

# The Phoenix ESTLR/STAR Pre-Screening Form

INTERVIEWER NAME: \_\_\_\_\_ \*\*\*\*\*DATE: \_\_\_\_\_  
 yyyy mmm dd

## Applicant Data

Applicant Name \_\_\_\_\_ Age \_\_\_\_\_ D.O.B \_\_\_\_\_  
 MMM DD YYYY

PHN: \_\_\_\_\_ S.I.N \_\_\_\_\_ Tel: \_\_\_\_\_

Length of abstinence as of today? \_\_\_\_\_ or Clean Date: \_\_\_\_\_

Are you an IV drug user? Yes  No

Are you on a methadone maintenance program? Yes  No  (If so, please complete MMT Questionnaire)

Is this your first time accessing any alcohol and drug services? Yes  No

Current Program or Address where you are now: \_\_\_\_\_

A&D Counsellor or Case Worker \_\_\_\_\_ Tel: \_\_\_\_\_

How did applicant hear about Phoenix? \_\_\_\_\_

Do you have TB test results? Yes  No  Referred to Sessional Physician for testing? Yes  No

Marital Status:  Single  Common Law  Married  Separated  Divorced  Widowed

Employment Status:  Unemployed  Employed  Not in the Labour Force  Student  Retired

Homelessness Status: Are you currently homeless? Yes  No

Are you currently at risk of homelessness? (Couch surfing, staying with friends or family ) Yes  No

Education:  University Degree  College/Diploma  Grade 9-12  Grade 1-8  Trades Training

## APPLICANTS' SELF ASSESSMENT OF FUNCTIONING OR CIRCUMSTANCES

The purpose of this (pre-test) survey is to gather information from applicants on how they rate their circumstances in the following areas. When talking with the applicant, you might try a conversational approach like this: I have to gather some information from you now that asks you to rate how you are doing in a variety of areas. One of these is substance use. I would guess that since you are applying for treatment that you would rate your circumstances as poor. Am I right? And for housing; well you told me you are homeless. Is "poor" the right answer in that area? (And so on).

	POOR	FAIR	GOOD	EXCELLENT	N/A
Substance use/misuse					
Physical health					
Mental/emotional health					
Family					
Friends					
Educational					
Employment					
Legal					
Housing					

### Substance Use History

Substance used	How	Age you first used this drug	How long have you used substance?	How much have you been using in the last 2 weeks?	When did you last use the substance? mm-dd-yyyy	Is it the Primary Drug of Choice?
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal					Yes <input type="checkbox"/> No <input type="checkbox"/>

### Health

#### Do you have any diagnosed Physical Health Conditions

Heart Disease    Diabetes    Back Injury    Pain Management Issue    HEP C    HIV+    AIDS

Food Allergies to

Medication Allergies to

Upcoming surgeries for

What is your worst medical health problem right now?

### WHAT CURRENT MEDICATIONS ARE YOU TAKING?

Medication Name	Dosage	How many times per day	How long have you been taking this medication?

I am taking these medications regularly Yes  No  If not, why not?

Do have any Diagnosed Mental Health Conditions		
Diagnosis	At what age:	Psychiatrist <input type="checkbox"/> Family Doctor <input type="checkbox"/> Other <input type="checkbox"/>
Diagnosis	At what age:	Psychiatrist <input type="checkbox"/> Family Doctor <input type="checkbox"/> Other <input type="checkbox"/>
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#### CURRENT MEDICATIONS FOR MENTAL HEALTH

Medication Name	Dosage	How long have you been taking this medication?	How many times per day

Are you taking these medications regularly now? Yes  No  If not, why not?

#### Health – Suicide Risk

Have you ever felt suicidal? Yes  No  How recently?

Have you ever made an attempt? Yes  No  how recently? By what method?

Where you hospitalized? Yes  No  How long was your stay in hospital?

Were you seen by a psychiatrist?  No

Name:

#### Medical Contacts

Medical Contact	Name	Telephone
Physician		
Specialist		
Psychiatrist		
Other		

Notes:

<b>Treatment History</b>			
<b>Dates of Treatment</b>	<b>Type: Detox, Support Recovery, Outpatient (OP), 28 day Treatment Program</b>	<b>Facility Name</b>	<b>Completed or incomplete (If incomplete, why?)</b>
<b>Clean Time History (Other Periods of Abstinence)</b>			
<b>From</b>		<b>To</b>	<b>What happened that started your substance use again?</b>
<b>Motivation for Treatment Now</b>			
What do you want to apply for treatment now?			
What is different for you this time as you are thinking about coming back to treatment?			
What is your worst problem right now?			
Do you have a 12 Step sponsor? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you seeing an outpatient counselor regularly? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Are you attending support meetings? Yes <input type="checkbox"/> No <input type="checkbox"/> How many per week?			
What are the 3 main goals you want to accomplish while you attend the program?			
Are you ready and willing to be in a highly structured program for a minimum of 3 months? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Are you ready and willing to enter the program as soon as possible Yes <input type="checkbox"/> No <input type="checkbox"/> If no, why not			
Do you have any outside problems that might prevent you from completing the program? (Relationships with spouse/partner, parents, kids, money, loss of job, loss of home, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/>  If yes, what are they?			

### Employment History and Goals

If you are unemployed, how long have you been unemployed?	If you are employed, how long have you been employed?
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What kind of work do you do?

What kind of work would you like to do?

What are the main employment action plan goals you want to accomplish?

### Educational Goals

Do you need help with education, skills or training to find and keep employment? Yes  No

What are the main educational action plan goals you want to accomplish while in this program?

### Criminal Justice Involvement History

Do you have a criminal record? Yes  No  If no, what are your previous charges?

**Charged with:**

**When**

Are you facing any current charges? Yes  No  What are the charges?

Are you on probation currently? Yes  No  If yes, what are the conditions of your order?

Do you have upcoming court dates? Yes  No  Date:

Probation/Parole Officer Name:

Contact Number:

### Sources of Income

Type	Amount per month	Comments
Employment	\$	
Employment Insurance	\$	
Employer (Union, EAP)	\$	
Income Assistance (Basic)	\$	
Income Assistance (PWD)	\$	
Income Assistance (PPMB)	\$	
Accommodation Fee Subsidy (ADS)	\$	
Self-pay	\$	
CPP	\$	
Other	\$	

**Accommodation History (In the last 12 months)**

Dates: From - to	Type – Program, Rented suite or shared	Monthly Cost to Applicant
		\$
		\$
		\$
		\$

**Family and Friends**

Are family and friends supportive? Yes  No

Do you have a significant other who is supportive of your recovery? Yes  No

Do you have children? Yes  No

Are you hoping to reunite with your family? Yes  No

Are there others who are supportive of your recovery? Yes  No

**Hopes and Dreams**

What are your hopes and dreams that you would like to achieve while in the Transition housing program?

Approved for ESTLR Date: \_\_\_\_\_  Through STAR Estimated Intake Date: \_\_\_\_\_

Not Approved Ineligible because: