ASAM Criteria® Treatment Plan Form

PATIENT INFORMATION	
Patient's name:	Primary counselor's name:
Level of care: Choose Item	
Initial Treatment Plan Date:_____	Updated treatment plan date:_____
Recent physical exam: ☐ Yes ☐ No	Date of physical exam (or date scheduled): _____

DIAGNOSES	

AREAS OF FOCUS	
Dimensional Drivers	
Subdimension	Describe the patient's risks in this subdimension

Patient Priorities
Priority 1:
Priority 2:
Priority 3:

Transition Barriers
Describe any barriers to transition to a less intensive level of care (eg, housing, transportation, childcare)

PROBLEM 1		
Problem Statement:		
Goal:		
Dimension(s)/Subdimension(s): 1. 2. 3.	Current Risk Rating(s): 1. 2. 3.	Dimensional Driver: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Objectives and Action Steps	
Objectives	Action Steps
1.	a. b. c.
2.	a. b. c.
3.	a. b. c.
4.	a. b. c.
Patient strengths and abilities to support this goal (consider the patient's personal, social, and community recovery capital):	
Target date:	Completion date:
Progress towards goal and objectives:	
Stage of change for this problem:	

PROBLEM 2		
Problem Statement:		
Goal:		
Dimension(s)/Subdimension(s): 1. 2. 3.	Current Risk Rating(s): 1. 2. 3.	Dimensional Driver: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Objectives and Action Steps	
Objectives	Action Steps
1.	a. b. c.
2.	a. b. c.
3.	a. b. c.
4.	a. b. c.
Patient strengths and abilities to support this goal (consider the patient's personal, social, and community recovery capital):	
Target date:	Completion date:
Progress towards goal and objectives:	
Stage of change for this problem:	

PROBLEM 3		
Problem Statement:		
Goal:		
Dimension(s)/Subdimension(s): 1. 2. 3.	Current Risk Rating(s): 1. 2. 3.	Dimensional Driver: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Objectives and Action Steps	
Objectives	Action Steps
1.	a. b. c.
2.	a. b. c.
3.	a. b. c.
4.	a. b. c.
Patient strengths and abilities to support this goal (consider the patient's personal, social, and community recovery capital):	
Target date:	Completion date:
Progress towards goal and objectives:	
Stage of change for this problem:	

PROBLEM 4		
Problem Statement:		
Goal:		
Dimension(s)/Subdimension(s): 1. 2. 3.	Current Risk Rating(s): 1. 2. 3.	Dimensional Driver: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Objectives and Action Steps	
Objectives	Action Steps
1.	a. b. c.
2.	a. b. c.
3.	a. b. c.
4.	a. b. c.
Patient strengths and abilities to support this goal (consider the patient's personal, social, and community recovery capital):	
Target date:	Completion date:
Progress towards goal and objectives:	
Stage of change for this problem:	

SUMMARY OF SERVICES

Are accommodations needed to enable the patient to participate in treatment? ☐ Yes ☐ No
If so, what accommodations will be provided:

☐ **Individual counseling** _____x per week

☐ **Group counseling** _____x per week

☐ **Medication management**
- Last appointment:
- Next appointment:

☐ **Case management** _____x per week

☐ **Medical services** (note appointment dates):
- Physical exam: _____
- Primary care appointment: _____
- Specialist appointment (specify): _____
- Prenatal/postnatal: _____
- Dental: _____
- Other (specify): _____

☐ **Mental health services**
- Group counseling _____x per week
- Individual counseling _____x per week
- Psychiatric assessment (date):_____
- Cognitive assessment (date):_____
- Other:_____

☐ **Crisis intervention**
- Date of last crisis intervention:_____

☐ **Drug testing/Breathalyzer**
- Date of last test: _____
- Anticipated frequency of testing:_____
- Clinical purpose of drug testing: _____

☐ **Recovery support services:**
- ☐ Peer support services ____x per week
- ☐ Mutual support group ____x per week
- ☐ Patient navigation: _____
- ☐ Social service navigation:
  - ☐ Housing services
  - ☐ Transportation support
  - ☐ Supplemental nutrition benefits
  - ☐ Health insurance
  - ☐ Intimate partner violence services
  - ☐ Legal services
  - ☐ Child protective services
- ☐ Educational services:
  - ☐ Parenting
  - ☐ Financial management
  - ☐ Self-care
  - ☐ Other (specify):_____

☐ **Harm reduction services:**
- ☐ Overdose reversal training
- ☐ Naloxone
- ☐ Safer use education
- ☐ Safer sex education
- ☐ Referral to harm reduction organization
- ☐ Other (specify): _____

Care coordination needs: Identify the responsible staff member, the external provider they will coordinate with, and the services provided (eg, psychiatric services, HIV care).

TRANSITION PLAN
Anticipated next level of care: Choose Item
Anticipated medication-related needs:
Anticipated need for mental health services:
Anticipated medical support needs (eg, mobility assistance, dialysis, wound care):
Recovery support service needs:
Harm reduction service needs:
Referral needs:
Services needed to prepare for transition (eg, housing, transportation):

SAFETY PLAN (IF APPLICABLE)
I am at risk for (eg, return to use, risky behavior, self-harm):
I will reach out for support if I see these signs that I am at risk:
I will use the following strategies to prevent risks to my safety and/or recovery:
If I see signs that I am at risk, I will reach out someone on this list who I trust to support me:
I will call 911 if:
I will call 988 if:

SIGNATURES	
Patient signature:	Date:
Parent or guardian signature (if applicable):	Date:
If patient is unable to sign the treatment plan, please explain:	
Clinician signature/credentials:	Date:
Clinical supervisor signature (if applicable):	Date: