FormPack

(NZTA)

Please fill in all sections and bring completed form

with you on the day of your assessment

Name:________________________________Telephone Number__________

Address____

Date of Birth__________________Age________Date:____________________

Consent to Assessment

Please read and sign.

I hereby give consent to provide information for a drug and alcohol assessment.

Recommendations will be made regarding my substance use according to information given.

All information and documents in any form remain the property of Taking Shop Limited and will be treated as medical in confidence.

I confirm that I understand the nature and likely effects of the proposed assessment.

Signed ____

Date____________

Consent to Obtain Information

Name:_________________________________

Address____

Date of Birth___________________Age________Date:____________________

Consent to Contact for Information

Please read and sign.

I hereby give consent for the assessor to obtain information in support of my assessment form the following people or organisations who can verify my information: (for example your partner, GP, Psychiatrist, counsellor, employer, relative, hospital information etc):

Medical Records, Mental Health Services, Dunedin Public Hospital, Dunedin. ☑
Medical Records, Mental Health Services, Southland Hospital, Kew Road, Invercargill. ☑

Others:

Name ________________ Contact Details __________________ Relationship ___________

Name ________________ Contact Details __________________ Relationship ___________

Name ________________ Contact Details __________________ Relationship ___________

Name ________________ Contact Details __________________ Relationship ___________

Name ________________ Contact Details __________________ Relationship ___________

Name ________________ Contact Details __________________ Relationship ___________

Signed ____

Date_____________

TALKING SHOP LIMITED
COURT APPOINTED ASSESSORS
Shane Pleasance | Managing Director | *MBA, R/N (Psych), PGCertHlthSc*
Telephone: 027 5899921 | PO Box 561, Invercargill, 9879 | web: www.talkingshop.co.nz | email: shane@talkingshop.co.nz

Disclosure of Information

Name:___________________________________Date of Birth______________

Address___________________________________Date:___________________

I, the abovementioned, understand the explanation of Rule 11 of the Health Information Privacy Code (1994) as outlined herein, and consent to the giving of information to the following people/entities only:

1. **The** Medical Review Advisor in the Medical section of the Transport Registry Centre, Land Transport New Zealand

Signed ____

Health Information Privacy Code

The Health Information Privacy Code is available from The Privacy Commissioner, PO Box 466 Auckland, and http://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/Health-Information-Privacy-Code-1994-including-Amendment.pdf

Rule 11

Limits on Disclosure of Health Information

(1) A health agency that holds health information must not disclose the information unless the agency believes, on reasonable grounds:

(a) that the disclosure is to:

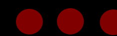
(i) the individual concerned; or

(ii) the individual’s representative where the individual is dead or is unable to exercise his or her rights under these rules;

(b) that the disclosure is authorised by:

(i) the individual concerned; or

(ii) the individual’s representative where the individual is dead or is unable to give his or her authority under this rule



The Alcohol Use Disorders Identification Test - AUDIT

Please **circle** the number that applies to you – This is your info **over the last 12 months**

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

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   - (0) 1 or 2
   - (1) 3 or 4
   - (2) 5 or 6
   - (3) 7, 8 or 9
   - (4) 10 or more

3. How often do you have six or more drinks 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 from 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 had a feeling of 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 a result of your drinking?
   - (0) No
   - (2) Yes, but not in the last year
   - (5) Yes, during the last year

10. Has a relative or friend or a doctor or another 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

Name____**Date**________________________

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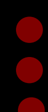

DAST (Drug Abuse Screening Test)

(Only complete if you take drugs)

Name:____

Date:____

Please circle the right answer Yes No

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 because of your use of drugs? Yes No
6. Does your spouse or a parent 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)?
    Yes No

Score (Office use only)_____________________________

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READINESS TO CHANGE QUESTIONNAIRE

Please tick the boxes

Name_______________________________________ Date_____________

	Question	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1	My drinking is ok as it is					
2	I am trying to drink less than I used to					
3	I enjoy my drinking, but sometimes I drink too much					
4	I should cut down on my drinking					
5	It is a waste of time thinking about my drinking					
6	I have recently changed my drinking habits					
7	Anyone can talk about wanting to do something about drinking. I am actually doing something about it					
8	I am at the stage where I should think about drinking less alcohol					
9	My drinking is a problem					
10	It's alright for me to keep drinking as I do now					
11	I am actually changing my drinking habits right now					
12	My life would be the same, even if I drank less					

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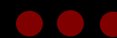

Leeds Dependence Questionnaire

The Leeds Dependence Questionnaire (LDQ) helps people to assess their level of dependence on alcohol or other drugs and can be used in addition to the AUDIT. It is a screening test (ie, a guide) only.

Please think about your drinking (drug use) **during the last month** when answering. Circle the answers that are most appropriate to you.

	Never	Sometimes	Often	Nearly always
1. Do you find yourself thinking about when you will next be able to have another drink (drug)?	0	1	2	3
2. Is drinking (drug use) more important to you than anything else you might do during the day?	0	1	2	3
3. Do you feel your need for drink (the drug) is too strong to control?	0	1	2	3
4. Do you plan your days around getting alcohol (the drug) and drinking (using the drug)?	0	1	2	3
5. Do you drink (use the drug) in a particular way in order to increase the effect it gives you?	0	1	2	3
6. Do you drink (use the drug) morning, afternoon and evening?	0	1	2	3
7. Do you feel you have to carry on drinking (drug use) once you have started?	0	1	2	3
8. Is getting the effect you want more important than the particular drink (drug) you use?	0	1	2	3
9. Do you want to drink (use the drug) more when the effect starts to wear off?	0	1	2	3
10. Do you find it difficult to cope with life without alcohol (drugs)?	0	1	2	3

To find out your score, simply add up the numbers from each of your answers.

Interpretation		**Total LDQ score**
0	No dependence	
1–10	Low to moderate dependence	
11–20	Moderate to high dependence	
21–30	High dependence	

This score is to be used as a guide to your level of dependence over the last month or so. It does not indicate whether your consumption is at risky levels or the extent of other alcohol or drug use related problems.

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Please list your **convictions** from the oldest to the most recent (not these current convictions), and please state whether alcohol or drugs were involved, for example drunk when committed.

Date	Conviction	Punishment	Substance affected?

Please list current or past medications, dosage, when you take them and how long you have taken them

Date started & stopped	**Medication name**	**Dose**	**When do you take them?**

Please list any medical conditions or treatments that you have had or received

Date	**Condition**	**Treatment**

Who is your GP and when did you last see them?____
Which practice?:____

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Please indicate any previous **drug or alcohol** treatment or assessments you have received.
Please indicate how long you attended, whether you completed and whether you found it useful.

Date	**Which service** / Where?	**Treatment received, and was it successful ?**

What are your thoughts about receiving drug and alcohol treatment now?________________________
____
____

Anything else you think would be useful for us to know?

____

____

____

____

Thank you.

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