**Fife ADP Multi-Agency Triage Assessment Form (May 2016)**

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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****(\*not applicable)** | **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? |[ ] [ ] [ ]   |  |
| Does client have Take Home Naloxone kit? |[ ] [ ]  [ ] **\*** |  |  |
| Does client require a Take Home Naloxone kit? |[ ] [ ]  [ ] **\*** |  |  |
| **PLEASE USE THIS SPACE TO REPORT OTHER SIGNIFICANT ISSUES:** *or provide additional information risk factors – Pets at home, etc* |
| **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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |