|  |  |
| --- | --- |
|  |  Patient ID #       |
|  |  |

## Online Screening form PLEASE COMPLETE AS MUCH INFORMATION AS POSSIBLE

Referral Date:       CSD Checked? Yes [ ]  No [ ]  Intake Date:

## Intake Applicant Information Section 1

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |      |       |       | DOB: |        |
|  | Last | First | M.I. |  |  |

|  |  |  |
| --- | --- | --- |
| Address: |        |       |
|  | Street Address | Apartment/Unit # |

|  |  |  |  |
| --- | --- | --- | --- |
|  |       |       |       |
|  | City | State | ZIP Code |

Home 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:

Which is your closest clinic? Main [ ]  North [ ]  West [ ]  San Tan [ ]

## Health Information Section 2

Are you on AHCCCS (Medicaid) or Medicare? Yes [ ]  No [ ]

AHCCCS (Medicaid) ID #:       Medicare ID #:       CIS ID #:

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?

Are you receiving services from any other behavioral health provider? Yes [ ]  No [ ]  If yes, where?

Do you have any medical issues? Yes [ ]  No [ ]  If yes, please provide details:

Are you receiving services from a medical provider? Yes [ ]  No [ ]  If yes, where?

What medications are you currently prescribed?

Are you taking your medications as prescribed? Yes [ ]  No [ ]

Are you pregnant? Yes [ ]  No [ ]

If yes, please provide details: (due date, OBGYN etc.)

## Non AHCCCS Eligible members Section 3

If you are not currently on AHCCCS (Medicare) or Medicaid

We do have a cash payment option available; we may also have funding available for people who do not have insurance or who are under insured. Please ask for additional information or see the information on SABG funding on our website [www.itsofaz.com](http://www.itsofaz.com)

**Please indicate below which options you are applying for:**

Intake [ ]  Readmission [ ]  No Insurance: [ ]

**Methadone** – If cash pay – Intake and readmission charges are $95 for the first week of treatment. This includes the intake screening, medical examination, clinical services and the first week of Methadone.

Additional Weekly Fees are $63.00

All payments are cash only. Any payments made in excess of the amount owed will be credited to your account.

Other Medications – Charges will be discussed with you as they are dependent upon what is prescribed.

## Current Drug Use Section 4

**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 [ ]  Last time used?

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 [ ]

If yes, what amount and frequency?

Method?

Are you using any benzodiazepines? Yes [ ]  No [ ]

If yes, what amount and frequency?

If opioids, have you previously been on: Methadone Yes [ ]  No [ ]  Suboxone Yes [ ]  No [ ]  Vivitrol Yes [ ]  No [ ]

If yes, when and where?

Last time taken?

Did you successfully withdraw from: Methadone Yes [ ]  No [ ]  Suboxone Yes [ ]  No [ ]  Vivitrol Yes [ ]  No [ ]

If no, reason for withdrawing? Transfer, AWOL, Other… please state:

Have you ever been in treatment at an ITS clinic before? Yes [ ]  No [ ]

If yes, when and where?

Did you leave with a balance? Yes [ ]  No [ ]

If yes, how much?

Are you transferring from another clinic/provider? Yes [ ]  No [ ]

If yes, who and why?

## Additional Information Section 5

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:

Do you have a medication preference? Methadone [ ]  Suboxone/Buprenorphine [ ]  Vivitrol [ ]

*(Our knowledgeable providers will discuss all medication options to determine the most appropriate medication for you.)*

## Military Service Section 6

Branch:       Service dates - From:       To:

Rank at Discharge:       Type of Discharge:

Are you registered with TriWest: Yes [ ]  No [ ]  ID or Account #:

## Disclaimer and Signature Section 7

**THANK YOU FOR CHOOSING INTENSIVE TREATMENT SYSTEMS (ITS) TO HELP YOU!**

I certify that my answers are true and complete to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** |       |
| **Print Name:** |        |  |  |

**How did you hear about ITS?** Please provide details:

## Staff Review – Office use only Section 8

**Form checked and reviewed by:**

Name:       Position:

Signature: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_

Intake appointment booked at: Main [ ]  North [ ]  West [ ]  San Tan [ ]

Transportation: Scheduled [ ]  Not Required [ ]

## OTP Eligibility – Office use only Section 9

**[ ]  18 years or older** (If under 18; has had two documented unsuccessful attempts at short-term detoxification or drug free treatment within a 12 month period and has consent for treatment from a parent, guardian, or custodian).

**[ ]  Physiologically dependent for at least 12 months** (If less than one year, must be evaluated by medical staff to determine if appropriate for treatment. Exceptions to this are release from a penal institution within last six months and/or pregnancy)

**[ ]  Pregnant (priority intake)**

**[ ]  On** **Methadone previously – within 24 months or less**

**[ ]  Released from a penal institution within the last six months**

**[ ]  Meets the criteria for SABG**