COLORADO
Behavioral Health Administration

Residential Monthly Involuntary Commitment Report

Please email report to CDHS_BHA_IC@STATE.CO.US and upload to Signal's Beacon Repository (or provide to your specific MSO) by the 15th of each month for each IC client in your care at that time.

Month: _____ Origination County for IC: _____
Client Name:_____ Program Name and Level of Care: _____

Date of Admission: _____ (MM/DD/YYYY) DOB: _____ (MM/DD/YYYY)

Treatment Summary: Please **TYPE** and provide a brief (2-3 sentences) summary of each ASAM dimension with Risk Rating (0-4), including treatment plan progress.
https://www.asam.org/asam-criteria/asam-criteria-3rd-edition

Dimension 1 (Acute Intoxication and/or Withdrawal Potential)**:** _____

Dimension 2 (Biomedical Conditions and Complications)**:** _____

Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications)**:** _____

Dimension 4 (Readiness to Change, Including Current Stage of Change)**:** _____

Dimension 5 (Relapse, Continued Use Use or Continued Problem Potential)**:** _____

Dimension 6 (Recovering/Living Environment)**:** _____

NUMBER OF POSITIVE UA'S: _____ **WHAT SUBSTANCES:** _____

CURRENT ASAM LEVEL OF CARE: _____ **RECOMMENDED ASAM LEVEL OF CARE:** _____

Attendance (# groups attended out of # required): _____

Treatment Progress: Please briefly describe clinical progress from group and individual sessions, such as the level of engagement, triggers the client has identified, coping skills they utilize, contributing factors of their use, challenges/barriers to recovery, etc. _____

Continuation or Transfer of Services: Note anticipated transfer date, anticipated level of care based on ASAM and potential treatment provider: _____

Report completed by: _____ Date: _____

***If client is discharging, submit your agency discharge form**