WYOMING PROFESSIONAL ASSISTANCE PROGRAM

APPLICATION FOR PARTICIPATION

NAME: _____SOC. SEC. # _____

HOME ADDRESS: _____PHONE #_____

CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ AGE: _____ SEX: (M) (F) RACE: _____

MARITAL STATUS: Married ( ) Separated ( ) Divorced ( ) Single ( )

SPOUSES NAME: _____ Children (Y) (N) (#) AGES:_____

SPECIALTY: _____

WORK STATUS: Group ( ) Private ( ) Clinic ( ) Other ( ) Unemployed ( )

WORKPLACE: _____

WORK ADDR: _____ PHONE: ( ) _____

CITY: _____ STATE:_____ ZIP:_____

HOSPITAL STAFF PRIVILEGES (if appropriate)

_____ADDRESS: _____

_____ADDRESS:_____

PROFESSIONAL LICENSE NUMBER: _____ DEA # _____

PROB LEM: Alcohol Use ( ) Chemical Use ( )

Primary Drug: _____ Length of Use: _____ Mode of Use: _____

Secondary Drug _____ Length of Use: _____ Mode of Use: _____

Other Drugs: _____ Length of Use: _____ Mode of Use: _____

PRIOR HOSPITALIZATION OR TREATMENT OF PROBLEM: (CD Treatment)

DATES FACILITY (S) SETTING TX INITIATOR

_____

_____

HISTORY OF ALCOHOL AND DRUG USE

1. Do you think your alcohol/drug use is a problem?
   Yes ___ No ___ Maybe

Explain:

_____

_____

2. What reason(s) do you have for seeking the service of WPAP at this time?

_____

_____

3. Indicate lifetime usage and/or experience you have had with each of the following:

	Frequency Of Usage	Amount used per Episode	Age First Used	Date of Last Use
Alcohol (e.g., beer	_____	_____	_____	_____
Wine, liquor)	_____	_____	_____	_____
Other _____	_____	_____	_____	_____
Narcotics (Morphine,	_____	_____	_____	_____
Codeine,Tylenol)	_____	_____	_____	_____
Fentanyl,	_____	_____	_____	_____
Darvon,Talwin	_____	_____	_____	_____
Demerol,Percodan	_____	_____	_____	_____
Other_____	_____	_____	_____	_____
Sedatives (Seconal,	_____	_____	_____	_____
Quaalude)	_____	_____	_____	_____
Other _____	_____	_____	_____	_____
Tranquilizers(Valium	_____	_____	_____	_____
Ativan,Xanax)	_____	_____	_____	_____
Other_____	_____	_____	_____	_____
Anti-Psychotics or	_____	_____	_____	_____
Antidepressants	_____	_____	_____	_____
(Haldol,Elavil,	_____	_____	_____	_____
Lithium,Sinequan,	_____	_____	_____	_____
Imipramine)	_____	_____	_____	_____
Other	_____	_____	_____	_____
Psychedelics &	_____	_____	_____	_____
Hallucinogens	_____	_____	_____	_____
(LSD,PCP,	_____	_____	_____	_____
Mushrooms,	_____	_____	_____	_____
Marijuana,hashish)	_____	_____	_____	_____
Other	_____	_____	_____	_____
Stimulants	_____	_____	_____	_____
(Amphetamines,	_____	_____	_____	_____
Methamphetamines),	_____	_____	_____	_____
Cocaine,Other	_____	_____	_____	_____
Volatile Inhalants	_____	_____	_____	_____
Other _____	_____	_____	_____	_____
Anabolic Steroids	_____	_____	_____	_____

Comments:_____

4. Prescription and Over the Counter Drugs you are currently taking:
***ADD EXTRA PAGE IF NEEDED. LIST ALL MEDICATIONS.**

Drug	Frequency	Amount/Episode	Rx Physician	Phone
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Describe any distinctive patterns of multiple drug use: i.e., cocaine/ morphine, alcohol/THC

