ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES
AND
ILLINOIS DEPARTMENT OF HUMAN SERVICES - DIVISION OF ALCOHOLISM AND SUBSTANCE ABUSE

ADULT SUBSTANCE ABUSE SCREEN

Check One: ☐ Investigation ☐ Open Intact ☐ Add On or Placement case

Person Screened: _____ Date of Screen: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ DCFS Case Name: _____ DCFS Case ID#: _____

Person Completing Screen: _____ Check one: ☐ DCP ☐ Intact Worker ☐ Placement Worker

DCFS Office or POS Agency Name: _____

Address: _____ Phone: _____

Supervisor: _____ Phone: _____

Instructions: Check **Yes or No** for each item in each category**.** Refer any individuals with a **"Yes"** response to any of the **Bolded item(s**) to a Division of Alcohol and Substance Abuse (DASA) provider for a substance abuse assessment.

I. Facts of the case:

Yes	**No**		Year(s)
☐	☐	**Delivered Substance Exposed Infant**	
☐	☐	Previous DCFS involvement	

Yes	**No**	Date of LEADS check:	Date of Last Occurrence	Charge
☐	☐	**Drug related criminal charges on LEADS**		
☐	☐	Non-drug related criminal charges on LEADS		
☐	☐	**Was there a police report indicating the presence of a methamphetamine laboratory: Specify:**		

II. Medical and Mental Health History

Yes	No	
☐	☐	Are you currently on any medication prescribed for a medical condition? Complete below.
☐	☐	Do you have or have you ever had a mental health diagnosis?
☐	☐	Are you currently on any medication prescribed for a mental health diagnosis? If YES Complete below.
☐	☐	Has a doctor ever prescribed medication to "calm you down," "help you sleep," or to "help lift depression"? If YES, what medications?
☐	☐	**Have you taken prescription drugs (such as vicodin, valium, oxycotin, others) that have not been prescribed for you? List below.**
☐	☐	Do you receive disability benefits?

Diagnosis/Condition	Medication	Dosage	Duration

Diagnosis/Condition	Medication	Dosage	Duration

_____ _____ _____

_____ _____ _____

III. Observation of Person being screened: Directions: If you mark Yes below, circle all that apply.

Yes	No	
☐	☐	**Smell of Alcohol and/or Marijuana**
☐	☐	**Visible drug paraphernalia: e.g. pipes, razor blades, syringe, other (specify):**
☐	☐	Staggering, tremors, slurred or rapid speech, glassy eyed
☐	☐	Unusual or extreme behavior (Overly alert, agitated, paranoid)
☐	☐	Difficulty concentrating, easily distracted, confused

IV. Person being screened: Any bolded item marked Yes must result in a referral for an assessment.

Yes	No	
☐	☐	Are you currently (or have you ever been) in a substance abuse or methadone maintenance treatment program? If yes, where & what year? _____
☐	☐	**Do you use drugs? If Yes, what drugs, how much, and last time used?** _____ _____
☐	☐	**Have you ever felt you should cut down on drinking and/or drug use?**
☐	☐	**Have people criticized your drinking and/or drug use?**
☐	☐	**Have you ever felt guilty about your drinking and/or drug use?**
☐	☐	**Have you ever taken a drink or used drugs in the morning to steady your nerves or get rid of a hangover?**

V. Direction: These questions must be asked of an adult household member or other extended family member.

Collateral Contact Name: _____

Relation to person being screened: _____

Yes	No	
☐	☐	**Does the person being screened have a drug or alcohol problem?**
☐	☐	Do any family members, caregivers, significant others, persons living in the home, or who interact with the child/ren have a problem with alcohol or drugs?
☐	☐	Does the person being screened need protection from anyone?
☐	☐	Are you aware of any indicators of domestic violence?

Waiver of Collateral Contact Requested:

Reason for waiver: _____

_____

_____

Waiver Approved: ☐ Yes ☐ No

Child Protection Specialist's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

VI. Additional Screener Observations and Comments

Instructions: Include any information obtained during the investigation or contained in the case file that would assist the DASA provider in conducting an assessment and/or treatment; e.g. (suspected drug dealing, heavy foot traffic in and out of the home, criminal justice that indicates a substance abuse problem, etc...) Identify family members or other with relevant information about the person being screened.

_____

_____

_____

_____

VII. Referral:

Instructions: Refer any individuals with a **"Yes"** response to any **Bolded item(s)**. Individuals may also be referred for an assessment to "rule out" alcohol or other drug abuse problem. **All referrals for assessment must include: CFS 440-5 Adult Substance Abuse Screen; CFS 440-6 DCFS Referral for Adult Alcohol and other Drug Treatment Services; and CFS 440-7 Consent for Disclosure of Information**. **Indicate action taken below.**

☐ **No** Referral for Assessment ☐ Referred for Assessment

Name of Assessment Provider: _____ Date: _____

Fax number: _____ Phone: _____

Fax the following documents to the Assessment Provider at the time of referral:

☐ CFS 440-5 Substance Abuse Screen ☐ CFS 440-6 Referral
☐ CFS 440-7 Consent for Disclosure

Address, City: _____

Contact Person: _____

Appointment Date: _____ Time: _____

_____ _____
Screener Supervisor

_____ _____
Date Date