TURNING POINT
TURNING LIVES AROUND

Assessment record

Exchange
tools for harm reduction

Initial assessment

Worker: .....

Client name: .....

Date: .....

Confidentiality explained	☐ Yes
Database completed	☐ Yes
Registered with GP **If no, information given?**	☐ Yes ☐ No ☐ Yes
Disposal and storage of injecting equipment and substances discussed **Children in the environment**	☐ Yes ☐ Yes ☐ No
Overdose risk and prevention discussed	☐ Yes
BBV's risk and prevention discussed **Hep. B Vaccinated**	☐ Yes ☐ Yes ☐ No
Saliva test explained	☐ Yes
N/EX Pharmacy used **If no, information given?**	☐ Yes ☐ No ☐ Yes
Contact with pharmacy explained	☐ Yes

Pharmacy used and name:

Detailed assessment and intervention record

	Initial assessment			**Follow up 1**			**Follow up 2**		
	Done	Date	Initials	Done	Date	Initials	Done	Date	Initials
Saliva test	☐			☐			☐		
1. **Substance specific**	☐			☐			☐		
2. **Blood borne viruses**	☐			☐			☐		
3. **Overdose**	☐			☐			☐		
4. **Injecting technique**	☐			☐			☐		
5. **Basic health check**	☐			☐			☐		
6. **Sexual health**	☐			☐			☐		
7. **Initiation**	☐			☐			☐		
8. **Treatment options**	☐			☐			☐		
9. **Injecting equipment supply**	☐			☐			☐		

Needle exchange record

to be completed at each visit

Date: ..... **Worker:** .....

Client name:

All drugs injected:

Usual amount injected: Cost: Quantity:

Frequency of injections: Times per day: Week:

Other substances used and amount: Alcohol:

Illicit:

Prescribed:

Sites of injection: Where injecting:

Condition of Sites:

Sites seen? ☐ Yes ☐ No

Current health problems: Overdosed since last visit? ☐ Yes ☐ No

Other .....

Hepatitis/HIV Risk: Sharing injecting equipment? ☐ Yes ☐ No

Sexual health discussion? ☐ Yes ☐ No

CHECK ASSESSMENT FOR INFORMATION THAT NEEDS TO BE DISCUSSED/GIVEN

Equipment issued: 1ml Insulin: 0.5ml Insulin:

Barrels: Needles:

Bins: 0.6ltr: 1ltr: 4ltr:

Citric:

Bins returned: 0.6ltr: 1ltr: 4ltr:

Current risks / information given:

Comments for next visit:

Part 1. **Substance**

Client name: ..... **Worker initials:** .....

Which of these substances have you used in the past 4 weeks:

- ☐ Heroin
- ☐ Alcohol
- ☐ Dihydrocodeine (DF118'S)
- ☐ Benzo's (Diazepam, Temazepam etc...)
- ☐ Crack
- ☐ Cocaine
- ☐ Amphetamine
- ☐ Steroids
- ☐ Cannabis
- ☐ Skunk
- ☐ Ketamine
- ☐ Ecstasy
- ☐ Other – please specify: .....

What do you know about the affects/side effects of each of the substances you use?
Details:

What do you know about the effect of mixing the substances that you use?
Details:

Verbal/written information given on specific risks and harm reduction measures:

Part 2. **Blood borne viruses**

Client name: ..... **Worker initials:** .....

Equipment sharing

During the past 4 weeks have you:
Used any of these items for injecting when they have already been used by someone else:

- ☐ Needles/syringes
- ☐ Spoon
- ☐ Filter ('wash')
- ☐ Water
- ☐ Other – please specify: .....

Passed on any of these items to someone else after using them yourself:

- ☐ Needles/syringes
- ☐ Spoon
- ☐ Filter ('wash')
- ☐ Water
- ☐ Other – please specify: .....

Filled your syringe from another syringe that had already been used/prepared for injection by someone else? ☐ Yes ☐ No

Let someone else fill their syringe with a syringe you had already used/prepared for injection? ☐ Yes ☐ No

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Hepatitis B

What can it do to you?

- ■ Acute illness (can be mild or severe) and possibly long term liver damage
- ■ More likely to be serious if infected with other blood borne viruses

How is it transmitted?

- ■ Sharing any injecting equipment
- ■ Sexual intercourse without a condom
- ■ Sharing personal items such as a razor or toothbrush where dried blood or bodily fluids may be present
- ■ Through contaminated bodily fluids (e.g. semen, vaginal fluid, saliva)

How do you protect yourself?

