YOUTH TREATMENT NEED SCREENER – PARENT / CAREGIVER VERSION

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 (_____)

_____

_____

Youth Demographic information					
Youth Name:			**Phone Number:** ☐ Mobile **Okay to text or 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 (specify):	☐ Medi-Cal (specify):	☐ Private (specify):	☐ Other (specify):
Living Arrangement (youth): ☐ Homeless	☐ Living with family	☐ Living in foster care	☐ Other (specify):		
Referred by (specify):					

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

_____

_____

3. **Has your child been using alcohol, marijuana and other drugs?** ☐ Yes ☐ No ☐ Not sure

Please explain: _____

_____

4. **How frequently do you think your child uses alcohol, marijuana, or other drugs?**

☐ Daily ☐Weekly ☐ Monthly ☐ Not Sure

Notes: _____

_____

5. **Have you noticed any signs in your child's behaviors that you think may be related to alcohol, marijuana or other drug use (such as acting out, having difficulties at school/work, becoming withdrawn or not getting along with his/her friends, etc.)?**

Please explain _____

_____

6. **Has your child received any treatment for alcohol, marijuana or other drugs in the past?** ☐ Yes ☐ No

Client Name: _____Medi-Cal or My Health LA ID:_____

Treatment Provider: _____

If "yes," please explain _____

_____

7. Has your child ever been diagnosed with a mental health condition or seen by a mental health counselor/therapist for an emotional, cognitive or behavioral issue? ☐ Yes ☐ No

If "yes," please explain _____

_____

8. Does your child have any current medical or mental health needs that require immediate attention? ☐ Yes ☐ No

If "yes," please refer to emergency services at 911.

_____

_____

Thank you for answering these questions. Based on what you shared, we would like to connect you to a local agency in your community for further assessment and information about needed services for your child. How does that sound? In the meantime, we would also like to provide you with information about youth substance use that may help you with further questions or concerns you may have.

Referral Information:

Agency Name: _____

Address: _____

Phone: _____

Appointment Date/ Time (if available): _____

Client Name: _____ Medi-Cal or My Health LA ID: _____

Treatment Provider: _____

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: _____

_____

_____

_____

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

_____

Supervisor Name: **Signature:** **Date:**

Client Name: _____Medi-Cal or My Health LA ID:_____

Treatment Provider: _____