

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: Client Name:	Origination County for IC: Program Name and Level of Care:
Date of Admission: (MM/DD/YYYY) DO	<u> </u>
	ide a brief (2-3 sentences) summary of each ASAM dimension plan progress.
Dimension 1 (Acute Intoxication and/or Withd	rawal Potential):
Dimension 2 (Biomedical Conditions and Comp	olications):
Dimension 3 (Emotional, Behavioral, or Cognit	tive Conditions and Complications):
Dimension 4 (Readiness to Change, Including 6	Current Stage of Change):
Dimension 5 (Relapse, Continued Use Use or C	Continued Problem Potential):
Dimension 6 (Recovering/Living Environment)	:
NUMBER OF POSITIVE UA'S: WHAT SU	BSTANCES:
CURRENT ASAM LEVEL OF CARE: RE	COMMENDED ASAM LEVEL OF CARE:
Attendance (# groups attended out of # require	ed):
	inical progress from group and individual sessions, such as the level of oping skills they utilize, contributing factors of their use,
Continuation or Transfer of Services: Note ASAM and potential treatment provider:	anticipated transfer date, anticipated level of care based on
	Report completed by: Date: