

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 st 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.