

Midlothian Healthcare Co-operative
Community Mental Health Team
Loganlea Centre, Based at Eastfield Medical Centre
Eastfield Farm Road, Penicuik, EH26 8EZ
Phone 01968 671 330 fax 01968 671 335

Dr Miller
Newbattle Medical Practice
Blackcot
Mayfield
Dalkeith
EH22 4AA

Our Ref: NL/LW/307601
Date: 31 January 2007
Dictated on:
Direct Dial: 01968 671 330

Dear Dr Miller

This gentleman did not attend an appointment with me on the 29th January 2007 – he has not contacted our department or indicated he wishes to be seen again. I note that when I saw him before Christmas his moderate depressive episode was resolved and we agreed that he should remain on Citalopram for the next 12 months. There is no need for me to see him again and he is discharged from our service.

Yours sincerely

Dr Nathan Langsley
Consultant Psychiatrist

COPY OF DOCTOR'S LETTER

**Midlothian Healthcare Co-operative
Community Mental Health Team
Loganlea Centre, Based at Eastfield Medical Centre
Eastfield Farm Road, Penicuik, EH26 8EZ
Phone 01968 671 330 fax 01968 671 335**

Dr Miller
Newbattle Medical Practice
Blackcot
Mayfield
Dalkeith
EH22 4AA

Our Ref: NL/LW/307601
Date: 12 December 2006
Dictated on:
Direct Dial: 01968 671 330

Dear Dr Miller

RE: John Kennedy (23.06.65), 3 Jacobs Way, Gorebridge

Newbattle Clinic dated 27.11.06

Diagnosis: Depressive Episode – in remission
Previous alcohol misuse
No clinically significant Bipolarity

Treatment Plan: Continue on Citalopram 40mg
Self help technique – e.g. Exercise

Clinic Review: 29th January 2007

Report

Referred by GP due to swings of mood. He feels “down” several times a month, this lasts a few hours and never into the next day – “I’m better after a nights sleep”. At these times he is uncomfortable with others, ruminates about the past, and “can’t be bothered to do anything”. All these episodes seem to occur at home and in the context of expectations from family members. These episodes do not interrupt his work life, or social activities (e.g. watching football).

Overall he has good mental health. He works hard as a garage manager where he has good concentration, is motivated and successful. Good appetite, balanced diet, energetic, 6 hours sleep at night, no diurnal variation in mood. Each weekend he watches Hearts FC, and he has several circles of friends. He does spend time with his wife and children but tells me “I have to work at doing that right”.

Background

No developed mental problems, his parents split when he was young and because his mother couldn’t support him he and his older brother were in care from the age of 6-16. Attended local schools which he enjoyed and had friends. From 16 an apprentice mechanic, always been in employment and a manager for the last 10 years. Met wife Stephanie at age 17, 2 teenage children. Brief separations from wife because of his excessive alcohol and associated behaviour. Possibly both his parents had alcohol problems, he first drank at the age of 14. Moderate intake through much of adult life, this became heavy several years ago, but following ultimatum from wife this time last year he has cut down dramatically.

COPY OF DOCTOR'S LETTER

Previous Psychiatric History

Reports an episode of depression of mild – moderate severity about 6 years ago, no apparent treatment. Recurrence of symptoms in February 2005 which led to tensions within the family (father-in-law was dying of cancer and his wife was less attentive). He became to drink excess alcohol which contributed to further low mood and he took 5 months off work. Commenced on Citalopram by GP with gradual improvement with increasing dose. Reduction in alcohol intake also beneficial – briefly in contact with Alcohol Problems Service in December 2005.

Mental State Examination

Young man, smart attire, relaxed, speech normal, logical coherent account. No preoccupations, no psychotic phenomena, mood euthymic and reactive. No thoughts of self harm, positive plans to be alive.

