|  |  |
| --- | --- |
|  |  Referral Name:       **Referral Contact Info:**       |
|  |        |

## Screening form PLEASE COMPLETE AS MUCH INFORMATION AS POSSIBLE

## Client Information Section 1

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patients Name:** |        |       |       | **DOB:** |        |
|   |  Last | First | M.I. |  |  |

|  |  |  |
| --- | --- | --- |
| **Address:** |        |       |
|  |  Street Address | Apartment/Unit # |
|  |  |  |
|  |       |       |       |
|  |  City | State | ZIP Code |

**Home or Emergency Telephone #:**       **Cell #:**

*Can we leave a message on this number? Yes* *[ ]  No* *[ ]  Can* we leave a message on this number? Yes [ ]  No [ ]

**Social Security #:**       **Email:**

**What Substance Use Services are you requesting?**

OP Counseling [ ]  IOP [ ]  Residential [ ]  RCBM [ ]  Sober Living [ ]  Detox [ ]  Other

## Health Information Section 2

Are you on AHCCCS (Medicaid) or Medicare? Yes [ ]  No [ ]

AHCCCS (Medicaid) ID #:       Medicare ID #:       DOC #:

Other Insurance information if not AHCCCS?

Do you have any behavioral or mental health issues? (Depression, anxiety, PTSD, etc.) Yes [ ]  No [ ]  If so, what?

Are you diagnosed with a Serious Mental Illness (SMI)? (Bipolar, schizophrenia, etc.) Yes [ ]  No [ ]  If yes, what is your mental health diagnosis?

Do you know what Clinic are you assigned to?

Are you receiving services from any other behavioral health provider? Yes [ ]  No [ ]  If yes, who/where?

Are you transferring your care to Axiom Care (Building Blocks Counseling)? Yes [ ]  No [ ]

Do you need a ROI in place to coordinate care with this provider? Yes [ ]  No [ ]

*(Staff will complete the ROI for you to sign if needed)*

Do you have any medical issues? Yes [ ]  No [ ]  If yes, please provide details:

Have you been diagnosed with any of the following chronic medical conditions?

Diabetes Yes [ ]  No [ ]

If so, are you insulin dependent? Yes [ ]  No [ ]

Hypertension (High blood pressure) Yes [ ]  No [ ]

Hep C/ HIV Yes [ ]  No [ ]

Seizure disorder Yes [ ]  No [ ]

If so, is it managed with medication? Yes [ ]  No [ ]

Which medication?

* Page 2 -

Are you receiving services from a medical provider? Yes [ ]  No [ ]  If yes, where?

What medications are you currently prescribed?

Are you taking these medications as prescribed?       Yes [ ]  No [ ]

Do you have any allergies? Yes [ ]  No [ ]

If so, explain:

Food?

Latex?

Medications?

Other?

Do you have a disability that requires specific accommodations? Yes [ ]  No [ ]

If yes, please explain:

Have you ever completed treatment at an inpatient facility or been hospitalized for

Mental Health or Substance Use Disorder? Yes [ ]  No [ ]

If Yes, Where and when?

Are you pregnant? Yes [ ]  No [ ]

If yes, please provide details: (due date, OBGYN etc.)

Have you ever been in treatment with Axiom Care (Building Blocks Counseling or Vivre) before? Yes [ ]  No [ ]

If yes, when and where?

How did you hear about Axiom Care (Building Blocks Counseling)?

Please provide details:

## Current Drug Use Section 3

**Are you seeking help for: Opioids: *[ ]*  Alcohol: *[ ]* Both: *[ ]* Other: *[ ]* (please state:)**

What type of opioids/alcohol are you currently using?

Quantity?

Method?

If Opioids, are you using Fentanyl? Yes [ ]  No [ ]

Have you been using any Opioid IV? Yes [ ]  No [ ]

How long – totally, have you been using opioids or alcohol?

When was the last time you used opioids or drank alcohol?

Are you using any other illicit drugs; like heroin, methamphetamine or cocaine? Yes [ ]  No [ ]

Are you using any benzodiazepines? Yes [ ]  No [ ]

If opioid addiction, are you on: Methadone Yes [ ]  No [ ]  Suboxone Yes [ ]  No [ ]  Vivitrol Yes [ ]  No [ ]

If yes, when and where and your dosing time?

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## Additional Information Section 4

Do you need transportation to your intake appointment? Yes [ ]  No [ ]

Do you have any disability requirements, so we can ensure we have the appropriate transportation? Yes [ ]  No [ ]

If yes, please provide details:

Do you need Interpreter services? Yes [ ]  No [ ]

If yes, what language? Please provide details:

## Military Service Section 5

Branch:       Service dates - From:       To:

Rank at Discharge:       Type of Discharge:

Were you deployed in a combat zone? Yes [ ]  No [ ]

Are you registered with TriWest: Yes [ ]  No [ ]  ID or Account #:

## Staff Review – Office use only Section 6

**Form checked and reviewed by:**

Name:       Position:

Intake appointment booked at: Axiom Main [ ]  Axiom Whitton [ ]  Axiom AJ [ ]  Other

 Date:       Time:

Transportation: Scheduled [ ]  Not Required [ ]

Interpreter: Scheduled [ ]  Not Required [ ]

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:       Time: