South East Regional Substance Misuse Services

Initial Assessment

Client Last Name:	**Client First Name: (Include nicknames)**	**Client Number:**
Address		
HSE Area:	**Centre:**	**Type:**
Phone Number: (Landline)	**(Mobile)**	**Which is best to contact you? (tick one) Landline Mobile**
Gender: (tick one) ☐ Male ☐ Female	**Age:**	**Date of Birth:**
PPS Number:		

Living with whom: (tick one)	**Living Where: (tick one)**	**Area of Residence (as per HRB)**	**Community Care Area (as per HRB)**	**City/County (as per HRB)**
☐ Alone ☐ Parents/Family ☐ Friends ☐ Partner Alone ☐ Partner & Child(ren) ☐ Alone with Child(ren) ☐ Foster Care ☐ Other specify_____ ☐ Not Known	☐ Stable Accommodation ☐ Institution-Prison ☐ Institution- (Residential Care; Halfway House) ☐ Homeless ☐ Other unstable accommodation ☐ Not Known			

Next of Kin Name: (Last, First)	**Next of Kin Phone:**
Next of Kin Address:	
Is this person aware of drug use/contact with this service? (tick one) ☐ Yes ☐ No	

Nationality (tick one)	**Ethnic Background (tick one)**	**Employment Status (tick one)**
☐ Irish ☐ Irish Traveller ☐ Other specify _____ ☐ Not Known	☐ White Irish ☐ White Irish Traveller ☐ Any other white background ☐ Black African background ☐ Any other black background specify_____ ☐ Chinese background ☐ Any other Asian background	☐ In paid employment ☐ Unemployed ☐ FAS/Training Course ☐ Student ☐ Housewife/husband ☐ Retired/unable to work ☐ Other specify _____

	☐ Other specify_____ ☐ Do not wish to answer this question	☐ Not known

Age left school or secondary school (Not third level) (tick one) ☐ Years _____ ☐ Never went to school ☐ Still at school ☐ Not known	**Education: highest level completed** ☐ Primary level incomplete ☐ Primary Level ☐ Junior Cert ☐ Leaving Cert ☐ Third Level ☐ Never went to school ☐ Special Needs Education ☐ Still in Education ☐ Not Known

Date of Referral:	**Main reason for referral: (tick one)** ☐ Alcohol ☐ Illicit Drugs ☐ Licit Drugs ☐ Other problem _____ ☐ Specify main drug/problem _____	**Source of Referral: (tick one)** ☐ Self ☐ Family ☐ Friends ☐ Other Drug Treatment Centre ☐ GP ☐ Acute Hospital service excluding A&E ☐ Social services/Community services ☐ Court/Probation/Police ☐ Outreach Worker ☐ Mobile Bus ☐ School ☐ Prison ☐ Employer ☐ Mental Health Liaison Nurse A&E ☐ A&E Other ☐ Mental Health Facility (+Psychiatrist) ☐ Not Known

If client was transferred from another treatment centre, please give reason for transfer:	**Date of Initial Assessment:**

☐ Client moved address
☐ Client management/security
☐ Dual Diagnosis (psychiatric/substance use co-morbidity)
☐ Treatment for blood borne diseases
☐ Client unstable requires methadone stabilisation
☐ Other additional treatment to satellite clinic or GP
☐ Other specify _____

Client treatment status (tick one)
☐ Offered treatment
☐ Placed on methadone waiting list
☐ Place on other drug treatment waiting list
☐ Psychiatric assessment only
☐ Transferred to another site
☐ Specify site (text box)

Assessment Outcome: (tick one)
☐ Suitable ☐ Unsuitable

Assessment criterion fulfilled
☐ Yes ☐ No
☐ Pending ☐ Not applicable

Date Assessment criterion fulfilled

If client was on a waiting list, please give reason client was removed from waiting list: (tick one)
☐ Treatment offered
☐ Client did not fulfil criteria to commence treatment
☐ Client did not accept methadone/other drug treatment
☐ Client transferred/commenced treatment with another centre specify
_____
☐ Client admitted to hospital
☐ Client sent to prison
☐ Client died
☐ Other specify _____

Accepted place at this treatment agency: (tick one) ☐ Yes ☐ No

Services/workers you are in contact with over the last year? (We will only contact them if required as part of your agreed care plan & after your signed consent):

Organisation Name	Key Worker's Name	Contact Details (if known)	Active Care Plan (Yes/No)

Number of times started treatment in this centre this year (Jan-Dec 2010):	Date THIS treatment started:	If received an opiate substitute (methadone/suboxone) date THIS substitution started:

Ever previously treated for problem drug or alcohol use
(If main problem is alcohol, circle appropriate answer
in alcohol options or if main problem is a drug circle
appropriate answer in drug option (tick one)

Alcohol

Type of contact with THIS centre (tick one):

☐ First treatment
☐ One or more treatment periods
☐ Not known

☐ Never treated ☐ Previously treated ☐ Not applicable ☐ Not known **Drugs** ☐ Never treated ☐ Previously treated ☐ Not applicable ☐ Not known					
Age first used any drug (excluding alcohol or tobacco):		**Specify first drug used (excluding alcohol or tobacco):**			
Problem substance(s) Including alcohol	**Route of administration**	**Frequency of use in the last month**			**Age of first use any drugs (years if unknown use code 99)**
Main substance *(Drop box of drugs list as HRB)*		**Drop list codes for column on the left:** 1=Inject 2=Smoke 3=Eat/Drink 4=Sniff/snort 5=Sublingual 6=Rectal 7=Topical 9=Not known		**Drop list codes for column on the left:** 1=Once a week or less 2=2-6 days a week 3=Daily 4=No use in past month 9= Not know	
Substance 2					
Substance 3					
Substance 4					
Usual cost of the amount used - € Main Substance €		**Substance 2** €	**Substance 3** €	**Substance 4** €	
initial Brief Relevant Drugs Case History: (additional information re: drug history during assessment)					
Services currently involved or which have been involved in Drug care plan to date?					

Please specify the preferred types of alcohol consumed (may tick more than one):

☐ Beer
☐ Spirits
☐ Wines
☐ Fortified Wines
☐ Cider
☐ Alco pops
☐ Other Specify _____

How many standard drinks were consumed on a typical drinking day over the past month:

_____

Standard Drink Guidance (HRB)

Ireland's standard drink contains 10 grams of pure alcohol. Examples are:

A pub measure of spirits (35.5ml)
A small glass of wine (100ml & 12.5% volume)
Half pint of normal beer/cider
An Alco-pop (275ml bottle)

	Millilitre	% Alcohol	No. Standards Drink (Rounded to the nearest whole number)
Bottle			
Wine	750ml	12.5	7
Vodka	700ml	37.5	21
Brandy	700ml	40	22
Whiskey	700ml	40	22
Gin	700ml	38	21
NAGGIN			
Vodka	175ml	37.5	5
Brandy	175ml	40	6
Whiskey	175ml	40	6
Gin	175ml	38	5
FLAGGON			
Cider	2 Litres	4.5	7

Please specify the number of days alcohol was consumed within the past month:

Please Categorise the extent of the drinking problem (as per the score from AUDIT tool): (tick one)

☐ Hazardous Drinker
☐ Harmful Drinker
☐ Dependent Drinker

Brief Relevant Alcohol Case History (additional information re: alcohol history during initial assessment):

Services currently involved or which have been involved in Alcohol care plan to date?

Ever injected: (tick one) ☐ Yes ☐ No ☐ Not known	**Injected in the past month (tick one)** ☐ Yes ☐ No ☐ Not known	**If yes, age first injected:**	**Frequency of injecting (tick one)** ☐ Injected in the last 30 days ☐ Injected in the last year but not last 30 days ☐ Injected but not in the last 12 months	**Sharing injecting Equipment: (tick one)** ☐ Yes ☐ No ☐ Not known	**Frequency of sharing equipment: (tick one)** ☐ Shared equipment in the last 30 days ☐ Shared equipment in the last 12 months ☐ Shared equipment more that 12 months ago

Brief Case History of Risky Behaviour(additional information re: risky behaviour during initial assessment including required interventions)

Harm Reduction Issues Discussed: ☐ Yes ☐ No

What supports/progress goals does the client required in this area of alcohol/drugs for the short term?

What supports/progress goals does the client required in this area of alcohol/drugs for the longer term?

Referral(s) to another service: ☐ Yes	**If yes, where for what type of service?**	**If no or pending, why:**	**Date referral(s) another agency completed**

☐ No ☐ Pending			
Move to a waiting list: (tick one) ☐ Yes ☐ No	**Comprehensive Assessment required? (tick one)** ☐ Yes ☐ No Pending **If pending, why?**	**What services are being offered to the client?**	**Care Plan Needs based on Initial Assessment:**