ASAM Criteria® Treatment Plan Form

PATIENT INFORMATION

Patients Name: ________________	Primary counselor's name: ________________
Level of Care: ________________	
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)

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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):	Current risk rating(s):	Dimensional Driver:
1. ______	1. ______	Yes No
2. ______	2. ______	Yes No
3. ______	3. ______	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):	Current risk rating(s):	Dimensional Driver:
1. ______	1. ______	Yes No
2. ______	2. ______	Yes No
3. ______	3. ______	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):	Current risk rating(s):	Dimensional Driver:
1. ______________________	1. ______________________	Yes No
2. ______________________	2. ______________________	Yes No
3. ______________________	3. ______________________	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:
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):

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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: