

ASSOCIATED BEHAVIORAL HEALTH ADULT CHEMICAL DEPENDENCY ASSESSMENT

Counselor: _____

Patient Name: _____

Date _____

I voluntarily consent to assessment of my involvement with alcohol or other drugs.

I affirm that the information I give is truthful and complete.

Patient Signature: _____

DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

- Alcohol Withdrawal – Must meet all 4 Criteria to be considered withdrawal**
- A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.
 - B. Two (or more) of the following, developing within a several hours to a few days after Criteria A (above) – check at least two if present:
 - (1) Autonomic hyperactivity (e.g. sweating or pulse rate greater than 100),
 - (2) increased hand tremor,
 - (3) insomnia (4) nausea or vomiting, (5) transient visual, tactile, or auditory hallucinations or illusions,
 - (6) psychomotor agitation,
 - (7) anxiety,
 - (8) grand mal seizures
 - C. Symptoms in Criteria B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The symptoms are not due to a general medical condition and are not better accounted for by another medical disorder.

- Amphetamine Withdrawal – Must meet all 4 Criteria to be considered withdrawal**
- A. Cessation of (or reduction in) amphetamine (or a related substance) use that has been heavy and prolonged.
 - B. Dysphoric mood and two (or more) of the following physiological changes, developing within a few hours to several days after Criteria A
 - (1) fatigue,
 - (2) vivid, unpleasant dreams,
 - (3) insomnia or hypersomnia, (4) increased appetite, (5) psychomotor retardation or agitation
 - C. Symptoms in Criteria B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - D. The symptoms are not due to a general medical condition and are not better accounted for by another medical disorder.

- Cocaine Withdrawal – Must meet all 4 Criteria to be considered withdrawal**
- A. Cessation of (or reduction in) cocaine use that has been heavy and prolonged.
 - B. Dysphoric mood and two (or more) of the following physiological changes, developing within a few hours to several days after Criteria A
 - (1) fatigue,
 - (2) vivid, unpleasant dreams,
 - (3) insomnia or hypersomnia,
 - (4) increased appetite,
 - (5) psychomotor retardation or agitation
 - C. Symptoms in Criteria B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - D. The symptoms are not due to a general medical condition and are not better accounted for by another medical disorder.

- Nicotine Withdrawal – Must meet all 4 Criteria to be considered withdrawal**
- A. Daily use of nicotine for at least several weeks.
 - B. Abrupt cessation of nicotine use, or reduction in the amount of nicotine used, followed within 24 hours by four (or more) of the following signs:
 - (1) dysphoric or depressed mood,
 - (2) insomnia,
 - (3) irritability, frustration, or anger,
 - (4) anxiety,
 - (5) difficulty concentrating,
 - (6) restlessness,
 - (7) decreased heart rate,
 - (8) increased appetite or weight gain
 - C. Symptoms in Criteria B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - D. The symptoms are not due to a general medical condition and are not better accounted for by another medical disorder

- Sedative, Hypnotic or Anxiolytic Withdrawal – Must meet all 4 Criteria to be considered withdrawal**
- A. Cessation of (or reduction in) sedative, hypnotic or anxiolytic use that has been heavy and prolonged.
 - B. Two (or more) of the following, developing within several hours to a few days after Criteria A
 - (1) Autonomic hyperactivity (e.g. sweating or pulse rate greater than 100),
 - (2) increased hand tremor,
 - (3) insomnia,
 - (4) nausea or vomiting,
 - (5) transient visual, tactile, or auditory hallucinations or illusions,
 - (6) psychomotor agitation,
 - (7) anxiety,
 - (8) grand mal seizures
 - C. Symptoms in Criteria B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - D. The symptoms are not due to a general medical condition and are not better accounted for by another medical disorder.

- Opioid Withdrawal – Must meet all 4 Criteria to be considered withdrawal**
- A. Either one of the following:
 - (1) cessation of (or reduction in) opioid use
 - (2) administration of an opioid antagonist after a period of opioid use
 - B. Three (or more) of the following, developing within minutes to several days after Criteria A (above):
 - (1) dysphoric mood,
 - (2) nausea or vomiting,
 - (3) muscle aches,
 - (4) lacrimation or rhinorrhea (runny nose),
 - (5) papillary dilation, piloerection (skin hair standing on end), or sweating,
 - (6) diarrhea,
 - (7) yawning
 - (8) fever,
 - (9) insomnia
 - C. Symptoms in Criteria B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - D. The symptoms are not due to a general medical condition and are not better accounted for by another medical disorder.

B. Withdrawal/Tolerance History

Have you ever been admitted to a Detoxification Facility for withdrawal from alcohol or other drugs? No Yes

Detox Date(s) _____ Where? _____ Drug? _____

Detox Date(s) _____ Where? _____ Drug? _____

Detox Date(s) _____ Where? _____ Drug? _____

If No, Where did the withdrawals occur? Home Jail Hospital _____ Other _____

Have you ever used a substance to relieve or avoid withdrawals? No Yes if so, which substance? _____

Have you noticed it takes more of a given substance to get the same results as before? No Yes _____

Have you noticed less of an effect from a given substance than you used to get before? No Yes _____

Risk Rating for Dimension 1 - (from PPC-2R - Appendix B):

- 4** Incapacitated with severe signs and symptoms of withdrawal.
 - Severe withdrawal presents danger (e.g. seizures).
 - Continued use poses an imminent threat to life.
- 3** Demonstrates poor ability to tolerate and cope with withdrawal discomfort.
 - Severe signs and symptoms of intoxication indicate patient may pose an imminent danger to self and others.
 - Severe signs and symptoms or risk of severe but manageable withdrawal, or withdrawal is worsening despite detoxification at a less intensive level of care.
- 2** Some difficulty tolerating and coping with withdrawal discomfort.
 - Intoxication may be severe but responds to treatment so patient does not pose imminent danger to self or others.
 - Moderate signs and symptoms, with moderate risk of severe withdrawal.
- 1** Demonstrates adequate ability to tolerate and cope with withdrawal discomfort.
 - Mild to moderate intoxication or withdrawal signs and symptoms interfere with daily functioning, but do not pose imminent danger to self or others.
 - Minimal risk of severe withdrawal.
- 0** Fully functioning. Demonstrates good ability to tolerate and cope with withdrawal discomfort.
 - No signs or symptoms of intoxication or withdrawal are present, or signs/symptoms, if present, are resolving.

Recommended ASAM Level of Care for Dimension 1 Acute Intoxication/Withdrawal Potential:

- No Detoxification services indicated
- Level III.2D Clinically Managed Residential Detoxification (Sub-acute)
- Level III.7D Medically Managed Residential Detoxification (Acute)
- OMT Opioid Maintenance Therapy

CDP Summary Interpreting Dimension 1 Data (include problems identified and why patient needs the above level of care DO NOT LEAVE BLANK):

Data Supports DSM Criteria? No Yes, meets Sub. Abuse Criteria # _____ Sub. Dependence Criteria # _____

DIMENSION 2:

BIOMEDICAL CONDITIONS AND COMPLICATIONS

1. Which of the following medical conditions do you currently have, or have had in the past?

TREATED.....UNTREATED		TREATED UNTREATED	
<input type="checkbox"/>	Anemia or blood disorder	<input type="checkbox"/>	High or low blood pressure
<input type="checkbox"/>	Rheumatic or scarlet fever	<input type="checkbox"/>	Chronic Pain.....
<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	Glaucoma.....
<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	Allergies (food or drug).....
<input type="checkbox"/>	Kidney disease or bladder infection	<input type="checkbox"/>	If yes, to what:
<input type="checkbox"/>	Liver disease-hepatitis or jaundice	<input type="checkbox"/>	Physical injury
<input type="checkbox"/>	Cancer-Type	<input type="checkbox"/>	If yes, what:
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Venereal disease
<input type="checkbox"/>	High or low blood sugar.....	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Tuberculosis	FOR FEMALES:	
Last Test Date _____ Test results: _____		<input type="checkbox"/>	Menopause or menopausal.....
<input type="checkbox"/>	Ulcers or pains in the stomach	<input type="checkbox"/>	Pre Menstrual Syndrome
<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	Pregnancy: <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed
<input type="checkbox"/>	Heart trouble	Number of months: _____	
<input type="checkbox"/>	Shortness of breath.....	Referred to First Steps? <input type="checkbox"/> No <input type="checkbox"/> Yes	

2. Have these, or any other medical conditions been impacted by your use of alcohol or other drugs? No Yes
If Yes, in what manner? _____

3. Have you ever had any surgeries or been hospitalized? No Yes If yes,
Why? _____ Where? _____ When? _____
Why? _____ Where? _____ When? _____
Why? _____ Where? _____ When? _____
Were any of these related to your use of alcohol or other drugs? No Yes, if so, how? _____

4. Do you have access to medical care? No Yes Provider Name _____
Physician's name: _____ City: _____ State: _____

5. Do you routinely access medical care? No Yes
Last saw a doctor for: _____ Date: _____ Outcome: _____

6. Are you currently taking any prescription medications? No Yes If Yes:
Name of Medication: _____ Dose _____ Prescribed by: _____
Name of Medication: _____ Dose _____ Prescribed by: _____
Name of Medication: _____ Dose _____ Prescribed by: _____

7. Current physical illnesses, other than withdrawal, that need to be addressed or which may complicate treatment (from checklist):

8. Are you sexually active? No Yes

9. Have you continued to use alcohol or other drugs despite having an identified medical problem that was caused or made worse because of that use? No Yes If so, what?

10. What is your body weight? _____ lbs. Are you comfortable with your weight? No Yes

Have you engaged in bingeing, purging, laxatives, fasting, diet pills, etc.? No Yes

Explain: _____

How many times per day do you eat? Describe: _____

Have you ever taken drugs to control your weight? No Yes Explain: _____

11. How would you describe your physical health? Poor Average Good Excellent

12. Counselor's observation of patient's physical health: Poor Average Good Excellent

Risk Rating for Dimension 2 (from PPC-2R - Appendix B):

- 4 Incapacitated, with severe medical problems.
- 3 Demonstrates poor ability to tolerate and cope with physical problems and/or general health is poor.
 Has a serious medical problem he/she neglects during outpatient or intensive outpatient treatment.
 Severe medical problems are present but stable.
- 2 Some difficulty tolerating and coping with physical problems and/or has other biomedical problems.
 Has a biomedical problem, which may interfere with recovery treatment.
 Neglects to care for serious biomedical problems.
 Acute, non-life threatening medical signs and symptoms are present.
- 1 Demonstrates adequate ability to tolerate and cope with physical discomfort.
 Mild to moderate signs or symptoms interfere with daily functioning.
- 0 Fully functioning and demonstrates adequate ability to tolerate or cope with physical discomfort.
 No biomedical signs or symptoms are present, or biomedical problems are stable.
 No biomedical conditions that will interfere with treatment

Recommended ASAM Level of Care for Dimension 2 Biomedical Conditions/Complications

- No immediate biomedical services are needed. Does not affect the placement decision.
- OMT Opioid Maintenance Therapy
- Level I.0 Outpatient – **referral** to medical primary care
- Level II.1 Intensive Outpatient– **referral** to medical primary care
- Level II.5 Partial Hospitalization/Day Tx – **referral** to medical primary care
- Level III.1 Recovery House - Clinically Managed Low-Intensity Residential Tx – **referral** to medical primary care
- Level III.3 Long Term Care - Clinically Managed Medium-Intensity Residential Tx – **referral** to medical primary care
- Level III.5 Intensive Inpatient - Clinically Managed High-Intensity Residential Tx – **referral** to medical primary care
- Level III.7 Intensive Inpatient – Medically Monitored Intensive Residential Tx – medical primary care
- Level IV Medically Managed Intensive Inpatient Treatment – medical primary care

CDP Summary Interpreting Dimension 2 Data (include problems identified and why patient needs the above level of care DO NOT LEAVE BLANK):

Data Supports DSM Criteria? No Yes, meets Sub. Abuse Criteria # _____ Sub. Dependence Criteria # _____

DIMENSION 3:
EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

A. Emotional Conditions/Complications

1. Have you ever been physically abused? No Yes; if yes, when and by whom: _____
Have you received or participated in counseling for this issue No Yes, When and what was the outcome? _____
2. Have you ever been sexually abused? No Yes; if yes, when and by whom: _____
Have you received or participated in counseling for this issue? No Yes, When and what was the outcome: _____
3. Have you ever been emotionally/verbally abused? No Yes, if yes, when and by whom: _____
Have you received or participated in counseling for this issue No Yes, When and what was the outcome? _____
4. Are there any other significant life events (losses, deaths, hardships, loss of custody of children, etc.)? No Yes
If yes, describe: _____
5. Are you currently experiencing any of the following:
 Feeling hopeless Moodiness Sleeplessness Self destructive Decreased energy
 Preoccupation with death Feeling Withdrawn Taking unnecessary risks Giving away valued possessions
6. Is there any history of suicide in your family? No Yes, If yes, explain: _____
7. Have you ever attempted suicide? No Yes, If yes, when and how? _____
8. Do you currently have any suicidal thoughts? No Yes, If yes, how recently? _____
9. Do you currently have a plan to harm yourself? No Yes, If yes, describe your plan: _____
10. Suicide risk assessment: (lowest risk to highest risk) None Low Moderate High Imminent Danger
As evidenced by: _____
If imminent danger describe immediate intervention: _____

B. Behavioral Conditions/Complications

1. Do you ever have homicidal thoughts? No Yes, if yes, explain: _____
2. Do you have any history of combative and/or assault behavior? No Yes; if yes, explain: _____
3. Have you ever driven a motor vehicle after consuming alcohol or any other mind/mood altering substance? No Yes, if yes:
How many times have you done it? _____ How often do you do it? _____ Does it concern you? No Yes
Did it ever result in arrest/charges for DUI? No Yes, if yes:
How many times? _____ What was the BAL/BAC at the time of arrest(s)? _____
How much did you consume before driving? _____ Over how much time? _____
How impaired did you feel at the time of arrest? _____
What were the circumstances? _____
4. Have you ever done anything while under the influence of alcohol or other drugs that you later regretted? No Yes, if yes:
Describe: _____
5. How much time do you spend, on average, in a typical week, in activities necessary to obtain, use or recover from the effects of using alcohol or other drugs? (spending time at bars/crack houses, seeking out dealers, recovering from hangovers, etc.)
Describe: _____
6. Have you ever given up or reduced important social, occupational or recreational activities because of using alcohol or other drugs? e.g. lost a job or marriage/relationship/friend, quit attending social events. No Yes, if yes explain: _____

7. Describe any negative impact the use of alcohol or other drugs has had on your life. (e.g. problems with legal system, school, work, at home, relationships, health, etc.):

C. Cognitive Conditions/Complications

1. Have you continued to use alcohol or other drugs despite having identified problems that were caused or made worse because of that use? No Yes If so what was made worse?

2. Have you ever been diagnosed with any cognitive disorder? No Yes, if yes, when, by whom, and what was it?

3. Do you have any problems with understanding written materials? No Yes, if yes, what is the problem? _____
Have you ever received any help with this problem? No Yes, if yes, what kind of help? _____

4. Do you need any help to understand written or verbal information? No Yes, if yes, what kind of help do you need?

D. Mental Health Conditions/Complications

1. Have you had a significant period (that was not a direct result of drug/alcohol use) in which you experienced any of the following:

- Anxiety/nervousness Grief/loss issues Sleep disturbances Hostility/violence
 Inability to comprehend Depression Phobias/paranoia/delusions Loss of appetite
 Eating disorders; if checked: Anorexia Bulimia Other _____
 Hallucinations; if checked: Auditory Visual

When did you experience them and what did you do about it?

2. Is there a history of mental illness in your family? No Yes, If yes, who and what is the illness?

Relative _____ Illness _____ Status _____
Relative _____ Illness _____ Status _____
Relative _____ Illness _____ Status _____

3. Have you ever been diagnosed with a mental health condition? No Yes, if yes what was the diagnosis? _____
Who diagnosed it? _____ Where? _____ When? _____

4. Are you currently a patient at a mental health center or seeing a private practitioner? No Yes, if yes, where/who?

5. Have you ever received counseling or psychiatric treatment? No Yes, If yes, where, when, and for what?

6. Are you currently using prescribed medications for mental health purposes? No Yes, If yes:

Name of Medication: _____ Dose _____ Prescribed by: _____
Name of Medication: _____ Dose _____ Prescribed by: _____
Name of Medication: _____ Dose _____ Prescribed by: _____

7. Are you currently using non-prescribed drugs for mental health purposes? No Yes, If yes:

Name of Drug: _____ Dose: _____ Frequency: _____ Duration: _____
Name of Drug: _____ Dose: _____ Frequency: _____ Duration: _____
Name of Drug: _____ Dose: _____ Frequency: _____ Duration: _____

8. How would you describe your current mental health: Poor Average Good Excellent

9. Evaluation of patient's mental health: Poor Average Good Excellent

10. Evaluation of patient's ability to perform daily living skills? Poor Average Good Excellent

For DUI Assessment - Imminent Danger Potential

1. CDP evaluation of BAL/BAC (Describe the clinical significance of the results, e.g. high tolerance/consumption, compare to self-report of use.): _____

2. CDP evaluation of the self-reported driving record and abstract of the legal driving record: _____

3. What is the likelihood of repeat offense? None Low Moderate High

4. What is the likelihood of significant risk to self or others if repeat offense occurs? None Low Moderate High

5. What is the likelihood of repeat offense in the immediate future? None Low Moderate High

As evidenced by _____

Risk Rating for Dimension 3 (from PPC-2R - Appendix A):

NOTE: A risk rating of 4 in this dimension requires an immediate intervention.

