

**WILLOW OAKS TREATMENT CENTER**

A Division Of Human Resources, Incorporated

**PRE-SCREENING/PRE-ADMISSION FORM**

Please answer all questions, if not applicable, indicate with N/A

Proposed Admission Date: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

Name: \_\_\_\_\_ Gender: M F  
Last First Mi

Address: \_\_\_\_\_ City & State: \_\_\_\_\_ zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (MM/DD/YYYY) Private Pay: Yes / No (Circle one)

Suggested Treatment days: 28 \_\_\_\_\_ 60 \_\_\_\_\_ 90 \_\_\_\_\_ Other: \_\_\_\_\_

**Medical History**

Medical/Dental Problems: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Doctor's Name, Address & Phone Number: \_\_\_\_\_  
 \_\_\_\_\_

When Did Client See Doctor Last? \_\_\_\_\_

Are special provisions needed (dietary, physical limitations, religious considerations)?  
 \_\_\_\_\_

Documented Blood Pressure Reading (**Attach most recent results**)

Documented PPD or Chest X-Ray (**Attach most recent results**)

**Medication Information:**

Name of Medication (Rx and OTC)	Dosage/Directions	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Note: Client must bring at least a 30-Day supply of any Medication currently prescribed. Prescription Narcotics and Benzodiazepines are not permitted.**

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Is client physically able to climb stairs &amp; walk short distances? \_\_\_\_\_

If client is a diabetic are they on insulin? \_\_\_\_\_

Does client have an Accucheck machine and supplies? \_\_\_\_\_  
(If so, client should bring enough for stay)

Does client know how to check their blood sugar? \_\_\_\_\_

Most recent "fasting" blood sugar: \_\_\_\_\_

If the client is female, is she pregnant? \_\_\_\_\_ Due Date: \_\_\_\_\_

**PSYCHIATRIC HISTORY**Psychiatric problems/diagnosis: \_\_\_\_\_  
\_\_\_\_\_Psychiatrist's Name, Address & Phone Number: \_\_\_\_\_  
\_\_\_\_\_

When did client see psychiatrist last? \_\_\_\_\_

**(Please attach recent Psychiatric evaluation)**

Is there a signed release to talk with the psychiatrist/therapist? Yes / No

**ALCOHOL HISTORY**

What is client drinking? \_\_\_\_\_

How often is client drinking? \_\_\_\_\_

How much is client drinking daily? \_\_\_\_\_

Date last used alcohol: \_\_\_\_\_

Does client have a history of DTs, hallucinations, seizures, blackouts? \_\_\_\_\_

Has client detoxed? \_\_\_\_\_ If yes, where? \_\_\_\_\_

Date admitted: \_\_\_\_\_ Date discharged: \_\_\_\_\_

**Willow Oaks does not provide alcohol detoxification.**

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**OTHER DRUG HISTORY**

<u>Drugs used</u>	<u>Frequency</u>	<u>Amount</u>	<u>Last usage</u>
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____
4 _____	_____	_____	_____
5 _____	_____	_____	_____

If opiate addicted, please specify usage, amount and if Suboxone detoxification at Willow Oaks is warranted? \_\_\_\_\_

If currently on Suboxone maintenance or is recommended after induction, please provide physician name: \_\_\_\_\_ address: \_\_\_\_\_  
 \_\_\_\_\_ phone: \_\_\_\_\_ who will provide follow-up care after completion of treatment. Please **include** a signed Release Of Information

**Legal History:** Any charges pending? Details: \_\_\_\_\_

**Court Dates:** Are there any that will disrupt treatment? Date: \_\_\_\_\_ (If any to be continued by attorney; please **include** a letter of verification from attorney)

**Referral Source:** \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Fax No.: \_\_\_\_\_ 24-Hour Emergency #: \_\_\_\_\_

Has a release of confidential information been signed by the client? Yes / No

Source of payment for treatment: \_\_\_\_\_

Source of payment for medication prescribed at Willow Oaks \_\_\_\_\_

Transportation to & from Willow Oaks by: \_\_\_\_\_

\*In the event of an *unplanned* discharge, transportation will be provided by: \_\_\_\_\_  
 24 hr. telephone#: \_\_\_\_\_

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What is client's aftercare plan and housing arrangement post-discharge?

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

What resources are available for payment of medications prescribed while in treatment or in the event of extended treatment? \_\_\_\_\_

Has client been in treatment at Willow Oaks previously? Yes No

If yes please give approximate dates: \_\_\_\_\_

For Community Services Board or Referring Agency:

AXIS I \_\_\_\_\_

\_\_\_\_\_

AXIS II \_\_\_\_\_

\_\_\_\_\_

AXIS III \_\_\_\_\_

\_\_\_\_\_

AXIS IV \_\_\_\_\_

\_\_\_\_\_

AXIS V \_\_\_\_\_

\_\_\_\_\_

Additional Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Person completing this Admission Packet: \_\_\_\_\_

(Signature)