WELLS HOUSE INC.

124 East Baltimore Street - Hagerstown, Md. 21740

Phone: 301-739-7748 - Fax: 301-739-4001

Please complete ALL applicable sections – MUST BE LEGIBLE!

PRESCREENING FORM

FULL Name First, Middle, Last (If incarcerated, include inmate ID, SID, etc.)			Date:
Address (If incarcerated, list the facility):			
City:	County	State:	Zip Code:
Date of Birth:	Male ☐ Female ☐	**Social Security # (Cannot process without #):**	
Applying for residential treatment (Adult men only): Y ☐ N ☐ **MUST PROVIDE TB TEST RESULTS PRIOR TO ADMISSION**	Outpatient treatment: Y ☐ N ☐ (Adult men or women)	Applying for Suboxone: Y ☐ N ☐	
If currently in treatment, where:	Additional Contact:	Telephone #:	
Do you give us permission to contact the above contact person? Y ☐ N ☐			
Military Veteran: Y ☐ N ☐ When: ☐ Vietnam Era or Gulf War ☐ Iraq ☐ Afghanistan			
Date available for admission:			
Current Forms of ID: ☐ State ID Card/Driver's License ☐ Birth Certificate ☐ Social Security Card			
Open Case with DSS: Y ☐ N ☐ (Food Stamps, Medicaid, Child Protective Services)			
Medical Insurance: Y ☐ N ☐ Name of Insurance Plan:		Medicaid ID Number:	

Current Legal Status

Do you have a valid driver's license: Y ☐ N ☐ If no, why not?	
On Probation: Y ☐ N ☐ County:	Probation/Parole Officer:
Pending Court Dates: Y ☐ N ☐ When?	What charges? :
Court Ordered To Treatment: Y ☐ N ☐ If yes, who ordered you? List court, judge or agency below:	
Legal History: Including outcome of ALL court appearances (Be honest, we will do a background search)	
1.	
2.	
3.	
4.	
5.	
Use reverse side, if necessary.	

Employment History

Income during this past year: $	Current monthly income: $
☐ Currently Employed ☐ VA Benefits ☐ Retirement ☐ SSDI (SS Disability) ☐ SSI (Social Security) ☐ TEHMA/TANF/TCA ☐ Unemployment Insurance ☐ Other Income Source (please list):	
Are you physically able to work: Y ☐ N ☐ If unemployed, last employment date:	
Reason for leaving:	

Dimension 1: Acute Intoxication/Withdrawal Potential

Drugs you have used:	Frequency:	How? Orally, Injection, Smoked, Inhaled	**Date of Last Use: Must be listed!**
First:			
Second:			
Third:			
History of DTs or seizures: Y ☐ N ☐			

Dimension 2: Medical Conditions and Complications:

IV Drug User (Must answer): Y ☐ **N** ☐ Pregnant: Y ☐ N ☐ HIV Y ☐ N ☐ Hepatitis C: Y ☐ N ☐
Are you currently taking methadone or Suboxone: Y ☐ N ☐
Do you have any OTHER physical/medical problems? Y ☐ N ☐
If Yes, Describe:
Do you have any drug allergies? Y ☐ N ☐ Do you have any food allergies? Y ☐ N ☐
Do you take medications for your physical/medical problems? Y ☐ N ☐ For mental health, see below.
If Yes, List Medications:
Are you able to take this medication by yourself? Y ☐ N ☐
Are you receiving medical services for your physical/medical problems? Y ☐ N ☐
If YES, by whom (name of provider, contact information):
Aare you physically able to climb stairs? Y ☐ N ☐

Dimension 3: Emotional/Behavioral Conditions and Complications

Do you have any mental health diagnoses? Y ☐ N ☐
If YES, Describe:
Are you taking any medication for this condition? Y ☐ N ☐
If YES, List Medications:
How long have you had this condition?
Have you consistently taken this medication as prescribed? Y ☐ N ☐
If NO Why not?
Are you currently receiving psychiatric services for this condition? Y ☐ N ☐
If YES, by whom (name of provider, contact information):
Do you have a history of suicidal or homicidal ideation or attempts? Y ☐ N ☐ If yes how many times and when was last attempt?

Emotional/Behavioral Conditions and Complications (continued):
What effect has your mental health condition had on attempts to remain abstinent from alcohol & drugs?

Dimension 4: Treatment Acceptance/Resistance

Are you currently in treatment: Y☐ N☐ **If Yes, list facility:** ___________________________________ If yes, is this your first treatment attempt? Y☐ N☐ If no, How many times before? Detox only: ___________ Inpatient: ____________ Outpatient: ______ **Have you ever been in treatment with the Wells House?** Y☐ N☐ If yes, when
What convinced you to seek treatment this time? Describe:
Did you decide to admit yourself into treatment or were others involved (not including legal system)? ☐ My Decision ☐ Others
If others, who was involved?
If applicable, what have you learned about yourself during your current treatment? Describe:
If you had previous treatment, how is this time different?
What value do you see coming to our program?

Dimension 5: Relapse/Continued Use Potential

What relapse prevention tools, if any, have you learned in your current treatment? :
What are your relapse triggers?
What are your plans if for some reason a treatment slot would not be available? :
What are you willing to do to stay clean and sober? :
Have you had a period of sobriety in the past? Y☐ N☐ How long?
If yes, what did you do to maintain your sobriety during this period? Why did you relapse?
Why do you think you need help?
What do you want to be different this time?
Why haven't you been able to stay sober on your own?
Are you currently experiencing any cravings or withdrawal symptoms? Y☐ N☐

Dimension 6: Recovery Environment

Relationship: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Describe your living situation prior to entering treatment:
What about this living situation did not help you in your attempt at recovery? Describe:
Do you have a significant other? Y ☐ N ☐ If yes, what is the status of this relationship?
Number of Children (under 18 y/o) ______ Name(s)/Age(s): Who has legal custody? Who has physical custody? Where do they reside?

I HEREBY GIVE MY CONSENT TO THE WELLS HOUSE TO COMMUNICATE WITH MY REFERRAL SOURCE OR OTHER CONTACTS LISTED ABOVE TO OBTAIN ANY NEEDED INFORMATION AND/OR DOCUMENTS NEEDED TO CONSIDER MY APPLICATION FOR ADMISSION TO THE WELLS HOUSE.

_______________________________________ Date: ____________________

Applicant's Signature

IF THE APPLICANT WISHES TO PROVIDE ADDITIONAL INFORMATION FOR THE WELLS HOUSE NOT COVERED ABOVE, USE REVERSE OR THE SPACE PROVIDED BELOW,

<u>OTHERWISE PLEASE STOP HERE!</u>

NEXT PAGE TO BE COMPLETED BY CURRENT TREATMENT PROVIDER OR REFERRAL SOURCE

ANY ADDITIONAL INFORMATION BY APPLICANT:

TO BE COMPLETED BY CURRENT TREATMENT PROVIDER OR REFERRAL SOURCE

Documentation from Referral Source

TB PPD or other test documentation: Date: Results: **We cannot admit anyone into our residential facility without TB test documentation on file!**
IV Drug User: Y ☐ N ☐ **Pregnant**: Y ☐ N ☐ **HIV** Y☐ N ☐ **Hepatitis C** Y ☐ N ☐ **Military Veteran:** Y ☐ N ☐ When: ☐ Vietnam Era or Gulf War ☐ Iraq ☐ Afghanistan
AXIS I:
AXIS II:
AXIS III:
AXIS IV: Problems with or access to: ☐ Primary support group ☐ Educational ☐ Economic ☐ Healthcare ☐ Housing ☐ Legal system ☐ Employment ☐ Social environment ☐ Other psycho-social & environment problems.
AXIS V: ☐ 40 or less ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71-80
REFERRAL SOURCE MUST PROVIDE MEDICAL AND PSYCHOLOGICAL EVALUATION DOCUMENTATION PRIOR TO INTERVIEW FOR ADMISSION TO WELLS HOUSE **MUST PROVIDE COPY OF TB TEST RESULTS PRIOR TO ADMISSION**

_____________________________________ Date: _____________________

Referral Source Signature

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Printed Referral Source Name, Title

RETURN FORM BY FAX IMMEDIATELY UPON COMPLETION (301-739-4001)
PRIOR TO ADMISSION WELLS HOUSE MUST RECEIVE: **PSYCHOSOCIAL, DISCHARGE SUMMARY AND TB TEST RESULTS** **THANK YOU!**
FOR WELLS HOUSE USE ONLY:
DATE RECEIVED BY WELLS HOUSE:
DATE PLACED ON WAITING LIST:
SCHEDULED ADMISSION DATE:
DATE TB TEST RESULTS RECEIVED:
TRANSPORTATION: