

BQuIP Screening Guide

Check list for items to be completed at time of screening:

- ☐ **BQuIP** ([Brief Questionnaire for Initial Placement](#)) to establish access criteria.
 - ☐ **Review Health Questionnaire**
 - ☐ **Diagnosis Document**- If further assessment is needed use Z codes, such as Z87.898. Document any R/O.
 - ☐ **Client Clinical Problem Details**- Can be completed within the Service Note.
 - ☐ **Screening Service Note**- Select Procedure, "SUD Screening".
 - ☐ **Complete NOABD if needed**- NOABD Denial
 - ☐ **Testing** (email DAS.ClientUpdates@co.slo.ca.us)
-

BQuIP Service Note

INTERVENTIONS:

Clinician completed screening using BQuIP Screening form, including assessing for risk factors (SI/HI, withdrawal symptoms, medical issues) for access criteria for SUD Treatment Services based on substance use in the last 12-months.

Clinician reviewed limits of confidentiality including mandated reporting requirements for child abuse and elder abuse and danger to self or danger to others (Tarasoff).

Clinician reviewed the client's Health Questionnaire

Clinician completed Diagnosis Document & Client Clinical Problem Details to establish access criteria.

Clinician informed client about drug testing program.

Clinician used motivational interviewing, strength based/solution focused techniques, and empathy to build the therapeutic alliance and complete BQuIP Screening with **(client name)**

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PLAN:

Based on client's report and clinical judgment, client appears to meet access criteria, LOC is to be determined at CA ASAM assessment. Further clinical impression will take place over the next 30 days as the client has agreed to participate in up to 3 times weekly Engagement Groups plus randomized testing. CA ASAM assessment appointment to be scheduled and completed following client's next appointment.

Next Scheduled Appointment:

Did the client accept the first offered appointment? YES/NO

****If applicable****

If client did NOT accept first offered appointment, enter first follow-up appointment offered date:

****If client does NOT meet criteria****

PLAN:

Based on the information provided by client, [CLIENT'S NAME] does not meet access criteria for substance use services at this time. Client denied diagnostic criteria related to their substance use in the last 12 months.

DAS staff to contact the referring party to inquire about any conflicting information regarding client's use in the last 12 months. If no conflicting information is provided, the client's case will be closed.

Close Reason: Client did not meet medical necessity criteria.

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****If client meets criteria and declines services****

PLAN:

Based on the information provided by client and clinical judgment, client appears to meet access criteria, however, at this time client is declining Drug & Alcohol Services. Client may return to DAS in the future as needed.

Client Referred to:

Close Reason: Client did not accept any offered assessment dates

BQuIP Screening (Disposition & Follow-up Box)

Presenting Problem:

Summary of the client's presenting problem (What brought them into our clinic today? Include Referral Source/Legal Issues/Active Restraining Orders/ Incarceration Dates/Court Recommendations/Substance Use Hx). Limits of Confidentiality Explained: YES/NO

Substance Use:

Client reports first use at age ____

Reports last use was ____

Reports use ____/30 days.

Reports typical use is AMOUNT____

Reports longest time of sobriety was _____ months/years

Reports typical route is _____

Naloxone:

Was Naloxone education indicated? Yes/No

Was Naloxone education accepted? Yes/No

Was Naloxone brochure provided? Yes/No

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Was client made aware that they can obtain Naloxone education/training/kit at any of our 4 DAS clinics and can obtain Naloxone without a prescription at any CVS/Walgreens stores? YES/NO

Medical/Health Concerns:

Refer to Health Questionnaire (HQ). List all current concerns/issues. (Add anything that you feel is urgent or needing to be addressed at time of screening)

Medications:

Refer to HQ. List all medications and prescribers. If client is unable to recall all medications, make note of that here.

Last Physical:

If unknown or not within the previous 12-month period; Document client is in need of an updated annual physical, was encouraged to contact PCP, and provide proof upon completion.

HepC, HIV and TB Testing:

Check client's HQ for information reported for HepC, HIV, & TB.

Insurance:

If a client does not have SLO County Medi-Cal, specify if they have no insurance, private insurance, or Out of County Medi-Cal. If they have no insurance or Out of County Medi-Cal, make a note here that client will be referred to DAS Case Manager for assistance in applying/transferring Medi-Cal.

Housing:

Briefly describe client's living environment. Ask where they live and who lives with them. If they are homeless, put where they stay most often (i.e. car, shelter, streets, couch surfing, etc.) Are there others using in the home? Any risk factors? (Keep it simple)

Mental Health:

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Assess for any SI, SIB, SA, and or HI – if none write in: CLIENT denies any current or past suicidal ideation/attempts/denies any homicidal thoughts. No risks found in today's screening.

Sex Offender Questions:

Have you been accused or charged with a sex crime? YES / NO

Are you a registered sex offender? YES / NO

Drug Testing Group:

Urgency Level: Crisis-Emergency/ Routine/ Urgent

RSS: If a client does not meet access criteria, would the client benefit from Recovery Support Services? YES/NO/NA

Summary and Disposition:

Per client's self-report and clinical judgment, client appears to meet access criteria, LOC is to be determined at CA ASAM assessment. Further clinical impression will take place over the next 30-days as client has agreed to participate in up to 3x weekly Engagement Groups plus randomized testing. CA ASAM assessment appointment to be scheduled and completed following client next appointment.

Client is also requesting MAT services and is scheduled to meet with MAT team on xx-xx-xx. (If you are referring a client to MAT, a Diagnosis should be listed in the Diagnosis Document. Example – client is requesting BUPs – they should be meeting at least a Mild OPIOID Use D/O if not higher).

Next Scheduled Services:

Client is scheduled to meet with MAT on xx-xx-xx and begin Engagement Group on xx-xx-xx.

If Screening/Assessment was completed by a Registered or Certified Counselor, an LPHA has been consulted and access criteria (DSM 5 and ASAM) for SUD services were verified by the LPHA. LPHA has also co-signed this document. YES / NO/ NA

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At least two of the following must occur within a 12-month period to be diagnosed with a use disorder:

- (1) The substance is often taken in larger amounts or over a longer period than was intended. YES/NO
- (2) There is a persistent desire or unsuccessful efforts to cut down or control the substance use. YES/NO
- (3) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects. YES/NO
- (4) Craving, or a strong desire or urge to use the substance. YES/NO
- (5) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home. YES/NO
- (6) Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. YES/NO
- (7) Important social, occupational, or recreational activities are given up or reduced because of use of the substance. YES/NO
- (8) Recurrent use of the substance in situations in which it is physically hazardous (DUI, DV, IV use). YES/NO
- (9) Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. YES/NO
- (10) Tolerance, as defined by either of the following: A need for markedly increased amounts of the substance to achieve intoxication or desired effect. A markedly diminished effect with continued use of the same amount of the substance. YES/NO
- (11) Withdrawal, as manifested by either of the following: The characteristic withdrawal syndrome for the substance. The substance (or closely related substance, such as benzodiazepine for alcohol) is taken to relieve or avoid withdrawal symptoms. YES/NO

Severity Specifier: Mild (2-3), Moderate (4-5), Severe (6 or more criteria)

Based on this clinician's clinical impression and client's report of symptoms and impairments related to their ongoing substance use within a 12-month period, [Client] meets criteria for [enter diagnosis]. Client endorses the following criteria: [list numbers associated with substance use criteria].

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Appendix

Appendix A: Summary & Disposition Example #1

Example: Client is a 42 y/o female who reports they are here as a self-referral and seeking support for their alcohol use. Client explained they have been drinking 4 – 5 mixed cocktails every other day for the past 4 – 5 mns, no w/d were mentioned, and none observed. They shared that their SO is beginning to be get upset with their drinking, has threatened to leave them if they do not seek help and shared their closest friends have also started to distance themselves due to the drinking. The only consistent emotional support is their cat named Bella. Client shared they have tried to cease or even reduce use on their own, but struggle to make it past 5 days as their anxiety and feelings of overwhelming sadness and hopelessness gets too strong and no other coping skills work except to drink; however, every time they fall into this pattern of use, they immediately feel guilt and shame and their initial emotions in which they were trying to escape from actually increase and cause more distress. Client shared that they do find themselves drinking and driving as they try to hide their drinking – no DUI's mentioned, but they are waiting for something “bad” to happen and feel like they need help now as they do not want to continue hurting themselves, their family or end up with legal issues.

MAT: client declined the need for MAT, understands they may be an option if they'd like to discuss further with LPT/NP.

Based on the client's report on the substance use tab and this clinician's diagnostic impression, **(client's name)** meets criteria for Alcohol use disorder; Moderate based on criteria: 1, 2, 5 and 6 (list all that apply).

Appendix B: Summary & Disposition Example #2

Another option as opposed to narrative form: this one may be easier to ensure you're supporting your dx

(1) Substance taken longer than intended or larger amounts – Client reports they used to smoke THC only “on the weekend with friends;” however, for the past

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7mns, they've noticed a steady increase and are now smoking a larger quantity of THC and smoking "every day that ends in a y."

(2) Unsuccessful attempts at cutting down or discontinuing use - "Yes, I've gone a couple weeks off and on" and is currently smoking THC 5 out of 7 days per week.

