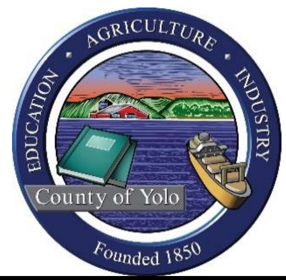
Yolo County Health & Human Services Agency
SUD BRIEF SCREENING TOOL- ADULTS



SUD RESIDENTIAL PROVIDERS ARE REQUIRED TO SUBMIT BRIEF SUD SCREENING TOOL
TO: Fax: 530-666-8637
ENCRYPTED E-MAIL: HHSAQualityManagement@yolocounty.org

Demographic information		
Name:		**Phone Number:** **Okay to leave voicemail?** Yes ☐ No
Address:		
DOB:	**Age:**	**Gender:**
Ethnicity:	**Preferred Language:**	**Avatar MR#:**
Insurance Type: ☐ None ☐ Medicare ☐ Medi-Cal ☐ Private ☐ Other (specify):		
Living Arrangement:	**Are there children under 18 in the home?** Yes No	
Referred By:		

Brief explanation of why client is currently seeking treatment:

Dimension 1: Substance Use, Acute Intoxication, Withdrawal Potential

1. In the past 30 days, have you used:

Alcohol:	☐ Yes ☐ No	Amount/Frequency:	Duration?	Route?	Date of Last Use:
Marijuana:	☐ Yes ☐ No	Amount/Frequency:	Duration?	Route?	Date of Last Use:
Cocaine:	☐ Yes ☐ No	Amount/Frequency:	Duration?	Route?	Date of Last Use:
Heroin:	☐ Yes ☐ No	Amount/Frequency:	Duration?	Route?	Date of Last Use:

***If client is abusing heroin, consider referral to Opioid Treatment Program or provider of Medication-Assisted Treatment**

Methamphetamine	☐ Yes ☐ No	Amount/Frequency:	Duration?	Route?	Date of Last Use:
Prescription Drugs:	☐ Yes ☐ No	Amount/Frequency:	Duration?	Route?	Date of Last Use:

☐ Benzodiazepines/Hypnotics/Sleeping Medication ☐ Opioid Pain Medication ☐ Stimulants ☐ Over the Counter ☐ Other

***If client is abusing opioid medications, consider referral to Opioid Treatment Program or provider of Medication-Assisted Treatment**

Inhalants:	☐ Yes ☐ No	Amount/Frequency:__________	Duration?__________	Route?	Date of Last Use:
Other:		Amount/Frequency:	Duration?	Route?	Date of Last Use:

2. Do you feel physically sick or become ill when you stop using alcohol or drugs? ☐ Yes ☐ No

3. Do you find yourself using larger amounts of alcohol or drugs, or using for a longer period of time than you intend to? ☐ Yes ☐ No

4. Are you currently experiencing withdrawal symptoms when you stop using alcohol and/or other drugs, such as tremors/shaking, excessive sweating, anxiety, nausea, and/or vomiting? ☐ Yes ☐ No

5. Do you have any serious medical problems that would be a potential danger during withdrawal management (aka: detox)? ☐ Yes ☐ No
If yes, briefly explain: ______________________________

6. Have you ever experienced alcohol-related seizures? ☐ Yes ☐ No

If yes, how many times and describe the circumstances:

7. Are you interested in medication-assisted treatment, such as buprenorphine, or methadone to help with your treatment?
☐ Yes ☐ No

Severity Rating- Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential)				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
No signs of withdrawal/intoxication present	Mild/moderate intoxication, interferers with daily functioning. Minimal risk of severe withdrawal. No danger to self/others.	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others.	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal.	Incapacitated. Severe signs and symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life.

Provide additional details justifying severity rating.
Client meets Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential) Severity Rating due to:

Dimension 2: Biomedical Condition and Complications

8. Do you have any active or serious medical problems that you are aware of? ☐ Yes ☐ No

If yes, do you have any medical problems that require immediate attention? ☐ Yes ☐ No
Briefly explain:
(if yes, may need to refer for medical treatment prior to entering SUD treatment)

9. Do you currently have any open sores or abscesses that require medical treatment?
☐ Yes ☐ No (if yes, may need to refer for medical treatment prior to entering SUD treatment)

10. Do you have a tuberculosis infection? ☐ Yes ☐ No
If yes, is it being treated or has it been fully treated in the past? ☐ Yes ☐ No

11. If Female: Are you pregnant? ☐ Yes ☐ No (if pregnant and using opioids, refer to OTP provider)

12. In the past 30 days, have you experienced any medical problems or been to the emergency room for any medical problems? ☐ Yes ☐ No If yes, briefly explain:

13. Are you currently taking medications for any medical conditions? ☐ Yes ☐ No
If yes, briefly explain:

Severity Rating- Dimension 2 (Biomedical Condition and Complications)				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Fully functional/ able to cope with discomfort or pain.	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with physical discomfort.	Some difficulty tolerating physical problems. Acute, nonlife threatening problems present, or serious biomedical problems are neglected.	Serious medical problems neglected during outpatient treatment. Severe medical problems present but stable. Poor ability to cope with physical problems.	Incapacitated with severe medical problems.

Provide additional details justifying severity rating.
Client meets Dimension 2 (Biomedical Condition and Complications) Severity Rating due to:

Dimension 3: Emotional, Behavioral, or Cognitive Condition and Complications

14. Do you ever hear or see things that others do not? ☐ Yes ☐ No
If yes, briefly describe:

15. Do you have any cognitive or emotional problems that may interfere with your substance use treatment? ☐ Yes ☐ No
If yes, briefly describe:

16. If you have any cognitive or emotional problems, do they occur mostly when using or withdrawing from alcohol and/or other drugs? ☐ Yes ☐ No
If yes, briefly explain:

17. In the past 30 days, how much have you been troubled or bothered by the previously discussed cognitive or emotional conditions?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

18. Do you currently have thoughts of hurting yourself or someone else? ☐ Yes ☐ No (if yes, consider transport to emergency room, or calling 9-1-1)

Have you ever acted on these feelings to hurt yourself? ☐ Yes ☐ No
Please describe:

19. Are you currently taking any medications for your psychological or emotional health? ☐ Yes ☐ No
If yes, briefly explain:

Severity Rating- Dimension 3 (Emotional, Behavioral, or Cognitive Condition and Complications [EBC])				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Good impulse control and coping skills. No dangerousness, good social functioning, self-care, and no interference with recovery.	Suspect diagnosis of EBC, requires intervention, but does not interfere with recovery. Some relationship impairment.	Persistent EBC. Symptoms distract from recovery, but no immediate threat to self/others. Does not prevent independent functioning.	Severe EBC, but does not require acute level of care. Impulse to harm self or others, but not dangerous in a 24-hr setting.	Severe EBC. Requires acute level of care. Severe and acute life-threatening symptoms (i.e. danger to self/others).

Provide additional details justifying severity rating.

Client meets Dimension 3 (Emotional, Behavioral, or Cognitive Condition and Complications [EBC] Severity Rating due to:

Dimension 4: Readiness to Change

20. How often have you missed important social, occupational or recreational activities as a result of your alcohol or drug use?
☐ Never ☐ Sometimes ☐ Regularly ☐ All the time

21. Have you continued to use alcohol or drugs despite experiencing problems at work or with your relationships?
☐ Yes ☐ No

22. Do you feel there is something holding you back from receiving treatment? ☐ Yes ☐ No
If yes, briefly explain:

23. How important is it for you to receive treatment for alcohol or drug problems:
☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably Extremely

24. How ready are you to change your alcohol or drug use?
☐ **Not Ready** (Pre contemplation) ☐ **Getting Ready** (Contemplation) ☐ **Ready** (Preparation) ☐ **In Progress of Changing** (Action) ☐ **Sustained Change** (Maintenance)

Severity Rating- Dimension 4 (Readiness to Change)				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Willing to engage in treatment.	Ambivalent to change, but willing to enter treatment.	Low commitment to change substance use. Reluctant to agree to treatment. Passive engagement in treatment.	Unaware of need to change. Unwilling or partial follow up on treatment recommendations.	Not willing to change. Unwilling/unable to follow through with treatment recommendations.

Provide additional details justifying severity rating.

