CONTRA COSTA
ALCOHOL & OTHER DRUGS SERVICES
A Program of Behavioral Health Services

Treatment Plan

NAME / MRN

Assigned Primary Counselor Name:	**Admission to Treatment Date:**	**Type of Treatment Plan** **Initial** ☐ **Update** ☐ Date: _______________
Primary DSM-5 Code:	**Primary ICD-10 Code:**	
Primary Diagnosis Narrative:		
ASAM DIMENSION 1: ACUTE INTOXICATION/WITHDRAWAL POTENTIAL	**ASI DOMAINS**: ALCOHOL, DRUG	
Severity: ☐0 ☐1 ☐2 ☐ 3 ☐ 4	**Stage of Change:** ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse	
Statement of Problem:		

Statement of Goal:	**Action Steps (**Indicate responsible party, type and frequency of service for each action step listed **)**	**Target Date**	**Completion Date**

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ASAM DIMENSION 2: BIOMEDICAL CONDITIONS/COMPLICATIONS		**ASI DOMAINS:** MEDICAL STATUS	
Severity: ☐0 ☐1 ☐2 ☐ 3 ☐ 4	**Stage of Change:** ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse		
Statement of Problem:			
Statement of Goal:	**Action Steps (**Indicate responsible party, type and frequency of service for each action step listed **)**	**Target Date**	**Completion Date**

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<table>
<tr><td colspan="4">ASAM DIMENSION 3: EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS/COMPLICATIONS ASI DOMAIN: PSYCHIATRIC</td></tr>
<tr><td colspan="2">Severity: ☐0 ☐1 ☐2 ☐ 3 ☐ 4</td><td colspan="2">Stage of Change: ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation
☐ Action ☐ Maintenance ☐ Relapse</td></tr>
<tr><td colspan="4">Statement of Problem:</td></tr>
<tr><td>Statement of Goal:</td><td>Action Steps (Indicate responsible party, type and frequency of service for each action step listed)</td><td>Target Date</td><td>Completion Date</td></tr>
</table>

NAME / MRN

ASAM DIMENSION 4: READINESS TO CHANGE		**ASI DOMAINS**: ALCOHOL, DRUG, PSYCHIATRIC	
Severity: ☐0 ☐1 ☐2 ☐ 3 ☐ 4	**Stage of Change:** ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse		
Statement of Problem:			
Statement of Goal:	**Action Steps (**Indicate responsible party, type and frequency of service for each action step listed **)**	**Target Date**	**Completion Date**

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ASAM DIMENSION 5: RELAPSE/CONTINUED USE/PROBLEM POTENTIAL **ASI DOMAINS:** ALCOHOL, DRUG, PSYCHIATRIC			
Severity: ☐0 ☐1 ☐2 ☐ 3 ☐ 4	**Stage of Change:** ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse		
Statement of Problem:			
Statement of Goal:	**Action Steps (**Indicate responsible party, type and frequency of service for each action step listed **)**	**Target Date**	**Completion Date**

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ASAM DIMENSION 6: RECOVERY/LIVING ENVIRONMENT **ASI DOMAINS**: EMPLOYMENT/SUPPORT, LEGAL, FAMILY/SOCIAL			
Severity: ☐0 ☐1 ☐2 ☐ 3 ☐ 4	**Stage of Change:** ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse		
Statement of Problem:			
Statement of Goal:	**Action Steps (**Indicate responsible party, type and frequency of service for each action step listed **)**	**Target Date**	**Completion Date**

Client Printed Name:	**Client Signature:**	**Date:**
Counselor Printed Name:	**Counselor Signature:**	**Date:**
Physician/LPHA Printed Name:	**Physician/LPHA Signature:**	**Date:**
***Document reason for no Client Signature on this Treatment Plan:**		
Client was offered a copy of this Treatment Plan: ☐ A copy was **given** ☐ A copy was **declined.** Date declined: ____________________		
THIS TREATMENT PLAN IS VALID FOR NINETY (90) DAYS.		
Authorization Committee Printed Name:	**Authorization Committee Signature:**	**Date:**