



# The ASAM Criteria<sup>®</sup>, Fourth Edition

## Level of Care Assessment Guide

### Adults

## Assessment Form

Patient Name:

Interviewer Name:


Date of Assessment:

Interviewer Credentials (eg, LCSW, MD, NP):

- Clinical/mental health** (eg, SUD or mental health counselor, social worker, psychologist) – complete medical questions to the best of your ability following physician-approved protocols. If there is any concern for emergent medical needs, transfer to emergency department.
- Medical/physical health** (eg, nurse, physician, advanced practice provider) – seek behavioral health consultation as needed.

### Mode of Interview:

- In person**    **Telehealth** – both audio and video    **Telehealth** – audio only (ie, telephone)


 Thank you for speaking with me today. I'd like to ask you some questions to get a sense of what kind of care you need. My purpose today is to help and support you. Everything we talk about is confidential EXCEPT [list limits to confidentiality]. I'll do my best to make this a safe and comfortable space for us, but some of these questions may get personal and make you uncomfortable. You can decline to answer any question at any time. Do you have any questions for me? Would it be all right with you if we proceed?

### Vital Signs




Unable to measure


Blood Pressure: \_\_\_\_ Heart Rate (bpm): \_\_\_\_ Temperature (°F): \_\_\_\_ Respiratory Rate (rpm): \_\_\_\_ Pulse Oximetry (%): \_\_\_\_

Comments:

 1. What brings you in today? [probes: What is leading you to seek help at this time? Who referred you to treatment?]

## Screen for Acute Medical Needs

	2. Do you have any physical health issues that feel like an emergency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, describe:			
	3. Are you concerned that you may have withdrawal symptoms severe enough to need care in a hospital?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	4. Have you ever been treated in a hospital for withdrawal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No


	5. Interviewer Assessment: Does the patient describe or seem to have <u>physical health symptoms</u> (including withdrawal) that might need hospital care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> <li>Is the patient able to communicate clearly and coherently? Do they seem to be very confused or have severe difficulty speaking? (if patient is unable to communicate, transfer to emergency department)             <ul style="list-style-type: none"> <li>(if patient is able to communicate) Does the patient describe any symptoms of severe illness or distress needing immediate medical attention? Does the patient expect to imminently experience very severe withdrawal?</li> </ul> </li> <li>To a layperson, does the patient appear very unwell to the point where they might need emergency services?             <ul style="list-style-type: none"> <li>Is the patient struggling to breathe? Breathing very fast or very slow?</li> <li>Is the patient unable to stop vomiting? Vomiting or coughing up blood?</li> </ul> </li> <li>(If able to measure): Does the patient have very high or low blood pressure or temperature? Very fast or slow heart rate?</li> <li>(If patient is pregnant): Is there bleeding? Contractions? Fluid loss? If at least 5 months pregnant, does the patient say they have stopped feeling the baby move?</li> <li>If the patient has been using alcohol or sedatives, do they report any history of severe withdrawal (eg, seizures, DTs)?</li> </ul>			
Comments:			

→ IF YES to Q5, STOP assessment and TRANSFER to emergency department/Level 4

→ IF NO, CONTINUE

## Screen for Acute Psychiatric Care Needs

	6. Are you having any mental health symptoms right now that feel like an emergency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	7. Have you recently had any thoughts of killing or severely harming yourself or others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "yes" to Q7, ask:			
	7a. Have you been thinking about how you might do this?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	7b. [if yes] Do you intend to act on these thoughts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	7c. Have you ever acted on thoughts about hurting yourself before? [if yes] When?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "yes" to Q7a, Q7b, or Q7c, follow established clinical policies and procedures for full risk assessment.			

	<b>8. Interviewer Assessment: Does the patient seem to be at imminent risk of harm to self or others? Are there other mental health signs/symptoms that may need inpatient psychiatric care?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> <li>Does the patient express a plan with clear and imminent intent to harm themselves or others?</li> <li>Are they acting in a way that is unpredictable, aggressive, or violent?</li> <li>Are there signs that the patient is gravely disabled due to a severe mental health condition? (eg, are they so catatonic from depression or bipolar disorder, or so distracted by psychosis that they are unable to communicate coherently? Do they lack the capacity for even minimal self-care? Are they unable to keep themselves safe?)</li> </ul>			
<p>Comments:</p>			

→ IF YES to Q8, STOP assessment and TRANSFER to emergency department/Level 4 Psychiatric  
 → IF NO, CONTINUE to Substance Use

## Substance Use

 9. Which substances have you used recently? For each substance mentioned, ask the following:

- When was your last use of [substance]? [Specify number and indicate unit of time, eg, 14 hours (H) ago]
- In the past month, how often have you used [substance]? [Check box if daily or near-daily use]
- How much [substance] do you usually use per day during periods when you're actively using? [Add number, unit of measurement, and unit of time: eg, 2 bags/day; 8 drinks/day; 0.5 oz/day; 1 gram per day]
- How do you normally use [substance]? [eg, orally, smoke, snort, inject]

Substance	Last use?	Past month: Daily use?	Usual amount per day	Route of use
<input type="checkbox"/> None				
<input type="checkbox"/> Alcohol:	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
<input type="checkbox"/> Sedative-hypnotics/anxiolytics (eg, alprazolam, other benzos):	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
<input type="checkbox"/> Opioids:	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
<input type="checkbox"/> Stimulants (eg, meth, cocaine):	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
<input type="checkbox"/> Cannabis:	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
<input type="checkbox"/> Hallucinogens:	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
<input type="checkbox"/> Inhalants:	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
<input type="checkbox"/> Tobacco/Nicotine:	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
	_____ H D W M	<input type="checkbox"/>		
<input type="checkbox"/> Other/Unknown: _____	_____ H D W M	<input type="checkbox"/>		
<input type="checkbox"/> Other/Unknown: _____	_____ H D W M	<input type="checkbox"/>		

Comments:

### Availability of After-hours Monitoring



10. Is there someone reliable who could help take care of you outside of treatment hours?

[probes: If you receive medical treatment, could someone make sure you are okay overnight? If you need to attend medical appointments or remember to take medications, could someone help you do those things?]

## Dimension 1



11. Interviewer Assessment: Based on your observations (if applicable) and the patient's report of recent substance abuse use: Is the patient intoxicated, or in withdrawal, or at imminent risk for withdrawal?

Yes

No

Comments:

→ IF NO, SKIP TO Addiction Medication Needs

→ IF YES, CONTINUE to Intoxication






### Intoxication



12. Are you feeling the effects of any substances right now? If so, how concerned are you about these effects?





[probe: Do you think you might need medical treatment now for intoxication or overdose?]


## Withdrawal

	<b>13.</b> Are you experiencing withdrawal now or do you think you will soon?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(If patient is likely to experience withdrawal, ask Q14 - Q15b)			
	<b>14.</b> How uncomfortable would your withdrawal symptoms likely become without treatment?		
	<b>15.</b> Have you ever needed medical care for withdrawal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<b>15a.</b> [if yes] Where did you receive it? [eg, hospital, residential program, doctor's office]		
	<b>15b.</b> [if yes to 15] Have you ever had severe withdrawal symptoms like seizures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

[if applicable] Current CIWA-Ar score: \_\_\_\_\_ [if applicable] Current COWS score: \_\_\_\_\_

## Addiction Medication Needs

	<b>16.</b> Have you received substance use treatment before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<b>16a.</b> [if yes] Were you unable to complete treatment due to cravings or lingering withdrawal symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments:			
	<b>17.</b> Are you now taking, or have you ever taken, prescribed medication to help control substance cravings or other unwanted symptoms when you're trying to stop? [eg, buprenorphine, methodone, naltrexone, acamprosate, bupropion, etc.]	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>17a.</b> If yes, specify:			
	<b>17b.</b> [if yes to 17] How has that worked for you? [probes: How much has it helped with cravings or lingering withdrawal symptoms? Did you have any difficulty starting or adjusting the medication dose?]		

 <b>18. Interviewer Assessment: Is the patient likely to need medically managed care for intoxication, withdrawal, or addiction medication needs (eg, to initiate or titrate addiction medications)?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please provide rationale:

### Dimension 1 Risk Rating

Intoxication, Withdrawal, and Addiction Medications ( <i>The ASAM Criteria</i> , pp 212-229)	Risk Rating
<b>Intoxication and Associated Risks</b> <ul style="list-style-type: none"> <li>Consider current intoxication only</li> <li>Level 3.7 BIO is for patients who need IV fluids, IV medications, and/or advanced wound care</li> </ul>	<input type="checkbox"/> 4 = Level 4 <input type="checkbox"/> 3B = Minimum Level 3.7 BIO <input type="checkbox"/> 3A = Minimum Level 3.7 (non-BIO) <input type="checkbox"/> 2 = Minimum Level 2.7 <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No Specific Needs
<b>Withdrawal and Associated Risks</b> <ul style="list-style-type: none"> <li>Consider anticipated peak severity of current withdrawal episode based on recent use and history of prior withdrawal episodes</li> <li>Level 3.7 BIO is for patients who need IV fluids, IV medications, and/or advanced wound care</li> </ul>	<input type="checkbox"/> 4 = Level 4 <input type="checkbox"/> 3B = Minimum Level 3.7 BIO <input type="checkbox"/> 3A = Minimum Level 3.7 (non-BIO) <input type="checkbox"/> 2 = Minimum Level 2.7 <input type="checkbox"/> 1 = Minimum Level 1.7 <input type="checkbox"/> EVAL = Prompt Evaluation <input type="checkbox"/> 0 = No Specific Needs
<b>Addiction Medication Needs</b> <ul style="list-style-type: none"> <li>Consider the need to initiate or titrate addiction medications (eg, buprenorphine or methadone for opioid use disorder; acamprosate or naltrexone for alcohol use disorder) and the anticipated complexity of medication management.</li> <li>For patients who are currently taking medication for OUD, "MOUD-C" is intended to flag the need to identify a program that will support medication continuation.</li> </ul>	<input type="checkbox"/> C = Minimum Level 3.7 <input type="checkbox"/> B = Minimum Level 2.7 <input type="checkbox"/> A = Minimum Level 1.7 <input type="checkbox"/> EVAL = Prompt Evaluation <input type="checkbox"/> ANY = Any Level of Care  <input type="checkbox"/> MOUD-C = MOUD Continuation*

\*MOUD-C can be selected alone or in addition to another risk rating. If the patient needs to continue MOUD and also initiate/titrate medications for another substance use disorder, the assessor can select both MOUD and an appropriate risk rating for the patient's other addiction medication needs.



## Dimension 2

	<b>19. Do you have any other health issues that are concerning you right now?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<b>19a. [if yes] What are they?</b>			
	<b>20. [if applicable] Are you pregnant?</b> [If unsure, offer pregnancy test as appropriate]	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Comments:</b>				




→ IF NO SIGNIFICANT HEALTH PROBLEMS or CURRENT PREGNANCY, SKIP to Dimension 3

→ IF PREGNANT, CONTINUE to Q20a

→ IF NOT PREGNANT, but has other health concerns, SKIP to Q21

	<b>20a. Are you receiving prenatal care from a doctor?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<b>20b. Do you have, or have you ever had, pregnancy complications like high blood pressure, gestational diabetes, pre-eclampsia, placental problems, premature labor, or others?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>If yes, describe complications:</b>			
<b>Comments:</b>			

→ IF PREGNANT but no other health concerns, SKIP to Q25. Otherwise, CONTINUE

	<b>21. How concerned are you about [your current health issue(s)]?</b>	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat	<input type="checkbox"/> Very
	<b>22. How much [do/does] [your current health issue(s)] affect your ability to take care of yourself (eg, hygiene, grooming, dressing, eating, housework, living independently, etc.), if at all?</b>	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat	<input type="checkbox"/> A lot
	<b>23. How much do you think [your current health issue(s)] might affect your ability to participate in addiction treatment, if at all?</b>	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat	<input type="checkbox"/> A lot
<b>Comments:</b>				





24. Are you seeing a medical professional now for [these health issues]? [If there is any doubt, confirm via collateral sources/medical records if available.]

Yes

No



24a. [if taking medication - optional] Which medications are you taking for physical health issues? Are you able to take them as directed (for example, not miss doses, remember to take them on time)?

Medication	Dose (if known)	Frequency	Taken as directed?
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More
			<input type="checkbox"/> Yes <input type="checkbox"/> Less <input type="checkbox"/> More



24b. [if yes to 24 or 24a] Do you feel like you need more or different care for [these health issues] to participate in addiction treatment?

Yes

No

Comments:

→ IF treatment is current and health issues will NOT affect SUD recovery, SKIP to Dimension 3  
 → OTHERWISE, CONTINUE



25. In the past, has it been hard to start or continue treatment [or prenatal care] for [these health issues]?

Yes

No



25a. [if yes] What has been challenging?



26. Do you feel able to attend medical appointments on your own in the community?

Yes

No



27. Interviewer Assessment: Is the patient likely to need integrated medical management to participate in addiction treatment? (ie, do you expect the patient will need medical services for co-occurring physical health/pregnancy needs to effectively participate in addiction treatment but is unable or unlikely to access concurrent care by an external medical provider?)

Yes




No


Please provide rationale:

## Dimension 2 Risk Rating

Biomedical Conditions ( <i>The ASAM Criteria</i> , pp 230-239)	Risk Rating
<b>Physical Health Concerns</b> <ul style="list-style-type: none"> <li>Level 3.7 BIO is for patients who need IV fluids, IV medications, and/or advanced wound care</li> </ul>	<input type="checkbox"/> 4 = Level 4 <input type="checkbox"/> 3B = Minimum Level 3.7 BIO <input type="checkbox"/> 3A = Minimum Level 3.7 (non-BIO) <input type="checkbox"/> 2 = Minimum Level 2.7 <input type="checkbox"/> 1 = Minimum Level 1.7 <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No Specific Needs
<b>Pregnancy-related Concerns</b> <ul style="list-style-type: none"> <li>Pregnant patients who are unable or unlikely to access prenatal care should receive a minimum of Level 1.7</li> <li>ANY means the pregnant patient is able and expected to access external prenatal care</li> </ul>	<input type="checkbox"/> 4 = Level 4 <input type="checkbox"/> 3 = Minimum Level 3.7 <input type="checkbox"/> 2 = Minimum Level 2.7 <input type="checkbox"/> 1 = Minimum Level 1.7 <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No Specific Needs




## Dimension 3






	<b>28. Do you currently have any troubling mental health symptoms?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<b>28a. [if yes] What are your current mental health symptoms?</b> [probes: Have you had any impulses to harm yourself, or symptoms that limit your ability to take care of yourself/others, or do what you need to do each day? Do you have them even when not using or withdrawing from substances?]		
	<b>28b. Do you have any mental health diagnoses? If so, which ones?</b>		
	<b>28c. Do you feel like you need to see a doctor or therapist urgently for mental health medication or talk therapy?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Comments:</b>			

 <b>29. Interviewer Assessment: (if able to assess) Do you observe any concerning mental health symptoms?</b> (Eg, is patient responding to internal stimuli, such as behaving or interacting as if someone or something unseen is present? Exhibiting signs of severe agitation or depression?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>30. Interviewer Assessment: Does the patient seem to have, or do you suspect, cognitive or memory issues that are <u>not</u> related to current intoxication or withdrawal symptoms?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Comments:</b>		

→ IF NO current mental health or cognitive concerns, SKIP to Dimension 3 Risk Ratings



→ IF the patient DOES HAVE current mental health or cognitive concerns, CONTINUE


 <b>31. Are you taking medication or getting “talk therapy” now for these symptoms?</b> <i>[Interviewer Note: If there is any doubt, confirm via collateral sources/medical records if available.]</i>	<input type="checkbox"/> Medication	<input type="checkbox"/> Therapy																																					
 <b>31a. [if current treatment] How is that going?</b>																																							
 <b>31b. [if taking medication - optional] Which medications are you taking for mental health? Are you able to take them as directed (for example, not miss doses, remember to take them on time)?</b>																																							
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	32. How concerned are you about your current mental health [or learning/memory-related] symptoms?	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat	<input type="checkbox"/> Very
	33. How much do these symptoms affect your safety (eg, impulsive behaviors; thoughts of harm to self or others)?	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat	<input type="checkbox"/> A lot
	34. How much do these symptoms affect your ability to care for yourself (eg, hygiene, grooming, dressing, eating, housework, living independently)?	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat	<input type="checkbox"/> A lot
	35. How much do these symptoms affect your daily life (eg, social life, relationships, work/school performance)?	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat	<input type="checkbox"/> A lot
	36. How much will these symptoms affect your ability to participate in addiction treatment?	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat	<input type="checkbox"/> A lot
Comments:				

→ IF treatment is current and symptoms are well controlled, SKIP to Dimension 3 Risk Ratings

→ OTHERWISE, CONTINUE

	37. In the past, has it been hard to start or adjust medication for your mental health needs? That is, have you had concerning side effects or needed frequent medical visits to adjust the dose? [if patient has not taken mental health medication, select N/A]	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No
37a. [if yes] Describe:				
	38. Do you feel able to attend mental health appointments on your own in the community?	<input type="checkbox"/> Yes		<input type="checkbox"/> No

	39. Interviewer Assessment: Is the patient likely to need integrated psychiatric medication management? (ie, do you expect the patient will need to initiate or titrate psychiatric medications, but they are unable or unlikely to access concurrent care by an external psychiatric provider?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	40. Interviewer Assessment: Is the patient likely to need integrated skilled mental health interventions for issues that cannot be managed in standard addiction treatment? (ie, do you expect the patient will need mental health services to effectively participate in SUD treatment, but they are unable or unlikely to access these services concurrently through an external provider?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please provide rationale:			

## Dimension 3 Risk Rating

Psychiatric and Cognitive Conditions ( <i>The ASAM Criteria</i> , pp 240-254)	Risk Rating
<p><b>Active Psychiatric Symptoms</b></p> <ul style="list-style-type: none"> <li>Levels 4 Psychiatric, 3.7 COE, 2.7 COE and 1.7 COE provide specialized psychiatric management and skilled mental health interventions</li> <li>Level 1.7 provides management of psychiatric medication for low acuity symptoms but does not provide skilled mental health interventions</li> <li>Levels 3.5 COE, 2.5 COE, and 1.5 COE provide skilled mental health interventions but not specialized psychiatric medication management</li> </ul>	<input type="checkbox"/> 4 = Level 4 Psychiatric <input type="checkbox"/> 3B = Minimum Level 3.7 COE <input type="checkbox"/> 3A = Minimum Level 3.5 COE <input type="checkbox"/> 2B = Minimum Level 2.7 COE <input type="checkbox"/> 2A = Minimum Level 2.5 COE <input type="checkbox"/> 1C = Minimum Level 1.7 COE <input type="checkbox"/> 1B = Minimum Level 1.7 <input type="checkbox"/> 1A = Minimum Level 1.5 COE <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No Specific Needs
<p><b>Persistent Disability</b></p> <ul style="list-style-type: none"> <li>Consider mental health or cognitive symptoms that need individualized staff attention to enable addiction treatment participation</li> </ul>	<input type="checkbox"/> 1Z = Minimum Level 1.5 COE <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No Specific Needs

→ IF patient meets criteria for LEVEL 3.7 or LEVEL 3.7 BIO in DIMENSIONS 1 and/or 2; OR IF patient meets criteria for LEVEL 3.7 COE in DIMENSION 3; assessment can END HERE, PROCEED to Level of Care Determination Rules

→ OTHERWISE, CONTINUE

## Dimension 4







**41. When you are trying to avoid [or control] use, what is most likely to trigger you to use [substances of concern]?**  
 [probes: Cravings or withdrawal symptoms? Emotions/mental health symptoms? Physical health issues like chronic pain? Substance use in living or social environments? Relationship/family stress? Financial stress? Boredom?]



**42. When something triggers you to want to use, how able are you to avoid using?**     Not at all     Somewhat     Very






**42a. What helps you avoid (or control) your use?**

 43. While working on recovery, will you have a safe daily routine that helps you avoid [or control] use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
43a. Describe:		
 44. Will you have enough support at night to help you avoid [or control your] use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
 44a. How about during the day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
 44b. Can you identify a healthy support system? If so, how often are they available?		

 45. Have you found yourself in risky situations, or engaging in risky behaviors, while using or trying to get substances? If so, which ones?

<input type="checkbox"/> Problem gambling	<input type="checkbox"/> Driving while intoxicated	<input type="checkbox"/> Sharing needles	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Risky sexual behavior (eg, unprotected sex, sex work)	<input type="checkbox"/> Illegal activities (eg, theft, B&E, drug sales)	<input type="checkbox"/> Perpetrating assault/violence	<input type="checkbox"/> Other: _____ _____
Comments:			

 46. Without treatment how soon do you think you would use [or continue using] [substances of concern]? Within...	<input type="checkbox"/> Hours	<input type="checkbox"/> Days	<input type="checkbox"/> Weeks	<input type="checkbox"/> Months or Years
 46a. [if risky SUD-related behaviors were endorsed] Without treatment, how soon do you think you would resume [risky behaviors]? Within...	<input type="checkbox"/> Hours	<input type="checkbox"/> Days	<input type="checkbox"/> Weeks	<input type="checkbox"/> Months or Years
 47. If you continued using/engaging in risky behaviors, what negative things would be likely to happen in the short term (within hours to days)? [probes: What has happened in the past? For example: has your substance use caused harm to you or others? Has it led to jail or prison time? If so, is your current pattern of use/behaviors similar to that time? Are there other negative consequences that haven't happened yet but could? How would that affect you?]				



48. Interviewer Assessment: Without appropriate treatment, how likely is the patient to engage in risky substance use and/or risky SUD-related behaviors imminently (within hours or days)? How serious are the potential consequences?

### Dimension 4 Risk Rating

Substance Use-related Risks ( <i>The ASAM Criteria</i> , pp 255-271)	Risk Rating
<b>Likelihood of Engaging in Risky Substance Use</b> <ul style="list-style-type: none"> <li>See Appendix C for guidance</li> </ul>	<input type="checkbox"/> E = Minimum Level 3.5 <input type="checkbox"/> D = Minimum Level 3.1 <input type="checkbox"/> C = Minimum Level 2.5 <input type="checkbox"/> B = Minimum Level 2.1 <input type="checkbox"/> A = Minimum Level 1.5
<b>Likelihood of Engaging in Risky SUD-related Behaviors</b> <ul style="list-style-type: none"> <li>Consider risky behaviors while intoxicated or trying to obtain substances, eg, risky sex work, DUI, sharing needles, aggression or exposure to violence or victimization</li> <li>See Appendix C for guidance</li> </ul>	<input type="checkbox"/> E = Minimum Level 3.5 <input type="checkbox"/> D = Minimum Level 3.1 <input type="checkbox"/> C = Minimum Level 2.5 <input type="checkbox"/> B = Minimum Level 2.1 <input type="checkbox"/> A = Minimum Level 1.5 <input type="checkbox"/> 0 = No Specific Needs

### Dimension 5

#### Ability to Function Effectively in Current Environment



49. When not using substances, do you ever have a hard time taking care of yourself or meeting daily obligations?  
 [probes: Keeping up with personal hygiene? Medications? Appointments? Household tasks? Work, school, or caregiving responsibilities?]



50. Do you have difficulty getting along with others? If so, how much?  Not at all  Some  A lot



50a. [if "some" or "a lot"] To what extent are these problems related to your substance use?  Not at all  Somewhat  Very

Comments:





## Dimension 5 Risk Rating

Recovery Environment Interactions ( <i>The ASAM Criteria</i> , pp 272-278)	Risk Rating
<p><b>Ability to Function Effectively in Current Environment</b></p> <ul style="list-style-type: none"> <li>Consider impairment in ability to fulfill daily obligations and navigate interpersonal interactions</li> <li>Consider baseline functional impairment that is NOT expected to resolve upon substance discontinuation</li> <li>See Appendix D for guidance</li> </ul>	<input type="checkbox"/> D = Minimum Level 3.5 <input type="checkbox"/> C = Minimum Level 3.1 <input type="checkbox"/> B = Minimum Level 2.5 <input type="checkbox"/> A = Minimum Level 2.1 <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No specific needs
<p><b>Safety in Current Environment</b></p> <ul style="list-style-type: none"> <li>Consider abuse or neglect, homelessness</li> </ul>	<input type="checkbox"/> A = Minimum Recovery Residence <input type="checkbox"/> 0 = No specific needs
<p><b>Support in Current Environment</b></p> <ul style="list-style-type: none"> <li>Consider presence of alcohol, drugs or other triggering influences in current environment</li> <li>If current environment is not supportive, consider if a recovery residence would be sufficient. If the patient lacks the necessary skills to effectively participate in a recovery residence, consider residential care.</li> </ul>	<input type="checkbox"/> B = Minimum Level 3.1 <input type="checkbox"/> A = Minimum Recovery Residence <input type="checkbox"/> 0 = No specific needs

→ CONTINUE to Level of Care Determination Rules



# The ASAM Criteria<sup>®</sup>, Fourth Edition

## Level of Care Assessment Guide

### Adults

## Level of Care Determination Rules

*The ASAM Criteria*, pp 279-281)

The following rules should be applied to determine the patient's recommended level of care.

### Inpatient Care: Levels 4 and 4 Psychiatric

- If the patient requires Level 4 in any subdimension, refer or transfer to Level 4.
- If the patient meets criteria for Level 3.7 BIO and any COE level of care (including Level 4 Psychiatric), refer or transfer to Level 4.
- If the patient meets criteria for Level 4 Psychiatric and does NOT meet criteria for Level 4 or 3.7 BIO in any subdimension, refer or transfer to Level 4 Psychiatric.

### Medically Managed Care: Levels 1.7, 2.7, and 3.7

- If the patient does not require Level 4 care, first determine if the patient requires medically managed care. Does any subdimension require a minimum of Level 1.7, 2.7, or 3.7 care?
  - If YES: Does any subdimension require a minimum of Level 3 care (ie, Level 3.1, 3.5, or 3.7)?
    - If YES: Recommend Level 3.7 or Level 3.7 BIO (if indicated in any subdimension).
    - If NO: Does any subdimension require a minimum of Level 2 care (ie, Level 2.1, 2.5, or 2.7)?
      - If YES: Recommend Level 2.7.
      - If NO: Recommend Level 1.7.

### Clinically Managed Residential Care: Levels 3.1 and 3.5

- If the patient does not require medically managed care, first determine if the patient requires clinically managed residential care. Does any subdimension require a minimum of Level 3.1 or Level 3.5 care?
  - If YES: Determine what intensity of clinical services is required. Does any subdimension require Minimum Level 2.5 or Minimum Level 3.5 care?
    - If YES: Recommend Level 3.5.
    - If NO: Recommend Level 3.1.

### Clinically Managed Outpatient Care: Levels 1.5, 2.1, and 2.5

- If the patient does not require medically managed or residential care, determine if the patient requires clinically managed outpatient care. What is the most intensive level of clinically managed outpatient care indicated in any subdimension?
  - If Minimum Level 2.5: Recommend Level 2.5.
  - If Minimum Level 2.1: Recommend Level 2.1.
  - If Minimum Level 1.5: Recommend Level 1.5.

### Co-occurring Enhanced (COE) Care

- If the patient meets criteria for any COE level of care, the final recommendation should be a COE level of care, with the specific level of care determined based on the previous rules.
  - Exceptions:
    - If the patient meets criteria for Level 4 and Level 4 Psychiatric:
      - Recommend Level 4, NOT Level 4 Psychiatric.
    - If the patient meets criteria for Level 3.7 BIO and any COE level of care (including Level 4 Psychiatric):
      - Recommend Level 4, NOT Level 4 Psychiatric.
    - If the patient would otherwise be recommended Level 3.1 but requires COE care:
      - Recommend Level 3.5 COE.
    - If the patient would otherwise be recommended Level 2.1 but requires COE care:
      - Recommend Level 2.5 COE.

### Recovery Residence

- If, based on the previous level of care determination rules, the patient is recommended outpatient or intensive outpatient care (ie, Level 1.5, 1.7, 2.1, 2.5, or 2.7), does any subdimension in Dimension 5 indicate the need for a minimum of a recovery residence?
  - If YES: Recommend the specific level of care determined based on the previous rules PLUS a recovery residence.

*When the recommended level of care or recovery residence is not available, a strategy must be crafted that provides the patient with the needed services in an alternative level of care or through coordinated services with external providers or programs (The ASAM Criteria, p 208).*

## Risk Rating Form

**Interviewer instruction:** If you want or need to complete a full risk rating form (eg, for clinical or utilization management purposes), please use the following form (risk ratings will populate if dimensional sections were filled out during the assessment). Refer to *The ASAM Criteria*, Fourth Edition, Volume 1: Adults, pp 214-278 to inform risk ratings. Otherwise, continue to Level of Care Recommendation.

### Dimension 1 Risk Rating

Intoxication, Withdrawal, and Addiction Medications ( <i>The ASAM Criteria</i> , pp 212-229)	Risk Rating
<b>Intoxication and Associated Risks</b>	<input type="checkbox"/> 4 = Level 4 <input type="checkbox"/> 3B = Minimum Level 3.7 BIO <input type="checkbox"/> 3A = Minimum Level 3.7 (non-BIO) <input type="checkbox"/> 2 = Minimum Level 2.7 <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No Specific Needs
<b>Withdrawal and Associated Risks</b>	<input type="checkbox"/> 4 = Level 4 <input type="checkbox"/> 3B = Minimum Level 3.7 BIO <input type="checkbox"/> 3A = Minimum Level 3.7 (non-BIO) <input type="checkbox"/> 2 = Minimum Level 2.7 <input type="checkbox"/> 1 = Minimum Level 1.7 <input type="checkbox"/> EVAL = Prompt Evaluation <input type="checkbox"/> 0 = No Specific Needs
<b>Addiction Medication Needs</b>	<input type="checkbox"/> C = Minimum Level 3.7 <input type="checkbox"/> B = Minimum Level 2.7 <input type="checkbox"/> A = Minimum Level 1.7 <input type="checkbox"/> EVAL = Prompt Evaluation <input type="checkbox"/> ANY = Any Level of Care
	<input type="checkbox"/> MOUD-C = MOUD Continuation*

\*MOUD-C can be selected alone or in addition to another risk rating. If the patient needs to continue MOUD and also initiate/titrate medications for another substance use disorder, the assessor can select both MOUD and an appropriate risk rating for the patient's other addiction medication needs.

## Dimension 2 Risk Rating

Biomedical Conditions ( <i>The ASAM Criteria</i> , pp 230-239)	Risk Rating
Physical Health Concerns	<input type="checkbox"/> 4 = Level 4 <input type="checkbox"/> 3B = Minimum Level 3.7 BIO <input type="checkbox"/> 3A = Minimum Level 3.7 (non-BIO) <input type="checkbox"/> 2 = Minimum Level 2.7 <input type="checkbox"/> 1 = Minimum Level 1.7 <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No Specific Needs
Pregnancy-related Concerns	<input type="checkbox"/> 4 = Level 4 <input type="checkbox"/> 3 = Minimum Level 3.7 <input type="checkbox"/> 2 = Minimum Level 2.7 <input type="checkbox"/> 1 = Minimum Level 1.7 <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No Specific Needs

## Dimension 3 Risk Rating

Psychiatric and Cognitive Conditions ( <i>The ASAM Criteria</i> , pp 240-254)	Risk Rating
Active Psychiatric Symptoms	<input type="checkbox"/> 4 = Level 4 Psychiatric <input type="checkbox"/> 3B = Minimum Level 3.7 COE <input type="checkbox"/> 3A = Minimum Level 3.5 COE <input type="checkbox"/> 2B = Minimum Level 2.7 COE <input type="checkbox"/> 2A = Minimum Level 2.5 COE <input type="checkbox"/> 1C = Minimum Level 1.7 COE <input type="checkbox"/> 1B = Minimum Level 1.7 <input type="checkbox"/> 1A = Minimum Level 1.5 COE <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No Specific Needs
Persistent Disability	<input type="checkbox"/> 1Z = Minimum Level 1.5 COE <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No Specific Needs

## Dimension 4 Risk Rating

Substance Use-related Risks ( <i>The ASAM Criteria</i> , pp 255-271)	Risk Rating
Likelihood of Engaging in Risky Substance Use	<input type="checkbox"/> E = Minimum Level 3.5 <input type="checkbox"/> D = Minimum Level 3.1 <input type="checkbox"/> C = Minimum Level 2.5 <input type="checkbox"/> B = Minimum Level 2.1 <input type="checkbox"/> A = Minimum Level 1.5
Likelihood of Engaging in Risky SUD-related Behaviors	<input type="checkbox"/> E = Minimum Level 3.5 <input type="checkbox"/> D = Minimum Level 3.1 <input type="checkbox"/> C = Minimum Level 2.5 <input type="checkbox"/> B = Minimum Level 2.1 <input type="checkbox"/> A = Minimum Level 1.5 <input type="checkbox"/> 0 = No Specific Needs

## Dimension 5 Risk Rating

Recovery Environment Interactions ( <i>The ASAM Criteria</i> , pp 272-278)	Risk Rating
Ability to Function Effectively in Current Environment	<input type="checkbox"/> D = Minimum Level 3.5 <input type="checkbox"/> C = Minimum Level 3.1 <input type="checkbox"/> B = Minimum Level 2.5 <input type="checkbox"/> A = Minimum Level 2.1 <input type="checkbox"/> ANY = Any Level of Care <input type="checkbox"/> 0 = No specific needs
Safety in Current Environment	<input type="checkbox"/> A = Minimum Recovery Residence <input type="checkbox"/> 0 = No specific needs
Support in Current Environment	<input type="checkbox"/> B = Minimum Level 3.1 <input type="checkbox"/> A = Minimum Recovery Residence <input type="checkbox"/> 0 = No specific needs

## Level of Care Recommendation

Based on the Level of Care Determination Rules, the patient meets criteria for the following level of care:

<input type="checkbox"/> Level 4	<input type="checkbox"/> Level 3.7	<input type="checkbox"/> Level 2.7	<input type="checkbox"/> Level 1.7
<input type="checkbox"/> Level 4 Psychiatric	<input type="checkbox"/> Level 3.7 COE	<input type="checkbox"/> Level 2.7 COE	<input type="checkbox"/> Level 1.7 COE
	<input type="checkbox"/> Level 3.7 BIO	<input type="checkbox"/> Level 2.5	<input type="checkbox"/> Level 1.5
	<input type="checkbox"/> Level 3.5	<input type="checkbox"/> Level 2.5 COE	<input type="checkbox"/> Level 1.5 COE
	<input type="checkbox"/> Level 3.5 COE	<input type="checkbox"/> Level 2.1	
	<input type="checkbox"/> Level 3.1		


Is recovery residence recommended in addition to an outpatient level of care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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## Additional Service Needs

Is the patient taking medications for opioid use disorder (MOUD) and need to continue them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
[if yes] Specify the medication(s):		
<p>Does the patient need prompt evaluation (EVAL) but NOT integrated medically managed care for withdrawal management (WM) or addiction medication (AM) needs? (select all that apply)</p> <p><b>NOTE:</b> If the Risk Rating Form was used, indicate here if the patient received a risk rating of “EVAL” in Dimension 1 – Withdrawal and Associated Risks or Dimension 1 – Addiction Medication Needs. Otherwise, follow the guidance below to determine if the patient needs prompt evaluation for withdrawal management or addiction medication needs.</p> <p><b>For WM EVAL:</b></p> <ul style="list-style-type: none"> <li>Does the patient have, or are they anticipated to have, mild withdrawal that has not been evaluated by a medical professional? If so:             <ul style="list-style-type: none"> <li>Do you anticipate that their symptoms can be addressed in any level of care (eg, with behavioral management strategies, referral to external medical provider)?</li> <li>Can they reliably self-administer medications for symptomatic relief of mild withdrawal?</li> <li>Do you expect their withdrawal symptoms be manageable without frequent medical check-ins?</li> </ul> </li> </ul> <p><b>For AM EVAL:</b></p> <ul style="list-style-type: none"> <li>If the patient has not recently been evaluated by a medical professional for addiction medication needs:             <ul style="list-style-type: none"> <li>Does the patient have a history of difficulty achieving recovery with clinically managed care alone?                 <ul style="list-style-type: none"> <li>For example, have they often returned to substance use soon after entering addiction treatment due to cravings or post-acute withdrawal symptoms?</li> </ul> </li> </ul> </li> </ul>	<input type="checkbox"/> WM EVAL	<input type="checkbox"/> AM EVAL

## Dimension 6

	<b>59. Are you willing to attend the recommended level of care?</b> <i>[If patient is ambivalent, use motivational interviewing techniques to encourage them to attend LOC]</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<b>60. Are you able to attend the recommended level of care?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<b>60a. [if no to 59 or 60] What are your concerns?</b> [eg, caregiving or employment responsibilities; transportation concerns, criminal legal system requirements]		
	<b>60b. [if no to 59 or 60] Do you think having additional support or services might help you to attend the recommended level of care?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	[if yes] <b>What kinds of support or services do you need?</b>		
	[if yes] <b>What type of addiction treatment do you think you could participate in at this time, if any?</b>		

 <b>61. Interviewer Assessment: Does the level of care recommendation need to be adjusted due to barriers to care or patient preference?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please indicate the selected level of care (where the patient plans to attend) below:

<input type="checkbox"/> Level 4	<input type="checkbox"/> Level 3.7	<input type="checkbox"/> Level 2.7	<input type="checkbox"/> Level 1.7
<input type="checkbox"/> Level 4 Psychiatric	<input type="checkbox"/> Level 3.7 COE	<input type="checkbox"/> Level 2.7 COE	<input type="checkbox"/> Level 1.7 COE
	<input type="checkbox"/> Level 3.7 BIO	<input type="checkbox"/> Level 2.5	<input type="checkbox"/> Level 1.5
	<input type="checkbox"/> Level 3.5	<input type="checkbox"/> Level 2.5 COE	<input type="checkbox"/> Level 1.5 COE
	<input type="checkbox"/> Level 3.5 COE	<input type="checkbox"/> Level 2.1	
	<input type="checkbox"/> Level 3.1		

Is recovery residence recommended in addition to an outpatient level of care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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### Additional Service Needs

MOUD Continuation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
[if yes] Specify the medication(s):		
Prompt Evaluation, Withdrawal Management	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prompt Evaluation, Addiction Medication Needs	<input type="checkbox"/> Yes	<input type="checkbox"/> No

[if applicable] Please indicate the reasons for discrepancy between the recommended level of care and the selected level of care:

<input type="checkbox"/> LOC is not available in area	<input type="checkbox"/> Financial barriers	<input type="checkbox"/> Court or other treatment mandates	<input type="checkbox"/> LOC available but patient is ineligible; specify reason: _____
<input type="checkbox"/> Clinician judgment	<input type="checkbox"/> Recommended LOC is too far away	<input type="checkbox"/> Lack of physical access (transportation or mobility challenges)	<input type="checkbox"/> Patient declined MOUD
<input type="checkbox"/> Patient preference	<input type="checkbox"/> Family/caregiver responsibilities	<input type="checkbox"/> Language accessibility	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Waiting list for LOC recommended	<input type="checkbox"/> Employment responsibilities	<input type="checkbox"/> LOC available but will not admit patient; specify reason: _____ _____	<input type="checkbox"/> Other (specify): _____ _____



Anticipated consequence(s) of level of care adjustment (check all that apply):

<b>Serious harm</b> <input type="checkbox"/> Admission to an acute care setting <input type="checkbox"/> Overdose <input type="checkbox"/> Victimization <input type="checkbox"/> Perpetration of violence
<b>Destabilizing Loss</b> <input type="checkbox"/> Divorce/loss of meaningful relationship <input type="checkbox"/> Loss of child custody <input type="checkbox"/> Loss of housing <input type="checkbox"/> Incarceration (ie, loss of freedom)
<input type="checkbox"/> Negative but not destabilizing consequences
<input type="checkbox"/> Continued service in acute care facility
<input type="checkbox"/> Patient will be discharged without ongoing engagement in care
<input type="checkbox"/> Other (specify):