

Harm Reduction Assessment

Section One

Basic Information

Location	Worker	Client No.	Date of Initial Assessment Date <input type="text"/>
			Date of this Assessment Date <input type="text"/>

<i>(Initial Required)</i>	Surname	<i>(Initial Required)</i>	First Name
<input type="checkbox"/>		<input type="checkbox"/>	
Date of Birth	Age	Main Drug of Injection	
/ /		Heroin <input type="checkbox"/>	Crack Cocaine <input type="checkbox"/> Speedball <input type="checkbox"/>
Postcode of Residence		Speed <input type="checkbox"/>	Subutex <input type="checkbox"/> Other <input type="checkbox"/>
	Male <input type="checkbox"/> Female <input type="checkbox"/>	Cocaine <input type="checkbox"/>	Other (please state)

Ethnicity				
White British <input type="checkbox"/>	White & Asian <input type="checkbox"/>	Other Asian - Asian British <input type="checkbox"/>	Other Black British <input type="checkbox"/>	
White Irish <input type="checkbox"/>	White & Black Caribbean <input type="checkbox"/>	Bangladeshi - Asian British <input type="checkbox"/>	Chinese - Other Ethnic <input type="checkbox"/>	
Other White <input type="checkbox"/>	Indian - Asian British <input type="checkbox"/>	African - Black British <input type="checkbox"/>	Other - Other Ethnic <input type="checkbox"/>	
White & Black African <input type="checkbox"/>	Pakistani - Asian Mixed <input type="checkbox"/>	Caribbean - Black British <input type="checkbox"/>	Other Mixed <input type="checkbox"/>	
If other ethnicity stated please give further details (for your records only):				

Section Two

Injecting History and Behaviour

When did you last inject?	Today	Yesterday	In Last Week	In Last 2 Weeks	In Last Month	Other (please state)
How often do you inject?	Daily (How Often)	Weekly (How Often)	Monthly (How Often)	Other (please state)		
Age of first injecting?						
Other drugs injected	Heroin <input type="checkbox"/>	Crack Cocaine <input type="checkbox"/>	Speedball <input type="checkbox"/>	Date last injected		
	Speed <input type="checkbox"/>	Subutex <input type="checkbox"/>	Other <input type="checkbox"/>			
	Cocaine <input type="checkbox"/>	Other (please state)				
Other drugs injected in the past	Heroin <input type="checkbox"/>	Crack Cocaine <input type="checkbox"/>	Speedball <input type="checkbox"/>	Date last injected		
	Speed <input type="checkbox"/>	Subutex <input type="checkbox"/>	Other <input type="checkbox"/>			
	Cocaine <input type="checkbox"/>	Other (please state)				
Injects self	Yes <input type="checkbox"/>	If no, injected by:				
	No <input type="checkbox"/>	Friend <input type="checkbox"/>	Partner <input type="checkbox"/>	Other <input type="checkbox"/>		

Section Three

Injecting sites and physical health

Registered with GP Yes <input type="checkbox"/> No <input type="checkbox"/>		If no, referral agreed and made
GP Details		Yes <input type="checkbox"/> No <input type="checkbox"/>
Registered with Dentist Yes <input type="checkbox"/> No <input type="checkbox"/>		If no, referral agreed and made
Dentist Details		Yes <input type="checkbox"/> No <input type="checkbox"/>

Physical Health

Please indicate any area of concern for physical health eg lungs; liver; teeth.

Please describe symptoms and length of symptoms

1. Area of Concern:

Symptoms:

Length of Symptoms:

2. Area of Concern:

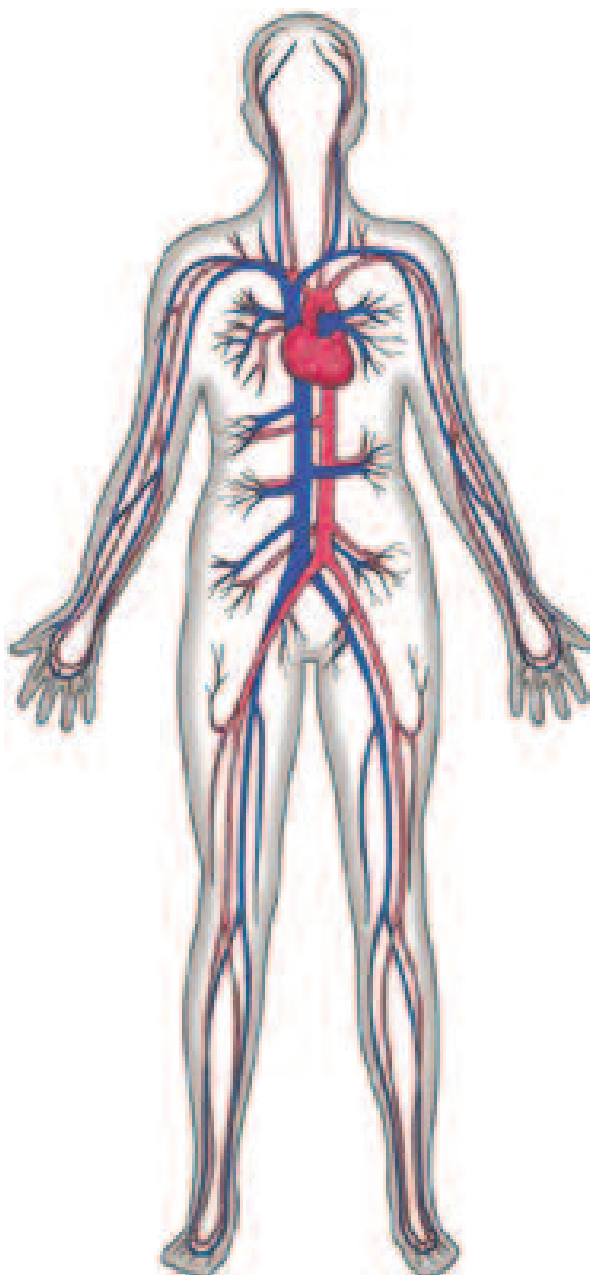
Symptoms:

Length of Symptoms:

3. Area of Concern:

Symptoms:

Length of Symptoms:



Injecting Sites

Please state Current Sites

Please state Past Sites

Please indicate any problem areas for injecting

Agreed actions

1.

2.

Review Date

Section Four

Injecting equipment use

Use of the below Please state which	Please state which e.g. pharmacy, fixed site exchange, outreach)	Shared Partner		Shared Friend		Shared Other		Advice Given
		Last Month	Ever	Last Month	Ever	Last Month	Ever	
Syringes / Needles								
Spoons / Cookers								
Water								
Acidifier								
Filters								
Tourniquet								
Other (please state)								

Section Five

Other Issues

Use of non-injected drugs What? How often? Quantity?	
Use of alcohol How often? Quantity? Use with drugs?	
Use of prescribed medication What? How long for?	
Housing situation (please state) NFA / Private rented / Hostel / Supported Housing / Own property?	

ADULTS: Accommodation		
No Fixed Abode		
		Yes <input type="checkbox"/> No <input type="checkbox"/>
NFA - urgent housing problem <input type="checkbox"/>	Housing problem <input type="checkbox"/>	No housing problem <input type="checkbox"/>

Living with	
Alone <input type="checkbox"/>	Friend: User <input type="checkbox"/> Non user <input type="checkbox"/>
Parents <input type="checkbox"/>	Partner: User <input type="checkbox"/> Non user <input type="checkbox"/>

BBV History										
	Yes	No	Latest test date	Test Result		Offered & accepted	Offered & refused	Immunised already	Not Offered	Acquired Immunity
				+ve	-ve					
Tested for HIV	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>					
Tested for HepA	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>					
Tested for HepB	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tested for HepC	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Vaccinated against HepB	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previously infected with Hep B	<input type="checkbox"/>	<input type="checkbox"/>								
HEP C Positive	<input type="checkbox"/>	<input type="checkbox"/>								
Referred to Hepatology	<input type="checkbox"/>	<input type="checkbox"/>								
Hep B vaccination count. <i>(Tick or enter date if known)</i>	One vaccination		Two vaccinations		Three vaccinations		Course Completed			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cross if client declined to answer communicable disease questions

History of Accidental Overdose	
In the last 30 days have you used opiates (alone or with other drug / alcohol) to the point of losing consciousness?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes , how many times in the last 30 days _____	

Loss of consciousness due to drug use When? Where? What happened?			
Accessing structured drug treatment services Which ones? Where?	Specialist Prescribing <input type="checkbox"/>	Structured Day Programmes <input type="checkbox"/>	Advice & Information <input type="checkbox"/>
	GP Prescribing <input type="checkbox"/>	Aftercare <input type="checkbox"/>	Structured Alcohol Intervention <input type="checkbox"/>
	Structured Counselling <input type="checkbox"/>	Outreach <input type="checkbox"/>	Other Structured Intervention <input type="checkbox"/>
Long Term illness/condition Eg asthma; epilepsy; diabetes; depression; psychosis			

If presented with Child Protection or Child in Need or Adult Protection concerns staff must follow the local safeguarding procedure as soon as any requirements to do so are identified.
(Sections 17 & 47 of the Children Act 2004)

How do you Store and Dispose of your Syringes?

How do you Store your Drugs?

Contact with other agencies, including child protection

Yes No

Do you have support from non-drug using friends / relatives

Yes No

Actions

Date of action	Action Agreed

We are always looking for ways to improve our service for you.
Do you have any comments on this form and / or the syringe exchange services you use?

Consent (Explicit)

The information you provide on this form will be held by.....
..... (the Treatment Provider)
and used by the Treatment Provider for the purposes of providing the help you need and ensuring the continuity of your healthcare.

Information provided on the slip on page 7 may, with your consent be shared the Kent Drug and Alcohol Action Team (KDAAT) for the purposes of research, audit and performance monitoring. Before being sent, your information is anonymised ensuring it is not possible to link data to particular individuals.

Your information will not be used for any other purpose and will not be passed to any other third party without your permission save that the Treatment Provider may share your information with certain law enforcement agencies, other public authorities or others for the purposes of the prevention or detection of crime. In accordance with the NTA guidelines on Record Retention (http://www.nta.nhs.uk/publications/documents/nta_data_protection_and_record_sharing_2003_dsp2.pdf) records will be kept for eight years after the conclusion of treatment.

I have been advised that I can withdraw my consent to this information being shared with KDAAT at any time and that if I do not consent to my information being shared with KDAAT it will not prevent me getting the treatment I need.

I do / do not consent to my information being shared with KDAAT.

Signature.....

Clients Signature		Date	
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Worker Completing Form		Date	
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