45-50 Day Re-Assessment
Continuum of Care Form
Substance Use Disorder Services

Date: _____ Time: _____ Screener: _____

Client Name: _____ Date of Birth: _____

Treatment Provider: _____ Modality(s):_____

For the next month, would you find it most helpful to? (Choose One):

1) Stay in same level of treatment intensity _____
2) Move to a more intensive level of treatment _____
3) Move to a less intensive level of treatment _____

Do You Believe You Need More Time In this Treatment Program? **Y / N**

If Yes, How Long? _____ Why? _____
_____

Do You Have An Outside Support System In Place? **Y / N**

If Yes, What? _____ Where? _____
_____

Have You Identified your Relapse Triggers? **Y / N**

If Yes, What are the Triggers? _____
If Yes, Do you have a Relapse Prevention Plan in Place? Y / N

Do You Have an Employment Opportunity? **Y / N**

If Yes, When: _____ Where: _____

Do You Have A Safe Place to Live? **Y / N**

If Yes, Where: _____ With Who? _____

Do You Have Transportation? **Y / N**

If Yes, How: _____

Does Client Need a Face to Face? **Y / N**

NEW Recommended / Referred Modality if Different: _____

Staff Printed Name & Signature (required)	**Date:**
Supervisor Printed Name & Signature (required)	**Date:**