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www.SBCounty.gov

Department of Behavioral Health
Substance Use Disorder and Recovery Services

ASAM LEVEL OF CARE (LOC)

This form is to be used by ***treating providers*** to document level of care information.

Client's MRN #
Client's Name
Client's Date of Birth
Screening ☐ or Assessment ☐
Date Completed
Treating provider Choose an Item
Type of screen/assessment Choose an item
Indicated LOC/WM Choose an item
Additional indicated LOC/WM, if any (1) Choose an item
Additional indicated LOC/WM, if any (2) Choose an item
Actual LOC/WM placement decision Choose an item
Additional Actual LOC/WM placement decision, if any Choose an item

If actual LOC/WM was not among those indicated, reason for difference
Choose an item

Explain reason why Actual LOC provided was not among those indicated, if reason for difference between Indicated LOC and Actual LOC was "Other":

If referral is being made but admission is expected to be DELAYED, reason
Choose an item

Additional Comments (optional):

Client Name	
DOB	
BHMIS#	
Program	