- ■ Having a full course of vaccinations against hepatitis B
- ■ Not sharing any injecting equipment with anyone
- ■ Always using a condom for sexual intercourse
- ■ Not using any personal items such as a razor or toothbrush that may be contaminated with dried blood or other bodily fluids

Good previous knowledge of above points ☐ Yes ☐ No

Part 2. **Blood borne viruses** continued

Hepatitis C

What can it do to you?
- Risk of long term illness and liver damage
- More likely to be serious if infected with other blood borne viruses or with heavy alcohol use
- Can be infected with more than one type

How is it transmitted?
- Sharing any injecting equipment
- Sharing personal items such as a razor or toothbrush where dried blood may be present
- Having sexual intercourse without a condom (although the risk is thought to be low)

How do you protect yourself?
- Not sharing any injecting equipment with anyone
- Not sharing personal items such as a razor or toothbrush where dried blood may be present
- Always using a condom when having sexual intercourse

Good previous knowledge of above points ☐ Yes ☐ No

HIV

What can it do to you?
- Cause chronic illness leading to AIDS
- More likely to be severe if already infected with other blood borne viruses (Hepatitis B or C)

How is it transmitted?
- Sharing any injecting equipment
- Having sexual intercourse without a condom
- Sharing personal items that may be contaminated with blood

How can you protect yourself?
- Not sharing any injecting equipment with anyone
- Always using a condom for sexual intercourse
- Not sharing any personal items that may be contaminated with blood

Good previous knowledge of above points ☐ Yes ☐ No

Verbal/written information given on specific risks and harm reduction measures:

Part 2. **Blood borne viruses** continued

Testing and vaccination

Have you ever been tested for:

HIV	☐ Yes	approx. date tested	☐ No
Hepatitis B (HBV)	☐ Yes	approx. date tested	☐ No
Hepatitis C (HCV)	☐ Yes	approx. date tested	☐ No

If you have ever received a test result for any of these infections and you are willing to disclose the result please tell us if you are positive for:

HIV	☐ Yes	☐ No
Hepatitis B (HBV)	☐ Yes	☐ No
Hepatitis C (HCV)	☐ Yes	☐ No

If yes to any of the above, are you receiving treatment? ☐ Yes ☐ No

Details:

Hepatitis B immunisation

Have you ever been vaccinated against Hepatitis B? ☐ Yes ☐ No

If yes, did you have a blood test confirming that you are immune? ☐ Yes ☐ No

Where did you receive your treatment?

- ☐ GP
- ☐ GU Clinic
- ☐ Prison
- ☐ Other – please specify: .....

Next vaccination/booster due: .....

Verbal/written information given on specific risks and harm reduction measures:

Part 3. **Overdose**

Client name: ..... **Worker initials:** .....

In the last 4 weeks have you used heroin at the same time that you have been under the influence of:

- ☐ Another opiate e.g. methadone, DF118s
- ☐ Alcohol
- ☐ Diazepam (Valium), Temazepam or other benzos
- ☐ Other sedatives e.g. chlormethiazole (Heminevrin)
- ☐ Crack/cocaine/amphetamine

In the last 4 weeks have you used opiates alone or with other drugs/alcohol to the point of losing consciousness?
☐ Yes ☐ No

If yes, how many times? .....

Have you overdosed on drugs in the past year? ☐ Yes ☐ No
If yes, what was the cause?
Details:

Roughly how many times in the past year have you been with someone else when they have accidentally overdosed?

.....

What did you do?
Details:

What are the risk factors that can lead to overdose?

- ■ Injecting Heroin
- ■ Mixing drugs
- ■ Mixing drugs and alcohol
- ■ Using opiates when tolerance is low – particularly after a detox or break in use

All above points covered ☐ Yes ☐ No

What are the signs and symptoms of overdose?

- ■ Turning blue
- ■ Unwakeable
- ■ Deep snoring
- ■ Not breathing

All above points covered ☐ Yes ☐ No

Part 3. **Overdose** continued

What is the best thing to do if someone overdoses?

- Put them in the recovery position
- Dial 999 and ask for an ambulance
- Stay with them until the ambulance arrives

All above points covered ☐ Yes ☐ No

If someone overdosed while they were with you:

Would you be confident about putting them in the recovery position? ☐ Yes ☐ No

Would you call an ambulance? ☐ Yes ☐ No

Did you know that the police are no longer routinely called to overdose situations? ☐ Yes ☐ No

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Video shown? ☐ Yes ☐ No

Interested in overdose prevention and response course? ☐ Yes ☐ No

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Verbal/written information given on specific risks and harm reduction measures:

Part 4. **Injecting Technique**

Client name: ..... **Worker initials:** .....

Have you experienced any of these problems due to injecting over the last 6 months? (tick all that apply)

- ☐ Blocked/collapsed veins
- ☐ Bruising
- ☐ Circulation problems
- ☐ Dirty hit – List symptoms experienced: .....
- ☐ Injected into a artery
- ☐ Numb patches
- ☐ Pain at the injection site
- ☐ Citric burns
- ☐ Abscess/infection at injection site
- ☐ Ulcers/open sores
- ☐ Cellulitis
- ☐ Blood infection (Septicemia)
- ☐ DVT (Deep Vein Thrombosis)
- ☐ Endocarditis
- ☐ Other – please specify: .....

Did you get medical help for any of these problems? ☐ Yes ☐ No
Details:

Has someone else injected you in the past 4 weeks? ☐ Yes ☐ No

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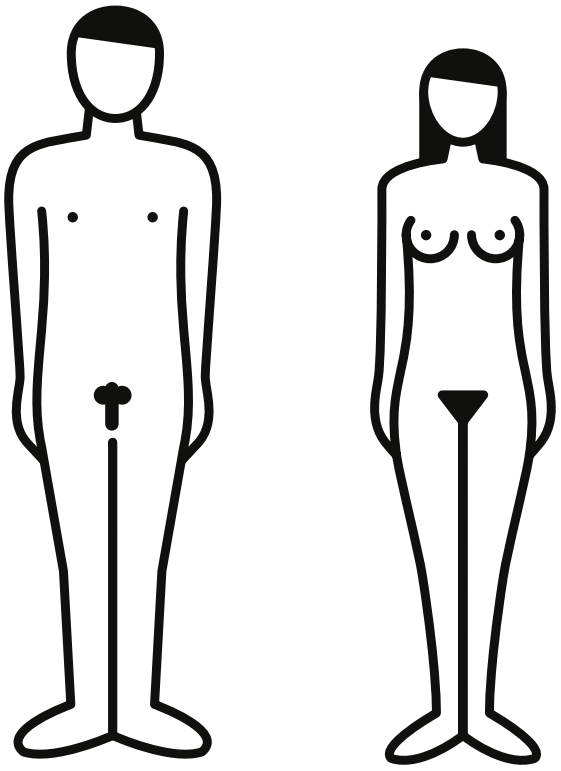
Where have you injected in the past 4 weeks?
(Please mark diagram with x's)



Part 4. **Injecting Technique** continued

Site specific risk information given
Details:

Good previous knowledge of risks? ☐ Yes ☐ No

What source of water do you use for injection?
Details:

What type of filters do you use for injection?
Details:

Do you store/re-use your filters? ☐ Yes ☐ No

Do you wash your injection site using soap and water before injecting? ☐ Yes ☐ No

Do you always use a new/sterile needle and syringe for each injection? ☐ Yes ☐ No

Do you rotate your injecting sites? ☐ Yes ☐ No

What, if any acidifiers do you use:

- ☐ Citric acid
- ☐ Vitamin C
- ☐ Lemon juice
- ☐ Vinegar
- ☐ Other – please specify: .....

Where do you get your acidifier from:

- ☐ Drugs Agency N/EX
- ☐ Pharmacy N/EX
- ☐ Other – please specify: .....

What alternatives to injecting have you considered?

- ☐ Substitute prescription/detox
- ☐ Self detox
- ☐ Smoking (chasing)
- ☐ Snorting
- ☐ UYB (rectal use)
- ☐ Other – please specify: .....

Written/verbal information given on specific risks and harm reduction measures:

Part 5. **Basic Health Check**

Client name: ..... **Worker initials:** .....

Physical health

Are you registered with a GP? ☐ Yes ☐ No

If yes, does your GP know that you inject? ☐ Yes ☐ No

Weight .....

Height .....

What do you eat on an average day?
Details:

Do you have tooth decay or other dental problems that need the attention of a dentist? ☐ Yes ☐ No
Do you have asthma or other breathing problems? ☐ Yes ☐ No
Do you have a cough that won't go away? ☐ Yes ☐ No
During the past year have you spent time with anyone who has been diagnosed with tuberculosis (TB)? ☐ Yes ☐ No
Do you have any problems sleeping? ☐ Yes ☐ No

Have you been diagnosed with any physical health problem in the last 6 months? ☐ Yes ☐ No
Details:

If yes are you receiving any treatment? ☐ Yes ☐ No
Details:

Have you felt unwell in the past 4 weeks? ☐ Yes ☐ No
Details:

Verbal/written information given on specific risks and harm reduction measures:

Part 5. **Basic Health Check** continued

Mental health

Have you experienced any of the following symptoms over the last 4 weeks:

- ☐ Paranoia (feel that people are after me or have beliefs that other people think are irrational)
- ☐ Hallucinations (hear voices/see things that aren't there)
- ☐ Anxiety
- ☐ Feelings of sadness/depression
- ☐ Feelings of anger/aggression
- ☐ Thoughts about harming yourself/committing suicide
- ☐ Feelings that you don't care whether you live or die

Are you in currently in contact with Mental Health services or receiving treatment for Mental Health issues?

