Talking Shop *Expert A&D Assessments*

Form Pack

Please fill in all sections as much as possible and return -

we will go through this together when we meet for an hour or so, next.

Email to Shane@talkingshop.co.nz or post to The Court Assessor, Talking Shop, PO Box 561, Invercargill, 9840

Name:_____

Mobile Number_____ Landline_____

Address_____

Date of Birth _____Age _____Date:_____

Email Address _____

Court Date _____

Consent to Assessment

Please read and sign.

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

Recommendations may 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. No treatment is provided.

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

Signed _____

Date_____

TALKING SHOP LIMITED
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

Consent to Obtain Information

Name:_____

Address_____

Date of Birth_____Age_____Date:_____

Consent to Contact for Information

Please read and sign.

WHO CAN I CONTACT TO VERIFY YOUR INFORMATION?

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, parent, GP, Psychiatrist, counsellor, employer, relative, friend etc:

Medical Records, Mental Health Services, Te Whatu Ora/Health New Zealand. ☑

Others:

Name _____ Contact _____ Relationship _____

Name _____ Contact _____ Relationship _____

Name _____ Contact _____ Relationship _____

Name _____ Contact _____ Relationship _____

Name _____ Contact _____ Relationship _____

Name _____ Contact _____ Relationship _____

Signed _____

Date_____

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 Presiding Judge @ (Please Circle):**

Dunedin | Queenstown | Invercargill | Oamaru | Timaru | Alexandra | Gore | Ashburton Court

2. **Community Probation Department._____ (Please name P.O.)**
3. **My Legal Representative (Lawyer)._____ (Please name lawyer)**
4. **The nominated treatment centre (as applicable). _____**

Signed _____

Health Information Privacy Code

The Health Information Privacy Code is available from The Privacy Commissioner, PO Box 466 Auckland, and https://www.privacy.org.nz/privacy-act-2020/codes-of-practice/hipc2020/

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

Your Assessment may be recorded, and that recording is subject to the same privacy conditions.

The Alcohol Use Disorders Identification Test - AUDIT

Please **circle** the number that applies to you – **This is your info over the last 12 months (prior to offending/jail, if appropriate)**

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**_____

DAST (Drug Abuse Screening Test)

(Only complete if you take non-prescribed drugs other than alcohol – **over the 12 months before** offending/prison as appropriate)

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 when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use?*	Yes	No

(*e.g., memory loss, oral issues, hepatitis)?

URINE DRUG SCREEN

You may be asked to provide a urine sample for intoxicant analysis.
If you did provide a urine drug sample, what would we find?

_____

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					

CONVICTIONS:

Please list your charges/convictions from the current to the oldest, and please state whether alcohol or drugs were involved, for example drunk when committed.

Date	Charge/Conviction	Punishment	Substance affected/intoxicated?

What are your sentencing recommendations/ expectations this time?:_____

MEDICATIONS: Please list current or past medications, dosage, when you take them, how long you have taken them and whether you were taking at the time of offence/s

Date started & stopped	Medication name	Dose	When do you take them/taking at offence?

MEDICAL CONDITIONS: 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?:_____

DRUG AND ALCOHOL TREATMENT

Please indicate any current or 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/counselling now?_____

_____

_____

Anything else you think would be useful for us to know? Please feel free to provide any references or certificates

_____

_____

_____

Thank you.