(3) Spending a lot of time getting, using, or recovering from use – Client reports struggling with low motivation which is causing issues with employment as they are oversleeping, late to work and then when they do show for work, they are preoccupied with how they're going to get more and not have family or employer notice.

(4) Cravings and urges to use the substance – Client shared that they have very intense cravings, most days and for several, if not all day long. They find themselves fantasizing about their "next high."

(5) Inability to manage obligations at work, home, or school – Client shared that they are probation referred, were in county jail for 3 days due to an under the influence charge which affected their employment, and they ended up getting fired. They shared that prior to incarceration, they were showing up late and even under the influence most days. Client believes their employer was "on to them" and them not being able to call in when they weren't able to show for their shift was the "final straw."

(6) Continuing to use, even when it causes problems in relationships – (Examples could be DV, ruptures w/in relationships/family/friends, etc) Client reports, the conflict involving his ex-girlfriend was worsened by their THC use and they attempted to reconcile their relationship but were unable to.

(7) Giving up important social, occupational, or recreational activities due to use – Client shared that they used to really enjoy surfing before work, but with the increase in their THC use and struggling to find the motivation to get out of bed, 5am surfing is no longer.

(8) Continuing use even when it puts the person in danger - IV use, DUI, DV relationships, using while driving? Client reports driving while under the influence. Client shared about 3 mns ago, they were so "stoned" that they were pulled over for

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going 15mph in a 45mph zone but did not get a ticket as they told the officer they had just gotten off work and had worked a 15 hr shift.

(9) Continuing use even when you know you have physical/psychological problem that could have been caused or made worse by the substance - "Yes, I knew it made my depression worse and I even checked myself into the CSU."

(10) Tolerance – (Do you use the same amount today as you did when you first started?) Client shared that they used to take a couple hits off their friend's pipe, but now they've increased to smoking 1 -2 grams per use and anything less, they do not feel the desired effects.

(11) Withdrawal sx's - Client reports the following withdrawal sx's when discontinuing (this is mainly your OPS, Benzo and Alcohol users): body aches, diarrhea, vomiting, GI distress, sweating, clammy skin, increased sleep, decreased sleep, depression, anxiety, lack of motivation, lack of energy, increased appetite, decreased appetite.

Practice Guidelines | Brief Questionnaire for Initial Placement (BQuIP)

Instructions: This is a progressive document, meaning as questions are answered additional questions may appear. Provide an answer for each question below, utilizing the helpful tips in blue font as needed.

BQuIP - Brief Questionnaire for Initial Placement

Effective 06/30/2023



Status New

Author 369, Staff

1.) Which of the following drugs or alcohol have you used in the last 12 months?

(Read list and select all that apply) [?](#)

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Opiates/opioids
(e.g., heroin, prescription narcotics) ? | <input type="checkbox"/> Stimulants
(e.g., cocaine, amphetamines) ? |
| <input type="checkbox"/> Cannabis
(e.g., marijuana,
Tetrahydrocannabinol [THC]) | <input type="checkbox"/> Benzodiazepines
(e.g., sedatives, tranquilizers) ? | <input type="checkbox"/> Other drug(s) ? |
| <input type="checkbox"/> None | | |
| <input type="checkbox"/> Skip this question | | |

☐ Click here if you stopped the BQuIP early, but **NOT FOR IMMEDIATE INTERVENTION.** (No recommendation will be generated)

Record clinical notes here:

To note, this text box is present throughout the questionnaire for use at any time if applicable

2.) Which of the following are your drug(s) of choice that you may want help with?

(Read list and select all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Opiates/opioids
(e.g., heroin, prescription narcotics) | <input type="checkbox"/> Stimulants
(e.g., cocaine, amphetamines) |
| <input type="checkbox"/> Cannabis
(e.g., marijuana,
Tetrahydrocannabinol [THC]) | <input type="checkbox"/> Benzodiazepines
(e.g., sedatives, tranquilizers) | <input type="checkbox"/> Other drug(s) |
| <input type="checkbox"/> None | | |

3.) Are you currently experiencing SEVERE WITHDRAWAL symptoms?

(e.g., tremors/shaking, recent seizures, hallucinations, vomiting, diarrhea, racing heartbeat or other significant physical symptoms)

☐ Yes ☐ No

If no, proceed to question 4

If yes, an alert will appear to prompt you to end the assessment for immediate intervention
(see below)

3.) Are you currently experiencing SEVERE WITHDRAWAL symptoms?

(e.g., tremors/shaking, recent seizures, hallucinations, vomiting, diarrhea, racing heartbeat or other significant physical symptoms)

☒ Yes ☐ No

ALERT: HIGH POTENTIAL FOR CLINICALLY RISKY WITHDRAWAL. CONSIDER NEED FOR IMMEDIATE INTERVENTION.

(e.g., provide immediate medical consult or referral to emergency room/911 or onsite withdrawal management if appropriate/available)

☐ Check this box and click "Sign" if you are ending this assessment early for immediate intervention.

-OR-

Press this button to indicate that immediate intervention is not needed, and to display the next question

**4.) If you stopped using now would you expect to get sick and experience milder withdrawal symptoms like mild tremors, excessive sweating, anxiety, nausea and/or vomiting, stomach cramps, or muscle aches?
Or are you currently experiencing these milder symptoms?**

☐ Yes ☐ No

5.) In your life, have you ever OVERDOSED (e.g., loss of consciousness) or experienced SERIOUS WITHDRAWAL OR LIFE THREATENING SYMPTOMS DURING WITHDRAWAL?

(e.g. irregular hear rate/arrhythmia, seizures, hallucinations with DTs/delirium tremens, need for IV therapy or inpatient medication management)

☐ Yes ☐ No

6.) Have you used any drugs or alcohol within the last 3 days?

☐ Yes ☐ No

If no, proceed to question 7

If yes, answer 6a (see below)

6.) Have you used any drugs or alcohol within the last 3 days?

☒ Yes ☐ No

6a.) Have you used any drugs or alcohol within the last 4 hours?

☐ Yes ☐ No

7.) Do you currently have any serious MEDICAL issues that you are aware of? ⓘ

☐ Yes ☐ No

If no, proceed to question 8

If yes, answer 7a & 7b (see below)

7.) Do you currently have any serious MEDICAL issues that you are aware of? ⓘ

☒ Yes ☐ No

7a.) Do these medical problems make it difficult to do your normal daily activities? ⓘ

☒ Not at all ☐ Sometimes ☐ Quite a bit ☐ All the time

7b.) Do you think these medical issues can improve if you do something more or different than what you are doing?

☒ Yes ☐ No ☐ Unknown

☐ Check this box to indicate that emergency services were engaged for Medical issues.

8.) In the past 30 days, have you experienced any *periods of sadness, hopelessness, loss of interest in activities, hallucinations, or significant anxiety* that are NOT resulting from withdrawal or drug use?

☐ Yes ☐ No ☐ Unknown

If no, proceed to question 9

If yes, answer 8a & 8b & 8c (see below)

8.) In the past 30 days, have you experienced any *periods of sadness, hopelessness, loss of interest in activities, hallucinations, or significant anxiety* that are NOT resulting from withdrawal or drug use?

☒ Yes ☐ No ☐ Unknown

8a.) Do these emotional problems make it difficult to do your normal daily activities? ⓘ

☒ Yes ☐ No

8b.) In the past 30 days, have you thought about wanting to kill yourself or wanting to die?

☒ Yes ☐ No

8c.) Are you currently having thoughts about wanting to kill yourself or wanting to die?

☒ Yes ☐ No

ALERT: CONSIDER POTENTIAL IMMINENT DANGER TO SELF. Follow your local county/program policies to assess for immediate intervention
(e.g., provide immediate consult, STOP screen and call 911 if imminent need is identified, provide information to call 911/suicide hotline/go to an emergency room)

☐ Check this box and click "Sign" if you are ending this assessment early for immediate intervention.

-OR-

Press this button to indicate that immediate intervention is not needed, and to display the next question

9.) Has a doctor ever given you medications for emotional or mental health issues?

☐ Yes ☐ No ☐ Unknown

10.) Which statement best describes your current thinking about your drug and alcohol use?

- ☐ My use is not a problem; I don't want treatment ☐ I am not sure I have a problem; I am not sure I would go to treatment ☐ I may or may not have a problem; I am willing to go to treatment ☐ I am committed to my recovery; I want supportive services

11.) Without help, do you think you would continue using?

- ☐ Definitely yes ☐ Probably yes ☐ Might or might not ☐ Probably not ☐ Definitely not

12.) Are you homeless? *(e.g., couch surfing, living outdoors in a car, no permanent housing)*

- ☐ Yes ☐ No

13.) Do you have a place to stay that is free of alcohol and other drugs?

- ☐ Yes ☐ No

14.) Do you currently have someone who you would consider as a social support, or someone you can rely on for support when needed?

- ☐ Yes ☐ No

15.) Are you or do you think you could be pregnant?

- ☐ Yes ☐ Don't Know ☐ No (or Not Applicable)

16.) Of the drugs we have talked about, have you injected any in the last year?

- ☒ Yes ☐ No

☐ Check this box to indicate that emergency services were engaged for Recovery Environment.

Interview complete- Please click "Sign" or "Save" in the top right.

You have completed the BQulP. Click "Sign" or "Save" in the top right.