Client meets Dimension 4 (Readiness to Change) Severity Rating due to:

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

25. What might cause you to relapse in the future?
Please describe:

26. How strong are your urges to use alcohol or drugs?
☐ None ☐ Slight urge ☐ Moderate urge ☐ Considerable urge ☐ Extreme urge

27. How likely do you think it is, the client might relapse because of cravings for alcohol and/or other drugs?
☐ Not at all likely ☐ Slightly likely ☐ Moderately likely ☐ Considerably likely ☐ Extremely likely

28. Without treatment, how likely do you think it is that the client will relapse or continue to use alcohol or drugs?
☐ Not at all likely ☐ Slightly likely ☐ Moderately likely ☐ Considerably likely ☐ Extremely likely

29. Have you been able to remain sober or decrease your alcohol or drug use for any period of time in the past? ☐ Yes ☐ No
If yes, briefly explain:

Severity Rating- Dimension 5 (Relapse, Continued Use, or Continued Problem Potential)				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Low/no potential for relapse. Good ability to cope.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition of risk for relapse. Able to self-manage with prompting.	Little recognition of risk for relapse, poor skills to cope with relapse.	No coping skills for relapse/ addiction problems. Behavior places self/other in imminent danger.

Provide additional details justifying severity rating.

Client meets Dimension 5 (Relapse, Continued Use, Or Continued Problem Potential) Severity Rating due to:

Dimension 6: Recovery/Living Environment

30. Do you currently have someone who you would consider as a social support, or someone you can rely on for support with needed? ☐ Yes ☐ No

31. How supportive are your friends/family of you receiving help for your alcohol or drug use?
☐ Not supportive ☐ Slightly supportive ☐ Moderately supportive ☐ Considerably supportive ☐ Extremely supportive

32. Do you currently live in an environment where others are using alcohol and/or other drugs? ☐ Yes ☐ No

33. How stable is your current living situation?
☐ Not stable ☐ Slightly stable ☐ Moderately stable ☐ Considerably stable ☐ Extremely stable

34. How likely is it that you could be hurt or victimized in your current living environment?
☐ Not at all likely ☐ Slightly likely ☐ Moderately likely ☐ Considerably likely ☐ Extremely likely

35. Are you currently involved with the legal system (e.g., on probation or parole)? ☐ Yes ☐ No
If yes, specify: ☐ Parole ☐ Probation ☐ Child Welfare Services ☐ Court Mandated
☐ Other:

Severity Rating- Dimension 6 (Recovery/Living Environment)				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Able to cope in environment/ supportive.	Passive/disinterested social support, but still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment, difficulty coping even with clinical structure.	Environment toxic/hostile to recovery. Unable to cope and the environment may pose a threat to safety.

Provide additional details justifying severity rating.

Client meets Dimension 6 (Recovery/Living Environment) Severity Rating due to:

LPHA OR MEDICAL DIRECTOR MUST COMPLETE, PRINT NAME, SIGN, AND DATE THIS PAGE

Diagnosis: Diagnostic Statistical Manual, 5th Edition (DSM-5)
Criteria For Substance Use Disorder

	Substance Use Disorder Criteria (DSM-5)	Name of Substance(s) #1: ___________	#2: ___________	#3: ___________
1	Substance often taken in larger amounts or over a longer period than was intended.	☐	☐	☐
2	There is a persistent desire or unsuccessful efforts to cut down or control substance use.	☐	☐	☐
3	A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.	☐	☐	☐
4	Craving, or a strong desire or urge to use the substance.	☐	☐	☐
5	Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.	☐	☐	☐
6	Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.	☐	☐	☐
7	Important social, occupational, or recreational activities are given up or reduced because of substance use.	☐	☐	☐
8	Recurrent substance use in situations in which it is physically hazardous.	☐	☐	☐
9	Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.	☐	☐	☒
10	Tolerance, as defined by either of the following: - A need for markedly increased amounts of the substance to achieve intoxication or desired effect. - A markedly diminished effect with continued use of the same	☐	☐	☐
11	Withdrawal, as manifested by either of the following: - The characteristic withdrawal syndrome for the substance. - Substance (or a closely related substance) is taken to relieve or or avoid withdrawal symptoms.	☐	☐	☐
	Total Number of Criteria			

Please check off any symptoms that have occurred in the past 12 months.

