DDAP-EFM-1002 6/18

pennsylvania
DEPARTMENT OF DRUG AND
ALCOHOL PROGRAMS

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.

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: _____