Discount Counseling Network, Inc.
352-332-9960 MON-THU 9:30am/4:30pm

Intake/Screening Form

COMPLETE THIS FORM FULLY BEFORE ARRIVING TO YOUR INTAKE

Priority will be given to those arriving with this form filled out fully

DO NOT BRING KIDS WITH YOU or LEAVE THEM WAITING IN THE CAR

TURN YOUR CELL PHONE OFF BEFORE ENTERING THE PREMISES

You have been scheduled for your evaluation on _____ at _____ at the following location:

_____

Please write clearly and legibly… Thank you.

EMAIL: _____

_____ _____ _____ _____
Print first, middle and last name | Date of Birth | Age | DOC Number

_____ _____ ____ _____
Mailing address | City | State | Zip

_____ _____ _____
Social Security | Cell phone | Home phone

1. **Explain fully the charge(s) for which you have been referred to this Agency:**

_____

_____

_____

Psychosocial

SUICIDAL/HOMICIDAL IDEATION

Have you ever attempted to commit suicide in the past? ☐ No ☐ Yes, how? _____

Are you presently suicidal? ☐ No ☐ Yes, explain: _____

Have you ever attempted to commit homicide in the past? ☐ No ☐ Yes, how? _____

Are you presently homicidal? ☐ No ☐ Yes, explain: _____

Emergency Contact: Who can we contact in an emergency while in counseling with the Agency?

Name_____ **Relationship**_____

Phone _____ **Other Phone** _____

CURRENT HEALTH STATUS: ☐ Excellent ☐ Good ☐ Fair ☐ Poor **Height**_____ **Weight**_____

Insurance: ☐ None ☐ Medicare ☐ Medicaid ☐ Private Insurance_____ ☐ Unknown

DRUG ALLERGIES: ☐ NONE KNOWN ☐ YES (describe)_____

Current health problems: ☐ None ☐ Yes (describe) _____

Are you now under the care of any doctor or psychiatrist? ☐ No ☐ Yes, Dr's name: _____

CURRENT PRESCRIBED MEDICATIONS: ☐ None ☐ Yes, (Name, Dose, Dates on/off):

_____

_____

OVER-THE-COUNTER MEDICATIONS USED: ☐ None ☐ Yes, if yes, please list medications, dosage, frequency:

_____

_____

Do you have any physical handicaps or limitations? ☐ None ☐ Yes, if yes, explain_____

Have you ever had any of the following? ☐ None ☐ Yes, please check all that apply:

☐ diabetes	☐ pancreatitis	☐ hernia	☐ syphilis
☐ epilepsy	☐ tuberculosis	☐ gout	☐ liver problems
☐ cancer	☐ hepatitis	☐ heart problems	☐ high blood pressure
☐ seizures	☐ sickle cell anemia	☐ gonorrhea	☐ ulcers

☐ other (explain) _____

Surgeries? ☐ None ☐ Yes, if yes, describe _____

Serious illnesses or hospitalizations? ☐ None ☐ Yes, if yes, explain _____

Current need mental health service? ☐ Yes ☐ No ☐ Unknown

Past Mental Health Treatment, Family, Marriage, or Individual Counseling: ☐ No ☐ Yes

If Yes, Describe detail, date, type, length of treatment: _____

Past Alcohol/Drug Counseling, Treatment, Rehab or Detox: ☐ No ☐ Yes, if Yes, Describe detail, date, type, length of treatment: _____

Current use/history IV drugs? ☐ Yes ☐ No ☐ Unknown

Last physical exam: Date _____ Reason_____ ☐ Don't know

Last dental exam: Date _____ Reason_____ ☐ Don't know

Psychosocial –(Continued)

Family History: Where did you grow up?_____ How many times did you move?_____

Who raised you? _____

How many children were in the family growing up?_____ What number child were you?_____

What was your family like? ☐ Stable ☐ unstable ☐ happy ☐ unhappy ☐ religious ☐ close ☐ distant ☐ strict ☐

Comments:_____

Are there any cultural practices or beliefs that may affect your recovery?:_____

Was church/religion part of your upbringing? ☐ No ☐ Yes ☐ Involved now? ☐ No ☐ Yes, explain _____

What kind of discipline did your parent use? ☐ Corporal (hit/whip) ☐ Verbal (talking) ☐ Time Out

Were you ever physically abused while growing up: ☐ No ☐ Yes, explain _____

Were you emotionally/verbally abused? ☐ No ☐ Yes, explain _____

Were you ever sexually abused? ☐ No ☐ Yes, explain _____

Did you see/hear any violence in your childhood home? ☐ No ☐ Yes, explain _____

Describe current relationship with any living parents: ☐ good/close ☐ negative/problematic ☐ little or no contact

Parents cause/age of death if deceased: _____

Family History of Substance Abuse: Does anyone in your family have alcohol or other drug problems? ☐ No ☐ Yes

If yes, tell who and what kind of problem, including related arrests and/or treatment._____

_____

Education: Highest grade completed: _____ ☐ High School ☐ GED ☐ College/Vocational/Job Training

Do you have difficulty ☐ reading ☐ writing ☐ understanding ☐ speaking ☐ Other:_____

If you quit high school, tell why: _____

Do you plan to go back to school any time soon? ☐ No ☐ Yes, to study what _____

Current Living Situation: Where do you live? ☐ House ☐ apartment ☐ mobile home ☐ Rented room ☐ Shelter

Do you ☐ own ☐ rent ☐ Other:_____

Who are you currently living with? ☐ Alone ☐ spouse/partner ☐ children ☐ parents ☐ friends ☐ relatives ☐ Other

Living Situation: ☐ Good (alcohol/drug-free) ☐ problems, describe: _____

Do you have any relationships with friends or acquaintances that could help, or hinder, your recovery? ☐ No ☐ Yes, describe:

_____

What do you like to do for fun or relaxation? ☐ Indoor: movies/TV, reading, Other_____

☐ Outdoor: sports, fishing, boating, gardening, other _____

Marital History (if applicable)

How many times have you been married? _____ What was the date of your current marriage? _____

Name and age of spouse: _____

Previous marriage? ☐ No ☐ Yes, date of last divorce _____

What is your perception of your current marriage (include communication patterns, problems, sexual relations)

_____

If on a relationship now, it is: ☐ happy/get along most of the time ☐ lots of arguments/conflict ☐ abusive

Psychosocial –(Continued)

Children: Any children from this or previous marriage? ☐ No ☐ Yes, how many? _____

How many minor children live with you? _____ If one or more, please list that name, ages and the custodial parent of each of your children. How do you get along with each one?

_____

_____

What kind of discipline do you use? ☐ Talking ☐ time out ☐ grounding ☐ yelling ☐ spanking/whipping ☐ Other, describe: _____

Are you Pregnant? ☐ No ☐ Don't know ☐ Yes, if Yes, how long: ☐ 1-3 months ☐ 4-6 months ☐ 7-9 months

Have you ever been in an abusive adult relationship? ☐ No ☐ Yes, if Yes, how many abusive relationships? _____

If yes, describe the abuse (Physical, verbal/emotional, other types of violence?) _____

_____

Is there abuse between you and your current partner? ☐ No ☐ Yes, if Yes, describe the abuse (Physical, verbal/emotional, other types of violence?) _____

How many times has the Law come to your home because of Domestic Disturbance? _____ What was happening?

Describe the reasons: _____

Were any arrest made? ☐ No ☐ Yes, if Yes, explain_____

_____

Were you or your partner drinking or using drugs at that time? ☐ No ☐ Yes, if Yes, explain _____

_____

Employment History: ☐ Full-time ☐ Part-time ☐ Unemployed/Seeking Work ☐ Unemployed/not seeking

☐ Not in labor force ☐ Retired ☐ Disable ☐ SSI/SSD ☐ Other:_____

Source of Income: ☐ Salary ☐ Wages ☐ Retired/Pension ☐ Disability ☐ Other:_____

What kind of work do you do?_____ How long at current job? _____

Employer_____ Location_____

How well do you like your work?_____ If unemployed, describe why: _____

_____

How Long unemployed?_____ How do you Support yourself?_____

Types of Work Done in Past _____

Type of worker: ☐ stable/long-term ☐ unstable, change often, work on and off ☐ steady (always work)

Longest time at one job: _____ Reasons for leaving or getting fired:_____

Military History: Have you been in the military? ☐ No ☐ Yes, if Yes, what branch? _____Rank: _____

Dates of Service _____ Type of Discharge/Comments_____

Do you own any guns, rifles, or other weapons? ☐ No ☐ Yes, if yes, explain, what type of weapons and where are they kept? _____

***Please notice:* If there are any weapons in your household, even if they do not belong to you, we advise you to let your probation officer or referral source know of this fact. Having access to weapons by a person on probation may constitute a violation of probation.**

Psychosocial –(Continued)

Present Problem-Precipitating Stressors

"In the recent months, I have worried a lot about: (Please check all that apply)

☐ Marital issues ☐ Health issues ☐ Job issues ☐ Financial issues
☐ Parent/child issues ☐ Issues of past (guilt, abuse, neglect, family of origin etc.)
☐ Other _____

Symptoms of above problems (Please check all that apply)

☐ Increased anxiety ☐ Change in appetite ☐ Decreased concentration ☐ Decreased energy
☐ Suicidal feelings ☐ Change in sleep pattern ☐ Decreased motivation
☐ Other _____

Recent Losses (Please check all that apply)

☐ Family ☐ Health ☐ Disruption in lifestyle ☐ Job ☐ Significant other
☐ Other _____

Psychiatric History

Please list any previous outpatient counseling experiences.

Place _____ Reason_____ Length of time _____ Dates _____

Place _____ Reason_____ Length of time _____ Dates _____

Have you ever been admitted to the hospital for mental health or addiction issues?

☐ No ☐ Yes, explain: _____

Place _____ Reason _____

Length of time _____ Dates _____

Name of current psychiatrist _____

List all medications you have taken in the past for anxiety, depression, and/or sleep:

_____

Perception of Strengths and Abilities: What are you personal strengths? What are you good at or proud of?

Education☐ Work☐ Family☐ Intelligence☐ Personality☐ Attitude☐ Skills☐ Support System☐

Describe other skill, quality or ability: _____

Perception of Problem Areas and Weaknesses: What issues have caused problems for you in your life?

What Challenges/Limitations do you have?

☐ Legal/Criminal Issues due to alcohol/drugs
☐ Lack of Education
☐ Family Issues due to alcohol/drugs
☐ Relationship/Family Communication Issues
☐ Health Issues due to alcohol/drugs
☐ Transportation. No Vehicle or No License
☐ Financial Issues due to alcohol/drugs
☐ Negative Social Environment/Peer Pressure
☐ Work/Employment Issues due to alcohol/drugs
☐ Low Self-Esteem/Self-Worth
☐ Relapse/failed drug test
☐ Grief Issues
☐ Defenses Mechanisms/Denial
☐ Mental Health Problems

Support System

Who can you count on for support?

☐ Parents ☐ Spouse ☐ Siblings ☐ Employer ☐ Church/Pastor
☐ Therapist ☐ Neighbor ☐ Extended Family ☐ Close Friend ☐ Self-help Group
☐ Co-Worker ☐ Medical Dr. ☐ Community Services

Psychosocial –(Continued)

Substance Abuse History

Number of prior substance abuse treatments: ☐ Anger Management treatments: ☐ Rehab/detox: ☐

Drug(s) of Choice: _____ Age First Used: _____ Frequency:_____

Recent use: ☐ None ☐ Daily ☐ 1 to 3 times in past month ☐ 1 to 2 times per week ☐ 3 to 6 times per week

Describe your current use or usage within the past year of alcohol, caffeine, tobacco, pornography, gambling, or prescription pain medication (Please list the substance, the amount, the frequency, the age of first time you used, and the date of last use).

_____

Have you experienced a recent increase in the use of alcohol and/or other substances?

_____

Do you see your current usage as a problem? _____ please describe any previous experience with drugs or alcohol:

_____

Do you use Tobacco Products? ☐ No ☐ Yes, age of first use: ___ Type: _____ How much/many per day:____

Sobriety: What is the longest time you have stayed clean (no alcohol/drugs) without being in jail or prison? _____

What helped you stay clean?: Rehab/Counseling/Treatment☐ AA or NA☐ Sponsor☐ Church☐ Other☐ describe: _____

Misrepresenting the facts or declining to disclose your substance use/abuse, will be considered withholding information to mislead this Evaluation and the need to conduct this Evaluation again, and for you to pay for a new Evaluation.

Please complete the following section truthfully and thoroughly:

History of use of other substances:		Age first tried	Last used	Pattern of Use: Daily, Weekly, Monthly, etc.
Alcohol…….:	☐ No ☐ Yes	_____	_____	_____
Marijuana…….:	☐ No ☐ Yes	_____	_____	_____
Powder Cocaine…….:	☐ No ☐ Yes	_____	_____	_____
Crack Cocaine…….:	☐ No ☐ Yes	_____	_____	_____
Heroin/Methadone…...:	☐ No ☐ Yes	_____	_____	_____
Sedatives/downers…...:	☐ No ☐ Yes	_____	_____	_____
X/LSD/Shrooms/Acid.:	☐ No ☐ Yes	_____	_____	_____
Meth/Amphet/Speed...:	☐ No ☐ Yes	_____	_____	_____
Other drug: _____		_____	_____	_____
Other drug: _____		_____	_____	_____

Substance Abuse Indicators: Check any you have experienced.

- ☐ Blackouts.
- ☐ Denial, minimizing.
- ☐ Loss of Control.
- ☐ Tolerance.
- ☐ Rapid Intake.
- ☐ Solitary use.
- ☐ Self-medication.
- ☐ Preoccupation.

Psychosocial –(Continued)

Legal/Criminal History

Total number of arrests: ☐ Total substance-related arrests: ☐ Total DUIs: ☐

Describe current charges: _____

How many times have you been incarcerated? _____

What is the total amount of time you have been incarcerated? ____ Years ____ Months ____ Days.

Have you been convicted as a sex offender? ☐ No ☐ Yes, explain: _____

How many times have you filed bankruptcy? _____

How many times you have been involved in a legal civil suit? _____

How many times have you been on probation? _____ PTI? _____ Deferred Prosecution? _____

Have you ever been VOP? ☐ No ☐ Yes, explain: _____

Have you ever been required to pay child support? ☐ No ☐ Yes, how much? $_____, Alimony? $_____

Have you ever had child custody problems? ☐ No ☐ Yes, explain: _____

Have you been charged with, or convicted of: (Check all that apply)

- ☐ Aiding & Abetting / Accessory
- ☐ Assault / Battery
- ☐ Aggravated Assault / Battery
- ☐ Burglary
- ☐ Child Abuse
- ☐ Conspiracy
- ☐ Credit / Debit Card Fraud
- ☐ Disorderly Conduct
- ☐ Disturbing the Peace
- ☐ Domestic Violence
- ☐ **Drug Cultivation and Manufacturing**
- ☐ **Drug Distribution / Trafficking**
- ☐ **Drug Possession**
- ☐ **DUI / DWI / BUI**
- ☐ Extortion
- ☐ Forgery
- ☐ Fraud
- ☐ Homicide
- ☐ Identity Theft
- ☐ Insurance Fraud
- ☐ Kidnapping
- ☐ Manslaughter: Involuntary
- ☐ Manslaughter: Voluntary
- ☐ **Medical Marijuana**
- ☐ MIP: A Minor in Possession
- ☐ Murder: First-degree
- ☐ Murder: Second-degree
- ☐ Open Container Law
- ☐ **VOP Probation Violation**
- ☐ Prostitution
- ☐ Public Intoxication
- ☐ Pyramid Schemes
- ☐ Racketeering / RICO
- ☐ Rape
- ☐ Robbery
- ☐ Sexual Assault
- ☐ **Shoplifting**
- ☐ Statutory Rape
- ☐ Theft / Larceny
- ☐ Vandalism
- ☐ Wire Fraud

Misrepresenting the facts or declining to disclose your criminal history, will be considered withholding information to mislead this Evaluation and the need to conduct this Evaluation again, and for you to pay for a Criminal Background report.

Detail the arrests/charges: DO NOT LEAVE BLANK. OTHERWISE, IT WILL BE CONSIDERED REFUSAL TO DISCLOSE MATERIAL FACTS ABOUT YOUR CASE.

Name of Charge	Date or Age	Disposition: Jai, Prison, Probation, etc	Using Substance?
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐

Psychosocial –(Continued)

Developmental History

List members of your family that you grew up with and how you got along with each one.

_____

_____

_____

What was your birth order? Number____of ____ children. Who primarily raised you? _____

How would you describe your childhood? ☐ Traumatic ☐ Painful ☐ Uneventful ☐ Happy

Were there any unusual or traumatic experiences for you as a child? (Please list the age that it occurred and the event that occurred):

_____

Were you abused as a child? ☐ No ☐ Yes, explain: _____

What is your sexual orientation? ☐ Heterosexual (straight) ☐ Homosexual (gay) ☐ Bisexual ☐ Asexual(none)

Religious/Cultural Factors

Please list any issues that are important or may have affected you in regard to religion or ethnic/cultural background.

_____

_____

What is your religious background? _____

Do you currently attend ☐ church ☐ synagogue ☐ mosque. If yes, where do you attend? _____

Nutrition: Have your eating habits changed recently? ☐ No ☐ Yes, explain: _____
Has your weight fluctuated more than +/- 10lbs. over the previous year? ☐ No ☐ Yes

Do you often eat out of depression, boredom, and anger? ☐ No ☐ Yes, explain: _____

Do you ever self-induce vomiting? ☐ No ☐ Yes

Do you ever binge eat or feel your eating is out of control? ☐ No ☐ Yes, explain: _____

If you use laxatives, water pills, or diet medications, how often do you use them? _____

Sleeping: How many hours do you sleep per day? _____

Do you suffer from: ☐ Nightmares ☐ Insomnia ☐ Wake early ☐ Other: _____

---------- End of Psychosocial ----------

Please sign below at this time.

✖ _____ _____ _____

Client name Signature Date

_____ _____ _____

Staff/Counselor Signature Date

CONFIDENTIAL HIV-AIDS RISK ASSESSMENT

Date of last HIV TEST? _____ POSITIVE? _____

Please check all that apply:

0) ☐ Never Been Tested

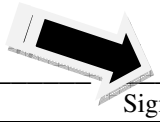
1. Yes ☐ Have you ever used IV drugs (needles)? If so, do/did you share needles? _____
2. Yes ☐ Have you had sex with a bisexual, homosexual or an IV drug user?
3. Yes ☐ Have you ever had or do you have more than one sex partner?
4. Yes ☐ Since your last HIV Test, have you had unsafe sex (no condoms)?
5. Yes ☐ Since your last HIV Test, have you received any blood transfusions or blood products?
6. Yes ☐ Have you had any significant, unexplained weight gain or loss in the past year?
7. Yes ☐ Have you had any unexplained fever, night sweats, or jaundice (yellowing of skin or eyes)?
8. Yes ☐ Have you ever had sex while in prison or jail?

Explain all positive findings_____

FOR FEMALES ONLY

Do you think you may be pregnant at this time? No ☐ Yes ☐ If yes, for along? _____

I have participated in answering this questionnaire. Also, I have received information, and had the opportunity to ask questions about the risk factors and related precautions associated with the HIV (AIDS) infection.



_____ _____ _____

Client Name Signature Date

STAFF USE ONLY PLEASE DO NOT WRITE HERE

No ☐ Yes ☐ this client has been referred for HIV testing due to: ☐

☐ Never Tested ☐ Hx of IV use/shared needle

☐ High Risk Behavior ☐ 1+ Sex partners ☐ Jail sex

☐ Hx of prostitution ☐ Unsafe Sex practices ☐ Serum Stage/HIV Suspect

Comments_____

_____ _____ _____

Staff Signature Date

RECIPROCAL RELEASE OF CONFIDENTIAL INFORMATION

1. I, the undersigned, authorize the Agency to release the information described below regarding my outpatient treatment.
2. I understand that my records are protected by federal regulations governing the Confidentiality of Alcohol & Drug Patient's Records, 42 CFR Part 2.
3. I understand that the information may be released in written and/or verbal form and that specific reports to be disclosed may include:
    a. Initial diagnostic Intake/Screening summary report;
    b. Updates on my participation and progress,
    c. Termination report/ discharge summary,
    d. Laboratory/drug test results,
    e. and any other information the Agency may have on me personally.

4. I give my permission for this information to be released to the following agencies, persons, or recipients, for up to seven (7) years from the date below:

☒ **Collection agencies hired to collect unpaid fees you may owe to this Agency.**

☒ **Florida Department of Corrections**, Probation & Parole or any other Probation/Parole, court, or supervising agency if on Probation.
☒ Department **of Children & Families (if minor children living or not with me).**

☒ DUI SCHOOL, DMV or any other vehicle-related agency in FL or within the USA, if on a DUI case.

☒ Attorney, criminal defense, prosecutor, and/or private attorney working on a case-related to me.

☐ Family member:_____

☐ Other_____

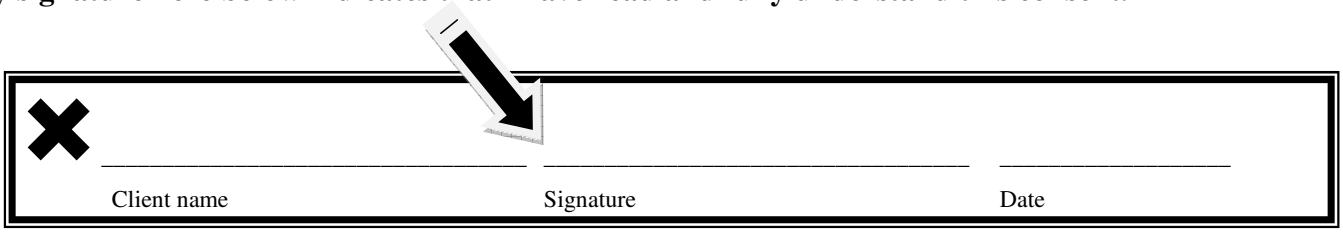
The purpose for the disclosure: ☒ Continuity of Care/Coordination of Services ☒ Billing ☒ Victim Safety

My signature here below indicates that I also agree that the above-mentioned agency/person may release information back to the counseling agency (This Agency). In other words, this is a **Reciprocal Release of Information**.

This consent is revocable upon written notice to the counseling agency at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance to it. This consent will expire 7 years from the date this client leaves the program.

Please sign below at this time.

My signature here below indicates that I have read and fully understand this consent.



✖ _____ _____ _____

Client name Signature Date

<u>MAST Questionnaire:</u> Please circle the Y or N for each one of the following questions, the words USE, USING, DRINKING, apply to alcohol <u>or</u> any drug you may have used or are using currently.

1. Do you enjoy using or drinking now and then? **Y N (2)**

2. *****Do you feel you are a normal user? ("normal" - use as much or less than most other people **Y N** (2)

3. Have you ever awakened the morning after some using the night before and found that you could not remember a part of the evening? **Y N** (2)

4. Does your wife, husband, a parent, or other near relative ever worry or complain about your using? **Y N** (1)

5. *****Can you stop using without a struggle using or drinking a small amount ? **Y N** (2)

6. Do you ever feel guilty about your using? **Y N** (1)

7. *****Do friends or relatives think you are a normal user? **Y N** (2)

8. *****Are you able to stop using when you want to? **Y N** (2)

9. Have you ever attended a AA or NA? **Y N** (5)

10. Have you gotten into physical fights or heated arguments when using? **Y N** (1)

11. Has you using or drinking ever created problems between you and your wife, husband, a parent, or other relative? **Y N** (2)

12. Has your wife, husband (or other family members or friend) ever gone to anyone for help about your drinking or using? **Y N** (2)

13. Have you ever lost friends because of your using? **Y N** (2)

14. Have you ever gotten into trouble at work or school because of using or drinking? **Y N** (2)

15. Have you ever lost a job because of using or drinking? **Y N** (2)

16. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were using or drinking? **Y N** (2)

17. Have you used or drank before noon? **Y N** (3)

18. Have you ever been told you have liver trouble? Cirrhosis? **Y N** (2)

19. After using or drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices, or seen things that are really not there? **Y N** (2)

20. Have you ever gone to anyone for help about your using or drinking? **Y N** (5)

21. Have you ever been in a hospital because of using or drinking? **Y N** (5)

22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where using or drinking was part of the problem that resulted in hospitalization? **Y N** (2)

23. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where using or drinking was part of the problem? **Y N** (2)

24. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of drugs or alcohol? (If YES, How many times? ___ **Y N** (2)

25. Have you ever been arrested, or taken into custody even for a few hours, in connection or while you were under the influence or drugs or alcohol? (If YES, How many times? __ **Y N** (2)

_____ _____

Consents and Disclosures

Program Rules, Orientation, and Drug Testing Policy & Agreement

PREMISE: I UNDERSTAND THAT THE NUMBER ONE TREATMENT GOAL OF THIS PROGRAM IS TO ESTABLISH AND MAINTAIN ABSTINENCE FROM ALL MOOD-ALTERING SUBSTANCES AS VERIFIED BY URINALYSES (DRUG TESTS)

CONSENT FOR TREATMENT: I, the undersigned, certify that I am voluntarily making application for Intake/Screening and/or treatment in the Outpatient Substance Abuse Counseling Program provided by this agency. I give my consent for the initial Intake/Screening interview and/or treatment provided by this agency. I further state that my attendance in treatment is voluntary–this is not a locked facility. I am free to leave at any time. My consent implies that am understand my obligation to pay any fees applicable to my program. I understand that sessions may be recorded or videotaped for training, legal, or commercial purposes. I have been given information about this program and my signature here below acknowledges orientation to the program.

CONFIDENTIALITY: I, the undersigned, acknowledge and fully understand that the confidentiality of client records is protected by Federal law and regulations. Information regarding a client's participation in treatment or any other identifying information will not be disclosed unless: a) The client consents in writing; b) the disclosure is allowed by court order; c) child Abuse or Neglect is reported/suspected; d) the client reports intent to harm self or another; and, e) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program Intake/Screening including approved peer and utilization reviews of client records, and the sharing of verbal information with other agencies to insure continuity of care and/or provide emergency services. I also acknowledge my responsibility to keep confidential the names and any identifying information about other group members. I acknowledge and agree that this counseling agency and/or its staff cannot be held responsible for any breach of confidentiality on the part of any counseling group member.

CONSENT TO URINALYSIS TESTING: I, the undersigned, understand that random urinalysis to detect drug usage is a part of the Outpatient Substance Abuse Treatment Intake/Screening and/or Treatment Program provided by this Agency. I consent to provide urine, saliva or hair samples for analysis on a monthly basis or whenever requested by the treatment staff. I further understand that test results will be used to monitor my progress in the program and determine compliance with the program rule that requires I remain alcohol/drug free while in the Substance Abuse Treatment Program. Test refusal or positive test results may result in my removal from the program and/or other disciplinary action as determined by my probation officer and/or the courts. I understand that I will be responsible for drug testing fees as priced at the time of testing, and if test results positive, I will bear the additional cost of laboratory test, if requested.

REPORTING OF COMMUNICABLE DISEASES AND UNIVERSAL INFECTION CONTROL: I, the undersigned, acknowledge that I have been informed of the risks of infection from HIV/AIDS and have been given information on prevention measures. As part of the Medical History completed at the time of intake, all DPS/PRAXIS clients shall be screened for high-risk behavior and symptoms of communicable disease. High risk clients shall be referred by the Medical Consultant, to the local county Health Department for medical screening and pre-and post-test counseling. High risk clients are those reporting any communicable diseases. Newly discovered/diagnosed cases of HIV/AIDS shall be reported by the Medical Consultant to the Department of Health in compliance with Sections 381.0031 and 384.24 FS and the Federal Center for Disease Control Guidelines and Recommendations for Infectious Diseases.

GRIEVANCE PROCEDURE: The agency recognizes that clients have the following rights which must be protected:

1. Right to individual dignity
2. Right to nondiscriminatory services
3. Right to quality services
4. Right to communication
5. Right to care and custody of personal effects of clients
6. Right to education of minors (where applicable)
7. Right to confidentiality of client records
8. Right to counsel
9. Right to Habeas Corpus

Any service provider personnel who violate or abuse any right or privilege of a client are liable for damages as determined by law. If you feel your rights have been violated, or you have a grievance, please discuss the problem with your counselor and/or your referral source within 30 days of the event. If not resolved, please submit your grievance in writing to the Director either in person, by fax to 352.332.9962, or by mail to: 7003 NW 11th Place, Suite 6, Gainesville, FL 32605. Upon receipt of the grievance form, the Director will make a determination and inform you of the decision within 15 business days.

If the issue is not resolved through this agency, you can contact the Florida Advocacy Council at 800.342.0825; the local Florida Department of Children and Families Substance Abuse and Mental Health Office at 352.955.5053 in Gainesville and 904.723.2014 in Jacksonville; and/or the State of Florida Abuse Hotline at 800.962.2873.

PROGRAM FEES: I acknowledge that all fees are due on or before service is provided. No balance due is allowed, and I acknowledge that I WILL NOT be allowed to attend group or individual sessions if I do not pay on or before services are provided. In addition, failure to attend sessions without a written excuse from my referral source, does not exempt me from having to pay the sessions I do not attend.

ACKNOWLEDGMENT: I, the undersigned, acknowledge that I have read and understand the program/group rules and that a copy of the rules is being given to me (this document). I acknowledge that I was orally briefed on the program I will be attending, and I understand that I must comply with all program rules and treatment goals for successful completion of the program.

ATTENDANCE POLICY AND AGREEMENT

SHOW OR NO SHOW, I WILL PAY FOR THE SESSION

1. You are required to pay the fee even if you do not show up for the scheduled appointment or for a regular class.
2. For an excused absence, the fee may be waived only when your Probation Officer provides the Agency with a written excuse.
3. For every un-excused absence you will still have to pay for the class and attend, and pay for a make up class.
4. In addition to the make-up class, one additional group class may be added to your total number of classes.
5. You may be unsuccessfully discharged if you have three (3) or more un-excused absences.

DRUG TESTING POLICY AND AGREEMENT, CONSENT TO DRUG TESTING

I, the undersigned, understand and agree that random urinalysis, saliva swab, or hair samples to detect drug usage are a part of the Outpatient Substance Abuse Treatment Intake/Screening and/or Treatment Program provided by this Agency. I hereby consent to provide urine, saliva or hair samples for analysis monthly, randomly, or at any time when requested by the treatment staff with or without cause.

I understand and agree that:

1. test results will be used to monitor my progress in the program and determine compliance with the program rule that requires that I remain alcohol and drug free while in the Substance Abuse Treatment Program;
2. I must remain quiet DURING and AFTER the DT, no comments, jokes, silly/nervous talk, etc.; and if I initiate or engage in arguments, accusations, inferences, etc., stemming from a drug test result or process, I may be discharged unsuccessfully from the Program;
3. I will be tested on my last class or thereafter, and if positive DT, I shall, among other penalties, attend at least 6 additional classes and that I may be discharged;
4. I will be responsible for drug testing fees as priced at the time of testing, and if a test results positive, I will bear the additional costs, charges and penalties;
5. test refusal or positive test results may result in my removal from the program and/or be subject of other disciplinary actions as determined by my probation officer and/or the courts;
6. if my drug test results positive, regardless of the substance, medically prescribed or otherwise, and regardless of my justification for the positive result, the results will be reported to my PO or referral source within 24 hours;
7. I shall report to my PO or referral source at 9:00 am on the next business day, and provide all my medical prescriptions that will justify your positive result;
8. if my DT results positive for a medically prescribed substance, I shall be responsible to seek and provide the Agency with a formal written justification from my PO, referral source, or medical doctor <u>within 5 working days</u> from the date of the positive DT;
9. this Agency will not request or accept any prescription or medical information; and I understand that this Agency is not responsible nor has the expertise or the duty to interpret my prescribed medications or doctors' orders, or interpret any interaction thereof that may or has produced a positive DT result, or accept my reasoning or explanations;
10. if an instant dip test is used in-house, all positive DT result will be sent out for a lab confirmation for an additional fee, and that I shall pay for this fee;
11. I shall pay the Positive DT Fee as required by the Agency and the additional fees required to send my specimen for a lab confirmation;
12. if I waive or refuse the lab confirmation, I am accepting, at such time and instance, the positive result and further recognize that my waiving or refusal constitutes a full admission of drug or substance use, legal or otherwise, during the period covered by the specimen;
13. if the lab confirmation returns negative findings, or a formal written justification from your PO, referral source or medical doctor is received <u>within 5 business days</u> from the date of the positive DT, the consequences as set forth herein may be eliminated retroactively;
14. if I make a dishonest offer, or say anything that may be construed to be an offer to change the result of a positive DT, I will be reported to my PO or referral source, and the local authorities, and it may be cause for VOP or a felony charge.
15. I shall refrain from using any mood-altering substance, including alcohol, during the time I attend the program and shall attend classes completely sober and alert.

Continue on Next page with Acknowledgments…

Acknowledgments

1. **Attendance** **Read below and initial here: _____**

   I am also aware that whether I show up or not I shall pay a session fee as stated herein this Document, on or before every session. I have also been explained the Attendance Policy and Agreement during my intake and have received from the Agency the full Attendance Policy and Agreement in writing.

SHOW OR NO SHOW I'LL PAY FOR THE SESSION

2. **Abandonment of Tx** **Read below and initial here: _____**

   Abandonment of Treatment is considered when you have missed two or more consecutive sessions or one full month from your last attendance. You shall be discharged unsuccessfully and will be required to re-start from your number one session, paying a Re-Instatement Fee, a re-entry drug test, and an adjustment in the number of sessions if necessary.

3. **No Balance Due** **Read below and initial here: _____**

   I acknowledge that no balance due is allowed and that I have to pay on or before every session; and that I may not be allowed to attend if I don't bring the session fee, and that in such case, I will be marked as Unexcused Absence and the penalties under the Attendance Policy and Agreement will apply to me.

4. **Drug Testing** **Read below and initial here: _____**

   I acknowledge and accept that I will be drug tested at random and I shall pay the drug test fee on the day of the drug test or on the following week. I have received from the Agency the full Drug Testing Policy and Agreement in writing.

Continue on next page with Charges and Fees…

Read the following but sign during your evaluation.

Charges and Fees

You have been thoroughly explained the charges and fees, and you agreed to the liabilities as set forth below and to pay these charges and fees on, or before the services are rendered:

0. **SHOW OR NO SHOW YOU'LL PAY FOR THE SESSION**

1. **Intake Fee:** ☐ **N/C** ☐ **$30** ☐ **$50** ☐ **$70**
2. **Hourly Fee:** ☐ **$30** ☐ **$40** ☐ **$50** ☐ **$60**
3. **Absences: $(Same as above). You may be discharged un-successfully upon your first un-paid absence.**
4. **Reinstatement Fee: $80**
5. **Drug Tests (Dip 10-Panel and/or Alcohol-only):**
   a. **NEGATIVE: ☒ $35 for each NEGATIVE Drug Test.**
   b. **POSITIVE: ☒ $80 + minimum of 6 additional sessions.**
   c. **Lab Confirmations: $120**
6. **Court Appearances in connection to your case: No charge if via electronically. Otherwise: $300/hour + travel and expenses.**
7. **Special correspondence, letters or reports other than routine reports to/with your Referral Source(s): $30/per document.**

I have read this AGREEMENT and understand my obligations and hereby agree to the above charges and fees:

✖ _____ _____ _____

Client name | Signature | Date

STOP HERE

The next pages are for <u>Staff Use Only</u> and will be completed during your Evaluation.

DUI # ___ BAL: _____ ☐Crash ☐Bodily Injury ☐Minors ☐Possession ☐DWSRL

Name					
Address					
DOB		SS#			
Cell:		**Home Tel:**			
Ref Sour				DC #:	
Progam		**# of Sess**		**Intk Fee $**	
Pay type		Ses Fee $		**Paid Today**	
Start Date		Day/Time Wk		**Bal Due**	

Arrest Worksheet

Arrest #	Year/Age of Arrest	Time Served	Probation	Com Srvc Hours	House Arrest	Type of Treatment
1						
Charge:						
2						
Charge:						

History of Substance Use

Substance	Age or Year	Last time used	Frequency
Alcohol			
Marijuana			
Powder Coc			
Crack Cocaine			
m/Amphetamine			
Presc. Drugs			
Pain Killers			
Inhalants			
Heroin			
Other:			

DSM-IV/ICD-9 CM		Abuse			Dependence
Alcohol		305.00			303.90
Cannabis/Marijuana		305.20			304.30
Hallucinogen (MDM/MOLLY)		305.30			304.50
Sedatives (BZO, Barbit)		305.40			304.10
Opioid		305.50			304.00
Cocaine/Crack		305.60			304.20
Meth/Amphetamines		305.70			304.40
Inhalants		305.90			304.60
PCP (Phencyclidine/LSD)		305.90			304.60
Other (or Unknown)		305.90			304.90
Polysubstance Dependence					304.80

	Male
	Female
	Single
	Married
	Divorced
	Widow(er)
	White
	Black
	Hispanic
	Pto. Rico
	Mexican
	# of Minor Children
Arrests	
	Lifetime
	Sub-Rel
	DUIs
Prior Tx	
	SA
	AM
	Detox
	Education Level
Employment	
	Employed
	Un-Employ
	Retired
	Disable
	Suicidal?
	Homicidal
	# of Sleep Hours
	Cigs/day
	Alcohl/day
	Energy Drnk

	Poss/Ctl Subs
	Poss w/Int/Sell
	DUI
	DWSRLic
	Robbery
	Battery
	Dom Violence
	Criminal Mischief
	Probation
	PTI
	Deferred Prosec.
	Self/Private
	No Arrest Report
	No Cond of Prob
	Denial/Minimiz
	Loss of control
	Preocupation
	Rapid intake
	Solitary use
	Increase tol
	Increase freq
Drugs of Choice	
Problem # 4	
	Hist of Selling Drugs
	DUI Susp Drv Lic
	Incomp Education
	Lack of AM skills
	Lack of impulse Ctl
	Low Self-esteem
	Crim thinking errors
	Depression
	Neg peer pressure
	Unemployed

Initial Treatment Plan

_____

Client Name:

Presenting Problem: _____ ☐ **Drug Dealer**

DSM-__: _____ / _____

_____

DSM-__: _____ / _____

Program: Substance Abuse Counseling Length of Service: 30 days
Individual TX Plan Due: Within 30 days from Assessment Date above.