* The presence of **at least 2** of these criteria indicates a **substance use disorder**.

** The severity of the substance use disorder is defined as:

- **Mild**: Presence of **2-3 criteria**
- **Moderate**: Presence of **4-5 criteria**
- **Severe**: Presence of **6 or more criteria**

List of Substance Use Disorder(s) that Meet DSM-5 Criteria and Date of DSM-5 Diagnosis (specify severity level):

____

____

____

(Print) LPHA or Medical Director Name **Signature** **Date:**

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Client Name: ______________________________
Avatar MR#: ______________________________
Treatment Agency: ___________________________

SUD LEVEL OF CARE DETERMINATION TOOL

Instructions: For each dimension, indicate the least intensive level of care that is appropriate based on the patient's severity/functioning and service needs.

SUD Criteria Level of Care- Withdrawal Management	SUD Level	Dimension 1 Substance Use, Acute Intoxication and/or Withdrawal Potential				Dimension 2 Biomedical Condition and Complications				Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications				Dimension 4 Readiness to Change				Dimension 5 Relapse, Continued Use, or Continued Problem Potential				Dimension 6 Recovery/Living Environment			
Severity / Impairment Rating		None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM																								
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM																								
Clinically Managed Residential Withdrawal Management	3.2-WM																								
Medically Monitored Inpatient Withdrawal Management	3.7-WM																								
Medically Managed Intensive Inpatient Withdrawal Management	4-WM																								

SUD Criteria Level of Care- Other Treatment and Recovery Services																									
Severity / Impairment Rating		None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev
Early Intervention	0.5												Consider referral to mental health facility												
Outpatient Services	1																								
Intensive Outpatient Services	2.1																								
Partial Hospitalization Services	2.5																								
Clinically Managed Low-Intensity Residential Services	3.1																								
Clinically Managed Population-Specific High-Intensity Residential Services	3.3																								
Clinically Managed High-Intensity Residential Services	3.5																								
Medically Monitored Intensive Inpatient Services	3.7																								
Medically Managed Intensive Inpatient Services	4																								

SUD Criteria Level of Care- Other Treatment and Recovery Services																									
Severity / Impairment Rating		None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev
Opioid Treatment Program	OTP																								

Would the patient with alcohol or opioid use disorders benefit from and be interested in Medication-Assisted Treatment (MAT)? ☐ Yes ☐ No Please describe:

____

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Client Name: ______________________________ **Avatar MR#:**______________________

Treatment Agency: ____

Updated: 07/2019

PLACEMENT SUMMARY

Level of Care/Service Indicated: Enter the SUD Level of Care number that offers the most appropriate level of care/service intensity given the client's functioning/severity:

Level of Care/Service Referred: If the most appropriate level of care/service intensity was not utilized, enter the most appropriate SUD Level of Care that is available and circle the reason for this discrepancy (below):

Reason for Discrepancy:

☐ Not applicable – no difference	☐ Clinical Judgement	☐ Lack of Insurance/Payer Source
☐ Level of Care not available	☐ Client Preference	☐ Geographic Accessibility
☐ Family Responsibility (children, job, house, etc.)	☐ Language	☐ Used two residential stays in 1 year

☐ Other (specify): ____________________

Designated Treatment Location and Provider Name:

____

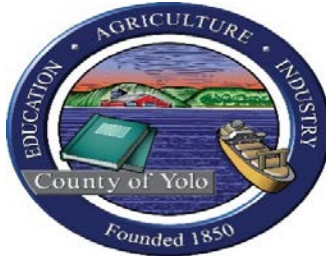
Printed SUD Counselor Name (If Applicable) **Signature** **Date**

____

***LPHA Printed Name** **Signature** **Date**

***Complete this line if individual conducting this assessment is not an LPHA**

LPHA (Licensed Practitioner of the Healing Arts) includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.



SUPPLEMENTAL ASSESSMENT

IF ASSESSMENT ITEMS LISTED BELOW ARE NOT CAPTURED IN INTAKE PAPERWORK PLEASE COMPLETE:

Client Social and Recreational History Details:
Client Financial Status History Details:
Client Educational History Details:
Client Employment History Details:
Client Criminal History, Legal Status Details:

Client Name:
Treatment Agency:
Client DOB: