THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM	**Client Name:** **Client Address:** **Client Date of Birth:**
Referred by	
GP	Phone
Other Agencies involved	Contact person
Presenting Issues	
Reasons for seeking Treatment	
Treatment Goals	
AOD Treatment History	
Drugs used today	
Drugs used yesterday	
Drugs used last week	
Current prescribed medication	
Complete where appropriate:	Pregnancy test
breathalyser	Urine test
Current status: Hep A	Hep B Hep C
Oractising safe sex	Last STI Check (if appropriate) HIV
Other tests	Last blood tests date
Recommendations	
Clinician Signature	Designation Date

THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM

Client Name:

Client Address:

Client Date of Birth:

AOD ASSESSMENT

Key: **U Age First Used**
P Age First Problematic
C Current Use Y /N

Drug Types		**History of Use**
ALCOHOL		
U		
P		
C		
BENZODIAZEPINES		
U		
P		
C		
OPIOIDS		
U		
P		
C		
AMPHETAMINES		**(base, powder, ice)**
U		
P		
C		
CANNABIS		
U		
P		
C		
NICOTINE		
U		
P		
C		
OTHER		
☐	HALLUCINOGENS	
☐	MDMA – Ecstasy	
☐	SOLVENTS	
☐	SYNTHETICS	
☐	EMERGING	

Associated risk behaviours and/or concerns

Exposure to injecting

Age first injected

Clinician	Signature	Designation	Date
Doctor	Signature	Designation	Date

THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM	**Client Name:** **Client Address:** **Client Date of Birth:**

MENTAL HEALTH ASSESSMENT

Past Mental Health Issues

Current Mental Health Issues

Past or current self-harm

Triggers

Past or current suicide attempts

Triggers

Past or current mental health treatment

Always consider undertaking and documenting a suicide risk assessment (SRA) in the following circumstances:

- Client reports current or recent suicidal thoughts
- Client has attempted suicide in the last year
- Client has a significant history of suicidal or self-harming behaviour
- Client has significant mental health problems
- Client has recently been discharged from an inpatient psychiatric facility
- Client has experienced a recent significant stressor which may increase risk (e.g. prison release and experiencing a difficult transition, significant loss, rejection, failure etc.)

Suicide Risk Assessment Completed? ☐ Yes ☐ No

MENTAL STATE ASSESSMENT

Appearance

Behaviour

Mood and affect

Speech

Language (form of thought)

Thought content

Perception

Cognition

Insight and judgment

Clinician	Signature	Designation	Date

THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM	**Client Name:** **Client Address:** **Client Date of Birth:**
PSYCHOSOCIAL ASSESSMENT	
Current accommodation (duration, stability)	
Employment/Education/Training	
Legal Issues	
Interests and hobbies	
Current relationship/s	
Children (ages)	
Social and developmental history	
Cultural identity	
Current supports	
Important people	
Supports during treatment	
Clinician Signature Designation Date	

THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM

Client Name:

Client Address:

Client Date of Birth:

Genogram

○ **Female**	† **Indicates Death**	**Connection - Married**	**Indicates Separation (add year if known)**	Indicates those enclosed live together
□ **Male**	△ **Unknown Sex**	**Connection De-facto**	**Indicates Divorce (add year if known)**	

Current general health

Medical surgical history

Allergies

Withdrawal history (including seizures etc.)

Baseline observations:

BP:	**Pulse:**	**Resps:**	**Temp:**
Clinician	Signature	Designation	Date

THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM	**Client Name:** **Client Address:** **Client Date of Birth:**
MEDICAL ASSESSMENT **Presenting issues**	
Treatment requested	
Substance use history	
Drugs used last week	
Features of physical dependence	
Past substance use treatment	
Past mental health history	
Medical/surgical history	
Current status: **Hep A** **Hep B** **Hep C**	
STI **HIV**	
Date last blood tests	
Current prescribed medication	
Allergies	
Family history of illness	
Current general health	
Current mental health	
Doctor Signature Date	

THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM	**Client Name:** **Client Address:** **Client Date of Birth:**
MEDICAL:ASSESSMENT **MENTAL STATE ASSESSMENT**	
Appearance	
Behaviour	
Mood and affect	
Speech	
Language (form of thought)	
Perception	
Cognition	
Insight and judgement	
Suicide Risk Assessment Required **Yes** **No**	
Physical appearance	
Stigmata/injection sites	
Signs of intoxication or withdrawal	
P **BP** **Ht** **Wt**	
Cardiovascular	**Gastrointestinal**
Respiratory	**Neurological**
Other findings	
Doctor Signature Date	

THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM	**Client Name:** **Client Address:** **Client Date of Birth:**
MEDICAL SUMMARY	
Drug and alcohol diagnosis	
Mental health diagnosis	
Physical health diagnosis	
Planned medical treatment/investigations	
IDENTIFIED RISKS	
Self-harm Suicide Drug overdose Parenting concerns STI/BBV Harm from other **Aggression/violence Allergies: Other:**	
Suicide Risk Assessment Completed? ☐ **Yes** ☐ **No**	
CASE SUMMARY/ FORMULATION	
CASE MANAGEMENT/ TREATMENT PLAN	
Plan for involvement of significant other	
Referral to	
Clinician Signature Designation Date	
Doctor Signature Date	