

CONFIDENTIAL ALL YELLOW BLOCKS MUST BE COMPLETED for NDTMS upon initial contact

Consent for NDTMS Y/N	<input type="checkbox"/>	Date Completed	<input type="text"/> / <input type="text"/> / <input type="text"/>
TOP Coordinator Y/N	<input type="checkbox"/>	Completed by	<input type="text"/>
		Agency Code	<input type="text"/>

CLIENT PROFILE

Forename <input type="text"/> Surname <input type="text"/> NB: only initials will be used in NDTMS DOB dd/mm/yyyy <input type="text"/> / <input type="text"/> / <input type="text"/> Sex M/F (at Birth) <input type="text"/> Ethnic Code <input type="text"/> Client Ref <input type="text"/> Nationality at Birth <input type="text"/> Sexuality <input type="text"/>	Address <input type="text"/> Town <input type="text"/> Post Code <input type="text"/> Accommodation Need <input type="text"/> DAT <input type="text"/> PCT <input type="text"/> Local Authority <input type="text"/> GP Code <input type="text"/>
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Parental Status <input type="text"/> Children Living with <input type="text"/> Pregnant Y/N <input type="checkbox"/> NB: Count of all children where client is living Employment Status <input type="text"/>	Referral Date <input type="text"/> / <input type="text"/> / <input type="text"/> Referral Source <input type="text"/> Triage Date <input type="text"/> / <input type="text"/> / <input type="text"/> Date care plan created and agreed <input type="text"/> / <input type="text"/> / <input type="text"/> Health Care Assessment Date <input type="text"/> / <input type="text"/> / <input type="text"/>
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Main Drug <input type="text"/> Age First Use (Main Drug) <input type="text"/> Route <input type="text"/>	Injecting Status (Any Drug) <input type="text"/> Injected last 28 days Y/N? <input type="checkbox"/> Ever Shared Y/N? <input type="checkbox"/>
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Second Drug (Please state if no 2nd or 3rd drug) <input type="text"/> Third Drug <input type="text"/>	Hep B Intervention Status <input type="text"/> Hep B Vac Count (within this episode of treatment) <input type="text"/> Previous Hep B infected Y/N/ NK <input type="text"/>
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Units of Alcohol <input type="text"/> (Daily average) Number Drinking Days <input type="text"/> (0-28) in last 28 days	Hep C Tested Y/N/NA <input type="text"/> Hep C Latest Test Date <input type="text"/>
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Previously Treated - tier 3/4 only Y/N <input type="checkbox"/> Dual Diagnosis (Special/Mental Health) Y/N <input type="checkbox"/>	Hep C Positive Y/N/ NK <input type="checkbox"/> Referred to Hepatology Y/N <input type="checkbox"/> Hep C Intervention Status <input type="text"/>
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TREATMENT MODALITY Complete all fields as appropriate for client's current journey

Treatment Modality 1	Treatment Modality 2	Treatment Modality 3
Date Referred <input type="text"/> / <input type="text"/> / <input type="text"/>	Date Referred <input type="text"/> / <input type="text"/> / <input type="text"/>	Date Referred <input type="text"/> / <input type="text"/> / <input type="text"/>
Date 1st App offered <input type="text"/> / <input type="text"/> / <input type="text"/>	Date 1st App offered <input type="text"/> / <input type="text"/> / <input type="text"/>	Date 1st App offered <input type="text"/> / <input type="text"/> / <input type="text"/>
Modality Start Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Modality Start Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Modality Start Date <input type="text"/> / <input type="text"/> / <input type="text"/>
Modality End Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Modality End Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Modality End Date <input type="text"/> / <input type="text"/> / <input type="text"/>
Modality Exit Status <input type="text"/>	Modality Exit Status <input type="text"/>	Modality Exit Status <input type="text"/>

Discharge Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Discharge Reason <input type="text"/>
NB: Discharge Reason 'Client Perspective'	

TREATMENT OUTCOMES PROFILE

Complete only for clients aged 16 and over

Name of Keyworker

Name of Client

TOP interview date dd/mm/yyyy

REMINDER—is TOP Co-ordinator field correct / updated? (overleaf)

Treatment Stage

Start

Review

Exit

Post Exit

SECTION 1: Substance Use

Please use NA only if the information is not disclosed/not answered

Record the average amount on a using day and number of days used in each of past 4 weeks

	Average		Week 4	Week 3	Week 2	Week 1	Total
a Alcohol	<input type="text"/>	units/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Opiates	<input type="text"/>	g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Crack	<input type="text"/>	g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
d Cocaine	<input type="text"/>	g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
e Amphetamines	<input type="text"/>	g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
f Cannabis	<input type="text"/>	spliff/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
g Other Problem Substance?	<input type="text"/>	g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28

Name

SECTION 2: Injecting risk behaviour

Please use NA only if the information is not disclosed/not answered

Record number of days client injected non-prescribed drugs in past 4 weeks (if none, enter zero and go to section 3)

	Week 4	Week 3	Week 2	Week 1	Total
a Injected	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Injected with needle or syringe used by someone else?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>
c Injected using a spoon, water or filter used by someone else?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Enter 'Y' if any yes, otherwise 'N'

SECTION 3: Crime

Please use NA only if the information is not disclosed/not answered

Record days of shoplifting, drug selling and other categories committed in past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
a Shoplifting	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Drug Selling	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Theft from or of a vehicle			Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>
d Other property theft of burglary			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
e Fraud, forgery and handing stolen goods			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
f Committing assault of violence			Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/> Y or N

Enter 'Y' if any yes, otherwise 'N'

SECTION 4: Health and Social Functioning

Please use NA only if the information is not disclosed/not answered

a Client's rating of psychological health status (anxiety, depression and problem emotions and feelings)

Poor	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Good	<input type="text"/>	0-20
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Record days worked and at college or school for past 4 weeks

	Week 4	Week 3	Week 2	Week 1	Total
b Days Paid Work	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Days attended college or school	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28

d Client's rating of physical health status (extent of physical symptoms and bothered by illness)

Poor	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Good	<input type="text"/>	0-20
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Record accommodation items for the past four weeks

e Acute Housing Problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>	Y or N
f At risk of eviction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>	Y or N

g Clients rating overall quality of life (e.g. able to enjoy life, gets on well with family and partner)

Poor	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Good	<input type="text"/>	0-20
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