MH RRTP SCREENING APPLICATION

Mental Health Residential Rehabilitation Treatment Program Screening Form The screening form is to be completed by veterans who are eligible for VA Services and seeking residential treatment for Substance Abuse and/or Post Traumatic Disorder and/or Homelessness. Upon completion and return of the screening form you will be screened by staff to determine eligibility and appropriate placement.

Program of Interest: (Please select)

Domiciliary Care for Homeless Veterans (DCHV) _____

Substance Abuse Residential Treatment (SARRTP) _____

Post Traumatic Stress Disorder Treatment (PTSD-RRTP) _____

Date: _____

Name/Address: _____ SSN: _____

_____ Date of Birth: _____

_____ Phone: _____

Service-Connected: _____ Percentage: _____

Service-Connected Diagnosis: _____

_____

(Please give full and complete information for accurate understanding of your needs)

1. Chief Complaint (What problems are you having that prompted you to seek treatment):

_____
_____
_____
_____

2. Indicate your goals for treatment in this program (your own words):

_____
_____

_____
_____
2a: Indicate your strengths, needs, abilities and interests (veterans) which will help accomplish your treatment goal:
Strengths: _____
Needs: _____
Abilities: _____
Interests: _____
3. Symptoms/Problems (check all that apply):
__ Depression,
__ Nervousness
__ Sleep Problems
__ Energy Problems
__ Suicidal thoughts/actions: Intent or plan to harm or kill self, past history of suicide attempts
__ Homicidal thoughts/actions: Intent or plan to harm someone else
__ Problems controlling anger or emotions,
__ Difficulty controlling violent behavior
__ Relationship Problems
__ Financial or money problems
__ Homeless or housing problems
__ Medication problems or side effects
__ Past history of DT's
__ Nightmares,
__ Night Sweats
__ Flashbacks
4. Are you experiencing any pain? _____
If Yes, specify location of pain: _____
On a scale from 0 to 10 (with 0 being No pain and 10 being out of control) how do you rate your pain at this moment?
_____
_____
5. Medical History-Check any of the following reported by Veteran (check all that apply):
__ Diabetes
__ Renal Disease
__ COPD
__ Coronary Disease
__ Cancer
__ Hypertension
__ CVA
__ Hepatic Disease
__ Seizure Disorder
__ Asthma
__ Other
_____
_____
6. Education/Employment: _____
What is the highest level of school that you have completed? _____

Are you currently working? Yes No
If so, can you arrange to be off work? Yes No
What is the last type of work you did? _____
What are your sources of income (Example: Social security, disability, workman's compensation)?
_____
_____

7. Legal History:
Have you ever been in jail or prison? _____
If Yes, what were the charges? _____
Do you have any legal charges pending? _____
If Yes, describe the charges:
_____
_____

8. Military History:
Have you ever experienced a military sexual trauma? _____
Branch of Service: _____
Dates of Service: _____
Highest rank attained in the military: _____
Places of Service:
_____
_____

9. Family/Social History:
Does anyone in your family have a family history of alcohol, drug, or emotional problems? Yes No
If Yes, which side of your family? _____
What is your marital status: _____

10.Homeless Screen:
a. Where are you currently staying? _____
Type of residence: _____
City/State: _____
b. If currently rent/own an apartment, room, or house, are you at risk of eviction from residence due to inability to sustain monthly rental or mortgage payments? _____
If staying with family or friend, can you get mail there? Yes No
c. Are you without a residence (staying outdoors or in an abandoned building)? Yes No
d. Are you currently hospitalized? Yes No
If Yes, indicate your living arrangement prior to hospitalization: _____
Living Arrangement: _____
City/State: _____
e. Have you met with the HCHV Coordinator from a VA Medical Center or facility in the last month? Yes No

11.Screen for Dangerous Behavior:
Do you have any suicidal or homicidal thoughts or plans?
_____
_____

If SI/HI with a specific plan, indicate thoughts/plans:

_____

_____

12.Have you ever been treated for psychiatric problems? Yes No
If Yes, describe the problem and indicate when and where treated:

_____

_____

13.Are you currently taking any medications prescribed by the VA? Yes No
If Yes, what are they?

_____

_____

14.List all No n-VA, herbal supplements, and over-the-counter medications
you are taking:
15.Do you have any allergies to medications? YES NO
If Yes, name the medication and describe the reaction to this
medication:

_____

_____

16.Substance Use History:
a. How much and how often do you drink alcohol? _____
b. Have you any history of withdrawal from alcohol? Yes No
c. Have you ever been treated for alcohol use? Yes No
If Yes, When and Where?

_____

_____

d. Have you used any of the following drugs in the past 12 months: Yes No
If Yes, which drugs:

_____

_____

How much and how often do you use illicit drugs?

_____

_____

Have you ever been treated for illicit drug use? Yes No
If Yes, When and Where?

_____

_____

e. Have you ever felt like you should cut down on drinking or drug use? Yes No
f. Have people criticizing you about your drinking or drug use? Yes No
g. Have you felt bad or guilty about your drinking or drug use? Yes No
h. Have you ever had a drink or used drugs first to steady your
nerves, get rid of a hangover, or to get the day started? Yes No
i. Have you ever had delirium tremens (DTs): Yes No
If Yes, explain:

_____

_____

j. Do you use tobacco products? Yes No
If Yes, which products do you use, how much do you use, and

how often?

_____

_____

k. If you have past or current problems with alcohol and drug use
and also have problems with depression, PTSD, or other emotional
disorders, are you willing to accept treatment for BOTH problems,
as appropriate? Yes No
If No , please explain:

_____

_____

17. Additional Programmatic Information:
1. Drugs, alcohol and weapons are prohibited in MH RRTP and on VA Grounds.
2. The guidelines, expectations, and limitations of MH RRTP
a. Participate in at least 4 Hours of treatment 7 days a week
b. Agree to weekly and random observed drug/alcohol testing
c. Be able to manage basic self care
d. Complete a long term co-pay test and agree to co-pay prior to admission if required
e. Therapeutic Passes once a month with treatment teams approval
f. Participate in treatment planning meeting
g. Save at least 85% of income if required by treatment team (required to show back statement of saving); this is done to ensure funds for housing/bills
h. Sign a pain contract
i. The unit is under video surveillance
j. The unit is under video surveillance
k. Agree to participate in Safe Medication Policy; daily inspections to ensure medication is secure
l. Keep area neat and clean; random inspections
m. Expected to be treated with respect and dignity
n. Expected to treated co-veterans and staff with respect