Substance Use Disorder Services
Treatment Authorization
Request Form

Agency Name_____
Address_____
Phone #_____**Fax#**_____

Please Fax: ATTN: Client Case Manager -_____ to (530)295-2596 or email ODSAccess@edcgov.us

EXTENSION REQUEST MUST BE MADE 7 BUSINESS DAYS PRIOR TO AUTHORIZATION END DATE

Date	Client Name	Age	Social Security #

Requesting Staff	Phone Ext.	Staff Facility Location

Entry Date	Assessment Date	Extension ASAM Date	# of Days Requested

History of Use

Substance	Age of Initial Use	Date of Last Use	How often and how much does client usually use?

List Treatment Plan Goal(s) progress and/or addressed during episode

List Treatment Plan Goals Extension will address.

ASAM Level of Function and Explanation of Rating

D-1: Acute Intoxication and/or Withdrawal Potential	Risk rating=

Client Name_____

D-2: Biomedical Conditions/Complications (Physical Health) Risk rating=
D-3: Emotional/Behavioral Conditions/Complications (Mental Health) Risk rating=
D-4: Treatment Acceptance/Resistance/Readiness to Change Risk rating=
D-4: **Stage of Change=**
D-5: Relapse/Continued Use Potential Risk rating=
D-6: Recovery Environment (Family, Social) Risk rating=

Client Exit Plan Details

Requesting Counselor Name_____

Certification/License Title_____

_____

Requesting Counselor Signature Date