**Fife ADP Multi-Agency Triage Assessment Form (November 2015)**

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| **PART A** | |
| **SERVICE UNDERTAKING TRIAGE:** | **SOURCE OF REFERRAL:** |
| **COMPLETED BY:** *Workers name & job title*  **DATE:** | **LOCATION:** *where triage is held* |
| **METHOD:** *Face to Face/Phone/Email/Fax* |
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| **PART B RECOVERY PLAN :** | |
| **NAME:** | **PERSONAL IDENTIFICATION REF** *date of birth NI NUMBER etc.* |
| **IN THE NEXT MONTH I AIM TO:** | **TO HELP ME DO THIS I WILL NEED:** |
| **IN THE NEXT SIX MONTHS I AIM TO:** | **TO HELP ME DO THIS I WILL NEED:** |
| **IN A YEARS TIME I AIM TO:** | **TO HELP ME DO THIS I WILL NEED:** |

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| **PART C** | | |
| **SURNAME:** | | **ALTERNITIVE ADDRESS:** *If different from permanent address* |
| **FORENAME:** | **TITLE:** |
| **PREFERRED NAME:** | |
| **ADDRESS:** | | **POSTCODE:** |
| **TEL NO (INC STD):** |
| **NEXT OF KIN/EMERGANCY CONTACT:** |
| **ADDRESS:** |
| **POSTCODE:** | |
| **TEL NO (INC STD):** | | **POSTCODE:** |
| **MOBILE:** | | **TEL NO (INC STD):** |

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| **GENDER: MALE  FEMALE  OTHER** | **MARITAL STATUS:** |
| **DOB: AGE:** |
| **EMPLOYMENT STATUS:** |
| **ETHNICITY:** |
| **BENFITS:** |
| **RELIGION:** |

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| **ARE YOU REGISTERED WITH A GP: YES  NO** | **ARE YOU REGISTERED WITH A DENTIST: YES  NO** |
| **DETAILS:** | **DETAILS:** |

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| **RESIDENTIAL CARE HOME: YES  NO**  **IN HOSPITAL: YES  NO**  **HOMELESS ACCOMMODATION: YES  NO**  **PRISON/RESIDENTAIL DETOX: YES  NO**  **RENTED ACCOMODATION: YES  NO**  **OWNER OCCUPIED: YES  NO**  **NO FIXED ABODE: YES  NO**  **ANY OTHER INFO:** | **DO YOU HAVE A DISABILITY? YES NO**  **IF YES PLEASE SPECIFY:** |
| **COMMUNICATION NEEDS YES  NO**  **IF YES PLEASE SPECIFY:** |
| **ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000:**  **HAS ANYONE BEEN APPOINTED RE: WELFARE AND/OR FINANCE**:  **YES  NO  DON’T KNOW**  **IF YES PLEASE SPECIFY:** |

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| **MENTAL HEALTH CARE AND TREATMENT (SCOTLAND) ACT 2003: YES  NO**  **IF “YES” SPECIFY SECTION OF ACT WHICH APPLIES:** |

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| **KEY ADDITIONAL INFO:** *e.g. needs home visit/preferred contact times etc.*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **CLIENT GIVEN INFORMATION SHARING PROTOCOL LEAFLET?** | | |
| **PART D** | | |
| **Reason for Attendance/Referral:** *Include brief history of previous involvement within current services. What support does client want?*  *Who are your key workers?* | | |
| **Physical Health History:** *Please use this space to report any significant physical health issues, e.g. cirrhosis of liver, hepatitis, respiratory problems* | | |
| **Mental Health History:** *Please use this space to report any significant mental health issues* | | |
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| **Prescribed Drugs** | **Daily Dosage** | **Prescribed By** |
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| **SUBSTANCE** | **CAUSING PROBLEMS**  **Y/N** | **LENGTH OF EPISODE** | **NO. USED IN THE LAST 30 DAYS** | **AMOUNT USED DAILY ON AVERAGE OVER LAST 30 DAYS** | **ROUTE** |
| Alcohol |  |  |  |  |  |
| Heroin |  |  |  |  |  |
| Methadone |  |  |  |  |  |
| Benzodiazepine |  |  |  |  |  |
| Cocaine |  |  |  |  |  |
| Amphetamine |  |  |  |  |  |
| Cannabis |  |  |  |  |  |
| Ecstasy |  |  |  |  |  |
| Mephedrone |  |  |  |  |  |
| Legal Highs |  |  |  |  |  |
| Other |  |  |  |  |  |
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| **ADDITIONAL INFORMATION:** | | | | | |
| **TREATMENT HISTORY:** *Please state treatment type, dates, medications used, outcomes* | | | | | |

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| **FAMILY RELATIONSHIPS** | | | | | | | | | | | | | | |
| **CHILDREN/STEP CHILDREN/ACCESS TO ANY OTHER CHILDREN** | | | | | | | | | | | | | | |
| **FIRST NAME** | **SURNAME** | | **D.O.B AND AGE** | | | **GENDER** | | | **LIVING SITUATION** *(at home / with other parent / with other family / foster care / adopted)* | | | | **CP REGISTER?**  **YES/NO** | |
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| **PARTNERS/SIGNIFICANT OTHERS/EXTENDED FAMILY** | | | | | | | | | | | | | | |
| **FIRST NAME** | | **SURNAME** | | **SUBSTANCE USER?**  **YES/NO** | | | | **LENGTH OF RELATIONSHIP** | | | | **IN TREATMENT?**  **YES/NO** | | |
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| **RISK FACTORS:** | | | | | **YES** | | **NO** | | | **DON’T KNOW** | **IN LAST 6 MONTHS** | | | **OVER 6 MONTHS** |
| Relevant criminal record | | | | |  | |  | | |  |  | | |  |
| Has client been in prison | | | | |  | |  | | |  |  | | |  |
| History of physical violence to others | | | | |  | |  | | |  |  | | |  |
| Sometimes carries a weapon | | | | |  | |  | | |  |  | | |  |
| History of verbal aggression to others | | | | |  | |  | | |  |  | | |  |
| Had thoughts of or made threats to others | | | | |  | |  | | |  |  | | |  |
| Feeling depressed/low mood | | | | |  | |  | | |  |  | | |  |
| Recent deliberate self-harm/overdose | | | | |  | |  | | |  |  | | |  |
| Accidental overdose | | | | |  | |  | | |  |  | | |  |
| Overdose Witnessed | | | | |  | |  | | |  |  | | |  |
| Is client or their partner pregnant? | | | | |  | |  | | |  |  | | |  |
| Does client live alone? | | | | |  | |  | | |  |  | | |  |
| Does client want a home safety visit? | | | | |  | |  | | |  |  | | |  |
| Does client have a working smoke alarm? | | | | |  | |  | | |  |  | | |  |
| Does client want a smoke alarm fitted? | | | | |  | |  | | |  |  | | |  |
| **PLEASE USE THIS SPACE TO REPORT OTHER SIGNIFICANT ISSUES:** *or provide additional information risk factors – Pets at home, etc* | | | | | | | | | | | | | | |

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| **PART E** | | |
| **OUTCOME OF REFERRAL: PLEASE TICK ALL THAT APPLY** | | |
| **1. SERVICE UNDERTAKING TRIAGE WILL PROVIDE ON-GOING SUPPORT** | |  |
| **2. REFERRAL TO ANOTHER SERVICE** | | |
| **ADAPT** | **Criminal Justice** | |
| **NHS Fife Addiction Services** | **Clued Up** | |
| **Community Pharmacy** | **Social Work** | |
| **DAPL** | **Barnardo’s** | |
| **FASS** | **Addaction** | |
| **FIRST** | **Psychology Services** | |
| **Frontline Fife** | **Other (Please State):** | |
| **3. INFORMATION PROVIDED ON OTHER SERVICES**  **Mutual Aid**  **Citizens Advice Rights Fife**  **How to access practical support**  **Volunteering Opportunities**  **Other (Please Give Details): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **4. ALCOHOL BRIEF INTERVENTION UNDERTAKEN**  **5. DRUG BRIEF INTERVENTION UNDERTAKEN**  **6. OVERDOSE TRAINING PROVIDED**  **7. NALOXONE ISSUED**  **8. HOME/FIRE SAFETY INFO** | | |

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| **PART F X FOR CLIENT SERVICE SIGNATURE ONLY** |
| **The information collected on this form will be used to provide an effective triage service and, where appropriate, to refer you for support services from other agencies.**    **I consent to the information I have provided on this form being processed and held for the above purposes.**    **I consent to the information on this form being shared with the other agencies listed above.**  **Detail any specific information, or agencies that the service user does not wish data shared with here**:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **I understand that in serious circumstances, where there is a risk of harm to myself or others, that the information obtained during this assessment might be shared about me without my consent.**  **Signed:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_ **Verbal Confirmation:**  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_  (Service User)  **Signed:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_ **Name of Assessor**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Triage Assessor)  **Designation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Service Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Telephone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |