

ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES
 AND
 ILLINOIS DEPARTMENT OF HUMAN SERVICES - DIVISION OF ALCOHOLISM AND SUBSTANCE ABUSE

ADULT SUBSTANCE ABUSE SCREEN

Check One: Investigation Open Intact Add On or Placement case

Person Screened: _____ Date of Screen: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ DCFS Case Name: _____ DCFS Case ID#: _____

Person Completing Screen: _____

Check one:
 DCP Intact Worker
 Placement Worker

DCFS Office or POS Agency Name: _____

Address: _____ Phone: _____

Supervisor: _____ Phone: _____

Instructions: Check **Yes** or **No** for each item in each category. Refer any individuals with a “**Yes**” response to any of the **Bolded item(s)** to a Division of Alcohol and Substance Abuse (DASA) provider for a substance abuse assessment.

I. Facts of the case:

Yes	No		Year(s)
<input type="checkbox"/>	<input type="checkbox"/>	Delivered Substance Exposed Infant	
<input type="checkbox"/>	<input type="checkbox"/>	Previous DCFS involvement	

Yes	No	Date of LEADS check:	Date of Last Occurrence	Charge
<input type="checkbox"/>	<input type="checkbox"/>	Drug related criminal charges on LEADS		
<input type="checkbox"/>	<input type="checkbox"/>	Non-drug related criminal charges on LEADS		
<input type="checkbox"/>	<input type="checkbox"/>	Was there a police report indicating the presence of a methamphetamine laboratory: Specify:		

II. Medical and Mental Health History

Yes	No																	
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently on any medication prescribed for a medical condition? Complete below.																
		<table border="1"> <thead> <tr> <th>Diagnosis/Condition</th> <th>Medication</th> <th>Dosage</th> <th>Duration</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Diagnosis/Condition	Medication	Dosage	Duration												
Diagnosis/Condition	Medication	Dosage	Duration															
<input type="checkbox"/>	<input type="checkbox"/>	Do you have or have you ever had a mental health diagnosis?																
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently on any medication prescribed for a mental health diagnosis? If YES Complete below.																
		<table border="1"> <thead> <tr> <th>Diagnosis/Condition</th> <th>Medication</th> <th>Dosage</th> <th>Duration</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Diagnosis/Condition	Medication	Dosage	Duration												
Diagnosis/Condition	Medication	Dosage	Duration															
<input type="checkbox"/>	<input type="checkbox"/>	Has a doctor ever prescribed medication to “calm you down,” “help you sleep,” or to “help lift depression”? If YES, what medications?																
<input type="checkbox"/>	<input type="checkbox"/>	Have you taken prescription drugs (such as vicodin, valium, oxycotin, others) that have not been prescribed for you? List below.																

<input type="checkbox"/>	<input type="checkbox"/>	Do you receive disability benefits?																

III. Observation of Person being screened: Directions: If you mark Yes below, circle all that apply.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Smell of Alcohol and/or Marijuana
<input type="checkbox"/>	<input type="checkbox"/>	Visible drug paraphernalia: e.g. pipes, razor blades, syringe, other (specify):
<input type="checkbox"/>	<input type="checkbox"/>	Staggering, tremors, slurred or rapid speech, glassy eyed
<input type="checkbox"/>	<input type="checkbox"/>	Unusual or extreme behavior (Overly alert, agitated, paranoid)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating, easily distracted, confused

IV. Person being screened: Any bolded item marked Yes must result in a referral for an assessment.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently (or have you ever been) in a substance abuse or methadone maintenance treatment program? If yes, where & what year? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you use drugs? If Yes, what drugs, how much, and last time used? _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever felt you should cut down on drinking and/or drug use?
<input type="checkbox"/>	<input type="checkbox"/>	Have people criticized your drinking and/or drug use?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever felt guilty about your drinking and/or drug use?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken a drink or used drugs in the morning to steady your nerves or get rid of a hangover?

V. Direction: These questions must be asked of an adult household member or other extended family member.

Collateral Contact Name: _____

Relation to person being screened: _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Does the person being screened have a drug or alcohol problem?
<input type="checkbox"/>	<input type="checkbox"/>	Do any family members, caregivers, significant others, persons living in the home, or who interact with the child/ren have a problem with alcohol or drugs?
<input type="checkbox"/>	<input type="checkbox"/>	Does the person being screened need protection from anyone?
<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of any indicators of domestic violence?

Waiver of Collateral Contact Requested:

Reason for waiver: _____

Waiver Approved: Yes No

Child Protection Specialist's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

VI. Additional Screener Observations and Comments

Instructions: Include any information obtained during the investigation or contained in the case file that would assist the DASA provider in conducting an assessment and/or treatment; e.g. (suspected drug dealing, heavy foot traffic in and out of the home, criminal justice that indicates a substance abuse problem, etc...) Identify family members or other with relevant information about the person being screened.

VII. Referral:

Instructions: Refer any individuals with a “Yes” response to any **Bolded item(s)**. Individuals may also be referred for an assessment to “rule out” alcohol or other drug abuse problem. **All referrals for assessment must include: CFS 440-5 Adult Substance Abuse Screen; CFS 440-6 DCFS Referral for Adult Alcohol and other Drug Treatment Services; and CFS 440-7 Consent for Disclosure of Information. Indicate action taken below.**

No Referral for Assessment

Referred for Assessment

Name of Assessment Provider: _____ Date: _____

Fax number: _____ Phone: _____

Fax the following documents to the Assessment Provider at the time of referral:

CFS 440-5 Substance Abuse Screen

CFS 440-6 Referral

CFS 440-7 Consent for Disclosure

Address, City: _____

Contact Person: _____

Appointment Date: _____ **Time:** _____

Screener

Supervisor

Date

Date