Date: \_\_\_\_\_\_\_\_\_\_\_\_\_Start time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stop time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total completion time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for calling the Los Angeles County Substance Abuse Service Helpline (SASH).

1. **How did you hear about us?** ☐ Website ☐ Family/Friend ☐ Provider ☐ Other agency (\_\_\_\_\_\_\_\_\_\_\_\_\_)
2. **Are you calling regarding service information for youth under the age of 18?**

* ☐ Yes (If YES, proceed to next question)
* ☐ No (If NO, proceed to adult prompt/Brief Triage Assessment)

1. **Are you calling for yourself or on behalf of someone else?**

☐ Self / Youth ☐ Parent/Guardian of Child ☐ SUD Provider for patient/client ☐ Court / Probation officer

☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(If caller is a parent or guardian seeking services for a youth, use the parent screener screening is not applicable for other types of caller such as SUD provider or court/probation officer.)*

|  |  |  |
| --- | --- | --- |
| **Youth Demographic information** | | |
| **Youth Name:** | | **Phone Number:** ☐ Mobile  **Okay to leave voicemail?** ☐ Yes ☐ No |
| **Parent / Guardian Name:** | |  |
| **Address or Zip Code:** | |  |
| **DOB:** | **Age:** | **Gender:** |
| **Race/Ethnicity:** | **Preferred Language:** | **Medi-Cal or MyHealthLA ID #:** |
| **Insurance Type:** ☐ None☐ MyHealthLA ☐ Medicare ☐ Medi-Cal☐ Private ☐ Other  (plan): (plan): (plan): (specify): | | |
| **Living Arrangement:** ☐ Homeless ☐ Living with family ☐ Living in foster care ☐ Other (specify): | | |
| **Referred by (specify):** | | |

1. **What are the main reasons you are seeking help today?**

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1. **Are you currently receiving other services such as physical or mental health counseling?** Please describe.

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1. **Are you currently experiencing any family, financial, legal, or school problems?** Please describe.

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**S2BI: Screening to Brief Intervention**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| In the past year, how many times have you used [X]? | Never | Once or Twice | Monthly | Weekly |
| 1. Tobacco Products | ☐ | ☐ | ☐ | ☐ |
| 1. Alcohol | ☐ | ☐ | ☐ | ☐ |
| 1. Marijuana | ☐ | ☐ | ☐ | ☐ |
| 1. Illegal Drugs (i.e. cocaine or Ecstasy) | ☐ | ☐ | ☐ | ☐ |
| 1. Prescription drugs that were not prescribed for you (i.e. Pain Medication or Adderall) | ☐ | ☐ | ☐ | ☐ |
| 1. Inhalants (i.e. nitrous oxide) | ☐ | ☐ | ☐ | ☐ |
| 1. Herbs or synthetic drugs (i.e. salvia, K2, or bath salts) | ☐ | ☐ | ☐ | ☐ |

**S2BI Algorithm**

**Never**

**Once or Twice**

**Weekly Use**

**Monthly Use**

**No Substance Use**

**No Substance Use Disorder Risk**

**Severe SUD Risk**

**Mild/Moderate SUD Risk**

**Positive Reinforcement**

**Brief Intervention/Motivational Intervention:** reduce use & risky behavior

**Brief Advice**

**Refer to SUD provider   
for further assessment**

Thank you for answering these questions. Based on what you shared, we would like to connect you to an agency in your local community (near you) for a further assessment and information about services to assist with your needs. How does that sound?

**Referral Information:**

Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment Date/ Time (if available): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Placement Summary** |

**Level of Care Assessment:** All youth are to be referred to the closest youth services agency for full ASAM assessment. However, youth who are just exiting residential- of hospital-based withdrawal management and those who are being referred to residential treatment from an outpatient program should be referred to a residential program for assessment.

Designated Assessment Location and Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Staff/Clinician Name: Signature: Date:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supervisor Name: Signature: Date:**