



Level 2 PASRR Supplemental Substance Use Disorder Questionnaire

DATE OF EVALUATION
DATE OF BIRTH

NAME: LAST	FIRST	MIDDLE
------------	-------	--------

NURSING FACILITY PLACEMENT

NURSING FACILITY MAILING ADDRESS

1. Current Substance Use

<p>A. Do you currently: Use drugs or alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often? Specify substance and amount:</p>

<p>B. Do you feel that your drug or alcohol use caused problems in your social, family, financial, or work life? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:</p>
--

<p>C. Do you feel that you need or would benefit from drug or alcohol treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>D. Do you have a history of tobacco product (including vaporizer) use? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? Method of use: Quit date (if no longer using):</p>
--

<p>E. Do you have a family history of substance or alcohol abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe type and relationship:</p>

Past Substance Use

<p>A. In the past, did you: Use drugs or alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify substance and amount: If yes, how often?</p>

<p>B. Do you feel that your drug or alcohol use caused problems in your social, family, financial, or work life? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:</p>
--

<p>C. Did you seek help for drug or alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list from who, or what groups, and when:</p>

Evaluator Information

SIGNATURE	DATE
-----------	------

PRINT NAME	TITLE
------------	-------

CONTRACTOR	COUNTY
------------	--------