CONTRA COSTA
HEALTH SERVICES

Behavioral Health Division
Alcohol and Other Drug Services Managed Care System
ASAM Criteria Placement Assessment

Demographic & Initial Information

Name:		**Date:**			
Phone Number : **Is it okay to leave voicemail?** ☐ **Yes** ☐ **No**		**Address:**			
DOB:		**Age:**	**Gender:**		
Race/Ethnicity:		**Preferred Language:**	**Referred by:**		
MRN/Client ID:	**Medi-Cal Beneficiary** ☐ **Yes** ☐ **No**	**Are you pregnant?** ☐ **Yes** ☐ **No**	**If yes, are you an IV substance user?**	☐ **Yes** ☐ **No**	
☐ **IV User**	☐ **Homeless**	☐ **Veteran**	☐ **AB 109**	☐ **Criminal Justice**	☐ **Other**

Preliminary Questions

Have you ever been in Alcohol and Other Drug Treatment?	☐ **Yes** ☐ **No**	**If Yes, when and where?**	
Transaction Type (check one)	**Initial Admission** ☐	**Transfer of Level of Care/Service:** ☐	
Is there a consent form allowing future possible contact with others? If so, please list with whom and provide contact information.		☐ **Yes**	☐ **No**

IMMEDIATE NEED PROFILE

IMPORTANT: **Yes** answers to questions, **1, 2 and/or 3 require** that the person immediately receive medical or psychiatric care for evaluation of need for acute, inpatient care.

Yes to answer questions **4a and b, or 4 b alone, require** the person be seen for assessment within 48 hours, and preferably earlier for motivational strategies, unless person is imminently likely to walk out and needs a more structured intervention.

Yes answer to question **5 a**, assess further for need for immediate intervention (eg, taking keys of car away; having a relative/friend pick person up if severely intoxicated and unsafe; evaluate need for immediate psychiatric intervention)

Yes to answers **5b, 5c and/or 6** without any yes answers in questions 1, 2, or 3, require that the patient be referred to a safe or supervised environment (eg shelter, alternative safe living environment, or residential or subacute care setting, depending on level of severity and impulsivity)

Dimension 1: Acute Intoxication and/or Withdrawal Potential		
a. Are you currently having severe, life-threatening, and/or similar withdrawal symptoms?	☐ **Yes**	☐ **No**
Dimension 2: Biomedical Conditions/Complications		
a. Any there any current, severe physical health problems? Is there anything out of the ordinary that you are experiencing in relation to your physical health?	☐ **Yes**	☐ **No**
Dimension 3: Emotional/Behavioral/Cognitive Conditions/Complications		
a. Are you currently in danger of harming yourself or someone else? Do you have thoughts about wanting to hurt yourself ? Do you have any intent or plan to hurt yourself and means by which to do so?	☐ **Yes**	☐ **No**

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b. Are you experiencing thoughts and feelings of homicidal or violent ideation, impulses and uncertainty about the ability to control impulses with the means to act upon them?	☐ **Yes**	☐ **No**
c. Are you unable to function in activities of daily living or care for yourself? Does this inability lead to dangerous consequences for you?	☐ **Yes**	☐ **No**
Dimension 4: Readiness to Change		
a. Does the person appear to need alcohol or other drug treatment/recovery and/or mental health treatment, but ambivalent or feels it unnecessary?	☐ **Yes**	☐ **No**
b. Do you feel you are being forced or required to seek screening, assessment and/or treatment?	☐ **Yes** **If yes, by who:** _____	☐ **No**
Dimension 5: Relapse, Continued Use, or Continued Problem Potential		
a. Are you currently under the influence? Is the person currently acutely psychotic, manic or suicidal?	☐ **Yes** **If Yes to any, please list:** _____	☐ **No**
b. Is the person likely to continue to use or have active, acute symptoms in a dangerous manner if they do not receive immediate, secure placement?	☐ **Yes**	☐ **No**
c. Is person's most troubling presenting problem(s) that promoted the call or brings them in for this. dangerous to the person or others?	☐ **Yes**	☐ **No**
Dimension 6: Recovery Environment		
a. Are there any dangerous family; significant others; living, work, or school situations threatening your safety, immediate well-being, and/or sobriety (eg., living with a drug dealer; physically abused by partner or significant other; homeless in freezing temperatures)?	☐ **Yes**	☐ **No**

	Substance Name	**Last 30 Days (# of Days)**	**Amount**	**Frequency**	**Age at First Use**	**Method of Use**
Primary						
Secondary						
Tertiary						
Other						

Date of Last Use: _____ Substance(s) Used: Number of Times: _____

Severity Rating: Dimension 1 Please mark rating in section to the right.	**0**	**1**	**2**	**3**	**4**

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DIMENSION 2: Biomedical Conditions/Complications

Have you ever been Hospitalized? ☐ **Yes** ☐ **No**	Please note dates/illness(es):
Have you been diagnosed with: (Check all that apply)	Clinician: Please specify dates of diagnosis, if able
Hepatitis C ☐ **Yes** ☐ **No** ☐ **Decline to State**	Allergies: ☐ **Yes** ☐ **No** ☐ **Decline to State** Please specify:
STDs ☐ **Yes** ☐ **No** ☐ **Decline to State**	Tuberculosis: ☐ **Yes** ☐ **No** ☐ **Decline to State**
Seizure(s) ☐ **Yes** ☐ **No** ☐ **Decline to State**	High blood pressure: ☐ **Yes** ☐ **No** ☐ **Decline to State**
Have you been tested for HIV/AIDS? ☐ **Yes** ☐ **No** ☐ **Decline to State**	Did you receive the results of the HIV/AIDS Test? ☐ **Yes** ☐ **No** ☐ **Decline to State**
Are you allergic to any medications: ☐ **Yes** ☐ **No** ☐ **Decline to State** **Specify:** _____	Ever had a head injury and been treated for it? ☐ **Yes** ☐ **No** ☐ **Decline to State** **Describe:** _____

Severity Rating: Dimension 2 Please mark rating in section to the right.	**0**	**1**	**2**	**3**	**4**

Dimension 3: Emotional/Behavioral/Cognitive Conditions/Complications

Have you ever been diagnosed with a mental illness? ☐ **Yes** ☐ **No** ☐ **Decline to State**	If YES, what diagnosis?
When was Diagnosis?	Who diagnosed?
Have you been prescribed any medication for psychological or emotional needs? (Please mark answer in box to the right)	☐ **Yes** ☐ **No** ☐ **Decline to State**

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If yes, please list medication(s)?	Who is prescribing the medication(s)?

Have you ever experienced significant periods of:	If **Yes**, please describe When/Comments (Please note if this was during times while using substances or not)
DANGEROUSNESS/LETHALITY	
Serious thoughts of suicide ☐ **Yes** ☐ **No**	
Wanting to hurt others ☐ **Yes** ☐ **No**	
Inability to control violent behavior ☐ **Yes** ☐ **No**	
INTERFERENCE WITH RECOVERY EFFORTS	
Depression ☐ **Yes** ☐ **No**	
Anxiety ☐ **Yes** ☐ **No**	
Hallucinations ☐ **Yes** ☐ **No**	
Trouble understanding, concentrating or remembering ☐ **Yes** ☐ **No**	
SOCIAL FUNCTIONING	
Conflicts in relationships (family, partner, friends) ☐ **Yes** ☐ **No**	
Struggles with vocational or educational demands ☐ **Yes** ☐ **No**	
Inability to meet personal responsibilities ☐ **Yes** ☐ **No**	
ABILITY FOR SELF CARE	
Difficulty performing activities of daily living ☐ **Yes** ☐ **No**	

Severity Rating: Dimension 3 Please mark rating in section to the right.	**0**	**1**	**2**	**3**	**4**

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DIMENSION 4: Readiness to Change

4A] Readiness to Change: SUD

Can you tell me how you view your substance use and its role in your life? What types of ideas have you had about changing your use?

☐ Pre-contemplation	☐ Contemplation	☐ Preparation	☐ Action	☐ Maintenance	☐ Relapse

Dimension 4: Readiness to Change- Contd.

4B] Readiness to Change: Mental Health

Can you tell me how you view your mental health and its role in your life? What ideas, if any have you had regarding changing anything about your mental health?

☐ Pre-contemplation	☐ Contemplation	☐ Preparation	☐ Action	☐ Maintenance	☐ Relapse

Severity Rating: Dimension 4 Please mark rating in section to the right.	**0**	**1**	**2**	**3**	**4**

DIMENSION 5a: Relapse /Continued Use/Continued Problem Potential (SUD Specific)

Are any of the following triggers for using substances? If yes, please describe:

☐ **Difficulty dealing with negative emotions**	☐ **Difficulty coping with cravings**
☐ **Relationship problems**	☐ **Financial stressors**
☐ **Work pressures**	☐ **Difficulty refusing peers**
☐ **Chronic Pain**	☐ **Other, please define**

What do you do when you are triggered to use and you do not use?

What was your longest period of sobriety/abstinence? When did this occur?

What helped during this period?

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DIMENSION 5b: Relapse /Continued Use/Continued Problem Potential (Mental Health Specific)

Are you aware of triggers regarding your mental health? ☐ **Yes** ☐ **No**

Are any of the following triggers? If yes, please describe:

☐ **Family relationships**	☐ **Partner Relationships**	☐ **Peer relationships**

☐ **Employment**	☐ **Financial**	☐ **Physical conditions**	☐ **Other**

Are there any other triggers or situations that you feel put you at a greater risk in regards to your mental health? ☐ **Yes** ☐ **No**
Please describe:

Severity Rating: Dimension 5 Please mark rating in section to the right.	**0**	**1**	**2**	**3**	**4**

DIMENSION 6a: Recovery Environment (SUD Specific)

Please describe any barriers you see in reaching your goals regarding your substance use:

☐ **Occupational problems** ☐ **Housing problems** ☐ **Economic problems** ☐ **Problems with primary support group**

☐ **Problems with access to health care** ☐ **Transportation** ☐ **Legal issues and/or criminal justice involvement**

☐ **Etc. and please describe**

Is there anybody in your life that you see daily or almost daily that is using alcohol and/or other drugs? ☐ **Yes** ☐ **No**
If yes, please describe your relationship to the person/people:

Who is supportive of you becoming and remaining substance free? Please describe what they do to support you.

Have you participated in any social support recovery activities (such as 12-step meetings, other self-help meetings, religious/faith recovery meetings, meetings of an organization other than those listed above, interactions with family members and/or friend for support of your recovery)?	☐ **Yes**	☐ **No**	☐ **Decline to State**

Specify what type and how often?

DIMENSION 6b: Recovery Environment (Mental Health Specific)

(If applicable, i.e., the client has a mental health problem) ***If N/A, check this box*** ☐

Please describe any barriers you see in reaching your goals regarding your mental health:

☐ **Occupational problems** ☐ **Housing problems** ☐ **Economic problems** ☐ **Problems with primary support group**

☐ **Problems with access to health care** ☐ **Transportation** ☐ **Legal issues and/or criminal justice involvement**

☐ **Etc. and please describe**

Are you currently using community mental health resources?	☐ **Yes**	☐ **No**
If YES, Which Mental Health Clinic or Program? Please be specific:		
If **NO**, do you know how to access community mental health resources?	☐ **Yes**	☐ **No**

Severity Rating: Dimension 6 Please mark rating in section to the right.	**0**	**1**	**2**	**3**	**4**

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ASAM SEVERITY RATING SUMMARY							
ASAM DIMENSIONS: 1: Acute Intoxication and/or Withdrawal Potential; 2-Biomedical Conditions and Complications; 3-Emotional/Behavioral/Cognitive Conditions and Complications; 4-Readiness to Change ; 5-Relapse, Continued Use or Continued Problem Potential; 6-Recovery Environment							
Severity Rating		**Dimensions**					
		1	**2**	**3**	**4**	**5**	**6**
0-No Risk: No current risk. Any acute or chronic problem mostly or entirely stabilized.	No immediate services needed.						
1-Mild: Mild or minimal difficult issue or minor symptoms present. Any existing	Low intensity of services needed for this dimension.						
2-Moderate	Moderate intensity of services, skills, training or supports needed.						
3-Substantial or Significant	Moderately high intensity of services, skills, training or supports needed. May be in danger or near imminent danger.						
4-Severe	High intensity of services, skills, training or supports needed. Immediate or urgent services required and need to be closely monitored.						

LEVEL OF CARE RECOMMENDATION	
If recommendation for level of care is different than what the criteria supports, please explain	

Staff/Clinician Printed Name **Staff/Clinician Signature** **Date Completed**

Staff/Clinician Phone Number: _____

Physician's Printed Name (Methadone) **Physician's Signature** **Date**

Clinical Supervisor's Printed Name(Methadone) **Clinical Supervisor's Signature** **Date**