

**Alcohol & Other Drugs COMPREHENSIVE Assessment Section 1B**




Name \_\_\_\_\_

What drug/ drugs are you using?

\_\_\_\_\_

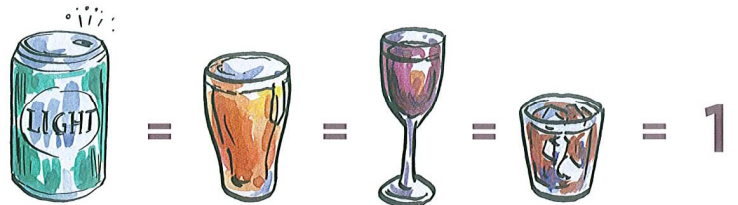
What drug/ drugs are you worried about?

\_\_\_\_\_

	Alcohol	Cannabis	Tobacco	Other
Days in last 14	▽▽▽▽▽▽▽ ▽▽▽▽▽▽▽	▽▽▽▽▽▽▽ ▽▽▽▽▽▽▽	▽▽▽▽▽▽▽ ▽▽▽▽▽▽▽	▽▽▽▽▽▽▽ ▽▽▽▽▽▽▽
Amount used/day e.g. 1 slab/carton			 30mg	
Money spent \$/week				
How long after waking first use				
How long like this e.g. months/years				

**What is a 'standard drink'?**

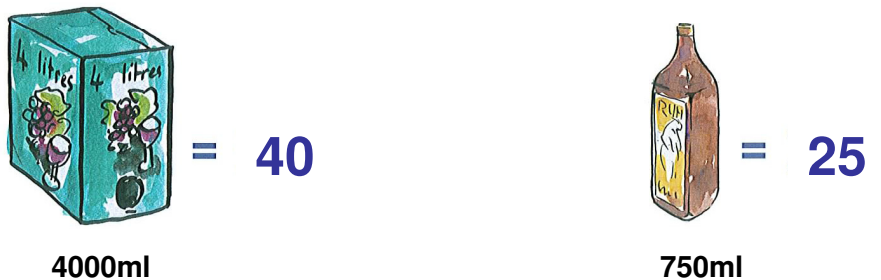
- ☞ a light beer
- ☞ a small glass of full strength beer
- ☞ a small glass of wine
- ☞ a single measure of spirits



- ☞ a can of full strength beer
- ☞ a slab of full strength beer



- ☞ a 4-litre cask of wine
- ☞ a bottle of rum



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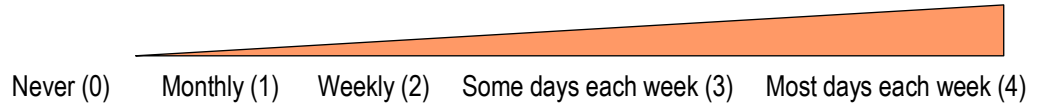
**AUDIT-C**

*Please circle the answer that is correct for you.*

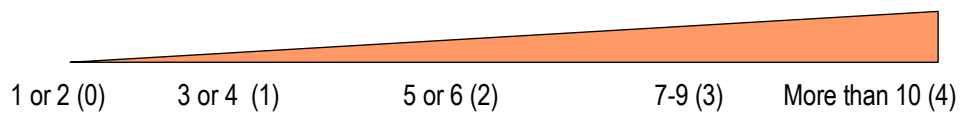
**Thinking about drinking alcohol**

**How often do you have a drink containing alcohol?**

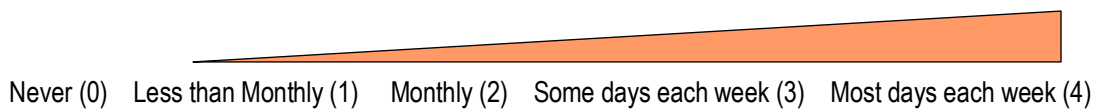
**Score**




**How many drinks containing alcohol do you have on a typical day when you are drinking?**




**How often do you have six (6) or more drinks on one occasion?**

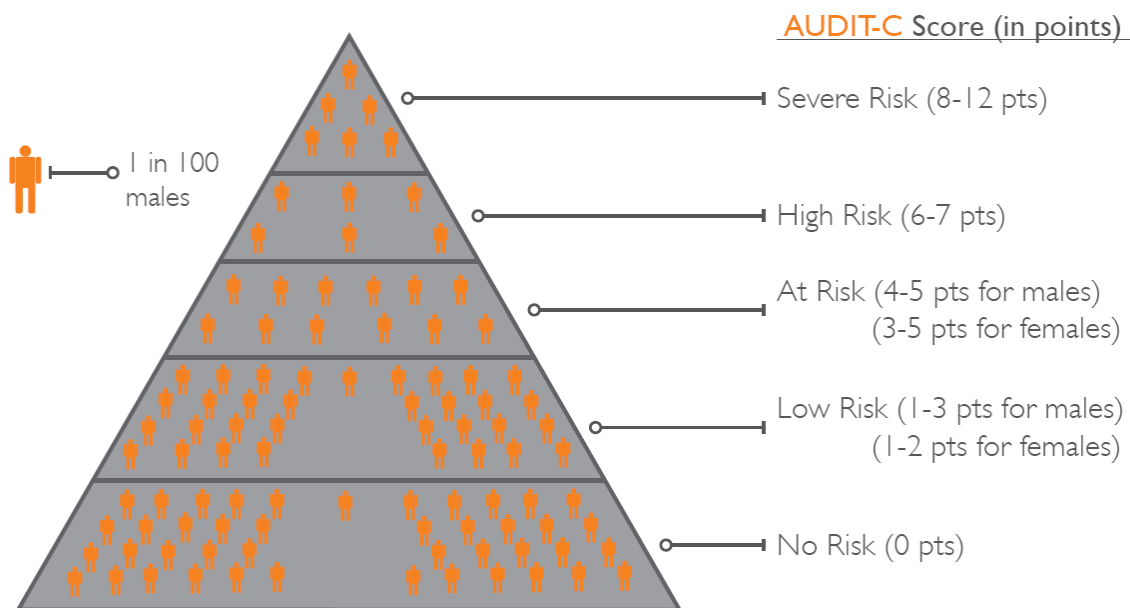



**TOTAL SCORE:**  
Add the number for each question to get your total score

/ 12

**High risk = score more than 6 in total: Scoring 0 to 4 across each scale as above**

Audit - C A maximum score is 12



## Alcohol & Other Drugs COMPREHENSIVE Assessment Section 1B

Family e.g. parents, children, names and ages

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Family History e.g. do any other members of your family use?

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Are you worried about what is happening when you use this drug?

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### What's the worry...

tick what drug is associated with the worry

WORRY	Alcohol	Cannabis	Tobacco	Other
Driving				
Hurt yourself				
Hurt others				
Not looking after children				
Argue with family				
Violence/fights				
Police trouble				
Humbug people				
No money left for food				
No work				

Any other worries?

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What would you like to do about this problem now? e.g. see Doctor, Counselling, Detox, Rehabilitation

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Have you stopped using this drug before?

Yes       No       N/A

How long ago? (e.g. days, months, years) \_\_\_\_\_

If yes, why did you stop?

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What happened when you stopped using? e.g. get angry, sad, felt better

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## Alcohol & Other Drugs COMPREHENSIVE Assessment Section 1B

Have you become unwell when you stopped using?

	Alcohol	Cannabis	Tobacco	Other
Body pain – where?				
See things/hear things				
Depressed				
Fits				
Get lazy				
Scared				
Paranoid (think other people are looking or talking about you)				
Lose temper				

Have you ever fited when you stopped using it? (if yes refer to Health Centre)

Have you ever seen a Doctor/Nurse or anybody else about this problem?

Yes       No       N/A

Who did you see?

How long ago was that?

Did that help you?       Yes       No       A little bit

Have you got a medical problem?       Yes       No       N/A

Describe

Have you got any legal issues at present?       Yes       No       N/A  
If yes what are they?

Have you got a mental health problem?       Yes       No       N/A

Describe

### Any Medications?

Name	How much?	How long?	Why?

**Alcohol & Other Drugs COMPREHENSIVE Assessment Section 1B**

**Risk Assessment**

- Have you thought about hurting other people?    Yes                    No                    Undetermined
- Have you hurt anybody?                            Yes                    No                    Undetermined
- Have you thought about hurting yourself?       Yes                    No                    Undetermined
- Do you hurt yourself?                              Yes                    No                    Undetermined
- Accommodation Problems                        Yes                    No                    Undetermined
- Are you frightened of somebody?              Yes                    No                    Undetermined
- Has someone hurt you?                          Yes                    No                    Undetermined

If yes to any of these above, please provide details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you safe to go home tonight?                Yes                    No

If no, what needs to be put in place? *i.e. safe house*

\_\_\_\_\_

**Outcome:**

Does the client need a referral to the clinic or another agency?

\_\_\_\_\_

Are you worried about this client?

\_\_\_\_\_  
\_\_\_\_\_

Do you think they need a referral to:

- 1.) Doctor
- 2.) Mental Health
- 3.) Hospital

\_\_\_\_\_

Why do you think they need to see this person? e.g. sad, talking about harming themselves or somebody else

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Case Management Plan**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Alcohol & Other Drugs COMPREHENSIVE Assessment Section 1B

(this page can be photocopied and given to the client for their own reference)

### Client Goal/s:

Goals for today	How will you do that?	Who can help you?
1)	STEP 1  STEP 2  STEP 3	1)  2)  3)
2)	STEP 1  STEP 2  STEP 3	1)  2)  3)
3)	STEP 1  STEP 2  STEP 3	1)  2)  3)
4)	STEP 1  STEP 2  STEP 3	1)  2)  3)

**Alcohol & Other Drugs COMPREHENSIVE Assessment Section 1B**

Do you want to come back to see me?

Yes      No      N/A

When? \_\_\_\_\_

Appointment time: \_\_\_\_\_

Is there anything else I can do for you today?

\_\_\_\_\_

\_\_\_\_\_

Any further information that you need to document?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name

Position

Date devised	December 2008	Doc 001
Date revised	August 2010	Doc 006

Date:

Signature: