An Roinn Sláinte
Department of Health

HSE

HSE Social Inclusion

INITIAL AND COMPREHENSIVE ASSESSMENTS AND CARE PLANS CONSENT & CONFIDENTIALITY

» No Initial Assessment = No Care Type (Plan) «

Is Comprehensive Assessment completed? ☐ Yes Date Completed _____ ☐ No

Client Name	DOB	AGE	File No	PASS No

Assessment summary notes:

Assessment checklist:

Consent signed and understood by Service User ☐

All sections completed ☐

Initial care plan developed and agreed with Service User based on assessment ☐

If no contact for 1 month:

- Explain consent and confidentiality
- Is this a new treatment episode?
- If a new episode, please ensure HRB status is updated
- Have the Service User's circumstances changed? If so, please update this assessment.
- Consider new Initial Assessment if significant change in circumstances

If updated:

Assessment updated on

Signed (Assessor)

"The manner in which the healthcare worker discusses the intervention with the person is as important as the information itself. The relationship between the healthcare worker and the person should be a partnership based on openness, trust and clear communication."
(HSE National Consent Policy 2022)

Signed (Assessor)	Organisation	Date

SERVICE USER INFORMATION & CONSENT FORMS

This consent & confidentiality form is designed to give you an understanding of:

What happens to the information you give ✔ *Who has access to the information you give* ✔

_____ Date of Birth: _____

1. I understand that by signing/marking this form below, I give consent to the recording of my personal information which is confidential to the Service. Consent does allow that information to be discussed as a Team*.
2. I understand that I have the right to withdraw consent for the sharing of information at any time, except where there is a professional obligation for confidentiality to be extended (e.g. Child Protection, risk to self, risk to others, Court order).
3. ** I understand that the information I provide is not disclosed to people outside of the care Team (see additional consent below) without further agreement from me or from my legal guardian, if I am under 18 years of age.
4. I understand that my information/records are retained in electronic [computer] and, or paper form, and are the property of the service provider.
5. I understand that I have the right to access information held in that record.
6. I understand that consent applies to the duration of this current assessment and subsequent treatment episode provided by the Team.
7. I understand that attending this service requires adhering to the code of behaviour.
8. I understand that selected information from my records is retained by the Health Research Board (HRB) without the use of my name and used for research purposes. Also, selected information, but not my name, may also be used for other approved research purposes.
9. All requests for a report for an external agency regarding my attendance at or my treatment with this service must be requested in writing with 10 working days advance notice. Such reports may require some additional consent.

*** Team** refers to all professionals and services named in this form that are involved in care provision coordinated by the case manager

**** Please note:** In the event of any member of the Team becoming aware of information that would indicate that you, or someone in your care, or any other person, may be at risk, then the Team, or member of, have a professional responsibility to report that concern to a relevant authority.

I CONFIRM THAT THE ABOVE CONDITIONS HAVE BEEN EXPLAINED TO ME AND THAT I FULLY UNDERSTAND AND AGREE TO THEM.

Signature of service user: _____ Date: _____

Signature of Staff: _____ Date: _____

CONSENT SPECIFIC TO MENTAL HEALTH SERVICES

I consent to a shared health record between Mental Health Service and HSE Addiction Service including Community/Voluntary partners that may be involved in my care. I understand that information recorded by one service will be accessible by the other service. I understand I can withdraw consent at any time.

Signed: _____ Service: _____
[service user]

Signed: _____ Service: _____
[staff]

Name of Staff: _____

Employing agency: _____ Location: _____

Agreement to Share your Information Guidance
SERVICE USER CONFIDENTIALITY INFORMATION

We would like your permission to collect and share information between workers involved in your care, so that we can better understand your needs, improve services and avoid asking you for the same information more than once. This information will only be shared on a need to know basis. This might include sharing information with relevant workers as agreed with yourself as part of your support plan. This agreement covers information in your assessment and support plan.

As some of the information that agencies hold about you is sensitive, they must follow the principles of the Data Protection Act. These ensure that the information agencies have is:

- Used fairly and legally
- Only used for the purposes for which it was collected
- Adequate, relevant and not excessive
- Correct and up to date
- Kept only for as long as needed
- Processed in accordance with a person's rights
- Stored safely

PLEASE COPY
AND GIVE TO SERVICE USER

Your confidentiality is assured except where there is an issue around Child Protection, risk to self, risk to others or Court order.

Care Plan Case Manager Transfer Form

Previous Case Manager: _____

Agency: _____

Newly Agreed Case Manager: _____

Agency: _____

I am satisfied with the manner in which this review has been conducted and with the agreements that have been reached with my involvement and/or on my behalf.

