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| **Person Served Information** |
| Person Served Name:        | Avatar 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 |

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| **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 |

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| **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:       |

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

**1.1** If you are submitting UA tests, how have test results been since admission into treatment?

Please provide details:

**1.2** If you had previous goals for this area/dimension, how have you been doing regarding those goals?

Please provide details:

 If the person served is not making progress, but has the capacity to do so please provide details:

**1.3** Are there any new challenges that have been identified since admission into treatment for this area/dimension?

Please provide details:

**1.4** If withdrawal symptoms were reported during your last assessment/re-assessment, have they increased or decreased?

Please provide details:

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

**1.5** Is there evidence or suspicion of intoxication (withdrawal potential) or current withdrawal?

[ ]  Yes [ ]  No; If yes, please explain:

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

Comments:

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

**2.1** Are you currently pregnant? [ ]  Yes [ ]  No [ ]  Unknown

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

If yes, name of doctor?

**2.2** If you had previous goals for this area/dimension, how have you been doing regarding those goals?

Please provide details:

 If the person-served is not making progress, but has the capacity to do so please provide details:

**2.3** Are there any new challenges that have been identified since admission into treatment for this area/dimension?

Please provide details:

**2.4** Have you completed the required physical exam and supplied a copy for review by the program’s medical director? [ ]  Yes [ ]  No

Please provide details:

**2.5** Are there any physical health needs that would warrant/prevent you from transitioning to a different level of care?

Please provide details:

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

Comments:

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

**3.1** If you had previous goals for this area/dimension, how have you been doing regarding those goals?

Please provide details:

 If the person served is not making progress, but has the capacity to do so please provide details:

**3.2** Are there any new challenges that have been identified since admission into treatment for this area/dimension?

Please provide details:

**3.3** Has there been a need to receive a mental health/psychological assessment since admission into treatment? [ ]  Yes [ ]  No

Please provide details:

**3.4** Are there any mental health/psychological needs that would warrant/prevent you from transitioning to a different level of care?

Please provide comments:

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

Comments:

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

**4.1** If you had previous goals for this area/dimension, how have you been doing regarding those goals?

Please provide details:

 If the person served is not making progress, but has the capacity to do so please provide details:

**4.2** Are there any new challenges that have been identified since admission into treatment for this area/dimension?

Please provide details:

**4.3** Are there any current complications or barriers that you feel are interfering with your treatment/recovery?

Please provide details:

**4.4** What is the current stage of change?

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

Please explain:

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

Comments:

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

**5.1** If you had previous goals for this area/dimension, how have you been doing regarding those goals?

Please provide details:

 If the person served is not making progress, but has the capacity to do so please provide details:

**5.2** Are there any new challenges that have been identified since admission into treatment for this dimension?

Please provide details:

**5.3** How likely is the possibility of relapse or continued substance use without remaining in treatment?

Please provide details:

**5.4** Describe the person served potential for relapse: Please provide details:

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

Comments:

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| **Dimension 6 – Recovery Environment** |

**6.1** If you had previous goals for this area/dimension, how have you been doing regarding those goals?

Please provide details:

 If the person served is not making progress, but has the capacity to do so please provide details:

**6.2** Are there any new challenges that have been identified since admission into treatment for this area/dimension?

Please provide details:

**6.3** Describe your housing situation and if it is/will be supportive to your treatment/recovery?

Please provide details:

 If housing situation is not supportive, is recovery residence an option?

Please provide details:

**6.4** Describe your support system and if it is/will be helpful to your treatment/recovery?

Please provide details:

 If you have a current support system, have they been involved in your treatment/recovery?

Please provide details:

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

Comments:

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| **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 |

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| **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 explainPerson 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 **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:** |