SUBSTANCE USE PRE-SCREEN CHECKLIST (LEVEL 2.1 IOP)

(5-Minute Screening Tool)

CLIENT INFORMATION

Name: _____DOB: _____

Phone: _____Date: _____

Referral Source: _____ Insurance: _____

Address: _____

SUBSTANCE USE

Primary Substance(s): _____

Last Use (date/time): _____

Frequency:
☐ Daily ☐ Several times/week ☐ Weekly or less

Recent overdose? ☐ Yes ☐ No

WITHDRAWAL RISK (DIMENSION 1)

Current withdrawal symptoms? ☐ Yes ☐ No
History of severe withdrawal (seizures/DTs)? ☐ Yes ☐ No

☐ **IF YES → REFER TO DETOX**

MENTAL HEALTH (DIMENSION 3)

Current mental health concerns? ☐ Yes ☐ No

Suicidal thoughts: ☐ None ☐ Passive ☐ Active

☐ **IF ACTIVE → IMMEDIATE HIGHER LEVEL CARE**

READINESS TO CHANGE (DIMENSION 4)

Wants help to reduce/stop use? ☐ Yes ☐ Unsure ☐ No
Motivation (1–10): _____

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RELAPSE RISK (DIMENSION 5)
Used in the past 30 days? ☐ Yes ☐ No
Difficulty staying abstinent? ☐ Yes ☐ No

RECOVERY ENVIRONMENT (DIMENSION 6)
Safe/stable housing? ☐ Yes ☐ No
Substance use in home? ☐ Yes ☐ No

FUNCTIONING / PRACTICAL NEEDS
Able to attend 9–19 hrs/week? ☐ Yes ☐ No
Transportation available? ☐ Yes ☐ No

SCREENING DECISION
☐ Appropriate for Level 2.1 IOP
☐ Needs full assessment
☐ Refer to higher level of care
☐ Refer to lower level of care

Notes / Rationale:

Staff Name: _____ Date: _____

For Progressive Staff Only:

Clinician Assigned: _____

Ax Date: _____

Expected Start Date: _____