**Welcome to Change Grow Live**

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| **Referral Details of person needing a service:** |
| Date of referral: Service user name:Date of birth: Gender: [ ]  Male [ ]  Female [ ]  Prefer not to say If you prefer to use your own term for your gender please provide it here: Address: Postcode:Telephone number: Email address:Description of drug and/or alcohol use and reason for referral:Any assistance needed (interpreter/disability/specialist needs): |
| **Is this a self-referral?** [ ]  Yes [ ]  No If no please complete the below:**Referrer and Contact Details:**Name and role: Agency/provider:Telephone number: Email Address:  |
| **Triage Assessment**  |
| **Consent**Change Grow Live are bound by laws, regulations and organisational values which inform how we use any information about you.  To ensure that we can offer, and remind you of, appointments with Change Grow Live we require permission to contact you and also your preferences for how you would like to be contacted.  Please tick here if you have been made aware and consent to Change Grow Live contacting you [ ] Please tick all that apply for your preferred contact methods: [ ]  phone call [ ]  voicemail [ ]  text [ ]  email [ ]  letterChange Grow Live will keep your information confidential within the service provision you are accessing - unless you give us permission to share information.  The only time we may breach your confidentiality without consent is if we are concerned that someone else is at significant risk of harm, such as a child/children or other vulnerable persons, or you yourself are at significant risk of harm.  In such instances we will seek to inform you before we share information.  Please tick here to confirm you have been made aware of this [ ] In the event that this session leads us to agreeing that another service/services are best placed to support you, we will need to share information about you with them to make a referral\*Please tick here if you have been made aware and consent to this [ ] \*(name/type of service will be agreed at the end of the triage) |
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| **Date of Triage:**Have you ever received structured drug or alcohol treatment from this or any other treatment provider?  |

[ ]  Yes [ ]  No If yes, please provide details:Do you currently receive any support or work with any other provider? [ ]  Yes [ ]  No If yes, please provide details:Are there any other health issues (pregnancy/mental health) you can tell us about?Are you currently serving in the UK Armed Forces? (Royal Navy, Royal Air Force, Army including part time/reservists)?[ ]  Yes [ ]  No If yes, please provide details:Have you ever served in the UK Armed Forces?[ ]  Yes [ ]  No If yes, please provide details: |
| What would you like to achieve by working with us? |
| **Drug use** |
| In order to support you we need to understand your drug and/or alcohol use in a bit of detail, the following information will enable us to agree how we can best meet your needs:1. What substance(s) are you currently using?
2. How do you use this/them?
3. How often do you use?

Drug Abuse Screening Test (DAST) score (if undertaken):  |
| **Alcohol use** |
| **AUDIT–C**

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| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 0 - 2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

 SCORE:**Scoring:**A total of 5+ indicates increasing or higher risk drinking.An overall total score of 5 or above is AUDIT-C positive, so continue with the following questions:**Remaining AUDIT questions**

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| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or somebody else been injured as a result of your drinking? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |

 TOTAL SCORE:**Scoring:**  0 – 7 Lower risk8 – 15 Increasing risk 16 – 19 Higher risk20+ Possible dependence |
| Do you currently look after anybody else (children or adults) in a paid or voluntary capacity? [ ]  Yes [ ]  NoIf yes, please provide further details:Are you currently worried about your safety or the safety of someone you know? [ ]  Yes [ ]  NoIf yes, please provide further details: |
| Who would you like us to contact in case of an emergency?  |
| GP details:  |
| **Onward pathway within Change Grow Live service:** |
| **Brief Intervention:**[ ] Recommend self-monitoring, provide harm reduction advice, record as one off brief intervention on system, email referrer to advise no further action[ ] Inappropriate for Change Grow Live service support at present, other support needs have been identified and consent to referral given\***\*Name of/type of service to be referred to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Extended Brief Intervention:** [ ]  Complete Consent, Contact and Confidentiality form [ ]  Complete NDTMS and TOP sections of Personalised Assessment [ ] Additional sections of Personalised Assessment can be completed if required and appropriate **Structured Treatment:**[ ]  Complete all sections of Personalised Assessment; Medical Assessment section to be completed by the Medic for those accessing Opioid Substitution Therapy [ ]  Complete Consent, Contact and Confidentiality form [ ]  Undertake drug screen if service user is accessing Opioid Substitution Therapy [ ]  Contact GP if the service user has consented for us to do so[ ]  Create a Service User Plan to enable risks and actions identified within the Personalised Assessment to be automatically transferred into the plan; plan to be reviewed a minimum of 12 weeks post assessment  |