

SCREENING-YOUTH (PAPER VERSION)

Date: _____	Start time: _____	Stop time: _____	Total completion time: _____
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Thank you for calling the Los Angeles County Substance Abuse Service Helpline (SASH).

1. How did you hear about us? Website Family/Friend Provider Other agency (_____)

2. Are you calling regarding service information for youth under the age of 18?

- Yes (If YES, proceed to next question)
- No (If NO, proceed to adult prompt/Brief Triage Assessment)

3. Are you calling for yourself or on behalf of someone else?

- Self / Youth Parent/Guardian of Child SUD Provider for patient/client Court / Probation officer
 Other _____

(If caller is a parent or guardian seeking services for a youth, use the parent screener screening is not applicable for other types of caller such as SUD provider or court/probation officer.)

Youth Demographic information					
Youth Name:		Phone Number:		<input type="checkbox"/> Mobile	
		Okay to leave voicemail?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent / Guardian Name:					
Address or Zip Code:					
DOB:		Age:		Gender:	
Race/Ethnicity:		Preferred Language:		Medi-Cal or MyHealthLA ID #:	
Insurance Type: <input type="checkbox"/> None <input type="checkbox"/> MyHealthLA <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Private <input type="checkbox"/> Other					
(plan): (plan): (plan): (specify):					
Living Arrangement: <input type="checkbox"/> Homeless <input type="checkbox"/> Living with family <input type="checkbox"/> Living in foster care <input type="checkbox"/> Other (specify):					
Referred by (specify):					

4. What are the main reasons you are seeking help today?

5. Are you currently receiving other services such as physical or mental health counseling? Please describe.

6. Are you currently experiencing any family, financial, legal, or school problems? Please describe.

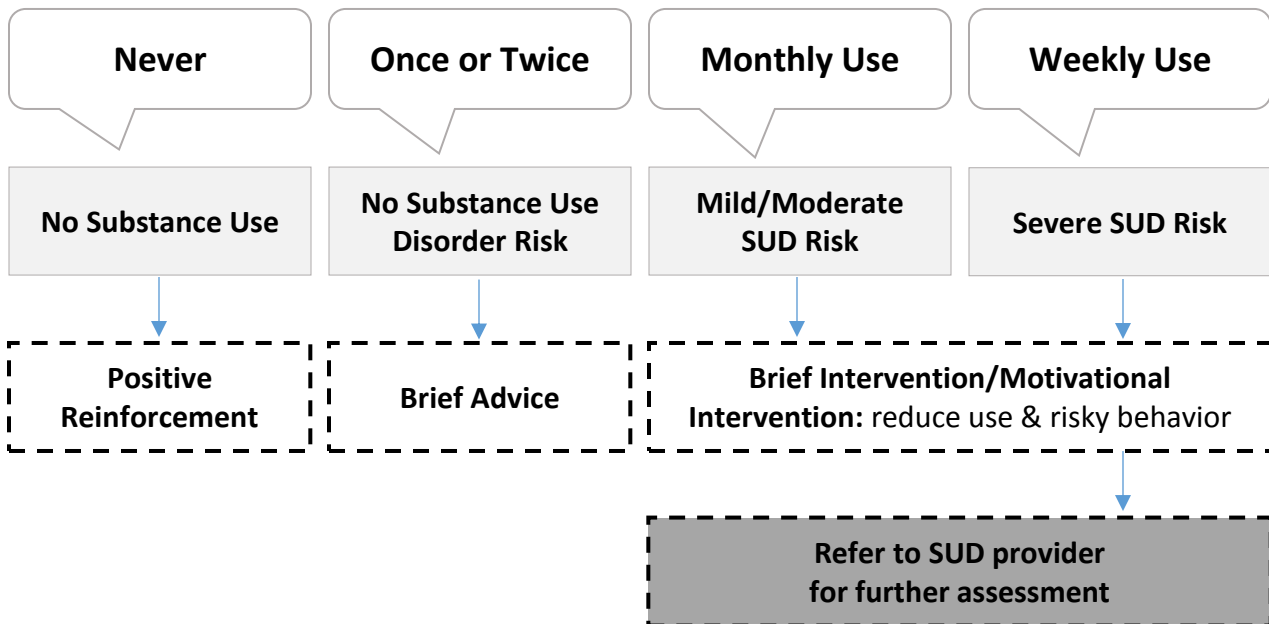
This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2 Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.	Client Name: _____ Medi-Cal or My Health LA ID: _____ Treatment Provider: _____
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S2BI: Screening to Brief Intervention

In the past year, how many times have you used [X]?	Never	Once or Twice	Monthly	Weekly
1. Tobacco Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Illegal Drugs (i.e. cocaine or Ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Prescription drugs that were not prescribed for you (i.e. Pain Medication or Adderall)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Inhalants (i.e. nitrous oxide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Herbs or synthetic drugs (i.e. salvia, K2, or bath salts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S2BI Algorithm



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Thank you for answering these questions. Based on what you shared, we would like to connect you to an agency in your local community (near you) for a further assessment and information about services to assist with your needs. How does that sound?

Referral Information:

Agency Name: _____

Address: _____

Phone: _____

Appointment Date/ Time (if available): _____

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Placement Summary

Level of Care Assessment: All youth are to be referred to the closest youth services agency for full ASAM assessment. However, youth who are just exiting residential- of hospital-based withdrawal management and those who are being referred to residential treatment from an outpatient program should be referred to a residential program for assessment.

Designated Assessment Location and Provider Name: _____

Staff/Clinician Name: **Signature:** **Date:**

Supervisor Name: **Signature:** **Date:**

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