

### ASAM REASSESSMENT FORM (F)

Client Name: _____	Today's Date: _____
Admission Date: _____	Number of days in treatment: _____
Avatar ID#: _____	SSN#: _____
	DOB: _____
Project: _____	County: _____
Phone: _____	Preferred Language: _____
Gender: Male ___ Female ___ Trans ___ Other _____	
If female, pregnant? Yes ___ No ___ Unsure ___	
Medi-Cal Status: _____	CIN #: _____

**DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL**

1. Are you continuing to have physical withdrawal symptoms while in treatment? Yes \_\_\_ No \_\_\_  
 If yes, describe? \_\_\_\_\_  
 If no, when was the last time you had any withdrawal symptoms? \_\_\_\_\_

Dimension 1 Comments/Rationale:

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Risk Severity Rating:      0          1          2          3          4

0	1	2	3	4
No signs of withdrawal/intoxication present	Mild/moderate intoxication, interferes 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.

**DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS**

1. Are you having any medical or physical health concerns at this time? Yes \_\_\_ No \_\_\_  
 If yes, what are they? \_\_\_\_\_  
 If no, what has helped you stay healthy? \_\_\_\_\_
2. Do you have medical or health conditions that are affecting your treatment? Yes \_\_\_ No \_\_\_  
 Further Detail: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Have you connected with a primary care physician while being in treatment? Yes \_\_\_ No \_\_\_  
 Date of last visit: \_\_\_\_\_  
 Date of scheduled appointment: \_\_\_\_\_  
 If no, how are you attempting to get one? \_\_\_\_\_



**DIMENSION 4: READINESS TO CHANGE**

1. What changes have you made while in treatment?

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2. What will continue to motivate you or enhance your motivation to stay clean/sober?

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3. (Counselor's observation) Stage of Change: \_\_\_\_\_

Dimension 4 Comments/Rationale:

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Risk Severity Rating:      0          1          2          3          4

0	1	2	3	4
Completely engaged in treatment.	Ambivalent of the need to change.	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

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

1. Date of your last use: \_\_\_\_\_

2. How often do you have cravings, urges, or thoughts to use? Hourly \_\_\_ Daily \_\_\_ Weekly \_\_\_ None \_\_\_

3. Rate your desire to use. 0=No Desire 10=Strongest Desire      0 1 2 3 4 5 6 7 8 9 10

4. What are your main triggers at this time, if any?

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5. What coping skills have you developed/learned while being in treatment?

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6. What support groups or activities do you find helpful to your recovery?

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Dimension 5 Comments/Rationale:

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Risk Severity Rating:      0          1          2          3          4

0	1	2	3	4
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.

**DIMENSION 6: RECOVERY/LIVING ENVIRONMENT**

1. What housing options are you currently considering after residential treatment?

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2. Are you or will you be responsible for the care of another person(s), including family, children, pets, or others?

Yes \_\_\_ No \_\_\_ If yes, explain: \_\_\_\_\_

3. Have you developed a recovery and/or social support network?

Yes \_\_\_ No \_\_\_

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4. How do you plan on supporting yourself financially?

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Dimension 6 Comments/Rationale:

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Risk Severity Rating:      0          1          2          3          4

0	1	2	3	4
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.

Re-Evaluation Disposition (UCLA tracking):

Indicated Level of Care (G)	Actual Level of care received (J)
<input type="checkbox"/> Recovery Support Services <input type="checkbox"/> ASAM 1.0 <input type="checkbox"/> ASAM 2.1 <input type="checkbox"/> ASAM 3.1 <input type="checkbox"/> ASAM 3.3 <input type="checkbox"/> ASAM 3.5 <input type="checkbox"/> ASAM 3.7 <input type="checkbox"/> ASAM 4.0 <input type="checkbox"/> Opioid Treatment Program (OTP) <input type="checkbox"/> ASAM 1 – WM <input type="checkbox"/> ASAM 3.2 – WM <input type="checkbox"/> ASAM 3.7 – WM <input type="checkbox"/> ASAM 4 – WM <input type="checkbox"/> Other _____ <input type="checkbox"/> Recovery Residence <input type="checkbox"/> MAT Services	<input type="checkbox"/> Recovery Support Services <input type="checkbox"/> ASAM 1.0 <input type="checkbox"/> ASAM 2.1 <input type="checkbox"/> ASAM 3.1 <input type="checkbox"/> ASAM 3.3 <input type="checkbox"/> ASAM 3.5 <input type="checkbox"/> ASAM 3.7 <input type="checkbox"/> ASAM 4.0 <input type="checkbox"/> Opioid Treatment Program (OTP) <input type="checkbox"/> ASAM 1 – WM <input type="checkbox"/> ASAM 3.2 – WM <input type="checkbox"/> ASAM 3.7 – WM <input type="checkbox"/> ASAM 4 – WM <input type="checkbox"/> Other _____ <input type="checkbox"/> Recovery Residence <input type="checkbox"/> MAT Services

Reason for Difference (if any - L):

N/A, no difference   
  Client preference   
  Family Responsibility   
  Lack of insurance/payment  
 Level of Care not avail   
  Clinical Judgement   
  Geographic limitations   
  Legal Issues  
 Mngnd care refusal   
  Language Needs   
  Ct on waiting list for indicated level   
  Other (M): \_\_\_\_\_

IF referral being made but admission is expected to be delayed, reason (N):

Waiting for LOC availability

Waiting for Language specific services

Incarceration

Hospitalization

Other (O): \_\_\_\_\_