

REMMSCO, Inc. Screening Form

Current Date		Contact Number	
Applicant Full Name		Person Referring	
Date of Birth		Age	
SSN (optional)			
Medicaid County or County of Residence		Insurance? Medicaid?	
Current Treatment/ Referral Source		Projected Discharge Date from Current Treatment	

	1 Primary	2 Secondary	3 Tertiary	4	5
Substance					
Age at 1 st use					
Frequency					
Route (IV, smoking, etc.)					
Average/day					
Date of last use					

Past Treatment History	
Medical Diagnoses	
Mental Health Diagnoses	
Medications	
Current Income	
Current/Past Legal Issues	
Current Probation/Parole?	
Pending Court Dates?	

Have you been vaccinated against COVID-19: Y ☐ N ☐

Has a TB test been performed in the last 12 months: Y ☐ N ☐

Have you ever been tested for STI's, TB, HIV, Hepatitis: Y ☐ N ☐ _____

Have you ever tested positive for HIV, Hepatitis, or TB: Y ☐ N ☐

Applicant Has Been Advised About \$50.00 Admission Fee: Y ☐ N ☐

Eligible for Food Stamps: Y ☐ N ☐

On Sex Offender List: Y ☐ N ☐

Optional:

Marital Status		Sexual Orientation	
Race		Ethnicity	
Educational Level		Veteran Status	
Head injury?			