LOUISIANA
Health & Rehab
CENTER, INC.

PRE-ADMIT SCREENING FORM

☐ **Reality House-Criteria:** ☐ Female 18 years or older ☐ Substance use ☐ Opioid use ☐ Injection drug use
☐ Dependent Children 12 years or younger ☐ Pregnant, How far along? _____
☐ **Life Care Center-Criteria:** ☐ 18 years or older ☐ Chemically Dependent Adult
☐ Chemically Dependent Juvenile ☐ IV (IVDU) user ☐ Court Ordered ☐ Recent treatment facility release

Interview Date: _____ Phone: _____ In Person _____ Time: _____

Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____

Parish_____ Education-Last Grade Completed: _____

Date of Birth: _____ Age:_____ Social Security #: _____

Agency referral? ☐ Yes ☐ No If yes, name of Agency: _____

_____

If yes, have you signed an authorization for release of records to La Health and Rehab? ☐ Yes ☐ No

_____

Urgent/Critical Care: ☐ Yes ☐ No
Medical: Refer to 911
Domestic Violence: Refer to IRIS Center Capital Area 24 Hour Crisis Line 225-389-3001/800-541-9706
Have you had suicidal/homicidal thoughts? ☐ Yes ☐ No
If yes, when was the last time you had these thoughts? _____
Is this person a danger to self or others? ☐ Yes ☐ No
Is there an immediate threat to self? ☐ Yes ☐ No
(If yes, MUST complete a Crisis Assessment)
Is there a need to develop a Personal Safety Plan ☐ Yes ☐ No

_____

Marital Status: ☐ Single ☐ Married ☐ Married (not living with spouse)
☐ Legally Separated ☐ Divorced ☐ Widowed

Ethnic Origin: ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native
☐ White ☐ Spanish/Hispanic ☐ Native Hawaiian/Pacific Islander

Children: Number of children _____ Age and Gender: _____
Are your children in your custody? ☐ Yes ☐ No
If no, in who's custody? Name: _____ Phone # _____

_____

Benefits and Insurance: Do you have the following benefits? Include amount and status, i.e. applied, denied, pending, appealing, act

☐ Social Security ☐ Child Support ☐ Public Assistance/FITAP ☐ Medicaid
☐ Food Stamps ☐ Family Trust ☐ Unemployment Insurance ☐ Medicare
☐ Veterans Benefits ☐ Retirement ☐ Workman's Compensation ☐ Medicare Advantage
☐ Long Term Disability ☐ Short Term Disability ☐ Other: _____
Amount or status: _____

Medical:
Do you have a Primary Care Physician? ☐ Yes ☐ No
If yes, Physician's name: _____ Physician's phone #: _____
Have you had a TB Test within the past year? ☐ Yes ☐ No If yes, when and where? _____
Please list past and current Medical Conditions: _____
_____
Medical Treatment History: _____
_____
List all current medications: _____
_____

Presenting Problem: <u>Substance Abuse</u>
Drug of Choice: _____ Last Use: _____ How Much? _____
Name and last use of other chemical substances including alcohol: _____
_____
How much money spent on all mood altering chemicals in the last 7 days? _____in the last 30 days?_____
Substance Abuse Treatment History (Facility/Date): _____
_____
Mental Health History? ☐ Yes ☐ No If yes, give diagnosis and treatment information: _____
_____

Medication Assisted Treatment
Have you ever participated in MAT programming? ☐ Yes ☐ No If yes, when/where?_____
Medication Issued: _____Prescriber: _____ Last Use: _____
Is MAT programming a viable option of care for you based on your OPI or ETOH dependence? _____
_____

Information Taken by: _____ **Date** _____

VERIFICATION OF INSURANCE
Insurance Company including Medicare and Medicaid: _____
Member #_____ Phone # _____
Behavioral Health Benefits:
Company (if different) _____ Phone # _____
Mental Health Benefits _____
Substance Abuse Benefits_____
Other Pertinent Benefits Information_____
Verified by: _____ **Date** _____

FOLLOW-UP
Follow-Up Date(s): _____ _____
APPROVAL/DENIAL OF SERVICES
☐ This person was approved for services on _____ until _____ time_____ ☐ This person was not approved for services Reason of Denial: _____ Referred to: _____ Signature of Clinical Director: _____

NOTES/FOLLOW UP: _____

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