Service User Signature (if present): _____

Previous Case Manager: _____

New Case Manager: _____

ADDITIONAL CONSENT(S) GIVEN

Additional Consent(s) for sharing my information with persons named below

I give consent to communicate with the below named people/family member/service provider (the Care Team)

Name: _____ Service: _____

Name: _____ Service: _____

Name: _____ Service: _____

Name: _____ Service: _____

Signed: _____ Date: _____
[service user]

Witnessed: _____ Date: _____

ADDITIONAL CONSENT(S) WITHDRAWN

Withdrawal of Additional Consent(s) for sharing my information with the persons named below

I withdraw consent to communicate with the below named people/service provider

Name: _____ Service: _____

Name: _____ Service: _____

Name: _____ Service: _____

Name: _____ Service: _____

Signed: _____ Date: _____
[service user]

Witnessed: _____ Date: _____

CONSENT SPECIFIC TO HOMELESS SERVICES PASS DATABASE SYSTEM

Signed: _____ Service: _____
[service user]

Signed: _____ Service: _____
[assessor]

Name of organisation: _____

Project Worker: _____

Contact telephone number: _____

HSE NATIONAL WAITING LIST FOR OPIATE ADDICTION TREATMENT – CLIENT CONSENT FORM

The National Waiting List (NWL) has been designed to ensure an equitable service for all clients who present for treatment for Opiate addiction. The NWL will provide information about waiting times and assist with service planning and development within the HSE Addiction Services.

All information on the NWL is treated in the strictest confidence in compliance with Data Protection legislation

_____ Date of Birth: _____

[Service User Name: Block Capitals]

I have been advised and I understand that my details will be placed on the HSE National Waiting List for treatment when the following validation processes are complete:

Ⓐ to establish that my name is not already on a waiting list

Ⓑ to establish that I am not currently in receipt of treatment

I have been advised and I understand that my details will be dealt with in a confidential manner and will be kept safe and secure and that I can request my details to be removed from the NWL at any time.

I have been advised and I understand that my details will be removed from the National Waiting List, when:

- I commence treatment
- I no longer require treatment, when offered treatment
- I cannot be located by the addiction service

I have been advised and I understand that I should keep in regular contact with the Addiction Service with regard to my status on the NWL.

Signature of service user: _____ Date: _____

I have explained the above to the client. A copy has been given to the client. The client has been given the opportunity to ask and verify any queries.

Signature of Staff: _____ Date: _____

INITIAL ASSESSMENT FORM

Source of Referral:

Date of Referral:

Ref Number

Name of Service User

Date of Birth | Age

- ☐ Man (including trans man)
- ☐ Woman (including trans woman)
- ☐ Non-binary
- ☐ In another way
- ☐ My gender is not listed here (Please describe)

You do not have to answer if you don't want to

Self-defined Sexual Orientation

Heterosexual or Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Other sexual orientation not listed ☐
Client does not know or is unsure ☐ Client did not wish to answer this question ☐ Not known ☐

*It is necessary for the care plan that relevant appendices are **fully** completed.*

» ALL INFORMATION MUST BE CONSIDERED FOR CARE PLAN «

What is the main reason for your referral/access to this service?

Alcohol Use ☐ Drug Use ☐ Homelessness ☐ Concerned person ☐ Other ☐

TICK ALL APPROPRIATE BOXES

If 'Other ☐' selected above give details _____

Most Recent Address:

_____

Phone Number: _____ Mobile Number: _____

Email (optional): _____

Do you agree to be contacted at the above address? Yes ☐ No ☐

Do you agree to be contact via phone, text? Yes ☐ No ☐

Do you agree to be contacted by email? Yes ☐ No ☐

Living Where Stable accommodation ☐ Homeless ☐ Other unstable accommodation ☐
Domestic Violence refuge ☐ Prison, Institution (residential care/halfway house ☐ Not known ☐

Living With Alone ☐ Parents/Family ☐ Friends ☐ Partner (alone) ☐ Partner & Children ☐
Alone & Children ☐ Foster Care ☐ Other ☐ Not Known ☐

Country of Birth _____ Nationality _____

Ethnicity **White** Irish ☐ Irish Traveller ☐ Roma ☐ Any other white background ☐
Black or Black Irish Black ☐ Any other black background ☐
Asian or Asian Irish Chinese ☐ Indian/Pakistani/Bangladeshi ☐ Any other asian background ☐
Other, including mixed group/background Arab ☐ Mixed, write in description ☐
Other, write in description ☐

Description: _____

Language other than English or Irish at home? Yes ☐ No ☐ Not known ☐

If Yes specify: _____ Preferred language to work with : _____

Age left Primary or Secondary School for the first time: _____

Primary level incomplete ☐ Primary level ☐ Junior cert ☐ Leaving Cert ☐ Third level ☐
Never went to school ☐ Not known ☐

Employment Status _____ Occupation: _____

Source of Income: _____ Amount of Income: _____

What days do you work?: _____

What hours do you work?: _____

G.P. Name: _____ GP Address: _____

If using alcohol/drugs is your GP aware of your use? Yes ☐ No ☐ GP Phone: _____

Medical Card: Yes ☐ No ☐ Applying for ☐

Homeless Service Only: Medical Card Number: _____ Valid until: _____

Total Number of Children: _____

	Under 5 Yrs	5 to 17yrs	18yrs & Over
Number of children living with you			
Number living with other parent			
Number in care			
Number living elsewhere			
Living status of child unknown			

Have you any current or recent social worker involvement(s)? Yes ☐ No ☐

If 'Yes', please note details: _____

Are you living with people who use drugs and/or alcohol, people with a gambling addiction or other addictions: Yes ☐ No ☐

Was there ever substance use in your family?: Yes ☐ No ☐

Is your loved one or family member(s) availing of family support?: Yes ☐ No ☐

If 'Yes', please note details:

CONSIDER *Family Support*

*Next of Kin	**Emergency Contact (EC)
Name of Next of Kin:	Name of EC:
Relationship to Next of Kin:	Relationship to EC:
Next of Kin aware of current problem(s): Yes ☐ No ☐	EC aware of current problem(s): Yes ☐ No ☐
Next of Kin contact details:	EC contact details:

***Next of Kin is your closest living blood relative including spouse or adopted family member**
****An Emergency Contact should be:**

✔ Contactable ✔ Available ✔ Able to contact your next of kin ✔ Aware of your health status

SPECIFIC HOUSING INFORMATION RELEVANT TO PRIMARY HOMELESS SERVICES

Here you can discuss your experience in relation to current and past accommodation and detail around any experience of homelessness.

Are you in:

- ☐ Emergency homeless accommodation (homeless hostels/one night only homeless accommodation) such as Supported Temporary Accommodation (STA),
- ☐ Private Emergency Accommodation (PEA),
- ☐ Emergency (on-night-only) Accommodation (EA)
- ☐ Long Term Accommodation (LTA)
- ☐ Sleeping rough outside
- ☐ Sleeping in a place not intended as a residence? (abandoned building/squat vehicle etc..)
- ☐ Couch-surfing (staying with friends/relatives on a short-term basis)
- ☐ Other unstable accommodation

Describe your current housing situation:

Can you outline the main reasons for you becoming homeless on this occasion?

Have you been homeless before?
If so, please give details:

Have you slept rough? If so, when and for how long?

Are you registered with the Local Authority? If so, please specify which Local Authority?

Do you have any rent arrears with a Local Authority?

Have you ever received a deposit from a Community Welfare Officer towards private rented accommodation?
If so, please give details:

Have you ever been in state care under age of 18 years?

Have you ever lived independently?

Have you ever had any difficulties in maintaining accommodation? If so, please give details

Consider domestic, gender or sexual-based violence (DSGBV) as a reason for homelessness

SUBSTANCE USE, GAMBLING, EATING DISORDERS, HISTORIES

Here you can discuss your drug and alcohol use and other addictions and identify what needs you may have at this time that can infor your care plan

NOTE: ***HRB has extensive list of substances***

It is vital to be specific when documenting drug types and quantities (e.g think milligrams, name, and number of tablets for benzodiazepine use)
NDTRS questions relate to the 30 days prior to treatment

RESOURCE ***www.drugs.ie***

Drugs used	Route of administration	Frequency of use in the last month	Quantity	Duration of use in the last month	Age 1st used	Date last used
Cannabis please state in what form						
Hallucinogens						
Benzodiazepine(S) **Source:** ▸ Prescribed ▸ Street ▸ Internet ▸ Multiple ▸ Other						
Heroin						
Methadone						
Other Opiates						
Cocaine ▸ Powder ▸ Crack ▸ Other						
Amphetamine						
Ecstasy/MDMA						
Over the Counter Drugs						
Any other drugs: *[i.e. Solvents/Gas Head-shop/Steroids Others...]*						
Gambling						
Eating Disorders						

Consider ***DUDIT or CUDIT***

Was it difficult to assess which was the main problem drug? **Yes** ☐ **No** ☐

ALCOHOL

Type	Route of administration	Frequency of use in the last month	Number of standard drinks consumed on a typical drinking day (last 30 days)	Duration of use in the last month	Age 1st used	Date Last Used
☐ **Beer**						
☐ **Spirits**						
☐ **Wine**						
☐ **Fortified wine**						
☐ **Cider**						
☐ **Alcopops**						
☐ **Others**						

CONSIDER *AUDIT*

- Please categorise the extent of the drinking problem ☐ Hazardous ☐ Harmful ☐ Dependent ☐ Not Known

RESOURCE *www.askaboutalcohol.ie*

PREVIOUS TREATMENT

Treatment is considered any engagement with services across the 4-tiers

Ever Treated for Substance Use Yes ☐ No ☐ Alcohol Yes ☐ No ☐ Gambling Yes ☐ No ☐

Total number of previous treatments: _____ Age first treated: _____

Treatment Type(s):

_____

Do you attend AA, NA or another self-help support group? Yes ☐ No ☐

Total number of previous medically supervised alcohol only detoxes: _____

Longest time abstinent: _____ Date: _____

Name of treatment provider(s):

_____

Reason for leaving: _____

Current opiate agonist treatment (e.g.methadone, buprenorphine) Yes ☐ No ☐

Other current treatments/prescribed medications Yes ☐ No ☐

Details

_____

Previous methadone maintenance: Yes ☐ No ☐

Age first received any opiate substitution: _____

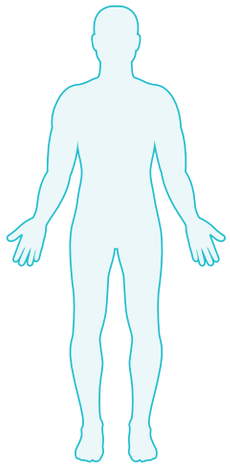
RISK BEHAVIOUR

Ever injected	Yes ☐	No ☐
Injected in last 30 days	Yes ☐	No ☐
Injected in last 12 months but not in last 30 days	Yes ☐	No ☐
Injected but not in the last 12 months	Yes ☐	No ☐
Client did not wish to answer	Yes ☐	
Ever shared Needles/syringes	Yes ☐	No ☐
Never shared	Yes ☐	No ☐
Shared in last 30 days	Yes ☐	No ☐
Shared in last 12 months but not last 30 days	Yes ☐	No ☐
Shared but not in last 12 months	Yes ☐	No ☐
Shared but time period not known	Yes ☐	No ☐
Client did not wish to answer	Yes ☐	
Not known if client ever shared	Yes ☐	
N/A	Yes ☐	
Ever shared other paraphernalia	Yes ☐	No ☐
Never shared	Yes ☐	No ☐
Shared in last 30 days	Yes ☐	No ☐
Shared in last 12 months but not last 30 days	Yes ☐	No ☐
Shared but not in last 12 months	Yes ☐	No ☐
Shared but time period not known	Yes ☐	No ☐
Client did not wish to answer	Yes ☐	
Not known if client ever shared	Yes ☐	
N/A	Yes ☐	

Age first injected _____

If you inject, what part of the body do you mostly inject into?

(please indicate below)



HARM REDUCTION ADVICE GIVEN

For the National Clinical Guideline on Hepatitis C go to
http://health.gov.ie/national-patient-safety-office/ncec/national-clinical-guidelines/prevention/

If using IV needles how are they obtained? _____

If using IV needles how are they disposed? _____

Needle Exchange time and places:	Yes ☐	No ☐
Drug Use	Yes ☐	No ☐
Drug Interactions	Yes ☐	No ☐
Alcohol Use	Yes ☐	No ☐
Overdose Prevention	Yes ☐	No ☐
Access to Naloxone	Yes ☐	No ☐
Safe Injecting Practice	Yes ☐	No ☐
Sexual Activity	Yes ☐	No ☐

Others give details:

RESOURCE
www.sexualhealthcentre.com

HEALTH

Consider any information below that should be noted on front cover. This section allows you to discuss your health and wellbeing and identify any needs that you may have in these areas

PHYSICAL HEALTH

Have you any concerns about your physical health? Yes ☐ No ☐

Have you any known allergies [medical or any other]: Yes ☐ No ☐

Have you ever had a head injury? Yes ☐ No ☐

When was the last time you had a check-up with your GP:

Describe any relevant medical history:

List currently prescribed medications:

Can you access your medication? Yes ☐ No ☐

Do you adhere to your medication? Yes ☐ No ☐

Have you any history of seizures? Yes ☐ No ☐

If 'Yes' to any of the above please give details :

Viral Screening(s)	**Hepatitis C**	**Hepatitis B**	**HIV**
Never screened	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Screened in last 12 months	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Screened but not in last 12 months	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Client did not wish to answer	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Unknown	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

HSE NATIONAL SCREENING SERVICE

Improving access so that everyone has access to screening regardless of who they are, where they are from, and how they define themselves (HSE)

RESOURCE
www.hse.ie/eng/services/healthcare-in-ireland/english/screening-programmes.html

The National Screening Service is responsible for:

- The National Breast Screening Programme
- The National Cervical Screening Programme
- The National Bowel Screening Programme
- The National Diabetic Retinal Screening Programme

Would you like to access screening to check for changes or early signs of disease? Yes ☐ No ☐

If yes, you can be added to the register for screening and will be contacted in due course.

RESOURCE
www.sexualwellbeing.ie

SEXUAL WELLBEING

Have you any concerns about your sexual health and wellbeing? Yes ☐ No ☐

Do you use condoms or other physical barriers? Yes ☐ No ☐

Do you know where condoms and other physical barriers are freely available via the HSE and partners? Yes ☐ No ☐

Have you ever gone to be screened/tested for a sexually transmitted infection? Yes ☐ No ☐

RESOURCE For information on alcohol and pregnancy go to www.askaboutalcohol.ie

CONSIDER
ASSIST/
STORM

MENTAL HEALTH

Have you and concerns around your mental health? Yes ☐ No ☐

Have you ever seen, or are you currently seeing a mental health professional? Yes ☐ No ☐

Have you a history of psychiatric care? Yes ☐ No ☐

Do you have a history of self-harm and/or suicidal thoughts? Yes ☐ No ☐

How would you rate your mood over the last month? Very low ☐ Low ☐ Reasonable ☐ Good ☐

Describe:

DOMESTIC VIOLENCE/JUSTICE/HEALTH AND SAFETY

It is important for your key worker to know this information so that they can refer you to the most appropriate accommodation/housing/refuge services and addiction treatment and support services. Also, your key worker needs to know this information in order to support you to deal with any blocks to these services.

Domestic Violence

Do you feel safe in your current relationship? Yes ☐ No ☐

Have you ever been physically, mentally or sexually abused by your current partner or someone in your current home? Yes ☐ No ☐

If yes to any of these questions please give details.

Justice

Are you or have you been engaged with probation services? Yes ☐ No ☐

Have you served a custodial sentence in prison or a detention centre? Yes ☐ No ☐

Have you any court cases pending? Yes ☐ No ☐

Have you a solicitor? Yes ☐ No ☐

If yes to any of these questions, please give details.

Health and Safety

Have you a history of any behaviour that may impact on your treatment plan in this or other services? Yes ☐ No ☐

If yes, please give details.

Additional comments

Is there any other information you feel is important to add to this assessment? Yes ☐ No ☐

If 'Yes' to ANY of the above, please give details:

HAPPINESS SCALE

This scale intends to estimate your current happiness with your life in each of the areas listed below. Ask yourself: How happy am I with this area of my life? Circle one of the numbers (1-10) beside each area. Numbers toward the left indicate various degrees of unhappiness, while numbers towards the right reflect various levels of happiness. Remember: Try to exclude all feelings of yesterday and concentrate only on the feelings of today in each of the areas. Also try not to allow one category to influence the results of the other categories.

										
Drug/Alcohol use	1	2	3	4	5	6	7	8	9	10
Job or Education Progress	1	2	3	4	5	6	7	8	9	10
Life Skills	1	2	3	4	5	6	7	8	9	10
Social Life	1	2	3	4	5	6	7	8	9	10
Physical Health	1	2	3	4	5	6	7	8	9	10
Mental Health	1	2	3	4	5	6	7	8	9	10
Relationship	1	2	3	4	5	6	7	8	9	10
Family	1	2	3	4	5	6	7	8	9	10
Legal Issues	1	2	3	4	5	6	7	8	9	10
Emotional Life	1	2	3	4	5	6	7	8	9	10
Communication Skills	1	2	3	4	5	6	7	8	9	10
Housing	1	2	3	4	5	6	7	8	9	10
Spirituality	1	2	3	4	5	6	7	8	9	10
Other (be specific)_____	1	2	3	4	5	6	7	8	9	10

(Meyers & Smith, 2000. Adapted by HSE South Drug and Alcohol Services, 2017)

ASSESSOR'S ACTIONS REQUIRED FOLLOWING INITIAL ASSESSMENT

- ☐ Children First/Child Protection/Social work referral
- ☐ Medical assessment
- ☐ Psychiatric assessment
- ☐ Nursing viral testing or review
- ☐ Progress to opiate substitution protocols
- ☐ Register with National Screening Service
- ☐ Referral to Homeless Action Team
- ☐ Key working toward another service provider _____
- ☐ Other action (e.g. placement on a waiting list)

_____

I am satisfied that this assessment has been completed in full:

Signature: _____

Organisation: _____ Date: _____

Comprehensive assessment needed:	Yes ☐ No ☐
Comprehensive assessment arranged:	Yes ☐ No ☐

COMPREHENSIVE ASSESSMENT AND CARE PLAN

The following section looks at areas of your life where you may be having difficulties.
It is important that these areas are looked at in detail so that together with your case manager, a proper care plan can be put in place.

