

SASD Adult Integrated Placement Assessment
(Electronic Version)

DIMENSION 1. ACUTE INTOXICATION AND / OR WITHDRAWAL POTENTIAL

Do you have a history of withdrawal symptoms when you haven't been able to obtain alcohol and/or other drugs (AOD), cut down on your use, or stopped using? Yes No If yes, explain below:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Agitated (fidget, pace, etc.) | <input type="checkbox"/> Fever | <input type="checkbox"/> Move and talk slower than usual | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hand Tremors | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Sweating or heart racing |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Vivid, unpleasant dreams |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Insomnia or Hypersomnia | <input type="checkbox"/> Runny nose / watery eyes | <input type="checkbox"/> Yawning |
| <input type="checkbox"/> Feeling sad, tense, or angry | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> See, feel, or hear things that aren't there | |

Are you currently experiencing any of the above? Yes No

If yes, explain: _____

Have any of these symptoms kept you from doing social, family, job or other activities? Yes No

If yes, explain: _____

Have you used AOD to stop or avoid having these symptoms? Yes No

If yes, explain: _____

Are the symptoms due to a medical condition or some other problem? Yes No

If yes, explain: _____

Substance Use Background Please use the following codes on the tables below:

Route of Administration:

1- Oral 2 - Smoking 3 - Inhalation 4 - Injection-IV 5 - Injection-Intramuscular 6 - Other (Specify) _____

Frequency of Use:

1 - No use in the past month 2 - 1-3 times in the past month 3 - 1-2 times in the past week
4 - 3-6 times in the past week 5 - Daily 6 - Other

Class of Substance	Specific Substance	Route of Admin.	Age First Used	Last Use	How Long Used	Amount of Use	Frequency of Use	Periods of Abstinence	Rank Substance in order of use
None									
Alcohol	Beer	1	37	5mo ago	8 yrs	A case	1	5 mos	1
Cocaine/Crack	Cocaine	3	43	8mo ago	2 yrs	Unk	1	8 mos	2
Marijuana									
Heroin									
Non-Prescription Methadone									
Other Opiates and Synthetics									
PCP									
Other Hallucinogens									
Methamphetamine									
Other Amphetamines									
Other Stimulants									
Benzodiazepines									
Other Nonbenzodiazepine tranquilizers									
Barbiturates									
Other non-barbiturate sedatives or hypnotics									
Inhalants									
Over-the-counter									
Other									
Unknown									

COMMENTS: _____

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DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS

Do you have / have you had any medical problems, including infectious communicable diseases? Yes No

If yes, explain: _____

Do you have any known allergies? Yes No If yes, explain: _____

Does your chemical use affect your medical conditions in any way? Yes No

If yes, explain: _____

List any medications you currently take, have taken, or should take including over the counter medications:

Medication	Prescribed For	Dosage	Frequency	Taking as Prescribed	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No

COMMENTS: _____

Have you ever been hospitalized? Yes No If yes, describe below:

Date	Facility	Length of Stay	Treated For

COMMENTS: _____

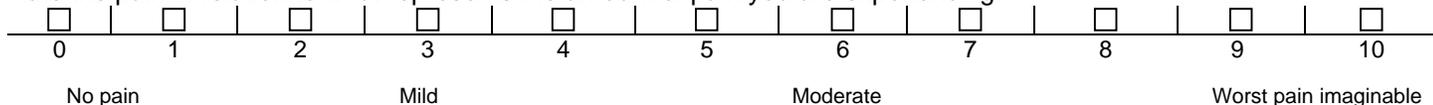
Are you pregnant? Yes No N/A If yes, how many weeks? _____

Are you receiving prenatal care? Yes No N/A # of Pregnancies _____

Pain Assessment Scale

Do you have pain now? Yes No If yes, where? _____

Rate the pain in relation to what represents the amount of pain you are experiencing:



Is this pain related to withdrawal? Yes No NA

If yes, explain: _____

How long have you been in pain? NA What makes the pain better or worse? NA

What medications do you take to relieve the pain? NA

Have you had this same pain in the recent past? Yes No NA

If yes, explain: _____

Are you under a doctor's care for this pain? Yes No NA

If yes, explain: _____

TB Checklist Have you had TB or tested positive for TB in the past? Yes No If yes, explain below:

For more than **two weeks** do you.... (consider possible withdrawal symptoms)

Have sputum-producing cough? Yes No Have night sweats? Yes No

Cough up blood Yes No Have a fever Yes No

Have loss of appetite Yes No Receive a TB medication Yes No

COMMENTS: _____

DIMENSION 3. EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

As a child, were there any serious physical injuries or mental illnesses causing trauma? Yes No

If yes explain: _____

Have you ever been diagnosed with a mental/emotional disorder? Yes No

If yes, explain: _____

Have you ever been treated for mental/emotional disorders? Yes No If yes, explain below:

When	Where	Level of Care	Length of Tx	Treated For

COMMENTS: _____

Have you ever been the victim of abuse? Yes No

If yes: Sexual Domestic Violence Neglect
 Physical Emotional

When and by whom? Childhood by my father

Did you receive intervention? Yes No

If yes, explain: Counseling

Further assessment needed? Yes No

If yes, explain: _____

COMMENTS: _____

Have you ever been the perpetrator of abuse? Yes No

If yes: Sexual Domestic Violence Neglect
 Physical Emotional

When and to whom? _____

Did you receive intervention? Yes No

If yes, explain: _____

Further assessment needed? Yes No

If yes, explain: _____

COMMENTS: _____

In the last year, have you felt like hurting or killing yourself? (suicidal ideation) Yes No

If yes, explain: _____

In the last year, have you felt like hurting or killing someone else? (homicidal ideation) Yes No

If yes, explain: _____

In the last year, have you experienced hallucinations or difficulty telling what is real from that which is not? (auditory, visual, olfactory, tactile) Yes No

If yes, explain: _____

In the last year, have you had trouble remembering, concentrating or following simple instructions? Yes No

If yes, explain: _____

COMMENTS: _____

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Mental Status Examination

While prompts are provided below, the assessor should make sure to describe his/her observations and impressions of the person for each grouping below.

ORIENTATION						
<i>(capacity to identify and recall one's identity and place in time and space; ask directed questions)</i>						
Orientation:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Deficits:	<input type="checkbox"/> Person	<input type="checkbox"/> Place	<input type="checkbox"/> Time	<input type="checkbox"/> Situation

COMMENTS: _____

GENERAL APPEARANCE

(Include general observations about the person's appearance and expression)

Dress:	<input checked="" type="checkbox"/> Appropriate	<input type="checkbox"/> Meticulous	<input type="checkbox"/> Eccentric	<input type="checkbox"/> Seductive	<input type="checkbox"/> Disheveled
Grooming:	<input checked="" type="checkbox"/> Appropriate	<input type="checkbox"/> Meticulous	<input type="checkbox"/> Dirty	<input type="checkbox"/> Poor	<input type="checkbox"/> Bizarre
Facial Expression:	<input type="checkbox"/> Appropriate	<input checked="" type="checkbox"/> Flat	<input type="checkbox"/> Sad	<input type="checkbox"/> Angry	<input type="checkbox"/> Fearful

COMMENTS: _____

MOOD/AFFECT

(Mood: sustained emotional state; emotional tone the client subjectively feels i.e. what the client says / Affect: outward expression of person's current feeling state, how they appear to you i.e. facial expressions, body language, laughter, use of humor, tearfulness)

Mood:	<input type="checkbox"/> Appropriate	<input checked="" type="checkbox"/> Depressed	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Anxious	<input type="checkbox"/> Irritable	<input type="checkbox"/> Euthymic (normal)
Affect:	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Hostile	<input type="checkbox"/> Blunted	<input type="checkbox"/> Labile	<input type="checkbox"/> Broad	<input checked="" type="checkbox"/> Flat

COMMENTS: _____

SELF-CONCEPT

Self-concept:	<input type="checkbox"/> Self-assured	<input type="checkbox"/> Realistic	<input checked="" type="checkbox"/> Low self-esteem	<input type="checkbox"/> Inflated self-esteem
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COMMENTS: _____

SPEECH

(comment on tone, volume and quantity)

Speech:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Pressured	<input type="checkbox"/> Stammering	<input type="checkbox"/> Mute	<input type="checkbox"/> Loud
	<input type="checkbox"/> Soft	<input type="checkbox"/> Rambling	<input type="checkbox"/> Slurred	<input type="checkbox"/> Echolalia (compulsive repetition of word)	

COMMENTS: _____

MEMORY

(could explain recent and past events in their history; recalls three words immediately after rehearsal then five minutes later; recalls your name after 30 minutes)

Immediate:	<input checked="" type="checkbox"/> Intact	<input type="checkbox"/> Mildly Impaired	<input type="checkbox"/> Moderately Impaired	<input type="checkbox"/> Severely Impaired
Recent:	<input checked="" type="checkbox"/> Intact	<input type="checkbox"/> Mildly Impaired	<input type="checkbox"/> Moderately Impaired	<input type="checkbox"/> Severely Impaired
Remote:	<input checked="" type="checkbox"/> Intact	<input type="checkbox"/> Mildly Impaired	<input type="checkbox"/> Moderately Impaired	<input type="checkbox"/> Severely Impaired

COMMENTS: _____

THOUGHT PROCESS

(the movement of thought, the dynamics of how one thought connects to the next; observe speech, some behavior; may need a few targeted questions)

Thought Process:	<input checked="" type="checkbox"/> Logical	<input type="checkbox"/> Relevant	<input type="checkbox"/> Coherent	<input type="checkbox"/> Goal Directed	<input type="checkbox"/> Illogical
	<input type="checkbox"/> Incoherent	<input type="checkbox"/> Circumstantial	<input type="checkbox"/> Rambling	<input type="checkbox"/> Flight of Ideas	
	<input type="checkbox"/> Loose Associations		<input type="checkbox"/> Tangential	<input type="checkbox"/> Grossly Disorganized	<input type="checkbox"/> Blocking
	<input type="checkbox"/> Neologisms	<input type="checkbox"/> Confused	<input type="checkbox"/> Perplexed	<input type="checkbox"/> Confabulating	

COMMENTS: _____

THOUGHT CONTENT*(A description of the topics one is thinking about)*

Thought Content:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Somatic Complaints	<input type="checkbox"/> Illogical Thinking	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Suspicious
	<input type="checkbox"/> Guilt	<input type="checkbox"/> Obsessions/Compulsions		<input type="checkbox"/> Phobias	<input type="checkbox"/> Poverty of Content
	<input type="checkbox"/> Suicidal or Homicidal Ideation		<input type="checkbox"/> Prejudices/Biases	<input type="checkbox"/> Hypochondriacal	<input type="checkbox"/> Depressive

COMMENTS: _____

JUDGMENT AND INSIGHT*(Judgment: ability to make wise decisions, especially in everyday activities and social matters; Insight: awareness of problems, what they are, and their implications)*

Judgment:	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Partial	<input type="checkbox"/> Limited	<input type="checkbox"/> Poor
Insight:	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Partial	<input type="checkbox"/> Limited	<input type="checkbox"/> Poor

COMMENTS: _____

DIMENSION 4. READINESS TO CHANGEDo you have any behaviors that you need to change? (e.g. criminal activity, fighting, cursing) Yes No

If yes, explain: _____

Do you think you have a problem with AOD and/or mental/emotional disorders? Yes No

If yes, explain: _____

Have you tried to hide your AOD use? Yes No

If yes, explain: _____

Has anyone ever complained about your AOD use? Yes No

If yes, explain: _____

Has your AOD use caused you to feel depressed, nervous, suspicious, decreased sexual desire, diminished your interest in normal activities or cause other psychological problems? Yes No

If yes, explain: _____

Has your AOD use affected your health in any way by causing numbness, blackouts, shakes, tingling, TB, STDs or other health problems? Yes No

If yes, explain: _____

Have you continued to use despite the negative consequences (at work, school, or home) of your use? Yes No

If yes, explain: _____

Have you continued to use despite placing yourself and others in dangerous or unsafe situations? Yes No

If yes, explain: _____

Have you had problems with the law because of your use? Yes No

If yes, explain: _____

Has your AOD use affected you socially (fights, problem relationships, etc.)? Yes No

If yes, explain: _____

Do you need more AOD to get the same high? Yes No

If yes, explain: _____

Do you spend a great deal of time in activities to obtain AOD and / or feeling its affects? Yes No

If yes, explain: _____

Has your AOD use caused you to give up or not participate in social, occupational or recreational activities that you once enjoyed?

 Yes No If yes, explain: _____Have you continued to use after knowing it caused or contributed to physical and psychological problems? Yes No

If yes, explain: _____

Have you used larger amounts of AOD than you intended? Yes No

If yes, explain: _____

Indicate the **URICA** score & stage of readiness:Alcohol Use: _____ Pre contemplation Contemplation Preparation (Action) MaintenanceDrug Use: _____ Pre contemplation Contemplation Preparation (Action) Maintenance

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DIMENSION 5. RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL

Have you ever been treated for an AOD problem?

Alcohol/Drug/BOTH	When	Where	Level of Care (including detox)	Type of Discharge

COMMENTS: _____

Have you had any periods of abstinence from an AOD? Yes No If yes, answer the next three questions:

1. How was that abstinence / maintenance achieved? Please explain: Fear of losing job

2. What would you consider your relapse triggers? Please explain: Don't know

3. Are you aware of what caused you to relapse? Please explain: No

Are you participating in any support groups? (AA, NA, church, other) Yes No Do you have a sponsor? Yes No
 If yes, how often? _____

Have you ever participated in: AA NA Support Group Had a Sponsor No

In the past year, have you tried to reduce the effect of your AOD/problems? Yes No

If yes, explain: _____

Have you had any periods without mental/emotional problems? Yes No If yes, answer the next 2 questions:

1. How was maintenance achieved? _____

2. What causes the symptoms to get worse? _____

DIMENSION 6. RECOVERY / LIVING ENVIRONMENT

Head of Household? Yes No Number in Household: 1

Living Arrangement: 25 years _____ months

- Alabama Housing Finance Authority
- Center Operated / Contracted Residential Program
- Center Subsidized Housing
- Homeless / Shelter
- Independent Living
- Jail / Correctional Facility
- Reside with Family
- Other Institutional Setting (nursing home, etc.)
- Other: _____

Current Employment Status:

- Confined to Institution/Correctional Facility
- Disabled
- Full-time
- Homemaker
- Part-time
- Retired
- Student
- Supported Employment
- Unemployed, looking
- Unemployed, not looking for 30 days

Employment History:

Employer	Position	Dates Employed	Reason for Leaving
Tru Green	Groundskeeping	1992 - present	N/A

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Education

Are you currently in school, enrolled in a GED program, or a vocational program? Yes No

If yes, explain: _____

Number of years completed in school: _____

Detailed Legal Status

None State /Federal Court Formal Adjudication Probation/Parole (Name): _____

Diversionary Program Prison Court Referral Other: _____

Current Charges: _____

of Arrests in 30 days Prior to Admission: _____

Table with columns: Arrest History, # of Arrests, Convicted: Yes/No, # of Arrests, Convicted: Yes/No. Rows include Assault, Auto Theft, Burglary, Robbery, Criminal Trespass, Distribution, DUI, Harassment, Minor in Possession, Possession, Other, Public Intoxication, Rape, Receiving Stolen Property, Fraudulent use of a credit card, Shoplifting, Theft of Property, Violation of Probation, Domestic Violence, Child / Elder Abuse, Negotiating a Worthless Negotiable Instrument (NWNi).

Explanation of the above to include outcome: _____

Family

Do you have dependent children? Yes No If yes, how many? _____ Ages: _____

If yes, please answer the next 4 questions:

Who has custody of these children? _____

Is there childcare available for these children? Yes No If yes, explain: _____

Are you required to pay child support? Yes No If yes, are you current in your child support? Yes No

Do you feel you have adequate parenting skills? Yes No If yes, explain: _____

Would you be interested in receiving more parenting skills? Yes No If yes, explain: _____

Quality of interaction with family: Excellent Good Fair Poor

Level of satisfaction with support system: Excellent Good Fair Poor

Describe your relationship with your:

Mother: Deceased

Father: Deceased

Siblings: None

Others: None

Children: None

Is your current living environment drug free? Yes No

If no, explain: Live by myself

Who would you ask to take you to the hospital if you were to suddenly become ill? my boyfriend

Would you call the same person to tell some really good news? Yes No If not, why and who would you call?

Do you have reliable transportation? Yes No Explain: Own a car

Do you have a valid driver's license? Yes No

ASAM PPC-2R Diagnostic Summary (summarize each dimension as assessed):

Risk Rating: 0 = Indicates full functioning; no severity; no risk in this Dimension. Risk Rating: 1-4 = Indicates various levels of functioning and severity and the level of risk in this Dimension. A: No Immediate Action Required and B: Immediate Action Required. Risk rating of 2 or higher is required for MH Dimensions 4, 5, & 6. (NOTE: A higher number indicates a greater level of severity) Source: ASAM PPC-2R, pgs 281-312

Dimension 1: Acute Intoxication and / or withdrawal potential:

Risk Rating: 0 1 2 3 4

Dimension 2: Biomedical conditions and complications:

Risk Rating: 0 1 2 3 4

Dimension 3: Emotional / Behavioral / Cognitive Conditions and Complications:

Risk Rating: 0 1 2 3 4

Dimension 4: Readiness to Change:

SA Risk Rating: 0 1 2 3 4

MH Risk Rating: 0 1 2 3 4 A B

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

SA Risk Rating: 0 1 2 3 4

MH Risk Rating: 0 1 2 3 4 A B

Dimension 6: Recovery / Living Environment:

SA Risk Rating: 0 1 2 3 4

MH Risk Rating: 0 1 2 3 4 A B

DSM-IV Diagnostic Impression and/or Diagnosis

	Code:	Description:
Axis I		
Primary	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Secondary	<input type="text"/>	<input type="text"/>
Axis II		
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Axis III	<input type="text"/>	

Axis IV

- | | | |
|---|--|--|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 4 Occupational Problems | <input type="checkbox"/> 7 Problems with access to health care services |
| <input type="checkbox"/> 1 Problems with primary support group | <input type="checkbox"/> 5 Housing Problems | <input type="checkbox"/> 8 Problems related to interaction with legal system / crime |
| <input type="checkbox"/> 2 Problems related to social environment | <input type="checkbox"/> 6 Economic Problems | <input type="checkbox"/> 9 Other psychological and environmental problems |
| <input type="checkbox"/> 3 Educational Problems | | |

Axis V Current GAF:

LEVEL OF CARE PLACEMENT SUMMARY

Assessed	Placed	Level of Care:
<input type="checkbox"/>	<input type="checkbox"/>	Level 0.5 - Early Intervention Services
<input type="checkbox"/>	<input type="checkbox"/>	Level I – Outpatient Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Level I-D - Ambulatory Detoxification without Extended On-Site Monitoring
<input type="checkbox"/>	<input type="checkbox"/>	Level I-O - Opioid Maintenance Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Level II.1 – Intensive Outpatient Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Level II.5 – Partial Hospitalization
<input type="checkbox"/>	<input type="checkbox"/>	Level II-D - Ambulatory Detoxification with Extended On-Site Monitoring
<input type="checkbox"/>	<input type="checkbox"/>	Level III.0I – Transitional Residential Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Level III.I – Clinically Managed Low Intensity Residential Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Level III.3 - Clinically Managed Medium Intensity Residential Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Level III.5 - Clinically Managed High Intensity Residential Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Level III.7 – Medically Monitored High Intensity Inpatient Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Level III.7-D – Medically Monitored Inpatient Detoxification

Reason for Difference:

- | | | |
|---|--|--|
| <input type="checkbox"/> N/A No Difference | <input type="checkbox"/> Service not available | <input type="checkbox"/> Other: <input type="text"/> |
| <input type="checkbox"/> Clinician/Supervisor override | <input type="checkbox"/> Consumer preference | |
| <input type="checkbox"/> Transportation or Logistical problem | <input type="checkbox"/> Client refused services | |

ASAIS ID: 01234	Last Name: Unknown	First Name: Cindy	MI: _____
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Disposition:

- Admitted to _____ for assessed level of care
- Admitted to _____ for interim level of care
- Referred to _____ for assessed level of care
- Referred to _____ for interim level of care

Medical provider review of LOC Assessment:

- Agree with the diagnostic impression
- Agree with the level of care determination
- Agree with the recommended admission to level of care
- Agree with the preliminary treatment plan
- Treatment authorization _____ Number of days / hours approved
- Recommended additional services _____
- Need additional information _____

Release of Information: An appropriate release for this information is on file for this client

Client Signature

Date

Staff Signatures and Credentials

Date

Staff Signatures and Credentials

Date

Physician Signature

Date