

Appendix C

Triage Assessment Form (for completion by the Open Access Service Only)

REFERRAL BY:	CODE:				
Drug Service Statutory	1	DTTO	6	Psychiatry	11
Drug Service non – stat	2	Youth Offending Team	7	Community Care Assessment	12
GP	3	Probation	8	CARAT	13
Self	4	A&E	9	Other; please state	
Arrest Referral	5	Needle Exchange	10		

About your legal circumstances (please tick)	
Have you been Arrested in the previous eight weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have any outstanding court appearances?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you been released from prison in the last eight weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you on a community sentence with condition of treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you involved with any of the below criminal justice agencies?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tower Project Arrest Referral Court Liaison Prison In-reach Probation Service	
If the answer is yes to any of the above, liaise with the Criminal Justice Team before completing a DIR form WITH THE CLIENTS CONSENT FIRST.	

Date of Triage:	Triage conducted by (name)
Referral Agency:	

Client details			Client reference number	
Last Name:			First Name:	
Date of Birth:	Age		Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:				
.....				
.....				
Postcode:			Telephone No:	
Mailing address if different from above:				
.....				
.....				
Postcode:			Telephone No:	

GP	
GP (Name):	
GP (Address):	
.....	
.....	
Postcode:	Telephone No:

Nationality			
1-UK <input type="checkbox"/>	2-EU National <input type="checkbox"/>	3-Other National <input type="checkbox"/>	4-Not Known <input type="checkbox"/>

Ethnicity Category:				
White	Mixed	Asian/ Asian British	Black/ Black British	Other
A-British <input type="checkbox"/>	D-White & Black Caribbean <input type="checkbox"/>	H-Indian <input type="checkbox"/>	M-Caribbean <input type="checkbox"/>	R-Chinese <input type="checkbox"/>
B-Irish Other <input type="checkbox"/>	E-White & Black African <input type="checkbox"/>	J-Pakistani <input type="checkbox"/>	N-African <input type="checkbox"/>	S-Any <input type="checkbox"/>
C-Other White <input type="checkbox"/>	F-White & Asian <input type="checkbox"/>	K-Bangladeshi <input type="checkbox"/>	P-Other Black <input type="checkbox"/>	Z-Not Stated <input type="checkbox"/>
	G-Other Mixed <input type="checkbox"/>	L-Other Asian <input type="checkbox"/>		

Please identify your first drug of choice:.....
Please identify your second drug of choice:.....
Please identify your third drug of choice:.....

Drugs used over the previous 4 weeks:										
Tick substances used	How?		How often? (tick)				Quantity Weight / Money / units	Prescribed Yes or No	Duration of this episode of use	Age of first use
	Oral / smoked	IV	Daily	Weekly	Monthly	Occasionally				
Alcohol										
Amphetamines										
Benzodiazepines										
Cannabis										
Crack Cocaine										
Cocaine										
Ecstasy										
GHB										
Heroin										
LDS										
Methadone										
Solvents/gas										
Subutex										
Zopiclone etc										

Other including prescribed medication (please specify)									
Have you ever injected?	Y <input type="checkbox"/> N <input type="checkbox"/>					Have you injected in the past 4 weeks? Y <input type="checkbox"/> N <input type="checkbox"/>			
Have you ever shared?	Y <input type="checkbox"/> N <input type="checkbox"/>					Have you shared in the past 4 weeks? Y <input type="checkbox"/> N <input type="checkbox"/>			
Where do you inject?						Injection sites inspected? Y <input type="checkbox"/> N <input type="checkbox"/>			

Reasons for seeking treatment:

About your social circumstances (accommodation, living with, employment, next of kin, pets, financial status etc)

Children								
Forename	Surname	Sex	DOB	Age	Primary Carer	Address	GP	School

Note any child protection issues raised:

About your Mental Health (Ever received treatment, from who inpatient CMHT GP, how many times, when was the last episode, currently in treatment, why receiving treatment)

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About your Physical Health (Serious illness or operations? Tested for blood borne viruses? Pregnant? Drug or alcohol related physical problems, prescribed medications, recent attendance at A&E)

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Dependence Checklist

	<i>In the past six months</i>	<i>if yes, score 1</i>		
A	Have you needed to use more (main substance) to get the desired effect, or has taking your usual amount had less of an effect than it used to?	<input type="checkbox"/>		
B	Have you felt sick or unwell when the effects of (main substance) have worn off, or have you taken more of it, or a similar drug, to relieve or avoid feeling unwell?	<input type="checkbox"/>		
C	Have you used (main substance) in larger amounts or for a longer period of time than you intended?	<input type="checkbox"/>		
D	Have you had a persistent or strong desire to take (main substance) or have you had problems cutting down, or controlling how often or how much you use?	<input type="checkbox"/>		
E	Have you spent a large amount of time obtaining, or using, or recovering from the effects of (main substance)?	<input type="checkbox"/>		
F	Have you given up work, recreational, or social activities as a result of your (main substance) use?	<input type="checkbox"/>		
G	Have you continued to use (main substance) despite having physical or psychological problems as a result?	<input type="checkbox"/>		
<i>If total score is 3 or more, dependence is diagnosed.</i>		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px 5px;"><i>Total Score</i></td> <td style="width: 30px; text-align: center;"><input type="text"/></td> </tr> </table>	<i>Total Score</i>	<input type="text"/>
<i>Total Score</i>	<input type="text"/>			

Have you been in contact with substance misuse services in the past?
 (if yes, please state the agency and when the contact occurred and the outcome)

Current Involvement with other services (Tick all that apply at present)			
Community prescribing	<input type="checkbox"/>	Social Services	<input type="checkbox"/>
Inpatient drug and alcohol misuse treatment	<input type="checkbox"/>	Probation	<input type="checkbox"/>
Care planned counselling	<input type="checkbox"/>	Midwife	<input type="checkbox"/>
Structured day care	<input type="checkbox"/>	GP	<input type="checkbox"/>
Residential rehab	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>
Advice & information	<input type="checkbox"/>	Other; please state	<input type="checkbox"/>
Aftercare Service	<input type="checkbox"/>		

Client's preferred treatment modality (Tick all that apply)		Previous experience of modality (Tick)	Notes on Previous experience
Inpatient treatment	<input type="checkbox"/>	<input type="checkbox"/>	
Community detox	<input type="checkbox"/>	<input type="checkbox"/>	
Community prescribing	<input type="checkbox"/>	<input type="checkbox"/>	
Residential rehab	<input type="checkbox"/>	<input type="checkbox"/>	
Structured day care	<input type="checkbox"/>	<input type="checkbox"/>	
Counselling	<input type="checkbox"/>	<input type="checkbox"/>	
Aftercare Service	<input type="checkbox"/>	<input type="checkbox"/>	
No Preference	<input type="checkbox"/>		

Referral to Treatment Modality			
Advice & Information	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>
Care Planned Counselling	<input type="checkbox"/>	Midwife	<input type="checkbox"/>
Structured Day Programmes	<input type="checkbox"/>	Probation	<input type="checkbox"/>
Community Prescribing	<input type="checkbox"/>	Social Services	<input type="checkbox"/>
Inpatient drug & alcohol misuse treatment	<input type="checkbox"/>	GP	<input type="checkbox"/>
Residential Rehab	<input type="checkbox"/>	Other, please state	<input type="checkbox"/>

.....

Client Signature:

Print:

Date of referral on:

To be completed by Triage Assessor		
	Yes (tick)	No (tick)
Part 1 Risk Assessment completed		
Confidentiality policy explained and client given copy		
Information Sharing agreement signed/dated, client given copy?		
All documents copied and attached to Screening and Triage forms before onward referral		
All relevant documents forwarded to agency receiving client		
Signature of assessor		
Date		