

CONFIDENTIAL

The fields marked with YELLOW boxes below require completion if appropriate i.e if client is referred to a new modality, discharged from an existing modality, changed address, blood borne virus information requires revision etc.
General Healthcare date should be entered when the first GH assessment is completed.

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"/>	Address	<input type="text"/>
Surname	<input type="text"/>		<input type="text"/>
DOB dd/mm/yyyy	<input type="text"/> / <input type="text"/> / <input type="text"/>	Town	<input type="text"/>
Client Ref	<input type="text"/>	Post Code	<input type="text"/> <input type="text"/>
Health Care Assessment Date	<input type="text"/> / <input type="text"/> / <input type="text"/>	DAT	<input type="text"/> PCT <input type="text"/>
		Local Authority	<input type="text"/> GP Code <input type="text"/>

HEPATITIS

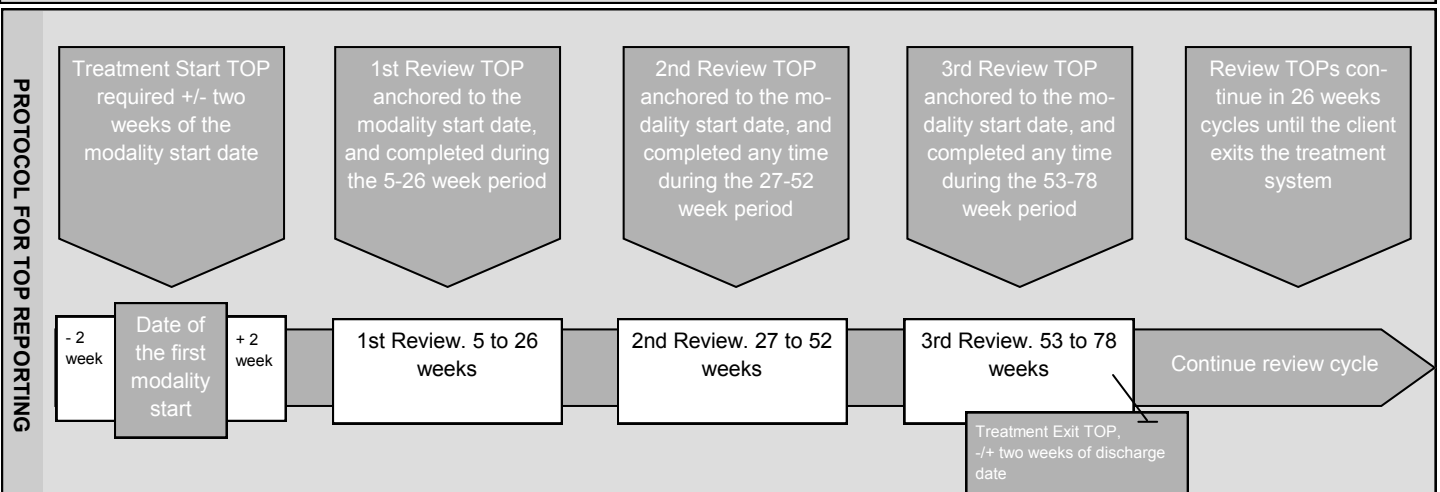
HEP B DETAILS	Hep B Intervention Status	<input type="text"/>	HEP C DETAILS	Hep C Tested Y/N/NA	<input type="text"/>
	Hep B Vac Count within this episode of treatment	<input type="text"/>		Hep C Latest Test Date	<input type="text"/>
	Previous Hep B infected Y/N /NK	<input type="text"/>		Hep C Positive Y/N/NK	<input type="text"/> Referred to Hepatology Y/N <input type="text"/>
				Hep C Intervention Status	<input type="text"/>

TREATMENT MODALITY

Treatment Modality	<input type="text"/>	Treatment Modality	<input type="text"/>	Treatment Modality	<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 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

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