

**FOR OFFICE USE ONLY**

Pregnant: YES or NO

IV Use History: YES or NO

ID #: \_\_\_\_\_

Eligibility: \_\_\_\_\_

Date: \_\_\_\_\_

ISIS #: \_\_\_\_\_

**SCREENING**  
**Roadback, Inc.**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Staff: \_\_\_\_\_ Referred By: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Maiden: \_\_\_\_\_ DOB: \_\_\_\_\_

Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Race: \_\_\_\_\_ Veteran? Yes/No Marital Status: \_\_\_\_\_

Permanent Address: \_\_\_\_\_  
Street & Number City State Zip

Phone Number: \_\_\_\_\_ Message Phone : \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Can you read/write English: Yes/No Referred By: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you receive any state or federal benefits? Yes or No

SSI \$ \_\_\_\_\_ SSDI \$ \_\_\_\_\_ Retirement \$ \_\_\_\_\_ Food Stamps \$ \_\_\_\_\_

Your Household Income: \_\_\_\_\_ Dependents: \_\_\_\_\_

Date of Last Drug/Alcohol Use? \_\_\_\_\_ What was used? \_\_\_\_\_

Drugs you have used within the last month or regularly when using:

Drug Used:	How Used:	How Often:	Amount:	Age of 1 <sup>st</sup> Use:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

History of IV Use? Yes or No What drug? \_\_\_\_\_ Have you had D/A treatment before? Yes/No

Where:	When:	Length:	Completed:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any physical or medical limitations or handicaps? Yes/No

Explain: \_\_\_\_\_

**Please be advised:** At this facility, all residents are expected to participate in the following activities on a regular basis: basic chores (sweeping, mopping, cleaning rooms/bathrooms, taking out trash and yard work), going on a walk three times per day, and going to the YMCA (walking, exercise machines, swimming) twice per week.

If you are not able to participate in the above listed activities, you will need to discuss this directly with the intake coordinator to determine what steps need to be taken **PRIOR** to being scheduled for an intake appointment into this facility. Please contact your doctor and request a letter stating what your limitations are and what accommodations are required and be prepared to provide this letter to the intake coordinator as needed.

**Please be advised:** This facility is a dorm-style living facility that requires the participants to sleep in bunk beds. If you require a bottom bunk, you will need to bring a doctor's statement requesting this. Comments/Concerns?

Are you pregnant? Yes/No    Complications? Yes/No    Have you seen a doctor? Yes/No

All expectant females are required to bring a medical release for treatment from her physician stating that the pregnancy is without complications, the estimated due date, and that she is able to safely attend a 45 day residential treatment program.

Comments: \_\_\_\_\_

**CURRENT MEDICATIONS:**

MEDICATION	PURPOSE	DOSE	DOCTOR	HOW LONG TAKEN?

Are there any medications you are prescribed but are not currently taking: Yes/No

Explain: \_\_\_\_\_

We require everyone to come to treatment with a minimum supply of 45 days of medications (this can include a refill that is able to be filled at a local pharmacy) **NOTE:** We are not a medical facility and we do not have a doctor on staff to assist with any medical or medication needs, therefore all needs must be addressed **PRIOR** to scheduling an intake appointment. This includes over the counter medications. Over the counter medications require a doctor's note stating the exact instructions for taking them and **MUST** be brought in the original, unsealed packaging.

Concerns/Comments: \_\_\_\_\_

Do you have any allergies to foods or medications? NKFA /NKDA

If yes, list here: \_\_\_\_\_

Have you ever had a mental health diagnosis such as depression, bi-polar disorder, borderline personality disorder, schizophrenia or anxiety: Yes/No If yes, list here:

\_\_\_\_\_  
\_\_\_\_\_

NOTE: We do not have timely access to psychiatric care at this facility. The local community mental health center has an extensive intake process and often takes more than 45 days to address psychiatric concerns. Therefore, it is required that all psychiatric issues are addressed **PRIOR** to scheduling an intake appointment.

Have you ever experienced any of the following:

Audio Hallucinations? Yes/No Explain: \_\_\_\_\_

Visual Hallucinations? Yes/No Explain: \_\_\_\_\_

DT's or Shakes? Yes/No Explain: \_\_\_\_\_

Blackouts? Yes/No Explain: \_\_\_\_\_

Convulsions or Seizures? Yes/No Explain: \_\_\_\_\_

Homicidal ideation? Yes/No Explain: \_\_\_\_\_

Suicidal ideation or attempt? Yes/No Explain: \_\_\_\_\_

Self Abusive? Yes/No Explain: \_\_\_\_\_

Respiratory Disorders? Yes/No Explain: \_\_\_\_\_

Heart Condition? Yes/No Explain: \_\_\_\_\_

Diabetes? Yes/No Explain: \_\_\_\_\_

Hearing or Visual Disorders? Yes/No Explain: \_\_\_\_\_

Eating Disorders? Yes/No Explain: \_\_\_\_\_

HIV/Aids or Hepatitis C? Yes/No Explain: \_\_\_\_\_

Have you ever been convicted of a violent crime? Yes/No Explain: \_\_\_\_\_

Have you ever been convicted of a sex offense? Yes/No Explain: \_\_\_\_\_

Do you have any outstanding warrants/legal issues: Yes/No Explain: \_\_\_\_\_

Are you involved in drug Court? Yes/No County: \_\_\_\_\_

Charges: \_\_\_\_\_

Are you involved with Mental Health court? Yes/No County: \_\_\_\_\_

Charges: \_\_\_\_\_

Are you a smoker? Yes/No This facility is a non-smoking facility. We recommended that you bring patches, gum, or lozenges in unopened store packaging with you for treatment. The 1-800-QUIT-NOW hotline will assist with these if needed, but it takes a week or more for them to ship the items to you, so we recommend you bring some with you if at all possible. Concerns/Comments: : \_\_\_\_\_

Additional Information that will assist us in appropriately placing you in the program:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FINAL INSTRUCTIONS:**

1. Call 580-357-8114 every Monday to check in. Provide current contact phone number. No contact for one month results in removal from wait list.
2. When the intake coordinator calls to inform you that a bed has become available, you will have 48 hours to contact her to schedule your intake. Failure to contact the coordinator within 48 hours will result in removal from the wait list.
3. If you miss your scheduled intake without contacting the intake coordinator, you will lose your bed and be removed from the waiting list.
4. Please apply for SoonerCare at <http://okhca.org/>. Once you have applied for SoonerCare, call and inform the intake coordinator. This could change your place on the waiting list and help you be placed in our program sooner.

**STAFF ONLY: REFERRALS ARE REQUIRED** – Please mark any/all referrals made at the time of the screening.

HIV/AIDS/Hep C/TB Education       HIV/AIDS/Hep C/ TB Treatment  
 Counseling – affects of use on fetus       Prenatal       Another residential provider  
 Detox       Incarcerated       Outpatient       Self-help/12-step group  
 Other: \_\_\_\_\_