- 4 Severe emotional condition/complication, with **acute risk/potential for imminent danger to self or others** as evidenced by _____ requires intensive/residential/involuntary addiction treatment.
- Severe behavioral condition/complication, with **acute risk/potential for imminent danger to self or others** as evidenced by _____ requires intensive/ residential/involuntary addiction treatment.
- Severe cognitive condition/complication, with **acute risk/potential for imminent danger to self or others** as evidenced by _____ requires intensive/ residential/involuntary addiction treatment.
- Severe mental health condition/complication, with **acute risk/potential for imminent danger to self or others** as evidenced by _____ requires intensive/residential/involuntary addiction treatment.
- 3 Severe emotional condition/complication requires residential intervention, with symptoms that significantly interfere with addiction treatment as evidenced by _____.
- Severe behavioral condition/complication requires residential intervention, with symptoms that significantly interfere with addiction treatment as evidenced by _____.
- Severe cognitive condition/complication requires residential intervention, with symptoms that significantly interfere with addiction treatment as evidenced by _____.
- Severe mental health condition/complication requires residential intervention, with symptoms that significantly interfere with addiction treatment as evidenced by _____.
- 2 An acute or persistent emotional condition/complication requires intervention, with symptoms that significantly interfere with addiction treatment, as evidenced by _____.
- An acute/persistent behavioral condition/complication requires intervention, with symptoms that significantly interfere with addiction treatment, as evidenced by _____.
- An acute/persistent cognitive condition/complication requires intervention, with symptoms that significantly interfere with addiction treatment, as evidenced by _____.
- An acute/persistent mental health condition/complication requires intervention, with symptoms that significantly interfere with addiction treatment, as evidenced by _____.
- 1 An emotional condition/complication requires intervention, but does not significantly interfere with addiction treatment.
- A behavioral condition/complication requires intervention, but does not significantly interfere with addiction treatment.
- A cognitive condition/complication requires intervention, but does not significantly interfere with addiction treatment.
- 0 No emotional, behavioral or cognitive conditions that require treatment.

Recommended ASAM Level of Care for Dimension 3 – Emotional/Behavioral/Cognitive Conditions

- No Treatment Services Recommended
- Level 0.5 Early Intervention/Education – Alcohol and Other Drug Information School
- OMT Opioid Maintenance Therapy
- Level I.0 Outpatient
- Level II.1 Intensive Outpatient
- Level II.5 Partial Hospitalization/Day Treatment
- Level III.1 Recovery House - Clinically Managed Low-Intensity Residential Treatment
- Level III.3 Long Term Care - Clinically Managed Medium-Intensity Residential Treatment
- Level III.5 Intensive Inpatient - Clinically Managed High-Intensity Residential Treatment
- Level III.7 Intensive Inpatient – Medically Monitored Intensive Residential Treatment
- Level IV Medically Managed Intensive Inpatient Treatment

CDP Summary Interpreting Dimension 3 Data (include problems identified and why patient needs the above level of care DO NOT LEAVE BLANK):

Data Supports DSM Criteria? No Yes, meets Sub. Abuse Criteria # _____ Sub. Dependence Criteria # _____

**DIMENSION 4
READINESS TO CHANGE:**

A. Chemical Dependency Treatment History

Program Name and Location	Dates of Treatment	Treatment Completed?	Length of Abstinence
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	

1. What was the reason you scheduled this appointment? Family pressure Employer intervention
 Physician intervention Legal pressure Child custody Reinstate driving privileges
 DUI? If so, date and BAC/BAL _____ Driving Abstract available for review No Yes
 Self motivated, reason(s): _____ Other reason(s): _____

2. Do you believe you currently have a problem with the use of alcohol/drugs? No Yes, If yes, which? _____
 Do you believe you have had a problem with the use of alcohol/drugs in the past? No Yes, if yes, which? _____

3. Have you ever felt you should cut down or control your substance use? No Yes, if so, why? _____

4. Have you ever tried to cut down or control your use but been unsuccessful. No Yes, if so, how many times? _____

5. How would you assess your overall use of alcohol/drugs? (Patient's self-assessment): _____

B. Legal Issues

1. Is this assessment prompted or suggested by anyone connected to the legal system? No Yes, If yes, who? _____
 Your Attorney-Name _____ Judge/Court-Name _____ Other _____

2. Have you ever been arrested or charged with any crime? No Yes

3. Arrest history:

CHARGES	ALCOHOL/DRUG RELATED	DATE	WHERE	DISPOSITION
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			

4. Have you ever been in jail and/or prison? No Yes, if yes, how many times? _____
 If yes, where: _____

5. Are you currently on probation? No Yes
 If yes, your probation officer's name: _____ Court _____
 Release of Information (ROI) signed? No Yes

6. Have you been court ordered to participate in treatment for a Substance Related Disorder or Mental Health Disorder? No Yes
 If yes, what court issued the order? _____ Judge _____
(Note: Obtain a copy of the court order for patient record documentation requirements if patient is admitted to treatment)

7. Are you currently under the supervision of the Department of Corrections? No Yes If yes, who is the person assigned to supervise your case? _____ Will you sign a release of information to allow contact with that person? No Yes ROI signed on _____ (date)

8. Are you a Drug Court client? No Yes, if yes where? _____

9. If yes, are you currently in Drug Court treatment? No Yes, if yes, where? _____

10. Any current charges pending: No Yes If yes, describe:
 When _____ Charge _____ Which Court? _____
 When _____ Charge _____ Which Court? _____
 When _____ Charge _____ Which Court? _____

11. Have your parental rights been terminated? No Yes, if yes:
 When? _____ Why? _____ By Whom? _____

Counselor Notes:

