COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
PROBLEM LIST

PATIENT INFORMATION			
1. Name (Last, First, and Middle):		2. Date of Birth (mm/dd/yyyy):	3. Medi-Cal or MHLA Number:
4. Address:			
5. Sage Client Number:	6. Gender:	7. Preferred Language:	8. Race/Ethnicity:
9. Phone Number:		Okay to Leave a Message? ☐ Yes ☐ No	
10. DSM-5 Diagnosis(es) Primary Diagnosis: Secondary Diagnosis: Tertiary Diagnosis:			
11. Was a Physical Exam Completed? ☐ Yes, provide the date the physical exam was completed: ☐ No, provide the date of scheduled physical exam appointment:			
12. Referred for Medication-Assisted Treatment (MAT)? ☐ Yes ☐ No 13. State Reason(s) for MAT Referral / Non-Referral:			
14. Initial Problem List Date:		15. Updated Problem List Date:	

PROVIDER AGENCY		
16. Name:	17. Address:	18. Email:
19. Contact Person:	20. Phone Number:	21. Fax Number:

ASAM Dimensions: 1. Acute intoxication and/or Withdrawal Potential; 2.Biomedical Conditions and Complications; 3. Emotional, Behavioral or Cognitive Conditions/Complications; 4. Readiness to change; 5. Relapse Continued Use, or Continued Problem Potential; 6. Recovery Environment

PROBLEM # 1		
22. Problem:		
23. Added By:	24. Practitioner's Title:	25. Date Added:
26. Dimension(s):		
27. Removed By:	28. Practitioner's Title:	29. Date Removed:

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PROBLEM # 2		
22. Problem:		
23. Added By:	24. Practitioner's Title:	25. Date Added:
26. Dimension(s):		
27. Removed By:	28. Practitioner's Title:	29. Date Removed:
PROBLEM # 3		
22. Problem:		
23. Added By:	24. Practitioner's Title:	25. Date Added:
26. Dimension(s):		
27. Removed By:	28. Practitioner's Title:	29. Date Removed:
PROBLEM # 4		
22. Problem:		
23. Added By:	24. Practitioner's Title:	25. Date Added:
26. Dimension(s):		
27. Removed By:	28. Practitioner's Title:	29. Date Removed:
PROBLEM # 5		
22. Problem:		
23. Added By:	24. Practitioner's Title:	25. Date Added:
26. Dimension(s):		
27. Removed By:	28. Practitioner's Title:	29. Date Removed:

NAME AND SIGNATURE OF INVOLVED PARTIES			
30. Patient Signature (optional):			31. Date:
32. If the patient's preferred language is not English, were linguistically appropriate services provided? ☐ Yes ☐ No If no, please explain:			
33. Counselor Name (if applicable):	34. Counselor Signature (if applicable):		35. Date:
36. (LE) LPHA Name:	37. (LE)LPHA Signature:	38. (LE)LPHA License Number:	39. Date:
PROBLEM LIST REVIEW			
40. Problem List Review Date:	41. Date of Progress Note Documenting Problem List Review:		
42. Counselor Name (if applicable):	43. Counselor Signature (if applicable):		44. Date:
45. (LE) LPHA Name:	46. (LE)LPHA Signature:	47. (LE)LPHA License Number:	48. Date:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to APPLICABLE Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider*

Comments:

Assigned Staff:_____ Reviewed by: _____ Signature: _____ Date: _____

INTERNAL SAPC USE ONLY *This section is reserved for internal SAPC use only.*

Comments:

Assigned Staff:_____ Reviewed by: _____ Signature: _____ Date: _____

Problem List Form Instructions

Red fields are required

PATIENT INFORMATION

1. Enter the patient's name in the order of last name, first name, and middle name.
2. Enter the patient's date of birth in mm/dd/yyyy format.
3. Enter the patient Medi-Cal or My Health LA (MHLA) number. If the number is not known, leave the space blank.
4. Enter the patient's address.
5. Enter the patient's Client Number from Sage.
6. Enter the patient's gender.
7. Enter the patient's preferred language.
8. Enter the patient race/ethnicity.
9. Enter the patient phone number. Check the appropriate box to indicate if it is okay to leave a message at this phone number.
10. Enter the DSM-5 Diagnosis(es) with ICD-10 coding as included in the Provider Diagnosis form.
11. Answer the question "Was a Physical Exam Completed". If a physical exam was completed, mark the "yes" box and enter the date the physical exam was completed. If the physical exam result is not available mark the "no" box and enter the date of scheduled physical exam appointment.
12. Indicate via check box Yes or No whether patient was referred for MAT
13. If patient was not referred to MAT indicate reasons why
14. If the problem list is an initial list, enter the date the list was created.
15. If the problem list is an update, enter the date the list was updated.

PROVIDER AGENCY

16. Enter the agency's name.
17. Enter the agency's address.
18. Enter the agency's email address.
19. Enter the contact person at the agency.
20. Enter the phone number for the contact person at the agency.
21. Enter the agency's fax number.

PROBLEM(S) # 1-5

22. List the problem. Within the scope of the practitioner identifying the problem, this can be listed as a diagnosis, social determinant of health, Z-Code, or description of an issue. Problems focus on the patient's current areas of concern.
23. Enter the Practitioner's Name who identified/added the problem AND their credential (ex. RADT-I, CADC-II, LCSW, MD).
24. Enter the practitioner's job title (ex. Registered SUD Counselor, Certified SUD Counselor, Licensed Social Worker).
25. Enter the date the problem was added to the problem list.
26. Enter the ASAM dimension(s) which correspond to the problem.
27. Enter the practitioner's name and credential that removed the problem. This should be within the scope of the practitioner to remove problems such as SUD diagnosis.
28. Enter the practitioner's job title.
29. Enter the date the problem as identified for removal. If Applicable, add the date the problem.

**FOR ADDITIONAL PROBLEMS PLEASE FILL OUT THE PROBLEM LIST ADDENDUM*

NAME AND SIGNATURE OF INVOLVED PARTIES

30. Enter the patient's signature. (This is optional)
31. Enter the date the patient signs the Problem List.
32. Check the appropriate box if services were provided were linguistically appropriate if the patient's preferred language is not English. If not, please explain.
33. Enter the counselor's name, if applicable.
34. Enter the counselor's signature, if applicable.
35. Enter the date the counselor signs the Problem List, if applicable.
36. Enter the LPHA or License Eligible (LE) LPHA's name.
37. Enter the LPHA or License Eligible (LE) LPHA's signature.
38. Enter the LPHA or License Eligible (LE) LPHA's license number.
39. Enter the date the LPHA or License Eligible (LE) LPHA's signed the form.

PROBLEM LIST REVIEW

40. Enter the date the counselor/LPHA reviewed the problem list.
41. Enter the date of the progress note documenting the problem list was review.
42. Enter the counselor's name, if applicable.
43. Enter the counselor's signature, if applicable.
44. Enter the date the counselor signs the Problem List Review, if applicable.
45. Enter the LPHA or License Eligible (LE) LPHA's name.
46. Enter LPHA or License Eligible (LE) LPHA's signature.
47. Enter LPHA or License Eligible (LE) LPHA's license number.
48. Enter the date the LPHA or License Eligible (LE) LPHA's signed the form.

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provider

INTERNAL SAPC USE ONLY

This section is reserved for internal SAPC use only.

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE
http://publichealth.lacounty.gov/sapc/NetworkProviders/Forms.htm