### INTERSYSTEM INTAKE SCREENING

**INSTRUCTIONS:** STAFF SHALL COMPLETE THIS SCREENING ON ALL PATIENTS ARRIVING FROM NON-DOC FACILITIES.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Received From:</th>
<th>Receiving Institution:</th>
</tr>
</thead>
</table>

- **Interpreter needed - Primary language:**
- **Current L&I claim - Claim #:**

#### Do you wear:
- If yes, explain:
  - Glasses: □ No □ Yes □ On person
  - Contacts: □ No □ Yes □ On person
  - Dentures: □ No □ Yes □ On person
  - Partial: □ No □ Yes □ On person
  - Artificial limbs: □ No □ Yes □ On person
  - Hearing aids: □ No □ Yes □ On person
  - Other (specify): □ No □ Yes □ On person

- **Do you have any allergies?** If yes, list types:
  - □ No □ Yes

- **Are you on any type of medication, including MAT?** If yes, list types and dosages:
  - □ No □ Yes

- **Do you have any physical or functional limitations?** If yes, explain:
  - □ No □ Yes

- **Have you had a fall within the past 90 days?**
- **Do you have a history of seizures?**
- **Do you have a significant medical problem or history, including dental?** If yes, explain:
  - □ No □ Yes

- **Are you thinking of harming yourself or others?**
- **Do you have a history of self-harm?**

#### Have you ever used:
- If yes, explain:
  - Alcohol: □ No □ Yes Last used ETOH: ________________ Amount: ________________
  - Drugs: □ No □ Yes Last used: ________________

- **Have you ever experienced withdrawal symptoms?** Explain:
  - □ No □ Yes

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Continued on page 2
Hepatitis and HIV Screen

Have you ever:

- Used I/V drugs
  - If yes, Drug of choice: ___________________________  Last used: ___________________________
  - ☐ No or ?  ☐ Yes

- Snorted drugs
  - ☐ No or ?  ☐ Yes

- Shared needles
  - ☐ No or ?  ☐ Yes

- Have you been diagnosed with Hepatitis C?
  - ☐ No or ?  ☐ Yes

- Do you have a history of liver disease or Hepatitis B?
  - ☐ No or ?  ☐ Yes

- Have you been diagnosed with HIV?
  - ☐ No or ?  ☐ Yes

As part of routine testing, everyone is tested for Hepatitis and HIV unless an individual declines.

☐ I would like to decline testing.

***Notify the IPN of patients with known chronic Hepatitis B, chronic Hepatitis C, or HIV infection***

Tuberculosis and Contagion Screen

- Have you ever had a positive blood test, skin test, or PPD test for tuberculosis?
  - ☐ No  ☐ Yes

- Do you currently have a cough that’s lasted for more than three weeks?
  - ☐ No  ☐ Yes

- Are you coughing up blood?
  - ☐ No  ☐ Yes

- Do you have fever, chills, or night sweats?
  - ☐ No  ☐ Yes

- Have you had unintentional weight loss?
  - ☐ No  ☐ Yes

- Has any close contact, friend, or relative recently been told they have tuberculosis?
  - ☐ No  ☐ Yes

- Do you currently have diarrhea, or have you had it in the past few days?
  - ☐ No  ☐ Yes

- Do you have pus or liquid draining from any part of your body?
  - ☐ No  ☐ Yes

- Do you have a rash?
  - ☐ No  ☐ Yes

☐ Emergent referral to provider

☐ Head/Body check for lice. Results: ____________________________

<table>
<thead>
<tr>
<th>LEVEL OF CONSCIOUSNESS</th>
<th>MENTAL STATUS</th>
<th>BEHAVIOR</th>
<th>APPEARANCE</th>
<th>SKIN CONDITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Alert</td>
<td>☐ Oriented x 3</td>
<td>☐ Cooperative</td>
<td>☐ Relaxed</td>
<td>☐ Unremarkable</td>
</tr>
<tr>
<td>☐ Drowsy</td>
<td>☐ Normal Affect</td>
<td>☐ Passive</td>
<td>☐ Clean &amp; Neat</td>
<td>☐ Bruises</td>
</tr>
<tr>
<td>☐ Confused</td>
<td>☐ Flat Affect</td>
<td>☐ Evasive</td>
<td>☐ Disheveled</td>
<td>☐ Breaks in Skin</td>
</tr>
<tr>
<td>☐ Agitated</td>
<td>☐ Elated</td>
<td>☐ Demanding</td>
<td>☐ Dirty</td>
<td>☐ Jaundice</td>
</tr>
<tr>
<td></td>
<td>☐ Fearful</td>
<td>☐ Angry</td>
<td>☐ Tremulous</td>
<td>☐ Diaphoretic</td>
</tr>
<tr>
<td></td>
<td>☐ Hypervigilant</td>
<td>☐ Threatening</td>
<td>☐ Deformity</td>
<td>☐ Track Marks</td>
</tr>
<tr>
<td></td>
<td>☐ Gait</td>
<td>☐ Combative</td>
<td>☐ Appears intoxicated</td>
<td>☐ Scars</td>
</tr>
<tr>
<td></td>
<td>☐ Normal</td>
<td>☐ Slurred Speech</td>
<td>☐ Odor of ETOH</td>
<td>☐ Infestations</td>
</tr>
<tr>
<td></td>
<td>☐ Unsteady</td>
<td>☐ Tearful</td>
<td>☐ Self-Inflicted Injury</td>
<td>☐ Skin Infections</td>
</tr>
<tr>
<td></td>
<td>☐ Limping</td>
<td>☐ Other:</td>
<td>☐ Other:</td>
<td>☐ Other:</td>
</tr>
<tr>
<td></td>
<td>☐ Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Prosthesis, Orthotics, or Special Equipment Needs:

FEMALES ONLY

Are you now or do you suspect you are pregnant?

☐ No  ☐ Yes

If yes, explain: ____________________________  LMP: _______

úde If patient has an emergent medical, dental, or mental health complaint, refer to appropriate provider immediately. ≥

Disposition: ☐ General Population  ☐ Referred to: ____________________________  ☐ EMERGENT REFERRAL

☐ Cleared for kitchen duty

COMPLETED BY (signature and stamp)  DATE/TIME