

Provider Prep Checklist

Bring this to the appointment. It will keep the conversation focused on the things that actually change which kind of treatment fits.

How to use this

Fill in what you know before the appointment. Use the open lines for the clinician's answers. If a question does not apply, skip it. The point is to surface the right factors before any treatment commitment, especially commitments tied to a fixed length of stay rather than to clinical progress.

Section 1 of 6: What is actually happening physically

Withdrawal risk and substance specifics

- Primary substance, plus everything else used in the past month.
- How much, how often, for how long. A rough estimate is fine.
- Any prior withdrawal seizures, hallucinations, or DTs.
- Any prior medical detox or withdrawal management, including where and when.
- Currently on any medication for substance use disorder?
Suboxone (buprenorphine), methadone, naltrexone, Vivitrol, acamprosate, disulfiram.

Questions to ask the clinician:

- Do I actually need supervised withdrawal management, and if so in which setting?
Three options exist: at home with daily check-ins, a short residential withdrawal program (a few days), or a hospital. Which fits depends on history.
- If withdrawal management, how long do you expect, and where?
- What medication options exist for the underlying use disorder, and which would you recommend for me?

Section 2 of 6: Is there an immediate crisis

Safety, mental health, medical stability

- Any thoughts of suicide or self-harm in the past 2 weeks. Plan or intent?
- Any active hallucinations, paranoia, or mania?
- Any acute medical concerns: chest pain, severe vomiting, jaundice, recent overdose, very high blood pressure?
- If pregnant, gestational age and any current substance use.

Questions to ask the clinician:

- Given my mental-health picture, are there co-occurring concerns I should be evaluated for?

- Is there a safer setting (ER, crisis stabilization, perinatal program) I should consider before any other treatment decision?

Section 3 of 6: Recovery environment

Where you sleep tonight changes which options work

- Current housing: stable, transitional, or unsafe.
- Active substance use in the home environment?
- Domestic violence or unsafe relationships at home?
- At least one trusted person who knows what is going on?
- Could outpatient treatment realistically happen from where you live right now?

Questions to ask the clinician:

- If home is the main problem, would a recovery residence (sober-living house) plus outpatient be enough, or is residential treatment needed?

Recovery residences are structured drug-and-alcohol-free houses, often paired with outside IOP or PHP. NARR-affiliated houses follow published quality standards.

- If residential is needed, how is length of stay decided? Is it tied to my clinical progress or to a fixed calendar?

Section 4 of 6: Daily-life capacity

Can outpatient actually be attended right now

- Day-to-day functioning: showering, eating, paying bills, getting out the door.
- Severe depression, anxiety, or panic that is making daily life hard, even without an active crisis.
- Recent psychiatric hospitalization, or planning one.
- Realistically, could outpatient appointments be attended reliably right now?

Questions to ask the clinician:

- If outpatient attendance would not be reliable right now, is residential the answer, or would a recovery residence with structured outpatient work?
- Would treating co-occurring mental-health symptoms in parallel make outpatient substance treatment workable?

Section 5 of 6: What has been tried, what is wanted

History, goals, readiness

- Prior treatment: outpatient, IOP, PHP, residential, MAT, peer support, mental-health treatment.
- What worked, even partially. What did not.
- Current goal: abstinence, moderation, harm reduction, or undecided.
- Honest readiness self-rating.

Questions to ask the clinician:

- Given my goal, can we build a treatment plan around that goal, or are you assuming a different goal?
- If I am not at full readiness, what do you suggest besides residential?

Section 6 of 6: Practical and financial reality

Insurance, time, obligations

- Insurance status and what you have already verified about coverage.
- Out-of-pocket maximum and deductible status.
- Realistic time off work, school, or caregiving.

Questions to ask the clinician (and any program):

- What is the all-in cost of the recommended option, including post-discharge care?
- If residential is recommended, how is length of stay decided? What triggers a step-down to outpatient?
- What is the program's 6-month and 12-month engagement and outcome data?
- How will the transition out be handled, and who will be the prescriber after discharge?

Five questions to ask before any treatment commitment

If you only ask five things, ask these.

1. Do I actually need supervised withdrawal management, and if so in which setting?

Three options exist, not just two: at home with daily check-ins; a short residential withdrawal program (a few days, with nursing supervision); or a hospital. Alcohol with prior withdrawal seizures or DTs, and long-term benzodiazepines, generally need supervised withdrawal. Stimulants and cannabis do not. For opioids, the question is usually about starting medication (buprenorphine, methadone), which often replaces a separate detox.

2. What is the medication plan for the underlying use disorder?

Buprenorphine, methadone, and naltrexone for opioid use disorder. Naltrexone, acamprosate, and disulfiram for alcohol use disorder. These work, and most can be prescribed in outpatient settings.

3. What is the right setting given my recovery environment and daily-life capacity?

If home is unsafe or daily functioning is severely impaired, 24-hour structured care may be the right starting point. That can mean residential treatment OR a recovery residence (sober-living house) paired with outpatient. They are not the same and they cost very different amounts.

4. What is the post-discharge plan, and who is the prescriber after this?

Residential without a strong post-discharge plan tends to be the worst of both worlds: expensive and short. Insist on continuity-of-care details before any commitment. Ask: who prescribes after discharge, and how is the handoff handled?

5. Is the length of stay tied to my clinical progress, or to a fixed calendar?

Federal guidance is clear that treatment duration at any level of care should be tied to clinical progress, not to a fixed calendar. Programs that answer 'we discharge at 28 days' without referencing your progress are not following current guidance. Ask for the specific clinical criteria that would trigger a step-down.

When 24-hour care is the right answer

A 24-hour structured setting (residential treatment or a recovery residence with outside outpatient) is empirically the right starting point when at least one of the following is true, even without an emergency-department-level crisis:

- Withdrawal is medically risky enough to need overnight monitoring (alcohol with seizure or DT history, severe alcohol or benzodiazepine pattern).
- The home environment is unsafe in a way outpatient cannot address (active substance use in the home with no support, domestic violence, or unstable housing).
- Daily-life functioning is severely impaired right now (cannot reliably show up for outpatient).
- Subacute psychiatric symptoms (severe depression, anxiety, recent psychiatric hospitalization) are interfering with the ability to engage in outpatient.
- Multiple prior outpatient attempts have not produced traction and a higher level of structure has not yet been tried.

Even when 24-hour care is the right answer, the length of stay should be tied to your clinical progress, not to a fixed calendar.

If anything in the conversation suggests crisis

988 Suicide and Crisis Lifeline. Call or text. Free, 24/7.

911 for active medical emergencies (chest pain, severe vomiting, ongoing seizure, suspected overdose).

1-800-662-HELP (4357) SAMHSA National Helpline. Free, confidential, 24/7 treatment referral.

Where this comes from

Federal guidance and public-domain instruments only.

This sheet is built on publicly available guidance from SAMHSA (TIPs 35, 42, 45, 63), NIDA (Principles of Effective Treatment), NIAAA (Rethinking Drinking), and public-domain clinical instruments (CIWA-Ar, COWS, AUDIT, DAST-10, PHQ-9, C-SSRS). It is not affiliated with, endorsed by, or derived from the ASAM Criteria or any other proprietary level-of-care framework. Full bibliography at avoidrehab.com/decide/sources.html.

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