Screening and Assessment
Allumbaugh House
400 N Allumbaugh
Boise, Idaho 83704

Date: _____ Time:_____
Person completing: _____
Agency: _____
Phone #: _____

IDENTIFYING INFORMATION:

Name: _____ DOB: _____Age: ____Marital Status: ___ Male □ Female □
Address: _____ City: _____ Zip: _____
Phone: _____ Emerg. Contact Name _____ #_____
Employment: Full □ Part □ Unemployed □ Employer: _____
Present outpatient MD/PCP: _____
Mental health prescriber: _____
Community providers: _____
Insurance: □ Y □ N □ Unknown - If Yes: _____ □ Medicaid □ Medicare
Insurance Name: _____ Policy #: _____
Region IV resident? □ Y □ N Veteran □ Probation/Parole: □ Y □ N (P.O Officer) _____
Previous Allumbaugh House Patient: □ Y □ N □ Unknown If Yes, When: _____

PRESENTING PROBLEM: (Including Current Symptoms)

_____
_____
_____
_____

PATIENT STATEMENT: (Motivation to Seek Treatment)

_____
_____

SERVICE REQUESTED:

□ Detoxification – Need for non- hospital level of medically monitored detoxification
□ Mental Health – Need for non-hospital level of care for stabilization of psychiatric s/sx

Allergies: _____
Physical health issues: □ Y □ N describe: _____
_____
Chronic Pain: □ Y □ N describe: _____
Oral health issues: □ Y □ N describe: _____ _____
Dental pain or swelling? □ Y □ N Last dental visit and reason: _____
Does pt have an **exclusionary physical condition:** □ Y □ N (see guidelines) **CPAP:** □ Y □ N **O2:** □ Y □ N
Ambulatory: □ Y □ N Wheelchair, Walker, Cane or Crutches: □ Y □ N Independent ADL's: □ Y □N
Vitals: T ____ P _____ R _____ B/P _____ Time: _____ Emergency treatment records? _____
_____
Labs completed: (send) _____
UDS: (send) _____ **BAC**: (send) _____ Xrays: (send) _____
Current medications (including dosage and times) _____
_____
_____
_____
_____
Last dose taken: _____ Prescribing physician: _____
Previous Tx for psychiatric or substance use: □ Y □ N □ Unknown If yes, where and when: _____
_____
Medication adherent: □ Y □ N describe: _____
HIV or TB testing: □ Y □ N results: _____Pregnant: □ Y □ N □ Unsure _____
Evidence of head/body lice,scabies or bedbugs: □ Y □ N _____
Current living situation: _____
Significant others involved in care/Tx: _____

SUBSTANCE USE: Describe use pattern

SUBSTANCE	ROUTE	AVG AMT	FREQ	LENGTH OF TIME USING	LAST USE

Method of acquisition □ Street □ Script □ Internet □ Other_____
IV drug use: □ Y □ N _____
Use of Opioid Replacement Rx: □ Y □ N Med _____When_____ Current interest in MAT: □ Y □ N
Drug/Alcohol arrests: □ Y □ N #: _____ DUI's: □ Y □ N #: _____ Age of 1st use: _____
Current withdrawal Sx: _____
Hx of withdrawal Sx: □ None □ Shakes □ Sweats □ Anxiety □ Aches □ Twitching □ Nausea /Vomiting
□ Diarrhea □ Confusion □ Difficulty Walking □ Fatigue/Sleep □ Insomnia □ Other: _____
Hx of withdrawal seizures: □Y □ N describe: _____
Hx of DT's: □Y □ N describe: _____
Hx of overdose? □ Y □ N #___ Medical treatment required? _____
Last period of sobriety: _____ How long? _____
Previous substance abuse Tx: □ Y □ N How many: _____Last treatment episode: _____
Negative impact of Covid 19? □ Y □ N Describe: _____

PT IS EXPERIENCING S/S OF DETOX OR WITHDRAWAL IS IMMINENT □ Y □ N

INTERACTION OF PT BIOMEDICAL CONDITION AND CONTINUED SUBSTANCE USE PLACE THEM IN IMMINENT DANGER OF SERIOUS DAMAGE TO PX HEALTH □ Y □ N

OR

CURRENT BIOMEDICAL CONDITION REQUIRES 24 HR NURSING AND MEDICALMONITORING BUT NOT THE FULL RESOURCES OF AN ACUTE CARE HOSPITAL □ Y □ N

MENTAL HEALTH:
Previously diagnosed with a psychiatric disorder: □ Y □ N describe: _____
When and where?_____Prescribed medications? □ Y □ N (list) _____
_____Last taken: _____
Family hx of psych illness: _____
Change in appetite? □ Y □ N describe _____ Change in sleep? □ Y □ N describe _____
Current Depression: □ Y □ N describe: _____
Current thoughts of harming self: □ Y □ N describe: _____
_____
Current thoughts of harming others: □ Y □ N describe: _____
_____
Recent attempts to harm self/others: □ Y □ N describe: _____
Psychosis: □ Y □ N describe: _____
_____
Recent losses and/or traumatic event: □ Y □ N describe: _____

PT HAS SIGNIFICANT FUNCTIONAL DEFICITS THAT REQUIRE PSYCHIATRIC MONITORING □ Y □ N

THE PT AT MODERATE RISK OF BEHAVIORS ENDANGERING SELF, OTHERS OR PROPERTY □ Y □ N

DISPOSITION:
Accepted: □ Y Scheduled admission date/time: _____
Denied: □ Y Reason for denial: _____
Placed on waitlist due to capacity: □ Y □ N Date/time removed from WL: _____
Reviewing AH staff: _____

PLEASE FAX THIS FORM TO: 208-377-1028 Include all Labs, x-Rays, UDS, and other pertinent clinical information PRIOR TO CASE REVIEW WITH ALLUMBAUGH HOUSE STAFF. THANK YOU.