



## NEW MEXICO REHABILITATION CENTER

### CDU Pre-Screening & Admissions Assessment

Patient ID #									
Last Name		MI		First Name					
Assessment Date		DOB		/ /		Age		Primary Diagnosis	
Friends/Relatives Working @ NMRC?		Y N		If yes, Who?					
New Admission		Re-Admission		Date of Last Discharge?		/ /		Reason for Discharge?	
If disciplinary discharge within last 6 months refer to: Turquoise Lodge (505) 841-8978 or Yucca Lodge (800) 541-6966									
Friends/Relatives/BF/GF currently @ NMRC?		Y N		If yes, Who?					
Gender		SSN		Religious Preference					
Race/Ethnicity		Currently Employed		Y N		How Long?			
Marital Status		Employer							
Street Address		Veteran Status		Y		N			
City		Veteran Medical Benefits		Y		N			
State		Zip Code		Primary/Preferred Language					
ID Available		Y N		Birth Certificate		Y N		Tax Return	
Current Living Arrangements		Level of Education							
Phone #1		Phone #2							
Ever a Patient @ NMRC		Y N		If Previous Patient, When ?					
Admission Fee		Y N		Referral Source:		Court/Parole/Jail		Hospital	
Primary Drug of Use									
Health Insurance		Y N		Insurance Co.					
Health Insurance Policy #		Contact Number:				Authorization			
Payment Information:		Self Pay		Y N		Other		Y N	
Emergency Contact/Next of Kin				Contact Phone #					

### DIAGNOSED PSYCHIATRIC PROBLEMS

Diagnosis		When Given		Where given diagnosis	
Diagnosis		When Given		Where given diagnosis	
Current psychiatric disability		Y N		Type of accommodation needed	
Currently seeing Psychiatrist/Counselor		Y N		Name of Provider	
Current psychiatric medications & Dose					

### CURRENT MEDICAL PROBLEMS

Current Medical Disability		Y N		Type & accommodation needed	
Usual hospital for medical treatment					
Primary Care Doctor		Phone #			
Current Medications & Dosage					
Known Allergies					
If you have chronic pain, how are you planning to handle it after discharge?					
Are you currently pregnant?		Y N		If yes, expected date of delivery?	
How many children do you have under the age of 18:		Ages			
Who do your children live with?		Is CYFD involved?		Y N	
Name of case worker		Phone #		Who will care for minor children while in treatment?	
Detox Status		Detox Plan			

**Do you currently have a history of:**

Blackouts	Y	N	Date of last episode	
Tremors	Y	N	Date of last episode	
Seizures	Y	N	Date of last episode	
Hallucinations	Y	N	Date of last episode	
Endocarditis/Heart valve infection	Y	N	Date of last episode	
Heart Disease/Heart attack, angina, bypass	Y	N	Date of last episode	
Stroke	Y	N	Date of last episode	
Aneurysm	Y	N	Date of last episode	
Current open sores or abscesses	Y	N	Description	
Gastrointestinal bleeding	Y	N	Last active bleed	

**If you do not use your primary drug a for 24-hour period, have you experienced any of the following:**

Nausea/vomiting	Y		N	
Tremors	Y		N	
Seizures	Y		N	
Anxiety	Y		N	
Any other symptoms	Describe			

**Prior treatment(s) for addiction (inpatient & outpatient):**

Where		When		Longest period of sobriety after treatment?	
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DRUG TYPE	1 <sup>ST</sup> USE	LAST 12-MONTHS	AMOUNT	LAST USE	ROUTE
Alcohol					
Benzodiazepines					
Heroin					
Methamphetamine					
Crack					
Cocaine					
Marijuana					
Methadone					
Inhalants					
Pain Pills					
Bath Salts					
Spice					
Nicotine					
Other					

Do other people use drugs where you live now?	Y		N	
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**Legal Issues:**

Any current legal issues?	Y		N		Charges:	
Are you currently on probation?		Y		N		

Were you ever abused in any way?		Y		N	
In what way?	Emotional		Physical		Sexual

Why are you seeking treatment now?	
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(Press client for more information other than "I am tired of it" or "I can't do this anymore" – but why now?)

**Do You Have An Advanced Directive?**

None known	
Information not available	
Copy attached	

**Admission Statement:**

Is all the information you have given me today true to the best of your knowledge? Please be aware that giving false, misleading or incomplete information may result in you being turned away from admission to our hospital upon entry.

- Do you understand this statement?  Y  N
- Client was informed that they would need to taper off all controlled substances, including Benzos and pain pills.  Y  N

**Pre-Screened Refusal:**

- Does not meet criteria
- Medically unstable
- Active legal charges
- Intoxicated
- Eloped
- Needs detoxification
- Mentally unstable
- Other \_\_\_\_\_

**Documents Needed:**

Face sheet, H & P, ER Report, Medications List, Labs, Advance Directives, Court Order

Lacking: \_\_\_\_\_

Were phone calls made to request documents? \_\_\_\_\_

Who was phoned? \_\_\_\_\_

Physician approval:  Y  N

Date: \_\_\_\_\_

Time: \_\_\_\_\_

**Physician Signature**

If unapproved, the person was referred to: \_\_\_\_\_

Date referred: \_\_\_\_\_

Interviewed by: \_\_\_\_\_

