PENFIELD
ADDICTION MINISTRIES

Main Campus	1061 Mercer Circle	Union Point,	GA 30669
South Campus	15320 Highway 129	Alapaha,	GA 31622
Heart Campus	1150 Bear Creek Road	Lavonia,	GA 30553

"Reclaiming Alcohol and Drug Addicted Men and Women Through Christ and Christian Love." II Corinthians 5:17

NURSING SCREENING AND ASSESSMENT

Date	Time	Name of Nurse or Qualified Medical Provider	Title

Client Name

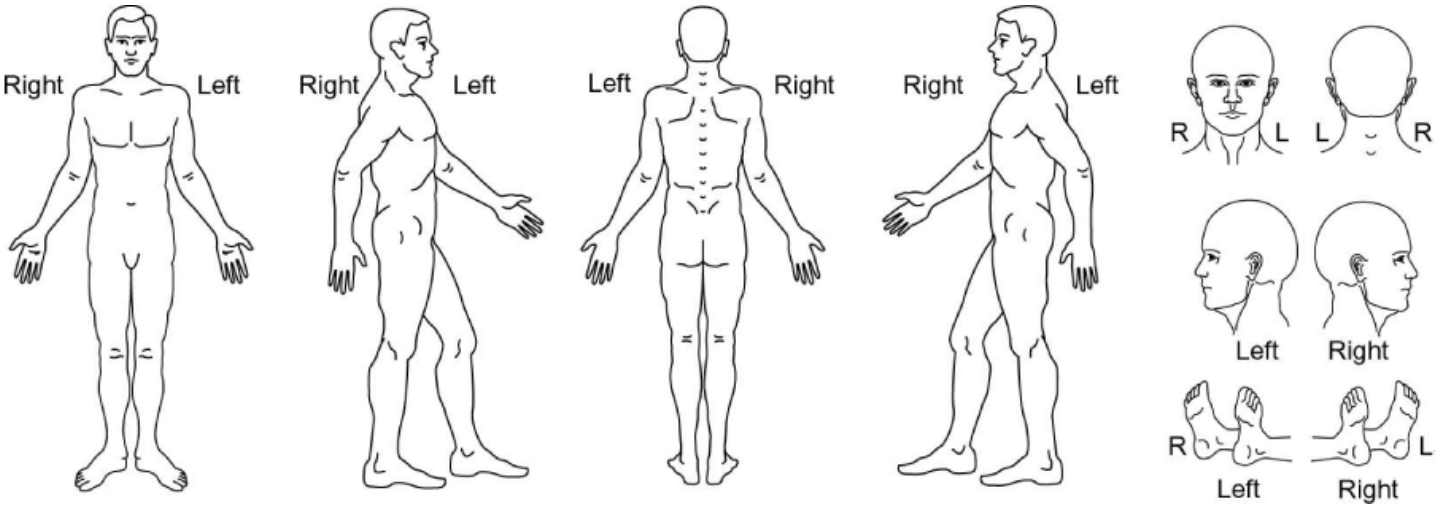
Impression

Date of last Visit	Reason

BP systolic	BP diastolic	Temperature	Pulse	Respirations	0^2 Saturation

Height	Weight	Eye Color	Hair Color

Indicate on diagram all body marks such as scars, lacerations, bruises of discoloration, ulcerations, deformities, marks, etc.



Explanation of markings:

PLEASE LIST ALL CURRENT MEDICATIONS (ATTACH SHEET FOR ADDITIONAL MEDICATIONS IF NECESSARY)				
NAME OF MEDICATION	DOSAGE	FREQUENCY	PURPOSE	PRESCRIBER

SIGNS AND SYMPTOMS OF WITHDRAWAL – PLEASE CHECK ALL APPLICABLE ITEMS				
☐ Tremors	☐ Nausea	☐ Anxiety	☐ Diarrhea	☐ Abd. Cramps
☐ Sweats	☐ Unsteady Gait	☐ Irritability	☐ Chills	☐ Vomiting
☐ Muscle Cramps	☐ Loss of Appetite	☐ Hypertension	☐ Headache	☐ Restlessness
☐ Other				

HISTORY OF PHYSICAL COMPLICATIONS FROM DRUG/ALCOHOL DETOX				
☐ Seizures	☐ DTs	☐ Blackouts	☐ Hallucinations	☐ Other

REVIEW OF SYSTEMS

HIV: Date of Last Test	Comments

Neurological				
☐ Denies problems	☐ Seizures	☐ Headaches	☐ Speech/Language/Gait	☐ Head trauma
☐ Hx of ECT? When				
☐ How many times?				
☐ Other findings				

Gastro-Intestinal				
☐ Denies problems	☐ Constipation	☐ Diarrhea	☐ Hemorrhoids	☐ Incontinence
☐ Laxative use often	☐ Other findings?			

Bowel				
☐ Denies problems	☐ Anorexia	☐ Nausea	☐ Vomiting	☐ Abdominal pain
☐ Hernia/ulcers	☐ Other findings?			

Urinary				
☐ Denies problems	☐ Dribbling	☐ Burning	☐ Incontinence	☐ Nocturia
☐ Hematuria	☐ Infection	☐ Prostate problems	☐ Frequency	
☐ Other findings				

Cardio-Respiratory				
☐ Denies problems	☐ Cough	☐ Asthma	☐ Chest Pain	☐ Edema
☐ Emphysema	☐ SOB-COPD	☐ History of CVD	☐ History of MI	☐ Hypertension
☐ Other findings				

Endocrine				
☐ Denies problems	☐ Diabetes	☐ Thyroid Problems	☐ Heat/Cold Intolerance	☐ Kidney

Skin									
	Denies problems		Dry		Moist		Warm		Flushed
	Abrasion		Rashes		Turgor		Brisk		Tenting
	Other findings								

Dental									
	Denies problems		Dentures		Pain/Loose Teeth		Bleeding		
	Other findings								

Nose Throat									
	Denies problems		Colds		Soreness/Redness		Hoarseness		Epistaxis
	Coughing Up Blood		Other findings?						

Reproductive									
	Denies problems		STD		Risk Behaviors				
	Not Sexually Active		Sexually Active		Safe Sex				
	Surgical History								
	Other Findings								

Reproductive – FEMALES ONLY	
Date of Last Menses	Comments

Are you currently, or could you possibly be pregnant?				
	Yes		No	
Comments:				

Speech									
	No Problems		Stutters		Muted		Rapid		Slurred
	Pressured		Mumbles		Soft				
	Other Findings								

Vision									
	No Problems		Blurring		Glasses		Contacts		Visually Impaired
	Legally Blind								
	Other Findings								

Hearing									
	No Problems		Ear Pain		Hearing Aid		Hearing Impaired		Deaf
	Uses ASL								
	Other Findings								

Sleep									
	No Problems (WNL)		Avg. Hours/Night		Early AM Awake		Night Time Awakening		Insomnia
	Need Medications								
	Other Findings								

Self Care (Hygiene)									
	Good		Fair		Poor		Needs Assistance		Needs Education
	Other Findings								

List Allergies

	No Known Allergies/NKA

Pain Screen					
Do you currently have any physical pain?					
	Yes		No		Score (1-10)
Comments:					
Within the past two weeks, have you taken any medications or treatments to control pain?					
	Yes		No		
If yes, list medications and treatments					
Have you had any significant, reoccurring, or chronic physical pain in the last six months that has not been resolved?					
	Yes		No		
	Unable to Verbalize		Can Verbalize		
Comments					

Suicide Screen			
Do you currently have any suicidal ideation?			
	Yes		No
	Comments		
Within the past two weeks, have you had any suicidal ideations?			
	Yes		No
	If yes, list medications and treatments		
Have you had any significant, reoccurring, or chronic suicidal thoughts in the past six months?			
	Yes		No
	Unable to Verbalize		Can Verbalize
	Comments		

(If the patient responds "Yes" to any of the three questions, continue with Suicide Assessment)

If a Suicide Risk Assessment was completed, what was the score and describe the results			
	NA		
	Unable to Demonstrate Signs/Symptoms of Suicidality		Can Demonstrate Signs/Symptoms of Suicidality
Comments			

Does the patient have a positive history of:									
	HA, Vertigo		Dysphasia		Itching/Rashes		Unusual Discharges		Seizures
	Sleep Disturbances		Psychiatric Problems		Mood or Behavior Changes		Dyspnea, Cough, or Shortness of Breath		Chest Pain or Discomfort
	Pain in Joints, Bones or Muscles		Abdominal Pain, Diarrhea, Constipation		Infectious Disease (MRSA, Hepatitis, etc.)		Allergies/Adverse Medication Reactions		Other Histories of Note
	Other								
If yes to any of the above, please give further details and explanations:									

PPD (REQUIRED)

Date Placed	Placed Right Arm	Placed Left Arm	
Date Read	Negative	Positive	Not Yet Read

Penfield staff can read the PPD results **IF** the person is in the program during the acceptable window of time from the time of placement.

If positive, explain how the patient was ruled out for TB

RPR (REQUIRED)

Date Drawn	Date Resulted	Is further treatment needed? (If yes, as noted above)

TREATMENT READINESS

Based on your assessment, is there any reason why the patient cannot participate in a substance abuse treatment program?

Based on your assessment, are there any concerns that need to be addressed before the patient attends a substance abuse program?

Based on your assessment, does the patient require detox from benzodiazepines or alcohol before entering a substance abuse treatment program? (REQUIRED RESPONSE IF EITHER IS INDICATED AS A PART OF PATIENT'S DRUG USE HISTORY)

ASSESSORS SUMMARY

NURSING ASSESSMENT (To be completed by an RN or other equivalent Qualified Medical Professional)

Letter of Medical Necessity

Section 1

Patient Name: _____ Date: _____

Employer Name: _____

Section II

Diagnosis: _____

Treatment Duration Start date: _____ End date: _____

(Please describe the **medical condition,** the **treatment you recommend,** and **how such treatment relates** to the diagnosed condition).

_____

_____

_____

Over the Counter (OTC) Medicines and Drugs - if you are prescribing vitamins/supplements please use Section II

I certify that I have issued a prescription for the Over-the-Counter Medicines and drugs listed below and that I am an individual authorized to issue a prescription in the state in which the prescription was issued and that the prescription meets the legal requirements of a prescription in the state in which the medical expense is incurred.

List Over-the-Counter medicines and drugs

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Provider's signature: _____

Clinic/Hospital/Office Name: _____

Address: _____

Phone Number: _____

What supplements are actually necessary?

- Vitamin D
- Magnesium
- Calcium
- Zinc
- Iron
- Folate
- VitaminB-12
- Multivitamin
- Fish Oil
- Magnesium
- Probiotics
- *Vitamin* C