Whitehall to Maryhaven Screening Form (614-643-6315)

Date: _____ / _____ / _____

Name: _____ DOB: _____ SSN: _____

Age: _____ Sex: _____ Current complaints: _____

Address: _____

Drug(s) of Choice: _____ Last Use: _____ Daily Use: _____

Vitals: BP: _____ . _____ Glucose: _____mg/dL

Pulse: _____ SpO2: _____%

Resp: _____

For any "Yes" answers, please record any helpful information. Some "yes" answers are not disqualifiers. Call MASC for final determination about patient intake decisions.

Have you been treated at ANY Maryhaven before?	☐ Y	☐ N	_____
Do you know anyone currently in treatment at MASC?	☐ Y	☐ N	_____
Do you use opiates on a daily basis?	☐ Y	☐ N	_____
Do you use Benzodiazepines (Xanax, klonopin, etc.?)	☐ Y	☐ N	_____
Do you use stimulants (cocaine, crack, meth)?	☐ Y	☐ N	_____
Do you drink alcohol on a daily basis?	☐ Y	☐ N	_____
Do you feel suicidal or homicidal?	☐ Y	☐ N	_____
Are you having hallucinations?	☐ Y	☐ N	_____
Do you have a seizure disorder or history of seizures?	☐ Y	☐ N	_____

Medical history requiring medications: _____

Current medications: _____

Do you have those medications with you? ☐ Y ☐ N

Do you have: (Circle any that apply) ☐ Active TB ☐ Active MRSA ☐ Diagnosed with Hep A

Do you need a nicotine patch?	☐ Y	☐ N	_____
(Females) Is there a possibility of being pregnant?	☐ Y	☐ N	_____
If yes, have you had an ultrasound? Where?	☐ Y	☐ N	_____

All pregnancies need an ultrasound confirming viability and due date, 32+ weeks require a reactive non-stress test. Transport any questionable patients to any hospital for "medical clearance" and request RREACT link to MASC.