DDAP-EFM-1302 Rev. 6/26

Pennsylvania
Department of Drug and Alcohol Programs

OUTPATIENT TREATMENT AND CASE MANAGEMENT
Gambling Behavioral Health Screening Tool

One Penn Center, 5th floor
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Harrisburg, PA 17110
Email: RA-DA_GAMBLING@pa.gov
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Type of Screening: ☐ Telephone ☐ Face to Face ☐ Telehealth **Date:** _____

DEMOGRAPHICS

Name: _____

Date of Birth: _____

Address: _____

City: _____ **State**:_____ **Zip Code:** _____

Phone: _____

Referral Source: _____

Gender: ☐ Man ☐ Woman ☐ Other _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower

GAMBLING ACTIVITIES

What types of gambling or gaming activities do you participate in? _____

_____

_____

How often do you participate in gambling or gaming activities?_____

Have you had to ask other people for money to help deal with financial problems caused by gambling? _____

Have you bet increasing amounts of money to achieve the level of desired excitement? _____

During the past 12 months, have you become restless, irritable, or anxious when trying to stop/ cut down on gambling or video gaming? _____

During the past 12 months, have you tried to keep your family or friends from knowing how much you gamble or play video games? _____

_____

CASE MANAGEMENT NEEDS

What additional services do you need assistance with? (Check all that caller may identify) ☐ N/A

- ☐ Childcare
- ☐ Clothing
- ☐ Digital Access (phone, computer)
- ☐ Employment
- ☐ Family Assistance
- ☐ Financial and/or Credit Counseling
- ☐ Food Insecurity
- ☐ Housing
- ☐ Legal Assistance
- ☐ Life Skills
- ☐ Mental Health Services
- ☐ Physical Health
- ☐ Safety (in your home)
- ☐ Social/Community Supports
- ☐ Substance Use Disorder Services
- ☐ Transportation
- ☐ Utilities
- ☐ Other_____

DRUG & ALCOHOL USE

☐ Yes ☐ No Are you currently using drugs or alcohol? Last use: _____

What are you currently using (alcohol/drug)?:

_____

MENTAL HEALTH

☐ Yes ☐ No Are you currently experiencing any mental health symptoms? _____

☐ Yes ☐ No Are you currently receiving any mental health services? _____

☐ Yes ☐ No Are you having any thoughts of harming yourself or others? (If yes, he/she must be transferred to a clinical staff person.)

Suicide Plan:_____

Ability to contract for safety:_____

Thoughts to harm others:_____

Plan to harm others:_____

EMPLOYMENT/FUNDING/LEGAL

☐ Yes ☐ No Are you employed?

☐ Yes ☐ No Do you have health insurance or Medical Assistance? (Specify) _____

☐ Yes ☐ No Other funding sources? (Specify): _____

☐ Yes ☐ No Are you involved with the criminal/juvenile justice system?

If yes, what is your status? _____

REFERRAL FOR SERVICES

Is the caller in need of a referral for services?

Gambling Outpatient Treatment Services	☐ Yes	☐ No	☐ Refused
Gambling Case Management Services	☐ Yes	☐ No	☐ Refused
Drug & Alcohol Services	☐ Yes	☐ No	☐ Refused
Mental Health Services	☐ Yes	☐ No	☐ Refused

If the client wants a referral, where were they referred to?

Gambling Outpatient Treatment Services _____

Gambling Case Management Services _____

Drug & Alcohol Services _____

Mental Health Services _____

SIGNATURE IS REQUIRED ON THIS FORM

_____ _____

Screener's Printed Name Screener's Signature

_____ _____

Screener's Title Date