



**SUBSTANCE ABUSE PREVENTION AND CONTROL  
FULL ASAM ASSESSMENT - ADULT**

Based on the ASAM Criteria [3rd Edition] Multidimensional Assessment

Mail: Substance Abuse Prevention and Control  
1000 S. Fremont Ave, Bldg. A9 East, 3rd Floor, Alhambra, CA 91803  
To check submission status call: (XXX) XXX-XXXX

Website: <http://publichealth.lacounty.gov/sapc/>  
Fax: (XXX) XXX-XXXX

DEMOGRAPHIC INFORMATION			
Name (Last, First, and Middle)			Date:
Address:			Phone Number:
Date of Birth (MM/DD/YYYY)	Age:	Gender:	Okay to Leave a Message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Race/Ethnicity:	Preferred Language:	Medi-Cal Identification Number:	Other ID# (Plan):
Insurance Type: <input type="checkbox"/> None <input type="checkbox"/> MyHealthLA <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Private <input type="checkbox"/> Other (Plan): (Plan): (Plan): (Plan):			
Living Arrangement: <input type="checkbox"/> Homeless <input type="checkbox"/> Independent living <input type="checkbox"/> Other (specify):			

**Explanation of why client is currently seeking treatment:** Current symptoms, functional impairment, severity, duration of symptoms (e.g., unable to work/school, relationship/housing problems): \_\_\_\_\_

**DIMENSION 1: SUBSTANCE USE, ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL**

**1. Substance use history:**

Alcohol and/or Drug Types	Recently Used? (Past 6 Months)	Prior Use? (Lifetime)	Route (Inject, Smoke, Snort)	Frequency (Daily, Weekly, Monthly)	Duration (Length of Use)	Date of Last Use
<b>Amphetamines</b> (Meth, Ice, Crank)	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Alcohol</b>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Cocaine/Crack</b>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Heroin</b>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Marijuana</b>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Opioid Pain Medications</b> Misuse or without prescription	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Sedative</b> (Benzos, Sleeping Pills) Misuse or without prescription	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Hallucinogens</b>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Inhalants</b>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Over-the-Counter Medications</b> (Cough Syrup, Diet Aids)	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Nicotine</b>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Other:</b>	<input type="checkbox"/>	<input type="checkbox"/>				

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	Treatment Agency:	

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**Additional Information:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**2. Do you find yourself using more alcohol and/or drugs than you intend to?**  Yes  No  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**3. Do you get physically ill when you stop using alcohol and/or drugs?**  Yes  No  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**4. Are you currently experiencing withdrawal symptoms, such as tremors, excessive sweating, rapid heart rate, blackouts, anxiety, vomiting, etc.?**  
 Please describe specific symptoms and consider immediate referral for medical evaluation:  Yes  No  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**5. Do you have a history of serious withdrawal, seizures, or life-threatening symptoms during withdrawal?**  Yes  No  
 Please describe and specify withdrawal substance(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**6. Do you find yourself using more alcohol and/or drugs in order to get the same high?**  Yes  No  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**7. Has your alcohol and/or drug use changed recently (increase/decrease, changed route of use)?**  Yes  No  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**8. Please describe family history of alcohol and/or drug use:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please circle one of the following levels of severity**

Severity Rating - Dimension 1 (Substance Use, Acute Intoxication and/or Withdrawl Potential)				
0	1	2	3	4
None	Mild	Moderate	Severe	Very Severe
No signs of withdrawal/intoxication present	Mild/moderate intoxication, interferers with daily functioning. Minimal risk of severe withdrawal. No danger to self/others.	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others.	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal.	Incapacitated. Severe signs and symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life.

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	_____	_____

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Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS**

9. Please list known medical provider(s):

Physician Name	Specialty	Contact Information

10. Do you have any of the following medical conditions:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Heart Problems                   | <input type="checkbox"/> Seizure/Neurological | <input type="checkbox"/> Muscle/Joint Problems                  | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Thyroid Problems     | <input type="checkbox"/> Vision Problems                        | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> High Cholesterol                 | <input type="checkbox"/> Kidney Problems      | <input type="checkbox"/> Hearing Problems                       | <input type="checkbox"/> Chronic Pain   |
| <input type="checkbox"/> Blood Disorder                   | <input type="checkbox"/> Liver Problems       | <input type="checkbox"/> Dental Problems                        | <input type="checkbox"/> Pregnant       |
| <input type="checkbox"/> Stomach/Intestinal Problems      | <input type="checkbox"/> Asthma/Lung Problems | <input type="checkbox"/> Sexually Transmitted Disease(s): _____ |   |
| <input type="checkbox"/> Cancer (specify types[s]): _____ |   | <input type="checkbox"/> Infection(s): _____                    |   |
| <input type="checkbox"/> Allergies: _____                 |   | <input type="checkbox"/> Other: _____                           |   |

11. Do any of these conditions significantly interfere with your life?  Yes  No

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

12. Provide additional comments on medical conditions, prior hospitalizations (include dates and reasons):

\_\_\_\_\_  
 \_\_\_\_\_

13. Question to be answered by interviewer: Does the client report a medical symptoms that would be considered life-threatening or require immediate medical attention?  Yes  No  
*\* If yes, consider immediate referral to emergency room or call 911*

14. List all current medication(s) for medical condition(s):

Medication	Dose/Frequency	Reason	Effectiveness/Side Effects

Please circle one of the following levels of severity

Severity Rating - Dimension 2 (Biomedical Conditions and Complications)				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Fully functional/ able to cope with discomfort or pain.	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with physical discomfort.	Some difficulty tolerating physical problems. Acute, nonlife threatening problems present, or serious biomedical problems are neglected.	Serious medical problems neglected during outpatient or intensive outpatient treatment. Severe medical problems present but stable. Poor ability to cope with physical problems.	Incapacitated with severe medical problems.

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	_____	_____

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Additional Comments: \_\_\_\_\_

**DIMENSION 3: EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS**

15. Do you consider any of the following behaviors or symptoms to be problematic?

**Mood**

- |   |  |                                       |   |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Depression/sadness | <input type="checkbox"/> Loss of Pleasure/Interest | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Irritability/Anger |
| <input type="checkbox"/> Impulsivity        | <input type="checkbox"/> Pressured Speech          | <input type="checkbox"/> Grandiosity  | <input type="checkbox"/> Racing Thoughts    |

**Anxiety**

- |  |   |   |                                     |
|--|---|---|-------------------------------------|
| <input type="checkbox"/> Anxiety/Excessive Worry | <input type="checkbox"/> Obsessive Thoughts | <input type="checkbox"/> Compulsive Behaviors | <input type="checkbox"/> Flashbacks |
|--|---|---|-------------------------------------|

**Psychosis**

- |                                   |   |  |
|-----------------------------------|---|--|
| <input type="checkbox"/> Paranoia | <input type="checkbox"/> Delusions: _____ | <input type="checkbox"/> Hallucinations: _____ |
|-----------------------------------|---|--|

**Other**

- |  |   |                                   |  |
|--|---|-----------------------------------|--|
| <input type="checkbox"/> Sleep Problems                                    | <input type="checkbox"/> Memory/Concentration | <input type="checkbox"/> Gambling | <input type="checkbox"/> Risky Sex Behaviors |
| <input type="checkbox"/> Suicidal Thoughts: please describe _____          |   |                                   |  |
| <input type="checkbox"/> Thoughts of Harming Others: please describe _____ |   |                                   |  |
| <input type="checkbox"/> Abuse (physical, emotional, sexual): _____        |   |                                   |  |
| <input type="checkbox"/> Traumatic Event(s): _____                         |   |                                   |  |
| <input type="checkbox"/> Other: _____                                      |   |                                   |  |

16. Have you ever been diagnosed with a mental illness?  Yes  No  Not Sure

Please describe (e.g., diagnosis, medications?): \_\_\_\_\_

17. Are you currently or have you previously received treatment for psychiatric or emotional problems?  Yes  No

Please describe (e.g., treatment setting, hospitalizations, duration of treatment): \_\_\_\_\_

18. Do you ever see or hear things that other people say they do not see or hear?  Yes  No

Please describe: \_\_\_\_\_

19. **Question to be answered by interviewer:** Based on previous questions, is further assessment of mental health needed?  Yes  No

Please describe: \_\_\_\_\_

20. List all current medication(s) for psychiatric condition(s):

Medication	Dose/Frequency	Reason	Effectiveness/Side Effects

21. Please list mental health provider(s):

Provider Name	Contact Information

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Please circle one of the following levels of severity

Severity Rating - Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications)				
0	1	2	3	4
None	Mild	Moderate	Severe	Very Severe
Good impulse control and coping skills. No dangerousness, good social functioning and self-care, no interference with recovery.	Suspect diagnosis of EBC, requires intervention, but does not interfere with recovery. Some relationship impairment.	Persistent EBC. Symptoms distract from recovery, but no immediate threat to self/others. Does not prevent independent functioning.	Severe EBC, but does not require acute level of care. Impulse to harm self or others, but not dangerous in a 24-hr setting.	Severe EBC. Requires acute level of care. Exhibits severe and acute life-threatening symptoms (posing imminent danger to self/others).

**Additional Comments:** \_\_\_\_\_

**DIMENSION 4: READINESS TO CHANGE**

**22. Is your alcohol and/or drug use affecting any of the following?**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Work                    | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Physical Health | <input type="checkbox"/> Finances                |
| <input type="checkbox"/> School                  | <input type="checkbox"/> Relationships | <input type="checkbox"/> Sexual Activity | <input type="checkbox"/> Legal Matters           |
| <input type="checkbox"/> Handling Everyday Tasks | <input type="checkbox"/> Self-esteem   | <input type="checkbox"/> Hygiene         | <input type="checkbox"/> Recreational Activities |
| <input type="checkbox"/> Other: _____            |  |  |  |

**23. Do you continue to use alcohol or drugs despite having it affect the areas listed above?**  Yes  No

Please describe: \_\_\_\_\_

**24. Have you received help for alcohol and/or drug problems in the past?**  Yes  No

Please list treatment providers(s)

Provider Name	Contact Information

**25. What would help to support your recovery?** \_\_\_\_\_

**26. What are potential barriers to your recovery (e.g., financial, transportation, relationships, etc.)?** \_\_\_\_\_

**27. How important is it for you to receive treatment for:**

- |                          |                                     |                                   |                                     |                                       |                                    |
|--------------------------|-------------------------------------|-----------------------------------|-------------------------------------|---------------------------------------|------------------------------------|
| <b>Alcohol Problems:</b> | <input type="checkbox"/> Not at all | <input type="checkbox"/> Slightly | <input type="checkbox"/> Moderately | <input type="checkbox"/> Considerably | <input type="checkbox"/> Extremely |
| <b>Drug Problems:</b>    | <input type="checkbox"/> Not at all | <input type="checkbox"/> Slightly | <input type="checkbox"/> Moderately | <input type="checkbox"/> Considerably | <input type="checkbox"/> Extremely |

Please describe: \_\_\_\_\_

Please circle one of the following levels of severity

Severity Rating - Dimension 4 (Readiness to Change)				
0	1	2	3	4
None	Mild	Moderate	Severe	Very Severe
Willing to engage in treatment.	Willing to enter treatment, but ambivalent to the need to change.	Reluctant to agree to treatment. Low commitment to change substance use. Passive engagement in treatment.	Unaware of need to change. Unwilling or partially able to follow through with recommendations for treatment.	Not willing to change. Unwilling/unable to follow through with treatment recommendations.

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Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL**

**28. In the last 30 days, how often have you experienced cravings, withdrawal symptoms, disturbing effects of use?**

- Alcohol:**       None                       Occasionally                       Frequently                       Constantly  
**Drug:**             None                       Occasionally                       Frequently                       Constantly

**29. Do you find yourself spending time searching for alcohol and/or drugs, or trying to recover from its effects?**       Yes       No

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**30. Do you feel that you will either relapse or continue to use without treatment or additional support?**       Yes       No

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**31. Are you aware of your triggers to use alcohol and/or drugs?**       Yes       No

Please check off any triggers that may apply:

- Strong Cravings                       Work Pressure                       Mental Health                       Relationship Problems  
 Difficulty Dealing with Feelings       Financial Stressors                       Physical Health                       School Pressure  
 Environment                       Unemployment                       Chronic Pain                       Peer Pressure  
 Other: \_\_\_\_\_

**32. What do you do if you are triggered?** \_\_\_\_\_  
 \_\_\_\_\_

**33. Can you please describe any attempts you have made to either control or cut down on your alcohol and/or drug use?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**34. What is the longest period of time that you have gone without using alcohol and/or drugs?** \_\_\_\_\_  
 \_\_\_\_\_

**35. What helped and didn't help?** \_\_\_\_\_  
 \_\_\_\_\_

Please circle one of the following levels of severity

Severity Rating - Dimension 5 (Relapse, Continued Use, or Continued Problem Potential)				
0	1	2	3	4
None	Mild	Moderate	Severe	Very Severe
Low/no potential for relapse. Good ability to cope.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition of risk for relapse. Able to self-manage with prompting.	Little recognition of risk for relapse, poor skills to cope with relapse.	No coping skills for relapse/addiction problems. Substance use/behavior, places self/other in imminent danger.

Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_

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	<input type="text"/>	<input type="text"/>
	<b>Treatment Agency:</b>	<input type="text"/>

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**DIMENSION 6: RECOVERY/LIVING ENVIRONMENT**

36. Do you have any relationships that are supportive of your recovery? (e.g., family, friends) \_\_\_\_\_

37. What is your current living situation (e.g., homeless, living with family/alone)? \_\_\_\_\_

38. Do you currently live in an environment where others are using drugs?  Yes  No

Please describe: \_\_\_\_\_

39. Are you currently involved in relationships or situations that pose a threat to your safety?  Yes  No

Please describe: \_\_\_\_\_

40. Are you currently involved in relationships or situations that would negatively impact your recovery?  Yes  No

Please describe: \_\_\_\_\_

41. Are you currently employed or enrolled in school?  Yes  No

Please describe (e.g., where employed, duration of employment, name and type of school): \_\_\_\_\_

42. Are you currently involved with social services or the legal system (e.g., DCFS, court mandated, probation, parole)?  Yes  No

Please describe: \_\_\_\_\_

**If on parole/probation:**

Name of Parole/Probation Officer	Contact Information

Please circle one of the following levels of severity

Severity Rating-Dimension 6 (Recovery/Living Environment)				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Able to cope in environment/ supportive.	Passive/disinterested social support, but still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment, difficulty coping even with clinical structure.	Environment toxic/hostile to recovery. Unable to cope and the environment may pose a threat to safety.

**Additional Comments:** \_\_\_\_\_

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**SUMMARY OF MULTIDIMENSIONAL ASSESSMENT**

Dimension	Severity Rating (Based on Ratings Above)				Rationale
<b>Dimension 1</b> Substance Use, Acute Intoxication and/or Withdrawal Potential	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	
<b>Dimension 2</b> Biomedical Condition and Complications	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	
<b>Dimension 3</b> Emotional, Behavioral, or Cognitive Condition and Complications	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	
<b>Dimension 4</b> Readiness to Change	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	
<b>Dimension 5</b> Relapse, Continued Use, or Continued Problem Potential	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	
<b>Dimension 6</b> Recovery/Living Environment	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	

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**DIAGNOSIS: DIAGNOSTIC STATISTICAL MANUAL, 5TH EDITION (DSM-5)  
CRITERIA FOR SUBSTANCE USE DISORDER**

	Substance Use Disorder Criteria (DSM-5)	Name of Substance(s)		
		#1: _____	#2: _____	#3: _____
1	Substance often taken in larger amounts or over a longer period than was intended.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	There is a persistent desire or unsuccessful efforts to cut down or control substance use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Craving, or a strong desire or urge to use the substance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Important social, occupational, or recreational activities are given up or reduced because of substance use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Recurrent substance use in situations in which it is physically hazardous.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	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 substance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Withdrawal, as manifested by either of the following: - The characteristic withdrawal syndrome for the substance. - Substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Total Number of Criteria</b>			

Please check off any symptoms that have occurred in the past 12 months.

List of Substance Use Disorder(s) that Meet DSM-5 Criteria and Date of DSM-5 Diagnosis (specify severity level):

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\* The presence of **at least 2** of these criteria indicates a **substance use disorder**.

\*\* The severity of the substance use disorder is defined as:

- **Mild:** Presence of **2-3 criteria**
- **Moderate:** Presence of **4-5 criteria**
- **Severe:** Presence of **6 or more criteria**

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### ASAM LEVEL OF CARE DETERMINATION TOOL

**Instructions: For each dimension, indicate the least intensive level of care that is appropriate based on the client's severity/functioning and service needs.**

ASAM Criteria Level of Care- Withdrawal Management	ASAM Level	Dimension 1 Substance Use, Acute Intoxication and/or Withdrawal Potential				Dimension 2 Biomedical Condition and Complications				Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications				Dimension 4 Readiness to Change				Dimension 5 Relapse, Continued Use, or Continued Problem Potential				Dimension 6 Recovery/Living Environment								
		None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev					
<b>Severity / Impairment Rating</b>																														
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM																													
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM																													
Clinically Managed Residential Withdrawal Management	3.2-WM																													
Medically Monitored Inpatient Withdrawal Management	3.7-WM																													
Medically Managed Intensive Inpatient Withdrawal Management	4-WM																													
<b>ASAM Criteria Level of Care- Other Treatment and Recovery Services</b>																														
<b>Severity / Impairment Rating</b>		None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	<b>Consider referral to mental health facility</b>	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev
Early Intervention	0.5																													
Outpatient Services	1																													
Intensive Outpatient Services	2.1																													
Partial Hospitalization Services	2.5																													
Clinically Managed Low-Intensity Residential Services	3.1																													
Clinically Managed Population-Specific High-Intensity Residential Services	3.3																													
Clinically Managed High-Intensity Residential Services	3.5																													
Medically Monitored Intensive Inpatient Services	3.7																													
Medically Managed Intensive Inpatient Services	4																													
<b>ASAM Criteria Level of Care- Other Treatment and Recovery Services</b>																														
<b>Severity / Impairment Rating</b>		None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev	
Opioid Treatment Program	OTP																													

**Would the patient with alcohol or opioid use disorders benefit from and be interested in Medication-Assisted Treatment (MAT)?**

Yes  No

Please describe: \_\_\_\_\_

<p style="font-size: small;">This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to whom it pertains unless otherwise permitted by law.</p>	<b>Client Name:</b> _____	<b>Medi-Cal ID:</b> _____
	<b>Treatment Agency:</b> _____	_____
	_____	_____

**FULL ASAM ASSESSMENT - ADULT**  
Based on the ASAM Criteria [3rd Edition] Multidimensional Assessment

**PLACEMENT SUMMARY**

**Level of Care:** Enter the ASAM Level of Care (e.g., 3.1, 2.1, 3.2, W.M) number that offers the most appropriate treatment setting given the client's current severity and functioning: \_\_\_\_\_

**Level of Care Provided:** If the most appropriate Level of Care is not utilized, then enter the next appropriate Level of Care and check off the reason for this discrepancy (below):

**Reason for Discrepancy:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Not Applicable                    | <input type="checkbox"/> Service Not Available | <input type="checkbox"/> Provider Judgment | <input type="checkbox"/> Client Preference |
| <input type="checkbox"/> Transportation                    | <input type="checkbox"/> Accessibility         | <input type="checkbox"/> Financial         | <input type="checkbox"/> Preferred to Wait |
| <input type="checkbox"/> Language/ Cultural Considerations | <input type="checkbox"/> Environment           | <input type="checkbox"/> Mental Health     | <input type="checkbox"/> Physical Health   |
| <input type="checkbox"/> Other: _____                      |  |  |  |

Briefly Explain Discrepancy: \_\_\_\_\_

Designated Treatment Location and Provider Name: \_\_\_\_\_

<b>Counselor/LPHA Name</b>	<b>Signature</b>	<b>Date</b>
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<b>*LPHA Name</b>	<b>Signature</b>	<b>Date</b>
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\*Complete this line if individual conducting this assessment is not an LPHA

LPHA (Licensed Practitioner of the Healing Arts) includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

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