

RECOVERY CARE

RESOURCE ASSISTANCE SCREENING

Patient Name _____

Date _____

Please check Yes or No for each area in which you would like assistance.

Need / Service	Yes	No
Obtaining food	☐	☐
Transportation assistance	☐	☐
Obtaining a license	☐	☐
Anxiety support	☐	☐
Depression support	☐	☐
Post-traumatic stress disorder (PTSD) support	☐	☐
Bipolar disorder support	☐	☐
Mental health evaluation	☐	☐
Assistance with erectile dysfunction	☐	☐
Flu vaccination	☐	☐
Vitamin B12 injection	☐	☐
Finding a rehabilitation program	☐	☐
Additional counseling (telehealth or in person)	☐	☐
Tapering off buprenorphine/Suboxone	☐	☐

Other assistance requested:
