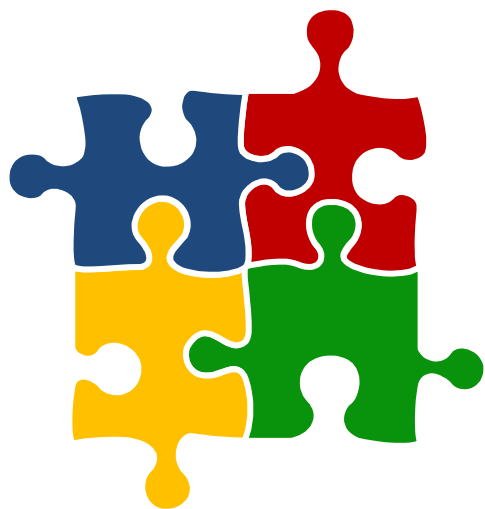


Dun Laoghaire Rathdown LDTF Area
Drug Rehabilitation Pilot Project

Initial Assessment Form



**Please enquire if individual has recently completed an Initial Assessment form.
All sections indicated by the symbol ★ are also required for NDTRS forms.**

GENERAL INFORMATION

★ Surname:	★ Forename(s):	★ Nickname(s):
★ Gender:	Male	Female
★ Age:	★ DOB: (dd/mm/yy)	
★ PPS No.:		
★ Address:		★ Telephone number:
County:	Landline:	Mobile:
CAN WE		CAN WE PHONE YOU ON
Write to you at this address	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mobile number
		Yes <input type="checkbox"/> No <input type="checkbox"/>
Call in person to the above address	Yes <input type="checkbox"/> No <input type="checkbox"/>	Landline number
		Yes <input type="checkbox"/> No <input type="checkbox"/>

IN CASE OF AN EMERGENCY

Name of next of kin: _____ Relationship to you: _____

Is this person aware of your substance use/ contact with this service: Yes No

Phone number: _____ Landline: _____ Mobile: _____

Address: _____

★ Referral date: _____

Date assessment commenced: _____

★ Source of referral: *(Please circle as appropriate)*

Self <input type="checkbox"/>	Family <input type="checkbox"/>	Friends <input type="checkbox"/>	GP <input type="checkbox"/>
Outreach Worker <input type="checkbox"/>	Employer <input type="checkbox"/>	School/College <input type="checkbox"/>	Harm Reduction Programme <input type="checkbox"/>
Prison <input type="checkbox"/>	Other drug treatment centre <input type="checkbox"/>	Social/ community service <input type="checkbox"/>	Accident & Emergency <input type="checkbox"/>
Acute hospital service (excluding A&E) <input type="checkbox"/>	Mental Health Service including psychiatrist <input type="checkbox"/>	Court/ probation/ police <input type="checkbox"/>	Mental Health Nurse at A&E <input type="checkbox"/>
Not Known <input type="checkbox"/>	Other (please identify)		

★ Where do you live: *(Please circle as appropriate)*

Stable accommodation <input type="checkbox"/>	Institution <input type="checkbox"/>	Homeless <input type="checkbox"/>	Other unstable accommodation <input type="checkbox"/>
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★ Who do you live with: *(Please circle as appropriate)*

Alone <input type="checkbox"/>	Parents/family <input type="checkbox"/>	Friends <input type="checkbox"/>	Partner (alone) <input type="checkbox"/>	Partner & children <input type="checkbox"/>
Foster care <input type="checkbox"/>	Alone with children <input type="checkbox"/>	Not known <input type="checkbox"/>	Other (please identify)	

★ Nationality – Country on passport: _____

★ Ethnic origin: *(Please circle as appropriate)*

Do not wish to answer question <input type="checkbox"/>	White Irish <input type="checkbox"/>	White Irish traveller <input type="checkbox"/>	Other white background <input type="checkbox"/>
Black African background <input type="checkbox"/>	Other black background <input type="checkbox"/>	Chinese background <input type="checkbox"/>	Other Asian background <input type="checkbox"/>
Other: (Please specify)			

★ Age left primary or secondary school: *(or circle below as appropriate)* _____

Never went to school <input type="checkbox"/>	Still at school <input type="checkbox"/>	Not known <input type="checkbox"/>
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★ Highest level of educational attainment: *(Please circle as appropriate)*

Primary level incomplete <input type="checkbox"/>	Primary level <input type="checkbox"/>	Junior cert. <input type="checkbox"/>	Leaving cert. <input type="checkbox"/>	Third level <input type="checkbox"/>
Never went to school <input type="checkbox"/>	Special needs education <input type="checkbox"/>	Still in education <input type="checkbox"/>	Not known <input type="checkbox"/>	

★ Employment status: *(Please circle as appropriate)*

In paid employment <input type="checkbox"/>	Unemployed <input type="checkbox"/>	FÁS training course <input type="checkbox"/>	Student <input type="checkbox"/>
Retired/ unable to work <input type="checkbox"/>	Not known <input type="checkbox"/>	Other (Please specify)	

Client Initials: DOB:

CURRENT SUBSTANCE USE

Current Drug Use refers to substances used for non-medical purposes over the past 30 days.

★ Drug type	★ Age at first use	★ How often used	★ Amount used	★ Route of transmission	★ Harm reduction awareness
Please rate in order of preference/regularity of use in the brackets e.g. 1, 2, 3, etc.		1. Daily or almost daily. 2. Several times a week. 3. At least once a week. 4. Less than once a week. 5. Not known.		1. Inject. 2. Smoke 3. Eat/ drink. 4. Sniff/ snort. 5. Sublingual. 6. Rectal. 7. Topical.	Discuss harm reduction issues. Y/N
Alcohol (__)					
Heroin (__)					
Methadone (non-prescribed or not taken as prescribed) (__)					
Other opiates (including codeine) (__)					
Benzodiazepines (__)					
Amphetamines (Crystal Meth) (__)					
Cocaine powder (__)					
Crack Cocaine (__)					
LSD (__)					
Ecstasy (__)					
Magic Mushrooms (__)					
Solvents (__)					
Cannabis (__)					
Steroids (__)					
Tobacco (__)					
Other medicines (__)					
Other (Please specify) (__)					

SUBSTANCE USE ASSESSMENT

For assessor.

Please explain that you are going to ask some questions about the persons use of substance (drugs and/ or alcohol, as appropriate). Explain that these questions are asked to determine if the person is experiencing risky or problematic use.

Explain that substance use can affect many areas of a persons life and it is important to know how much and the ways/ patterns in which substances are consumed and whether any problems have been experienced in relation to use.

Also explain that some questions asked in the screening tools/ assessment may repeat other questions asked in the course of the interview but are necessary to obtain a clear picture of potential difficulties experienced.

ALCOHOL USE

The Alcohol Use Disorder Identification Test (AUDIT)¹

Please ensure questions are read as written. Record answers carefully. Begin the AUDIT by saying 'Now I am going to ask you some questions about your use of alcohol beverages during this past year'. Explain what is meant by 'alcoholic beverages' by showing examples of Irish standard drinks. Code answers in terms of Irish 'standard drinks'. Place the correct answer number in the box at the right. **(See overleaf for standard drinks.)**

<p>1. How often do you have a drink containing alcohol?</p> <p>(0) Never (skip to Qs 9 – 10) (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week</p> <p style="text-align: right;"><input type="checkbox"/></p>	<p>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="checkbox"/></p>
<p>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p>(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more</p> <p style="text-align: right;"><input type="checkbox"/></p>	<p>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="checkbox"/></p>
<p>3. How often do you have six or more drinks on one occasion?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="checkbox"/></p> <p>Skip to Questions 9 and 10 if Total Score for Questions 2 & 3 = 0</p>	<p>8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="checkbox"/></p>
<p>4. How often during the last year have you found that you were not able to stop drinking once you had started?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="checkbox"/></p>	<p>9. Have you or someone else been injured as a result of your drinking?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <p style="text-align: right;"><input type="checkbox"/></p>
<p>5. How often during the last year have you failed to do what was normally expected from you because of drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="checkbox"/></p>	<p>10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <p style="text-align: right;"><input type="checkbox"/></p>
<p>Record total score here <input type="checkbox"/></p>	

For guidance and reference please refer to
AUDIT The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (WHO, 2001)¹

Standard Drinks Information

A "standard drink" in Ireland is approximately 10 grams of alcohol. This is not to be confused with a "unit of alcohol" which is a UK measurement and contains 8 grams of alcohol. Below is a rough guide to how many standard drinks are contained in Irish measures of alcohol ².

BEVERAGE TYPE	SERVING SIZE DESCRIPTION	SERVING SIZE MLS
Beer	Half pint/ glass	(284mls)
Cider	Half pint/ glass	(284mls)
Alcopops/ RTD	Long neck bottle	(275mls)
Wine	Small glass	(100mls)
Liqueurs	Glass	(71mls)
Spirits	Single measure	(35.5mls)



AUDIT SCORING AND INTERPRETATION OF SCORES¹

Total scores of 8 or more are recommended as indicators of hazardous & harmful alcohol use as well as possible alcohol dependence. (A cut-off score of 10 will provide greater specificity but at the expense of sensitivity.)

Since the effects of alcohol vary with average body weight and differences in metabolism, establishing the cut-off point for all women and men over the age of 65 one point lower at a score of 7 will increase sensitivity for these population groups.

Professional judgement should be exercised in cases where the individual's score is not consistent with other presenting evidence or if the individual has a prior history of alcohol dependence.

It may also be instructive to review responses to individual questions dealing with dependence symptoms (Q4, 5, & 6) and alcohol related problems (Q 9 & 10). Provide the next highest level of intervention to individuals who score 2 or more on Q 4, 5, & 6, or 4 on Q 9 or 10.

AUDIT SCORE	RISK LEVEL	INTERVENTION
0 - 7	Low risk drinking or abstinence.	Provide individual with appropriate alcohol education materials to reinforce low-risk drinking.
8 - 15 (NOTE: 7 is cut-off point for all women and men over aged 65)	Risky or hazardous drinking. Moderate level of risk.	Undertake brief intervention using simple advice and appropriate alcohol education materials which focus on the reduction of hazardous drinking.
16 - 19	High-risk, harmful & hazardous drinking.	Simple advice, brief counselling and continued monitoring should be undertaken. Further diagnostic evaluation should be undertaken if the individual does not respond to interventions or alcohol dependence is suspected.
20 - 40	High-risk. Alcohol dependence likely.	Referral should be made to a specialist services for diagnostic evaluation and possible treatment of alcohol dependence.

Please obtain a brief relevant alcohol case history: (Continue on back page if required)

★ Please specify the main type of alcohol you consume:

Beer <input type="checkbox"/>	Spirits <input type="checkbox"/>	Wine <input type="checkbox"/>	Fortified wine <input type="checkbox"/>	Cider <input type="checkbox"/>	Alcopops <input type="checkbox"/>	Other (specify) <input type="checkbox"/>
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★ How many drinks would you have consumed over a typical drinking session over the last month: (If none put 0)

★ On how many days did you drink alcohol over the past month: (If none put 0)

Please categorise the extent of drinking problem (as per tool):

Low risk drinking/ abstinence <input type="checkbox"/>	Hazardous drinking <input type="checkbox"/>	Harmful drinking <input type="checkbox"/>	Dependent drinker <input type="checkbox"/>
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★ Have you ever previously been treated for problem alcohol use:


Never treated <input type="checkbox"/>	Previously treated <input type="checkbox"/>	Not known <input type="checkbox"/>	Not applicable <input type="checkbox"/>
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Client Initials: DOB:


DUDIT

Drug Use Disorders Identification Test

Here are a few questions about drugs. Please answer as correctly and honestly as possible by indicating which answer is right for you.

	<input type="checkbox"/> Man	<input type="checkbox"/> Woman	Age	<input type="text"/>	<input type="text"/>
1. How often do you use drugs other than alcohol? (See list of drugs on back side.)	Never <input type="checkbox"/>	Once a month or less often <input type="checkbox"/>	2-4 times a month <input type="checkbox"/>	2-3 times a week <input type="checkbox"/>	4 times a week or more often <input type="checkbox"/>
2. Do you use more than one type of drug on the same occasion?	Never <input type="checkbox"/>	Once a month or less often <input type="checkbox"/>	2-4 times a month <input type="checkbox"/>	2-3 times a week <input type="checkbox"/>	4 times a week or more often <input type="checkbox"/>
3. How many times do you take drugs on a typical day when you use drugs?	0 <input type="checkbox"/>	1-2 <input type="checkbox"/>	3-4 <input type="checkbox"/>	5-6 <input type="checkbox"/>	7 or more <input type="checkbox"/>
4. How often are you influenced heavily by drugs?	Never <input type="checkbox"/>	Less often than once a month <input type="checkbox"/>	Every month <input type="checkbox"/>	Every week <input type="checkbox"/>	Daily or almost every day <input type="checkbox"/>
5. Over the past year, have you felt that your longing for drugs was so strong that you could not resist it?	Never <input type="checkbox"/>	Less often than once a month <input type="checkbox"/>	Every month <input type="checkbox"/>	Every week <input type="checkbox"/>	Daily or almost every day <input type="checkbox"/>
6. Has it happened, over the past year, that you have not been able to stop taking drugs once you started?	Never <input type="checkbox"/>	Less often than once a month <input type="checkbox"/>	Every month <input type="checkbox"/>	Every week <input type="checkbox"/>	Daily or almost every day <input type="checkbox"/>
7. How often over the past year have you taken drugs and then neglected to do something you should have done?	Never <input type="checkbox"/>	Less often than once a month <input type="checkbox"/>	Every month <input type="checkbox"/>	Every week <input type="checkbox"/>	Daily or almost every day <input type="checkbox"/>
8. How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never <input type="checkbox"/>	Less often than once a month <input type="checkbox"/>	Every month <input type="checkbox"/>	Every week <input type="checkbox"/>	Daily or almost every day <input type="checkbox"/>
9. How often over the past year have you had guilt feelings or a bad conscience because you used drugs?	Never <input type="checkbox"/>	Less often than once a month <input type="checkbox"/>	Every month <input type="checkbox"/>	Every week <input type="checkbox"/>	Daily or almost every day <input type="checkbox"/>
10. Have you or anyone else been hurt (mentally or physically) because you used drugs?	No <input type="checkbox"/>	Yes, but not over the past year <input type="checkbox"/>		Yes, over the past year <input type="checkbox"/>	
11. Has a relative or a friend, a doctor or a nurse, or anyone else, been worried about your drug use or said to you that you should stop using drugs?	No <input type="checkbox"/>	Yes, but not over the past year <input type="checkbox"/>		Yes, over the past year <input type="checkbox"/>	

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Turn the page to see the list of drugs 

LIST OF DRUGS

(Note! Not alcohol!)

Cannabis	Amphetamines	Cocaine	Opiates	Hallucinogens	Solvents/inhalants	GHB and others
Marijuana	Methamphetamine	Crack	Smoked heroin	Ecstasy	Thinner	GHB
Hash	Phenmetraline	Freebase	Heroin	LSD (Lisergic acid)	Trichlorethylene	Anabolic steroids
Hash oil	Khat	Coca	Opium	Mescaline	Gasoline/petrol	Laughing gas (Halothane)
	Betel nut	leaves		Peyote	Gas	Amyl nitrate (Poppers)
	Ritaline (Methylphenidate)			PCP, angel dust (Phencyclidine)	Solution	Anticholinergic compounds
				Psilocybin	Glue	
				DMT (Dimethyltryptamine)		

PILLS – MEDICINES

Pills count as drugs when you take

- more of them or take them more often than the doctor has prescribed for you
- pills because you want to have fun, feel good, get "high", or wonder what sort of effect they have on you
- pills that you have received from a relative or a friend
- pills that you have bought on the "black market" or stolen

SLEEPING PILLS/SEDATIVES

Alprazolam	Glutethimide	Rohypnol
Amobarbital	Halcion	Secobarbital
Apodorm	Heminevrin	Sobril
Apozepam	Iktorivil	Sonata
Aprobarbital	Imovane	Stesolid
Butabarbital	Mephobarbital	Stilnoct
Butalbital	Meprobamate	Talbutal
Chloral hydrate	Methaqualone	Temesta
Diazepam	Methohexital	Thiamyl
Dormicum	Mogadon	Thiopental
Ethchlorvynol	Nitrazepam	Triazolam
Fenemal	Oxascand	Xanor
Flunitrazepam	Pentobarbital	Zopiklon
Fluscand	Phenobarbital	

PAINKILLERS

Actiq	Durogesic	OxyNorm
Coccilana-Etyfin	Fentanyl	Panocod
Citodon	Ketodur	Panocod forte
Citodon forte	Ketogan	Paraflex comp
Dexodon	Kodein	Somadril
Depolan	Maxidon	Spasmofen
Dexofen	Metadon	Subutex
Dilaudid	Morfin	Temgesic
Distalgesic	Nobligan	Tiparol
Dolcontin	Norflex	Tradolan
Doleron	Norgesic	Tramadul
Dolotard	Opidol	Treo comp
Doloxene	OxyContin	

Pills do NOT count as drugs if they have been prescribed by a doctor and you take them in the prescribed dosage.

DUDIT SCORING AND INTERPRETATION OF SCORES³

Scoring for each DUDIT item:

ITEMS	SCORING
1-9	0,1,2,3,4
10 - 11	0,2,4

Sum up all the points for the 11 items. The maximum score is 44.

It is suggested that **men** with drug- related problems be identified at a cut-off score of **6 points or more** (≥ 6).**Women** with drug- related problems are identified at a cut- off score **2 points or more** (≥ 2).An individual with **25 points or more** is probably heavily dependent on drugs.

Record total DUDIT score here

**DRUG USING HISTORY**

Please obtain a brief and relevant drug using history:

★ What has been your type of contact with this programme/ service:

First treatment <input type="checkbox"/>	One or more treatment periods <input type="checkbox"/>	Not known <input type="checkbox"/>
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What is the number of times you started treatment in this programme/ service this year (Jan – Dec) :

★ Have you ever previously been treated for problem drug use:

Never treated <input type="checkbox"/>	Previously treated <input type="checkbox"/>	Not known <input type="checkbox"/>	Not applicable <input type="checkbox"/>
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If previously treated please state for which drug(s):

★ If you previously received opioid replacement treatment, please specify age first received opioid substitution treatment:

★ Please specify the first drug you used (excluding alcohol):

★ What age were you when you first used:

DRUG USING RISK BEHAVIOURS

Please obtain a brief history of possible drug using risk behaviours:

★ History of injecting:

Never injected	<input type="checkbox"/>	Has injected	<input type="checkbox"/>	Not known	<input type="checkbox"/>
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★ What age were you when you first injected (if applicable) :

Not known

★ Frequency of injecting (if applicable):

Injected in the last 30 days	<input type="checkbox"/>	Injected in the last year but not in the last 30 days	<input type="checkbox"/>	Ever injected but not within The last 12 months	<input type="checkbox"/>
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If you are currently injecting, which sites do you use?

Are you experiencing any problems or difficulties with your injection sites? Yes No
 If 'yes' to above please elaborate.

★ History of sharing needles & syringes:

Never shared needles & syringe	<input type="checkbox"/>	Has shared	<input type="checkbox"/>	Not known	<input type="checkbox"/>
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★ Frequency of sharing needles & syringes (if applicable):

Has shared in the last 30 days	<input type="checkbox"/>	Shared needle or syringe in the last 12 months (but more than 30 days ago)	<input type="checkbox"/>	Shared needles or more than 12 months ago	<input type="checkbox"/>	Don't know/ don't want to answer	<input type="checkbox"/>
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History of sharing other drug using equipment (spoons, sterile water, citric acid, tourniquet, swabs, snorting equipment.):

Never shared equipment	<input type="checkbox"/>	Has shared equipment	<input type="checkbox"/>	Not known	<input type="checkbox"/>
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Frequency of sharing equipment (spoons, filters, mixing tools, sterile water, citric acid, tourniquet, swabs, snorting equipment.):

Has shared in the last 30 days	<input type="checkbox"/>	Shared equipment in the last 12 months (but more than 30 days ago)	<input type="checkbox"/>	Shared equipment more than 12 months ago	<input type="checkbox"/>	Don't know/ don't want to answer	<input type="checkbox"/>
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Have you ever experienced an overdosed?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If 'yes' to above can you tell me what happened and when it happened?

HEALTHCARE

PHYSICAL HEALTH:

Are you currently receiving medical treatment for any health condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please give details:
Have you experienced any ill health in the past that required medical treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please give details:
Do you currently have any concerns about your physical health? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please give details:

Are you currently taking any prescribed medications?

NAME	DOSE/ FREQUENCY	PRESCRIBED BY	COMMENTS: e.g. why prescribed.

Do you have any physical access requirements/ physical disabilities? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please give details:
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IF FEMALE:

Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
If yes, do you know which date your baby is due? (Please insert expected due date if known)			
Is the Drug Liaison Midwife involved in your pregnancy care?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If other healthcare workers are involved in your pregnancy care please give details: (E.g. General Practitioner, Obstetrician, Hospital Midwife, Social Worker, etc)			

MENTAL HEALTH:

Are you currently receiving any help for mental health difficulties? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please give details:
Have you received help for mental health difficulties in the past? Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	If yes, please give details:
Do you currently have any concerns about your mental health? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please give details:

ONGOING CARE

Please identify any services/ workers you have been in contact with over the past year. (This may include: addiction treatment service, housing /homeless services, GP, counsellor, children's support services, employment services, education & training agencies, etc.)

N.B. We will not contact any service you are or have been in contact with without discussing it with you first and obtaining your consent to do so.

Service/ organisation	Workers name	Contact details: phone number +/- address

Do you currently have a care plan to help you with any needs you may have?

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Known <input type="checkbox"/>
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If 'yes' to above and you have a Case Manager can you please identify the worker (Case Manager), the organisation and their contact details?

Can you identify any goals you may have in relation to your substance use in the long term?

1.
2.
3.

Please identify any goals you may have in relation to your substance use in the short- term?

1.
2.
3.

Please indicate any of the areas below that you think you would like help/ support with:

Physical / dental health <input type="checkbox"/>	Mental / psychological health <input type="checkbox"/>	Housing/ living arrangements <input type="checkbox"/>	Family/ relationships <input type="checkbox"/>
Income & finance <input type="checkbox"/>	Education & training <input type="checkbox"/>	Hobbies / recreational activities <input type="checkbox"/>	Legal issues <input type="checkbox"/>

ASSESSMENT DETAILS – For office use only.

★ Date initial assessment completed (dd/mm/yy):

★ Assessment outcome:

Is this person suitable for substance use treatment?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Is this person being referred for comprehensive assessment:

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If 'yes' to above to which agency/ service is this person being referred to for comprehensive assessment?

★ Has this centre (to which person is being referred) assessment criteria being fulfilled:

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Pending	<input type="checkbox"/>
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★ Date assessment criteria fulfilled, if applicable (dd/mm/yy):

Date of referral:

Assessors observations and comments:

Please outline any interventions carried out or advice/ information given:

1.	4.
2.	5.
3.	6.

Please outline any service this person has been referred to:

1.	4.
2.	5.
3.	6.

Has the confidentiality policy been explained to individual?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Has a 'Consent to share information' form been signed?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Assessment completed by:

Name:	Service/ organisation:
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ADDITIONAL INFORMATION

References:

- ¹ Babor, T., Higgins-Biddle J., Saunders, J. & Monteiro, M. (2001). *AUDIT The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (2nd Ed.)*. World Health Organisation.
- ² Hope, A. (2009). *A Standard Drink in Ireland: What strength?* Health Service Executive—Alcohol Implementation Group.
- ³ Berman, A., Bergman, H., Palmstierna T. & Schlyter, F. (2003). *DUDIT (Drug Use Disorders Identification Test) Manual*. Stockholm: Karolinska Institutet.