C. Readiness to Change:

1. Would you like to reduce or quit drinking/drug use if you could do so easily?
 No (PC) Yes (C)
2. At this moment, how important is it that you change your current drinking/drug use?
 Not important at all. (PC)
 About as important as most of the other things I would like to achieve now. (C)
 Most important thing in my life now (PR)
3. At this moment, how confident are you that you will change your current drinking/drug use?
 I do not think I will change my drinking/drug use. (PC)
 I have a 50 percent chance of changing my drinking/drug use (C)
 I think I will definitely change my drinking/drug use. (PR)
4. How seriously would you like to reduce or quit drinking/drug use altogether?
 Not at all (PC)
 Probably yes (C)
 Definitely yes (PR)
5. Do you intend to reduce or quit drinking/using drugs in the next 2 weeks?
 Definitely not (PC)
 Probably will (C)
 Definitely will (PR)
6. What is the possibility that 12 months from now you will have a problem with alcohol or other drugs?
 Definitely not (PC)
 Probably will (C)
 Definitely will (PR)

The patient appears to be in the following stage of change:

- Precontemplation (PC) Contemplation (C) Preparation (PR) Action (A) Maintenance (M)

Risk Rating for Dimension 4 (from PPC-2R - Appendix A):

- 4b** Unable to follow through with treatment recommendations resulting in **imminent danger to self or others, immediate intervention required.**
 Unable to function independently and to engage in self-care
- 4a** Unable to follow through, has little or no awareness of substance use problems and associated negative consequences.
 Knows very little about addiction and sees no connection between personal suffering and substance use
 Not willing to explore change in substance use, as evidenced by _____.
 Is in denial regarding substance use disorder and its implications, blames others for problems, and rejects treatment.
 Is not in imminent danger and is able to care for self
- 3** Exhibits inconsistent follow-through, shows minimal awareness of substance use disorder and need for treatment.
 Appears unaware of need to change, unwilling or only partially able to follow through with treatment recommendations.
- 2** Reluctant to agree to treatment for substance use problems, as evidenced by _____.
 Able to articulate negative consequences of substance use, but has low commitment to change use of substances
 Low readiness to change, passively involved in treatment as evidenced by _____.
 Variably compliant with attendance at outpatient treatment sessions or mutual self-help support groups/meetings.
- 1** Willing to enter treatment and explore strategies for changing substance use, but ambivalent about need to change.
 Willing to explore the need for treatment and strategies to reduce or stop substance use.
 Willing to change substance use, but believes it will not be difficult, or does not accept a full recovery treatment plan
- 0** Willing to engage in treatment/education as proactive, responsible participant, committed to changing alcohol/drug use.

Recommended ASAM Level of Care for Dimension 4 – Readiness to Change

- No Treatment Services Recommended
- Level 0.5 Early Intervention/Education – Alcohol and Other Drug Information School
- OMT Opioid Maintenance Therapy
- Level I.0 Outpatient
- Level II.1 Intensive Outpatient
- Level II.5 Partial Hospitalization/Day Treatment
- Level III.1 Recovery House - Clinically Managed Low-Intensity Residential Treatment
- Level III.3 Long Term Care - Clinically Managed Medium-Intensity Residential Treatment
- Level III.5 Intensive Inpatient - Clinically Managed High-Intensity Residential Treatment
- Level III.7 Intensive Inpatient – Medically Monitored Intensive Residential Treatment
- Level IV Medically Managed Intensive Inpatient Treatment

CDP Summary Interpreting Dimension 4 Data (include problems identified and why patient needs the above level of care DO NOT LEAVE BLANK):

Data Supports DSM Criteria? No Yes, meets Sub. Abuse Criteria # _____ Sub. Dependence Criteria # _____

**DIMENSION 5:
RELAPSE/CONTINUED USE POTENTIAL**

A. Substance Use History:

PST CODES	ADMINISTRATION CODES				PERIODICITY CODES	FREQUENCY OF USE	
1- Primary 2- Secondary 3- Tertiary (See also PST Codes in Diagnostic Statement)	O- Oral J- Injection S- Smoking N- Intra Nasal H- Inhalation X- Other				C- Continuous E- Episodic/Binge R- Remission U- Unknown	1- No use in past month 2- 1 to 3 times in past month 3- 1 to 2 times per week 4- 3 to 6 times per week 5- Daily 6- Unknown	
PST CODE(S)	TYPE OF DRUG	AGE OF FIRST USE	AGE WHEN REGULAR USE BEGAN	AGE & DATE OF LAST USE	ADMIN CODE	LAST 3 YEAR USE PATTERN <small>YEAR/FREQUENCY/AMOUNT USED</small>	INITIAL USE AND MAJOR EXPERIENCES
	ALCOHOL -beer -hard alcohol -wine -other _____				O S H J N X _____		
	CANNABIS -marijuana -hashish				O S H J N X _____		
	HALLUCINOGENS -LSD -mescaline -mushrooms				O S H J N X _____		
	COCAINE -crack -rock -ice				O S H J N X _____		

PST CODE(S)	TYPE OF DRUG	AGE OF FIRST USE	AGE WHEN REGULAR USE BEGAN	AGE & DATE OF LAST USE	ADMIN CODE	LAST 3 YEAR USE PATTERN <small>YEAR/FREQUENCY/AMOUNT USED</small>	INITIAL USE AND MAJOR EXPERIENCES
	NICOTINE -cigarettes -chew -patches/gum				O S H J N X _____		
	STIMULANTS -amphetamines -Ritalin -methamphetamine -caffeine -crank				O S H J N X _____		
	INHALANTS -glue -gas -butyl -nitrate -whippets				O S H J N X _____		Do you use alone? Length of time inhaling: _____
	OVER THE COUNTER -cough med -cold med -diet aids -minithins -benedryl -viviran				O S H J N X _____		
	OPIATES -heroin -methadone -codeine -talwin -morphine -percodan				O S H J N X _____		
	BENZODEAZAPINE -valium -librium -tranquilizers -muscle relaxers				O S H J N X _____		
	SEDATIVES/ BARBITURATES -halcyon -dolman -secobarbital -amyl				O S H J N X _____		
	PCP -phencyclidine -sherm				O S H J N X _____		
	OTHER				O S H J N X _____		
	OTHER				O S H J N X _____		

AMOUNT USED DURING THE LAST WEEK (For evaluating detox needs-Revise Dimension 1 if needed)							
Drug	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1 st Drug of Choice							
2 nd Drug of Choice							
3 rd Drug of Choice							

Relapse History

- Have you ever attempted to discontinue your use of alcohol? No Yes If yes, how many times? _____
What is the longest time you have abstained? _____ What motivated you to abstain? _____
- Have you ever attempted to discontinue your use of drugs? No Yes If yes, how many times? _____
What is the longest time you have abstained? _____ What motivated you to abstain? _____
- Did you resume using? No Yes If yes, what led you to resume use? _____
How it make you feel to resume using? _____
- Have you ever experienced cravings to use alcohol or drugs? No Yes Which? _____
If yes, what are the thoughts or events that evoke cravings? _____
- CDP assessment of patient's ability to attain and maintain abstinence: Unknown Good Moderate Poor
As evidenced by _____
- CDP assessment of patient's risk for relapse: Unknown High Moderate Low
As evidenced by _____
- CDP assessment of patient's potential for continued use: Unknown High Moderate Low
As evidenced by _____

Risk Rating for Dimension 5 (from PPC-2R - Appendix A):

- 4b** No skills to arrest the addictive disorder or prevent relapse to substance use. Continued uncontrolled substance use.
 Continued addictive behavior places the patient and/or others in imminent danger. Immediate intervention required
- 4a** Repeated treatment episodes have had little positive effect on the patients functioning as evidenced by _____
 No skills to cope with and interrupt addiction problems or to prevent or limit relapse or continued use but is not in imminent danger and is able to care for self.
- 3** Little recognition and understanding of substance use relapse issues and has poor skills to cope with and interrupt addiction problems or to avoid or limit relapse or continued use as evidenced by _____.
- 2** Impaired recognition and understanding of substance use relapse issues but is able to manage with prompting.
- 1** Minimum relapse potential with some vulnerability. Fair self-management and relapse prevention skills.
- 0** No potential for further substance use problems.
 Low relapse or continued use potential and good coping skills.

Recommended ASAM Level of Care for Dimension 5 – Relapse/Continued Use Potential

- No Treatment Services Recommended
- Level 0.5 Early Intervention/Education – Alcohol and Other Drug Information School
- OMT Opioid Maintenance Therapy
- Level I.0 Outpatient
- Level II.1 Intensive Outpatient
- Level II.5 Partial Hospitalization/Day Treatment
- Level III.1 Recovery House - Clinically Managed Low-Intensity Residential Treatment
- Level III.3 Long Term Care - Clinically Managed Medium-Intensity Residential Treatment
- Level III.5 Intensive Inpatient - Clinically Managed High-Intensity Residential Treatment
- Level III.7 Intensive Inpatient – Medically Monitored Intensive Residential Treatment
- Level IV Medically Managed Intensive Inpatient Treatment

CDP Summary Interpreting Dimension 5 Data (include problems identified and why patient needs the above level of care DO NOT LEAVE BLANK):

Data Supports DSM Criteria? No Yes, meets Sub. Abuse Criteria # _____ Sub. Dependence Criteria # _____

**DIMENSION 6:
RECOVERY ENVIRONMENT**

1. What jobs have you held in the last six months? _____
 Primary occupation: _____
 Last full time employment: _____

2. Which of the following employment problems have you ever experienced due to Alcohol/Drug use?
 Late for work Diminished productivity Absenteeism Quit Fired Used at work None

3. Do you currently identify with any organized religion? No Yes, if yes, which: _____
 Were you raised in an organized religion? No Yes, if yes, which: _____
 Do you consider yourself to be a spiritual person? No Yes, if yes, in what ways? _____

4. Do you identify yourself with any particular cultural, ethnic background or community? No Yes , describe _____
 Is there a particular form of support from this community you can use for your recovery? No Yes, describe _____
 Cultural considerations/barriers to treatment or recovery _____

5. Are there any barriers to accessing treatment? No Yes, If yes, explain: _____

6. Have you ever been involved with any self-help support group? No Yes , if yes, Past Current
 Which one? _____ When? _____ Why? _____
 How do you feel about your involvement? _____
 Are you willing to attend self-help support groups now? No Yes , if yes, which one? _____

7. . **Leisure Activities:**
 What do you do in your leisure time? _____
 What kinds of activities do you participate in that involve drinking/using? _____
 What kinds of activities do you participate in that do not involve drinking/using? _____
 Have you given up any leisure activities because of using or drinking? No Yes
 If yes, what? _____

8.	<u>NO</u>	<u>YES</u>	<u>COMMENTS</u>
Family history of chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family supportive of abstinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Friends supportive of abstinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spouse supportive of abstinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Living arrangements supportive	<input type="checkbox"/>	<input type="checkbox"/>	_____
Funds for basic needs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Employment opportunities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Safe environment in home/neighborhood	<input type="checkbox"/>	<input type="checkbox"/>	_____

Risk Rating for Dimension 6 (from PPC-2R - Appendix A):

4b Environment is not supportive of addiction recovery, and is actively hostile to recovery posing an **immediate threat to safety and well-being. Immediate intervention required.**

4a Environment is not supportive of addiction recovery, and is chronically hostile and toxic to recovery or treatment progress.
 Unable to cope with the negative effects of the living environment on recovery efforts as evidenced by _____.

3 Environment is not supportive of addiction recovery, and the patient finds coping difficult, even with clinical structure.

2 Environment is not supportive of addiction recovery, but with clinical structure, the patient is able to cope most of the time.

1 Has passive support in environment.
 Significant others are not interested in supporting addiction recovery but patient is not too distracted by this situation and is able to cope with the environment.

0 Has a supportive environment, or is able to cope with poor support.

Recommended ASAM Level of Care for Dimension 6 – Recovery Environment

- No Treatment Services Recommended
- Level 0.5 Early Intervention/Education – Alcohol and Other Drug Information School
- OMT Opioid Maintenance Therapy
- Level I.0 Outpatient
- Level II.1 Intensive Outpatient
- Level II.5 Partial Hospitalization/Day Treatment
- Level III.1 Recovery House – Clinically Managed Low-Intensity Residential Treatment
- Level III.3 Long Term Care – Clinically Managed Medium-Intensity Residential Treatment
- Level III.5 Intensive Inpatient – Clinically Managed High-Intensity Residential Treatment
- Level III.7 Intensive Inpatient – Medically Monitored Intensive Residential Treatment
- Level IV Medically Managed Intensive Inpatient Treatment

CDP Summary Interpreting Dimension 6 Data (include problems identified and why patient needs the above level of care DO NOT LEAVE BLANK):

Data Supports DSM Criteria? No Yes, meets Sub. Abuse Criteria # _____ Sub. Dependence Criteria # _____

DIAGNOSTIC ASSESSMENT STATEMENT

A. Diagnostic Criteria for Substance Dependence Disorder

INDICATE IF THE PATIENT HAS EXHIBITED ANY OF THE FOLLOWING SEVEN CRITERIA WITHIN ANY 12-MONTH PERIOD IN HIS OR HER LIFETIME. AT LEAST THREE OF THE SEVEN CRITERIA MUST BE MET TO DIAGNOSE SUBSTANCE DEPENDENCE DISORDER.

P S T P = Primary; S = Secondary; T = Tertiary Drugs of use

- 1. Tolerance, as defined by either of the following:
 - a. Markedly increased amounts of the substance in order to achieve intoxication or desired effect;

As evidenced by:

 drinks or uses more to get same effect increased amounts
 increased amounts and frequency
 - b. Markedly diminished effect with continued use of the same amount.

As evidenced by:

 takes less to get same effect "burned out" on alcohol "burned out" on other drugs
 - 2. Withdrawal, as manifested by either of the following:
 - a. characteristic withdrawal syndrome for the substance

As evidenced by:

 none
 ETOH: (↑sweat, ↑pulse, shakes, insomnia, N/V, anxiety, hallucinations, seizure activity)
 meth/speed/cocaine: (depression, insomnia, increased appetite)
 opioids: (dysphoric mood, N/V, aches, runny nose/eyes, dilated pupils, diarrhea, yawning, fever)
 flu-like symptoms tachycardia fatigue cramping
 crawling skin/goose flesh other _____
 - b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

As evidenced by:

 Patient reports using _____ to ease withdrawal symptoms if _____
 is not available.
 - 3. Substance is often taken in larger amounts and/or over a longer period than the patient intended.

As evidenced by:

 prolonged periods of intoxication use upon arising binges
 taking larger doses than Rx calls for blackouts overdoses
 can't predict outcome one use begins vomiting drinks to get drunk
 frequency increased drinks/uses more often
- List specific substance: _____

4. Persistent desire or unsuccessful efforts to cut down or control substance use.
As evidenced by:
 treatment failures cold turkey periods of abstinence geographic cure
 talk about quitting tried to quit changed pattern of use changed substance used
5. A great deal of time is spent in activities necessary to obtain the substance , use the substance, or recover from its effects.
As evidenced by:
 theft to get alcohol or other drugs elaborate plans to get out of the house
 periods of inactivity (nodding out) cultivating plants
 using for several days in a row keeping a stash/supply at all times
 plans revolve around using manufacturing substances
 protective of supply hangovers
 rituals associated with use getting intoxicated as often as possible
 used alcohol or other drugs to get a "head start" before going out
 used money gained by selling stolen items to buy alcohol or other drugs
6. Important social, occupational or recreational activities given up or reduced because of substance abuse.
As evidenced by:
 quit work drop out of school lost interest in family activities
 quit leisure activities or hobbies lost interest in work or school
 friends all use changed peer group to support using
 skip family get-to-gathers/celebrations
 declining interest in community activities
 mostly going to placers where alcohol and other drugs are available
7. Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the use of the substance.
As evidenced by:
 Continued use after diagnosis of : _____
 Continued use caused physical deterioration of known medical condition: _____
 Continued use interfered with medical treatment
 Continued use to self-medicate symptoms of (ADHD, PTSD, BiPolar, etc) _____
 Continued use caused psych Suicide attempts when using
 Continued use after doctor's warning that it would make following condition worse: _____
 Continued use worsened depression
 Other: _____

B. Diagnostic Criteria for Substance Abuse Disorder

Note: For DUI Assessments, if the initial diagnosis is other than Substance Dependence, the CDP must obtain or document efforts to obtain, the following: The police report, a court-originated criminal case history, and the results of a urinalysis or drug testing obtained at the time of the assessment.

INDICATE IF THE PATIENT HAS EXHIBITED ANY OF THE FOLLOWING FOUR CRITERIA WITHIN A 12-MONTH PERIOD. ONE OR MORE OF THE FOLLOWING CRITERIA MET WITHIN THE A 12-MONTH PERIOD INDICATES SUBSTANCE ABUSE.

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
As evidenced by meeting the following more than once in a year's time:
 poor work performance disregard for house rules
 absence from work disregard for responsibilities at home
 suspended from work/school sacrificing family needs for substance use
 demoted or suspended from work broken promises or commitments
 used at work/school
2. Recurrent substance use in situations in which it is physically hazardous.
As evidenced by meeting the following more than once in a year's time:
 driving when using or under the influence.
 operating equipment or heavy machinery while under the influence
 caring for children while under the influence
 Other: _____
3. Recurrent substance-related legal problems.
As evidenced by meeting the following more than once in a year's time::
 MIP citation DUII arrest DWS citation
 PCS citation theft to get substance
 substance related disorderly conduct substance related assault
 other _____

4. Continued substance use despite persistent/recurrent social or interpersonal problems caused/exacerbated substance use.

