Appendix 1: Initial Assessment– Minimum Standard Guidance

Note that any information relating to the NDTRS is in italics, although NDTRS requirements are subject to change.

These items/domains are considered minimum requirements; any other items/domains can be added subject to the requirements of the initial assessing programme.

(Starts on next page)

General Information

- **Name (also include nick names):**
- **Address:**
- **County:**
- **Phone number:**
- ***Date of birth*** *(dd/mm/yy):* ***& Age***
- ***PPS no.*** *(7 numbers followed by 1 or 2 letters):*
- ***Source of referral*** *(please circle):*
  Self Family Friends Other drug treatment centre GP
  Acute Hospital Service (excluding A&E) Social / Community Services
  Court/Probation/Police Outreach Worker Harm Reduction programme School
  Prison Employer Mental Health Liaison Nurse at A&E Accident & Emergency other Mental health service (including psychiatrist) Not known
- **Date of referral** *(dd/mm/yy)*:

- **Next of Kin 1**

Name
Address
Phone
Is this person aware of drug use / contact with this service? Y N

- ***Living with*** *(circle one):*

alone parents /family friends partner partner & children alone with children foster care other.. Not known

- ***Living where*** *(circle one):*

stable accommodation institution homeless other unstable accommodation

- ***Ethnic Origin (****circle as many as appropriate)*

white Irish white Irish Traveller other white background black African other black background Chinese background other Asian background Do not wish to answer, other, please list

- ***Nationality / Country on passport:***

- **Services / workers you are in contact with over the last year (we will only contact them after consenting with you).**

Organisation Workers Name (contacts if known)

(The worker may wish to prompt the following: probation officer, addiction treatment centre, counsellor, social worker, housing service, other key working service, children's support services).

Alcohol Use

- **Measurement tool to be agreed as per national guidelines (e.g. AUDIT)**
- **Brief relevant case history**
- **Services currently involved or which have been involved in the care plan to date.**
- **What supports / progress are required in this area (shorter term)?**
- **Any future goals (longer term)?**

- ***Specify main type of alcohol consumed***:
  Beer spirits wine fortified wine cider alcopops
  Other...

- ***How many drinks were consumed over a typical drinking session over the past month***............... *If none, put 0*

- ***Number of days alcohol was consumed over the past month***.. *If none, put 0*

- **Please categorise the extent of the drinking problem (as per tool)**
  hazardous drinker harmful drinker dependent drinker

- **Ever previously treated for problem alcohol use?** *Circle one*
  Never treated Previously treated Not known Not applicable

Drug Use

- **Measurement tool to be agreed as per national guidelines (e.g. MAP)**

- **Type of contact with this programme** *circle one*
  First treatment One or more treatment periods Not known

- **Number of times started treatment in this programme this year (Jan to Dec)** ....

- **Ever previously treated for problem drug use?** *Circle one*
  Never treated Previously treated Not known Not applicable

- **If previously treated, state which drug** ....

- **If previously received opioid replacement treatment,** *please specify age first received opioid substitution treatment ....* Not known

- *Specify first drug used (excluding alcohol) ....age at first ....*

Drug type *Please rate order of preference / regularity in the brackets e.g. 1, 2, 3 ect..*	***Age at first use***	***How often*** *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*	***Amount used***	***Route of transmission.*** *1. inject* *2. smoke* *3. eat/drink* *4. sniff/snort* *5. sublingual* *6. rectal* *7. topical*	***Harm reduction awareness (Y / N)*** *Discuss harm reduction issues, (see guidebook for info)*
Heroin *(____)*					
Cocaine *(____)*					
Benzodiazepine *(____)*					
Amphetamines (Crystal Meth) *(____)*					
Ecstasy *(____)*					
Cannabis *(____)*					
Alcohol *(____)*					
Methadone *(____)*					
Tobacco *(____)*					
Codeine *(____)*					
Other *(____)*					

Risk behaviours

- **Brief relevant history of possible risk behaviours**
- **History of injecting** *circle one* *never injected* *has injected* *not known*
- **Age in years first injected** ……………………… *not known*
- **Frequency of injecting** *circle one* *injected in the last 30 days* *injected in the last year, but not in the last 30 days* *ever injected, but not in the last 12 months*
- **History of sharing needles or syringes** *circle one* *never shared needle or syringe* *Has shared* *Not known*
- **Frequency of sharing** *circle one* *shared needle or syringe in last 30 days* *shared needle or syringe in last 12 months but more than 30 days ago* *shared needle or syringe more than 12 months ago* *not known/don't want to answer*

Ongoing Care

- **Services currently involved or which have been involved in the care plan to date.**
- **What supports / progress are required in this area (shorter term)?**
- **Any future goals (longer term)?**

ASSESSMENT DETAILS – for office use only

- **Date of initial assessment** *(dd/mm/yy)*:
- **Assessment outcome:** *circle one* *Suitable* *Unsuitable*
- **?Assessment criterion fulfilled** *circle one* *YES* *NO* *Pending*
- **Date assessment criteria fulfilled** *(dd/mm/yy):*
- **Referral for Comprehensive Assessment** *circle one* *YES* *NO*

END