|  |  |
| --- | --- |
|  | 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: