

*Lisa Annulis, LCSW-C, SAP, SAE*  
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**INSTRUCTIONS FOR YOUR NON-DOT SAP APPOINTMENT**

Welcome to the office of Lisa Annulis, LCSW-C, SAP, SAE. Please follow the instructions for your appointment:

1. When you come into the building, come up the stairs and to the right are bathrooms. The waiting area right outside the bathrooms are the black and white chairs and tables. Don't follow the signs to suite #311.
2. If you are completing paperwork **at the office** come in 15 minutes early for your appointment. Look for a clip board on one of the black and white chairs with your initials on it. Complete the paperwork and I will come out to get you at the time discussed.
3. If you are completing the paperwork **prior to our appointment**, please bring all forms with you and have a seat in the black and white chairs as noted above. I will come out to get you at the discussed time.

**PLEASE DO NOT KNOCK ON THE DOOR TO MY OFFICE WITH MY NAME ON IT. THE OFFICE IS A ONE ROOM SUITE.**

4. The forms include:
  - a. INTAKE FORM Page 2  
Complete all information that applies to your situation. If you are unsure leave it blank. If you want me to communicate with a Designated Employer Representative (DER), I need all company information including a phone, fax and email for the contact.
  - b. HIPAA FORM Page 3  
Please review all information and sign.
  - c. NON-DOT RELEASE OF INFORMATION Page 4  
Complete all information requested that applies to your situation.
  - d. DRUG/ALCOHOL SCREENING TOOL Page 5-6  
Answer the questions the best you can and leave blank any questions you are unclear about. We can discuss these questions when we meet.

**INTAKE FORM**

Referral Source and Date: \_\_\_\_\_

Name of Company: \_\_\_\_\_ Date Infraction: \_\_\_\_\_

Company Address: \_\_\_\_\_ Substance: \_\_\_\_\_

Company (DER): \_\_\_\_\_ Type of Test: \_\_\_\_\_

Contact Ph/Fax/Email: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: xxx-xx-\_\_\_\_\_

Address: \_\_\_\_\_

Phone/Email: \_\_\_\_\_

Results of D/A Screening Tool: \_\_\_\_\_

*Do not write below the line*      Payment if Applicable: \_\_\_\_\_

Schooling:

Work History/CDL:

Substances:

Incident:

Legal/Consequences/Treatment:

- Legal Hx Verified?

Medical/Mental Health/Meds/Hospitalizations:

Leisure/Family History:

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**AND HIPAA NOTICE OF PRIVACY PRACTICES**

Welcome. I have the responsibility to give you the best care possible and to respect your rights.

1. **Services provided**--This agreement documents and describes the services rendered including a substance use assessment, recommendations and diagnosis if any.

2. **Notice of Right to Privacy and Confidentiality**--Confidentiality is maintained as part of the SAP Assessment. Your written authorization is required for any release of information or records. Information can be exchanged in various forms at your request i.e. written, verbal, telephone, fax, and/or E-mail. Measures are taken to ensure confidentiality and maintain federal, state and local regulations. Exceptions are made to this policy only in the following circumstances:

I am a mandated reporter, which means that if I have knowledge of, or reasonable cause to believe, that a child is being neglected or abused I must, and will, report this to a state/local agency.

If someone threatens to hurt himself or herself, or someone else, and in my professional judgment I believe there is a safety concern, I will take the necessary steps to protect you or the other person.

3.**Non-discrimination**--You have the right to not be discriminated against in the provision of professional services on the basis of race, age, gender, ethnic origin, disabilities, or sexual orientation.

5.**Right to Professional Disclosure**--You have the right to ask me what my training is, where I received it, my professional competencies, experience, education, and other relevant information that may be important to you in the provision of services. I am licensed to practice in Maryland as a Licensed Clinical Social Worker. And I have passed an exam to conduct SAP and SAE assessments.

6.**Right to Professional Recommendations, Opinions, and Referrals**--You have the right to be informed of my assessment of the presenting problem(s) and to know recommendations. I will provide referrals based on my assessment finding. You may ask if I have a diagnosis if it is relevant to your situation.

7. Appointment Responsibilities- **You will be charged \$60 for any cancelled appt. and if you fail to cancel within 48 hours that will go up to your full fee rate.**

8. Evaluation and Recommendations-this process is time limited

**THIS EVALUATION IS GOOD FOR 30 DAYS.**

**YOU ARE REQUIRED TO COMPLETE THE RECOMMENDATIONS FROM THE DATE YOU WERE SEEN OR YOU WILL NO LONGER BE ELIGIBLE FOR REEVALUATION.**

By signing this form, you have read, understand, and agree to the aforementioned terms.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have confirmed with the client, wish to precede with treatment:

Lisa M. Annulis, LCSW-C, SAP, SAE: \_\_\_\_\_ Date: \_\_\_\_\_



*Adapted from the Michigan Alcoholism Screening Test*

**DIRECTIONS:** If a statement is true about you, put a check ( ) in the nearby space under YES. If a statement says something not true about you, put a check in the nearby space under NO. Please answer all of the questions and put your name and signature at the end.

	<b>YES</b>	<b>NO</b>
1. Do you consider your drug/alcohol behavior normal?	_____	_____
2. Do you ever experience memory loss or convulsions the day after heavy drug/alcohol use?	_____	_____
3. Does your spouse (or parents) ever worry or complain about your drug/alcohol use?	_____	_____
4. Can you stop using drugs/alcohol without a struggle once you have begun?	_____	_____
5. Do you ever feel bad about your drug/alcohol use?	_____	_____
6. Do friends or relatives think that your drug/alcohol use is normal?	_____	_____
7. Are you always able to stop using drugs/alcohol when you want to?	_____	_____
8. Have you ever gone to Alcoholics Anonymous or Narcotics Anonymous, or other self-help groups for your drug/alcohol use?	_____	_____
9. Have you ever gotten into fights while using drugs or alcohol?	_____	_____
10. Has drug/alcohol use ever created problems with you and your spouse (or parents)?	_____	_____
11. Has your spouse (or family member) ever gone to anyone for help about your drug/alcohol use?	_____	_____
12. Have you ever lost friends, or girlfriends or boyfriends because of your drug/alcohol use?	_____	_____
13. Have you ever gotten into trouble at school or at work because of your drug/alcohol use?	_____	_____

	YES	NO
14. Have you ever lost a job (or been suspended or expelled from school) because of your drug/alcohol use?	_____	_____
15. Have you ever neglected your obligations, family, and work or school for two or more days in a row because you were using drugs/alcohol?	_____	_____
16. Do you ever use drugs/alcohol before noon?	_____	_____
17. Have you ever been told that you have liver trouble?	_____	_____
18. Have you ever had seizures, severe shaking, heard voices, seen things that were not there or felt out of control and panicky after heavy drug/alcohol use?	_____	_____
19. Have you ever gone to anyone for help about your drug/alcohol use?	_____	_____
20. Have you ever gone to a hospital because of your drug/alcohol use?	_____	_____
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward, or a general hospital where drug/alcohol use was part of the problem?	_____	_____
22. Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker or clergyman for help with an emotional problem in which drug/alcohol use played a part?	_____	_____
23. Have you ever been arrested (even for a few hours) because of behavior related to your drug/alcohol use?	_____	_____
24. Have you ever been arrested for driving while intoxicated?	_____	_____

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**Name of Client**

**Date**

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**Signature of Client**

**Date**