



Department of Behavioral Health

Adolescent (Age 12-17) and Young Adult (Age 18-20) ASAM Level of Care Screening

 Screener Instructions:

1. Complete the Immediate Need Profile. Complete all six dimensions, checking "yes" or "no" to these questions and obtaining from the client sufficient data to assess for immediate needs.
2. Answer all questions, leave no blanks. If something is not applicable indicate: N/A.
3. Include sufficient information to allow anyone reviewing this document to have a complete, clear picture of the client's perception of their situation. (Please limit the use of acronyms and abbreviations that are not widely known or defined.)
4. **Screener inform the client:** "I am a mandated reporter which requires me to report any suspicion of child/elder abuse or neglect to the appropriate authorities."
5. Additional instructions for completing this form can be found on the website.

Date:	
Screener:	Title:
Provider:	Location:

A. CLIENT INFORMATION

Last Name: _____ First Name: _____

Current location/address (this may be different from your home address): _____

Phone number: _____

B. IMMEDIATE NEED PROFILE**1. Acute intoxication and/or withdrawal potential**

a. Currently having severe, life-threatening, and/or similar withdrawal symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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2. Biomedical Conditions and Complications

a. Any current, severe physical health problems (e.g., bleeding from the mouth or rectum in the past 24 hours; recent unstable hypertension; recent, severe pain in chest, abdomen, head; significant problems in balance, gait, sensory, or motor abilities not related to intoxication)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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3. Emotional/ Behavioral /Cognitive Conditions and Complications

a. Imminent danger of harming self or someone else (e.g., suicidal ideation with intent, plan, and means to succeed; homicidal or violent ideation; impulses and uncertainty about ability to control impulses, with means to act on)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Unable to function in activities of daily living or care for self with imminent, dangerous consequences (e.g., unable to bathe, feed, groom, and care for self-due to psychosis, organicity, or uncontrolled intoxication with threat to imminent safety of self or others as regards death or severe injury)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

4. Readiness to Change

a. Does client appear to need alcohol or other drug treatment/recovery and/or mental health treatment, but ambivalent or feels it unnecessary (e.g., severe addiction, but client feels controlled use still okay; psychotic, but blames a conspiracy)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Client has been coerced, mandated, or required to have assessment and/or treatment by mental health court or criminal justice system, health or social services, work or school, or family or significant other?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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	DOB:	
	Chart Number:	
	Program:	

5. Relapse, Continued Use, or Continued Problem Potential

a. Is client under the influence and/or acutely psychotic, manic, suicidal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Is client likely to continue to use or have active, acute symptoms in an immediately dangerous manner, without immediate secure placement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Is client's most troubling presenting problem(s) that brings the client for assessment dangerous to self or others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

6. Recovery Environment

a. Are there any dangerous family; significant others; living, work, or school situations threatening clients' safety, immediate wellbeing, and/or sobriety (e.g., living with a drug dealer; physically abused by partner or significant other; homeless in freezing temperatures)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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KEY

"Yes" answer to questions **1, 2 and/or 3 require** that the client immediately receive medical or psychiatric care for evaluation of need for acute, inpatient care.

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

For a "yes" answer to questions **5a**, assess further for need for immediate intervention (e.g., taking keys of car away; having a relative/friend pick client up if severely intoxicated and unsafe; evaluate need for immediate psychiatric intervention).

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

Immediate Need Profile Determination

If yes was answered to questions in dimension 1, 2 and/or 3 consult with Supervisor/LPHA/Physician and refer to emergency services as necessary.

Outcome of Immediate Needs Profile:

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Adolescent (Age 12-17) and Young Adult (Age 18-20) ASAM Level of Care Screening

Date: Click here to enter a date.	Service Type: <input type="checkbox"/> Initial ASAM Triage Level of Care Screening <input type="checkbox"/> Update
Screener:	Title:
Provider:	Location:

CLIENT INFORMATION

Last Name:		First Name:		Middle Name:	
DOB:	Age:	SS#:	Race/Ethnicity:		
Phone Number:		Is it ok to leave a voice mail?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Address:					
City:		Zip Code:		County:	
Primary Language:			Preferred Language:		
Medi-Cal:	<input type="checkbox"/> Yes <input type="checkbox"/> No		Medi-Cal ID Number:		
Additional Funding Source:	<input type="checkbox"/> CFS	<input type="checkbox"/> Youth	<input type="checkbox"/> CalWORKs	<input type="checkbox"/> Post Release Community Supervision (PRCS-AB109)	<input type="checkbox"/> Block Grant
	<input type="checkbox"/> TAP	<input type="checkbox"/> Drug Court		<input type="checkbox"/> Juvenile Drug Court	<input type="checkbox"/> Perinatal
Self-Identified Gender:	<input type="checkbox"/> Male		<input type="checkbox"/> Female		Other:
Living Arrangement:	<input type="checkbox"/> Homeless		<input type="checkbox"/> Foster Care or Group Home		<input type="checkbox"/> Living w/Parent or Caregiver (other relative)
	<input type="checkbox"/> Institution				
Parent or Guardian Name:				Telephone:	
Priority Population:		<input type="checkbox"/> Pregnant		<input type="checkbox"/> Intravenous Drug Use <input type="checkbox"/> All Others	

Dimension 1: Substance Use, Acute Intoxication, Withdrawal Potential

The following questions will assist us in finding out what substance you have been abusing over the last six months:

Alcohol and/or Drug Types	Recent Use? (Past 6 Months)	Prior Use (Lifetime)	Route (IV, Smoke, Snort, Oral)	Frequency (Daily, Weekly, Monthly)	Age of First Use	Quantity Used	Duration at This Quantity	Date of Last Use
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>						
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>						
Cocaine/Crack	<input type="checkbox"/>	<input type="checkbox"/>						
Heroin	<input type="checkbox"/>	<input type="checkbox"/>						
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>						
Fentanyl	<input type="checkbox"/>	<input type="checkbox"/>						
Other Opioid Pain Medications	<input type="checkbox"/>	<input type="checkbox"/>						
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>						
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>						
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>						
Over the Counter Medications	<input type="checkbox"/>	<input type="checkbox"/>						
Nicotine	<input type="checkbox"/>	<input type="checkbox"/>						
Spice	<input type="checkbox"/>	<input type="checkbox"/>						
Bath Salts	<input type="checkbox"/>	<input type="checkbox"/>						
Kratom	<input type="checkbox"/>	<input type="checkbox"/>						
Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>						
Other:	<input type="checkbox"/>	<input type="checkbox"/>						

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1. **Screener – If opiate use is indicated, ask the client:** Have you been prescribed Narcan in the last 30 days? Yes No

If yes, briefly explain:

2. Have you ever been hospitalized due to your alcohol/drug use? Yes No

If yes, briefly explain:

3. Within the last 30 days, has your alcohol and/or drug use increased or changed the route of administration? Yes No

If yes, briefly explain:

4. Do you have a history of serious withdrawal such as seizures, or life-threatening symptoms during withdrawal? Yes No
 (Please include information on the substance(s) the client was withdrawing from and specific symptoms that occurred and the date of each occurrence)

If yes, briefly explain:

5. **Screener – Ask only clients 16 years of age and older:** Would you be interested in Medication Assisted Treatment (MAT) services? Yes No

If yes, briefly explain:

Please check the level of severity that applies:

Severity Rating – Dimension 1 - Substance Abuse, Acute Intoxication, Withdrawal Potential

0 <input type="checkbox"/> None	1 <input type="checkbox"/> Mild	2 <input type="checkbox"/> Moderate	3 <input type="checkbox"/> Severe	4 <input type="checkbox"/> Very Severe
No signs of withdrawal/intoxication present.	Mild/moderate intoxication, interferes with daily function, 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.

Narrative Justification for Risk Rating:

Dimension 2: Biomedical Conditions and Complications

1. Do you have any current physical health problems (Seizures, Allergies) or have you been hospitalized for any medical conditions in the last 12 months? Yes No

If yes, briefly explain:

2. Are you currently prescribed or taking any medications for a medical issue? Yes No

If yes, list medication:

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3. If female, are you pregnant? Yes No N/A

If yes, how many weeks/months?

4. Do you have a physical impairment that substantially limits a major life activity? (Indicate if accommodations are Yes No needed)

If yes, briefly explain:

Please check the level of severity that applies:

Severity Rating – Dimension 2 - Biomedical Conditions and Complications

0 <input type="checkbox"/> None	1 <input type="checkbox"/> Mild	2 <input type="checkbox"/> Moderate	3 <input type="checkbox"/> Severe	4 <input type="checkbox"/> Very Severe
Full functional/able to cope with discomfort or pain	Mild/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.

Narrative Justification for Risk Rating:

Note: Screener will remind client of the mandated reporting requirements and any information disclosed during the screening may result in a referral to the appropriate agency.

Dimension 3 - Emotional, Behavioral, or Cognitive Conditions and Complications

Do you have any of the following? (Please check all boxes that apply and briefly describe in the narrative.)

<input type="checkbox"/> Trouble staying focused	<input type="checkbox"/> Depression	<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Irritability	<input type="checkbox"/> Loss of interest	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Hear things others don't
<input type="checkbox"/> See things others don't			

1. Have you ever had trouble controlling your anger? Yes No

If yes, briefly explain:

2. Has anyone ever done something in front of you or hurt you, which made you feel unsafe? Yes No

If yes, who and when:

3. Have you been hospitalized for any mental health conditions? Yes No

Describe reason and dates of hospitalizations:

4. Are you currently taking any medications for a mental health condition(s)? Yes No

If yes, list medications:

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5. Have you ever attempted suicide? Yes No

If yes, when was the date of last attempt and briefly explain:

6. Do you currently have thoughts of suicide? Yes No If yes, do you have a plan? Yes No

(If yes, consult with LPHA) briefly explain:

7. Do you currently have thoughts of harming yourself (cutting) or others? Yes No If yes, do you have a plan? Yes No

(If yes, consult with LPHA) Briefly explain:

8. Do you have a history of memory loss and/or head trauma such as concussion? Yes No

If yes, briefly explain:

Please check the level of severity that applies:

Severity Rating – Dimension 3 - Emotional, Behavioral, or Cognitive Conditions and Complications				
0 <input type="checkbox"/> None	1 <input type="checkbox"/> Mild	2 <input type="checkbox"/> Moderate	3 <input type="checkbox"/> Severe	4 <input type="checkbox"/> 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).
Narrative Justification for Risk Rating:				

SCREENER – Please inform the client if medical/psychiatric clearance will be needed prior to placement into a residential program.

Type of Clearance Needed:

- Medical Clearance Medical and Psychiatric Clearance
 Psychiatric Clearance Not Needed

Dimension 4: Readiness to Change

1. How often have you missed important social, occupational, educational or recreational activities as a result of your alcohol or drug use?
 Never Sometimes Regularly All the Time

2. On a scale of 1-10 how important is it to stop drinking or using? (On a Scale of 1 to 10 - with 1 being least important and 10 being the most important):

3. Do you feel your drinking and/or substance use is affecting other areas of your family life? Yes No

Briefly explain:

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4. Have you received help for alcohol and/or drug problems in the past? Yes No

If yes, briefly explain:

5. Are you being asked to get help? (Parent, Probation, School) Yes No

If yes, briefly explain:

6. Is there anything that would prevent you from getting treatment? Yes No

If yes, briefly explain:

Please check the level of severity that applies:

Severity Rating – Dimension 4 - Readiness to Change

0 <input type="checkbox"/> None	1 <input type="checkbox"/> Mild	2 <input type="checkbox"/> Moderate	3 <input type="checkbox"/> Severe	4 <input type="checkbox"/> 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 of treatment	Not willing to change. Unwilling/unable to follow through with treatment recommendations.

Narrative Justification for Risk Rating:

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

1. On a scale of 1 – 5 what degree of cravings or urges to use alcohol and/or drugs in the past 7 days have you had?
 1 (None) 2 (Slight Urge) 3 (Moderate Urge) 4 (Considerate Urge) 5 (Extreme Urge)

2. In the past 7 days, how frequent are these cravings or urges to use alcohol and/or drugs?
 Hourly Daily Weekly None

3. Do you feel that you will continue to use substances without help or additional support? Yes No

4. What is the longest time you have gone without using alcohol and/or drugs?

Briefly explain:

5. Are there important stressors or triggers in your life that contribute to your substance use? (Check all that apply) Yes No

<input type="checkbox"/> Academic/School Issues	<input type="checkbox"/> Family Issues	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Strong Cravings
<input type="checkbox"/> Peer Pressure	<input type="checkbox"/> Relationship Problems	<input type="checkbox"/> Sexual Victimization	<input type="checkbox"/> Living Environment
<input type="checkbox"/> Physical Health Issues	<input type="checkbox"/> Bullying	<input type="checkbox"/> Financial Stressors	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Mental Health Issues	<input type="checkbox"/> Gang Involvement	<input type="checkbox"/> Weight Issues	<input type="checkbox"/> Sexual Orientation
<input type="checkbox"/> Immigration Issues	<input type="checkbox"/> Legal Issues (CFS, Probation, Court mandate, etc.)	<input type="checkbox"/> Gender Identity	<input type="checkbox"/> Other:

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Name:	
DOB:	
Chart Number:	
Program:	

Please check the level of severity that applies:

Severity Rating – Dimension 5 - Relapse, Continued Use, or Continued Problem Potential

0 <input type="checkbox"/> None	1 <input type="checkbox"/> Mild	2 <input type="checkbox"/> Moderate	3 <input type="checkbox"/> Severe	4 <input type="checkbox"/> 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.
Narrative Justification for Risk Rating:				

Dimension 6: Recovery/Living Environment

1. What is your current living situation?

- Homeless Other people's couches Living with family Living alone Living with partner/spouse Other: _____

2. Do you have relationships that are supportive of you stopping or reducing your substance use? (e.g., family, peers/friends, mentor, coach, teacher, etc.) Yes No

If yes, briefly explain:

3. Are you currently in an environment where others use substances? (e.g., family, friends/peers, significant others, roommates, neighborhood, school) Yes No

If yes, briefly explain:

4. Are you currently involved with any of the following? (Check all that apply)

- CFS Court Mandated Treatment Probation Parole CalWORKs

5. Have you ever been convicted of arson, a sexual offence or any violent crime? Yes No

If yes, briefly explain:

Screener – Notify client that they will be assigned a County Care Coordinator once they are placed in a residential facility.

Please check the level of severity that applies:

Severity Rating – Dimension 6 - Recovery/Living Environment

0 <input type="checkbox"/> None	1 <input type="checkbox"/> Mild	2 <input type="checkbox"/> Moderate	3 <input type="checkbox"/> Severe	4 <input type="checkbox"/> 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.
Narrative Justification for Risk Rating:				

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Name:	
DOB:	
Chart Number:	
Program:	

Instructions: For each dimension, indicate the least intensive level of care that is appropriate based on the client's severity/functioning and service needs.

LEVEL OF CARE DETERMINATION TOOL	Level	Dimension 1				Dimension 2				Dimension 3				Dimension 4				Dimension 5				Dimension 6											
		Substance Use, Acute Intoxication, Withdrawal Potential				Biomedical Conditions and Complications				Emotional, Behavioral, or Cognitive Conditions and Complications				Readiness to Change				Relapse, Continued Use, or Continued Problem Potential				Recovery/Living Environment											
ASAM Criteria Level of Care – Withdrawal Management																																	
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	None	Mild	Mod	Sev				
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
Clinically Managed Residential Withdrawal Management	3.2-WM			<input type="checkbox"/>	<input type="checkbox"/>																												
Medically Monitored Inpatient Withdrawal Management	3.7-WM				<input type="checkbox"/>																												
Medically Managed Intensive Inpatient Withdrawal Management	4-WM				<input type="checkbox"/>																												
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	None	Mild	Mod	Sev				
Early Intervention	0.5	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Services	1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Intensive Outpatient Treatment	2.1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Partial Hospitalization Services	2.5																																
Clinically Managed Low-Intensity Residential Services	3.1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinically Managed Population-Specific High-Intensity Residential Services	3.3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinically Managed High-Intensity Residential Services	3.5			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medically Monitored Intensive Inpatient Services	3.7				<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Medically Managed Intensive Inpatient Services	4.0				<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Opioid Treatment Program (OTP)	1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Consider referral to mental health treatment facility

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Residential Treatment Pre-Authorization (Adolescents and Young Adults)

**This form is to be used by SUDRS only to Pre-Authorize a Residential Treatment Episode.*

Priority Population: Pregnant Intravenous Drug Use All Others

LEVEL OF CARE PRE-AUTHORIZED BY THE COUNTY			
<input type="checkbox"/> Young Adult Withdrawal Management (WM) – Level 3.2	<input type="checkbox"/> Adolescent Withdrawal Management (WM) – Level 3.2 (TTC Only)		
<input type="checkbox"/> Young Adult Residential <input type="checkbox"/> 3.1 <input type="checkbox"/> 3.3 <input type="checkbox"/> 3.5	<input type="checkbox"/> Adolescent Residential (TTC Only) <input type="checkbox"/> 3.1 <input type="checkbox"/> 3.5		
<input type="checkbox"/> Young Adult Residential w/Children <input type="checkbox"/> 3.1 <input type="checkbox"/> 3.5			

PROVIDER WHERE CLIENT IS BEING REFERRED

Provider Name: Cedar House Life Change Center Inland Valley Recovery Services VARP

His House/New Creation Tarzana Treatment Centers (TTC)

Number of Residential Treatment episodes in the last 12 months? 0 1 2 More than 2

Comments:

Name: _____ Title: _____

Signature: _____ Date: _____

Telephone: _____ Fax: _____

<i>This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.</i>	Name:	
	DOB:	
	Chart Number:	
	Program:	