|  |
| --- |
| **Person Served Information** |
| Person Served Name:       | ID Number:       |
| **Person Served Address:** | **Person Served Phone #:** |
| **Date of Birth:** Enter DOB | **Race/Ethnicity:** Enter Race/Ethnicity |
| **Preferred Name:** Enter Preferred Name | **Preferred Pronouns:** Choose pronouns |
| **Gender assigned at birth:** Choose gender | **Gender Identity:** Choose gender |
| **Preferred Language:** Enter Language | **Interpreter Utilized?** Choose answer |
| **Referral Source:** Provide details as to how/why person served enteredprogram |

|  |
| --- |
| **Provider Information** |
| **Program Name:** Enter Program Name | **Counselor/LPHA Name:** Enter Counselor/LPHA Name |
| **Date:** Enter Service Date | **Start Time:** Start Time | **End Time:** End Time |
| **Additional Dates and Times (if applicable):** Enter Information |
| **Total Time:** Total Minutes for Service including Documentation time |

|  |
| --- |
| **Substance Use History**(Use the + sign to the bottom right of this box for additional sections to document the history of multiple substances) |
| **Choose a substance Specify when necessary:**      **Age of First Use:**       **Number of Years Used:**       **Route of Use:**       **Date of Last Use:**      **Pattern of Use for this Substance Including Frequency/Amount/Quantity within the past 12 months:**      **DSM-5 Diagnostic Criteria: Answers to the following questions must link specifically to the substance identified above and have occurred within the past twelve (12) months. Please include dates within the detailed explanation.****1.** Have you taken the substance often and in larger amounts or over a longer period than you wanted?  [ ]  Yes [ ]  No; If yes, please explain:      **2.** Do you have an ongoing desire or unsuccessful efforts to cut down or control your substance use? [ ]  Yes [ ]  No; If yes, please explain:      **3.** Do you spend a lot of time in activities trying to get the substance, use the substance or recover from its effects? [ ]  Yes [ ]  No; If yes, please explain:      **4.** Have you experienced cravings, strong desires or urges to use the substance? [ ]  Yes [ ]  No; If yes, please explain:      **5.** Have you been unable to fulfill major responsibilities and obligations at work, school or home due to ongoing substance use? [ ]  Yes [ ]  No; If yes, please explain:      **6.** Do you continue to use the substance although it has caused ongoing social or interpersonal problems or made existing problems worse? [ ]  Yes [ ]  No; If yes, please explain:      **7.** Have you given up or reduced your participation in important social, occupational or recreational activities because of your substance use? [ ]  Yes [ ]  No; If yes, please explain:      **8.** Do you frequently find yourself using the substance in physically dangerous situations? [ ]  Yes [ ]  No; If yes, please explain:      **9.** Do you continue to use the substance even though it has caused physical or psychological problems or made existing problems worse?  [ ]  Yes [ ]  No; If yes, please explain:      **10.** Have you experienced tolerance, by either a need for increased amounts of the substance to become intoxicated or desired effect or a reduced effect when using the same amount of the substance? [ ]  Yes [ ]  No; If yes, please explain:      **11.** Have you experienced withdrawal, by either typical withdrawal symptoms from the substance or taking the substance, (or a closely related substance) to relieve or avoid withdrawal symptoms? (*Not applicable to Hallucinogen or Inhalant-Related Use Disorders*)  [ ]  Yes [ ]  No; If yes, please explain:       |

|  |
| --- |
| **Dimension 1 – Acute Intoxication and/or Withdrawal Potential** |

**1.1** Are there any intoxication symptoms you are currently experiencing from your most recent substance use?

Please explain:

**1.2** Have you ever experienced any significant issues while intoxicated from your substance use? (Overdose, Hospitalization, etc.)

Please explain:

**1.3** Are there any withdrawal symptoms you are currently experiencing form your most recent substance use?

Please explain:

**1.4** Have you ever experienced withdrawal symptoms when you stop using substances?

Please explain:

**1.5** Have you ever experienced withdrawal symptoms (e.g. seizure) that required you to seek medical attention or to be admitted into a hospital?

Please explain:

**1.6** If you have a history of experiencing withdrawal symptoms and/or craving/urges, how have you managed these in the past?

Please explain:

**1.7** How are you managing the issues discussed in this area/dimension?

Please explain:

**(Questions to be answered by Counselor/LPHA)**

**1.8** Is there evidence or suspicion of intoxication and is there a need for immediate attention?

Please explain:

**1.9** Is there evidence or suspicion of current withdrawal potential or current withdrawal and is there a need for immediate attention?

Please explain:

**1.10** Will discontinuing the use of substances (Alcohol, Barbiturates, Benzodiazepines) require the need for medical attention?

Please explain:

**Please provide any additional information that would help to support the rating of this dimension.**

Comments:

|  |
| --- |
| **Dimension 2 – Biomedical Conditions and Complications** |

**2.1** Do you have a primary care physician? [ ]  Yes [ ]  No

If yes,Physician’s name.       Date of last visit?

**2.2** Have you received a physical examination within the past twelve months?

Please explain:

**2.3** Are you experiencing any current medical issues or disabilities?

Please explain:

If so, how are you managing these medical issues or disabilities?

Please explain:

**2.4** Are you currently taking any prescribed medications for medical issues? [ ]  Yes [ ]  No;

List prescribed medications:

How effective are these medications?

**2.5** Have you recently been to urgent care, emergency room, or were you hospitalized for any medical condition?

Please explain:

**2.6** Have you had a history of memory loss and/or head injury such as a concussion? [ ]  Yes [ ]  No

If yes, when?       Did you lose consciousness? [ ]  Yes [ ]  No

**2.7** Are you currently pregnant? [ ]  Yes [ ]  No; If yes, how many weeks?       What is your due date?

a. Are you under OB/GYN care for the pregnancy (prenatal care)? [ ]  Yes [ ]  No

If yes, name of doctor?

**2.8** How are you managing the issues discussed in this area/dimension?

Please explain:

**(Questions to be answered by Counselor/LPHA)**

**2.9** What medical issues were identified on the Health Questionnaire that need to be addressed in treatment?

Please list all relevant issues:

**2.10** What medical issues have been reported that could be life-threatening or require immediate attention/referral/treatment?

Please explain:

**Please provide any additional information that would help to support the rating of this dimension.**

Comments:

|  |
| --- |
| **Dimension 3 – Emotional, Behavioral or Cognitive Conditions and Complications** |

**3.1** Are there any emotional/behavioral/cognitive issues you are currently experiencing? (Sadness, Depression, Anxiety, Hallucinations, Paranoia, Impulsivity, Hyperactivity, Problems Reading/Writing/Math, etc.)

Please explain:

If so, how are you managing these emotional/behavioral/cognitive issues?

Please explain:

**3.2** Have you ever been diagnosed with any emotional/behavioral/cognitive issues?

Please explain:

**3.3** Have you ever received treatment for any emotional/behavioral/cognitive issues?

Please explain:

**3.4** Are you currently taking any prescribed medications for emotional/behavioral/cognitive issues? [ ]  Yes [ ]  No;

Please explain, including list of prescribed medications and their effectiveness:

**3.5** Have you ever been hospitalized for emotional/behavioral/cognitive reasons?

Please explain:

**3.6** Have you ever experienced or witnessed traumatic events that have had an impact on you? (Abuse, Neglect, Interpersonal Violence,

Sexual Assault, Gang Violence, Loss of a Loved One, etc.)

Please explain:

How are you managing the impact of those traumatic events?

Please explain:

**3.7** Are you experiencing any emotional/behavioral/cognitive issues that interfere with your daily functioning? (Self-care, Work/School Attendance, etc.)

Please explain:

**3.8** Have you had any past or current thoughts of hurting yourself and or someone else?

Please explain:

If so, when was the last time you had these thoughts and how did you manage them?

Please explain:

**3.9** How are you managing the issues discussed in this area/dimension?

Please explain:

**(Questions to be answered by Counselor/LPHA)**

**3.10** What emotional/behavioral/cognitive issues were identified on the Health Questionnaire that need to be addressed in treatment?

Please list all relevant issues:

**3.11** Does it appear the person-served would benefit from further assessment for emotional/behavioral/cognitive needs?

Please explain:

**3.12** Does the person-served report any emotional/behavioral/cognitive symptoms that would be considered life-threatening or require immediate attention/referral/treatment?

Please explain:

**Please provide any additional information that would help to support the rating of this dimension.**

Comments:

|  |
| --- |
| **Dimension 4 – Readiness to Change** |

**4.1** Have you had any thoughts or considerations about changing your substance use?

Please explain:

**4.2** Are they any areas of your life that have been negatively impacted by substance use? (School, Work, Family, Finances, Legal, etc.)

Please explain:

**4.3** How willing are you to enter and engage in treatment for your:

Substance Use:

[ ]  Not at all [ ]  Slightly [ ]  Moderately [ ]  Considerably [ ]  Extremely

Please explain:

Medical Issues:       [ ]  Not Applicable

[ ]  Not at all [ ]  Slightly [ ]  Moderately [ ]  Considerably [ ]  Extremely

Please explain:

Emotional/Behavioral/Cognitive Issues:       [ ]  Not Applicable

[ ]  Not at all [ ]  Slightly [ ]  Moderately [ ]  Considerably [ ]  Extremely

Please explain:

**4.4** Are there any challenges or barriers you are experiencing that would interfere with your willingness to participate in treatment?

Please explain:

**4.5** Have you been mandated to have an assessment or receive treatment?

Please explain:

**(Question to be answered by Counselor/LPHA)**

**4.6** What stage of change/motivation level does the person-served have regarding treatment of substance use:

[ ]  Pre-Contemplation [ ]  Contemplation [ ]  Preparation [ ]  Action [ ]  Maintenance

Please explain:

**Please provide any additional information that would help to support the rating of this dimension.**

Comments:

|  |
| --- |
| **Dimension 5 – Relapse, Continued Use or Continued Problem Potential** |

**5.1** Are there any immediate risks or dangers that substance use may cause for you?

Please explain:

**5.2** How might the continued use of substances impact areas of your life? (Family, Work, School, Relationships, Daily Functioning, etc.)

Please explain:

**5.3** Are there any issues that might continue or be made worse from substance use if you do not engage in treatment?

Please explain:

**5.4** Have you ever been able to maintain sobriety from substance use by utilizing coping skills and if so, how long?

Please explain:

**5.5** Are there any coping skills you would like to learn to help prevent relapse or continued use?

Please explain:

**5.6** Have you ever received any previous treatment for substance use?

Please explain:

If so, were there any aspects of treatment that were helpful or posed challenges for you?

Please explain:

**5.7** Have you ever received Medication Assisted Treatment?

Please explain:

Are you interested in medications to be included with treatment for alcohol or opioids?

Please explain:

**5.8** How are you managing the issues discussed in this area/dimension?

Please explain:

**(Question to be answered by Counselor/LPHA)**

**5.9** Is person-served requesting or currently receiving Medication Assisted Treatment services? (If requesting, please complete referral)

Please explain:

**Please provide any additional information that would help to support the rating of this dimension.**

Comments:

|  |
| --- |
| **Dimension 6 – Recovery Environment** |

**6.1** What are your current living arrangements? [ ]  Homeless [ ]  No stable arrangements [ ]  Stable housing

 Please explain:

**6.2** Does your current living arrangement include interactions with others that are actively using substances?

Please explain:

**6.3** What is your family’s history? (Substance Use, Relationship Dynamics, Mental Health, etc.)

 Please explain:

**6.4** Are there any supportive relationships you have that might assist you during your treatment?

Please explain:

**6.5** Are there any responsibilities you have that might impact your treatment? (Caring for children or others)

Please explain:

**6.6** Have you ever been or are you currently involved with Child Protective Services?

Please explain:

**6.7** Do you have any criminal history and what is your current legal status? (Probation, Parole, or Pending Charges/Sentencing)

Please explain:

Have you ever been arrested, charged, or convicted of any sex crimes or arson?

Please explain:

**6.8** What is your educational history including highest level of education completed and any current educational/vocational goals?

 Please explain:

**6.9** What is your employment history and current employment status including training programs and military experience?

 Please explain:

**6.10** What is your current financial status and financial history? (Source of Income, Ability to Meet Basic Needs, etc.)

 Please explain:

**6.11** Are there any activities you enjoy? (Social/Recreational History)

 Please explain:

**6.12** What are some of your personal strengths, abilities and/or interests?

 Please explain:

How might your strengths, abilities and interests support you during your treatment?

 Please explain:

**6.13** Do you have any spiritual or religious preference and if so, what aspects might support you during your treatment?

 Please explain:

**6.14** Is there any culture(s) you identify with and what aspects could support you during your treatment?

 Please explain:

**6.15** Are there any other needs that we have not discussed that you want to be addressed during your treatment?

 Please explain:

**6.16** What would be your version of a happy life?

 Please explain:

**6.17** Are you currently in a relationship that could negatively impact your engagement in treatment/recovery? (Family, Significant Other, Friends, etc.)

Please explain:

**6.18** Are you currently in a situation that could negatively impact your engagement in treatment/recovery? (Work, School, Home, Legal, etc.)

Please explain:

**6.19** Do you have access to necessary resources that will be supportive during your treatment/recovery? (Transportation, Childcare, Housing, etc.)

Please explain:

**6.20** How are you managing the issues discussed in this area/dimension?

Please explain:

**Please provide any additional information that would help to support the rating of this dimension.**

Comments:

|  |
| --- |
| **Level of Care Summary** |
| **Dimension** | **Severity Rating** | **Rational for Severity Rating** |
| **Dimension 1**Acute Intoxication and/or Withdrawal Potential | Choose a Severity Rating | Enter Rationale |
| **Dimension 2**Biomedical Conditions and Complications | Choose a Severity Rating | Enter Rationale |
| **Dimension 3**Emotional, Behavioral, Cognitive Conditions and Complications | Choose a Severity Rating | Enter Rationale |
| **Dimension 4** Readiness to Change | Choose a Severity Rating | Enter Rationale |
| **Dimension 5**Relapse, Continued Use or Continued Problem Potential | Choose a Severity Rating | Enter Rationale |
| **Dimension 6** Recovery Environment | Choose a Severity Rating | Enter Rationale |

|  |
| --- |
| **Placement Summary** |
| **Initial Level(s) of Care Indicated:**Indicated Level of Care: Choose Level of Care Additional Level of Care (if applicable): Choose Level of Care  Additional Treatment Services (Recovery Residence, MAT): Please explain**Person Served Preference:** Please explain**Final Level(s) of Care Determined:**Indicated Level of Care: Choose Level of Care  Additional Level of Care (if applicable): Choose Level of Care  Additional Treatment Services (Recovery Residence, MAT): Please explain**P Please provide any additional information that would help to support the level of care placement including any**  **discrepancies or decision not to place in a level of care.** Comments:       Designated Provider/Referred to: Please explain Admission Date: Enter date If admission is delayed, please explain: Please explain |
| **Counselor/LPHA Name Printed, Title:**      | **Counselor/LPHA Signature:** | **Date:** |
| **LPHA/Medical Director Name Printed, Title:**      | **LPHA/Medical Director Signature:** | **Date:** |