


Suffolk Treatment System – Comprehensive Assessment Form




Guidance to assessors – All core sections must be completed.

These are shaded in the lighter grey and are also indicated by the symbol: 

At the point of any reassessment, the content of both triage and comprehensive assessment must be reviewed.

To be completed by Tier 3 and above.

Please complete this form in black ink

1	Assessment undertaken by:	 Client Reference/Name:
	 Referral source:	Date referral commenced:
	Agency name	
	 Care Coordinator For the purposes of collecting Treatment Outcome Profiles are you (agency) the client's care coordinator? <input type="checkbox"/> Yes <input type="checkbox"/> No If no please give name of care coordinator agency:	

Additional Information – Substance use (including alcohol)

2	Could you tell me some more details about your current substance use?
3	Could you tell me some more details about your previous substance misuse? <i>e.g. – what did you use, amount, frequency, route of use, pattern of use, over how long, periods of abstinence.</i>
4	Have you ever experienced withdrawal symptoms? <i>e.g. nausea, vomiting, shakes, sweating, anxiety, panic attacks, memory loss, blackouts or convulsions.</i>
5	Have you ever received detox medication for alcohol withdrawal? <input type="checkbox"/> Yes <input type="checkbox"/> No
6	Have you ever been advised against having an alcohol detox in the community? <input type="checkbox"/> Yes <input type="checkbox"/> No
7	Have you any significant periods of abstinence from drugs and/or alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how did you manage this and what helped?

Previous Treatment Episodes

8 What previous contact have you had with treatment agencies? (Include age of first treatment / contact)?

9 What kind of help have you had? What worked best/least?
e.g. day programme, one to one, methadone, detox, residential rehabilitation.

10 Have you ever dropped out of treatment? Yes No

If yes, for what reason?

11 Have you ever experienced relapse during or after treatment? Yes No

If yes, what happened?

What could help to prevent this happening again? (Please give details)

12 Is there anything else about your substance use that you would like to add?

Additional Information – Injecting History

13

How often do you inject?

Per day

Per Week

Comments:

14

When, if ever, did you last share equipment?

15

Where are your current injecting sites?

Do you have concerns about any of these sites?

Yes

No

Comments:

16

How do you store and dispose of your paraphernalia or prescribed or other medication (eg *methadone*)?

17

Is there anything else about your injecting that you would like to add?
e.g. have you ever experienced any injecting related harm?

18

Is there any further information or support we can offer you related to your injecting?

Note to Service User

To help us provide the most appropriate level of support for you, we sometimes have to ask quite personal or sensitive questions. It would help us to help you if you could answer some questions about your private life, but we will respect your decision not to answer if you would prefer not to. If you do answer, then please be assured that we operate strict confidentiality policies and we will be happy to explain that to you at any time.

More about Sexual Health and Blood Borne Viruses (BBV)	
19	<p>Do you have any concerns regarding your sexual health? <i>e.g. symptoms of sexually transmitted infections</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments</p>
20	<p>Have you ever had a sexual health screen? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments</p>
21	<p>Are you aware of how BBVs can be transmitted and affect you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments</p>
22	<p>Are you aware of how to protect yourself against BBVs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments</p>
23	<p>NOTE TO ASSESSOR – Has client confirmed immunity to Hep B on triage?</p> <p>If no, has test been offered? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please state date client completed course <input style="width: 150px; height: 20px;" type="text" value="/ /"/></p>

More about Physical Health	
24	In what way has substance misuse affected your health generally? Comments
25	Have you visited your GP in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Do you feel there is anything we need to be aware of? Comments
26	What concerns, if any, do you have about your physical health (including dental health)? Comments
27	Have you had any major illness in the past requiring treatment/admission to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments
28	Do you have any chronic conditions that require ongoing medical treatment, such as Asthma, Epilepsy or Diabetes?

More about Mental / Psychological Health	
29	Do you have any chronic mental health issues requiring ongoing treatment, such as depression, schizophrenia or eating disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently receiving treatment? Diagnosis/Treatment details:
30	Have you ever self-harmed? Comments
31	Have you ever attempted or seriously considered suicide? Comments
32	How would you describe your mood over the past week?

