

**CDFC Pre-Admission Screening**

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance: \_\_\_\_\_ Email/Telephone #: \_\_\_\_\_

How did you hear about CDFC (Who referred you, date of referral):

- DCYF (which location) \_\_\_\_\_
- Doorway (which location) \_\_\_\_\_
- Legal (Probation/Parole/DOC)
- Shelter
- Detox (name) \_\_\_\_\_
- Harbor Care Internal
- Respite
- Other \_\_\_\_\_

**Background information:**

Do you have any children? We will need guardianship papers, birth certificates, and immunization records prior to any child spending the night in our facility.  No children/no legal rights to children

- A. \_\_\_\_\_ DOB: \_\_\_\_\_ Who has guardianship? \_\_\_\_\_  
Coming to CDFC?  Y  N      DCYF?  Y  N
- B. \_\_\_\_\_ DOB: \_\_\_\_\_ Who has guardianship? \_\_\_\_\_  
Coming to CDFC?  Y  N      DCYF?  Y  N
- C. \_\_\_\_\_ DOB: \_\_\_\_\_ Who has guardianship? \_\_\_\_\_  
Coming to CDFC?  Y  N      DCYF?  Y  N

Where are you coming from (home, incarceration, respite, detox, etc.): \_\_\_\_\_

Do you have any legal history?  Y  N Reason for arrest? \_\_\_\_\_

Arson  Y  N    Violent/Assault  Y  N    Sexual Assault  Y  N    Registered Sex Offender  Y  N

Any court dates in the near future?  Y  N Reason: \_\_\_\_\_

**Substance Use Screening**

| Currently detoxing or intoxicated?:    |       |                            |                  |           |       |
|--|-------|----------------------------|------------------|-----------|-------|
| Substance/Drug                         | Route | Age of 1 <sup>st</sup> Use | Date of last use | Frequency | Notes |
| Opioids (i.e. fentanyl, heroin, pills) |       |                            |                  |           |       |
| Alcohol                                |       |                            |                  |           |       |

|                                     |  |  |  |  |  |
|-------------------------------------|--|--|--|--|--|
| Stimulant (i.e. meth, cocaine, amp) |  |  |  |  |  |
| Sedative (i.e. benzo)               |  |  |  |  |  |
| Other (please specify)              |  |  |  |  |  |

Have you had any overdoses? Y N If Yes, please list dates(s) and whether they were accidental or planned: \_\_\_\_\_

Have you ever received Substance Use Treatment? Y N

| Location of Treatment Facility | Dates of Treatment | Type of Discharge |
|--------------------------------|--------------------|-------------------|
|                                |                    |                   |
|                                |                    |                   |
|                                |                    |                   |

What is your reason for treatment at this time? \_\_\_\_\_

### Mental Health Screening

Have you ever been diagnosed with a Mental Health condition? Y N

If yes, please describe: \_\_\_\_\_

Have you ever been hospitalized for mental health? Y N

If yes, please describe (dates/locations): \_\_\_\_\_

Have you ever had suicidal ideation? Y N Most recent: \_\_\_\_\_

Have you ever had a suicide attempt? Y N Most recent: \_\_\_\_\_

### Medical Screening

Are you currently Pregnant? Y N Date of last menstrual period? \_\_\_\_\_

Current health concerns and diagnoses (e.g. asthma, heart conditions, diabetes, hypertension, wounds, etc.):  
\_\_\_\_\_

Past hospitalizations or surgeries (please include Hospital name and date): \_\_\_\_\_  
\_\_\_\_\_

Do you have any mobility concerns (walker, cane, wheel chair, leg braces, crutches?): \_\_\_\_\_

Are you able to perform activities of daily living such as bathing, eating, and dressing? Y N

Medications

Current Pharmacy:

| Rx | Strength | Instructions | Prescriber/Practice |
|----|----------|--------------|---------------------|
|    |          |              |                     |
|    |          |              |                     |
|    |          |              |                     |
|    |          |              |                     |

Are you receiving MAT?  Y  N Facility: \_\_\_\_\_

We will need a signed medication list from the prescribing provider for any medications you will be taking here.

To provide comprehensive and integrated care during your stay at CDFC, we will ask you to transfer your primary and MAT care to Harbor Care at least while you are in the program.