# *INITIAL ASSESSMENT FORM CORK/KERRY REGION*

**GENERAL INFORMATION**

| | | | |
|---|---|---|---|
| **Name of Client:** | | **Male** | **Age** |
| **Date of Birth** | | **Female** | |

**Source of referral:**

**Date of referral:**

**What is the primary reason for your referral/access to this service:**

***Address:***

***Phone Number_____*** ***Mobile Number_____***

Agree to contact at above address Yes No On mobile Yes No

***Living Status (i.e lives with)***

***Living status (where)***

- Stable accommodation ❑
- Institution (prison, clinic) ❑
- Homeless ❑
- Other unstable accommodation ❑
- Not known ❑

***Accommodation type***: _____

**G.P Name**_____

**G.P aware of Drug Use**_____

**GP Address** :

Medical Card Yes ❑ No ❑ Number _____

Substance use in family Yes ❑ No ❑

_____

***No. of children*** ***Age Range***:

Living with Substance Users/Gamblers/other addictions Yes❑ No❑

Details:

## *Other services involved in care plan to date:*

## *SIGNIFICANT OTHERS*

***NEXT OF KIN:***

Family aware of Substance Use: Yes / No

Enter details of Significant others if relevant _____

## *ALCOHOL USE*

Brief relevant case history:

Current agency or services involved with Care Plan:

What supports are required in this area (short term):

Any future goals (longer term)

Specify main alcohol consumed: *beer spirits wine cider alcopops other……*

Number of days alcohol was consumed over the past month…….

How many drinks were consumed over a typical drinking session over past month……

***SUBSTANCE/GAMBLING HISTORY RECORD***

| **Drugs used** | **Route of transmission** e.g inject,smoke,snort etc | **Frequency** e.g daily, once a week, less than once a week etc | **Quantity** | **Duration of Use** | **Age 1st used** | **Date Last Used** |
|---|---|---|---|---|---|---|
| Alcohol | | | | | | |
| Cannabis | | | | | | |
| Hallucinogens | | | | | | |
| Benzodiazepines (Hypnotics & Sedatives) Names<br>• Prescribed<br>• Street | | | | | | |
| Heroin (Opiates) | | | | | | |
| Methadone (Opiates) | | | | | | |
| Other Opiates? | | | | | | |
| Cocaine (Stimulants) | | | | | | |
| Amphetamine (Stimulants) | | | | | | |
| Ecstasy (Stimulants) | | | | | | |
| Over the Counter Meds: | | | | | | |
| Other: | | | | | | |
| | | | | | | |
| **Drug of Choice** | | | | | | |
| • Past | | | | | | |
| • Present | | | | | | |
| **First Drug taken**<br>• | | | | | | |
| **Gambling** | Forms of | Frequency | Amount(s) | Duration | Age 1st | Date Last Gambled |
| | | | | | | |
| | | | | | | |

## *Risk Management*

**Ever injected** Yes ❑ No ❑

**Age first injected** _____

**Ever shared** Yes ❑ No ❑

**Injected in last month** Yes ❑ No ❑

**Shared in last month** Yes ❑ No ❑

**If using I.V. needles how are they obtained**

## *HARM REDUCTION ADVICE GIVEN: (AS APPROPRIATE)*

Needle Exchange time and places Yes ❑ No ❑

Safer sex Yes ❑ No ❑

Other (give details) _____

## *PREVIOUS TREATMENT*

**Ever Treated for Substance Use/Gambling?** Yes❑ No❑

**Number of previous treatments** ☐ **Treatment Type(s)**

_____

**Longest time Drug/Gambling Free: _____**

Date Free From _____ Date Free To

**Previous Treatment**

**Agency:**_____

_____

Reason for leaving:

Current methadone treatment Yes ❑ No ❑

**Other Current Treatments/Medications:** Yes ❑ No

**Details:**

_____

Previous maintenance Yes ❑ No ❑

Services involved in care plan to date:

## *Other Relevant History:*

**Past medical history:**

**Currently Prescribed Medications:**

**Ever seen by a Psychiatrist/Psychologist/Counsellor:** Yes ❑ No ❑

Details

**History of Overdoses** Yes ❑ No ❑

**History of Self Harm** Yes ❑ No ❑

**History of Domestic Violence** Yes ❑ No ❑

Detail:

_____

_____

_____

_____

_____

_____

_____

Assessment details – for office use only

**Date of initial assessment:**

**Assessment outcome (please circle):** Suitable for service unsuitable for service onward referral

**Comprehensive assessment needed: Yes No**