As evidenced by meeting the following more than once in a year's time:

- | | |
|---|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> frequent arguments with spouse/s.o. about using | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shunned by co-workers |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Embarrassment to family and friends | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Friends drop you |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> no longer invited to socialize with friends/family | |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> other _____ | |

Additional indicators of alcoholism or drug addiction (not diagnostic criteria):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Compulsion to use | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Decreased tolerance | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Increased tolerance | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Binge use | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neglected responsibilities | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Severe withdrawal |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent using/drinking | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failed attempts to control | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Financial difficulties | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of control | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Protecting/hoarding supply | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty performing job | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Indefinable fears |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Preoccupation with use | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unusual behavior | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Family/friends concerned | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arrested use |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> A.M. use | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crawling skin/goose flesh | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Medical consequences | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gulping/sneaking |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blackouts | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Violence when using | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Seizures | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> + genetic history |

DSM-IV DIAGNOSIS

- Denied use of alcohol**
- 305.00 Alcohol abuse
- 303.90 Alcohol dependence: In Remission Sustained Full Remission With Physiological dependence
- Denied use of other substance(s) (drugs other than alcohol)**
- 305.50 Opioid abuse
- 304.00 Opioid dependence: In Remission Sustained Full Remission With Physiological dependence
- 305.60 Cocaine abuse
- 304.20 Cocaine dependence: In Remission Sustained Full Remission With Physiological dependence
- 305.20 Cannabis abuse
- 304.30 Cannabis dependence: In Remission Sustained Full Remission With Physiological dependence
- 305.70 Amphetamine abuse
- 304.40 Amphetamine dependence: In Remission Sustained Full Remission With Physiological dependence
- 305.30 Hallucinogen abuse
- 304.50 Hallucinogen dependence: In Remission Sustained Full Remission With Physiological dependence
- 305.90 Inhalant abuse
- 304.60 Inhalant dependence: In Remission Sustained Full Remission With Physiological dependence
- 305.90 Phencyclidine (PCP) abuse
- 304.90 PCP dependence: In Remission Sustained Full Remission With Physiological dependence
- 305.40 Sedative, hypnotic, anxiolytic abuse
- 304.10 Sedative, hypnotic dependence: In Remission Sustained Full Remission With Physiological dependence
- 304.80 Poly substance dependence In Remission Sustained Full Remission With Physiological dependence
- 305.10 Nicotine dependence In Remission Sustained Full Remission With Physiological dependence
- Screening of substance use revealed insufficient symptoms to indicate abuse or addiction.**

PLACEMENT RECOMMENDATION

DIMENSIONAL LEVEL OF CARE RECOMMENDATIONS

The patient meets admission criteria for the following Levels of Care:

Dimension 1: Level _____ Dimension 3: Level _____ Dimension 5: Level _____

Dimension 2: Level _____ Dimension 4: Level _____ Dimension 6: Level _____

OVERALL RECOMMENDATION (Level of Care recommended per ASAM):

- | | |
|--|---|
| <input type="checkbox"/> .5 Early Intervention (ADIS) | <input type="checkbox"/> III.1 Clinically-Managed Low-Intensity Residential Services |
| <input type="checkbox"/> I Outpatient Services | <input type="checkbox"/> III.3 Clinically-Managed Med-Intensity Residential Services |
| <input type="checkbox"/> II.1 Intensive Outpatient | <input type="checkbox"/> III.5 Clinically-Managed High-Intensity Residential Services |
| <input type="checkbox"/> II.5 Partial Hospitalization Services | <input type="checkbox"/> III.7 Medically-Monitored Intensive Inpatient Treatment |
| <input type="checkbox"/> OST Opioid Maintenance Therapy | <input type="checkbox"/> IV Medically-Managed Intensive Inpatient Services |
| | <input type="checkbox"/> No Services |

WRITTEN SUMMARY JUSTIFICATION FOR THE OVERALL LEVEL OF CARE RECOMMENDATION

This justification must indicate how the patient meets ASAM admission criteria for the recommended Level of Care:

Overrides:

Are there any circumstances that would override the ASAM PPC clinical recommendations for placement? No Yes
(e.g., legal mandates, logistical barriers, lack of available services, etc
If yes, explain:

Childcare considerations:

Does the patient need part time or around the clock childcare in order to access treatment? No Yes if yes
Does the patient need help accessing or selecting childcare? No Yes if yes
Referral information for child care services: _____

Also recommended:

- Domestic Violence Perpetrator Program
- Vocational Rehabilitation
- Literacy/Tutoring Program
- GED
- Anger Mgmt
- Mental Health Counseling.
- Self-help support groups
- Other (explain): _____

HIV/AIDS Brief Risk Intervention conducted by a CDP during the assessment process? Yes No
If no, explain: _____

INFORMED OF ASSESSMENT OUTCOME

My signature below signifies that I have been informed of assessment results, or due to items pending below, I will be informed of the results at a later date.

- Police Report
- BAC
- DCH
- Collateral Information
- Other Supporting Documentation
- Staffing with CDP Supervisor
- Other: _____

I have chosen to receive services from: _____ or Undecided at this time: _____

Patient Signature

Date

AUTHENTICATION INFORMATION

DASA Certified Agency completing assessment: **Associated Behavioral Health Care, Inc.**

____ **BV:** DASA Agency No. 17081600 ____ **NS:** DASA Agency No. 17092200 ____ **WS:** DASA Agency No. 17045600

Name of CDP or CDP Trainee (CDPT) completing assessment: _____

CDP or CDPT Signature

Date

Approved Supervisor or other authorized CDP Signature (If required)

Date