124 East Baltimore St – Hagerstown, MD 21740
Phone: 301-739-7748 Fax: 301-739-4001

427 East Patrick St – Frederick, MD 21701
Phone: 301-662-7003 Fax: 301-694-8527

Prescreening Form

Please complete ALL applicable sections – MUST BE LEGIBLE

Please check the location for which you are applying to receive treatment (SEE ABOVE FOR APPROPRIATE FAX#)

☐ **Wells House, Inc.** ☐ **Gale Recovery**

FULL Name: First, Middle, Last (If Incarcerated, Please Include Inmate ID, SID etc)			Date:
Address (If Incarcerated, Please list the Facility):			
City:	County:	State:	Zip Code:
Date of birth:	Male ☐ Female ☐		Social Security # (Required to Process)
Telephone #	List any urgent needs, such as currently needing detox services/referral, homelessness during winter/extreme conditions (cold or heat), lacking access to food or clothing, needing medical attention, gender expression concerns, or the need for assistive technology.		
Applying for outpatient treatment: Yes ☐ No ☐	Applying for residential treatment: Yes ☐ No ☐ MUST PROVIDE TB TEST RESULTS PRIOR TO ADMISSION	If currently in treatment, where:	
Counselor/Case worker contact info:	Do you give us permission to contact the Counselor/ Case Worker? Yes ☐ No ☐		
Military Veteran: Yes ☐ No ☒	Date available for admission:		
Current Forms of ID: ☐ State ID Card/Driver's License ☐ Birth Certificate ☐ Social Security Card			
Open Case with DSS for Food Stamps and/or TDAP: Yes ☐ No ☐			
Insurance: ☐ Yes ☐ No Type: ☐ Medicaid ☐ Medicare ☐ Other Private Insurance Issue Date: MA # Expiration Date: Name: Group#: Member# Insurance Issuer: ☐ Self ☐ Other (person)			
PLEASE PROVIDE A COPY OF INSURANCE CARD WITH THIS PRESCREEN			

Current Legal Status

Do you have a valid driver's license: Yes ☐ No ☐ If no, why not?	
On Probation: Yes ☐ No ☐ County:	Probation/Parole Officer:
Pending court dates: Yes ☐ No ☐ When?	What charges?
Court ordered to treatment: Yes ☐ No ☐ If yes, who ordered you? List court, judge or agency below:	
Legal History: Including outcome of ALL court appearances (Be honest, we will do a background search)	
1.	
2.	
3.	
Use reverse side, if necessary.	

Employment History

Income during this past year: $	Current monthly income: $
☐ Currently Employed ☐ VA Benefits ☐ Retirement ☐ SSDI (SS Disability) ☐ SSI (Social Security) ☐ TEHMA/TANF/TCA ☐ Unemployment Insurance ☐ Other Income Source (please list):	
Are you physically able to work: Yes ☐ No ☐ If Unemployed, last employment date:	
Reason for leaving:	

Dimension 1: Acute Intoxication/Withdrawal Potential

Substances you have Used:	Frequency	How? Orally, Injection, Smoked, Inhaled	Date of last use: (Required)
1st:			
2nd:			
3rd:			
History of DT's or seizures: Yes ☐ No ☐			

Dimension 2: Medical Conditions and Complications

IV Drug use (must answer): Yes ☐ No ☐	Pregnant: Yes ☐ No ☐	HIV Yes ☐ No ☐	Hepatitis C: Yes ☐ No ☐	
Are you currently taking Methadone, Suboxone or Vivitrol: Yes ☐ No ☐				
Do you have any OTHER physical/medical problems? Yes ☐ No ☐				
If yes, describe (Use reverse side or Notes section on last page, if you need additional space):				
Do you have any drug allergies? Yes ☐ No ☐		Do you have any food allergies? Yes ☐ No ☐		
Do you take medication for your physical/medical problems? Yes ☐ No ☐				

If yes, list Medications (Use reverse side or Notes section on last page, if you need additional space):
Are you able to take this medication by yourself? Yes ☐ No ☐
Are you receiving medical services from a physician for your somatic or medical issues: Yes ☐ No ☐
If yes, by whom (name of provider, contact information):
Are you physically able to climb stairs? Yes ☐ No ☐
Do you have any other physical limitations that are important for us to know?

Dimension 3: Emotional/Behavioral Conditions and Complications

Do you have any mental health diagnosis? Yes ☐ No ☐ If yes, please describe:
Are you taking any medication for this condition? Yes ☐ No ☐ If yes please list your medications:
Date you were Diagnosed with this condition:
Have you consistently taken this medication as prescribed? Yes ☐ No ☐ If no, Why not?
Are you currently receiving psychiatric services for this condition? Yes ☐ No ☐ If yes, by whom?
Do you have a history of suicidal or homicidal ideation or attempts? Yes ☐ No ☐ If yes, how many times, and when was the last attempt?
What effect has your mental health condition had on attempts to remain abstinent from alcohol & drugs?

Dimension 4: Readiness to Change

Are you currently in treatment: Yes ☐ No ☐ If yes, list facility: _____ If yes, is this your first treatment attempt? Yes ☐ No ☐ If no, How many times before? Detox only: _____ Inpatient: _____ Outpatient: _____ Have you ever been in treatment with the Wells House? Yes ☐ No ☐ If yes, when _____
Did you decide to admit yourself into treatment or were others involved (Not including legal system) My Decision ☐ Others ☐ If others, who: _____
What life consequences have you experienced as a result of your use?
How ready do you feel to reduce your use of drugs and/or alcohol?

Dimension 5: Relapse/Continued Use Potential

What relapse prevention tools, if any, have you learned in your current treatment or from previous treatment episodes?
What are your biggest relapse triggers?
What are your plans if a treatment slot is not available?
How do you resist temptation?
How do you resist frustrations?
How do you resist urges?
Have you had a period of sobriety in the past year? Yes ☐ No ☐ How long? If yes, what did you do to maintain your sobriety and why did you relapse?
Do you sometimes wonder if you can control your use of alcohol?
Do you sometimes wonder if you can control your use of drugs?
Do you sometimes wonder if your substance use is hurting others?
What are the reasons you believe you have not been able to stay clean and sober on your own?
Are you currently experiencing any Cravings or Withdrawal Symptoms?Yes ☐ No ☐ If yes what?

Dimension 6: Recovery Environment

Current Relationship: Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐
Describe your living situation prior to entering treatment:
What about this living situation did not help you in your attempt at recovery? Describe:
Do you have a significant other? Yes ☐ No ☐ If yes what is the status of this relationship: _____
Number of children (under 18)? ____ Names/Ages: Who has legal custody? _____ Who has physical custody? _____ Where do they reside? _____

I HEREBY GIVE MY CONSENT TO WELLS HOUSE, INC TO COMMUNICATE WITH MY REFERRAL SOURCE OR ANY CONTACTS LISTED ABOVE TO OBTAIN ANY INFORMATION AND/OR DOCUMENTS NEEDED TO CONSIDER MY APPLICATION FOR ADMISSION TO WELLS HOUSE.

_____ _____

Applicant's Signature Date

SUBMIT

IF THE APPLICANT WISHES TO PROVIDE ADDITIONAL INFORMATION TO WELLS HOUSE NOT COVERED ABOVE, USE THE REVERSE SIDE OR NOTE SECTION ON LAST PAGE!

OTHERWISE PLEASE STOP HERE!

NEXT PAGE TO BE COMPLETED BY CURRENT TREATMENT PROVIDER OR REFERRAL SOURCE

TO BE COMPLETED BY CURRENT TREATMENT PROVIDER OR REFERRAL SOURCE

Documentation from Referral Source

TB PPD or other Test Documentation: Date: Results: We cannot admit any patients into our residential facility without TB test documentation on file!		
IV Drug user: Yes ☐ No ☐	HIV: Yes ☐ No ☐	Hepatitis C Yes ☐ No ☐
Pregnant: Yes ☐ No ☐	☐ Other: _____	
Military Veteran: Yes ☐ No ☐ When/What tour: _____		
DSM 5 Diagnosis:		

REFERRAL SOURCE MUST PROVIDE MEDICAL AND PSYCHOLOGICAL EVALUATION DOCUMENTATION PRIOR TO INTERVIEW FOR ADMISSION TO WELLS HOUSE

MUST PROVIDE COPY OF TB TEST RESULTS PRIOR TO ADMISSION

_____ _____

Referral Source Signature Date

_____

Referral Source Name and Title

PRIOR TO ADMISSION WELLS HOUSE, MUST RECEIVE THE FOLLOWING

☐ Psychosocial Assessment ☐ Discharge Summary ☐ TB Test Results ☐ Copy of Insurance Card

RETURN FORM BY FAX IMMEDIATELY UPON COMPLETION TO:
301-739-4001 (WELLS) or 301-694-8527 (GALE)

FOR WELLS HOUSE USE ONLY:
Date received by Wells House:
Date Placed on Waiting List:
Scheduled Admission Date:
Date TB Test Results Received:
Transportation Needed: