658 E. Brier Drive Suite 250 San Bernardino CA | Phone: 909-501-0728 • Fax: 909-501-0831
www.SBCounty.gov

SAN BERNARDINO COUNTY
Department of Behavioral Health

RESET

ADULT (21+) 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 caller 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 DBH 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?	☐ Yes	☐ No

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)*?	☐ Yes	☐ No

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)*?	☐ Yes	☐ 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 or self or others as regards death or severe injury)?*	☐ Yes	☐ 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 OK; psychotic, but blames a conspiracy)*?	☐ Yes	☐ 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?	☐ Yes	☐ No

Name:	
DOB:	
Chart #:	
Program:	

5. Relapse, Continued Use, or Continued Problem Potential		
a. Is client under the influence and/or acutely psychotic, manic, suicidal?	☐ Yes	☐ No
b. Is client likely to continue to use or have active, acute symptoms in an immediately dangerous manner, without immediate secure placement?	☐ Yes	☐ No
c. Is client's most troubling presenting problem(s) that brings the client for assessment dangerous to self or others?	☐ Yes	☐ 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)*?	☐ Yes	☐ No

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:

Name:	
DOB:	
Chart #:	
Program:	

ADULT (21+) ASAM LEVEL OF CARE SCREENING

Date:	Service Type: ☐ Initial – ASAM Level of Care Screening ☐ Update
Screener:	Title:
Provider:	Location:

Client Information			
Last Name:	First Name:	Middle Name:	
DOB: MM/DD/YYYY	Age:	SS#:	Race/Ethnicity:
Phone Number:	Is it ok to leave a voice mail? ☐ Yes ☐ No		
Address:			
City:	Zip Code:	County:	
Primary Language:	Preferred Language:		
Medi-Cal: ☐ Yes ☐ No	Medi-Cal ID Number:		
Additional Funding Source	☐ CFS ☐ CalWORKs ☐ Post Release Community Supervision (*PRCS-AB109*) ☐ Block Grant ☐ TAP ☐ Drug Court ☐ Perinatal		
Self-Identified Gender:	☐ Male ☐ Female ☐ Other:		
Living Arrangement:	☐ Homeless ☐ Independent Living ☐ Dependent Living ☐ Conservatee		
Priority Population:	☐ Pregnant ☐ Intravenous Drug Use ☐ 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	☐	☐	Choose an Item	Choose an Item				
Alcohol	☐	☐	Choose an Item	Choose an Item				
Cocaine/Crack	☐	☐	Choose an Item	Choose an Item				
Heroin	☐	☐	Choose an Item	Choose an Item				
Marijuana	☐	☐	Choose an Item	Choose an Item				
Fentanyl	☐	☐	Choose an Item	Choose an Item				
Other Opioid Pain Medications	☐	☐	Choose an Item	Choose an Item				
Sedatives	☐	☐	Choose an Item	Choose an Item				
Hallucinogens	☐	☐	Choose an Item	Choose an Item				
Inhalants	☐	☐	Choose an Item	Choose an Item				
Over the Counter Medications	☐	☐	Choose an Item	Choose an Item				
Nicotine	☐	☐	Choose an Item	Choose an Item				
Spice	☐	☐	Choose an Item	Choose an Item				
Bath Salts	☐	☐	Choose an Item	Choose an Item				
Kratom	☐	☐	Choose an Item	Choose an Item				
Benzodiazepines	☐	☐	Choose an Item	Choose an Item				
Other:								

Name:	
DOB:	
Chart #:	
Program:	

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

2. Have you ever been hospitalized due to your alcohol/drug use? ***If yes, briefly explain:*** ☐ Yes ☐ No

3. Within the last 30 days, has your alcohol and/or drug use increased or changed the route of administration? ***If yes, briefly explain:*** ☐ Yes ☐ No

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

5. Would you be interested in Medication Assisted Treatment (MAT)? ***If yes, briefly explain*:** ☐ Yes ☐ No

Please check the level of severity that applies:

Severity Rating – Dimension 1 - Substance Abuse, Acute Intoxication, Withdrawal Potential				
0 ☐ None	1 ☐ Mild	2 ☐ Moderate	3 ☐ Severe	4 ☐ 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:				

Name:	
DOB:	
Chart #:	
Program:	

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? ***If yes, list medication:*** ☐ Yes ☐ No

3. If female, are you pregnant? ***If yes, how many weeks/months?*** ☐ Yes ☐ No ☐ N/A

4. Do you have a physical impairment that substantially limits a major life activity? *(Indicate if accommodations are needed)*. ***If yes, briefly explain:*** ☐ Yes ☐ No

Please check the level of severity that applies:

Severity Rating – Dimension 2 - Biomedical Conditions and Complications				
0 ☐ None	1 ☐ Mild	2 ☐ Moderate	3 ☐ Severe	4 ☐ 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:				

Name:	
DOB:	
Chart #:	
Program:	

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

1. Do you ever hear or see things that others do not? ☐ Yes ☐ No

   If yes, do they occur mostly when using or withdrawing from alcohol and/or other drugs? ☐ Yes ☐ No

If yes, briefly explain:

2. Have you been hospitalized for any mental health conditions? *(Describe reason and dates of hospitalization).* ***If yes, briefly explain:*** ☐ Yes ☐ No

3. Are you currently taking any medications for a mental health condition(s)? ***If yes, list medications:*** ☐ Yes ☐ No

4. Have you ever attempted suicide? ***If yes, when was the date of last attempt and briefly explain:*** ☐ Yes ☐ No

5. 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:

Name:	
DOB:	
Chart #:	
Program:	

6. 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) please explain:

7. Do you have a history of memory loss and/or head trauma such as concussion? *(If the client has a cognitive or mental health condition that requires a slower pace and residential level of care indicated, consider referral to level 3.3 residential care)* ☐ Yes ☐ No

Please check the level of severity that applies:

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).
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):*

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	DOB:	
	Chart #:	
	Program:	

3. Do you feel your drinking and/or substance use is affecting other areas of your family life? ***If yes, briefly explain:*** ☐ Yes ☐ No

4. Have you received help for alcohol and/or drug problems in the past? ***If yes, briefly explain:*** ☐ Yes ☐ No

5. Is there anything that would prevent you from getting treatment? ***Briefly explain:*** ☐ Yes ☐ No

Please check the level of severity that applies:

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 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 30 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

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	DOB:	
	Chart #:	
	Program:	

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

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

Please check the level of severity that applies:

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.
Narrative justification for risk rating:				

Dimension 6: Recovery/Living Environment

1. What is your current living situation? *(e.g. homeless. other people's couches, living with family/alone, with a partner)*

☐ Homeless ☐ Other people's couches ☐ Living with family ☐ Living alone ☐ Living with partner or spouse

☐ Other: _____

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	DOB:	
	Chart #:	
	Program:	

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.)*. ***If yes, briefly explain:*** ☐ Yes ☐ No

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

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 offense or any violent crime? ***(If yes, please explain)*** Yes ☐ No ☐

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 ☐ None	1 ☐ Mild	2 ☐ Moderate	3 ☐ Severe	4 ☐ 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:				

Screener Name: Title:

Signature: Date:

Telephone: Fax:

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	DOB:	
	Chart #:	
	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: Substance Use, Acute Intoxication, Withdrawal Potential				Dimension 2: Biomedical Conditions and Complications				Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications				Dimension 4: Readiness to Change				Dimension 5: Relapse, Continued Use, or Continued Problem Potential				Dimension 6: Recovery/Living Environment			
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
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				☐																				
Criteria Level of Care - Other Treatment and Recovery Services																									
Severity/Impairment Rating		None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Consider referral to mental health treatment facility	None	Mild	Mod	Sev	None	Mild	Mod	Sev	None	Mild	Mod	Sev
Early Intervention	0.5	☐	☐			☐	☐			☐	☐			☐	☐			☐	☐			☐	☐		
Outpatient Services	1	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐	
Intensive Outpatient Treatment	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	4.0				☐			☐	☐			☐				☐	☐			☐	☐				☐
Opioid Treatment Program (OTP)	1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Name:	
DOB:	
Chart #:	
Program:	

Residential Treatment Pre-Authorization

**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

☐ Adult Withdrawal Management (WM) – Level 3.2

☐ Adult Residential ☐ 3.1 ☐ 3.3 ☐ 3.5

☐ Adult Residential w/Children ☐ 3.1 ☐ 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

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

Comments:

Name: Title:

Signature: Date:

Telephone: Fax:

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	DOB:	
	Chart #:	
	Program:	