



Client Admission Assessment Form

Secondary Accommodation – Substance Use Support

Confidential

Date of Assessment: ____ / ____ / ____

Assessor Name & Role: _____

1. Client Personal Details

Field	Information
Full Name	
Preferred Name	
Date of Birth	
National Insurance Number	
Gender	
Ethnicity	
Nationality	
Immigration Status	
Contact Number	
Email	
Next of Kin / Emergency Contact (Name, Relationship, Phone)	
GP Name & Contact	

2. Referral Information

Field	Details
Referral Agency	
Referrer's Name & Contact	
Date of Referral	
Reason for Referral	
Has the client had a previous placement in supported housing?	☐ Yes ☐ No
If yes, where and when?	

3. Substance Use History

Question	Response
Substances used (past & present)	
Frequency & quantity of use	
Method of use (e.g., oral, injection)	
Age started using substances	
Last use (substance & date)	
Any periods of abstinence? If yes, when and how?	
Current treatment/support in place?	☐ Yes ☐ No
If yes, details of service provider (e.g., Turning Point, CGL)	
Prescribed substitute medication (e.g., methadone, buprenorphine)?	
Risky behaviours (e.g., needle sharing)?	☐ Yes ☐ No
History of overdose?	☐ Yes ☐ No — Details:

4. Physical & Mental Health

Condition	Details
Physical health issues	
Mental health diagnosis (if any)	
Self-harm or suicidal ideation (past/present)	
Current medication	
Registered with GP?	☐ Yes ☐ No
Engaged with mental health services?	☐ Yes ☐ No – Details:

5. Housing History

Question	Response
Current living situation	
Previous accommodation (last 3 years)	
Reason for leaving last accommodation	
History of homelessness	☐ Yes ☐ No
History of eviction	☐ Yes ☐ No — Reason:
Housing-related support needs	

6. Risk Assessment

Risk Area	Yes/No	Details
History of violence or aggression	☐ Yes ☐ No	
Arson	☐ Yes ☐ No	
Criminal history	☐ Yes ☐ No	
Sexual offences	☐ Yes ☐ No	
Domestic abuse (victim or perpetrator)	☐ Yes ☐ No	
Safeguarding concerns	☐ Yes ☐ No	
Risk to self or others	☐ Yes ☐ No	
MAPPa involvement	☐ Yes ☐ No	

7. Support Needs

Please rate level of need:

(1 = No Support, 5 = High Support)

Area	Rating (1–5)	Notes
Substance use		
Mental health		
Physical health		
Managing accommodation		
Budgeting / benefits		
Daily living skills		
Social support / isolation		
Meaningful use of time		
Offending behaviour		

8. Client Goals

- **Short-term goals:**

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- **Long-term goals:**

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9. Additional Notes

(Include any observations, client motivation, strengths, concerns, or relevant background info.)

10. Assessor Summary & Recommendation

- Suitable for secondary accommodation? ☐ Yes ☐ No
- Any conditions for placement (e.g., engage with keyworker, attend treatment)?
- Suggested support plan outline:

Assessor Signature: _____

Client Signature: _____

Date: ____ / ____ / ____