Be honest, we will do a background search)	
1.	
2.	
3.	
Use reverse side, if necessary.	

Employment History

Income during this past year: $	Current monthly income: $
☐ Currently Employed ☐ VA Benefits ☐ Retirement ☐ SSDI (SS Disability) ☐ SSI (Social Security) ☐ TEHMA/TANF/TCA ☐ Unemployment Insurance ☐ Other Income Source (please list):	
Are you physically able to work: Yes ☐ No ☐ If unemployed, last employment date:	
Reason for leaving:	

Education

Last Grade Completed:	Current Grade (if applicable):	
☐ Currently in School ☐ Currently working on GED ☐ Want to work on GED ☐ Want to take College courses ☐ Want to attend trade school ☐ Not interested in furthering my education (if no longer in school)		
What school do you attend:		

Dimension 1: Acute Intoxication/Withdrawal Potential

Drugs you have used	Frequency	How? Orally, injection, smoked, inhaled	Date of last use: must be listed	Age started using
1st:				
2nd:				
3rd:				
History of DT's or seizures: Yes ☐ No ☐				

Dimension 2: Medical Conditions and Complications

IV Drug use (must answer): Yes ☐ No ☐ Tested for HIV, Hep C, TB? Yes ☐ No ☐ Date _____ Tested Positive for any of these? Yes ☐ No ☐ If Yes, which one (s)
Are you currently taking Methadone, Vivitrol or Suboxone: Yes ☐ No ☐ Which one:
Do you have any OTHER physical/medical problems? Yes ☐ No ☐
If yes, describe (use reverse side if you need additional space):
Do you have any drug allergies? Yes ☐ No ☐ Do you have any food allergies? Yes ☐ No ☐ List your allergies:
Do you take medication for your physical/medical problems? Yes ☐ No ☐
If yes, list medications (use reverse side if you need additional space):
Are you able to take this medication by yourself? Yes ☐ No ☐
Are you receiving medical services for your physical/medical ailments: Yes ☐ No ☐
If yes, by whom (name of provider, contact information):

Dimension 3: Emotional/Behavioral Conditions and Complications

Do you have any mental health diagnosis? Yes ☐ No ☐ If yes, please describe:
Are you taking any medication for this condition? Yes ☐ No ☐ If yes please list your medications:
Date you were Diagnosed with this condition:
Have you consistently taken this medication as prescribed? Yes ☐ No ☐ If no, Why not?
Are you currently receiving psychiatric services for this condition? Yes ☐ No ☐ If yes, by whom?
Do you have a history of suicidal or homicidal ideation or attempt? Yes ☐ No ☐ If yes, how many times, when was the last attempt and method?

Dimension 4: Treatment Acceptance / Resistance

Are you currently in treatment: Yes ☐ No ☐ If yes, list facility: _____ If yes, is this your first treatment attempt? Yes ☐ No ☐ If no, How many times before? Detox only: _____ Inpatient: _____ Outpatient: _____
What convinced you to seek treatment this time? Describe:
Did you decide to admit yourself into treatment or were others involved (Not including legal system) My Decision ☐ Others ☐ If others, who: _____
If applicable, what have you learned about yourself during your current treatment?
If you had previous treatment, how is this time different?
What value do you see coming to our program?

Dimension 5: Relapse/Continued Use Potential

What relapse prevention tools, if any, have you learned in your current treatment?
What are you relapse triggers?
Have you had a period of sobriety in the past year? Yes ☐ No ☐ How long? If yes, what did you do to maintain your sobriety and why did you relapse?
Why do you think you need help?
What do you want to be different this time?
Why haven't you been able to stay sober on your own?
Are you currently experiencing any cravings or withdrawal symptoms? Yes ☐ No ☐ If yes what?

Dimension 6: Recovery Environment

Current Relationship: Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐
Describe your living situation prior to entering treatment:
What about this living situation did not help you in your attempt at recovery? Describe:
Do you have a significant other? Yes ☐ No ☐ If yes what is the status of this relationship:
Number of children (under 18)? ____ Names/Ages: Who has legal custody? _____ Who has physical custody? _____ Where do they reside? _____

I HEREBY GIVE MY CONSENT TO THE RANCH TO COMMUNICATE WITH MY REFERRAL SOURCE OR ANY CONTACTS LISTED ABOVE TO OBTAIN ANY INFORMATION AND/OR DOCUMENTS NEEDED TO CONSIDER MY APPLICATION FOR ADMISSION TO THE RANCH. I UNDERSTAND THAT THIS CONSENT WILL EXPIRE EXACTLY ONE YEAR FROM THE DATE WRITTEN BELOW.

_____ _____

Applicant's Signature Date

IF THE APPLICANT WISHES TO PROVIDE ADDITIONAL INFORMATION TO THE RANCH NOT COVERED ABOVE, USE THE REVERSE SIDE.

<u>OTHERWISE PLEASE STOP HERE!</u>

TO BE COMPLETED BY CURRENT TREATMENT PROVIDER OR REFERRAL SOURCE

ASAM Dimensions

Complete all sections with appropriate narrative justification to support the circled dimension rating as low, medium, or high.

Dimension 1 (Acute intoxication and/or withdrawal potential): Low, Medium, High
Dimension 2 (Biomedical conditions and complications): Low, Medium, High
Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications): Low, Medium, High
Dimension 4 (Readiness to Change): Low, Medium, High
Dimension 5 (Relapse, Continued Use or Continued Problem Potential): Low, Medium, High
Dimension 6 (Recovery/Living Environment): Low, Medium, High

Recommended Level of Care:

_____

_____

_____

TB PPD or other test documentation: Date: Results:
IV Drug user: Yes ☐ No ☐ HIV: Yes ☐ No ☐ Hepatitis C Yes ☐ No ☐ ☐ Other:
Military Veteran: Yes ☐ No ☐ When/what tour:
Name of current Program _____ Current Level of Care_____
Substance Use and Mental Health Diagnosis
Problems with or access to ☐ Primary support group ☐ Education ☐ Economic ☐ Healthcare ☐ Housing ☐ Legal System ☐ Employment ☐ Social Environment ☐ Other psycho-social & environment problems Describe:
Name of Contact for Referral _____ Referral Contact phone number _____ Referral Contact email _____

REFERRAL SOURCE MUST PROVIDE MEDICAL AND PSYCHOLOGICAL EVALUATION MOST RECENT SUBSTANCE ABUSE EVALUATION ALONG WITH ASAM JUSTIFICATION DOCUMENTATION PRIOR TO ADMISSION TO THE RANCH

MUST ALSO PROVIDE COPY OF TB TEST RESULTS PRIOR TO ADMISSION

_____ _____

Referral Source Signature Date

_____

Referral Source Name and Title

PRIOR TO ADMISSION THE RANCH, MUST RECEIVE THE FOLLOWING

☐ Biopsychosocial ☐ Medical Evaluation ☐ SUD Evaluation ☐ Discharge Summary

☐ TB Test Results

THANK YOU FOR YOUR REFERRAL

RETURN FORM BY FAX IMMEDIATELY UPON COMPLETION TO: 888-965-0597.