Goals:

1. Client will cooperate with assessment and treatment staff, sign forms and provide accurate information.
2. Client will be oriented to the program and begin attending weekly groups within one week.
3. Counselor and Supervisor will review psychosocial assessment for treatment needs within 30 days.
4. Client and counselor will develop/review/sign individual treatment plan within 30 days.

Recommended Services:

☐ **OPSA**: Outpatient Substance Abuse Group counseling: Min: ☐ Max: ☐ HOURS.
☐ **IOPSA** Intensive OPSA (Immersion Group 4-Hour/sess).

☒ **Random Urinalysis Testing.**

Comments: _____

No Ancillary Services Recommended unless otherwise noted here: _____

I affirm that I have been instructed to, and acknowledge that I shall start treatment on:

Date: _____ Day:_____ Time: _____, And continue to attend and pay my weekly session fees of $_____every week/session, until discharged successfully.

Length of Service: 30 Days. Review Date: On or before 30 days from date of this Tx Plan.

My signature below indicates that I am willing to participate and attend treatment as stated above.

✖ _____ _____ _____
Client name Signature Date

_____ _____ _____
Staff/Counselor name Signature Date

_____ _____ _____
Supervisor name Signature Date

Individual Treatment Plan

Individual Goals and Objectives: _____

1) Abstain during Tx. Immediately report to Counselor any relapse.
2) Random 10-panel Drug testing. At least 6 additional session if positive drug test.
3) Cannot Graduate from Program if positive drug test during the last six week of Tx.

Time Frame:
Above Goals and objectives to be completed within _____ weeks, (on or about: _____)

Recommended Services:

☐ **OPSA**: Outpatient Substance Abuse Group counseling: Min: ☐ Max: ☐ WEEKLY sessions.
☐ **IOPSA** Intensive OPSA (Immersion Group 4-6h/sess):

☒ **Random Urinalysis Testing.**

Ancillary Services Recommended: ☐ Legal ☐ Vocational ☐ Employment ☐ Mental Health ☐ Prenatal Care
☐ Diagnostic Testing ☐ Child Care ☐ Transportation ☐ Public Assistance ☐ Other_____

Length of Service: 30 Days. Review Date: <u>On or before 30 days from date of this Tx Plan.</u>

My signature here below indicates I am willing to participate as stated above.

✖ _____ _____ _____
Client name Signature Date

_____ _____ _____
Staff/Counselor name Signature Date

_____ _____ _____
Supervisor name Signature Date

Multiaxial Assessment

Axis I: Clinical Disorders and Other Conditions that may be the Focus of Clinical Attention:

DSM-4 Dx: See cover of this document for DSM-4 Dx and Coding.

DSM-5 Dx: See Initial Tx Plan for DSM-5 Dx and Coding.

Axis II: Personality Disorders and/or Mental Retardation: V71.09 (No Diagnosis)
Axis III: General Medical Conditions: Diagnosis Deferred
Axis IV: Psychosocial and Environmental Problems: Check all that apply.

- ☐ Problems Related to Legal System/Crime
- ☐ Occupational Problems (Un-Employed)
- ☐ Economic Problems
- ☐ Problems with primary support group
- ☐ Other Psychosocial and Environmental Problems_____
- ☐ Educational Problems
- ☐ Problems related to social environment
- ☐ Problems with Access to Health Care Services
- ☐ Housing Problems

Axis V: Global Assessment of Functioning Scale: **GAF Score**_____ **Time Frame: Intake**

Progress Note:
Met with client for individual session to assess appropriateness for outpatient substance abuse treatment. Completed Psycho-Social (P/S) Intake/Screening.

Poly-Drug Abuser Indicator: ☐ Drug Dealer/Manufacturer… Check if ☐ Methamphetamines

- ☐ Never exposed
- ☐ Exposed never-used
- ☐ Experimental user
- ☐ Non-dependent regular user
- ☐ Addicted user
- ☐ Dependent User
- ☐ Vulnerable ex-user

The following Treatment Recommendation was made:

☒ Substance Abuse (Process) Group Counseling: **Min**: ☐ **Max**: ☐ HOURLY sessions with Random Urinalysis Testing.

☐ Other Treatment: _____

☐ No Treatment. Explain: _____

Comments: _____

_____ _____ _____
Staff/Counselor name Signature Date

_____ _____ _____
Supervisor name Signature Date

Discount Counseling Network, Inc

352-332-9960 MON-THU 9:30am/4:30pm

Start Date: _____ Arrive at:_____

Location: _____

Required to attend between _____ and _____ hours.

Session Fee: $_____ for _____ hours per session.

_____

Charges and Fees

You have been thoroughly explained the charges and fees, and you agreed to the liabilities as set forth below and to pay these charges and fees on, or before the services are rendered:

0. **SHOW OR NO SHOW YOU'LL PAY FOR THE SESSION**

1. **Intake Fee:** ☐ **N/C** ☐ **$30** ☐ **$50** ☐ **$70**
2. **Hourly Fee:** ☐ **$30** ☐ **$40** ☐ **$50** ☐ **$60**
3. **Absences: $(Same as above). You may be discharged un-successfully upon your first un-paid absence, or if not attending for 30 days.**
4. **Reinstatement Fee: $80**
5. **Drug Tests (Dip 10-Panel and/or Alcohol-only):**
   a. **NEGATIVE: ☒ $35 for each NEGATIVE Drug Test.**
   b. **POSITIVE: ☒ $80 + minimum of 6 additional sessions.**
   c. **Lab Confirmations: $120**
6. **Court Appearances in connection to your case: No charge if via electronically. Otherwise: $300/hour + travel and expenses.**
7. **Special correspondence, letters or reports other than routine reports to/with your Referral Source(s): $30/per document.**

TURN CELL PHONES OFF AND PUT THEM AWAY BEFORE ENTERING THE PREMISES, IF NOT:

1. **YOU WILL BE EXPELLED FROM GROUP,**
2. **YOU WILL BE MARKED UN-EXCUSED ABSENT,**
3. **YOU MAY BE DISCHARGED UN-SUCCESSFULLY FROM THE PROGRAM.**

GRIEVANCE PROCEDURE

The agency recognizes that clients have the following rights, which must be protected:

1. Right to individual dignity.
2. Right to nondiscriminatory services.
3. Right to quality services.
4. Right to communication.
5. Right to care and custody of personal effects of clients.
6. Right to education of minors (where applicable).
7. Right to confidentiality of client records.
8. Right to counsel.
9. Right to Habeas Corpus.

Any service provider personnel who violate or abuse any right or privilege of a client are liable for damages as determined by law. If you feel your rights have been violated, or you have a grievance, please discuss the problem with your counselor and/or your referral source within 30 days of the event. If not resolved, please submit your grievance in writing to the Director either in person, by fax to 352.332.9962, or by mail: 4424 NW 13th St. # C-11. Gainesville, FL 32609. Upon receipt of the grievance form, the Program Director will make a determination and inform you of the decision within 15 business days. If the issue is not resolved through this Agency, you can contact the Florida Advocacy Council at 800.342.0825; the local Florida Department of Children and Families Substance Abuse and Mental Health Office at 904.723.2014 in Jacksonville; and/or the State of Florida Abuse Hotline at 800.962.2873.

Program Rules and Orientation

PREMISE: I UNDERSTAND THAT THE NUMBER ONE TREATMENT GOAL OF THIS PROGRAM IS TO ESTABLISH AND MAINTAIN ABSTINENCE FROM ALL MOOD-ALTERING SUBSTANCES AS VERIFIED BY URINALYSES (DRUG TESTS)

PROGRAM FEES: I acknowledge that all fees are due on or before service is provided. No balance due is allowed, and I acknowledge that I WILL NOT be allowed to attend group or individual sessions if I do not pay on or before services are provided. In addition, failure to attend sessions without a written excuse from my referral source, does not exempt me from having to pay the sessions I do not attend.

ACKNOWLEDGMENT: I acknowledge that I have read and understand the program/group rules and that a copy of the rules is being given to me (this document). I acknowledge that I was verbally briefed on the program I will be attending, and I understand that I must comply with all program rules and treatment goals for successful completion of the program.

DRUG TESTING: I acknowledge and agree that upon a positive drug test, I will pay the additional fees and a minimum of six extra sessions will be added to my total number of sessions; also, I may be discharged from the Program.

ATTENDANCE POLICY AND AGREEMENT

SHOW OR NO SHOW, YOU PAY FOR THE SESSION

1. Money or transportation issues are not excused absences.
2. You may/will be unsuccessfully discharged if you have one or more un-excused absences. DOC Clients are required to be discharged unsuccessfully with a maximum of three (3) un-excused absences.
3. You are required to pay the full fee even if you do not show up for the scheduled appointment or for a regular class.
4. If you show up late, you will be marked un-excused absent. Be proactive! Plan ahead! No excuses! **Late = No-Show.**
5. For an excused absence, the fee may be waived AT THE DISCRETION OF THE AGENCY and only when your Probation Officer provides the Agency with a written excuse stating a verifiable reason **within 5 business days from the date of the absence. Submitted written excuses after five days from the date of the absence ore not considered.**
6. For every un-excused absence, you will still have to pay for the class, then attend and pay for a makeup class.
7. Sessions are 60 minutes long from start to finish. Plan accordingly! No excuses to leave early! **Leave Early = No-Show.**
8. You will NOT be allowed to attend a class if you don't pay the full fee on or before the class and you will be marked as having an un-excused absence. The full amount is due at the time of the class. No balance due is allowed.
9. Only Cash or Money Order for the full amount is accepted. No change is provided. No bills larger than $20 are accepted.

Consents and Disclosures

CONSENT FOR TREATMENT: I certify that I am voluntarily making application for Intake/Screening and/or treatment in the Outpatient Substance Abuse Counseling Program provided by this Agency. I give my consent for the initial Intake/Screening interview and/or treatment provided by this agency. I further state that my attendance in treatment is voluntary–this is not a locked facility. I am free to leave at any time. My consent implies that am understand my obligation to pay any fees applicable to my program. I understand that sessions may be recorded or videotaped for training, legal, or commercial purposes. I have been given information about this program and my signature on the Evaluation documents acknowledge orientation and agreement with the various program rules.

CONFIDENTIALITY: I acknowledge and fully understand that the confidentiality of client records is protected by Federal law and regulations. Information regarding a client's participation in treatment or any other identifying information will not be disclosed unless: a) The client consents in writing; b) the disclosure is allowed by court order; c) child Abuse or Neglect is reported/suspected; d) the client reports intent to harm self or another; and, e) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program Intake/Screening including approved peer and utilization reviews of client records, and the sharing of verbal information with other agencies to insure continuity of care and/or provide emergency services. I also acknowledge my responsibility to keep confidential the names and any identifying information about other group members. I acknowledge and agree that this counseling agency and/or its staff can not be held responsible for any breach of confidentiality on the part of any counseling group member.

CONSENT TO URINALYSIS TESTING: I understand that random urinalysis to detect drug usage is a part of the Outpatient Substance Abuse Treatment Intake/Screening and/or Treatment Program provided by this Agency. I consent to provide urine or saliva samples for analysis on a monthly basis or whenever requested by the treatment staff. I further understand that test results will be used to monitor my progress in the program and determine compliance with the program rule that requires I remain alcohol/drug free while in the Substance Abuse Treatment Program. Test refusal or positive test results may result in my removal from the program and/or other disciplinary action as determined by my probation officer and/or the courts. I understand that I will be responsible for drug testing fees as priced at the time of testing, and if test results positive, I will bear the additional costs, charges and consequences.

REPORTING OF COMMUNICABLE DISEASES AND UNIVERSAL INFECTION CONTROL: I acknowledge that I have been informed of the risks of infection from HIV/AIDS and have been given information on prevention measures. As part of the Medical History completed at the time of Intake/Screening, all Agency's clients shall be screened for high-risk behavior and symptoms of communicable disease. High risk clients shall be referred by the Medical Consultant, to the local county Health Department for medical screening and pre-and post-test counseling. High risk clients are those reporting any communicable diseases. Newly discovered/diagnosed cases of HIV/AIDS shall be reported by the Medical Consultant to the Department of Health in compliance with Sections 381.0031 and 384.24 FS and the Federal Center for Disease Control Guidelines and Recommendations for Infectious Diseases.