

CLIENT SELF-REFER INTAKE SCREENING

Fill out during phone screen with client:

Intake Information

Date of Self-Referral	Date of Intake Screening
Intake Screener Name	Intake Screener Email

Client Information

Name	DOB / /	Phone	Email
Address	City, State, Zip	County	
Insurance? Y/N	Insurance Provider	PMI/Insurance #	

Chemical Use

Primary DOC, Additional DOCs
Frequency of Use / Use History
Tolerance / Quantity of Use
Last Date of Use / Withdrawal Potential

Mental Health

Known Diagnoses	
Current Mental Health Services	
Hallucinations? Y/N	History of suicidal attempts/ideations? Y/N

Intimate Partner Violence

History of IPV? Y/N	Recency of IPV
Hospitalized? Y/N	Currently living with partner? Y/N

Fill out without client:

Screener Observations (*ex: appeared to be intoxicated as evidenced by..., appeared to be uncomfortable answering questions regarding criminal history as evidenced by..., etc.*)

Safety Concerns for PRSS (*ex: meet in team of 2, meet in public, do not transport, etc.*)

MnPRA Information

Admitted? Y/N - if “no,” provide reason	
PRSS Provider Name	Date Assigned
PRSS phone	PRSS email