Opinion

Did experience a moderate episode of depression in early 2005, this has now resolved. His descriptions of down days are brief connected with family life, and resolved spontaneously. We should not medicalise these and there is no need to alter his medication. I have given him information about self help and will review him once more to reinforce this. On this scenario we advise him to remain on anti depressants for at least 12 months after getting better – he is at this juncture but may wish to continue indefinitely. I will discuss this with him.

Yours sincerely

Dr N Langsley
Consultant Psychiatrist

LOGANLEA CENTRE

Community Mental Health Team

Based at Eastfield Medical Centre Eastfield Farm Road

Penicuik Midlothian EH26 8EZ

Telephone: **01968 671330** Fax No: **01968 671335**

Mr John Kennedy

3 Jacobs Way

GOREBRIDGE

Midlothian

EH23 4GG

Our ref: NL/WR/Kennedy

Chi. No. 2306651175

Date: 07 November 2006

Dear Mr Kennedy

As you will know your GP has referred you to our service.

The first available appointment to see Dr. Nathan Langsley, Consultant Psychiatrist at the Newbattle Medical Centre, Blackcote, Mayfield is on **Monday 27th of November 2006 at 2.00 pm.**

I hope this appointment is suitable for you, but if not, please telephone the above number so that an alternative arrangement can be made.

Yours sincerely

W J Ramsay

Medical Secretary

Cc Dr J N Miller Newbattle Medical Centre Blackcote Mayfield

rec'd / reg / 04.11.06

PARTICULARS OF PATIENT
IN BLOCK LETTERS PLEASE

Hospital use Only	Clinic	Day Date	Time	Hospital No.	GP112B			
Ambulance Transport Required: Yes/No Sitting/Stretcher		REQUEST FOR OUT-PATIENT CONSULTATION THE INFORMATION IN THIS SECTION MUST BE COMPLETED			Appointment Category Routine <input type="checkbox"/> Soon <input type="checkbox"/> Urgent <input type="checkbox"/>			
Hospital LOGANLEA CENTRE		Date 27.10.06		CHI No. 2806651175				
Please arrange for this patient to attend the MENTAL HEALTH TEAM		clinic of Dr/Mr Dr. D. Bennett						
Patient's Surname KENNEDY		Maiden Surname						
First Names John		Single/Married/Widowed/Other						
Address 3 Jacobs Way		Date of Birth 23.06.65						
Gorebridge		Patient's Occupation						
Postal Code EH23 4GG		Contact telephone number 01845 822355						
Has the patient attended hospital before? YES/NO If "YES" please state:								
Name of Hospital								
Year of Attendance Hospital No.								
If the patient's name and/or address has/have changed since then please give details:								
.....								
Can patient attend at short notice? YES/NO								
If YES, minimum notice required days								
<table border="1"><tr><td>Name, Address and Telephone number of MEDICAL/DENTAL PRACTITIONER</td></tr><tr><td>NEWBATTLE MEDICAL PRACTICE BLACKCOT MAYFIELD DALKEITH EH22 4AA TEL: 0131 663 1051 FAX: 0131 654 0665</td></tr><tr><td>Please use rubber stamp</td></tr></table>						Name, Address and Telephone number of MEDICAL/DENTAL PRACTITIONER	NEWBATTLE MEDICAL PRACTICE BLACKCOT MAYFIELD DALKEITH EH22 4AA TEL: 0131 663 1051 FAX: 0131 654 0665	Please use rubber stamp
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NEWBATTLE MEDICAL PRACTICE BLACKCOT MAYFIELD DALKEITH EH22 4AA TEL: 0131 663 1051 FAX: 0131 654 0665								
Please use rubber stamp								

77106 77106

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Dear Dr. Bennett,

Thank you for seeing this 41-year-old patient, who has been suffering from a depressive illness since February 05. It was brought on initially by problems within his family life, relating to illness of an in-law. Since that time, he has been on Citalopram, at a dose initially of 10mgs, rising to 20mg. and since May of last year, 40mgs. mane. He was doing quite well on this up until recently, when he feels he is having more ups and downs than before.

I enclose a copy of the summary sheet from his notes. He is on no other regular medication.

Thank you for seeing him.

Yours sincerely,

Dr. J.N. Miller

Diagnosis/provisional diagnosis:
Dr. J.N. Miller

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

..... Signature

Registration

Mr John A Kennedy

3 Jacobs Way
GOREBRIDGE
Dalkeith

EH23 4GG

Telephone: 01845 822355

Contact: ?

ContactRelship: ?

Email: ?

CHI Number: 2306651175

Registered GP: Dr Miller

Service Code: Permanent

DoB: 23/06/1965

Age: 41

Clinical / User Marker

Date Recorded	Start Date	Priority	Description	Modifier
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Priority Clinical / User Marker

Date Recorded	Start Date	Priority	Description	Modifier
18/10/2005	18/10/2005	High	Alcohol dependence syndrome NOS	
22/06/2005	None	High	Notes summary on computer	
12/05/2005	12/05/2005	High	Bereavement	
Freetext:	grandfather.			
10/02/2005	10/02/2005	High	Neurotic depression reactive type	
06/03/1996	None	High	Light drinker - 1-2u/day	
01/02/1996	None	High	U-S abdominal scan	Normal
26/05/1995	None	High	Bilateral vasectomy for contraception	
01/09/1993	None	High	Ex-heavy smoker (20-39/day)	
14/05/1974	None	High	Fracture of upper limb	Left
Freetext:	Elbow.			
18/02/1971	None	High	Primary repair of inguinal hernia	Right
	None	High	No relevant family history	

Last 4 Clinical Notes

Date	Clinical Notes
26/10/2006	S. Not quite so good in the last two weeks. P(M). Refer Glenesk.
23/08/2006	S. Snoring. Wife has noticed that he stops breathing in the night. Wakes up tired. A ? Sleep Apnoea. P(M). Refer.
31/07/2006	sore throat red no abscess no trismus
26/06/2006	S. Still some ups and downs.

Alcohol Problem Service

Sally Wray
Nurse Counsellor
Newbattle Medical Group
Blackcot Road
Mayfield
EH22 4AA

Ref: RG/BG
Date Dictated: 23 December 05
Date typed: 9 January, 2006

Dear Sally

Re: John Kennedy, 3 Jacobs Way, Gorebridge. D.O.B: 23-06-65

Thank you for your referral for this gentleman, whom I saw on behalf of Brendan Perry who remains on long-term sick. I saw him on Friday 16th December at Loganlea Centre. John reports a problem with alcohol stemming from the beginning of this year. Prior to this he would normally drink a couple of pints on his way home almost every night. He has suffered from depression in the past and had been off work for sometime, however he has now returned to this and is coping extremely well at present.

He has had some instances where he has lost control whilst under the influence of alcohol and acted completely out of character in these situations. He instigated a situation whereby he assaulted some youths who "reciprocated", with him suffering the greatest injuries. The police were involved but he does not think that any charges will be brought against him. He was also in the habit of drinking and driving not knowing how he got home as he was so drunk. The last time this occurred was about 8 or 9 weeks ago. He would not contemplate drinking and driving at this moment in time.

He reports that both his parents being heavy drinkers but does not know if either of them sought help with this or if they had any treatment. His wife does not have a problem with alcohol however most of his friends drink to excess. They are relationships difficulties within the marriage and this he blames entirely on his alcohol abuse and subsequent misbehaviour. His wife has issued an ultimatum with him that he either stop drinking or the marriage is ended. He has taken her threat seriously and has not been drinking to excess for at least 3 months. He does go to the football every weekend and has "a couple" of pints but she is unaware of this. He does not drink any

Loanhead Social Work Centre
4 Clerk Street, Loanhead EH20 9DR
Telephone 0131 271 3900 Fax 0131 448 2151

alcohol other than this at present. He does not express any desire to drink nor does he describe any withdrawal symptoms when he does not drink.

