Nevada State Opioid Response Grant
Client Screening Form

Name of Participant: _____

Please circle **Y** for "YES" or **N** for "NO" to each of the following questions. For any YES answers, please indicate **O** for opioid, **S** for stimulant, or **B** for both opioids and stimulants in the space after the question. You may reference the list at the bottom of this page if you are unsure of what is considered an opioid or a stimulant.

Commented [LMW1]: The client must include this information. This is how the agency will determine if the client has a current opioid use disorder diagnosis and/or stimulant use disorder diagnosis.

1. Do you have a current diagnosis for an opioid use disorder and/or stimulant use disorder (if you have participated in inpatient or outpatient treatment for either type of substance, the answer is likely yes)? **Y / N** _____
2. Do you use opioids and/or stimulants recreationally, at least 1-time monthly? **Y / N** _____
3. Have you ever overdosed on opioids or stimulants? **Y / N** _____
4. Are you pregnant and have any history of intravenous opioid or intravenous stimulant use within the last two years? **Y / N** _____
5. Were you recently released from incarceration but had a history of opioid or stimulant use that may have required or benefitted from treatment before incarceration? **Y / N** _____

If you answered NO to all of the above questions, you do not need to proceed to the second page.

If you answered YES to ONE OR MORE of the questions, proceed to the second page.

Opioids: Heroin, Fentanyl, Oxycodone (Oxycontin, Percodan, Percocet, Roxicodone) Hydrocodone (Vicodin, Lortab, Norco), Morphine, Hydromorphone (Dilaudid), Methadone, Opium

Stimulants: Methamphetamine (Desoxyn), Amphetamines (Adderall, Ritalin, Vyvanse, Concerta), Cocaine, or Khat

First letter of first name: _____ First letter of your middle name (if none, use X): _____

Sex (1 = male 2 = female): _____ First letter of city/town you were born in: _____

First letter of mother/female guardian's first name (can be natural or adoptive): _____

How many older brothers do you have (half, living, or deceased, if none write X): _____

How many sisters do you have (half, living, or deceased, if none write X): _____

Commented [LMW2]: These components make up the client's SOR client ID. The complete client ID will also include the assigned agency code.

In the past 30 days, which US Food and Drug Administration (FDA)-approved medication have you received for the treatment of an opioid use disorder? Select all that apply.

- ☐ Methadone
- ☐ Buprenorphine
- ☐ Naltrexone
- ☐ Extended-Release Naltrexone
- ☐ I was diagnosed with an opioid use disorder, but did not receive any FDA-approved medication for an opioid use disorder
- ☐ I do not have an opioid use disorder
- ☐ I don't know

Do you have a current diagnosis for an alcohol use disorder? **Y / N**

Are you **currently** receiving **substance use treatment services** from one of the below agencies or providers (circle any that apply)? Please note, that acknowledging yes does not give *Insert Agency Name* consent or permission to contact this provider. This question is only asked to avoid potential duplication of services.

NORTHERN NEVADA AREA:

Carson Community Counseling

EMPOWERED Program

The Empowerment Center

The Life Change Center