_____

_____

_____

_____

_____

_____

6. Symptoms you have experienced due to alcohol/drug use (If YES, please indicate how recently):___

	Yes	No	3 mos.	6 mos.	l yr/or less	More than 1 yr.
Shakes	___	___	_____	_____	_____	_____
Blackouts	___	___	_____	_____	_____	_____
Hallucinations	___	___	_____	_____	_____	_____
Convulsions	___	___	_____	_____	_____	_____
Delerium Tremens(DT's)	___	___	_____	_____	_____	_____

Comments _____

_____

Treatment or Therapy	Therapist Name or Program and Address/Telephone	Dates of Visits	Frequency
AA/NA/CA or other SelfHelp	_____	_____	_____
Individual	_____	_____	_____
Group	_____	_____	_____
Inpatient	_____	_____	_____
Outpatient	_____	_____	_____

10. FAMILY HISTORY OF CHEMICAL DEPENDENCY:

Father	Alcohol_____	Drug _____	Prescription Drug _____
Mother	Alcohol _____	Drug _____	Prescription Drug _____
Aunt	Alcohol _____	Drug _____	Prescription Drug _____
Uncle	Alcohol _____	Drug _____	Prescription Drug _____
Brother	Alcohol _____	Drug _____	Prescription Drug _____
Sister	Alcohol _____	Drug _____	Prescription Drug _____
Grandmother	Alcohol _____	Drug _____	Prescription Drug _____
Grandfather	Alcohol _____	Drug _____	Prescription Drug _____
Other _____	Alcohol _____	Drug _____	Prescription Drug _____

11. CURRENT LIVING SITUATION/MARITAL HISTORY:

Are you living with another person?_____

Are you currently married? _____ Number of Prior Marriages _____

12. Have you ever filed for bankruptcy or had a pending malpractice case against you?

Have you had any citation for driving while under the influence of alcohol or drugs? What Dates?

Have you ever been arrested? If so, when and for what reason?

Have you ever been charged with a felony or misdemeanor for an offense which relates to unlawful manufacture, distribution, prescribing, or dispensing of a controlled substance._____

If yes, have you entered into a first offender, deferred adjudication, or other arrangement where judgement or conviction has been withheld? Was violation related solely to personal drug use?

_____

_____

_____

I ATTEST THAT I HAVE DISCLOSED FULLY TO WPAP ALL INFORMATION AROUND MY SUBSTANCE USE DISORDER, MENTAL HEALTH ISSUES, AND PRESCRIPTION MEDICATION.

SIGNATURE_____ Date_____

WYOMING PROFESSIONAL ASSISTANCE PROGRAM
P.O. Box 1496
CASPER, WY, 82602
TEL: 307-472-1222 * FAX: 866-277-6550**

WPAP Consent for the Release of Confidential Information

I, _____, hereby authorize the WPAP to request from the Wyoming Board of Pharmacy, a detailed report of medications that have been prescribed for me, or that I have prescribed, and I hereby authorize the Wyoming Board of Pharmacy to comply with such requests.

The purpose of and need for the disclosure is to facilitate my intake process into WPAP.

This consent is subject to revocation at any time, except to the extent that the program, which is to make the disclosure, has already taken action in reliance upon it.

Information disclosed may be protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as other-wise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____Date_____
(Client Signature)

_____
(Witness Signature)

*Complete a separate release for all organizations/individuals involved in treatment or evaluations relating to drug and alcohol use. Also complete a release for any court documents pertaining to legal issues related to drug or alcohol use.

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WPAP Consent for the Release of Confidential Information

I, _____, hereby authorize ongoing direct communication and disclosure of my alcohol and drug treatment status and treatment records (including any medical, alcohol and drug history, including assessments or evaluations; information regarding my attendance, lack of attendance or participation in treatment sessions or continuing care program sessions; my cooperation with the treatment program or continuing care program; and my prognosis or progress in recovery) between the Medical Director and/or Executive Director of the Wyoming Professional Assistance Program and the following individuals:

_____

The purpose of and need for the disclosure is to facilitate coordination of my care between treatment providers and to allow verification of treatment progress and assessment of any concerns regarding my behavior in my work or home environment.

This consent is subject to revocation at any time, except to the extent that the program, which is to make the disclosure, has already taken action in reliance upon it.

Information disclosed may be protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as other-wise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____Date_____
(Client Signature)

_____
(Witness Signature)