# Providence Safe Stations

## Field Intake Assessment

Date: _____ Time Patient Arrived: _____

Time Recovery Service Called: _____ Time Recovery Service Arrived: _____

Patient Name: _____

Address/City or Town: _____

Date of Birth: _____ Sex: F M _____

Emergency Contact: _____ _____
(name) (phone)

Vital Signs:

BP: _____ HR: _____ Resp: _____

SPO2: _____ Blood Sugar: _____ Temp: _____

Pertinent Past Medical History: _____

_____

Substance(s) Last Used/Time/Amount: _____

_____

I hereby voluntarily acknowledge and state that I am seeking Peer Counseling and/or Recovery Treatment for substance use disorder, and I hereby voluntarily receive or accept such medical care as recommended by representatives of the Providence Fire Department and The Providence Center as notified: and I do hereby for myself, my heirs, executors, administrators and assigns forever release and fully discharge said representatives above, its officers, employees, medical consultants, hospitals, servants or agents from any liability in the premise and I agree to hold them harmless and acting with the best intent as defined by the Providence Safe Stations program.

Patient Signature: _____ Date: _____

**TO BE COMPLETED BY RECOVERY SERVICE**

Recovery Coach Name(s): _____

Patient SSN: _____

Insurance: No Yes If yes, provider: _____

Transferred to: _____

White – Providence Fire Department | Yellow – TPC/Anchor Recovery | Pink – Other