COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
FULL ASAM ASSESSMENT- ADULT

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

SUBMIT THE FULL ASAM ASSESSMENT FORM TO:
Website: http://publichealth.lacounty.gov/sapc/
Fax: (XXX) XXX-XXXX

Demographic information

Name:	**Date:**	**Phone Number:** **Okay to leave voicemail?** ☐ Yes ☐ No
Address:		
Date of Birth:	**Age:**	**Gender:**
Race/Ethnicity:	**Preferred Language:**	**Medi-Cal ID #:** **Other ID# (Plan):**

Insurance Type: ☐ None	☐ MyHealthLA	☐ Medicare (Plan):	☐ Medi-Cal (Plan):	☐ Private (Plan):	☐ Other (Plan):

Living Arrangement: ☐ Homeless	☐ Independent living	☐ Other (specify):

Referred by (specify):

Explanation of why patient 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
Amphetamines (Meth, Ice, Crank)	☐	☐				
Alcohol	☐	☐				
Cocaine/Crack	☐	☐				
Heroin	☐	☐				
Marijuana	☐	☐				
Opioid Pain Medications Misuse or without prescription	☐	☐				
Sedatives (Benzos, Sleeping Pills) Misuse or without prescription	☐	☐				
Hallucinogens	☐	☐				
Inhalants	☐	☐				
Over-the-Counter Medications (Cough Syrup, Diet Aids)	☐	☐				
Nicotine	☐	☐				
Other:	☐	☐				

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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.?** ☐ Yes ☐ No

   Please describe specific symptoms and consider immediate referral for medical evaluation: _____

   _____

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/ decreased, 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 Withdrawal Potential)				
0 None	1 Mild	2 Moderate	3 Severe	4 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.

Additional Comments: _____

_____

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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**:

☐ Heart Problems ☐ Seizure/Neurological ☐ Muscle/Joint Problems ☐ Diabetes

☐ High Blood Pressure ☐ Thyroid Problems ☐ Vision Problems ☐ Sleep Problems

☐ High Cholesterol ☐ Kidney Problems ☐ Hearing Problems ☐ Chronic Pain

☐ Blood Disorder ☐ Liver Problems ☐ Dental Problems ☐ Pregnant

☐ Stomach/Intestinal Problems ☐ Asthma/Lung Problems ☐ Sexually Transmitted Disease(s): _____

☐ Cancer (specify type[s]):_____ ☐ Infection(s): _____

☐ Allergies: _____ ☐ 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. **<u>Question to be answered by interviewer</u>: Does the patient 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

Patient Name: _____ **Medi-Cal ID:**_____

Treatment Agency: _____

Please circle one of the following levels of severity

Severity Rating- Dimension 2 (Biomedical Conditions and Complications)				
0	1	2	3	4
None	Mild	Moderate	Severe	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.

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			
☐ Depression/sadness	☐ Loss of Pleasure/Interest	☐ Hopelessness	☐ Irritability/Anger
☐ Impulsivity	☐ Pressured Speech	☐ Grandiosity	☐ Racing Thoughts
Anxiety			
☐ Anxiety/Excessive Worry	☐ Obsessive Thoughts	☐ Compulsive Behaviors	☐ Flashbacks
Psychosis			
☐ Paranoia	☐ Delusions: _____	☐ Hallucinations: _____	
Other			
☐ Sleep Problems	☐ Memory/Concentration	☐ Gambling	☐ Risky Sex Behaviors
☐ Suicidal Thoughts: please describe _____			
☐ Thoughts of Harming Others: please describe _____			
☐ Abuse (physical, emotional, sexual): _____			
☐ Traumatic Event(s): _____			
☐ 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: _____

_____

Patient Name: _____ **Medi-Cal ID:**_____

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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	Reason	Effectiveness/Side Effects

21. **Please list mental health provider(s):**

Provider Name	Contact Information

Please circle one of the following levels of severity

Severity Rating- Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications)				
0 None	1 Mild	2 Moderate	3 Severe	4 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?**

☐ Work	☐ Mental Health	☐ Physical Health	☐ Finances
☐ School	☐ Relationships	☐ Sexual Activity	☐ Legal Matters
☐ Handling Everyday Tasks	☐ Self-esteem	☐ Hygiene	☐ Recreational Activities
☐ 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 provider(s)

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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:**

Alcohol Problems:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Considerably	☐ Extremely
Drug Problems:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Considerably	☐ Extremely

Please describe: _____

Please circle one of the following levels of severity

Severity Rating- Dimension 4 (Readiness to Change)				
0 None	1 Mild	2 Moderate	3 Severe	4 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.

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

Please Describe: _____

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

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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 None	1 Mild	2 Moderate	3 Severe	4 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: _____

_____

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: _____

_____

Patient Name: _____ **Medi-Cal ID:**_____

Treatment Agency: _____

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 Probation/Parole Officer	Contact Information

Please circle one of the following levels of severity

Severity Rating- Dimension 6 Recovery/Living Environment				
0	1	2	3	4
None	Mild	Moderate	Severe	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
Dimension 1 Substance Use, Acute Intoxication and/or Withdrawal Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 2 Biomedical Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 4 Readiness to Change	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 5 Relapse, Continued Use, or Continued Problem Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 6 Recovery/Living Environment	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	

Patient Name: _____ **Medi-Cal ID:**_____

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Diagnosis: Diagnostic Statistical Manual, 5th Edition (DSM-5)
Criteria For Substance Use Disorder

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

	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.	☐	☐	☐
2	There is a persistent desire or unsuccessful efforts to cut down or control substance use.	☐	☐	☐
3	A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.	☐	☐	☐
4	Craving, or a strong desire or urge to use the substance.	☐	☐	☐
5	Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.	☐	☐	☐
6	Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.	☐	☐	☐
7	Important social, occupational, or recreational activities are given up or reduced because of substance use.	☐	☐	☐
8	Recurrent substance use in situations in which it is physically hazardous.	☐	☐	☐
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.	☐	☐	☐
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.	☐	☐	☐
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.	☐	☐	☐
	Total Number of Criteria			

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

_____

_____

Patient Name: _____ **Medi-Cal ID:**_____

Treatment Agency: _____

***** The presence of **<u>at least 2</u>** of these criteria indicates a **substance use disorder**.

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

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

Patient Name: _____ Medi-Cal ID:_____

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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 patient'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			
Severity / Impairment Rating		**None**	**Mild**	**Mod**	**Sev**	**None**	**Mild**	**Mod**	**Sev**	**None**	**Mild**	**Mod**	**Sev**	**None**	**Mild**	**Mod**	**Sev**	**None**	**Mild**	**Mod**	**Sev**	**None**	**Mild**	**Mod**	**Sev**
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																								
ASAM Criteria Level of Care- Other Treatment and Recovery Services																									
Severity / Impairment Rating		**None**	**Mild**	**Mod**	**Sev**	**None**	**Mild**	**Mod**	**Sev**	**None**	**Mild**	**Mod**	**Sev**	**None**	**Mild**	**Mod**	**Sev**	**None**	**Mild**	**Mod**	**Sev**	**None**	**Mild**	**Mod**	**Sev**
Early Intervention	0.5												Consider referral to mental health facility												
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																								
ASAM Criteria Level of Care- Other Treatment and Recovery Services																									
Severity / Impairment Rating		**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: _____

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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 patient'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:

☐ Not Applicable	☐ Service Not Available	☐ Provider Judgment	☐ Patient Preference
☐ Transportation	☐ Accessibility	☐ Financial	☐ Preferred to Wait
☐ Language/ Cultural Considerations	☐ Environment	☐ Mental Health	☐ Physical Health
☐ Other: _____			

Briefly Explain Discrepancy: _____

_____

Designated Treatment Location and Provider Name: _____

_____

_____

_____

Counselor/LPHA Name **Signature** **Date**

_____

***LPHA Name** **Signature** **Date**

*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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