BRYANT COMMUNITY OUTREACH

CONDENSED ADULT BEHAVIORAL HEALTH & SUBSTANCE USE INTAKE

Purpose: One coordinated intake for behavioral health and substance use services. Complete client sections before the assessment; the qualified clinician completes the clinical sections. Use additional pages only when clinically necessary.

1. Client Identification & Access Needs

Legal name	Preferred name	DOB	Age
Pronouns	Sex at birth	Gender identity	Race / ethnicity

Home address	City / State / ZIP
Mobile phone / OK to text?	Email / OK to email?

☐ English
☐ Spanish
☐ Interpreter needed
☐ Reading assistance
☐ Vision/hearing accommodation
☐ Mobility accommodation
☐ Other communication need: _____

Medicaid / payer	Member ID	MCO	Preferred contact

Emergency contact & safety permissions

Name	Relationship	Phone	May receive appointment/safety calls?

Referral & immediate need

Referral source / person / agency: _____

In your own words, why are you seeking services now? _____

_____

What would you most like help with? _____

_____

Client / legal representative
Signature: _____ Date: _____

2. Immediate Safety, Crisis & Urgent Medical Screen

If any imminent risk, overdose, severe withdrawal, acute psychosis, medical instability, abuse/neglect, or inability to maintain safety is identified: pause routine intake, maintain supervision, notify the qualified clinician, and activate BCO emergency/mandated-reporting procedures. Call 911 or 988 as appropriate.

Current / recent concern	No	Yes	Details, date, plan, means, intent, protective factors
Thoughts of suicide or wishing to be dead	☐	☐	
Suicide attempt or interrupted/aborted attempt	☐	☐	
Thoughts, plan, intent, or behavior to harm others	☐	☐	
Self-injury without suicidal intent	☐	☐	
Hallucinations, paranoia, severe confusion, mania	☐	☐	
Recent overdose or high-risk substance use	☐	☐	
Withdrawal symptoms / seizure / delirium history	☐	☐	
Abuse, neglect, exploitation, trafficking, unsafe home	☐	☐	
Access to firearms, weapons, or lethal medications	☐	☐	

Clinician immediate disposition

☐ No acute risk identified
☐ Same-day clinical evaluation
☐ 911 / emergency department
☐ Mandated report initiated
☐ Naloxone education or supply referral
☐ Safety plan completed
☐ 988 contacted
☐ Mobile crisis / other crisis service
☐ Higher level of care / detox evaluation
☐ Other: _____

Risk formulation (acute/chronic risk, protective factors, rationale): _____

_____

_____

Disposition, people notified, referrals and follow-up time: _____

_____

Screen completed by / credential	Date	Time	Client location (if telehealth)

3. Presenting Problems, Symptoms & Functioning

☐ Depressed mood ☐ Loss of interest ☐ Anxiety/worry

☐ Panic ☐ Trauma symptoms ☐ Nightmares/flashbacks

☐ Mood swings ☐ Irritability/anger ☐ Impulsivity

☐ Sleep disturbance ☐ Appetite/weight change ☐ Poor concentration

☐ Obsessions/compulsions ☐ Hallucinations ☐ Paranoia

☐ Grief/loss ☐ Substance cravings ☐ Gambling concern

☐ Relationship conflict ☐ Work/school problem ☐ Housing/financial stress

☐ Legal/court concern ☐ Chronic pain ☐ Other: _____

Primary concern	Onset / duration / frequency	Severity 0-10	Impact on daily functioning
Second concern			
Third concern			

Functional needs

Area	Independent	Needs help	Description / current supports
Personal care / ADLs	☐	☐	
Medication management	☐	☐	
Transportation	☐	☐	
Housing / food / finances	☐	☐	
Appointments / communication	☐	☐	
Parenting / caregiving	☐	☐	
Work / school	☐	☐	

Strengths, preferences & recovery supports

Strengths, skills, interests and past successes: _____

_____

Supportive people, culture, spirituality, community and recovery resources: _____

_____

Treatment preferences, barriers, and what has or has not helped before: _____

_____

4. Medical, Medication & Wellness Review

Primary care / prescriber	Phone / fax	Last visit	Permission to coordinate?

☐ No known medical conditions
☐ Seizure disorder
☐ Cardiac condition
☐ Respiratory condition
☐ Chronic pain
☐ Sleep disorder
☐ Pregnant / possible pregnancy
☐ Liver disease / hepatitis
☐ Diabetes
☐ Infectious disease concern
☐ Head injury / loss of consciousness
☐ Other: _____

Current and past medical conditions, surgeries and hospitalizations: _____

_____

_____

Medication / dose / route	Frequency	Indication	Prescriber	Taking as prescribed?

Allergy / adverse reaction	Reaction	Severity / action needed

Wellness and preventive needs

☐ No current need
☐ Nutrition
☐ Tobacco cessation
☐ Other: _____
☐ Dental
☐ Sexual/reproductive health
☐ Pain management
☐ Vision
☐ HIV/STI/hepatitis testing
☐ Sleep

Medical coordination, labs, referrals, medication reconciliation or precautions: _____

_____

_____

5. Substance Use History & Current Pattern

Substance	First use age	Last use	Typical amount / route	Frequency	Longest abstinence / withdrawal
Alcohol					
Cannabis					
Opioids / fentanyl / heroin					
Methamphetamine / stimulants					
Cocaine / crack					
Benzodiazepines / sedatives					
Tobacco / nicotine					
Other / prescribed misuse					

Substance-related risks and consequences

- ☐ Cravings / loss of control
- ☐ Withdrawal
- ☐ Injection use
- ☐ Naloxone available
- ☐ Medical consequences
- ☐ Family/social consequences
- ☐ Legal consequences
- ☐ Recovery supports / mutual aid
- ☐ Tolerance
- ☐ Overdose history
- ☐ Using alone
- ☐ Blackout
- ☐ Mental health consequences
- ☐ Work/school consequences
- ☐ Prior unsuccessful attempts to stop
- ☐ MAT history or interest

Overdose(s), withdrawal complications, periods of abstinence, relapse pattern and triggers: _____

_____

_____

Past SUD treatment and response (include medications for OUD/AUD): _____

_____

6. Consent, Privacy, Rights & Program Acknowledgment

Consent for treatment

I voluntarily consent to assessment and medically necessary outpatient behavioral health and/or substance use services offered by Bryant Community Outreach (BCO), as described to me and reflected in my treatment plan. I understand the nature and purpose of services, expected benefits, material risks, alternatives, limits of confidentiality, my right to ask questions, refuse a service, or withdraw consent subject to legal and safety requirements, and that no outcome is guaranteed.

Privacy and confidentiality

I received or was offered BCO's Notice of Privacy Practices and understand that health information may be used or disclosed for treatment, payment, and health care operations as permitted by HIPAA. Substance use disorder records may receive additional protection under 42 CFR Part 2. Separate written authorization is used when required. Confidentiality may be limited by emergencies, court orders meeting legal requirements, mandated reporting, threats of serious harm, and other disclosures allowed or required by law.

Client rights and responsibilities

☐ Respectful, nondiscriminatory, trauma-informed care

☐ Privacy and confidential records

☐ Information in an understandable language

☐ Participate in and receive a copy of the treatment plan

☐ Know provider names and credentials

☐ Accept or refuse treatment as allowed by law

☐ Access or request amendment of records as allowed by law

☐ Freedom from abuse, neglect, exploitation and retaliation

☐ Voice a complaint / grievance and appeal a decision

☐ Receive emergency and after-hours instructions

☐ Provide accurate information and participate in care

☐ Respect safety, privacy and program rules

Financial and program information

I received information about fees, insurance billing, attendance, cancellation, discharge, emergency procedures, grievance/appeal procedures, and how to contact the client advocate. I understand authorization or eligibility does not guarantee payer payment and I may request an explanation of charges before services.

Acknowledgment	Initials
Consent for treatment and participation	
Notice of Privacy Practices received / offered	
Client rights, grievance and appeal process received	
Fees, attendance, emergency and program rules explained	
Copy of signed forms offered	

Client / legal representative	BCO staff / witness
Signature: _____ Date: _____	Signature: _____ Date: _____

7. Telehealth Consent (Complete if Telehealth May Be Used)

I consent to the use of secure telehealth when clinically appropriate. I understand telehealth differs from an in-person visit; potential benefits include access and convenience, while risks include technology failure, interruption, reduced ability to observe some clinical information, and unauthorized access despite safeguards. I may ask questions, request an in-person service when available, or stop a telehealth session, but BCO may recommend in-person or emergency care when needed.

☐ Telehealth is not an emergency service; call 911 or 988 for an emergency

☐ At each visit I will confirm my identity, physical location, callback number and emergency contact

☐ I will use a private setting when possible and will not share the session link

☐ People present at either location will be identified and my permission obtained when required

☐ Recording is prohibited unless all required parties give prior written consent

☐ If technology fails, BCO may call me, reschedule, or direct me to another level of care

☐ Privacy protections and their legal limits also apply to telehealth

☐ I understand payer coverage and technology access may affect availability

Telehealth preference	Client initials
I consent to telehealth when clinically appropriate	
I decline telehealth at this time	

Client's usual telehealth location and nearest emergency department: _____

Emergency contact authorized for telehealth safety response: _____

Client / legal representative	BCO staff / witness
Signature: _____ Date: _____	Signature: _____ Date: _____

Program contacts

For routine questions, privacy requests, complaints or grievances, contact Bryant Community Outreach at the current number listed on BCO materials or www.yestobco.com. For urgent danger call 911; for suicide or behavioral health crisis call or text 988.

8. Specific Authorization to Obtain and/or Disclose Information

Optional and separate from consent for treatment. Complete one authorization per recipient/source when practical. Treatment generally may not be conditioned on signing this authorization except as permitted by law.

Client name	DOB	Member / record ID

BCO may disclose information to and/or obtain information from (name/entity): _____

_____

Address / phone / fax / secure email: _____

☐ Disclose from BCO ☐ Obtain for BCO ☐ Two-way exchange

Purpose and information authorized

Specific purpose (for example: care coordination, benefits, legal requirement): _____

☐ Assessment / diagnosis

☐ Treatment plan

☐ Progress / attendance

☐ Medication / medical information

☐ Laboratory / drug test results

☐ Billing / eligibility

☐ Discharge / continuing care

☐ Other: _____

Date(s) of service or limited date range: _____

Specially protected information - authorize only by specific initial

Category	Initials
Substance use disorder records protected by 42 CFR Part 2	
Mental / behavioral health records	
HIV/AIDS or communicable disease information	
Genetic information	
Reproductive / sexual health information	

Expiration, revocation and redisclosure

This authorization expires on _____ or upon this event: _____. I may revoke it in writing, except to the extent action has already been taken in reliance on it. I understand information disclosed may be redisclosed and may no longer be protected, except when federal or state law prohibits redisclosure. For Part 2 records, disclosure is limited to the named recipient(s), purpose, and information described above, and further use or disclosure must comply with 42 CFR Part 2.

☐ I received / was offered a copy

☐ I authorize this disclosure

☐ I decline authorization

Client / legal representative	Witness / staff
Signature: _____ Date: _____	Signature: _____ Date: _____

Legal representative authority / relationship (attach verification when applicable): _____