BRIDGES OF FLORIDA
Restoring Families Through Trauma Sensitive Therapeutic Communities

LORI COSTANTINO-BROWN
PRESIDENT

Referring Source:

Bridges of Florida would like to thank you for your referral to our Residential Treatment Programs that are in Orlando, Florida (Male) and Auburndale, Florida (Female). The length of stay for the Residential Treatment Programs may vary from (6-18) months depending upon the offenders' needs as our Residential Program is also a Dual Diagnosis Program. As part of the referral process the following referral documents are required to begin the initial screening process:

1. Consent for Release of Information
2. Bridges of Florida Residential Referral
3. Assessment Forms

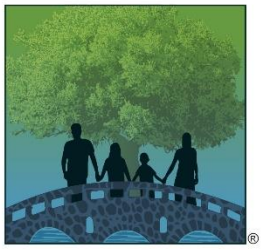
The documents are to be completed in their entirety and forwarded via email to referral@bridgesofflorida.org . Upon receipt of the referral documents, a notification of receipt will be sent within 72 hours. The documents will be upload into Bridges of Florida Electronic Health Record system. A Qualified Professional at Bridges of Florida will review and document the offender's eligibility in the Electronic Health Record system.

We kindly request that criminal history (examples: CCIS report/ Scoresheet/ Arrest Warrants) also be sent with the referral as it will help with the review to see if the client meets the criteria for our Residential Program. If client has had a Psychological Evaluation or Mental Health Evaluation, please submit those with the referral also.

Notification of approval or denial will be provided to the referral source. If a denial letter is received, the reason for denial will be listed on the letter.

Thank you again, for being a part of the referral process for the Bridges of Florida Residential Treatment Programs.

Cordially,
Bridges International
Programs Department



LORI COSTANTINO-BROWN
PRESIDENT

Client of Bridges of Florida:

Bridges of Florida has developed a procedure to apply for services with us. After meeting with lawyers and judges throughout Florida, it has been recommended that they would consider a treatment option as part of a sentence more seriously if we were able to provide them with more information about your alcohol or drug problem. To do this, we need to obtain more details about your alcohol or drug usage. We have developed a questionnaire that once completed by you, would provide the information needed. A summary of our recommendations will be given to your lawyer once the "**CONSENT TO RELEASE CONFIDENTIAL INFORMATION**" form has been completed, signed, and dated by you. If not completed, we will not be able to release information that you provided to them.

If the information is being obtained via video call, these forms will be read to you by an interviewer and the interviewer will sign and date the forms confirming that the answers were provided by you during a video call. Please ensure that you have answered all the questions, or it is invalid.

This program requires that you **MUST BE PHYSICALLY ABLE TO WORK 40 HOURS A WEEK.**

Thank you for your patience. We hope any treatment needs you may have will be fulfilled.

Cordially,

Bridges International
Programs Department

CONSENT TO RELEASE CONFIDENTIAL INFORMATION AND SCREENING/ASSESSING FOR DRUG AND/OR ALCOHOL PROGRAM PLACEMENT

I, _____, hereby authorize Bridges of Florida to,
(PLEASE PRINT NAME)
GATHER INFORMATION (pre-screening) and PERFORM MY ALCOHOL AND/OR DRUG SCREENING FOR SUBSTANCE ABUSE PROGRAM PLACEMENT and to release such information in written and/or verbal form to the following organization(s).

The Judicial Court Systems
A. Public Defenders/Defense Attorney's Office
B. State's Attorney Office
C. The Sentencing Judge

Public Defenders/Defense Attorney Name: _____
Email Address: _____
Telephone Number: _____

I understand that the specific report disclosed will include my BOA screening and program recommendation.
I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse 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 as follows:

This authorization will remain in force for the duration of my participation in the program, including aftercare commitment, in order to affect the purpose for which it is given. Federal regulations (42CFR Part 2) prohibit making any further disclosure of such information without the specific written authorization of the undersigned, or as otherwise permitted by such regulations.

_____ _____
(CLIENT SIGNATURE) **(DATE)**

_____ _____
(INTERVIEWER SIGNATURE IF COMPLETED VIA VIDEO CALL) **(DATE)**

Bridges Of Florida Referral

Name: (Please Print):		**Officer Name/Location:** (Including County)
DC#	**Race/Sex:**	**DOB:**
Date Sentenced:		**Date of Referral:**

Ordered to Which Bridge: (Check One)

☐ **Any** ☐ **Auburndale** (Female) ☐ **Orlando** (Male)

Offender Receiving SSI or SSD: (Decided on a case-by-case basis if the offender receiving SSI or SSD are eligible for Bridge Program)

☐ **SSI** ☐ **SSD** ☐ **None**

Status: Current location: Jail Name or Home Address(If at home please provide phone number.)

History of Physical Violence to include Sex Offense and Arson:

☐ **Yes** ☐ **No**

If yes, did the offense occur while under the influence? ☐ **Yes** ☐ **No**

If yes, date of offense: _____ Number of Occurrences: _____

Referring source please check documentation provided:

☐ **CCIS** ☐ **Arrest Report** ☐ **Other _____**

Medical/Psychological Problems to include Psychotropic Medications:

☐ **Yes** ☐ **No**

If yes, please provide any available information:

If yes, referring source please check documentation provided:

☐ **Psychological Evaluation** ☐ **Mental Health Evaluation** ☐ **Other _____**

Offender Able to work Full Time: ☐ **Yes** ☐ **No**

Offender Currently taking any Schedule II or Benzodiazepine medication:

☐ **Yes** ☐ **No**

If yes, is the client willing to change to an alternative medication that is not a Schedule II or Benzodiazepine medication: ☐ **Yes** ☐ **No**

If yes, client must complete and sign alternative medication agreement form.

Bridges of Florida
Screening Assessment

Please answer the following questions as honestly as you can so that we can offer you the best help possible. Your answers are confidential and will be used only to assess the most appropriate treatment for you.

Last Name **First** **M.I.** **Date of Birth**

DOC Number: _____ **Marital Status:** (circle one) Divorced Married Separated Single

Age: _____ **Circle one:** Male or Female **Number of Dependent Children:** _____

Permanent address: _____

_____ **Telephone Number:** _____

What county are you a resident of: _____

Are you currently in a Correctional Facility? If yes, where? _____

_____ **Today's date:** _____

Do you have a child support obligation? (circle one) YES NO
If yes, are you current on your child support payment? (circle one) YES NO

Ethnic Origin: (circle one) White Black American Indian Alaskan Native Asian Hispanic

Did you graduate High School or get a GED? (circle one) YES NO

Have you ever been convicted of any of the following? (circle answer): sale of drugs, rape, possession charges, soliciting, battery/assault, murder, prostitution, some type of theft, sexual assault, escape, counterfeiting, uttering and/or forgery, DUI, manslaughter, stalking simple or aggravated, domestic violence.
If none of the above applies, then list what you have been arrested for: _____

How many of your crimes were committed either under the influence of some substance or to obtain the substance? _____

Have you ever been convicted of a sex crime? (circle one) YES NO
If yes, number of sexual offenses: _____

Have you ever committed a crime that involved a weapon? (circle one) YES NO

Have you ever received treatment for drug or alcohol use? (circle one) YES NO
If yes, how many times: _____

Client initials: _____ Interviewer initials (if completed via video call): _____

Did you attend an inpatient/residential or outpatient program? (circle your answer)
YES NO BOTH (inpatient/residential and outpatient programs)

Did you complete any of the programs? (circle one) Yes NO
If yes, how long was it before you relapsed and why? _____

Have you ever received counseling for a different reason? (circle one) YES NO
If yes, what was the counseling for? _____

Have you ever been diagnosed with any of these conditions? (circle any you have)
Depression Bi-Polar Schizophrenia Personality Disorders ADHD ADD

Have you ever been on medication for any of those conditions? YES NO
If yes, what medications? _____

Are you currently on any medications for any of those conditions? YES NO
If yes, what medications are you taking? _____
_____

Do you have any medical problems? YES NO
If yes, what are they? _____

Are you able to work full time? (circle one) YES NO

Are you receiving any type of disability income? (circle one) YES NO
If yes, what type? _____
_____

Client initials: _____ Interviewer initials (if completed via video call): _____

Circle the substances you have used (whether in the past or recently), write the age you started using, last time it was used (month and year), and circle how often it was used:

Alcohol:
Age Started: _____ **Last time used:** Month _____ Year _____
How often? (circle one) Everyday 2-3 Times a week Weekends Every other week
Once a month Every other month A few times a year or less Never used

Marijuana, hash or hash oil:
Age Started: _____ **Last time used:** Month _____ Year _____
How often? (circle one) Everyday 2-3 Times a week Weekends Every other week
Once a month Every other month A few times a year or less Never used

Cocaine/Crack:
Age Started: _____ **Last time used:** Month _____ Year _____
How often? (circle one) Everyday 2-3 Times a week Weekends Every other week
Once a month Every other month A few times a year or less Never used

Heroin/Pain Pills/Methadone/Oxycontin/Dilaudid/Demerol:
Age Started: _____ **Last time used:** Month _____ Year _____
How often? (circle one) Everyday 2-3 Times a week Weekends Every other week
Once a month Every other month A few times a year or less Never used

Valium/Xanax, Sleeping Pills/Rohypnol (roofies)/Special K (ketamine):
Age Started: _____ **Last time used:** Month _____ Year _____
How often? (circle one) Everyday 2-3 Times a week Weekends Every other week
Once a month Every other month A few times a year or less Never used

Methamphetamine/Amphetamine/Crank/Speed:
Age Started: _____ **Last time used:** Month _____ Year _____
How often? (circle one) Everyday 2-3 Times a week Weekends Every other week
Once a month Every other month A few times a year or less Never used

Ecstasy/Mitsubishi Pills/Mescaline/PCP (angel dust)/ LSD/Peyote/Trumpets:
Age Started: _____ **Last time used:** Month _____ Year _____
How often? (circle one) Everyday 2-3 Times a week Weekends Every other week
Once a month Every other month A few times a year or less Never used

Inhalants (smelling, sniffing, or huffing): gas/white-out/glue/paint/related drugs:
Age Started: _____ **Last time used:** Month _____ Year _____
How often? (circle one) Everyday 2-3 Times a week Weekends Every other week
Once a month Every other month A few times a year or less Never used

Client initials: _____ Interviewer initials (if completed via video call): _____

Answer all the following questions to the best of your ability: (circle YES or NO)

- Did you need to use more than alcohol or drugs as time went on to feel the same effects? **YES NO**
- Did you feel physically uncomfortable or sick after using (hangover, headache, and/or muscle pain)? **YES NO**
- Have you used any alcohol or drugs to keep from getting sick, or make hangovers go away? **YES NO**
- Have you used larger amounts than you intended to (whether you over dosed or not)? **YES NO**
- Have you used for a longer period of time than you intended to (binges)? **YES NO**
- Have you had a persistent desire to use alcohol or drugs (thinking about getting high a lot)? **YES NO**
- Have you ever tried to cut down or control your usage unsuccessfully or substituted substances (drank beer instead of bourbon because you thought it was not as strong)? **YES NO**
- Have you spent a lot of time in activities necessary to obtain drugs/alcohol? (Visiting doctors, driving long distances, planning illegal actives to get it) **YES NO**
- Have you spent a lot of time using drugs or alcohol? YES NO
- Have you spent a lot of time recovering (hangovers) from the effects of a drug or alcohol? **YES NO**
- Have you given up family, hobbies, or recreational activities because of using? **YES NO**
- Have you missed work, gotten fired, or quit a job due to using? **YES NO**
- Have you continued using after being aware that using creates problems for you? **YES NO**
- Does your family, friends, or any loved ones feel you have a problem with drugs or alcohol? **YES NO**
- Have you ever gotten into an argument or physical fights with others when using? **YES NO**
- Have you failed to meet any major responsibilities in your life because of using or its consequences? (recurring absences from work or school or neglect of family) **YES NO**
- Have you used in situation that was dangerous (operating a car or machinery)? **YES NO**
- Has your using resulted in related legal problems? **YES NO**
- Did you ever forget what you did when you were high or drunk? **YES NO**

Circle any of these you have experienced while coming down from alcohol or drugs:

Nausea Tremors Seizures Diarrhea Vomiting Increased Heartbeat Sweating Fatigue Fever

_____ _____

(CLIENT SIGNATURE) **(DATE)**

_____ _____

(INTERVIEWER SIGNATURE IF COMPLETED VIA VIDEO CALL) **(DATE)**

Revised August 2021