With regards to his depression he feels that he is coping quite well however he feels he has reached a plateau on 40mgs Citalopram and has been on this for a subsequent length of time and perhaps this may need to be reviewed as he is not 100% yet. He reports receiving counselling from yourself, which he has found a great help in him understanding the causes of depression and the difficulties he has had in his early life. He also reports that he and his wife are attending Relate for their marriage difficulties which he feels he does not benefit as much as his wife.

In view of the fact that John appears to have his drinking under control and is drinking well within the recommended Government limits I do not feel there is a role for me at this moment in time. I have given him information on AXIS Midlothian, which I have encouraged him to make contact with if he feels he needs ongoing support with regards to remaining sober. I have encouraged him to keep a written record of the amount of alcohol he is drinking and perhaps negotiate with his wife what is acceptable to both himself and herself with regards to his Saturday drinking. If however the situation with regards to his alcohol abuse escalates please do not hesitate to refer him to our service.

Yours sincerely

Bernie Gilbertson CPN
Alcohol Problem Service

Cc. Dr Miller, Newbattle Medical Practice, Blackcot, Gorebridge.

Alcohol Problem Service

Private & Confidential

John Kennedy
3 Jacobs Way
Gorebridge

Ref: RG/BG
18 October, 2005

Dear Mr Kennedy

I received a referral from Sally Wray, Nurse Counsellor requesting that I send you an appointment for help with your alcohol problem. Your name has been placed on a waiting list and an appointment will be sent out to you at the earliest opportunity.

Yours sincerely

Bernie Gilbertson CPN
Alcohol Problem Service

Cc. Dr Miller, Newbattle Medical Group, Blackcot, Mayfield, EH22 4AA

Cc Sally Wray, Nurse Counsellor, Newbattle Medical Group, Blackcot, Mayfield,
EH22 4AA

Loanhead Social Work Centre
4 Clerk Street
Loanhead
EH20 9DR
Telephone 0131 271 3900 Fax 0131 448 2151

Alcohol Problem Service

Private & Confidential

John Kennedy
3 Jacobs Way
Gorebridge

Ref: RG/BG
30 November, 2005

Dear Mr Kennedy,

I would like to offer you an appointment to attend APS, Loganlea Centre, Eastfield Medical Practice, Penicuik **on Friday 16th December 2005 at 1pm.**

If you are unable to attend for any reason, please contact me on the telephone number below.

I look forward to seeing you on the above date.

Yours sincerely

Bernie Gilbertson CPN
Alcohol Problem Service

Loanhead Social Work Centre
4 Clerk Street
Loanhead
EH20 4DR
Telephone 0131 271 3900 Fax 0131 448 2151

ASSESSMENT FORM

Unit No ☐ ☐ ☐ ☐ ☐ ☐

Name of assessor:

Date:

Team:

Location:

Client's Personal Details:

Name:

Address:

Post Code:

Phone no:

Sex:

D.O.B.:

Age:

Ethnic:

Next of Kin (if changed):

Name:

Address:

Post code:

Phone no:

Relationship:

Person to be contacted in an emergency:

GP (if changed):

Name:

Address:

Phone no:

Social Worker (if changed):

Address:

Phone no:

Probation Officer (if changed)

Address:

Phone no:

Significant Others (ie Solicitors/supportive friend/housing officer)

Comments

FOR RESEARCH PURPOSES ONLY

RESEARCH No. _____

DATE _____

UNIT No. _____

Section A: Substance Use

A1. Non-prescribed substance use

To assist recall for past 6 months and past 30 days use Cards 1 and 2.