This comprehensive assessment is appropriate for service users with more complex needs where two or more services are, or will need to be involved. The assessment will identify the services that will be involved in the shared care plan so as to meet those needs. This comprehensive assessment should be part of an ongoing process and review so as to accommodate these needs as they change over the course of the shared care plan (National Drug Rehabilitation Framework 2010)

Please ensure Initial Assessment and Consents are up-to-date before proceeding

Comprehensive Assessment Form completed by: _____

Name of Project: _____

Project Telephone No: _____

Referring Agency: _____

Date of Assessment: _____

If no case manager exists then the service undertaking the comprehensive assessment will take on the role of case manager

Other Organisations/Services involved in care provision

1 Signed: _____ Service: _____

2 Signed: _____ Service: _____

3 Signed: _____ Service: _____

Case Management Needed Yes ☐ No ☐

Case management case conference required Yes ☐ No ☐

Case Manager assigned **[Name]:** _____

Case Managed Case Conference **[Date]:** _____

Case manager contacted Key workers / Key Agencies:

1. ACCOMMODATION

This section allows you to talk about your experience in relation to current and past accommodation and any experience you may have had with homelessness.

It is important for your case manager to know this information so that they can refer you to the most appropriate services.

Have there been any changes to your housing situation since you completed your Initial Assessment?
Yes ☐ No ☐ If so please update the Initial Assessment and describe what changes have occurred?

Describe any needs or concerns you have in relation to current accommodation

Is your current accommodation situation suitable for:

Children Yes ☐ No ☐

Spouse/partner Yes ☐ No ☐

Care plan Yes ☐ No ☐

Have you any history of involvement with any homeless services?

Describe any difficulties you may have had in maintaining housing (this can include any history of eviction)?

Describe any history of sleeping rough:

Have you ever had a local authority tenancy? Yes ☐ No ☐
If Yes, please give details

Do you currently own, or part own, a house or flat? Yes ☐ No ☐

Are you registered (joint or single) for social housing with a local authority? Yes ☐ No ☐
What local Authority?

Are you now or have you been in receipt of HAP/rent supplement in the past? Yes ☐ No ☐
If yes, please give details

Have any referrals been made to any other housing provider on your behalf? Yes ☐ No ☐
If yes, please give details

Please provide details of your previous accommodation:

Address (as much as can be remembered)	**Type**	**Dates** (from – to, or approx.)	**Reason for leaving**
1			
2			
3			
4			
5			

Services currently or most recently involved in accommodation:

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

If you drink or use drugs does it impact on your accommodation situation or vice versa? Yes ☐ No ☐

Details?

2. DRUG & ALCOHOL USE AND OTHER ADDICTIONS SUCH AS GAMBLING

In this section you can discuss your Drug and/or Alcohol use with your case manager and identify what needs you may have in this regard and to ensure that they can refer you to an appropriate service. Please consider how all sections in this assessment are affected by drug and alcohol use so that your care plan can look to address issues that you may have in this regard.

Have there been any changes in your drug or alcohol use since you completed your Initial Assessment?

Yes ☐ No ☐

Please describe what changes have occurred since the Initial Assessment.

What are your needs in relation to your drug or alcohol use?

Have there been any changes to any other addiction (e.g. gambling) since you completed your Initial Assessment? Yes ☐ No ☐

What services are currently or most recently involved in your drug or alcohol (or other addiction) use:

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

3. PHYSICAL HEALTH

This section allows you to discuss your discuss your physical health and sexual wellbeing, and identify any needs that you may have, and help thecase manager refer you to the most appropriate service.

Have there been any changes to your physical health since you completed your Initial Assessment?
Yes ☐ No ☐ If so, please update the Initial Assessment and describe what changes have occurred.

Have you any physical health diagnosis or disability? Please describe:

Would you see a need for making medical appointments?

Have there been any changes to your sexual wellbeing since you completed your Initial Assessment
Yes ☐ No ☐ If so, please update the Initial Assessment and describe what changes have occurred.

What services are currently or most recently involved in your physical health?

Name & Org:_____ Phone/email:_____

Name & Org:_____ Phone/email:_____

Name & Org:_____ Phone/email:_____

If you drink or use drugs does it affect your physical health or vice/versa? Yes ☐ No ☐ Details?	Does your housing situation affect your physical health or vice versa? Yes ☐ No ☐ Details?

4. MENTAL HEALTH

This section allows you to discuss your mental health and identify any needs that you may have, and help the case manager refer you to the most appropriate service.

Have there been any changes to your mental health since you completed your initial assessment?
Yes ☐ No ☐ If so, please update the Initial Assessment and describe what changes have occurred.

