OTP Screening

Screen Completed By: _____ Today's Date: _____

Client First Name: _____ MI: _____ Last Name: _____

DOB: _____ Phone #: _____ Email: _____

Address: _____ Current CARS Client? Yes or No

SSN: _____ Mother's First Name: _____

Preferred Dosing Time: 6:15AM-7AM 7AM-8AM 8AM-9AM 9AM-10AM

10AM-11AM 11AM-11:30AM

Referral Source: _____ Referral Source Phone #: _____

Insurance Provider: _____ Insurance #: _____

Date of Last ER Visit: _____ Related to overdose? Yes or No

Opioid Use Diagnosis? Yes or No Actively using opiates? Yes or No

Date of last opiate use: _____ IV use? Yes or No

Pregnant? Yes or No HIV Status: Positive Negative Unknown

Any history of MAT? Yes or No Currently Prescribed MAT? Yes or No

Currently in another OTP Program? Yes or No Consent on file? Yes No N/A

Other Medications Prescribed? _____

Any other important physical health conditions? _____

Transportation needed? Yes or No

Appointments:

Counseling Assessment Date and Time: _____ Counselor: _____

Nursing Assessment Date and Time: _____ Induction Date and Time: _____