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 • Prescribed • 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 •						
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