# Section A: LINGUISTIC/CULTURAL PREFERENCES

Have there been any major changes in your cultural or linguistic preference? ❒ Yes ❒ No

If yes, what are they:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been changes in who makes decisions regarding your health in your family? ❒ Yes ❒ No

If yes, what are they:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section B: FAMILY AND SOCIAL SUPPORT NETWORK

Have you disclosed to former partner(s) about your HIV status? ❒ Yes ❒ No ❒ N/A

Have you disclosed to your current partner about your HIV status? ❒ Yes ❒ No ❒ N/A, no relationship

Do you know your current spouse/partner’s HIV status? ❒ Yes, positive ❒ Yes, negative ❒ No ❒ N/A

Have you had any major changes in your family or support network? ❒ Yes ❒ No

If yes, what:­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section C: HOUSING/LIVING SITUATION

Have you had any changes in your living situation, including number of people?❒ Yes ❒ No

**If yes, ask questions below. If no, move to section D.**

|  |  |  |
| --- | --- | --- |
| **Have you had any changes in the following affordable housing priority groups:** | **Yes** | **No** |
| Veteran? |  |  |
| 55+? |  |  |
| Serious mental illness (Schizophrenia, Bipolar, or Major Depression), or chronic substance use? |  |  |
| Chronic homelessness (see definition)? |  |  |

**HUD definition of chronic homelessness:**

Have you been living in a place unfit for human habitation such as a shelter, street, car, abandoned building:

❒ continuously for a year or more OR ❒ at least four episodes in the past three years?

**Current housing status (HRSA/RSR data requirements):**

[ ]  **Stable/Permanent (**❒ apartments, ❒ houses, ❒ foster homes, ❒ long-term residences, ❒ boarding homes)

[ ]  **Temporary** (❒ Transitional housing, ❒ temporary stay with family or friends, ❒ temporary placement in an institution (e.g., ❒ hospital, ❒ psychiatric facility, ❒ substance abuse treatment facility, or ❒ detoxification center), ❒ hotel or motel paid for without emergency shelter voucher.

[ ]  **Unstable** (❒ Emergency shelter, ❒ car, ❒ an abandoned building, ❒ a bus/train/subway station/airport, or ❒ outside, ❒ jail, prison, ❒ juvenile detention facility ❒ hotel or motel paid for with emergency shelter voucher.

If housed in an institution or non-permanently housed, will you need help with finding shelter or a place to live once discharged? ❒ Yes ❒ No ❒ NA

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section D: FINANANCIAL PLANNING / EMPLOYMENT STATUS

Have you had a change in employment? ❒ Yes ❒ No ❒ N/A currently not working

If yes, what is it:­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not working, would you like help finding employment? ❒ Yes ❒ No

|  |  |
| --- | --- |
| Do you have enough money each month for rent and /or utilities? | ❒ Yes ❒ No ❒ NA |
| Do you have past due medical bills? | ❒ Yes ❒ No ❒ NA |

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section E: TRANSPORTATION

Have you had any changes to your main source of transportation?

❒ Own car ❒ Bus ❒ Receive ride from family/friends ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will you need help to get to your medical or social service appointments? ❒ Yes ❒ No

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section F: LEGAL NEEDS

Do you need assistance with any of the following that relates to your HIV condition?

(*Check all that apply*):

❒ None Needed

❒ Confidentiality concerns

❒ Discrimination

❒ Will

❒ Living will

❒ Power of attorney

❒ Notarial services

Have you gone on probation or parole? ❒ Yes ❒ No ❒ N/A If yes, until what date? \_\_\_\_\_\_\_\_\_\_\_\_

Is your parole/probation officer aware of your HIV Status? ❒ Yes ❒ No ❒ N/A

Are you required to register as a sex offender? ❒ Yes ❒ No ❒ N/A

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section G: FOOD/NUTRITIONAL

Have you had any significant changes to your food or eating habits?

Are there any new physical problems that make it difficult to eat? ❒ Yes ❒ No

If yes, please check all that apply:

❒ Tooth/mouth problems ❒ Swallowing problems ❒ Food allergies

❒ Nausea ❒ Taste alteration problems ❒ Cannot eat certain foods

❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food or nutrition concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section H: FUNCTIONAL (Activities of daily living and home health care)

Have you had any changes to your physical, visual or cognitive abilities? ❒ Yes ❒ No

If yes, what\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section I: ORAL HEALTH CARE

In the last 6 months, have you had an oral health exam? ❒ Yes ❒ No

 If yes, when and where was your last appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please state reasons \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you want us to refer you to a dentist? ❒ Yes ❒ No

Dental concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section J: SEXUAL ORIENTATION, GENDER IDENTITY & SEXUAL HEALTH

In the last 6 months, have you been sexually active? ❒ Yes ❒ No

Are you experiencing any concerns with sexual function or sexual relationships? ❒ Yes ❒ No

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section K: MEDICAL HISTORY

Have you changed or started seeing a primary care provider for your HIV condition? ❒ Yes ❒ No

If yes, who: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please state the reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, would you like for us refer you to a primary care provider? ❒ Yes ❒ No

 If no, please state the reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the last 6 months, have you gone to the **emergency room** (including for mental health)?

❒ Yes ❒ No ❒ Refused to answer ❒ Unknown

In the last 6 months, have you been **admitted** to the hospital (including for mental health)?

❒ Yes ❒ No ❒ Refused to answer ❒ Unknown

Do you want more information on an anal, or vaginal Pap screening or self-breast exams?

❒ Yes ❒ No

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section L: MEDICATION/ADHERENCE

Are you currently taking HIV medications? ❒ Yes ❒ No

 If no, please state reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other reason why you might miss a dose of medication: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any herbal medicine or supplements for your HIV disease? ❒ Yes ❒ No

If yes, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, refer to Primary Care Physician

Do you have a problem with any of the following? (*Check all that apply*.)

❒ Understanding instructions for taking medications ❒ Storing medications properly

❒ Keeping medical provider appointments ❒ Keeping to dietary restrictions

❒ Picking up prescription at the pharmacy ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section M: PERINATAL / REPRODUCTIVE HEALTH ASSESSMENT

Are you planning on becoming pregnant or on having biological child in the future? ❒ Yes ❒ No

If yes, would you like more information about HIV transmission or risk factors? ❒ Yes ❒ No

Are you or is your partner pregnant?

❒ No, not pregnant

❒ Yes, pregnant

If yes, are you currently seeing someone for your prenatal care? ❒ Yes ❒ No

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please refer client:

Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appointment date:\_\_\_\_\_\_\_\_\_\_\_\_ or ❒ client refused

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section N: MENTAL HEALTH AND PSYCHOSOCIAL STATUS

Are you **currently** receiving professional help for any mental health concerns? ❒ Yes ❒ No ❒ N/A

If yes, what kind of help? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, are you on medications for any symptom above? ❒ Yes ❒ No

Prescribed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please state reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anything changed in the way you cope with stress? ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Depression Screening (PHQ-9):** Provide screening.

|  |  |
| --- | --- |
| **PHQ-9 Score:** |  |

**Anxiety Screening (GAD-7):** Provide screening.

|  |  |
| --- | --- |
| **GAD-7 Score:** |  |

**Optional Trauma Screening (PC-PTSD):** Provide screening.

|  |  |
| --- | --- |
| **PC-PTSD Score:** |  |

**Suicide/Self-Harm Screening**

Have you ever had thoughts of hurting yourself or of suicide? ❒ Yes ❒ No

 If yes, please describe situation: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **currently** having any thoughts about suicide? ❒ Yes ❒ No

If yes, have you thought of a plan to hurt yourself? ❒ Yes ❒ No

If yes, what is your plan (include, time, method, access)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the reasons that would stop you from carrying out your plan?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Explore the following Risk, Stressor, and Protective Factors with anyone who has attempted or thought of suicide. Discuss this information in safety planning with an individual who is having thoughts of suicide.***

Suicide Risk Factors (do any of the following apply?):

❒ Prior attempt ❒ Social isolation

❒ Drug/alcohol misuse ❒ Chronic disease and disability

❒ Depression or mood disorder ❒ Lack of access to behavioral healthcare

❒ Access to lethal means ❒ Knowing someone who died by suicide

Psychosocial Stressors:

❒ End of a relationship ❒ Death of a loved one

❒ An arrest ❒ Serious financial problems

Suicide Protective Factors:

❒ Effective behavioral healthcare

❒ Connections to individuals, family, community, or social institutions

❒ Life skills including problem solving, coping mechanisms, and ability to adapt to change

❒ Self-esteem and a sense of purpose or meaning in life

❒ Cultural, religious, or personal beliefs that discourage suicide

What do you feel like before these thoughts occur: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Internal coping strategies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Homicidal indicators**

Have you had thoughts of harming others **in the past?** ❒ Yes ❒ No

If yes, did you act on that? (Who was harmed? How? When?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If yes and did not act on them, what were the reasons that kept you from harming them?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you **currently** have thoughts of harming others? ❒ Yes ❒ No

If yes, what are your thoughts? (Who? How? When?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what are some reasons that might stop you from harming others?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you think the person might harm him/herself or others—do not leave client alone, contact your supervisor!**

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section O: SUBSTANCE USE/ALCOHOL USE

**DAST-10:** Provide screening. **Alcohol Assessment (CAGE):** Provide Screening

|  |  |
| --- | --- |
| **DAST-10 Score:** |  |

|  |  |
| --- | --- |
| **CAGE Score:** |  |

Are you **currently** in recovery? ❒ Yes ❒ No If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **currently** smoking cigarettes?

 If yes, how often do you smoke? ❒ Every day ❒ Some days ❒ Not at all

 If currently still smoking have you tried to quit in the last 12 months? ❒ Yes ❒ No

Do you use any other tobacco or nicotine products? ❒ Pipe ❒ Cigar ❒ Smokeless Tobacco products (snuff, chew)

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section P: VIOLENCE / ABUSE / NEGLECT

Are you currently in a relationship? ❒ Yes ❒ No

Have you ever experienced a violent event? ❒ Yes ❒ No

Has anything changed with your relationship in the last 6 months?

If yes, what:­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section Q: EMERGENCY EVACUATION PLAN / CRISIS PLANNING

Are there any changes to your evacuation or crisis plan in the last 6 months?❒ Yes ❒ No

If yes, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_