

BRENT SUBSTANCE MISUSE SERVICES TRIAGE ASSESSMENT FORM

Date of referral (Date client presents to Duty or referral received)		Source of referral	Letter	Visit	Phone	Initial assessment date (Date client attended)
Confidentiality policy explained (See back page)	Yes	No	Priority Status	Low	Medium	
ASSESSING AGENCY & NAME OF ASSESSOR		Date & Time				

SERVICE USER

First Name: _____ Client ID: _____ DOB _____ AGE _____
 Surname: _____ A.K.A: _____ **Under 18 years? YES/NO** Gender F M

Address: _____

Full Postcode	Borough (L/A):	NFA	Yes	No
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Tel. No. _____ Mobile _____
 'Ok to leave messages?' Yes No 'Ok to leave messages?' Yes No

' Emergency Contact No. _____ Name / Relationship to service user _____

Nationality (Country of nationality at birth) _____ Religion _____

Ethnicity	White	A) British	B) Irish	C) White Other	
	Mixed Ethnicity	D) White & Black Caribbean	E) White & Black African	F) White & Asian	G) Other mixed
	Asian/ Asian British	H) Indian	J) Pakistani	K) Bangladeshi	L) Asian Other
	Black/ Black British	M) Caribbean	N) African	P) Other Black	
	Other	R) Chinese	S) Any Other	Z) Not Stated	

Language First language? _____ Interpreter needed? (details) _____

REFERRER

Drug Service Statutory (1)	GP (3)	Arrest Ref/DIP (5)	YOT (7)	A&E (9)	Psy-chiatry (11)	CARAT (13)	Other (15)	Pupil referral unit (17)	Social services (19)	Sex worker project (21)	Psycho-logical services (23)	Con-cerned other (25)
Drug Service Non - Statutory (2)	Self (4)	DRR (6)	Prob (8)	Syringe ex-change (10)	CCA (12)	Employ-ment service (14)	Education service (16)	Connex-ions (18)	Looked after children (20)	General hospital (22)	Relative (24)	

Referrer's Contact Details: _____

Is service user aware of this referral? Yes No If "other" please specify below

If self-referral, how did service user find out about the service? _____

EMPLOY- MENT STATUS	Regular Employment (1)	Pupil / Student (2)	Economically Inactive (3)	Unemployed (4)	Other (5)	Seeking Employment	Not Known (6)
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GP DETAILS	Is Service User	Registered with GP	Not registered with GP	Unable to register with GP (note reason / offer support)
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Name: Dr _____ Address: _____
 Telephone: _____ Fax: _____

Is GP aware of substance use and willing to work with the service Yes No Unsure

CURRENT SUBSTANCE USE (used in the last 4 weeks before presenting to treatment)

	Age of 1 st use	Amount / Unit	Frequency of use (see below)	Route. If IV please state where	How long used for?	Prescribed Y / N (If Yes by whom)
Problem Substance No 1: (this referral) DRUG1	DRUG1AGE					
Problem Substance No 2: (this referral) DRUG2						
Problem Substance No 3: (this referral) DRUG3						
Problem Substance No 4:						
Other						
Other						

NB: Report alcohol consumption in relation to daily units & no. of drinking days in 4 weeks

Daily (1)	Inject (1)
Weekly (2)	Sniff (2)
Monthly (3)	Smoke (3)
Occl. (4)	Oral (4)
	Other (5)

DRINKDAYS UNITS ALC

Assessment that the client consumed Alcohol (1 - 28) to initial assess-

No. of days in the 28 days prior to initial a drinking day in the 28 days prior ment

Typical no. of units consumed on

Detail any other prescribed drugs. Is medication used as directed?

How does Service User finance their drug / alcohol use e.g.: working, benefits, theft.

If **SEXWORK** please circle: **selling sex on the street (1)** **selling sex from a premises (2)** **not a sex worker (3)**

INJECTING HISTORY (See comprehensive assessment for further details)

Has service user ever injected? Currently injecting (C) Never injected (N) Previously injected (but not currently) (P) No Ever shared equipment? Yes No

How often has Service User injected in the in last 30 days Frequently Sometimes Hardly ever Never

TREATMENT HISTORY

PREVTR: Previous treatment	Yes	No	Previously treated at this agency	Yes	No
				Previously treated elsewhere	Yes

If yes, what treatment has been accessed previously? _____

Any periods of abstinence? _____

If yes, how was this achieved / what was helpful? _____

What support / treatment does client require from service now? _____

Does service user have any children? Yes No If Yes, how many children under 16 live with the client at least part of the time?

If Yes: Name	Age	DOB	Residing?

PARENT: Parental Status (Please tick)

Children living with client
 Children living with partner if not residing together
 Children living with other family member
 Children in care
 Client pregnant and no other children
 Contact with other children (step/ friends/ relations)
 No children under sixteen (7)
 Client declined to answer

Does the service user have any concerns about their children e.g.: School attendance, registered with GP, substance misuse _____

Does the family have any support from social services? Yes No Is service user a carer for anybody? YES NO

If Yes, Name of Social Worker _____
 Contact details _____
 Nature of support _____

What other social support is needed? _____

Accommodation Need:
 ACM NEED

<input type="checkbox"/>	NFA Urgent housing problem (1)	Live on streets, Use night hostels, Sleep on different friends floor each night. <i>(Please circle appropriate option)</i>
<input type="checkbox"/>	Housing problem (2)	Staying with friend's / family as a short term guest, Night winter shelter, Direct Access short stay hostel, Short term B&B
<input type="checkbox"/>	No Housing problem (3)	Local Authority (LA) Registered Social Landlord (RSL) rented, Private rented, Approved premises, Supported housing/hostel, Traveller, Own property, Settled with friends / family

Consider referral to housing support e.g. PCHA

Sexuality: Heterosexual (H) Gay (G) Bi-Sexual (B) Other (R) Not disclosed

MENTAL HEALTH

Has service user ever been diagnosed with a mental health problem Yes No Dual diagnoses? YES NO

If Yes, what was this diagnosis _____

Do you have a Psychiatrist or CPN Yes No Details Name: _____

Has previous contact with MH services Yes No Contact No: _____

In the last year: **Overdose** **Suicide attempt** **Self-harm** Briefly describe _____

Assessor's perception of service users mental health / presentation _____

PHYSICAL HEALTH

Has a disability? Yes No Specific requirements? _____

PREGNANT Due Yes No date? _____

Booked into ante-natal care Yes No Where? _____

Any health issues? _____

Has Service user been tested for

Count of Hep B Vaccinations	Hep B	Tested: Yes / No	Positive / Negative	Vaccinated History: <i>Please circle</i> None One Vaccination (1) Two Vaccinations (2) Three Vaccinations (3) Course Completed (4)
HEPCDATE	Hep C	Tested: Yes / No	Positive / Negative	Latest test date:
	HIV	Tested: Yes / No	Positive / Negative	Latest test date:

ALL SERVICE USERS MUST BE OFFERED ACCESS TO SCREENING AND VACCINATION SERVICES

HEPBSTAT—Please Circle

- Offered & Accepted (A)
- Offered & Refused (B)
- Immunised Already (C)
- Not offered (D)
- Acquired immunity (E)

HEPCSTAT—Please Circle

- Offered & Accepted (A)
- Offered & Refused (B)
- Not offered (D)

HEPATOL Referred to Hepatology Yes (Y) / No (N)

Provide Health Promotion Information as appropriate

Yes	No
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LEGAL ISSUES

Is Service user actively involved with criminal justice system

Yes	No
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If yes: (details) _____

Is Service User engaged in DIP Services?

Yes	No
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Has the service user been involved in any violent incidents over the last 12 months? (e.g. DV, ABH, GBH, Arson, carry a weapon etc.) *Please give details* . Also note relevant history.

Has the service user been the victim of violence / exploitation e.g. domestic violence, abuse. *Please give details*

Any other comments, additional information

SUMMARY OF RISKS

-Immediate Risk/s identified in Initial Assessment -Historical Risk Factors	Comments: Outline risks & plan to manage immediate risk should be included in initial care plan
Current risk of suicide History of suicide	
Current risk of overdose (intentional / unintentional) History of overdose	
Significant mental health problems. Include deliberate self harm History mental health problems	
Significant physical health problems History physical health Problems	
Potential / actual risk of harm to children or others History risk / harm to children or others	
Young person	

INITIAL TREATMENT/ CARE PLAN

Care plan start date: / /

Treatment Goals / Aims	Review Date & Outcome
Physical Health (e.g. complete BBV screening and vaccination; register with a GP)	
Mental Health (e.g. refer to psychology & attend)	
Social (e.g. access housing support, social activities)	
Legal (e.g. access legal advice)	

NOTE TO SERVICE USER:

Please sign below to declare that you agree with the Treatment Goals/Aims outlined above AND that you have been offered a copy of the above care plan to keep for your records.

Signature _____ Date _____

HHLCASDST: Drug treatment health care assessment date : / /

DISRS: DISCHARGE REASON *Please Circle*

Treatment Completed Drug Free	Treatment Completed alcohol free	Treatment completed - (occasional user– not heroin or crack)	Treatment completed— occasional user (alcohol)	Transferred— In custody	Incomplete – dropped out	Incomplete- treatment withdrawn by provider
Incomplete— retained in custody	Incomplete— treatment commencement declined by client	Incomplete— client died	Referred on	Moved away	other	No appropriate treatment available
Inappropriate referral						

MODAILITY EXIT STATUS *Please Circle*

DISD: DISCHARGE DATE From this episode

Mutually Agreed Planned Exit	Service User Unilateral Unplanned Exit	Intervention Withdrawn
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MODAILITY EXIT DATE _____

RESIDENCY

Evidence of residency e.g. utility bill—electricity/water rates/gas bill, DSS letter/Order Book, driving Licence. **Evidence seen / Not seen. NB: Photocopy for records.**

If unable to provide evidence at triage assessment this must be provided prior to starting treatment & should be noted on tracking sheet for follow up. If NFA & not claiming benefits, service user must be supported to access benefits & accommodation to enable stabilisation in treatment.

Please ensure the Treatment Outcomes Profile is now completed on the next page.

Photocopy form for Team Co-ordinator to enable tracking of referrals

BRENT SUBSTANCE MISUSE SERVICES CONSENT TO DISCLOSE FORM



I _____ (Service User Name) consent to information about my treatment being shared with the following

Liaise with... (name)	Contact address	Contact number

If you drop out of treatment Brent Outreach & Engagement Team can help you get back into this or another service. Do you consent to your details being passed on to BOET? **YES** **NO**

I consent to the service contacting me after discharge (saying no will not affect treatment options)
Yes **No**

I consent for correspondence to be sent to my home address. **Yes** **No**

I consent to information being given to the National Drug Misuse Monitoring System (NDTMS). “The NDTMS system involves collecting information about the type of treatment you receive from a treatment agency. Sometimes you may be seen by more than one agency. Consequently, to avoid duplication of reporting, NDTMS may share a minimal amount of information about you between the agencies from whom you may have received treatment” such as DOB, M or F and post code NW10.
Reports DO NOT include information that will identify you. **Yes** **No**

You have the right to see information held about you at any time although there may be a fee for this.
You have the right to withdraw your consent at any time

Signed _____ Date _____

Assessor _____ Date _____