☐ Yes ☐ No

Details:

Do you have other mental health problems that you want to discuss?

Details:

Verbal/written information given on specific health risks and harm reduction measures:

Part 6. **Sexual health**

Client name: ..... **Worker initials:** .....

During the past year have you had vaginal/anal or oral sex without using a condom? ☐ Yes ☐ No

If no, did you use any other form of contraception? ☐ Yes ☐ No

Is there any chance that you/your sexual partner is currently pregnant? ☐ Yes ☐ No

Do you know how to use a condom effectively to prevent blood borne viruses?

- Check expiry date (it is not safe to use if it is out of date)
- Be careful not to tear or snag the condom when opening the packet
- The condom must be put on the erect penis before any sexual contact (not just before ejaculation)
- The condom must be rolled down to the base of the penis when being put on while holding the teat at the top (or leave half an inch at the top if there is no teat)
- After ejaculation the condom must be held in place while the penis is withdrawn to prevent the condom from slipping off
- Each condom must be used only once
- Only water based lubricants (such as K-Y jelly) should be used
- Anal sex requires stronger condoms

Above points covered ☐ Yes ☐ No

Where do you get your condoms?

- ☐ GP
- ☐ Family Planning Clinic
- ☐ GU clinic
- ☐ N/Exchange
- ☐ Bought them
- ☐ Other – please specify: .....

Have you ever been unable to get condoms when you needed them? ☐ Yes ☐ No

Do you have any concerns about your sexual health at present?
Details:

In the past year, have you sold sex for money/drugs at any time? ☐ Yes ☐ No

Verbal/written information given on specific risks and harm reduction measures:

Section 7. **Initiation**

Client name: ..... **Worker initials:** .....

How did you first start injecting/what made you want to start?
Details:

Did someone else inject you? ☐ Yes ☐ No

Have you ever been asked to give someone else their first hit? ☐ Yes ☐ No

Have you ever given someone else their first hit? ☐ Yes ☐ No

Break The Cycle completed ☐ Yes

Verbal/written information given on specific risks and harm reduction measures:

Part 8. **Treatment options**

Client name: ..... **Worker initials:** .....

Have you received treatment for your injecting drug use in the past year? ☐ Yes ☐ No
Details:

Are you currently receiving treatment for your drug use? ☐ Yes ☐ No
Details:

Do you know the treatment options available to you at Turning Point?

- ☐ Needle Exchange
- ☐ Drop-in
- ☐ Acudetox
- ☐ Key working
- ☐ MDAC
- ☐ Brief solution focused work
- ☐ Counselling
- ☐ Advocacy
- ☐ Referral to other services
- ☐ Telephone helpline
- ☐ Services for families, friends and carers

Do you know the medical treatment options available to you through your GP/SDS?

- ☐ Methadone stabilisation/maintenance
- ☐ Subutex stabilisation/maintenance
- ☐ Subutex detox
- ☐ Lofexidine detox
- ☐ Naltrexone
- ☐ Inpatient detoxification
- ☐ Residential detox/rehabilitation

Are there any other issues that you would like information about
(e.g. housing, benefits, debt management, family planning etc.)
Details:

Verbal/written Information given:

Part 9. **Injecting equipment supply**

Client name: ..... **Worker initials:** .....

What other sources do you use for collecting sterile injecting equipment?

- ☐ Pharmacy N/Ex
- ☐ Bought at Pharmacy
- ☐ Supplied by other injectors
- ☐ Other – please specify: .....

Do you regularly give the sterile injecting equipment that you collect at this needle exchange to others?

☐ Yes ☐ No

If yes:

How many? .....

Are they known to this needle exchange? ☐ Yes, all ☐ Some ☐ No, none

Of the injectors that you know how many use this needle exchange? ☐ All ☐ Some ☐ None

If this needle exchange is not used where do they get their supply of injecting equipment?

- ☐ Pharmacy N/Ex
- ☐ Bought at Pharmacy
- ☐ Supplied by other injectors
- ☐ Other – please specify: .....

Verbal/written information given: