COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL BUREAU

REENTRY SUBSTANCE USE DISORDER (SUD) TREATMENT PRE-INTAKE FORM

Reset Form

Client Information				Contact Date:	
Client Name:				DOB:	
Address:					
Height:	Weight (lbs):	☐ At-risk of losing home	☐ Address is temporary	☐ Homeless	
SSN:		Age:		Gender:	
Ethnicity:		Phone Number:			
Client Booking Number:			AB 109:	◯ Yes ◯ No	
Parole/Probation Status:					
Officer:		Phone Number:			
Location:					
Has the client signed a consent to release information?	◯ Yes ◯ No	Consent Date:			

Client Court Criminal History			
Court Name:		Court Department #:	
Client is court-order for SUD treatment?	◯ Yes ◯ No		
If yes, please describe SUD treatment recommendation by court:			

Legal Risk Factors:	◯ Yes ◯ No
If yes, please check off all that apply:	Explanation:
☐ Registered Sex Offender	
☐ History of Arson	
☐ History of Serious Violence	
Gang Involvement?	☐ Current ☐ Prior ☐ None ☐ Unknown

Client Mental Health History		☐ Don't know
Name of Mental Health Provider:		
Address:	Phone:	

Client has the following:	Describe below:	
☐ Mental Health Treatment History		☐ None
☐ Psychiatric Hospitalization History		☐ None
☐ Diagnosis		☐ None
☐ Currently thinking of suicide or hurting self or others (If applicable, describe history of suicidal behavior including any history of suicide attempts.)		☐ None
☐ History of conservatorship		☐ None

Functional Status:	◯ Stable	◯ Not Stable	◯ Other:

Current Medication(s) for Mental Health:

Name	Dosage	Frequency

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Client Medical History			☐ Don't know
Current Primary Care Provider:			☐None
Primary Care Address:			
Telephone:		Email:	

Current medical condition(s):

Medical record of:		
☐Diabetes	☐High Blood Pressure	☐Cardiac Issues
☐Head Trauma	☐Seizures	☐Other, describe:

☐HIV Positive	☐Unknown	☐ Prefer not to answer	
☐Hepatitis C Positive	☐Unknown		
☐Positive TB (Tuberculosis) skin test (PPD)	☐Unknown	If TB result was positive, what is the date of the most recent chest X-ray:	
☐Currently Pregnant: ◯ Yes ◯ No ◯ Not applicable		If yes, which trimester:	

Client has the following condition(s):	Describe each condition(s) below:	
☐Open wounds/lesions		☐None
☐Disability		☐None

Client can do the following without assistance? ☐ Eat ☐ Walk ☐ Climb Stairs ☐ Climb to Top of Bunk Bed ☐ Bathe

Current medication(s) for physical health:

Name	Dosage	Frequency

Client Substance Use Disorder (SUD) Evaluation (1 of 2)			☐Don't know
Date:		Level of Care Determination:	Please choose from drop down

☐ Client received in-custody OTP or other addiction medicine services.

Received any Medication for Addiction Treatment (MAT) (e.g. Vivitrol, Buprenorphine (Suboxone), Methadone, etc.)?	◯ Yes ◯ No

If Yes, List Type:		Date:	
Provider:			
☐ History of SUD (i.e., length of use):			☐None

Note: B*ased on client's status 30 days prior to incarceration*

Drug of Choice	Last Used	Method of Use/Frequency

Has client attended SUD treatment before incarceration?	◯ Yes ◯ No
If yes, describe SUD treatment history that includes the most recent date of admission, location, and type/level of SUD care received.	

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Client Substance Use Disorder (SUD) Evaluation (2 of 2)					
Current Benefits/Insurance Status (check all that apply):					
☐ Medi-Cal	ID:		☐ Medicare	ID:	
☐ Medi-Cal Eligible (if not enrolled)	☐ GR	☐ SSI	☐ CalWORKs	☐ Other:	
Upcoming Appointments or Court dates:	◯ Yes ◯ No		Type:		
If Yes, When:		Where:			
Reason:					
Designated Treatment Provider Name:					
Location:					
Appointment Date:		Time:			

Recommended Medication for Addiction Treatment (MAT):		
☐ N/A – MAT not recommended	☐ Naltrexone	☐ If other, please describe:
☐ Buprenorphine	☐ Acamprosate	
☐ Methadone	☐ Disulfiram	
☐ **Check if client will be provided with Naloxone upon exiting correctional facility.**		

Counselor Name:		Signature:		Date:	
Telephone:		Email Address:			

Please complete the following checklist if referring to a residential treatment level of care.			
Clinician Name:		Title:	
Email Address:		Phone:	

Referral Questions **Note:** Answer questions based on client's current level of functioning, not diagnosis. If Question #1 is "Yes", Question #2 cannot be "Yes".	Yes	No	N/A
1. Patients with co-occurring psychiatric condition referred to residential SUD treatment should be in the **mild to moderate** range of psychiatric impairment to be safely managed in a residential SUD setting. Is the patient in this range of functioning?	◯	◯	◯
2. If the patient has more **severe** psychiatric symptoms (e.g., hallucinations, delusions, paranoia, suicidal/homicidal ideation, intent, and/or plan), are the symptoms functionally manageable so they can be safely managed in a residential SUD setting?	◯	◯	◯
3 Patients must be able to function independently without staff assistance – they should be capable of performing all activities of daily living, managing a schedule independently to get to groups on time, participating in groups, functioning in a setting with other patients, getting to the cafeteria for meal and to the medication line on time, keeping appointments for individual SUD and MH counseling, etc. Is the patient able to function at this level?	◯	◯	

Comments:

Revised 4/10/25