MATHER
JOHN T. MATHER MEMORIAL HOSPITAL

CHEMICAL DEPENDENCY CLINIC
100 HIGHLANDS BLVD • SUITE 101
PORT JEFFERSON • NEW YORK 11777
631-331-8200 • FAX 631-331-8259

Name:____**DOB**:__________________

Address: ___________________________________ **City:** __________________ **Zip Code**:_________

Phone Numbers: Home: ( ) ______________________ Can we call you at Home? Yes No

Cell: ( ) ______________________

Work: ( ) ______________________ Can we call you at Work? Yes No

Gender: MALE FEMALE **Social Security #:** ______________________________

Marital Status (circle one): Single Married Divorce Separated Widowed Living Together

Race (circle one): American Indian or Alaska Native Black/African American Chinese Filipino Guamanian or Chamorro Hispanic White Japanese Korean Native Hawaiian Other Asian Other Pacific Islander Other Race Samoan Vietnamese White/Caucasian Undisclosed

Ethnicity (circle one): Caucasian Afro-American Hispanic Asian Other__________

Employer / School: ______________________________________ **Occupation:** __________________

Primary Care Physician: ____

Preferred Pharmacy: ____

EMERGENCY CONTACT:

Name:____**DOB**:__________________

Address: ___________________________________ **City:** __________________ **Zip Code**:_________

PRIMARY INSURANCE:

Insurance Plan:_________________________________ **Policy Number**:_______________________

Policy Holder: __________________________________ **Relation to Patient:** __________________

Policy Holder DOB: _____________________________ **Policy Holder SS#:** ___________________

SECONDARY INSURANCE:

Insurance Plan:_________________________________ **Policy Number**:_______________________

Policy Holder: __________________________________ **Relation to Patient:** __________________

Policy Holder DOB: _____________________________ **Policy Holder SS#:** ___________________

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Patient Name: ______________________________________ Date of Birth: _________________

Patient/Family Self-Reported Home Medication List
Medical and Psychiatric Medications

Please list below any medications that you are currently taking for medical and psychiatric illnesses, and the name of the practitioner who prescribes them. Please include any over the counter medications, herbal remedies or dietary supplements.

Medication	Dose	Route	Directions	Prescriber

Form Completed By: _______________________________________ Date: __________________

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Part A
Brief Medical Screening

Doctor's Name:	Address:	Phone Number:	**Date of Last Exam**:
Dentist's Name:	Address:	Phone Number:	**Date of Last Exam**:

Has a Doctor EVER told you that you had any of the following conditions?				
Condition	**Check One**		**Currently Under a Doctor's Care**	**Comment**
	Now	Past		
Alzheimer's Disease or Dementia	☐	☐	☐ No ☐ Yes	
Blood Sugar-High	☐	☐	☐ No ☐ Yes	
Blood Pressure (High)	☐	☐	☐ No ☐ Yes	
Cancer	☐	☐	☐ No ☐ Yes	
Deafness or other hearing impairment	☐	☐	☐ No ☐ Yes	
Diabetes	☐	☐	☐ No ☐ Yes	
Endocrine Condition (High or Low thyroid, Pituitary or Adrenal Disease)	☐	☐	☐ No ☐ Yes	
Epilepsy/Seizures	☐	☐	☐ No ☐ Yes	
Heart Attack	☐	☐	☐ No ☐ Yes	
Hyperlipidemia (High blood fat/Cholesterol and/or Trigycerides)	☐	☐	☐ No ☐ Yes	
Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis	☐	☐	☐ No ☐ Yes	
Kidney Disease	☐	☐	☐ No ☐ Yes	
Liver Disease ((Cirrhosis), Hepatitis A/B/C))	☐	☐	☐ No ☐ Yes	
Mobility Impairment	☐	☐	☐ No ☐ Yes	
Other Cardiac Condition	☐	☐	☐ No ☐ Yes	
Progressive neurological condition (Multiple Sclerosis (MS), Cerebral palsy, Amyotrophic Lateral Sclerosis (ALS))	☐	☐	☐ No ☐ Yes	
Pulmonary (Emphysema (Chronic Pulmonary Disease (COPD), Asthma)	☐	☐	☐ No ☐ Yes	
Sexually Transmitted or other Communicable Disease (for example, Herpes, Human Immunodeficiency Virus (HIV), History of active tuberculosis)	☐	☐	☐ No ☐ Yes	
Sight Impairment	☐	☐	☐ No ☐ Yes	
Speech Impairment	☐	☐	☐ No ☐ Yes	
Stroke	☐	☐	☐ No ☐ Yes	
Traumatic Brain Injury	☐	☐	☐ No ☐ Yes	
Weight (Obesity, Unexplained Gain or Loss)	☐	☐	☐ No ☐ Yes	
Other physical related health conditions	☐	☐	☐ No ☐ Yes	

Organization Name:	Program Name:	Date:
Individual's Name (First MI Last):	**Record #:**	**DOB:**

CURRENT Medication Information ☐ None (Include all current medication-Psychiatric/Non-Psychiatric, Prescription/Over-the-counter drugs/Herbal)					
Medication	**Reason for Taking**	**Dosage/Frequency and When taken** (Dates/Length of time)	**Side-effects**	**Helpful?**	**Prescriber**
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	
Additional:					

Medication HISTORY Information ☐ None **(As best as possible, list all additional medications taken for psychiatric or substance abuse issues in the past)**					
Medication	**Reason for Taking**	**Dosage/Frequency and When taken** (Dates/Length of time)	**Side-effects**	**Helpful?**	**Prescriber**
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	
Additional - Are there any medications you would like to avoid taking in the future?:					

Allergies/Drug Sensitivities ☐ None

☐ Food (specify):

☐ Medicine (specify):

☐ Latex / ☐ Other (specify):

Medical hospitalizations/significant operative and invasive procedures? ☐ No ☐ Yes If yes, complete information below:		
Hospital	**Date**	**Reason**
Comments:		

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Nutrition/Hydration Screening Check if you have experienced:

1. ☐ **Any weight loss or gain of 10 pounds or more in the past three months**
2. ☐ **Change in appetite**
3. ☐ **Are you experiencing any other problems eating or drinking?**

The Joint Commission

Pain Screening

Do you have any ongoing pain problems? ☐ No ☐ Yes If yes, Medical Staff completes pain section below.

For Women Only

Currently pregnant?

☐ No ☐ Yes - If yes, expected delivery date:

Receiving pre-natal healthcare?

☐ No ☐ Yes – If yes, indicate provider:

Are you currently breastfeeding? ☐ No ☐ Yes

Any significant pregnancy history?

☐ No ☐ Yes – If yes, explain:

Menstruation

Last menstrual Period Date:

Pre-menstrual symptoms: ☐ No ☐ Yes

Menstrual Pain: ☐ No ☐ Yes

Polycystic Ovary Syndrome? ☐ No ☐ Yes

Menstrual Irregularities: ☐ No ☐ Yes ☐ Other:

If yes, Indicate provider:

For Children Only

Immunizations: Has the child or adolescent been immunized for the following diseases? Please check all that apply.

☐ Chicken Pox ☐ Diphtheria ☐ German Measles (rubella) ☐ Hepatitis B ☐ Measles ☐ Mumps

☐ Polio ☐ Small Pox ☐ Tetanus ☐ Other:

All immunizations up to date? ☐ Yes ☐ No – Comments:
Prenatal exposure to Alcohol or other Drugs? ☐ Yes ☐ No – Comments:
Any other significant information that may affect care or place the child or adolescent at risk (for example, accidents or injuries):

Completed By - Print Name:	**Signature:**	**Date:**

Organization Name:	Program Name:	Date:
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Part B. Medical Assessment – (To be completed by Medical Staff/Reviewer)

Vital Signs/Physical Health Indicators
(Required, Where Indicated, For PROS W/CLINIC & Vitals Required for COA Opioid and Strongly Recommended for Others)

Blood Pressure:	Abdominal girth:	Temperature:	Pulse:
Respiration:	**Height:**	**Weight:**	**BMI:**

Nutritional/Hydration Status

If individual answered yes to any of the items in Nutrition/Hydration Screening above, provide referral information below or rationale if no further action taken:

Does individual have any medical concerns that may interfere with treatment or for which s/he needs assistance? ☐ No ☐ Yes
If Yes, explain:

Pain Assessment

Individual has pain based on Pain Screen section above: ☐ No ☐ Yes If yes, complete:

Site #1	**Site #2**
Location:	Location:
Description:	Description:

Pain is adequately controlled: ☐ No ☐ Yes
If no, is individual under medical care: ☐ No ☐ Yes - ***If no, make referral and document below:***

Actions Taken

OASAS

For those between the ages of 13 and 64: If HIV Test was negative, has the medical provider offered an HIV test? ☐ No ☐ Yes If no, explain:

Did the undersigned check the Prescription Drug Monitoring Program (PDMP) for this individual?
☐ No ☐ Yes If no, provide reason:

Physical Exam Information

OASAS

☐ No Physical Exam within the past 12 months; within 45 Days the individual will:
- ☐ Have a physical exam ***[Residential-Attach Copy]***; or
- ☐ Have a face-to-face assessment by a medical staff member to determine the need for a physical exam ***[Outpatient-See Referral Section Below]***; or
- ☐ Be referred for a physical examination ***[Outpatient-Complete Referral Information Below].***

☐ Physical Exam within the past 12 months or admitted directly to the service of another OASAS-certified service; the medical history and physical examination (including required laboratory tests) from such other services or physicians, (dated:) has been reviewed and determined to be current and accurate by:

- ☐ clinical or medical staff member ***[Residential Signature & Credentials: Date:]; or***
- ☐ medical staff member **[*Outpatient Signature & Credentials:* *Date:*].**

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

The Joint Commission	**Was Last physical completed more than one year ago?** ☐ No ☐ Yes - If Yes, document referral below:

Referrals and Recommendations

OASAS	**Based on Face to Face Medical Assessment:** ☐ **Individual requires physical exam- see referral below, OR**	☐ **Individual does not require physical exam**

☐ Nutrition/Hydration Referral:
☐ Pain Referral:
☐ Specialty Care:
☐ Primary Care Physician (General Referral):
☐ Primary Care Physician for Physical Exam and Date, if known:

☐ Other:

Comments, if indicated:

Completed By - Print Staff Name/Credentials:	**Staff Signature:**	**Date:**