Department of Corrections
WASHINGTON STATE

RESIDENTIAL DRUG OFFENDER SENTENCING ALTERNATIVE EXAMINATION REPORT

To: County Superior Court Date of report: _____

Cause number(s): _____

Name: _____ DOC number: _____ Birthdate: _____

Defense attorney: _____ Sentencing date: _____

Assessing Substance Use Disorder Professional (SUDP): _____

Assessing agency: _____

Enter name was assessed by the SUDP on Date. The following is a summary of the findings:

1. Enter name was assessed and diagnosed per **RCW 9.94A.660** based on the following Diagnostic and Statistical Manual-5 (DSM-5) criteria:
   a. Choose an item.
      As evidenced by:
   b. Choose an item.
      As evidenced by:
   c. Choose an item.
      As evidenced by:
   d. Choose an item.
      As evidenced by:
2. Without substance use disorder treatment there is a probability of future criminal behavior.
3. Enter name will benefit from treatment.
4. There is a proposed monitoring plan in place.
5. Enter name is eligible for Level 3 residential treatment and effective treatment is available from a certified agency.

INDIVIDUALS SELF-ASSESSMENT OF SUBSTANCE USE DISORDER PROBLEM

SUDP ASSESSMENT OF AMENABILITY TO TREATMENT

IMPACT OF SUBSTANCE USE ON EDUCATION, OCCUPATION, SOCIAL, AND FAMILY

SUBSTANCE USE HISTORY (INCLUDING TOBACCO)

SUBSTANCE USE DISORDER TREATMENT HISTORY				
Program name and location	Treatment dates	Completed Yes	Completed No	Abstinence length
		☐	☐	
		☐	☐	
		☐	☐	

MENTAL HEALTH TREATMENT HISTORY	
Program name and location	Treatment dates

Individual reported major or ongoing medical issues? ☐ Yes ☐ No

Bio-medical complications: _____

Individual under the care of a physician? ☐ Yes ☐ No

If yes, include name and contact information: _____

Note: DOC 14-172 Substance Abuse Recovery Unit Compound Release of Confidential Information must be signed and include the physician as a recipient.

Has the individual reported prescribed medications for either medical or mental health-related conditions? ☐ Yes ☐ No

MEDICATIONS INDIVIDUAL IS CURRENTLY TAKING			
Name	Dose	Name	Dose

Was the individual notified they must have enough medication for the 90 days of treatment if a Drug Offender Sentencing Alternative (DOSA) sentence is granted? ☐ Yes ☐ No

DIAGNOSTIC CODES FROM DSM-5	
ALCOHOL USE DISORDER	**TOBACCO USE DISORDER**
☐ 305.00 Mild	☐ 305.10 Mild
☐ 303.90 Moderate	☐ 305.10 Moderate
☐ 303.90 Severe	☐ 305.10 Severe
OPIOID USE DISORDER	**CANNABIS USE DISORDER**
☐ 305.50 Mild	☐ 305.20 Mild
☐ 304.00 Moderate	☐ 304.30 Moderate
☐ 304.00 Severe	☐ 304.30 Severe
STIMULANT USE DISORDER	
☐ 305.70 Mild Amphetamine-type	☐ 304.20 Moderate Cocaine
☐ 305.60 Mild Cocaine	☐ 304.40 Severe Amphetamine-type
☐ 304.40 Moderate Amphetamine-type	☐ 304.20 Severe Cocaine
PHENCYCLIDINE USE DISORDER	**SEDATIVE HYPNOTIC USE DISORDER**
☐ 305.90 Mild	☐ 305.40 Mild
☐ 304.60 Moderate	☐ 304.10 Moderate
☐ 304.60 Severe	☐ 304.10 Severe
INHALANT USE DISORDER	**OTHER HALLUCINOGEN USE DISORDER**
☐ 305.10 Mild	☐ 305.30 Mild
☐ 305.10 Moderate	☐ 304.50 Moderate
☐ 305.10 Severe	☐ 304.50 Severe

Monitoring plan will be determined by the individual's case manager.

Individual's planned address: _____

Contact person and phone: _____

RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT PROVIDER

American Behavioral Health Systems (ABHS) Phone (866) 729-8038 Fax (509) 242-1867

☐ **In Spokane at** 12715 E. Mission Avenue, Spokane Valley, WA 99216

☐ **In Chehalis at** 500 S.E. Washington Avenue, Chehalis, WA 98532

☐ **In Cozza at** 44 E. Cozza Drive, Spokane, WA 99208

Bed date: _____ Appointment time: _____

Transportation will be provided by **ABHS Transport** Phone (509) 362-4690

ABHS must be notified at least 48 hours before the scheduled admission date to ensure appropriate arrangements for transfer to the treatment facility.

Transport date: _____ Appointment time: _____

Bus location: _____

If the individual is on methadone, suboxone, or any other medication-assisted therapy, treatment placement will be at Spokane Cozza Facility.

The assessing SUDP must send the following copies **within 10 business days** of receiving the court order to the Sentencing Court, Prosecuting Attorney, Defense Attorney, Substance Abuse Recovery Unit (SARU), and ABHS:

- Copy of court order
- DOC 14-179 Residential Drug Offender Sentencing Alternative Examination Report
- DOC 14-172 Substance Abuse Recovery Unit Compound Release of Confidential Information

☐ I have provided DOC 09-298 Affirmative Conditions and Crime-Related Prohibitions to the individual.

☐ The individual has signed DOC 14-172 Substance Abuse Recovery Unit Compound Release of Confidential Information.

_____	_____	_____
Submitted by	Signature	Date

The records contained herein are protected by Federal Confidentiality Regulations 42 CFR Part 2. The Federal rules prohibit further disclosure of this information to parties outside of the Department of Corrections unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Distribution: **ORIGINAL** - SARU **COPY** - Sentencing court, Prosecuting attorney, Defense attorney, ABHS