Soilse Application / Initial Assessment Form

Please read this form carefully, answer all questions as best you can, sign the completed form and return it to Soilse. Our address is at the bottom of the form.

Are you applying for: Henrietta Place _____ (pre-treatment programme)
Green Street _____ (post-treatment programme - drug-free)

Your name: _____ **Your date of birth:** _____

Your age: _____ **Your gender:** male ____ female: _____

Your home address: (not treatment address)

_____

Your phone number: _____ **Your mobile number:** _____

Who referred you to Soilse?

Name: _____

Address: _____

Phone number: _____ Mobile number: _____

What is your relationship with him or her? _____

When were you referred to Soilse? _____

Are you drug-free? Yes: _____ No: _____

If yes, how long have you been drug-free? _____

Have you completed a residential detox programme? Yes: ___ No: ___

If yes, where? _____ When? _____

_____

If you are still in residential detox, what is your end date? _____

Have you completed a residential treatment programme? Yes: _____ No: _____

If yes, where? _____ When? _____

_____

Are you attending?

Aftercare: Yes: ___ No: ___ **12-Step Fellowships:** Yes: ___ No: ___

Are you attending a day programme? Yes: ___ No: ___ Name: _____

Do you have a sponsor? Yes: _____ No: _____

If you are still in residential treatment, what is your end date? _____

Are you attending a psychiatrist? Yes: _____ No: _____

Name of psychiatrist: _____

Address of psychiatrist: _____

Phone number of psychiatrist: _____

Are you on medication prescribed by a psychiatrist? Yes: ___ No: ___

Are you on medication prescribed by a GP (family doctor)? Yes: ____ No: ____

Please describe and give amount (dosage) of any medication prescribed for you

Medication	**What dose do you take?**	**How often do you take this?**
Methadone		
Valium		
Sleeping tablets		
Anti-depressants		
Anti-psychotics		
Other (give name)		

Why was this medication prescribed? _____

Where do you get your medication?

Name of doctor or clinic: _____

Address of doctor or clinic: _____

Phone number of doctor or clinic: _____

Who is your family doctor (GP)? (if different from above)

Name of family doctor: _____

Address of family doctor: _____

Phone number of family doctor: _____

If you are applying for our Henrietta Place programme, does your doctor support you coming on a detox preparation programme? Yes: _____ No: _____

Do you have a counsellor? Yes: _____ No: _____

Name of counsellor: _____

Address of counsellor: _____

Phone number of counsellor: _____

Are you taking any medication that is *not* prescribed by a doctor? If yes, please give the amount and how often you take it.

_____

_____

_____

Have you used any of the following drugs in the past two weeks?

Drug	How much do you take?	How often?
Zimmovane (zimmo's)		
Heroin		
Cocaine		
Cannabis		
Alcohol		
Ecstasy		
Benzodiazepines (benzo's)		
Codeine		
Methadone		
Tobacco		
Other (please describe)		

Do you gamble? Yes: _____ No: _____

Are you willing to stop using drugs before you start in Soilse? Yes: __ No: ___

Please sign and date this form.

_____ _____

Your signature **Today's date**

Please return this form to:

Soilse, Basement Offices, 16-22 Green Street, Dublin 1
Ph: (01) 872 4535 Fax: (01) 894 3396
Email: soilse@hse.ie Web: www.soilse.ie

For official use

Actions (for example, phone calls to service user, referrer or psychiatrist)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Decisions

Client for comprehensive assessment: Yes: _____ No: _____

If no, why not? _____

Client referred elsewhere: Yes: ____ No: ____

If yes, where? _____