Hull City Council

Humber NHS Foundation Trust

ASSESSMENT SUMMARY

Name of Patient:-

Assessment Date& Time:

Address:

Venue:

Tel no:

DOB:

NHS Number:

Assessed by:

GP:

Address:

Signature:

Tel no: **Fax no:**

Designation:

Reason for referral:- (Include areas of risk and physical condition)

Summary and outcome of assessment:
(Short-term crisis management plan) Actions to be taken and by whom. Does the service user have a current Advanced Directive?

Psychosocial Assessment

Family History (Parents, siblings, single, in relationship, separated, widowed, children)

Social Circumstances (Housing/employment/education/support networks)

Medical History (including current medication and allergies, physical health problems, smoker, hospital admissions or any long term conditions)

Past/Current Psychiatric Involvement (self or family) *please complete contacts list at the back of the assessment*

History of Presenting Complaint

Forensic History

Patient Name……………………… ……………………… DOB……………………………. NHS Number ……………………………………..

Assessor's Signature…………………………………………………………… Date …………………………….

Current Mental State

Tick all that apply/give details where appropriate

Thought content Including delusions, over-valued beliefs
Hallucinations (Type, pseudo hallucinations)
Orientation (time, place & person)
Concentration/memory problems (reported or observed)
Insight into problems and need for treatment
Any evidence of impaired/lack of capacity
Any other

Patient Name……………………… ……………………… .DOB……………………………. NHS Number ……………………………………..

Assessor'sSignature…………………………………………………………… Date …………………………….

Current Mental State

Appearance and behaviour			
Speech			
Subjective mood			
Objective mood			
Energy	**No Change** ☐	**Decreased** ☐	**Increased** ☐
Sleep	**No Change** ☐	**Decreased** ☐	**Increased** ☐
Appetite	**No change** ☐	**Decreased** ☐	**Increased** ☐
Hopelessness	**Yes** ☐	**No** ☐	
Enjoyment			
Anxiety			
Self Care/Daily Living			
Dietary needs, i.e. special diets, dietary preferences			

Precipitants of Crisis

Relationship problem - partner		Legal problems	
Relationship problem – parents / siblings		Victim of crime	
Relationship problems with others		Physical health problems	
Bullying / intimidation		Miscarriage, stillbirth	
Bereavement		Financial problem	
Housing problem		Direct response to mental symptoms	
Employment or study problems		Abuse (physical / mental / sexual)	
Substance misuse		Not known	
Other precipitants (please specify)			

Outcome

Referral on to (Tick all that apply)

Admission	**Formal**		**Informal**	**Unit (specify**	
Home Treatment			**Consultant**		
Out of Hours Support			**CRHT to reassess**		
New referral to CMHT			**Other organisation**		
GP			**Social Services**		
No Referral on			**Key worker**		
Other (specify)					

Other Professionals Involved

	Name	**Contact Number**
Psychiatrist		
GP		
Community Nurse		
Social Worker		
Other (specify designation)		
Other		
Other		
Other		

Consent

Verbal Consent given for information to be shared with the following – (please tick)

GP ☐
Workers ☐
Family ☐
Other (specify) ☐

If information is to be shared without consent, please state rationale below

Patient Name……………………… ……………………… DOB……………………………. NHS Number ……………………………………..

Assistant's Signature…………………………………………………………… Date …………………………….

Further Assessment Tool

Assessments	Needed Y/N	Date completed		Date Completed	Other	Date Completed
Joint service single assessment (informs CCA)						
Carers Family Reception meeting	Genogram Time line		**K**nowledge **A**bout **S**chizophrenia **I**nterview			
Assessment signs and symptoms	**KGV** Symptom Scale		**B**rief **P**sychiatric **R**ating **S**cale			
Assessment of anxiety and depression	**H**amilton Depression Scale		BDI Scale			
Assessment of psychosis	**PSYRATS**					
Medication management	**HOGAN**		**LUNSERS**			
Assessment of Substance Use	Assessment Form Alcoholmeter/Drug Swab. Diagnostic Tools.					
Relapse Prevention			Back in the saddle or similar			

	YES	**NO**
Grist completed	☐	☐
Audit completed	☐	☐
DAST completed	☐	☐
SAHN 17 completed	☐	☐
If not completed, please give rationale as to why		

Patient Name………………………. ……………………… DOB……………………………. NHS Number ……………………………………..

Assessor's Signature…………………………………………………………. Date …………………………….

Admission/Home Treatment

Client perceptions of treatment planned (Advance Directive considered, used, etc)

Family/Carer perception of treatment planned.
Any issues arising form admission/home treatment (e.g. home security, child care, pet care)

Other needs (physical/ disability/ cultural/ religious)

Patient Name……………………… ……………………… DOB……………………………. NHS Number ……………………………………..

Assessor's Signature…………………………………………………………… Date …………………………….

AUDIT

1. How often do you have a drink containing alcohol?
(0) Never (1) Monthly (2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week

2. How many units of alcohol do you have on a typical day when you are drinking?
(0) 1-2 (1) 3 or 4 (2) 5 or 6 (3) 7-9 (4) 10 or more

3. How often do you have six or more units of alcohol on one occasion?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

7. How often during the last year have you felt guilt or remorse after drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

9. Have you or someone else been injured as the result of your drinking?
(0) no (2) yes, but not in the last year (4) yes, during the last year

10. Has a friend, relative, doctor or other health worker been concerned about your drinking or suggested you cut down?
(0) no (2) yes, but not in the last year (4) yes, during the last year

Total Score_________

DAST

These questions refer to the past 12 months.

	Circle Your Response	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you abuse more than one drug at a time?	Yes	No
3. Are you always able to stop using drugs when you want to?	Yes	No
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
5. Do you ever feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

Patient Name……………………… …………………….. DOB…………………………… NHS Number ……………………………………..

Assessor's Signature…………………………………………………………… Date ……………………………

AUDIT

The 10-item questionnaire takes about 2 minutes to complete and covers alcohol consumption, drinking behaviour and alcohol-related problems.

A score of 8 or more in men and 7 or more in women indicates a strong likelihood of hazardous or harmful alcohol consumption. A score of 13 or more is indicative of significant alcohol-related harm/dependence and further assessment is advisable.

SCORING THE AUDIT

Scores for each question range from 0 to 4, with the first response for each question (e.g. never) scoring 0, the second (e.g. less than monthly) scoring 1, the third (e.g. monthly) scoring 2, the fourth (e.g. weekly) scoring 3, and the last response (e.g. daily or almost daily) scoring 4. For questions 9 and 10, which only have 3 responses, the scoring is 0, 2, and 4 (from left to right).

AUDIT INTERPRETATION

AUDIT Score	**Suggested** Action
0-7	Alcohol education
8-15	Simple advice
16-19	Simple advice plus brief counseling and continued monitoring
20-40	Specialist referral and assessment

DAST-10

The questions included in the DAST-10 concern information about possible involvement with drugs not including alcoholic beverages during the past 12 months.

In the statements, "drug abuse." refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (marijuana, hashish), solvents, tranquillisers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or opiates (e.g. heroin). Remember that the questions do not include alcoholic beverages.

SCORING THE DAST-10

For the DAST-10, score I point for each question answered "yes," except for question 3 for which a "no" scores 1 point

DAST-10 INTERPRETATION

DAST- 10 Score	Degree of Problems Related to Drug Abuse	**Suggested** Action
0	No problems reported	none at this time
1-2	Low level	monitor, re-assess at a later date
3-5	Moderate level	further investigation
6-8	Substantial level	intensive assessment
9-10	Severe level	intensive assessment