Drug & Alcohol Services

CWS Testing Only Clients Triage Sheet

Name: (First, Middle, & Last) _____

(Please spell out middle name)

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Ok to leave msg? ☐ Yes ☐ No

Date of Birth: _____ Social Security: _____

Referral Source: CWS Medi-Cal: ☐ Yes ☐ No County? _____

ANSWER ALL QUESTIONS

What is your drug of choice?..... ☐ Alcohol ☐ Other Substance

Are you an IV user..... ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No?..... If so, due date: _____

Have you had a suicide attempt within the last 30 days? ..... ☐ Yes ☐ No

Have you experienced an overdose in the last 30 days?..... ☐ Yes ☐ No

Are you using methadone? ..... ☐ Yes ☐ No

Do you have any prescriptions for opiates and/or pain killers? ..... ☐ Yes ☐ No

Are you an active pain management patient? ..... ☐ Yes ☐ No

Have you been discharged from the hospital in the last 14 days? ..... ☐ Yes ☐ No

MEDICATIONS (please list)

Medication Name	Dosage	Frequency	Prescribing Physician

AZ#_____ Date: _____