Oceans Thailand

Oceans Thailand
Prachuap Khirir Khan

(+66) 99 185 7740
(+61) 49 811 7226
E: info@oceansthailand.com
W: oceansthailand.com

ASSESSMENT FORM

PROPSOED ADMISSION DATE……………………

PERSONAL DETIALS:		Name Of Family Doctor:
Surname:		Suburb:
Given Names:		Doctor Phone No:
Address:		Doctor Email:
		Next of Kin:
Phone No:	Mobile:	Next of Kin Phone No:
DOB:		Other Contacts:
Source of Referral:		Phone No:

I hereby give Oceans permission to contact…………………………………… To obtain background family information.

Signature…………………………………… Date…………………………

Reason for presentation:

	Current use or behaviour	Amount used or acted upon per day	No. Days used or acted upon in the last month	Total length of use or behaviour	Last used or acted upon
Alcohol					
Medication N/S					
Gambling					
Illicit					
Marijuana					
Ice					
Synthetics					

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Age commenced using Drug (s):	
Age commenced gambling:	
Longest drug free period:	
Longest gambling free period:	
Circumstances involved (Why?)	

PREVIOUS ALCOHOL, DRUG, GAMBLING TREATMENTS

………..

PREVIOUS PSYCHIATIRC HISTORY

………..

Further risk assessment required: ☐ Yes ☐ No

CURRENT MEDICATION: …………………………………………………………………………………..

………...

SIGNS AND SYMPTONS RESIDENT HAS EXPERIENCED IN THE PAST OR PRESENT:							
Blackouts		Memory loss		Fits		Poor appetite & diet	
Insomnia		Night sweats		Shakes		Depression	
Loss of control during substance use or gambling		Increase tolerance to substance use		Increased levels of gambling		Avoiding people, work, activities	
Residents perception of main problems related to addiction: ……….. ………..							

Referral Completed by:

Name: ________________________________ Date: ________

Organisation (If applicable) ___________________________ Ph.: ________________________

Email: ____________________________________ Signature: _______________________________