|  |  |
| --- | --- |
| Staff Name:       | Date:       |

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| **Member Information** |
| Member Name:       | Date of Birth:       |
| Time of Assessment:       |
| Allergies:       |
| Reason for Admission (Per Member):       |
| Nursing Note:       |
| Drug of Choice:       |
| DSM-5 Codes:       |

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| **Drug Use History** |
| Substance | First Use | Route | Amount | Last Use |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

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| Past Detox/Withdrawal Symptoms and Treatment:       |
| Current Withdrawal Symptoms:       |
| Current CIWA or COWS Score:       |
| History of Withdrawal Seizures:       |
| Medical History:       |
| Psychiatric History:       |
| UDS Results:       |
| BAC:       |
| Medications Taken on a Regular Basis:       |
| Most Recent Pharmacy:       |

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| **Vital Signs** |
| Temperature:       |
| Blood Pressure:       |
| Heat Rate:       |
| Respirations:       |
| O2 SAT:       |
| Pain:       |
| Reported Weight:       |
| Reported Height:       |
| Skin Assessment:       |
| ADLs:       |

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| **Mental Status Exam** |
| Appearance:       |
| Behavior:       |
| Speech:       |
| Affect:       |
| Attitude to Examiner:       |
| Mood:       |
| Thought Process:       |
| Thought Content:       |
| Cognition:       |
| Insight:       |
| Judgement:       |
| Past Medical Hospitalization History:       |
| Primary Care Doctor Name:       |
| Most Recent Visit with Primary Care Doctor:       |

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| **NEEDS:**       |
| 1. Client Identified:
 |
| 1. Staff Identified, medication management for detox from:
 |

**REFERRALS**: (e.g. Outpatient treatment, Medication management, Smoking cessation)

1.

**RECOMMENDATIONS:**

1.

**DIETARY:**

**NURSING DISCHARGE PLANNING:**

|  |  |
| --- | --- |
|  |  |
| Signature of Nurse | Date |
|  |  |
| Printed Name |  |