



RESIDENTIAL DRUG OFFENDER SENTENCING ALTERNATIVE EXAMINATION REPORT

To: County Superior Court
Cause number(s):

Date of report:

Name DOC number Date of birth
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

Blank lines for self-assessment

SUDP'S ASSESSMENT OF AMENABILITY TO TREATMENT

Blank lines for SUDP's assessment

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		Abstinence Length
		Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

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	OPIOID USE DISORDER	CANNABIS USE DISORDER
<input type="checkbox"/> 305.00 Mild <input type="checkbox"/> 303.90 Moderate <input type="checkbox"/> 303.90 Severe	<input type="checkbox"/> 305.50 Mild <input type="checkbox"/> 304.00 Moderate <input type="checkbox"/> 304.00 Severe	<input type="checkbox"/> 305.20 Mild <input type="checkbox"/> 304.30 Moderate <input type="checkbox"/> 304.30 Severe
STIMULANT USE DISORDER		
<input type="checkbox"/> 305.70 Mild Amphetamine-type <input type="checkbox"/> 305.60 Mild Cocaine <input type="checkbox"/> 304.40 Moderate Amphetamine-type	<input type="checkbox"/> 304.20 Moderate Cocaine <input type="checkbox"/> 304.40 Severe Amphetamine-type <input type="checkbox"/> 304.20 Severe Cocaine	
PHENCYCLIDINE USE DISORDER	SEDATIVE HYPNOTIC USE DISORDER	
<input type="checkbox"/> 305.90 Mild <input type="checkbox"/> 304.60 Moderate <input type="checkbox"/> 304.60 Severe	<input type="checkbox"/> 305.40 Mild <input type="checkbox"/> 304.10 Moderate <input type="checkbox"/> 304.10 Severe	
INHALANT USE DISORDER	OTHER HALLUCINOGEN USE DISORDER	
<input type="checkbox"/> 305.10 Mild <input type="checkbox"/> 305.10 Moderate <input type="checkbox"/> 305.10 Severe	<input type="checkbox"/> 305.30 Mild <input type="checkbox"/> 304.50 Moderate <input type="checkbox"/> 304.50 Severe	

Prior DOSAs:

Sentencing date: _____ Offense date: _____ Offense type: _____
 Sentencing date: _____ Offense date: _____ Offense type: _____
 Sentencing date: _____ Offense date: _____ Offense type: _____

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, Washington at 12715 E Mission Avenue, Spokane Valley WA 99216
- In Chehalis, Washington at 500 S.E. Washington Avenue, Chehalis, WA 98532

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. Upon completion, the data classification category may change.

Distribution: **ORIGINAL** - SARU

COPY - Sentencing Court, Prosecuting Attorney, Defense Attorney, ABHS