Have you any concerns regarding your mental health?

Describe the treatment you are receiving for this diagnosis or condition?

Have you got a mental health diagnosis or condition?

Would you see the need for discussing with your GP about making an appointment with a mental health service?

What services are currently or most recently involved in your mental health?

Name & Org:_____ Phone/email:_____

Name & Org:_____ Phone/email:_____

Name & Org:_____ Phone/email:_____

If you drink or use drugs does it affect your mental health or vice/versa? Yes ☐ No ☐ Details?	Does your housing situation affect your mental health or vice versa? Yes ☐ No ☐ Details?

5. FAMILY AND RELATIONSHIPS

This section allows you to discuss your family and relationships circumstances with your case manager and identify any supports that you need in this area. It also looks at the positive, supportive people in your life.

Have there been any changes to your family/relationships since you completed your Initial Assessment?
Yes ☐ No ☐ If so, please update the Initial Assessment and describe what changes have occurred.

Who did you grow up with in your family?

Currently, who are the supportive people in your life?

Is there a friend or family member you would like to be involved in your care plan?
Details:

Are there any relationships which pose a risk to you or others or your care plan?

Have you any concerns with regards to your significant relationship?
(e.g. domestic violence, substance use, criminal activity etc...)

Would you see a need for attending a support service for your relationships?

What services are currently or most recently involved in family support or your relationships?

Name & Org:_____ Phone/email:_____

Name & Org:_____ Phone/email:_____

Name & Org:_____ Phone/email:_____

If you drink or use drugs does it affect your relationships/friends or family or vice/versa? Yes ☐ No ☐ Details?	Does your housing situation affect your relationships/ friends or family or vice/versa? Yes ☐ No ☐ Details?

6. CHILD WELFAREREMIND OF CONFIDENTIALITY

This section allows you to talk to your case manager about your children and discuss any needs and concerns you have in this regard.

Has there been any significant change in relation to your children since completing the initial assessment?

Yes ☐ No ☐ If so, please update the Initial Assessment and describe what changes have occurred.

Are there any relationships which pose a risk to your children (including barring orders)?

Are there any behaviours which pose a risk to your children?

Would you see the need for availing of family support?

What services are currently or most recently involved with your children?

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

If you drink or use drugs does it affect your children? Yes ☐ No ☐ Details?	Does your housing situation affect your children? Yes ☐ No ☐ Details?

7. LEGAL/OFFENDING BEHAVIOUR ISSUES

This section allows you to discuss any offending behaviour or legal issues, past or present, where you may need support. This information is also important for your case manager to know in case there may be issues accessing services due to legal issues or offending history.

Have there been any changes to your legal/offending behaviour issues since you completed your Initial Assessment?
Yes ☐ No ☐ If so, please update the Initial Assessment and describe what changes have occurred.

Do you have current (or suspected) outstanding charges? Yes ☐ No ☐
Details:

Do you have current (or suspected) arrest warrants? Yes ☐ No ☐
Details:

Do you have upcoming court dates? Yes ☐ No ☐
Details:

What is your most serious charge to date?

Have you spent time in prison? Yes ☐ No ☐
If so, please describe:

Have you any history of sexual assault, arson, firearms or other weapons charges? Yes ☐ No ☐
Details:

What services are currently or most recently involved with your legal issues?

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

If you drink or use drugs does it affect your legal situation/offending behaviour or vice/versa?
Yes ☐ No ☐

Details?

Does your housing situation affect your legal situation/offending behaviour or vice/versa? Yes ☐ No ☐

Details?

8. FINANCIAL ISSUES

This information in this section can identify issues that you may have in relation to managing your finances which your case manager could assist you to address in your care plan.

Do you have any current financial needs, or financial concerns or financial stressors?

Do you have any current debts?

Are you in receipt of social welfare payment?
Please give details

Do you have any problems claiming?

Services currently or most recently involved in financial support?

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

If you drink or use drugs does it affect your financial situation? Yes ☐ No ☐

Details?

Does your housing situation affect your finances?
Yes ☐ No ☐

Details?

9. HOBBIES/INTERESTS/SOCIAL SUPPORTS

This section allows you to discuss interests or social supports that you have in your life, or ones that you would like to pursue. It is important for you to have positive enjoyment in your life. Your case manager may be able to assist you with this in your care plan.

What non-substance using hobbies/interests do you have?

What hobbies/interests did you have in the past?

Would you like to develop a new hobby/interest/social supports?

What non-substance using activities/social supports are there available to you that you know of?

Do you attend any fellowship (AA, NA etc...) or Faith/Church-based support?
Would you like to?

Do you have a sponsor?

Services currently or most recently involved in hobbies or social supports?

Name & Org:_____ Phone/email:_____

Name & Org:_____ Phone/email:_____

Name & Org:_____ Phone/email:_____

If you drink or use drugs does it affect your hobbies/ interests? Yes ☐ No ☐ Details?	Does your housing situation affect your hobbies/ interests? Yes ☐ No ☐ Details?

10. EDUCATION/TRAINING/EMPLOYMENT

In this section you can discuss with your case manager your education, training and employment situation and identify if you have any needs in this area which could form part of your care plan.

Have there been any changes in your training/employment situation since completing the Initial Assessment?
Yes ☐ No ☐ If so please update and describe what changes have occurred.

Have you completed any educational/training courses? Yes ☐ No ☐
Details:

Have you any learning difficulties including reading and writing? Yes ☐ No ☐
Details:

Would you like to do more education or training? Yes ☐ No ☐
Details:

If you are unemployed presently, have you ever been in paid employment?
Details:

Are you interested in getting a job? Yes ☐ No ☐
If so, what kind of job?

What services are currently or most recently involved in your education or training?

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

Name & Org: _____ Phone/email: _____

If you drink or use drugs does it affect your education, training or employment? Yes ☐ No ☐ Details?	Does your housing situation affect your education, training or employment? Yes ☐ No ☐ Details?

OTHER RESIDENTIAL HISTORY

If you have lived in any of the list below, you can discuss this with your case manager to help inform your care plan and possibly explore other sources of funding for treatment

Have you ever been in any of the following for any period of time?

☐ Residential Care ☐ Foster Care ☐ Special Needs School ☐ Residential Secure Unit ☐ Armed Forces

If yes, or you have been in any of these outside Ireland, please give details.

INDEPENDENT LIVING SKILLS ASSESSMENT

Do you feel you need support in any of the following areas – Please tick the appropriate box.

Shopping	Yes ☐	No ☐
Attending a course or job 9-5, Monday to Friday	Yes ☐	No ☐
Making and remembering appointments	Yes ☐	No ☐
Finding out about and using local services	Yes ☐	No ☐
Understanding tenants' rights and obligations	Yes ☐	No ☐
Caring for your health	Yes ☐	No ☐
Living within a budget	Yes ☐	No ☐
Paying rent and bills	Yes ☐	No ☐
Caring for your personal hygiene	Yes ☐	No ☐
Laundry	Yes ☐	No ☐
Cooking/nutrition	Yes ☐	No ☐
Keeping accommodation clean	Yes ☐	No ☐
Dealing with landlord or housing authorities	Yes ☐	No ☐
Dealing with basic maintenance e.g. changing light bulbs, fuses etc.	Yes ☐	No ☐
Commitments i.e. seeing things through to the end	Yes ☐	No ☐
Dealing with loneliness/isolation	Yes ☐	No ☐
Dealing with difficult/stressful situations	Yes ☐	No ☐
Filling your day	Yes ☐	No ☐
Managing your medication	Yes ☐	No ☐

ASSESSMENT OF PRIORITIES

What are your care plan priorities over the next three months?

Have you any other relevant information that you would like to add?

Assessor's comments:

CARE PLAN – REVIEW SHEET

Client Name	DOB	AGE	File No

Present

1: _____ 5: _____

2: _____ 6: _____

3: _____ 7: _____

4: _____ 8: _____

Location

Item	Outcome
1	
2	
3	
4	
5	
6	

ASSESSOR'S ACTIONS REQUIRED FOLLOWING COMPREHENSIVE ASSESSMENT

- ☐ Children First/Child Protection/Social work referral
- ☐ Medical assessment
- ☐ Psychiatric assessment
- ☐ Nursing viral testing or review
- ☐ Progress to opiate substitution protocols
- ☐ Referral to Homeless Action Team
- ☐ Key working toward another service provider
- ☐ Other action (e.g. As above)
- ☐ other

Signed (Service user):	Date:

Signed (Case Manager):	Date:

COMPREHENSIVE CARE PLAN

» Please be SMART (Specific, Measurable, Achievable, Realistic, Time lined) «

State actions to be undertaken	By whom?	When?
Drug and Alcohol Use: 1 2 3 4		
Physical and Mental Health: 1 2 3 4		
Relationships, Children and Social Supports : 1 2 3 4		
Education & Accommodation: 1 2 3 4		
Financial & Legal: 1 2 3 4		

Signature of service user: _____ Date: _____

Signature of Staff: _____ Date: _____

Outcome to Date

INITIAL CARE PLAN

» Please be SMART (Specific, Measurable, Achievable, Realistic, Time lined) «

	In the area of	I aim to	Time scale	Actions needed	Other services required	How will I measure my progress	Outcome	What went well/ Not well
Objective 1								
Objective 2								
Objective 3								