MEDWAY COMMUNITY SAFETY PARTNERSHIP

KDAAT

HARM reduction
come around to the facts

Harm Reduction Assessment

Location	Worker	Client No.	Date of Initial Assessment Date			
			Date of this Assessment Date			

Section One

Injecting History and Behaviour

When did you last inject?	Today	Yesterday	In Last Week	In Last 2 Weeks	In Last Month	Other (please state)	
How often do you inject?	Daily (How Often)	Weekly (How Often)	Monthly (How Often)	Other (please state)			
Main Drug of Injection	Heroin ☐	Crack Cocaine ☐	Speedball ☐	Speed ☐	Subutex ☐	Cocaine ☐	Steroids ☐
	Other ☐	Other (please state)					
Age of first injecting?							
Other drugs injected	Heroin ☐	Crack Cocaine ☐	Speedball ☐	Speed ☐	Date last injected		
	Subutex ☐	Cocaine ☐	Steroids ☐	Other ☐ (please state)			
Other drugs injected in the past	Heroin ☐	Crack Cocaine ☐	Speedball ☐	Speed ☐	Date last injected		
	Subutex ☐	Cocaine ☐	Steroids ☐	Other ☐ (please state)			

Injects self	Yes ☐	If no, injected by:		
	No ☐	Friend ☐	Partner ☐	Other ☐

Section Two

Injecting equipment use

Use of the below Please state which	Please state which e.g. pharmacy, fixed site exchange, outreach)	Shared Partner		Shared Friend		Shared Other	
		Last Month	Ever	Last Month	Ever	Last Month	Ever
Syringes / Needles							
Spoons / Cookers							
Water							
Acidifier							
Filters							
Tourniquet							
Store & Dispose Syringes							
Store Drugs							
Other (please state)							

How do you Store and Dispose of your Syringes?

How do you Store your Drugs?

Section Three

Injecting sites and physical health

Registered with GP Yes ☐ No ☐	If no, referral agreed and made
GP Details	Yes ☐ No ☐
Registered with Dentist Yes ☐ No ☐	If no, referral agreed and made
Dentist Details	Yes ☐ No ☐

Physical Health

Please indicate any area of concern for physical health eg lungs; liver; teeth.

Please describe symptoms and length of symptoms

1. Area of Concern:

Symptoms:

Length of Symptoms:

2. Area of Concern:

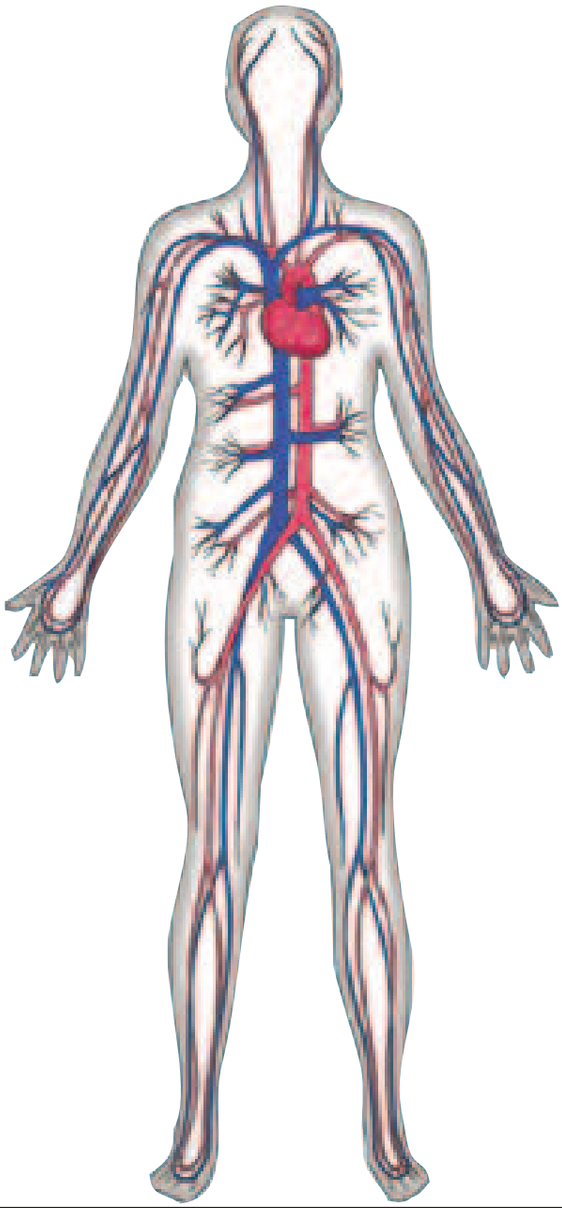
Symptoms:

Length of Symptoms:

3. Area of Concern:

Symptoms:

Length of Symptoms:



Injecting Sites

Please state **Current Sites**

Please state **Past Sites**

Please indicate any **problem areas** for injecting

Agreed actions	**Review Date**
1.	
2.	

Section Four

Other Issues

Use of non-injected drugs What? How often? Quantity?	
Use of alcohol How often? Quantity? Use with drugs?	
Use of prescribed medication What? How long for?	
Housing situation (please state) NFA / Private rented / Hostel / Supported Housing / Own property?	

ADULTS: Accommodation

No Fixed Abode			Yes ☐	No ☐	
NFA - urgent housing problem ☐		Housing problem ☐		No housing problem ☐	

Living with

Alone ☐		Friend: User ☐ Non user ☐	
Parents ☐		Partner: User ☐ Non user ☐	

BBV History

	Yes	No	Latest test date	Test Result +ve	Test Result -ve	Offered & accepted	Offered & refused	Immunised already	Not Offered	Acquired Immunity
Tested for HIV	☐	☐		☐	☐	☐	☐			
Tested for HepA	☐	☐		☐	☐	☐	☐	☐		
Tested for HepB	☐	☐		☐	☐	☐	☐	☐	☐	☐
Tested for HepC	☐	☐		☐	☐	☐	☐		☐	
Vaccinated against HepB	☐	☐		☐	☐	☐	☐	☐	☐	☐
Previously infected with HepB	☐	☐								
HEP C Positive	☐	☐								
Referred to Hepatology	☐	☐								

HepB vaccination count. *(Tick or enter date if known)*	One vaccination	Two vaccinations	Three vaccinations	Course Completed
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Cross if client declined to answer communicable disease questions ☐

Do you have support from non-drug using friends / relatives?	Yes ☐ No ☐
Contact with other agencies, including child protection?	Yes ☐ No ☐

History of Accidental Overdose

In the last 30 days have you used opiates (alone or with other drug / alcohol) to the point of losing consciousness? Yes ☐ No ☐

If ***yes***, how many times in the last 30 days _____

Loss of consciousness due to drug use When? Where? What happened?	
Accessing structured drug treatment services Which ones? Where?	Specialist Prescribing ☐ · Structured Day Programmes ☐ · Advice & Information ☐ GP Prescribing ☐ · Aftercare ☐ · Structured Alcohol Intervention ☐ Structured Counselling ☐ · Outreach ☐ · Other Structured Intervention ☐
Long Term illness/condition Eg asthma; epilepsy; diabetes; depression; psychosis	

Actions

Date of action	Action Agreed

We are always looking for ways to improve our service for you.
Do you have any comments on this form and / or the syringe exchange services you use?

Consent (Explicit)

The information you provide on this form will be held by……
…….... (the Treatment Provider) and used by the Treatment Provider for the purposes of providing the help you need and ensuring the continuity of your healthcare.

Information provided on the slip on page 7 may, with your consent be shared the Kent Drug and Alcohol Action Team (KDAAT) for the purposes of research, audit and performance monitoring. Before being sent, your information is anonymised ensuring it is not possible to link data to particular individuals.

Your information will not be used for any other purpose and will not be passed to any other third party without your permission save that the Treatment Provider may share your information with certain law enforcement agencies, other public authorities or others for the purposes of the prevention or detection of crime. In accordance with the NTA guidelines on Record Retention (http://www.nta.nhs.uk/publications/documents/nta_data_protection_and_record_sharing_2003_dsp2.pdf) records will be kept for eight years after the conclusion of treatment.

I have been advised that I can withdraw my consent to this information being shared with KDAAT at any time and that if I do not consent to my information being shared with KDAAT it will not prevent me getting the treatment I need.

I do / do not consent to my information being shared with KDAAT.

Signature.....

Clients Signature		Date	
Worker Completing Form		Date	

If presented with Child Protection or Child in Need or Adult Protection concerns staff must follow the local safeguarding procedure as soon as any requirements to do so are identified. (Sections 17 & 47 of the Children Act 2004)

Notes

Basic Information

(Initial Required)	Surname	*(Initial Required)*	First Name
☐		☐	
Date of Birth	**Age**	**Postcode of Residence**	**Gender**
/ /		*(1st four characters)*	Male ☐ Female ☐

Ethnicity			
White British ☐	White & Asian ☐	Other Asian - Asian British ☐	Other Black British ☐
White Irish ☐	White & Black Caribbean ☐	Bangladeshi - Asian British ☐	Chinese - Other Ethnic ☐
Other White ☐	Indian - Asian British ☐	African - Black British ☐	Other - Other Ethnic ☐
White & Black African ☐	Pakistani - Asian Mixed ☐	Caribbean - Black British ☐	Other Mixed ☐
If other ethnicity stated please give further details (for your records only):			

Please fill out form and return to: ICT Team, KDAAT, Stoneborough House, Chequers Centre, King Street, Maidstone, Kent ME15 6AW

Information for KDAAT

Location	Worker	Client No.	Date of Initial Assessment Date	
			Date of this Assessment Date	

(Initial Required) Surname		*(Initial Required)* First Name		
☐		☐		
Date of Birth	**Age**	**Main Drug of Injection**		
/ /		Heroin ☐	Crack Cocaine ☐	Speedball ☐
Postcode *(1st four characters)*	**Gender**	Speed ☐	Subutex ☐	Other (please state) ☐
	Male ☐ Female ☐	Cocaine ☐	Steroids ☐	

Client didn't consent to info being shared ☐