N Referral date: ie date referral received at agency	Norfolk Drug & Alcohol Partnership	Client reference / Name
N Date of first face to face presentation:		

Assessment Form

Substance misuse assessment for adults

Note to staff: If a full referral/triage/consent form has been received – this should be checked with the client and attached to this assessment. Then fill in question 1 and continue with the assessment from question 16. Otherwise – please fill in questions 1 – 15 (including consent) as appropriate before continuing with the assessment.

Fields with prefix N indicate information required for data purposes and must be completed.

1. Name of worker carrying out assessment

Agency name

Agency address

Phone

N **2. Referral source**
(ie referring agency)

N **3. Name of client + title**

4. Address

N **5. Postcode**

6. Phone number

Can a message be left on this number? No ☐ Yes ☐

7. Is this your address for correspondence? No ☐ Yes ☐
If not how is it best to contact you?

Next of kin and contact number

N **8. Date of birth**

N **9. Gender:** **male** ☐ **female** ☐ (please tick)

10. Reason for referral

N **11. Ethnicity** (**Note to staff:** Please tick one ethnicity only).

Code	Group	Ethnicity	Tick one	Code	Group	Ethnicity	Tick one
A	White	White British	☐	H	Asian/Asian British	Indian	☐
B	White	White Irish	☐	J	Asian/Asian British	Pakistani	☐
C	White	Other white	☐	K	Asian/Asian British	Bangladeshi	☐
D	Mixed	White and Black Caribbean	☐	L	Asian/Asian British	Other Asian	☐
E	Mixed	White and Black African	☐	M	Black/Black British	Caribbean	☐
F	Mixed	White and Asian	☐	N	Black/Black British	African	☐
G	Mixed	Other mixed	☐	P	Black/Black British	Other Black	☐
				R	Other Ethnic	Chinese	☐
				S	Other Ethnic	Other	☐
				Z		Not stated	☐

N **12. Nationality**

13. GP: name, address, phone
(if not registered please state)

Client reference / Name

14. Consent to share information

I consent to the details contained in this form to be shared where appropriate with the agency/agencies and individuals below if this is required for my future care. I understand that I can withdraw consent at any time; these details will be checked with me (maximum 3 months).

Organisation	Staff contact name	Client initial	Review date

Name of client

Signature of client **Date**

I understand that details without my name/address on will be used to monitor service levels and quality and will be collected for NDTMS (National Drug Treatment Monitoring System) and N-DAP (Norfolk Drug and Alcohol Partnership).

N **Signature of client** **Date**

Signature of individual filling in referral form **Date**

Does the client have any literacy problems? No ☐ Yes ☐

What is the client's first language?

Does the client consider themselves to have a disability? If yes, what?

Substance Misuse Details

Current use

Client reference / Name

15. Substance misuse details: Current use

Substance	**Prescribed / not prescribed**	N **Frequency of use** (enter code) 1. Not used in past month 2. Used once per week or less 3. Used 2-6 days per week 4. Used daily 5. Used more than once daily 6. Not known	**Amount / cost** (indicate per day or week)		N **Route of administration** (enter code) 1. Inject 4. Oral 2. Sniff 5. Other 3. Smoke	N **Problem Substance 1, 2 or 3** (enter 1, 2, 3)	**Last used**	N **Age first used problem substance no 1**
Alcohol (cont. below)								
Heroin								
Methadone								
Other opiates								
Other								
Diazepam								
Benzodiazepines								
Cocaine								
Crack cocaine								
Ecstasy								
Amphetamine								
Cannabis								
LSD								
Solvents								
Other prescribed medication								
Other								
			Approx total cost per week					

Additional information about alcohol misuse

Type of alcohol (eg wine, spirits, beer, lager, cider)

N **Drinking days** (in 30 days prior to assessment)

N **Units per day** (on typical day in last 30 days)

Is this binge drinking? No ☐ Yes ☐

Additional information about drug misuse

N **Have you ever injected?** (please tick)

P – Previously ☐
C – Currently ☐
N – Never ☐

N **Have you injected over the last 30 days?** No ☐ Yes ☐

How often do you inject per day / week?

Client reference / Name

16. Are you receiving any treatment for your substance misuse currently? No ☐ Yes ☐ (please tick)
If yes, what / where

Previous treatment

N **17. Have you ever received any structured treatment for your substance misuse in the past?** No ☐ Yes ☐

Note to staff: NDTMS only want to know about 'structured' treatment for the NDTMS returns.
Structured – Inpatient treatment, residential rehab, prescribing, counselling, structured day programmes and any other care planned work.

Type of treatment	Ever received	When?	Agency name	In this treatment currently?	Nos of time received	Reason for leaving
Community prescribing ***Tier 3*** (structured)						
Community detox **Tier 3** (structured**)**						
Care planned counselling **Tier 3** (structured)						
Structured day care **Tier 4** (structured)						
Inpatient detox **Tier 4** (structured)						
Residential rehab **Tier 4** (structured)						
Any other treatment that is structured and care planned?						
Any other treatment that is unstructured? eg Drop-in/needle exchange/ AA / NA						

N **18. Is there anything about your substance misuse that you would like to add?**
Note to staff: eg periods of abstinence

Substance misuse section:
Are there issues here that need to be addressed in the care plan?
No ☐ **Yes** ☐

Client reference / Name

Physical Health

N Date Physical/Psychological Health Section completed

Note to staff: This is an information gathering section – it is not diagnostic.
If physical/psychological health filled in at different time to rest of assessment – you will need this date entering for NDTMS – not the date for the rest of the assessment.

Medical history

19. Is there anything you would like to mention about your physical health?
No ☐ Yes ☐ (please tick) **If yes, can you give details?**

20. Have you had any major diseases / illnesses / traumas? No ☐ Yes ☐

If yes, can you give details?
(eg when / treatment)

21. Have you had any operations? No ☐ Yes ☐

If yes, can you give details?

22. Are you currently taking any prescribed medication for physical problems? No ☐ Yes ☐

If yes, can you give details?

23. Have you taken any medication for physical problems in the past? No ☐ Yes ☐

If yes, can you give details?

24. (if not already clear) **Have you ever been treated in hospital as a result of your substance misuse?**

No ☐ Yes ☐ **If yes, can you give details?**

Physical health section:
Are there issues here that need to be addressed in the care plan?
No ☐ **Yes** ☐

Client reference / Name

Overdose

25. Have you experienced an overdose or been around when another person has overdosed?
No ☐ Yes ☐ (please tick)

If yes, was this an intentional or unintentional overdose?

Do you remember what substances were involved?

26. Do you know what to do in an overdose situation? No ☐ Yes ☐

Are there any other details about overdose issues you would like to discuss?

Prompt to staff: Has overdose / tolerance information been provided for client if necessary?
If appropriate, take action and enter in care plan.

Symptoms related to drug / alcohol misuse

27. Have you ever experienced any symptoms that might be due to drug or alcohol misuse?

Symptom	Have you ever experienced this? (please tick box)	Might this be to do with: - drugs - alcohol - don't know	Comment
Nausea / vomiting	No ☐ Yes ☐		
Shakes	No ☐ Yes ☐		
Numbness / tingling (peripheral neuropathy)	No ☐ Yes ☐		
Sweating	No ☐ Yes ☐		
Anxiety / panic attacks	No ☐ Yes ☐		
Memory loss	No ☐ Yes ☐		
Blackouts	No ☐ Yes ☐		
DTs	No ☐ Yes ☐		
Insomnia	No ☐ Yes ☐		
Loss of appetite	No ☐ Yes ☐		
Low moods	No ☐ Yes ☐		
Convulsions	No ☐ Yes ☐		
Abscesses	No ☐ Yes ☐		
Stimulant use symptoms	No ☐ Yes ☐		
Other	No ☐ Yes ☐		

28. Is there anything else you would like to discuss about your symptoms and substance misuse?

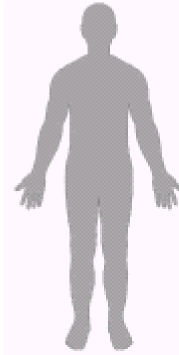
Overdose / symptoms section:
Are there issues here that need to be addressed in the care plan?
No ☐ **Yes** ☐

Client reference / Name

Injecting history

Note to staff: Look back to referral question 24 or assessment question 15.
Only ask the following questions if appropriate.

29. What sites do you use to inject?



30. Do you have problems with any of these sites?

Prompt to staff: Does client need to see GP / nurse about infected sites?
If appropriate, take action and enter in care plan.

N **31. Have you ever shared any injecting equipment / paraphanalia?** No ☐ Yes ☐ (please tick)

32. Have you shared any other equipment?

33. What do you do with used injecting equipment?

34. Do you know of needle exchange schemes in your area? No ☐ Yes ☐

Prompt to staff: Has needle exchange information been provided to the client if necessary?
If appropriate, take action and enter in care plan.

35. Is there any other information that you think is relevant about your injecting?

36. Do you think that your injecting causes any harm to others?
If yes, how do you think it affects them?

Injecting section:
Are there issues here that need to be addressed in the care plan?
No ☐ **Yes** ☐

Client reference / Name

Blood borne viruses

Note to staff: You may need to return later to these questions to complete.

N **37. Hep C – Latest test date:** date client was last tested for Hep C.
Note to staff: If exact date not known, please give approximate date.

N **38. Hep C – Intervention status:** has client been offered test within current treatment episode?

(please tick)

A Offered and accepted ☐
B Offered and refused ☐
C Not offered ☐

N **39. Hep B – Intervention status:** has client been offered vaccination for Hep B in current treatment episode?

(please tick)

A Offered and accepted ☐
B Offered and refused ☐
C Immunised already ☐
D Not offered ☐
E Acquired immunity ☐

N **40. Hep B – Vaccination count:** number of Hep B vacs given to client within current treatment episode or if course of vacs was completed (please tick)

1 One vaccination ☐
2 Two vaccinations ☐
3 Three vaccinations ☐
4 Course completed ☐

N **41. Previously Hep B infected?** No ☐ Yes ☐

N **42. Hep C Positive?** No ☐ Yes ☐

N **43. Referred to Hepatology?** No ☐ Yes ☐

Prompt to staff: Does the client require BBV tests / vaccinations? If appropriate, take action and enter in care *plan.*

BBV section: Are there issues here that need to be addressed in the care plan?
No ☐ **Yes** ☐

Client reference / Name

Sexual health

This section looks at sexual health and the impact substance misuse might have on it.
Note to staff: The following questions are prompts to use where appropriate.

44. Do you have a sexual partner or partners?

45. How do you think your substance misuse impacts on your sexual health or vice versa?

46. If appropriate: **What / methods of protection do you and your partner(s) use?**

47. If appropriate: ***Are* you concerned that the method(s) of protection that you and your partner(s) are using puts either of you at risk of pregnancy or sexually transmitted infections (STIs)?**

Prompt to staff:
Has contraception information been provided to client?
Has STI information been provided to client? If appropriate take action and enter in care plan.

48. If the person is under 25: **Do you know that all men and women under the age of 25 can easily be screened and treated for chlamydia and gonorrhoea?**

Prompt to staff:
Does the client wish to be screened?
If appropriate take action and enter in care plan.

49. Do you have any other issues about your sexual health or sexual relationships that you would like to discuss further?

Note to staff: If appropriate – give out condoms/leaflets/screening information

Sexual health section: Are there issues here that need to be addressed in the care plan? **No** ☐ **Yes** ☐

Women's health

50. Could you tell me details of any pregnancies, miscarriages or terminations you may have had?

51. When was your last menstrual period?

N **52. Do you know if you are pregnant?** Pregnant ☐ Not pregnant ☐ Don't know ☐ (please tick)

Prompt to staff:
If client is pregnant, does she need to be referred to GP?
If client does not know, would she like a pregnancy test?
Is Child Protection action necessary?
If appropriate take action and enter in care plan.

53. If appropriate: **Are you trying to become pregnant?** No ☐ Yes ☐

Prompt to staff:
If client is trying to get pregnant, has information on pre-conceptual care been given? eg – folic acid supplements, antenatal care, smoking, alcohol.
If appropriate take action and enter in care plan.

54. Have you ever had a smear test? No ☐ Yes ☐

If yes, do you remember when?

Prompt to staff:
Does client want a smear test?
If appropriate take action and enter in care plan.

Women's health section: Are there issues here that need to be addressed in the care plan? **No** ☐ **Yes** ☐

Client reference / Name

Psychological Health

Current psychological health

Note to staff: check questions 27 to 30 in the referral first and check safety needs screen at end of referral

55. How is your mood today?

56. How do you think your substance misuse has had an impact on your psychological health and vice versa?

N **57. Are you currently receiving care from mental health services for psychological health reasons?**

No ☐ Yes ☐ (please tick)

If yes, can you give details?

58. Are you currently being treated or supported for any psychological problems other than through mental health services – for example your GP?

No ☐ Yes ☐ (eg anxiety, depression)

59. Are you experiencing psychological problems but not receiving treatment or support?

No ☐ Yes ☐ **If yes, could you explain?**

Prompt to staff:
Does client need to see GP about psychological health?
If appropriate take action and enter in care plan.

Past psychological health

60. Have you been treated in the past for any psychological problems? No ☐ Yes ☐
(eg anxiety, depression)

61 Have you ever deliberately harmed yourself? No ☐ Yes ☐

If yes, can you give details.

62 Have you ever attempted or seriously considered suicide? No ☐ Yes ☐

If yes, can you give details.

63. Note to staff: How is the client presenting today?

Psychological health section:
Are there issues here that need to be addressed in the care plan?
No ☐ **Yes** ☐

Client reference / Name

Offending History

Note to staff: Indicate if this is self disclosure or evidenced.

64. Do you think that your substance misuse has caused you to offend?

No ☐ Yes ☐ (please tick)

If so, how?

65. What is your current legal status?
(state what)

Community sentence
Current DRR
Custody
Bail
Licence
Fines
Suspended sentence
Other

66. Have you any cases pending? No ☐ Yes ☐

If yes, can you give details?

67. Can you tell me if you have any previous convictions or cautions? What are they?

Periods in prison?

68. Have you a current offender manager or DIP worker?

Do you give permission for us to contact them if appropriate?
Note to staff: This must be entered on the consent sheet

Offending section: Are there issues here that need to be addressed in the care plan?
No ☐ **Yes** ☐

Client reference / Name

Social / Personal History

Note to staff: Indicate if this is self disclosure or evidenced.

69 Could you tell me about your past and what brought you here?

Social/personal section: Are there issues here that need to be addressed in the care plan?
No ☐ **Yes** ☐

Client reference / Name

70. Has anyone else in your family got a problem with any substances? No ☐ Yes ☐ (please tick)

If yes, can you give details?

71. Has domestic violence ever been an issue for you? No ☐ Yes ☐

If so, how?

Domestic violence section: Are there issues here that need to be addressed in the care plan?
No ☐ **Yes** ☐

Prompt to staff:
Are there safety issues for client / children arising from this situation?
If appropriate take action and enter in care plan.

72. Can you give any information about your housing situation?
Note to staff: check referral questions 21 and 22

Prompt to staff:
Does client need specialised help with housing?
If appropriate take action and enter in care plan.

N **73.** ***Note to staff:*** **What was the client's accommodation need (30 days prior to treatment start)?**

(please tick)

1. NFA – urgent housing problem ☐
2. Housing problem ☐
3. No housing problem ☐

74. Can you give details of your financial situation?
(eg Benefits / Income / Current debts)

75. Are your finances directly affected by substance misuse?

Prompt to staff:
Does client need specialised help with finance?
If appropriate take action and enter in care plan.

76. Are you in employment or training?

Prompt to staff:
Does client need specialised help with employment or training?
If appropriate take action and enter in care plan.

N **77. Current employment status**

(please tick)

1. Regular employment ☐
2. Pupil / student ☐
3. Economically inactive ☐
4. Unemployed ☐
5. Other ☐
6. Not known ☐

78. Do you currently drive No ☐ Yes ☐
Note to staff: Has the leaflet been given out about the DVLA requirements?

79. Have you any mobility issues?

Housing/financial/ employment and training section: Are there issues here that need to be addressed in the care plan
No ☐ **Yes** ☐

Client reference / Name

Dependants

Note to staff: check questions 31, 32 and 33 in the referral

N **80. How many children under 16 live with you at least part of the time?** (This means age 15 years and under) (number only required)

81. Could you tell me about any children that are yours, or that you care for that are 18 years old and under.

Where child lives	Names and ages of children	Who has parental responsibility?	Have specific concerns been raised with reference to any of these children? If yes, please enter name	Is social services involved? (please tick)		Name of social worker
1. With client				No ☐	Yes ☐	
2. With partner or ex partner				No ☐	Yes ☐	
3. With other family member (inc grandparents)				No ☐	Yes ☐	
4. In care				No ☐	Yes ☐	
5. Client pregnant				No ☐	Yes ☐	
6. Other				No ☐	Yes ☐	

N **82. Parental status of client** (**NB**: for this question NDTMS want to know children of 15 and under only)

(Please tick one of the following)

1. Children living with client ☐
2. Children living with partner or ex partner ☐
3. Children living with other family member ☐
4. Children in care ☐
5. Client pregnant ☐
6. Other ☐
7. No children under 16 ☐

Note to admin staff: enter number ticked nearest top of list.

83. Additional information about dependants

Prompt to staff:
Should Child Protection procedures be started?
If appropriate take action and enter in care plan.
Note to staff: If live with children ask about storage of injecting equipment, substances, medication, disposal.

Dependants section:
Are there issues here that need to be addressed in the care plan?
No ☐ **Yes** ☐

Client reference / Name

84. Is there anything else about yourself and your situation that you would like to mention?

Safety Needs Screen

Note to staff: This page must be filled in if one was not received with a referral / triage.
This is not a formal risk assessment, but an indicator of safety issues.

85. Current risk areas

Risk area	Is this a risk? (please tick) **Note to staff:** You must tick one of the boxes			Is the source of this information self disclosure from the client (SD) or evidenced from another source (E)?	If evidenced, state what the source is
Self harm	No ☐	Yes ☐	Don't know ☐		
Suicide	No ☐	Yes ☐	Don't know ☐		
Overdose	No ☐	Yes ☐	Don't know ☐		
Violence to others	No ☐	Yes ☐	Don't know ☐		
Sexual offending	No ☐	Yes ☐	Don't know ☐		
Other offending	No ☐	Yes ☐	Don't know ☐		
Accidents	No ☐	Yes ☐	Don't know ☐		
Neglect	No ☐	Yes ☐	Don't know ☐		
Abuse/exploitation by others	No ☐	Yes ☐	Don't know ☐		
Absconding/withdrawal from treatment	No ☐	Yes ☐	Don't know ☐		
Children	No ☐	Yes ☐	Don't know ☐		
Staff	No ☐	Yes ☐	Don't know ☐		
Homeless/sofa surfing	No ☐	Yes ☐	Don't know ☐		
Other	No ☐	Yes ☐	Don't know ☐		

Please give further details if necessary

NB: Note to staff:
Has all necessary harm reduction information been given out?
Have all NDTMS data requirements been filled in?

Care plan start date (today's date)		Client reference / Name

Initial Care Plan

For use until the comprehensive care plan is drawn up

Issues identified in assessment requiring action	Action agreed	Identified risks	Review date *	Comments
Substance misuse				
Physical health				
Overdose / symptoms				
Injecting				
BBV				
Sexual health / women's health				
Psychological health				
Offending				
Social / personal				
Domestic violence				
Housing / financial / employment and training				
Dependants				
Other				

(eg at comprehensive care plan appointment / modality appointment)

Signature of client	Signature of staff member carrying out assessment