

ADULT ASSESSMENT (NEW)

Please use this form to support access to DAPL's counselling and recovery services. This assessment is underpinned by Person Centred Planning and the Motivational Interviewing Approach. Only suitably competent DAPL staff should undertake the treatment aspect of this process.

The respondent's email (**robell@dapl.net**) was recorded on submission of this form.

Assessment Date: *

DD MM YYYY

08 / 05 / 2024

Email address of DAPL Worker undertaking this assessment *

robell@dapl.net

Can you tell me why you are referring yourself/have been referred to DAPL & what are the specific issues you would like to work through with your allocated counsellor? *

Maintaining recovery. Taken by surprise by sudden rage at a family member and suddenly did not feel safe. Exploring anxiety and managing life. Trauma management around incident downstairs

Are you supported by any other service(s)? e.g housing support, other counselling services, FIRST, Restoration etc. *

Addiction Services - Lyndsay Jones.

CLIENT'S PERSONAL DETAILS

Client's ID Code *

13122

Client's Full Name *

Ricky Smith

Known as (optional)

Ricky

Date of Birth *

DD MM YYYY

04 / 09 / 1973

Address (including Postcode) *

48 Herriot Cres METHIL KY8 3NE

Home Telephone No

Mobile Telephone No

07 858 958 865

Email Address

rickylad73@gmail.com

Gender *

Male

Ethnicity *

White Scottish

Name & Tel No of Next of Kin

George Ruckert 52 Herriot Cres Methil KY8 3NE

Relationship to you

Best Pal

GP/Healthcare Details

Name of GP & GP Practice Details (including tel no) *

Merlin Cres, Buckhaven, Leven KY8 1HJ

Phone: 01592 713299

Products and services: muiredgesurgery.co.uk

How would you rate your ability to read and write? *

1

2

3

4

5

Unable to read and write

☐

☐

☒

☐

☐

Very able to read and write

Are you Dyslexic? *

☐ No

☐ Yes - Dyslexia with Reading

☐ Yes - Dyslexia with Writing

☒ Yes - Dyslexia with Both Reading & Writing

☐ Other:

Please let us know of any impairments that affect you. *

☒ No Impairment

☐ Specific Learning Difficulties

☐ Hearing Impairment

☐ Language & Communication Disorder

☐ Physical or Motor Impairment

☐ Visual Impairment

☐ Cognitive Impairment

☐ Combined Sight & Hearing Loss

☐ Other:

Do you live with chronic pain? *

- ☐ No
- ☒ Yes - Back Pain
- ☐ Yes - Fibromyalgia
- ☐ Yes - Headaches
- ☐ Yes - Migraine
- ☐ Yes - Other

If other please tell us here

.....

Do you have any allergies or healthcare issues that we may need to know about?

.....

REFERRER'S DETAILS

Name of Referrer *

self
.....

Source of Referral *

Self ▼

Referrer's Telephone Number

Referrer's Email Address

ADULT SUPPORT & PROTECTION PART 1

https://docs.google.com/spreadsheets/d/13t30v5zurEYeWzg2_LumzlgNLPf-pVewrNLMcZ4jXEs/edit#gid=0

I have a history of being violent and/or aggressive? *

No



Have services refused to work with you due to your behaviour? *

If yes contact Line Manager

No

**ADULT SUPPORT & PROTECTION PART 2**

If the client answers yes to any of part 2 please fill in the Client Risk Management Form and send it to the admin. If the client answers yes to either question 2 or 3 AND also 4 and 5 then complete the adult protection form and send to Social Work (see link below)

<https://www.fife.gov.uk/kb/docs/articles/health-and-social-care2/help-for-adults-and-older-people/adult-support-and-protection/staff-information-and-training>

Risk Management Form: <https://forms.gle/VMr64WaoqNUMQmfH6>

If the Client is in immediate risk call 999

1. Do you have a history of self-harm and suicide attempts? *

- ☐ Yes
- ☒ No

If yes, when was the last time you self harmed or attempted suicide?

.....

2. Do you regularly consume alcohol/drugs to the point of unconsciousness? *

No ▼

3. Do you feel you are unable to safeguard your own wellbeing, property, rights or other interests? *

No ▼

4. Do you regularly place yourself in situations where you are open to exploitation and are at risk from someone else? *

No ▼

5. Are you affected by any of the following issues? *

Psychological Issues ▼

DAILY ROUTINE

Briefly describe your current substance use *

1.5 g per day cannabis

Morning routine *

Once a week to chemist

Afternoon Routine *

Sat in the hoose.

Evening Routine *

Take away every night.

GAMBLING

Do you gamble? *

I have never gambled

SUMMARY OF USE

My alcohol / drug use causing difficulties in my life *

1

2

3

4

5

6

7

8

9

10

Strongly Disagree

Strongly Agree

I am using alcohol / drugs every day (or almost every day) *

1 2 3 4 5 6 7 8 9 10

Strongly Disagree

☐☐☐☐☐☐☐☐☐☒

Strongly Agree

My alcohol / drug use is becoming unmanageable *

1 2 3 4 5 6 7 8 9 10

Strongly Disagree

☐☐☐☐☒☐☐☐☐☐

Strongly Agree

SERVICE OPTIONS BASED ON NEEDS & MOTIVATION

On a scale of 1-10 how strongly do you feel you want support from DAPL? *

1 2 3 4 5 6 7 8 9 10

Strongly disagree

☐☐☐☐☐☐☐☐☐☒

Strongly agree

Can you manage to attend meetings on a regular basis? *

1 2 3 4 5 6 7 8 9 10

Strongly disagree

☐☐☐☐☐☐☐☐☐☒

Strongly agree

Are you good at communicating your needs to others? *

1 2 3 4 5 6 7 8 9 10

Strongly disagree

☐☐☐☐☐☐☐☐☐☒

Strongly agree

Have you engaged positively with agencies in the past? *

12345678910

Strongly disagreeStrongly agree

Can you engage in conversations about how you feel? *

12345678910

Strongly disagreeStrongly agree

Do you like to talk about your feelings? *

12345678910

Strongly disagreeStrongly agree

Total score *

52

Suggestion for treatments *

- 0-12 Very low motivation for change – Consider offering harm reduction & brief interventions then close.
- 12-36 Low to Medium motivation for change – Consider offering Motivation and Behavioural Coaching (MBC) & SMART with the offer to progress to counselling if required after attendance.
- 36-60 High motivation for change – Consider referral directly for counselling engagement

CORE 10 - How you have felt over the last week?

A score or 10 or below may indicate that the client does not need counselling. A score above 10 would indicate that counselling may be useful.
Not at all- Occasionally- Sometimes- Often- Mostly

1) I have felt tense, anxious or nervous *

0

1

2

3

4

Not at all

☒

☐

☐

☐

☐

Most/all of the time

2) I have felt I have someone to turn to for support *

0

1

2

3

4

Most/all of the time

☒

☐

☐

☐

☐

Not at all

3) I have felt able to cope when things go wrong *

0

1

2

3

4

Most/all of the time

☒

☐

☐

☐

☐

Not at all

4) Talking to people has felt too much for me *

0

1

2

3

4

Not at all

☒

☐

☐

☐

☐

Most/ all of the time

5) I have felt panic or terror *

0

1

2

3

4

Not at all

Most/ all of the time

6) I made plans to end my life *

0

1

2

3

4

Not at all

Most/all of the time

7) I've had difficulty getting to sleep or staying asleep *

0

1

2

3

4

Not at all

Most/ all of the time

8) I have felt despairing or hopeless *

0

1

2

3

4

Not at all

Most/ all of the time

9) I have felt unhappy *

0

1

2

3

4

Not at all

Most/ all of the time

10) Unwanted images or memories have been distressing me *

0

1

2

3

4

Not at all

☒

☐

☐

☐

☐

Most/ all of the time

TOTAL SCORE: *

(If client scores over 24 in total or above 2 in the suicide question please complete the client risk management form and notify your manager.

[Risk Management Form Link](#)

I will create base line with Ricky in session

Recovery WEB

Recovery Outcomes Web Tool- Scale 1-10 (1 indicates problematic 10 indicates positive)

Substance Use *

Drugs ▼

Recovery Outcome 1: Substance Use *

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Recovery Outcome 2: Self-care and nutrition *

1	2	3	4	5	6	7	8	9	10
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Recovery outcome 3: Relationships *

1	2	3	4	5	6	7	8	9	10
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Recovery outcome 4: Physical health and wellbeing *

1	2	3	4	5	6	7	8	9	10
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Recovery outcome 5: Mental health and emotional well-being *

1	2	3	4	5	6	7	8	9	10
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Recovery outcome 6: Occupying time and achieving goals *

1	2	3	4	5	6	7	8	9	10
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Recovery outcome 7: Housing and independent living *

1

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3

4

5

6

7

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9

10

Recovery outcome 8: Offending *

1

2

3

4

5

6

7

8

9

10

Recovery outcome 9: Money Matters *

1

2

3

4

5

6

7

8

9

10

Recovery outcome 10: Children *

1

2

3

4

5

6

7

8

9

10

TOTAL SCORE: *

0 Base line at first

FAST Alcohol Screening Tool

Everyone must answer these questions

How often have you had 6 or more units on a single occasion in the last year?

Never (0)



How often during the last year have you failed to do what was normally expected from you because of your drinking?

Never (0)



How often during the last year have you been unable to remember what happened the night before because you had been drinking?



Never (0)



Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

No (0)



If score is 0, 1 or 2 on the first question continue with the next three questions. If score is 3 or 4 on the first question – stop here. An overall total score of 3 or more is FAST positive. What to do next? If FAST positive, complete remaining AUDIT questions (this may include the three remaining questions above as well as the six questions below) to obtain a full AUDIT score. Please enter the score here

0

How often do you have a drink containing alcohol?

Never (0)



How many units of alcohol do you drink on a typical day when you are drinking?



0-2 (0)



How often during the last year have you found that you were not able to stop drinking once you had started?



Never (0)



How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?



Never (0)



How often during the last year have you had a feeling of guilt or remorse after drinking?



Never (0)



Have you or somebody else been injured as a result of your drinking? *

No (0)

▼

TOTAL FAST Score (all 10 questions completed): 0 – 7 Lower risk 8 – 15 *
Increasing risk 16 – 19 Higher risk 20+ Possible dependence

0

ALCOHOL USE HISTORY

All information here is needed for DAISY if client has referred for alcohol use/co-dependency.

When did you last consume alcohol? *

Never Used Alcohol

▼

ALCOHOL USE

(If client hasn't been drinking for a while e.g months, years etc please still fill out all questions below with what they drank previously)

Please select all types of alcohol the client drinks?

	Wine	Beer	Spirits	Cider & Perry	Ready to Drink	Fortified Wine	Other
Main Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinks But Not Main Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please select how often for all types of alcohol the client drinks?

	Wine	Beer	Spirits	Cider & Perry	Ready to Drink	Fortified Wine	Other
Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5-6 days a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3-4 days a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-2 days a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2-3 days a month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
About 1 day a month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less Often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many units of each type of alcohol is the client drinking per day?

	Wine	Beer	Spirits	Cider & Perry	Ready to Drink	Fortified Wine	Other
1 Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17 Units

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18 Units

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34 Units

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35 Units

36 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50+ Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50+ Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

On the heaviest drinking day, how many units of alcohol do you consume?

Choose ▼

How often do you consume alcohol at this level?

Choose ▼

What age did you start drinking?

.....

Age at onset problematic drinking?

This must be filled in for daisy

.....

DRUG USE HISTORY

All information needed for Daisy if client has referred for drug use/co-dependency

When did you last use drugs? *
including NPS & volatile substances

In the last month ▼

DRUG USE

(If client hasn't used drugs for a while e.g months, years etc please still fill out all

questions below with what they used previously)

What drugs is the client using?

Please list all drugs the client is using and mark beside one which is their main type of drug being used (example: Heroin - Main Type, Cannabis, Valium)

1.5 g of cannabis per day

How often is each drug being used?

Please list each drug type with how often each is being used next to them

Cannabis

How much is the client spending on each drug?

Please list each drug type with how much they are spending on each next to them

£10 per day

Please state the quantity of each drug the client is using

1.5g

Please state the route of how they are taking each drug

(Example - Heroin - Inject, Cannabis - Smoke)

smoke with tobacco

What age were you when you first started using drugs?

14yrs

What age were you when your drug use became a problem?

22

How do you fund your drug use?

- ☐ Employment
- ☐ Crime
- ☐ Debt
- ☐ Begging
- ☐ Benefits
- ☐ Sex Work
- ☐ Pension
- ☐ Pocket Money/Lunch Money
- ☐ Borrowing
- ☐ Other Not Listed
- ☒ Did not want to answer

PRESCRIBED MEDICATION INFORMATION

Information needed for DAISY

Have you been prescribed medication for your substance/alcohol *

Yes

If yes, Medication Type?

Methadone

▼

Daily Dosage

50mls

How often?

Daily

▼

Supervision

Unsupervised

▼

What age were you when you were first prescribed this medication?

25

INJECTING

Have you ever injected? *

Previous to last month

▼

INJECTING BEHAVIOUR

What age were you when you first injected?

23

Have you ever used a needle or syringe that someone else has used?

Never

Have you ever used a spoon/filter/water that someone else has used?

Never

Have you ever overdosed?

Yes

If yes, how many times

Last known date of overdose

DD MM YYYY

06 / 06 / 2000

BLOOD BORNE VIRUS (BBV)

Have you ever had a Hep B Test? *

Never ▼

Have you ever had a Hep B Vaccination? *

Never ▼

Have you ever had a Hep C Test? *

Never ▼

Have you ever had a HIV Test? *

Never ▼

Would you like a HIV & Hep C Test? *

If yes, please refer to We are with you on Fife@wearewithyou.org.uk

No ▼

SOCIAL CIRCUMSTANCES

Please describe your current accommodation *

Owned/Rented - Stable ▼

Do you live with other adults? *

No



What is your employment status *

Long term sick/disabled



Have you served in Armed Forces? *

No



If Yes, length of service

Choose



Have you been in prison/YOI in the last 12 months? *

- ☐ Currently in Prison/YOI
- ☐ Was in Prison 0-3 months ago
- ☐ Was in Prison 4-12 months ago
- ☒ No
- ☐ Did not wish to answer

Has a routine enquiry been carried out for domestic or childhood abuse? *

No ▼

How many children under 16 years old do you have? *

0

How many children under 16 years old live in the same household as you? *

0

Are you or your partner pregnant? *

☐ Partner Pregnant

☒ No

☐ Pregnant

Your history of tobacco use? *

Currently using tobacco ▼

If currently using, have you ever been referred to a specialist smoking cessation service?

No ▼

Would you like a naloxone kit? *

☐ Yes

☒ No

If no, please state the reason

Declined - has access to kit



If you need support to access naloxone *

Please contact we are with you for someone to go out to the client to provide them with Naloxone: Fife@wearewithyou.org.uk

Not applicable



Are you in a co-dependent relationship? A co-dependent relationship is a kind of dysfunctional relationship where one person is a caretaker and the other person takes advantage. *

No



Are you or have you ever been involved in Chemsex?

If yes, we can direct you to support for both your drug use and the possible sexual health issues that sometimes arise within this activity.

No



CONTRACT, CONSENT & GDPR

If you would like us to communicate with other services, agencies or people about the service you are receiving from DAPL, please tell us their Name and Contact Details here. *

Addiction Services Lyndsay Jones

Consent to Liaise given *

Form to fill in for written consent to liaise [Consent to Liaise Form](#) (please go up to the file tab then download - microsoft word doc to be able to edit the form - then send to admin to upload to clients file once form is complete)

- ☒ Verbal
- ☐ Written
- ☐ None Given

Did you receive a text from DAPL to read over DAPL's GDPR statement? *This would be at the bottom of the text with your appointment details for this assessment.* *

If no, please send link to client either by text or email or print a copy to give to them/post out to them. If client was unable to read GDPR statement please read out to client & ask for verbal consent

Text/email: <https://forms.gle/mr5EjqIWk7w2uGs98>

Post Out/To Read to

client: <https://docs.google.com/document/d/1HwzFmszH8nMjIYjBwtMM3BFyt9tZFdW2/edit?usp=sharing&oid=103255579450856022742&rtpof=true&sd=true>

No



Do you agree to DAPL holding your information in accordance with the General Data Protection Regulations? *

If client answers No, please contact your line manager

Yes I give my verbal consent ▼

Are there any days or times you CANNOT attend an appointment? *

later in the afternoon

Do you have any special requests to support access? (Disabilities, specific times due to work/school hours etc) *

Telephone with Ro

TREATMENTS

Government Units Guidelines: <https://www.nhs.uk/live-well/alcohol-advice/calculating-alcohol-units/>

Drugs Info: <https://www.crew.scot/drugs-information/>

Treatments

- ☐ Alcohol Brief Intervention (ABI)
- ☒ Drug Brief Intervention (DBI)
- ☐ Harm Reduction Information
- ☐ Psycho-Educational Information
- ☒ Relapse Prevention
- ☐ Mental Health First Aid
- ☐ Suicide Intervention

Engagement Plan

During this assessment we have discussed *

- ☐ Alcohol Safety by undertaking an Alcohol Brief Intervention
- ☒ Harm Reduction by undertaking a Drug Brief Intervention
- ☐ Overdose Interventions
- ☐ Naloxone & how to use it

I give DAPL my permission to contact me approximately 3 /6 / 12 months after engagement has stopped to ask about my experience of the service, progress and any comments to make to improve the service. *

- ☒ Yes
- ☐ No

I am planning to access *

(If the client is interested in SMART please ask them to speak to their counsellor or the client can email for information directly to stewtalbot@dapl.net) **Clients cannot be put in for MBC only they must also be receiving counselling from DAPL.**

- ☒ COUNSELLING
- ☐ COUNSELLING THEN MBC
- ☐ MBC THEN COUNSELLING (Please discuss with Susan to check this is ok)
- ☐ ANOTHER AGENCY

I prefer to meet _____ but I understand my first choice may not be available. *

Via Telephone ▼

Is this client suitable to be allocated to a student? *

☐ Yes

☒ No

Please give a reason to why the client is or isn't suitable for a student? *

Work with Ro maintaining recovery and working with the fear of being triggered.

Does this client need medical intervention from Addiction Services? (for opiates, alcohol, valium reduction etc) *

If yes please fill out triage form and submit for admin to send over to Addiction Services - [Triage Form](#)

☐ Yes

☒ No

This space is to inform the counsellor of the contexts of the therapy to be offered and why *

ACES and past life trauma.

Summary/Additional Notes for Counsellor *(any notes/info for admin please email to admin)*

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This form was created inside DAPL.

Google Forms