AODTS001

PATIENT LABEL

UR Number:

Surname:

Given name:

Date of birth:

VICTORIAN AOD INTAKE TOOL

FOR STAFF ONLY

Clinician name:

Agency:

Catchment:

Signature:

Date:

Version No. 2

VICTORIA State Government

DEMOGRAPHIC INFORMATION

UR Number:

Family name: Name/preferred name(s):

Date of birth: / / Preferred pro-noun (she/he/they):

Gender identification: ☐ Male ☐ Female ☐ Other (please specify):

Identification as LGBTIQA+: ☐ No ☐ Yes ☐ Prefer not to say ☐ Other (please specify):

Private health Insurance? ☐ No ☐ Yes Details:

Person with a disability: ☐ No ☐ Yes Details:

Reason for call/ visit today: ☐ Self ☐ Other

Details:

Address:

Postcode: Is it safe to send mail to this address? ☐ No ☐ Yes Preferred contact method:

Mobile number: Is it safe to leave voicemail/text message on this phone? ☐ No ☐ Yes

Other contact number: Does anyone else have access to this phone?

Email address: Emergency contact name:

Relationship to client: Emergency contact number:

Country of birth: Cultural background:

Identifies as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Refugee status: ☐ Refugee ☐ Asylum seeker ☐ Neither Visa Status details:

Preferred language/dialect: Interpreter required: ☐ No ☐ Yes

Employment status:

Living with: ☐ Family ☐ Friends ☐ Alone ☐ Care home ☐ Other

Family members to be involved in assessment/ treatment: ☐ No ☐ Yes

Details:

Primary caregiver/living-with child/ren or other dependents aged 16 or under: ☐ No ☐ Yes

Has children not in their care: ☐ No ☐ Yes

Changes to parenting arrangements /orders (Details):

Age(s) of children or dependents:

Family Reunification Order: ☐ No ☐ Yes If yes, AOD treatment a condition: ☐ No ☐ Yes

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GP name: Email:

Fax: Phone number: ( )

Medicare number: Expiry date: Health Care Card number: Expiry date:

Engaged with other services: ☐ Child protection ☐ NDIS ☐ Housing ☐ Mental health ☐ Legal

☐ Financial ☐ Family Violence Service ☐ Mens Behaviour Change Program ☐ Other (please specify):

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

SECTION 1: ALCOHOL AND OTHER DRUG USE

1. Alcohol or drug use in the past year: ☐ No ☐ Yes

2. At risk of lapse/relapse: ☐ No ☐ Yes

Details:

IF NO TO Q1 AND Q2 GO TO SECTION 2

3. Primary drug of concern:

4. Days of use of primary drug of concern in past month:

5. Amount of primary drug of concern per day: (amount) (units of measurement)

6. Last use of primary drug of concern: Date:

7. Usual route of administration: ☐ ingests (swallows) ☐ smokes ☐ injects ☐ sniffs (powder)
☐ inhales (vapour) ☐ other ☐ multiple ☐ not stated

8. Other drugs of concern:

9. Any recent (past 3 months) injecting drug use: ☐ No ☐ Yes Days of injecting use in past month:

10. History of drug overdose: ☐ No ☐ Yes

11. Other risky drug practices (past 3 months, e.g. DUI, unsafe injecting practices, injected by another, using alone, unsafe sex, etc.):

☐ No ☐ Yes Details:

12. Evidence of harm from substance use (e.g. interpersonal, financial, legal, mental health, physical issues):

☐ No ☐ Yes Details:

13. Evidence of substance dependence (e.g. tolerance, withdrawal, previous quit attempts, preoccupation, craving, etc.):

☐ No ☐ Yes

14. On pharmacotherapy program? (e.g. methadone/buprenorphine) ☐ No ☐ Yes

Details (including prescriber details and buprenorphine formulation):

15. Previous use of AOD services: ☐ No ☐ Yes

16. If yes, which program/s (e.g. counselling services (including court ordered), withdrawal services, pharmacotherapy)

FURTHER COMMENTS:

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

SECTION 2: RISK AND COMPLEXITY

17. Any current physical health/medical issues (tick all that apply):

☐ History of seizures (date of last seizure: .....) ☐ Chronic pain ☐ Pregnancy ☐ Diabetes

☐ Chronic physical illness (e.g. cardio, respiratory) ☐ Liver disease ☐ Acquired Brain Injury

☐ Other (please specify):

18. Any current mental health issue (e.g. major depression, etc.): ☐ No ☐ Yes

Details (diagnosis, most recent hospitalisation):

19. Are you currently taking any medications for your mental/physical health issues? ☐ No ☐ Yes

(Please specify):

20. Recent/current self-harm: ☐ No ☐ Yes

Details:

21. Recent/current suicidal ideation/suicidal attempts: ☐ No ☐ Yes

If yes, details of safety plan:

22. Homeless / risk of homelessness: ☐ No ☐ Yes

Details:

23. Unemployed / risk of unemployment: ☐ No ☐ Yes

Details:

24. Concerned about gambling: ☐ No ☐ Yes

Details:

25. History / Risk of aggression to / from others: ☐ No ☐ Yes

Details:

26. Any significant court / legal issues(involvement with justice): ☐ No ☐ Yes Pending court date: ☐ No ☐ Yes

Details: Details:

27. Current family violence intervention order: ☐ No ☐ Yes

Details:

As Affected Family Member: ☐ No ☐ Yes As Respondent: ☐ No ☐ Yes Children on FVIO: ☐ No ☐ Yes

Details on Order:

28. Family Violence: ☐ No ☐ Yes

Details (e.g. perpetrator actions controlling behaviors, physical assaults, threats to you/children /existing safety plan):

Do you have immediate concerns about your safety: ☐ No ☐ Yes Details (e.g. imminence, risk management etc):

(Note - if you are concerned about the immediate safety of your client – escalate to your supervisor, call Safe Steps on 1800 015 188 or police if necessary).

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

SUMMARY OF IDENTIFIED NEEDS, INCLUDING NEED FOR AOD AND OTHER SERVICES:

OUTCOME OF INTAKE

REFER FOR FURTHER ASSESSMENT?

☐ No (go to "Next Steps") Reason assessment not needed:

☐ Yes (dependent, harm or high risk substance use)

Requires assessment for: ☐ Counselling ☐ Non-residential withdrawal ☐ Residential withdrawal ☐ Care and recovery co-ordination

Prioritisation: ☐ Low ☐ Medium ☐ High

Justification for prioritisation (based on AOD problem severity, client risks, family violence, complexity and protective factors):

Able to attend assessment/treatment appointment (e.g. transport needs): ☐ No ☐ Yes

Details:

Recommended optional modules:

Recommend MARAM risk assessment(s):

Next Steps: (e.g. bridging support, psycho-education, brief intervention, harm reduction information, referral to non-AOD service, family violence service, neuropsychology assessment, housing etc.)

Client Preferences: (e.g. service type, gender of clinician, time of day, location, services that cater for specific populations, such as Indigenous, LGBTIQA+, disability, youth etc.)

Information requested for affected significant other (e.g. family member): ☐ No ☐ Yes

Referred to intake by: Phone number: Date:

Has the agency 'consent to share information' form been completed? ☐ No ☐ Yes

Referral sent? ☐ No ☐ Yes Sent date: Referral accepted? ☐ No ☐ Yes

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Clinician name: Position: Signature: Date: