PHOENIX HOUSE SCREENING INSTRUMENT

Program Type: ___Long Term Residential (DOC Men and Women) ___Short Term Non-Secure (DOC Men) ___Short Term w/ Mental Heath (DOC Men)

___DCEP ___Lutheran ___DPTI ___BOCC ___Marchman ___CFBHN ___Drug Court (Pasco) (Pinellas) (Volusia)

Date: _____ Current Location: _____ County: _____

Name: _____ DC#: _____ (If applicable)

R/S ___/___ DOB: _____ Age ____ SSN: _____

Judge's Name		**Referral Source**	
Phone		Phone	
E-Mail Address		E-Mail Address	
Judge's Assistant		Mailing Address	

_____(1) If a D.O.C. referral, must have a minimum of 24 Months of community-based supervision remaining on sentence (Felony Probation). It must be a Florida Case and there must be a special condition requiring "completion of a Phoenix House Program and aftercare." (Program type can be listed from above)

_____(2) Is there a history of arson, child abuse, or sex crimes?

_____(3) Is there a significant history of violent/assaultive behavior? **A page titled <u>legal history</u> will be required to complete the application. (Score sheets are acceptable). All adult charges required.**

_____(4) Is there a significant history of psychiatric disorders that require specialized psychiatric nursing and close observation, they do need monitoring and interventions by a mental health staff to limit and e-escalate their behaviors (such as psychosis, schizophrenia or multiple personality disorder).

_____(5) Any pre-existing medical conditions which would be adversely affected by high stress & high confrontation? (Heart conditions, history of non-drug related seizures; Insulin dependent diabetes will be looked at on case by case basis).

Additional information:

For additional information please call (352)595-5000 ext. 6740

15681 N US HWY 301 CITRA, FL 32113 352-595-5000

PHOENIXHOUSE.ORG

Phoenix House Florida
25TH ANNIVERSARY

Medical Screening Form

Drug of Choice: _____ Date of Last Use: _____

Suicide attempts in past? _____

Are you currently Suicidal? _____

Do you have homicidal thoughts? _____

Do you have a history of seizures? _____

Do you have a history of eating disorders? _____

Do you Have Visual or Auditory Hallucinations? _____

Do you have any Dental Problems? _____

Do you have any Visual Impairments? _____

Have you been diagnosed with Hepatitis or HIV? _____

How many days have you experienced medical problems in the past 30 days? _____

How many times in your life have you been hospitalized for medical problems?

_____

_____

Past Medical History:

_____

_____

Are you taking any prescribed medications? Please list them all with dosages:

_____

Are there any other medical issues we should be aware?

_____

15681 N US HWY 301 CITRA, FL 32113 352-595-5000

PHOENIXHOUSE.ORG

Phoenix House Florida
25TH ANNIVERSARY

Consent for Evaluation, Assessment, Treatment And Release of Referral Information

Before we begin working with you we are required to have your consent for evaluation, assessment and, if appropriate, treatment. Please read the following statement:

I, _____ **,** certify that I am making application for evaluation, assessment and, if appropriate, treatment with Phoenix House. I give consent for the staff of Phoenix House to begin the initial evaluation, assessment and/or treatment. I also hereby consent to the release of my evaluation, assessment, treatment and referral information by Phoenix House to the source(s) of my referral as indicated below.

The individuals to whom the disclosure is to be made are **(please <u>check each box</u> that applies and <u>add the name of the individual who serves in that role</u>)**:

☐ Judge _____, of the _____ Court, or their successor or designee.

☐ _____, the prosecuting attorney, or their successor or designee.

☐ _____, my attorney, or their successor or designee.

☐ _____, my probation officer, or their successor or designee.

☐ _____, my parole officer, or their successor or designee.

☐ _____, my drug court agency liaison, or their successor or designee.

☐ _____, my child protective services agency case worker, or their successor or designee.

☐ _____, my/the _____, or their successor or designee.

(Add the name and title/role of any other individual who needs to receive information from Phoenix House in connection with your participating in the drug court program or in connection with your criminal case, probation or parole)

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abused Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it,

and that in any event, this consent expires automatically with one calendar year from the date indicated by my signature below.

I understand that this consent will remain in effect until there has been a formal termination or revocation of the conditions of my sentence, probation or parole by the court and/or agency under which I have been mandated to Phoenix House for treatment. If I choose to revoke this consent prior to the formal termination or revocation of these conditions, then Phoenix House, under the terms of its reporting requirements to the court and/or agency, will inform the appropriate individuals of my decision to withdraw my consent. I may revoke this consent, in whole or with respect to one or more of the individuals named above, in writing at any time except to the extent that action has already been taken in reliance upon it, and, in any event, this consent will automatically expire when there has been a final disposition of the conditional release, or other action under which this consent was given, by the court and/or agency.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

_____	_____	_____	_____
Signature of Patient	Date	Signature of Person Signing Form if Not Patient	Date
		_____ Describe Authority to Sign on Behalf of Patient	

Prohibition on Re-disclosure: Drug and alcohol treatment information is disclosed from records whose confidentiality is protected by federal regulations governing *Confidentiality of Alcohol and Drug Abuse Patient Records, 442 U.S.C.* Federal rule 42 CFR part2 prohibits re-disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

15681 N US HWY 301 CITRA, FL 32113 352-595-5000

PHOENIXHOUSE.ORG

Consent to Obtain and/or Release PHI

I, _____,authorize Phoenix House to obtain from and/or release to the following parties my protected health information (PHI) identified below for the purpose of communicating with such parties regarding, and informing such parties of, my attendance, progress and treatment at and discharge from Phoenix House. I understand that such disclosure of my PHI by Phoenix House may include, among other things, having Phoenix House employees or representatives testify at a court or agency hearing or in open court.

The individuals to whom the disclosure is to be made are **(please check each box that applies and add the name of the individual who serves in that role)**:

☐ Judge_____, of the _____Court, or his/her successor or designee.

☐ _____, the prosecuting attorney, or his/her successor or designee.
☐ _____, my attorney, or his/her successor or designee.
☐ _____, my probation officer, or his/her successor or designee.
☐ _____, my parole officer, or his/her successor or designee.
☐ _____, my drug court agency liaison, or his/her successor or designee.
☐ _____, my child protective services agency case worker, or his/her successor or designee.
☐ _____, my/the_____, or his/her successor or designee.

(Add the name and title/role of any other individual who needs to receive information from Phoenix House in connection with your participating in the drug court program or in connection with your criminal case, probation or parole)

Purpose of disclosure: Consideration for admission to the Phoenix House residential substance abuse treatment program located in Citra, Florida.

Phoenix House Florida
25TH ANNIVERSARY

Check the appropriate boxes to specify the type of PHI that may be obtained and/or released:

- ☐ Status/Location of patient's treatment (e.g. active, program completed)
- ☐ Admission/Induction Records
- ☐ Progress Information
- ☐ Attendance Information
- ☐ Discharge or Termination Information
- ☐ Drug Test Results
- ☐ All Alcohol /Drug Treatment Records
- ☐ All Medical records (other than HIV records) Patient must sign a separate form to release HIV records.
- ☐ All Psychiatric/Psychological/Psychosocial Records
- ☐ All Vocational Records
- ☐ Records received by Phoenix House from third-party agencies, organizations, courts, substance use treatment providers or health care providers
- ☐ Specified Medical Records:

_____

- ☐ Other Records/Information (specify):

_____

I understand that my treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. pts 160 & 164, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that this consent will remain in effect until there has been a formal termination or revocation of the conditions of my sentence, probation or parole by the court and/or agency under which I have been mandated to Phoenix House for treatment. If I choose to revoke this consent prior to the formal termination or revocation of these conditions, then Phoenix House, under the terms of its reporting requirements to the court and/or agency, will inform the appropriate individuals of my decision to withdraw my consent. I may revoke this consent, in whole or with respect to one or more of the individuals named above, in writing at any time except to the extent that action has already been taken in reliance upon it, and, in any event, this consent will automatically expire when there has been a final disposition of the conditional release, or other action under which this consent was given, by the court and/or agency.

15681 N US HWY 301 CITRA, FL 32113 352-595-5000

PHOENIXHOUSE.ORG

_____	_____	_____	_____
Signature of Patient	Date	Signature of Person Signing Form if Not Patient	Date
		_____	
		Describe Authority to Sign on Behalf of Patient	

Prohibition on Re-disclosure: Drug and alcohol treatment information is disclosed from records whose confidentiality is protected by federal regulations governing *Confidentiality of Alcohol and Drug Abuse Patient Records, 442 U.S.C.* Federal rule 42 CFR part2 prohibits re-disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

15681 N US HWY 301 CITRA, FL 32113 352-595-5000

PHOENIXHOUSE.ORG