WCDHB Rata AOD Service Provision Framework
Assessment Process Flowchart

Version 1

	Tasks/Standards	Who	Forms
Assessment preparation	● Collect file and collate applicable forms ● Check accuracy of previous demographic data, e.g. ethnicity, contacts, etc. if applicable ● Up date information (if any changes as appropriate) ● Ensure consent to treatment form is available for signing/updating	Clinician/ key worker	Comprehensive assessment form, risk assessment, recovery plan, registration form, psychometric testing forms if applicable
Does person arrive for assessment — No	● Record in clinical notes and record as DNA in iSoft ● Contact person by telephone and/or send letter or appointment card to attend another appointment (3 opportunities). Discuss at AOD MDT ● Liaise with referrer if appropriate ● Send letter to referrer of person not attending 3 consecutive DNA's ● After third DNA discharge from service. Advise person of discharge by mail offering another appointment if they re contact /re engage with service in the future		
Yes — Assessment	● When person (& family/support person) presents, welcome and explain process of assessment, including confidentiality, Code of Rights, etc. (approx 2 hours) ● Explain possible outcomes that may occur as a result of the assessment ● Establish rapport ● Answer any questions and obtain consent to treatment and update registration form. ● Conduct assessment as per assessment format, complete risk assessment, undertake relevant screening/psychometric testing, negotiate care plan, and complete HONOS manually/electronically ● If necessary, inform of further assessment with CMH/MMH (dual diagnosis/cultural input) and/or referral for self or significant others as required		
Formulation and feedback	● Provide immediate feedback to person/support person ● Make treatment recommendations including discharge planning ● Negotiate individualised care plan with person/others as appropriate ● Allocate follow up appointment as required ● Confirm person understands process and answer any relevant questions ● Record attendance in clinical notes and iSoft ● Arrange next scheduled appointment and record		
MDT review Acceptance assessment, confirmation of care plan	● After completion of assessment present case at next AOD MDT meeting (within 10 working days) ● Discuss diagnosis, clinical management plan, referral to other services if applicable ● Check the person meets treatment criteria – if not- refer on/discharge	AOD Multi-disciplinary team	
	● Update information, print more labels if necessary	Admin/ Secretary	
Does person meet treatment criteria — No	● Inform person that they do not meet the treatment criteria ● With consent of person, send copy of assessment/report and/or explanation of non acceptance to referrer within 10 working days ● Refer person on to other agencies/services as appropriate ● Update Client Information Form and give to administration ● Written feedback to referrer and/or GP, family/whanau/support person if appropriate	Clinician/ key worker	
Yes — Treatment process	● End episode of care/case on iSoft ● Return file to central filing	Administration Secretary	