NB: For routes code: 1=oral; 2=snort/sniff; 3=smoke/chase; 4=inject

Type	Past 6 mo? ✓/X	Days used 6 months (Card 1)	Amount on typical day past 6 months	Usual route(s)	Past 30 days? ✓/X	Days used past 30 days (Card 2)	Amount on typical day past 30 days	Usual route(s)	Used past 3 days?
Heroin									
Methadone (Liquid)									
DHC _____									
Other Opioid 1 _____									
Other Opioid 2 _____									
Diazepam _____									
Temazepam _____									
Other Benzo _____									
Alcohol									
Cocaine (powder)									
Crack									
Amphetamines									
LSD									
MDMA (etc)									
Cannabis									
Tobacco									10 daily
Other									

Additional Description

Severity of dependency (non-prescribed drugs)

A2. In the past 30 days, did you ever think your use of any non-prescribed drugs was out of control?

No <input type="checkbox"/> Yes <input type="checkbox"/> If yes:	*How often did you think your use of _____ (drug) was out of control?*		
Which drug? - record	Sometimes	Often	Always or nearly always
1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A3. In the past 30 days, did the prospect of not taking any non-prescribed drugs make you anxious or worried?

No <input type="checkbox"/> Yes <input type="checkbox"/> If yes:	*How often did the prospect of not taking any _____ make you anxious or worried?*		
Which drug? - record	Sometimes	Often	Always or nearly always
1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A4. In the past 30 days, did you worry about your use of any non-prescribed drugs?

No <input type="checkbox"/> Yes <input type="checkbox"/> If yes:	*How often did you worry about your use of _____?*		
Which drug? - record	Sometimes	Often	Always or nearly always
1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A5. In the past 30 days, did you wish you could stop using any non-prescribed drugs?

No <input type="checkbox"/> Yes <input type="checkbox"/> If yes:	*How often did you wish you could stop using _____?*		
Which drug? - record	Sometimes	Often	Always or nearly always
1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- A6. Which of the non-prescribed drugs you used in the past 30 days would you find it difficult to stop or go without?

None <input type="checkbox"/> One or more - list	How difficult did you find it to stop or go without _____?		
Drug type - record	Quite difficult	Very difficult	Impossible
1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Severity of Dependence (alcohol) [NB: if client has not drunk any alcohol in past 30 days, skip to A8]

- A7. Thinking about your use of alcohol in the past 30 days:

	Never or almost never	Sometimes	Often	Always or nearly always
Did you ever think that your use of alcohol was out of control?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the prospect of not drinking make you anxious or worried?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you worry about your alcohol use?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you wish you could stop drinking?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Easy	Quite difficult	Very difficult	Impossible
How difficult would you find it to stop or go without alcohol?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- A8. Addiction treatment

In the past 6 months, have you been treated for a drug or alcohol problem, where you stayed for one or more nights in a hospital?

No ☐ Yes ☐ If yes: _____ times _____ total nights

In the past 6 months, have you been treated for a drug or alcohol problem in a residential rehabilitation unit (eg Phoenix House)?

No ☐ Yes ☐ If yes: _____ times _____ total nights

Describe any additional treatment services attended in the past 6 months

Relate for relationship

A9. Current prescribed drugs

*N.B. For routes code 1=oral, 2=snort/sniff, 3=smoke/chase, 4=inject

Type	Days used past 90 days	Amount on typical day	Usual route(s)	Comments
1.				
2.				
3.				
4.				
5.				

Additional remarks

A10. Injecting

Have you ever injected?

No ☐ (Skip to A14) Yes ☐ Year 1st Injected _____

If yes:

Have you injected non-prescribed drugs at any time in the past 6 months? No ☐ Yes ☐

If No, skip to A12??

(Card 1)

On how many days in the past 6 months, did you inject non-prescribed drugs? _____ days (1-180)

On a typical day in the past 6 months, how many times did you inject? _____ times

(Card 2)

On how many days in the past 30 days, did you inject non-prescribed drugs? _____ days (1-30)

On a typical day in the past 30 days, how many times did you inject? _____ times

A11. Injection-related risk behaviour

Thinking back have you:	Ever	In the past 6 months?	In the past 30 days?
Injected in a situation where other people were also injecting themselves?	Yes ____ No ____	Yes ____ No ____	Yes ____ No ____
Used the same spoon, filter or water that had been used by someone else?	Yes ____ No ____	Yes ____ No ____	Yes ____ No ____
Reused a needle or syringe which you have used before?	Yes ____ No ____	Yes ____ No ____	Yes ____ No ____
Used a needle or syringe which has been used by someone else?	Yes ____ No ____	Yes ____ No ____	Yes ____ No ____

A12. In the past 30 days, how many times have you used a needle or syringe which had been used by someone else?

_____ times

Comments - Injecting risks

Injecting sites damage assessment (Card 1&2)

A13. Can I just check any IV sites? No ☐ Yes ☐

If yes - complete frequency of injecting in each area and assess site damage.

Area	Sites Ever Used	Sites Used in last month	Damage 0=None 1=Minor 2=Moderate 3=Severe	Description
Left Arm				
Left Hand				
Right Arm				
Right Hand				
Left Leg				
Left Foot				
Right Leg				
Right Foot				
Left Groin				
Right Groin				
Neck				

Comments

Overdose

A14. Have you ever had a drugs overdose?

No ☐ (Skip to Section B) Yes ☐ If yes:

Times in lifetime: _____

Times in past 6 months: _____

Times in past 30 days: _____

A15. How many of the above were accidental? _____

A16. Which drugs did you take on each occasion you overdosed?

1. _____

2. _____

3. _____

Section B: Physical and Psychological Health

B1. In the past month, how often have you had the following problems:

in last Not recently.

	Never	Rarely	Sometimes	Often	Always
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness/fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot or cold sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Racing heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint/bone pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetting things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fits/seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremors (shakes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty injecting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV related abscesses/ infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Client's perception of main health problems

*May/June assaulted 30 youths he come
off worse, Change in behaviour attitude
when re-getting to certain situations*

Medical Assessment

Current medical problems

Depression

Current medication

Citalopram 40mg

B2. General Medical

In the past 6 months, have you been treated for a medical problem where you had to stay overnight in a hospital?

No ☐ Yes ☐

If yes: ___ times ___ total nights

In the past 6 months, have you been treated for a medical problem at an Accident and Emergency Department?

No ☐ Yes ☐

If yes: ___ times treated

In the past 6 months, how many times have you seen a GP? ___ times seen GP

Blood tests - complete new information as required

N.B. For every test code 1=Yes, 2=No, 9=don't know

	Ever Tested	When Last Tested		Result? (+/-)	Where?	Confirmed +ve/-ve
		Month	Year			
HIV						
HBV						
HCV						

Comments

Section C: Treatment History

Psychological Health

C1. In the past month, how often have you had the following experiences or feelings?

	Never	Rarely	Sometimes	Often	Always
Feeling tense or keyed up	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suddenly scared for no reason	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling fearful	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness or shakiness inside	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spells of terror or panic	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling hopeless about the future	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of worthlessness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling no interest in things	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling lonely	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts of ending your life	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C2. Psychological treatment

a) In the past 6 months, have you been treated for a psychological or emotional problem where you had to stay overnight in a hospital?

No ☒ Yes ☐

If yes: ____ times ____ total nights

b) In the past 6 months, have you had any out-patient or community treatment for a psychological or emotional problem (not from a GP)?

No ☐ Yes ☒

If yes: ____ times ____ visits made/received

Who did you see? _____

How often were you seeing them? _____

c) Are you currently receiving any medication for a psychological problem?

No ☐ Yes ☒

If Yes, details: _____

If yes to any of the above, can you tell me more about the difficulties you have been having?

Recent life events

C3. The following questions are about events or problems which may have happened to you during the past 6 months which might have caused you distress.

In the past 6 months	Yes	No
Have you yourself suffered from a serious illness, injury or an assault?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has a serious illness, injury or an assault happened to a close relative?	<input type="checkbox"/>	<input type="checkbox"/>
Has a parent, spouse (or partner), child, brother or sister of yours died?	<input type="checkbox"/>	<input type="checkbox"/>
Has a close family friend or another relative died (eg such as an aunt, cousin or grandparent)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a separation due to marital difficulties or broken off a steady relationship?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a serious problem with a close friend, neighbour or relative?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

12 months ago father in law

Section D: Life Context and Social Functioning

Accommodation

D1. What type of accommodation do you currently have? Only accommodation

D2. How long have you lived at your current address? 4 days weeks/months/years

D3. In the past 30 days, how many nights have you spent (stayed the night) in the following places?

Own home	Partner's/ Relatives/ Friends	Hostel/ temporary	On the street (homeless)	Police/prison/ other detention	Hospital/ residential treatment

Other: specify _____ No. Nights: _____ NB: Check sum of nights spent in past month = 30

Is client satisfied with the current accommodation?

Nice

How does client describe the local area?

Nice

Relationships

D4. Which category describes you now:

Married ☐ Single - in a relationship ☒ Single - no relationship ☐ Other ☐ _____

D5. Do you have any dependent children?

None ☒ Number of children 2 Number living with client 2

Number living elsewhere 1 Number in care 14 & 12

D6.

- a) Do you have any relatives that you feel close to? No ☒ Yes ☐ no: _____
- b) If so, who?: _____
- c) Do you live with them? Yes ☐ No ☐
- d) If not, how much do you see them? _____
- e) Are there any difficulties in your relationship with them? Yes ☐ No ☐
- f) Do you think that your are having more arguments/conflict with them? Yes ☐ No ☐

Why? _____

D7.

- a) Do you have any friends that you feel close to? No ☐ Yes ☒ no: _____
- b) Who are they? Sunit (friend)
- c) Are there any difficulties in your relationship with them? Yes ☐ No ☒
- d) Do you think that your are having more arguments/conflict with them? Yes ☐ No ☐

Why? _____

D8. How many sexual partners have you had in the last 6 months?

No. _____

D9. Have you traded sex for money/drugs/gifts in the last 6 months?

Yes ☐ No ☐

D10. Have you had a primary sexual partner in the last 6 months?

Yes ☐ No. _____ No ☐

D11. Have you had sex without using a condom in the last 6 months?

Yes ☐ No. _____

Comments - Sexual Behaviour Risks

D12. How would you describe your relationship with your partner?

Problems

D13. Would you say your partner has a problem with drugs?

No ☒ Yes ☐

D14. Would you say your partner has a problem with alcohol?

No ☒ Yes ☐

D15. How many of your friends would you say have a problem with drugs?

None ☒ Some ☐ Most ☐ All or nearly all ☐

D16. How many of your friends would you say have a problem with alcohol?

None ☐ Some ☐ Most ☐ All or nearly all ☒

D17. How many of your relatives would you say have a problem with drugs?

None ☒ Some ☐ Most ☐ All or nearly all ☐

D18. How many of your relatives would you say have a problem with alcohol?

None ☐ Some ☐ Most ☐ All or nearly all ☐

Comments

Father
Mother

Heavy drinker
h *h*

Education and employment

Describe career or educational goals:

Worries in Garage

At any time in the past 30 days ---

D20. Did you have a paid job (including casual work)?

No ☐ If No, skip to D24 Yes ☐ If Yes: ____ Number of days had job (1-30)

D21. Did you miss any days from work because of sickness or unauthorised absence?

No ☐ Yes ☐ If Yes: ____ Number of days missed (1-30)

D22. Did you have a place on a training or education course?

No ☐ Yes ☐ If Yes: ____ Number of days attended (1-30)

D23. Were you looking after dependants (children/relatives)?

No ☐ Yes ☐ If Yes: ____ Number of days (1-30)

D24. Were you unemployed?

No ☐ Yes ☐ If Yes: ____ Number of days u/e (1-30)

Section E: Legal Issues and Offending

E1. Have you every been in prison: Yes ☐ No ☐

E2. In the past 6 months, have you been in prison?

No ☐ Yes ☐ If Yes: _____ no. times in past 6 months _____ time in prison in past 6 months

E3. Have you been arrested in the past 6 months?

No ☐ Yes ☐ If Yes: _____ no. of times arrested in past 6 months

Outline any pending court cases, outstanding charges, etc:

Assaulting MINOR

How many of the above are related in some way to your drug use? _____

E4. I'm now going to ask you about things you may have done in the past 30 days that are against the law.
Remind client about confidentiality.

	In the past month? (✓ or X)	Days committed (1-30) (Card 2)	Number of times on typical day
Selling drugs	<input type="checkbox"/>	if yes	and...
Fraud/forgery	<input type="checkbox"/>	if yes	and...
Theft from a property	<input type="checkbox"/>	if yes	and...
Theft from a person	<input type="checkbox"/>	if yes	and...
Shoplifting	<input type="checkbox"/>	if yes	and...
Theft from a vehicle	<input type="checkbox"/>	if yes	and...
Theft of a vehicle	<input type="checkbox"/>	if yes	and...
Other theft (specify)	<input type="checkbox"/>	if yes	and...
Criminal damage	<input type="checkbox"/>	if yes	and...
Public order offence	<input type="checkbox"/>	if yes	and...
Soliciting	<input type="checkbox"/>	if yes	and...

Assessor's Opinion of Client's Needs

Short term wants/goals

Satisfied where he is at

Long term wants/goals

Prove to wife that he can handle

Our short term goals

Our long term goals

Garage Manager O.H.

O.P. CLINICAL NOTES

(Psychiatry)

NUMBER

NAME

DATE

SHEET No.

Depression 6/12 off work. Father & now died.
Binge drinking. Behaving out of character
split with wife but living in same house.
AA present: W/E 5-6 Pints Saturday.
Nights out soft drinks soda & water.
Change in character
Assaulting 12 months.
Drinking & Driving Not now. Last time P-9/5c
No thoughts of self harm
40mg Citalopram.
Generally great help
Previous history
Life works.
Drinking history 2 couple pints every
night. this year out of control.

27/11/

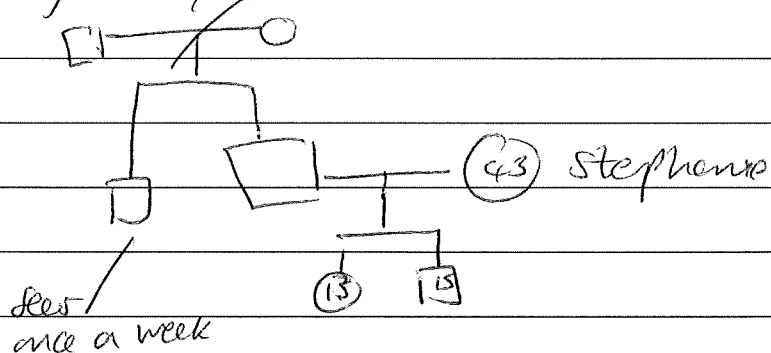
Some days - "down" - several times a month
less at work

- withdrawn
- don't want to do anything "do not to do things"
- mumbling
- last no more than a day - "better after a night's sleep"
- variable time to bed - 6 hours sleep - sometimes

- Garage Manager - going well, can concentration

- watch reverts

- time with kids



- Parents split - mother couldn't

- 6-16 - care ^{central} Edinburgh

- local school - friends

- Mechanic apprenticeship - manager for 10 years

- Met wife at age 17 - brief separations

- Some friends - associated with drinking

1 year ago.

- alcohol from 14 - heavy, dependence

- only at weekends - 14 units

O.P. CLINICAL NOTES

(Psychiatry)

NUMBER

NAME

DATE

SHEET No.

Citalopram from GP for 15 months — when off work
— gradual increase —> irritable / anxious
— out of control

Pharm — Same meds
— Behavioural techniques.

Wiley.