

MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE

FOCUS – SUD CHANGE IN LEVEL OF CARE

Name: _____ Case #: _____
 Date of Birth: _____
 Address: _____

Provider:	Location Type:	Address:
Phone:	Fax:	

Change in Level of Care

Request Date: Requesting Therapist:
 Times Available:

DIAGNOSIS

	ICD-9	ICD-10	Description	Status Date	Status
Pri					
Sec					
Ter					
Quat					

Diagnostic Formulation

Level of Care Information

Current Level of Treatment

- Detox
 ST Residential
 LT Residential
 IOP
 OP
 Case Management

Additional Service Categories

- Peer Recovery Coach
 Recovery Home

Request Change To

- Detox
 ST Residential
 LT Residential
 IOP
 OP
 Case Management
 Peer Recovery Coach
 Recovery Home

Current Substance(s) of Abuse

	Primary	Secondary	Tertiary
Type of Substance			
Date Last Used			
Frequency of Use			
Route of Administration			
Amount Used in Last 30 Days			

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Results of past 30 days drug screen (testing date, substance and result)

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MAT only: Current dose amount

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Is Client Currently (check all that apply):

Injecting Drugs?

Yes No

Pregnant?

Yes No N/A

On Rx Methadone?

Yes No

A Parent at risk of losing child(ren) due to substance use?

Yes No

Eligible for Women Specialty Funds?

Yes No

ASAM Result

Dimension 1:		Dimension 4:	
Dimension 2:		Dimension 5:	
Dimension 3:		Dimension 6:	

Comments:

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General Comments:

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