BCARES BRIEF ASSESSMENT

Client Name:_____Date of Birth: _____Social Security #:_____
Client Insurance Status: ☐ Medicaid/Health Choices (Ex: Magellan or CBH) ☐ Commercial/private
☐ Medicare ☐ No Insurance ☐ Other: _____

Does the referring facility plan to use the 3 days of BCARES funding? ☐ YES ☐ NO

Current Drug & Alcohol Use:

In the past 30 day, have you used:

Drug	Amount Last Used	Frequency of use (daily, weekly, etc.)	Date of Last use	Route of Administration (Nasal, IV, orally, smoking, etc.)	Age of First Use
Alcohol					
Marijuana					
Cocaine/Crack					
Heroin					
Fentanyl/Carfentanyl					
Methamphetamines					
Hallucinogen: Please list type:_____					
Barbiturates Please list type:_____					
Opioid Pain medications Please list type:_____					
Benzodiazepines Please list type:_____					
Amphetamines Please list type:_____					
Suboxone (non-prescribed)					
Methadone (Non-prescribed)					
Tobacco					
Inhalants Please list type:_____					
Other:_____					

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Drug and Alcohol Treatment History:

Please list three most recent treatment facilities:

Facility	Month/ Year	Level of Care	Length of Treatment	Funding Source	Discharge Status (recommended aftercare, successful/ unsuccessful discharge)

What will be different about this treatment episode? _____

_____

Longest time drug free/What led to recurrence of use/What helped you remain drug free? _____

_____

_____

Previously or currently on Medication Assisted Treatments?

Methadone ☐ YES ☐ NO Suboxone ☐ YES ☐ NO Vivitrol ☐ YES ☐ NO

Do you have any interest in starting or remaining on any Medication Assisted Treatments?

Methadone ☐ YES ☐ NO Suboxone ☐ YES ☐ NO Vivitrol ☐ YES ☐ NO

Current Mental Health Status

Are you currently experiencing any mental health symptoms? If so, please list: _____

_____

Have you even been diagnosed with a mental health disorder? ☐ Yes ☐ No

If so, please list below: _____

_____

Are you currently on any medications to help manage your mental health? If yes, please list below:

Medications	Dose	Prescribing Doctor/facility	Date Last Taken

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In the past, have you received outpatient mental health treatment or been hospitalized for psychological or emotional reasons? ☐ Yes ☐ No

If yes, please list below three most recent mental health treatments:

Facility	Month/ Year	Level of Care	Length of Treatment	Funding Source	Discharge Status (recommended aftercare, successful/ unsuccessful discharge)

In the last 30 days have you acted physically aggressive towards people or property? ☐ Yes ☐ No If yes, briefly explain:

In the past 30 days, have you had thoughts about wanting to hurt yourself and/or someone else or wanting to die? ☐ Yes ☐ No

If yes, do you currently have any thoughts of hurting yourself or someone else? ☐ Yes ☐ No

* Have you acted on these feelings to hurt yourself or someone else? ☐ Yes ☐ No

Please describe:

Have you ever experienced, or witnessed, or been confronted with other traumatic events? ☐ Yes ☐ No

If yes, Please explain below: _____

_____

Current Medical Status:

Current Medical Issues (broken bones or injuries, high blood pressure, abscesses, cellulitis, etc.)**:**

_____

_____

Are you on any medications for any medical issues? If so, please list below:

Medication	Dosage/Frequency	Start Date	Last Date Taken	Prescriber

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Do you have any allergies? If yes, please list: _____

Any documented history of seizures? ☐ Yes ☐ No If yes, please list date of last seizures and where you went for medical care: _____

Any history of black outs? ☐ Yes ☐ No If yes, please list date of last blackout: _____

Any history of delirium tremors (DT's)? ☐ Yes ☐ No If yes, please list of date of last DT's? _____

Are you pregnant? ☐ Yes ☐ No If yes, please answers the questions below (if applicable):

Due Date	OBGYN Doctor Name	Date of last ultrasound

Social Support Involvement:

Who is in your recovery/support network? _____

_____

_____

Where are you living now and is that an appropriate discharge living situation? _____

_____

Legal Issues

Current legal issues/Charges/Warrant: _____

When is next court date?: _____

Probation/Parole Officer: _____ Contacted ☐ YES ☐ NO

Children and Youth Worker _____ Contacted ☐ YES ☐ NO

BCARES Assessor Information:

Name of person completing the assessment: _____

Facility/Organization: _____

Contact Information: _____