Vancouver CoastalHealth

PARIS PRIMARY ACCESS Regional Information System

MH & SU SCREENER

Name:		**PARIS ID:**	
DOB:	**Age:**	**PHN:**	
Gender:		**Phone:**	
Home Address:		**GP/NP:**	**GP/NP Phone:**

Assessment Start Date: **Assessment End Date:**

Reason For Assessment: **Carried Out By:**

Other People Involved

Copies To Be Sent To

Mental Health Screener

1. Is the client currently engaged in Mental Health Services?

☐ Yes ☐ No

2. Are you or someone in your life concerned about your Mental Health?

☐ Yes ☐ No

Frequency

Frequency Value for Q #3-10:

-All of the time
-Some of the time
-None of the time
-Unknown

3. Have you been feeling trapped, lonely or sad?

4. Have you noticed changes in your mood or level of energy or activity?

5. Have you been feeling anxious or panicked?

6. Have you been having troubles with sleep?

7. Have you been seeing or hearing things that no one else can see or hear?

8. Have you been feeling that someone else can read/control your thoughts?

9. Are you experiencing any thoughts about hurting yourself?

If all of the time or some of the time, complete further risk assessment (Suicide Risk Assessment DST - Community)

10. Has you mental health impacted your work/school, social life, and family/home responsibilities?

Mental Health Comments

Other Clinical Information (i.e. Current mental health team involvement, hospitalization, diagnosis)

MH & SU SCREENER

Name:	PARIS ID:

Substance Use Screener

1. Is the client currently engaged in Substance Use Services?

☐ Yes ☐ No

2. Are you or someone in your life concerned about your Substance use or Alcohol use?

☐ Yes ☐ No

	Frequency
3. Has your substance use impacted your school/work, social life, ar family/home responsibilities?	

Frequency Value for Q #3:

-All of the time
-Some of the time
-None of the time
-Unknown

4. In the past 6 months, have you experienced an overdose?	☐ YES	☐ NO	☐ UNKNOWN
Indicate substance:	If other, specify		
Additional substance (if applicable)	If other, specify		
Additional substance (if applicable)	If other, specify		
Additional substance (if applicable)	If other, specify		
Additional substance (if applicable)	If other, specify		
5. Have you ever been treated with Naloxone for an overdose?	☐ YES	☐ NO	☐ UNKNOWN

MH & SU SCREENER

Name:	PARIS ID:

Substance Use [MRR]

Substance Use: ☐ **Not Assessed** ☐ **No Identified Issues**

Prim Prob	Substance	Primary Route	Date Last Used	# Days of use in last 30 Days	Typical Day Amt Used	Age at First Use	Current Pattern	Stage of Change
☐	Alcohol							
☐	Non-beverage Alcohol							
☐	Tobacco							
☐	Cannabis							
☐	Crack Cocaine							
☐	Cocaine							
☐	Heroin							
☐	Opioids:							
☐	Opioids:							
☐	Benzos:							
☐	Benzos:							
☐	Crystal Meth							
☐	Amphetamines							
☐	Club Drugs:							
☐	Hallucinogens:							
☐	Inhalants:							
☐	Over-the-Counter Drugs (exc. codeine)							
☐	Other Prescription Drugs (exc. opioids)							
☐	Other:							
☐	Other:							

Has client shared needles with other users within the last 30 days? ☐ Yes ☐ No ☐ Unknown ☐ Not Applicable

MH & SU SCREENER

Name:	PARIS ID:

Substance Use Comments

Other clinical information (i.e. Current substance use team involvement, detox visits, hospitalization, diagnosis, overdose details)

Recommendations/Plan

MH & SU Screener Outcome:

Indicate any follow-up recommendations

☐ Client declined services

☐ Follow-up with GP/NP

☐ Refer to Substance Use Services

☐ Refer to Mental Health Services

☐ Refer to 1-1 Individual Counselling

☐ Refer to Group-Based Services

☐ Refer to Bed-Based Services

☐ Refer to Other Services; Internal or External

Referral details:

Information Source:

☐ Client/Self Reportec ☐ Family ☐ CareConnect ☐ GP/NP ☐ Hospital Report ☐ Other Assessments

Complete Mental Health Substance Use Screeners at planned review (recommended every year) and at transitions to care.

Next Planned Review Date:

Once screener is complete, return to the details tab to end date the assessment.

Comments

---------- **End of Report** ----------