

WILLOW OAKS TREATMENT CENTER

A Division Of Human Resources, Incorporated

PRE-SCREENING/PRE-ADMISSION FORM

Please answer all questions, if not applicable, indicate with N/A

Admission Date: _____ Date Of Screening: _____

Name: _____ Gender: M F
Last First Mi

Date of Birth: _____ (MM/DD/YYYY) Private Pay: Yes / No (Circle one)

Reason for Referral: _____

Medical History

Medical Problems: _____

Doctor's Name, Address & Phone Number: _____

When Did Client See Doctor Last? _____

Blood Pressure Reading? _____ **(Attach most recent results)**

PPD or Chest X-Ray? _____ **(Attach most recent results)**

Medication Information:

Name of Medication (Rx and OTC)	Dosage	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: Client must bring at least a 30-Day supply of any Medication currently prescribed.

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If client is a diabetic are they on insulin? _____

Does client have an Accucheck machine and supplies? _____
(If so, ask client to bring enough for stay)

Does client know how to check their blood sugar? _____

What range does client's blood sugar usually run? _____

If the client is female, is she pregnant? _____ Due Date: _____

PSYCHIATRIC HISTORY

Psychiatric problems: _____

Psychiatrist's Name, Address & Phone Number: _____

When did client see psychiatrist last? _____
(Attach Psychiatric evaluation)

ALCOHOL HISTORY

What is client drinking? _____

How often is client drinking? _____

How much is client drinking? _____

Date last used alcohol? _____

Does client have a history of DTs, Hallucinations or Blackouts? _____

Has client detoxed? _____ If yes, where? _____

Date admitted: _____ Date Discharged: _____

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OTHER DRUG HISTORY

<u>Drugs used</u>	<u>Frequency</u>	<u>Amount</u>	<u>Last usage</u>
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____
4 _____	_____	_____	_____
5 _____	_____	_____	_____

If opiate addicted, please specify usage, amount and if Suboxone detoxification is warranted? _____

Are special provisions needed (dietary, physical limitations, religious considerations)? _____

Legal issues: _____

Court dates: (If any, to be continued by attorney – please forward a letter of verification from attorney): _____

Referral Source: _____

Contact Person: _____ Phone Number: _____

Fax Number: _____ 24-Hour Emergency Number: _____

Has a release of confidential information been signed by the client? Yes / No

Source of payment: _____

Transportation arrangements: _____

What are client's housing arrangements post-discharge? _____

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Additional information: _____

For office use only

_____ Telephone Interview With CSB And/Or Reporting Agency
_____ Telephone Interview With Client _____ 28 Days
_____ In-Person Interview With Client _____ Other