Welcome to change, grow, live

Triage Form

Are you completing this for yourself? ☐ Yes ☐ No
Have you ever received support from this service before? ☐ Yes ☐ No

What would you like to achieve by engaging with us?		Date of referral:
☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other:	First name:	D.O.B:
	Surname:	Age:

Address and Postcode	Telephone number:
	Mobile number:

Email address:

GP Surgery (& NHS No. if known):

Gender:	**Relationship:**	**Sexual Orientation:**
What gender do you currently identify as? ☐ Male ☐ Female ☐ Prefer not to say If you prefer to use your own term please provide it here:	☐ Single ☐ With a partner ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Civil Partnership ☐ If you prefer to use your own term please provide it here:	☐ Gay Women/Lesbian ☐ Gay Man ☐ Bisexual ☐ Heterosexual ☐ Unsure ☐ Prefer not to say If you prefer to use your own term please provide it here:

Nationality: *(based on top 10 nationalities as identified by ONS)*

☐ British	☐ Romanian	☐ Lithuanian
☐ Polish	☐ Portuguese	☐ French
☐ Indian	☐ Italian	☐ American
☐ Irish	☐ Pakistani	☐ If other please provide details:

Ethnic Origin:		
☐ White British	☐ White & Asian	☐ Black/Black British Caribbean
☐ White Irish	☐ Asian/Asian British Indian	☐ Black/Black British African
☐ Other White	☐ Asian/Asian British Pakistani	☐ Other – Chinese
☐ White & Black	☐ Asian/Asian British Bangladeshi	☐ Traveller/Gypsy
☐ Caribbean	☐ Asian/Asian British Other	☐ Other
☐ White & Black African	☐ Other Mixed	If other please provide details:

Religion:			
☐ Baha'i	☐ Hindu	☐ Pagan	☐ None
☐ Buddhist	☐ Jain	☐ Sikh	☐ Prefers not to say
☐ Christian	☐ Jewish	☐ Zoroastrian	☐ Unknown
	☐ Muslim	☐ Other	

Language:
Do you require an interpreter? ☐ Yes ☐ No
Do you require support through a British Sign Language Interpreter? ☐ Yes ☐ No

Disability:
Do you consider yourself to have a disability? ☐ Yes ☐ No If yes please provide details:

Employment Status:	☐ Long term illness	**Accommodation Status:**
☐ Regular employment	☐ Ex Armed Services	☐ Problem with Housing
☐ Student	☐ Current Armed Services	☐ No housing problem
☐ Unpaid work (voluntary)	☐ Unemployed (receiving no benefits)	☐ Homeless
☐ Homemaker	☐ Unemployed (seeking work)	Please provide details:
☐ Retired	☐ Other	

Time since last paid employment:
☐ Less than 1 year ☐ 2- 3 years ☐ Currently employed ☐ Prefer not to say
☐ 1 – 2 years ☐ 3+ years ☐ Never employed

Smoking Status:	Currently pregnant: ☐ Yes ☐ No ☐ Unsure
☐ Current ☐ Previous ☐ Never	Partner currently pregnant: ☐ Yes ☐ No ☐ Unsure

Do you currently provide care in a paid or voluntary capacity for anyone else? ☐ Yes ☐ No
Are you currently worried about your safety or the safety of someone you know? ☐ Yes ☐ No
If you answered yes to either of the above questions please provide further details below:

Next of Kin: (we will only contact this person in a case of an emergency)

Do you consent to us sharing information with this person? ☐ Yes ☐ No

Do you have any children (under the age of 18)?
☐ No
☐ Yes - living with; ☐ Yes – not living with but have contact; ☐ Yes – not living with and no contact;

Drug and/or Alcohol Use

Main substance of choice: Age First Used:

How do you use: ☐Inject ☐Sniff ☐Smoke ☐Oral ☐Other

How often do you use?

How much do you use?

How much do you spend a week on this substance?

Second substance of choice: Age First Used:

How do you use: ☐Inject ☐Sniff ☐Smoke ☐Oral ☐Other

How often do you use?

How much do you use?

How much do you spend a week on this substance?

Third substance of choice: Age First Used:

How do you use: ☐Inject ☐Sniff ☐Smoke ☐Oral ☐Other

How often do you use?

How much do you use?

How much do you spend a week on this substance?

Do you use Novel Psychoactive Substances (Legal/Illegal Highs) ☐ Yes ☐ No ☐ Previously If yes please list:	Do you use any volatile substances? (Gas, Glue, Aerosols) ☐ Yes ☐ No ☐ Previously If yes please list:
Do you use Steroids or any other image/performance enhancing drugs? ☐ Yes ☐ No ☐ Previously If yes please list:	Do you use any over the counter medications (such as Co-codamol, Paracetamol)? ☐ Yes ☐ No ☐ Previously If yes please list:

Injecting:

Have you ever injected drugs: ☐ Never injected ☐ Previously injected ☐ Currently inject

If you have previously injected drugs:

At what age did you first inject?

Have you injected in the last 28 days? ☐ Yes ☐ No

Have you ever shared injecting equipment? ☐ Yes ☐ No

Have you shared injecting equipment in last 28 days? ☐ Yes ☐ No

Have you ever allowed someone else to inject you? ☐ Yes ☐ No

Criminal Justice:

Are you currently working with Criminal Justice Services (e.g. Police, National Probation Service, Community Rehabilitation Companies, Prisons)?

☐ Yes ☐ No **If no please go to next section 'Referrer details.'**

If yes, what prompted the contact?

☐ Required Assessment Imposed Following Positive Drug Test
☐ Conditional Cautioning
☐ Pre-Sentence Report
☐ Required by Offender Management Scheme
☐ DRR/ATR
☐ Restriction On Bail
☐ Voluntary – Following Release From Prison
☐ Voluntary – Following Cell Sweep
☐ Voluntary – Other
☐ Following Referral by Treatment Provider (Post Treatment)
☐ Rehabilitation Activity Requirement (RAR)
☐ Integrated Offender Management (IOM)
☐ Multi-agency Public Protection Arrangements (MAPPA)
☐ Other

What is offence and date of the offence that prompted your contact with criminal justice services?

If you have recently been released from prison, what date were you released and from which prison?

If you are completing this form for yourself you don't need to do this section:

Referrer details:

Name and job title:

Agency:

Preferred means of contact:

Does the person know you are referring them? ☐ Yes ☐ No

Do they want to be referred? ☐ Yes ☐ No

Would you like feedback on the outcome of this referral? ☐ Yes ☐ No

Triage Outcome:

☐ Brief Intervention facilitated and no further action required

☐ Personalised Assessment required