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| DDAP-EFM-1002 6/18 | American Society of Addiction Medicine**ASAM Placement****Summary Sheet**(Required fields are in **BOLD**) | **Provider Location:**       **Provider Name:**       **DDAP License #:**        |
|  | **NOTE:**  For all SCA-funded individuals, the ASAM information is required to be entered into [PA WITS](https://pa-sts.witsweb.org/LdapPlugin/Account/Login?returnUrl=%2Fissue%2Fwsfed%3Fwa%3Dwsignin1.0%26wtrealm%3Dwits%253Apennsylvania%253Aprod%26wctx%3Drm%253D0%2526id%253Dpassive%2526ru%253D%25252Finit%26wct%3D2017-11-01T18%253A49%253A25Z%26whr%3Dwits%253Aauth%253Astrong%26wreply%3Dhttps%253A%252F%252Fpa.witsweb.org%252Finit). |
| **UCN:** |       | **Date:** |       |
| **First Name:** |       | M.I.: |    | **Last Name:** |       | Suffix: |        |
|  |  |  |  |  |
| **Assessor:** |       | **Phone # & Ext.:** |       |  |
| **Type** (Check One): **[ ]  Admission [ ]  Continued Stay [ ]  Discharge** |  |
| **Dimension** |  |  |
| **D1. Acute intoxication and/or withdrawal potential:** | **Level of Risk:**       | **Level of Care:**       |
| **Criteria Included/Comments:**       |
|   |
| **D2. Biomedical Conditions and Complications:** | **Level of Risk:**       | **Level of Care:**       |
| **Criteria Included/Comments:**       |
|   |
| **D3. Emotional/Behavioral or cognitive conditions and complications:** | **Level of Risk:**       | **Level of Care:**       |
| **Criteria Included/Comments:**       |
|   |
| **D4. Readiness to change:** | **Level of Risk:**       | **Level of Care:**       |
| **Criteria Included/Comments:**       |
|   |
| **D5. Relapse, continued use or continued problem potential:** | **Level of Risk:**       | **Level of Care:**       |
| **Criteria Included/Comments:**       |
|   |
| **D6. Recovery Environment:** | **Level of Risk:**       | **Level of Care:**       |
| **Criteria Included/Comments:**       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicate the level of care recommended:** |       |  |  |
|   |
| **Indicate the level of care received:** |       |  |  |
|   |
| **If recommended level of care is different from received, why?** |       |  |
|   |
| **Indicate the program or****Facility referred to:** |       |  |
|   |
| **Supervisor signature is only required until the assessor has met the training and competency requirements.**  |
| Supervisor Signature:  |  | Date: |       |  |
|  |