More about Mental / Psychological Health continued

33 Have you experienced any panic attacks, phobias or feelings of paranoia? Yes No

Comments

34 Have you ever had concerns about your mental/ psychological health? Yes No

If yes, have you ever, or are you currently, receiving any help from the following? (Please tick)

- Psychiatrist Psychologist
 Psychotherapist Self help group
 Community Psychiatric Nurse Other (specify) _____

35 Please provide details of any of those ticked above:

36 What help did you receive?

37 How long did you receive the help?

38 What was the connection, if any, with your substance use?

Family History

39 Could you tell me more about yourself? *e.g. childhood, family origin, education, significant relationships, cultural and/or religious beliefs, significant losses or traumas*

Please use Additional Information sheet if required

Family History continued

Current Family Situation / Relationships

40 Who do you live with?

41 Do you have a partner? Yes No

42 Do you have any children who live with you that we don't already know about? Yes No

Name of child 1:

Date of Birth:

Living with Client/
Full or part time

Living elsewhere,
name of main carer:

Carer's relationship
to child:

School:

GP:

S/S involved:

Name of child 2:

Date of Birth:

Living with Client/
Full or part time

Living elsewhere,
name of main carer:

Carer's relationship
to child:

School:

GP:

S/S involved:

Name of child 3:

Date of Birth:

Living with Client/
Full or part time

Living elsewhere,
name of main carer:

Carer's relationship
to child:

School:

GP:

S/S involved:

43 Are any of the people living with you aware of your substance use? Yes No

44 Would they support you changing and in what way? Yes No

Comments

45 How would you describe your current relationship with:

Your Family

Your Partner

Your Friends

46 Are any of the above drug and/or alcohol users? Yes No

Comments

If yes, are they likely to be seeking support for their substance use? Yes No

Family History continued

47 Please describe any other significant relationships

48 Does your substance misuse affect your social life?

49 Does your substance use have an effect on any of your cultural or religious beliefs?

More about Accommodation

50 Do you feel safe where you live? Yes No

Would you describe your accommodation as stable? Yes No

If no, how would you describe your housing needs?

How urgent would you describe the need for alternative accommodation?

51 Please give details of your housing over the past 5 years

Please use Additional Information sheet if required

52 Do you currently have any rent arrears? Yes No

If yes, please state lists:

53 Are you currently on any housing waiting list (Borough Council or otherwise)?

If yes, please state lists:

More about Employment / Education / Training

54 Are you currently working or in training? Yes No
 Can you tell me more about your work history? Please use additional information sheet.

55 Have you ever dropped out of education or lost employment as a result of your substance use? Yes No
 If yes, please provide details:

56 In relation to education or employment, what would you like to achieve in the future?

57 Have you any hobbies/interests/activities you enjoy doing?
 Have any of these activities been affected by substance use?

More about Criminality / Legal History

TO ASSESSOR – If you did not complete the triage form, please check if criminality status is still current

58 Do you have any outstanding court appearances? Yes No
 If yes, please provide details below:

Nature of offence	Court	Date of appearance

59 Do you have any warrants outstanding? Yes No
 If yes, please provide details below:

60 Are any of the above offences or convictions due to your substance use (including alcohol)? Yes No
 Additional information

Motivation

61 Do you feel you are ready for change/treatment now? Yes No

If yes, why?

If no, why?

62 What help do you think you need to achieve change or to access treatment (What has helped you in the past)?

63 Please list any aims and ambitions you may have regarding your treatment and your future?

Short term: (next 3 months)

Medium term: (3–12 months)

Longer term:

64 What steps could you take to achieve your short term goals?

Checklist

	Yes	No	Date Actioned
Confidentiality policy explained			
Further risk assessment required			
Hep B vaccination required			
Referral for medical assessment			
Referral for psychiatric assessment			
Referral to external care coordinator Name:			
Testing required Name of test:			
Referral to other support service (please list)			
Investigation required (blood, breath, urine, oral swab or other)			
Immediate actions required by client? If yes, please state:			
Immediate actions required by Assessor? If yes, please state:			

Review period agreed (e.g. monthly)

Yes

No

Please state:

Suffolk Treatment System

Summary/Additional information



A large, empty rectangular box with a thin black border, intended for entering summary or additional information.