

SMR25 ASSESSMENT REPORT Introduced April 2006

1) PERSONAL DETAILS

First Name Surname
First initial only First and fourth letter only

Date of Birth Gender Male Female

Local Ref

ETHNIC GROUP

White
 Scottish Other British Irish Other White (specify) _____

Asian, Asian Scottish or Asian British
 Indian Pakistani Bangladeshi Chinese Other Asian (specify) _____

Black, Black Scottish or Black British
 African Caribbean Other Black (specify) _____

Mixed Background
 Any (specify) _____

ISD Ref A

ADDRESS
 City/Town _____
 Postal Sector
Please do not enter last two items of postcode

8) INJECTING/ SHARING DETAILS

EVER	Yes	No	IN THE PAST MONTH	Yes	No
Injected	<input type="checkbox"/>	<input type="checkbox"/>	Injected	<input type="checkbox"/>	<input type="checkbox"/>
<i>If no go to section 10</i>					
Always used new equipment first	<input type="checkbox"/>	<input type="checkbox"/>	Always used new equipment first	<input type="checkbox"/>	<input type="checkbox"/>
Used a needle or syringe that someone else has used	<input type="checkbox"/>	<input type="checkbox"/>	Used a needle or syringe that someone else has used	<input type="checkbox"/>	<input type="checkbox"/>
Lent someone else a needle or syringe which client has used	<input type="checkbox"/>	<input type="checkbox"/>	Lent someone else a needle or syringe which client has used	<input type="checkbox"/>	<input type="checkbox"/>
Used the same spoon, filter or water as someone else	<input type="checkbox"/>	<input type="checkbox"/>	Used the same spoon, filter or water as someone else	<input type="checkbox"/>	<input type="checkbox"/>
Age first injected	<input type="text"/> years				

9) BLOOD BORNE VIRUSES

Tested for:

	Yes	No	Date of last test
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	m m y y y y
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Has client been at risk since last test? Yes No

Has client **completed** a course of vaccination for Hep B?

2) PRESENTING INFORMATION (OF THIS EPISODE)

MAIN SOURCE OF REFERRAL	CO-OCCURRING HEALTH ISSUES
Self <input type="checkbox"/> Health <input type="checkbox"/> GP <input type="checkbox"/> Primary Care <input type="checkbox"/> Mental Health <input type="checkbox"/> Other <input type="checkbox"/> Social work <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Child and Family <input type="checkbox"/> Other <input type="checkbox"/> Criminal Justice <input type="checkbox"/> DTTO <input type="checkbox"/> Arrest Referral <input type="checkbox"/> Drug Court <input type="checkbox"/> Prison <input type="checkbox"/> Other <input type="checkbox"/> Voluntary service <input type="checkbox"/> Education <input type="checkbox"/> Housing <input type="checkbox"/> Other <small>(specify)</small> _____	Tick all that apply Drug related physical health <input type="checkbox"/> Mental health <input type="checkbox"/> Alcohol <input type="checkbox"/> Other (specify) _____

3) CONTACT WITH THIS SERVICE

Institution code

Contact name _____

Date contact first made (this episode only) - include letter/ phone referrals

Date first appointment offered

Date this assessment completed/ last seen

4) PREVIOUS CONTACT WITH OTHER SERVICES

Previous contact with any drug treatment services Yes No

If yes, year of last contact

Age when help first sought years

5) AGE PROFILE

Age when first started using illicit drugs years

Age at onset of problem illicit drug use years

10) ALCOHOL PROFILE (PAST MONTH)

Consumed alcohol? Yes show details No go to section 11

How often did client have an alcoholic drink?

Every day 2 - 3 days per month
 5 - 6 days per week about one day a month
 3 - 4 days per week less often
 1 - 2 days per week

In a typical day how many units did the client usually have? units

11) SOCIAL PROFILE (CURRENT)

ACCOMMODATION	LEGAL SITUATION
Owned/ Rented <input type="checkbox"/> Supported accommodation (drug related) <input type="checkbox"/> Residential rehabilitation <input type="checkbox"/> In prison <input type="checkbox"/> Homeless - Temporary/ Unstable accommodation/ Hostel <input type="checkbox"/> Homeless - Roofless <input type="checkbox"/> Other <small>(specify)</small> _____	Tick all that apply None <input type="checkbox"/> Case pending <input type="checkbox"/> DTTO <input type="checkbox"/> On probation/ subject to supervision order <input type="checkbox"/> In Prison <input type="checkbox"/> Other <small>(specify)</small> _____
LIVING SITUATION	HAS CLIENT BEEN IN PRISON IN PREVIOUS 12 MONTHS?
Tick all that apply With spouse/ partner <input type="checkbox"/> With parents <input type="checkbox"/> Alone <input type="checkbox"/> Other <small>(specify)</small> _____	Yes <input type="checkbox"/> No <input type="checkbox"/> Did not wish to answer <input type="checkbox"/> How long since release _____ Name of Prison of release _____
EMPLOYMENT/ EDUCATION	DRUG USE FUNDED BY
Employed (paid or unpaid) <input type="checkbox"/> Support into employment <input type="checkbox"/> Unemployed <input type="checkbox"/> Never employed <input type="checkbox"/> Long term sick/ disabled <input type="checkbox"/> School <input type="checkbox"/> Excluded from school <input type="checkbox"/> Full time education/ training <input type="checkbox"/> In Prison <input type="checkbox"/> Other <small>(specify)</small> _____	Tick all that apply Employment <input type="checkbox"/> Crime <input type="checkbox"/> Debt <input type="checkbox"/> Other <small>(specify)</small> _____ Benefits <input type="checkbox"/> Sex work <input type="checkbox"/> Did not wish to answer <input type="checkbox"/>

6) PRESCRIPTION DRUGS PROFILE (CURRENT) - Give details of current prescription related to treatment of addiction

None Not known Details verified? Yes No

If none or not known, go to section 7

	Drug name	Daily dosage (mg)
Main drug		
Drug 2		
Drug 3		
Drug 4		
Drug 5		

7) ILLICIT DRUGS PROFILE (PAST MONTH) - Including solvents & OTC medicine taken inappropriately

Used in past month? Yes show details No go to section 8

	Drug name	Route(s) e.g. IV/ IM/ smoke/ swallow/ inhale/ snort				In a 'typical' drug using day	
		Main route	How often	Other route	How often	Quantity e.g. mg/ml/oz/binge	Spend £
Main Drug							
Drug 2							
Drug 3							
Drug 4							
Drug 5							

12) DEPENDENT CHILDREN

Does client have dependent children Yes No

If yes provide age of each child in table below

	Child one	Child two	Child three	Child four	Child five	Child six
Living with own children						
Own children living elsewhere						
Living with partner's children						

Is client or their partner pregnant? Yes No

13) CURRENT CONTACT WITH SERVICE

Is client still in contact with this service Yes No

Please provide details below

Received required support
 Disciplinary
 Unplanned
 Deceased
 Referred to other service
 If referred, name of service _____

Date of referral/ discharge/ contact ended

14) LOCAL USE

ISD Ref A