SUBMIT CLEAR

FORM 1

Intake for "Negative" Full Screen AUDIT and/or DAST

HEALTH QUALITY PARTNERS of Southern California

Health Center: Imperial Beach Health Center **Site:** IBHC ___

Proxy Patient ID: _____ **Staff Name:**

A. RECORD MANAGEMENT

Interview Date:

Month/ Day/ Year

A. BEHAVIORAL HEALTH DIAGNOSES

1. In the past 30 days, was this client diagnosed with an opioid use disorder?

- ○ Yes
- ◉ No ***[SKIP TO 2.]***
- ○ Don't know ***[SKIP TO 2.]***

a. *[IF YES]* In the past 30 days, which U.S. Food and Drug Administration (FDA)-approved medication did the client receive for the treatment of this opioid use disorder? *[CHECK ALL THAT APPLY.]*

- ☐ Methadone — ***[IF RECEIVED]*** Specify how many days received |___|_0|
- ☐ Buprenorphine — ***[IF RECEIVED]*** Specify how many days received |___|_0|
- ☐ Naltrexone — ***[IF RECEIVED]*** Specify how many days received |___|_0|
- ☐ Extended-release naltrexone — ***[IF RECEIVED]*** Specify how many days received |___|_0|
- ☐ Client did not receive an FDA-approved medication for an opioid use disorder
- ☐ Don't know

2. In the past 30 days, was this client diagnosed with an alcohol use disorder?

- ○ Yes
- ◉ No ***[SKIP TO 3.]***
- ○ Don't know ***[SKIP TO 3.]***

a. *[IF YES]* In the past 30 days, which FDA-approved medication did the client receive for the treatment of this alcohol use disorder? *[CHECK ALL THAT APPLY.]*

- ☐ Naltrexone — ***[IF RECEIVED]*** Specify how many days received |___|_0|
- ☐ Extended-release naltrexone — ***[IF RECEIVED]*** Specify how many days received |___|_0|
- ☐ Disulfiram — ***[IF RECEIVED]*** Specify how many days received |___|_0|
- ☐ Acamprosate — ***[IF RECEIVED]*** Specify how many days received |___|_0|
- ☐ Client did not receive an FDA-approved medication for an alcohol use disorder
- ☐ Don't know

***Use FORM 1 only for clients whose FULL-SCREEN results for AUDIT and/or DAST are NEGATIVE .

Use FORM 2 or FORM 3, as appropriate for all other clients.

3. Was the client screened by your program for co-occurring mental health and substance use disorders?

○ YES ○ NO

4. How did the client screen for your SBIRT?

AUDIT = | | (negative score = 0 – 7)

DAST = | | (negative score = 0 – 2)

Other (CRAFFT) = | | (negative score = 0)

A. DEMOGRAPHICS

1. What is your gender?

○ MALE
○ FEMALE
○ TRANSGENDER
○ OTHER (SPECIFY)_____
○ REFUSED

2. Are you Hispanic or Latino?

☐ YES ☐ NO REFUSED

What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused	
Central American	○	○	○	
Cuban	○	○	○	
Dominican	○	○	○	
Mexican	○	○	○	
Puerto Rican	○	○	○	
South American	○	○	○	
Other	○	○	○	***Please specify:***

3. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Black or African American	○	○	○
Asian	○	○	○
Native Hawaiian or other Pacific Islander	○	○	○
Alaska Native	○	○	○
White	○	○	○
American Indian	○	○	○

4. What is your date of birth? ☐ REFUSED

Month / Year

A. MILITARY FAMILY AND DEPLOYMENT

5. Have you ever served in the Armed Forces, in the Reserves, or in the National Guard?
(If yes) In what area did you serve? No

If NO, REUSED, or DON'T KNOW - STOP HERE.

5a. Are you currently on active duty?

5b. Have you ever been deployed to a combat zone? ***[CHECK ALL THAT APPLY.]***

- ☐ NEVER DEPLOYED
- ☐ IRAQ OR AFGHANISTAN (E.G., OEF/OIF/OND)
- ☐ PERSIAN GULF (OPERATION DESERT SHIELD/DESERT STORM)
- ☐ VIETNAM/SOUTHEAST ASIA
- ☐ KOREA
- ☐ WWII
- ☐ DEPLOYED TO A COMBAT ZONE NOT LISTED ABOVE (E.G., BOSNIA/SOMALIA)
- ☐ REFUSED
- ☐ DON'T KNOW

FAX all 3 pages of this completed form to HQP's SOS program: 619-906-2479

OR click "SUBMIT" on page 1 to email form to SOS@hqpsocal.org