



**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 <input type="checkbox"/> or	Assessment <input type="checkbox"/>
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):

This confidential information is provided to you in accordance with State and Federal law and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient or authorized representative to who it pertains unless otherwise permitted by law.

Client Name	
DOB	
BHMIS#	
Program	