FOR OFFICE USE ONLY:
Date of First Contact:

_____

ADMISSIONS:
Phone: 307.672.2044
Fax: 307.674.6867
www.voanr.org

SCREENING SHEET

Date: _____

PERSONAL INFORMATION:

First Name: _____ Middle: _____ Last: _____

Maiden: _____

Sex: ☐ Male ☐ Female Combat Veteran: ☐ Yes ☐ No WY Resident: ☐ Yes ☐ No

How did you hear about us? Paper Friend Website Other _____

Race _____

SSN: _____ Age: _____ DOB: _____

Tribal Affiliation: _____

Current Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Children? ☐ Yes ☐ No (**if yes, list ages**: _____)Pregnant? ☐ Yes ☐ No ☐ N/A

Contact Person: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Chemical use history:

Substances Used on a Regular Basis:

Substance	Route of Administration	Date of Last Use

Treatment History:

Facility Name	Dates of Attendance	Nature of Discharge

PSYCHOLOGICAL HISTORY:

Mental Health Diagnosis:

Diagnosis/Date of diagnosis Diagnosed by whom?	Medication Prescribed	Date Medication Last Used

If taking medications, how do/will you pay for them? _____

Have you been prescribed medications that you are not taking: ☐ Yes ☐ No

History of Suicidal Thoughts: Last 30 Days: ☐ Yes ☐ No Lifetime: ☐ Yes ☐ No Attempts: ☐ Yes ☐ No

-If yes, did you have a plan? _____

History of Homicidal Thoughts: Last 30 Days: ☐ Yes ☐ No Lifetime: ☐ Yes ☐ No Attempts: ☐ Yes ☐ No

-If yes, did you have a plan? _____

Do you hear voices or see things that other people don't see? ☐ Yes ☐ No

-If yes, please describe _____

_____

MEDICAL HISTORY:

Current Medical Conditions

Diagnosis/Date of Diagnosis Diagnosed by whom?	Medications Prescribed	Date Medication Last Used

If taking medications, how do/will you pay for them? _____

Have you been prescribed medications that you are not taking? ○ Yes ○ No

Physician's Name _____Facility _____

City / State: _____

-Date of last appointment _____ For: _____

Date of Last Physical: _____

Date of Last Hospitalization: _____ For: _____

Who is filling out this screening sheet? ☐ Self ☐ Family ☐ Friend ☐ Counselor

Do you have a Living Will? ☐ Yes ☐ No

If yes, have you provided a copy of your Living Will? ☐ Yes ☐ No

LEGAL STATUS

Are you currently in Drug Court? ☐ Yes ☐ No If yes, where? _____

Are you currently in jail? ☐ Yes ☐ No

-If yes, where? _____

-If yes, when were you incarcerated? _____

-If yes, how long will you be there? _____

-Upon leaving treatment will you be required to return to jail? ☐ Yes ☐ No

Are you on probation/parole? *(Unsupervised, supervised, ISP)* ☐ Yes ☐ No

-If yes, where? _____

-If yes, agent's name: _____

Are you court ordered to treatment? ☐ Yes ☐ No If yes, what court / judge _____

Are you ordered to have a substance abuse evaluation? ☐ Yes ☐ No

-If yes, have you provided a copy of your court order? ☐ Yes ☐ No

Are you awaiting sentencing? ☐ Yes ☐ No

-If yes, for what charges? _____

Will you be on furlough to attend treatment? ☐ Yes ☐ No

-If yes, from what jail will you be coming? _____

Do you have any outstanding warrants that you are aware of? ☐ Yes ☐ No

-If yes, out of what county and for what? _____

Do you have an attorney? ☐ Yes ☐ No

-If yes, name and address _____

FINANCIAL STATUS

Are you currently employed? ☐ Yes ☐ No If yes, where? _____

Household income for last quarter (3 months): _____ Dependents: _____

How will treatment be paid for? ☐ Self ☐ Insurance ☐ Drug Court ☐ Other

Do you have: Medicare? ☐ Yes ☐ No Do you have Medicaid? ☐ Yes ☐ No

Do you have insurance? ☐ Yes ☐ No

-Insurance company's name: _____ Policy #: _____

***If you have insurance, you must obtain pre-authorization and provide a claim form prior to your bed date ***

When a bed becomes available, we will attempt to contact you at the last phone number and address you provided. If we are unable to contact you, your name will be removed from our waiting list.

If you are incarcerated and transferred to another facility, you must notify us.