Adolescent Substance Abuse Program

2530 South Alma School Road

Mesa, Arizona 85210

phone: (602) 434-0249 fax: (480) 704-5550 e-mail: asap71@cox.net web: [www.asapaz.com](http://www.asapaz.com)

Treatment Documentation Policy

Some clients (especially those involved with the legal system or those mandated to receive counseling by their school) request documentation of their counseling experience at ASAP. This policy defines what documentation can and cannot be provided.

Let us be clear: ASAP staff must tell the full truth regarding each teen’s attendance, urine drug test results, participation, motivation to stay clean, and the statements each teen makes at ASAP regarding his/her intent to stay drug and alcohol free in the future. ASAP staff cannot, and will not, omit any piece of critical information. We must tell the truth (As the legal system says: “The truth, the whole truth, and nothing but the truth”) about each teen’s progress, or lack of progress, in the counseling program at ASAP. ASAP will not report that you are clean if you am not, that you are attending counseling if you are not, that you are coming on time and working hard if you are not-- and etc. Further, ASAP must report your statements accurately. If you come in to ASAP and say “I will stay clean now, because I want to get out of legal trouble, but as soon as I am off probation I am going to start using again” -- then of course that is critical information and ASAP staff is obligated to include it in any report. We must simply report the whole truth of exactly what you do, and exactly what you say. We are making this policy abundantly clear now so there can be no confusion later.

We strongly wish to be able to report that each teen is producing negative urine drug tests, attending each therapy session on time, demonstrating a genuine commitment to sobriety, and working to change his/her life in many positive ways. But of course we can only produce such a positive report when it is true.

Once a teen is discharged from the ASAP Program the medical record is closed, and no new or additional documentation of any kind can be produced by ASAP staff after the day of discharge. Teens in need of documentation following discharge from the ASAP Program will of course need to have that documentation provided by their current behavioral health professional or facility.

See below the forms that ASAP will use to provide treatment documentation when required. These forms, and none other, will serve as the complete reports that we will make to the legal system, to your attorney, to the Court, to your school, to other professionals that are treating you, to you directly, or to any other person or organization named in any release of information form. Again, we will only use the three forms below.

Only the following three forms are used to document treatment:

Enrollment Documentation

ASAP Treatment Summary

ASAP Discharge Summary

See the following three pages for these forms

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Date:

To Whom It May Concern:

 This letter confirms that \_\_\_\_\_\_ dob \_ is currently participating in the Adolescent Substance Abuse Program (ASAP). ASAP is an Intensive Outpatient Program for teens ages 12-18 that meets 3 times a week for 3 hours each session, for a total of 30 group therapy sessions and 90 hours of outpatient substance abuse counseling.

 was admitted to the ASAP Program on . As of , has successfully completed of the required 30 sessions (each session is 3 hours of treatment).

 At ASAP one session each week also includes the parents for multi-family therapy. The treatment plan includes addressing relapse prevention, identifying high risk situations and triggers, family dynamics, learning healthy communication, anger management, grief and loss issues, identifying and coping with emotions in substance abuse, and problematic thoughts and beliefs.

 Our recommendation at present is that be allowed to continue in the ASAP Program, and also required to complete the Program, assuming progress continues and drug test results continue to be negative. Treatment at ASAP is underway for this family. We can contact you when treatment is concluded with this family if you require that treatment at ASAP has been successfully completed.

Sincerely,

print name of ASAP staff signature of ASAP staff date

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**ASAP Program Treatment Summary**

**Client Name:**  dob

**Site (check one)**: [ ]  East Valley [ ]  West Valley [ ]  Paradise Valley/Scottsdale

**Dates of Attendance**:

**Urinalysis Test Results**:

 Date collected [ ]  None detected [ ]  Detected – what?

 Date collected [ ]  None detected [ ]  Detected – what?

 Date collected [ ]  None detected [ ]  Detected – what?

 Date collected [ ]  None detected [ ]  Detected – what?

 Date collected [ ]  None detected [ ]  Detected – what?

 Date collected [ ]  None detected [ ]  Detected – what?

**Topics / Education / Lectures / Activities**: Substance Use and Dependency Feelings Communication Effects of Use Family Systems Relapse Prevention Understanding Anger Enabling Thoughts and Beliefs Grief and Loss

**Recent Use / Intoxication / Problematic Withdrawal (Check all that apply)**: [ ]  Continued Use [ ]  Recent Relapse

 [ ]  Suspected but unproven use [ ]  Use Reported by Parents [ ]  No use at all [ ]  Cravings

 [ ]  Acute Withdrawals [ ]  Post Acute Withdrawals (Difficult sleeping, poor concentration, mood swings)

Explain**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical concerns made or noted**:

**Concurrent Psychological Conditions or Concerns**:

**Treatment Willingness (Check one)**: [ ]  Very Willing [ ]  Willing [ ] Appears Superficially Motivated

 [ ] Ambivalent [ ] Unwilling [ ]  Passively Resistant [ ]  Actively Resistant

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Potential for Relapse (Check one)**: [ ]  Low [ ]  Moderate [ ]  High [ ]  Very High

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Status of the Recovery Environment:** [ ]  Very Positive [ ]  Positive**[ ]** Somewhat Positive [ ] Neutral [ ]  Somewhat negative [ ]  Questionable [ ]  Negative [ ]  Toxic [ ] Not yet determined

**Comments/Treatment Recommendations**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Form completed by ASAP Staff:**

 Print name of ASAP Lead Therapist Signature of ASAP Lead Therapist date

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Discharge Summary

Client name: DOB:

Date Admitted: Date of Discharge: Number of sessions completed (out of 30):

**Presenting Problem:**

ASAP is an Intensive Outpatient Program (IOP) for the treatment of substance abuse in teens that meets 3 times a week for 3 hours each session for 10 weeks for a total of 30 sessions and 90 hours of treatment. One session each week includes the family members for multi-family therapy. Random urine drug testing is conducted. The ASAP treatment plan includes a focus on the following topics: Relapse prevention, identifying high risk situations and triggers, family dynamics, enabling, communication, anger management, grief and loss, emotions and substance abuse, and thoughts and beliefs.

**Summary of Treatment**: The ASAP 10-week intensive outpatient program was the treatment program utilized with this client. Progress towards the treatment goals was judged to be:

Excellent Good Moderate Minimal Poor

**Urine drug test results summary:**

 date result date result

**Reason for discharge**: Completed all 30 sessions successfully, OR

Terminated prior to 30 sessions due to:

**Treatment summary:**

**Discharge recommendations:**

 If treatment was NOT completed successfully at ASAP:

Return to complete IOP treatment, at ASAP or another facility

 OR Placement in a higher level of care as follows:

 If treatment WAS completed successfully at ASAP:

 Individual Therapy and/or Family Therapy:

 Support Group Meetings:

 Ongoing Drug Testing:

Signature of ASAP Lead Therapist date print name of ASAP Lead Therapist