

Chemical Dependency Assessment Summary

Assessment Date: _____

Assessment Performed In Person By Phone Other _____

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

Court: _____ Case #: _____

BAC Level Analysis	<input type="checkbox"/> Refused <input type="checkbox"/> BAC Level _____ <input type="checkbox"/> UA results at intake/assessment _____
	Analysis of BAC _____ _____ _____
History of CD Related Arrests	_____ _____
Prior CD Eval.?	<input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> None Reported Have you reviewed the previous evaluation? <input type="checkbox"/> Yes Is it consistent with your evaluation? (If not please comment:) _____ _____
Prior ADIS?	<input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> None Reported
Prior Def. Pros.?	<input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> None Reported
Prior CD Tx.?	<input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> None Reported
Diagnostic Assessment:	_____ _____
Treatment Recommendation ASAM Level & Estimated Duration	_____ _____ Recommendations for appropriate level of care and length of stay in accordance with ASAM PPC will be made periodically to the court and the patient based on ongoing assessment of the patient's progress in treatment and individual treatment needs. If defendant is recommended for treatment and the patient is amenable to treatment—set forth basis of amenability.
Factors Considered in Recommendation	_____ _____ _____ _____
This assessment includes collateral information from:	<input type="checkbox"/> Attorney <input type="checkbox"/> Court/Probation <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Treatment Agency <input type="checkbox"/> Child Protective Services <input type="checkbox"/> Physician <input type="checkbox"/> Family/Who? _____ <input type="checkbox"/> Police Report <input type="checkbox"/> Criminal History <input type="checkbox"/> D.O.L. <input type="checkbox"/> Other: _____
This assessment, and the treatment recommendations attached, are voided if the patient has failed to fully and honestly disclose information requested of him/her throughout the assessment process.	

Assessing CD Counselor/Assessment Officer _____

Agency Name _____

Date Signed _____

Telephone Number (_____) _____