Stage I: Readiness Assessment

Name _____

Date of Assessment: _____

Components	Positive Readiness	Negative Readiness
Mental Health		
Substance Use		
Environmental		
Cognitive		
Attitudinal		

Barriers to Readiness:

_____

_____

_____

Goals:

_____

_____

_____

Plan:

_____

_____

_____

Next Appointment: _____

Signature: _____

Date: _____

Stage I: Readiness Assessment

Mental Health Assessment

CES-D Scale

(U.S. Department of Health and Human Services, NIH, National Institute of Mental Health)

Circle the number for each statement that best describes how often you felt or behaved this way During the Past Week.	Rarely of None of the time (Less than 1 Day)	Some or a Little of the Time (1 - 2 Days)	Occasionally or a Moderate Amount of Time (3 - 4 Days)	Most or All of the Time (5 - 7 Days)
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt that I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people disliked me.	0	1	2	3
20. I could not get along.	0	1	2	3

Stage I: Readiness Assessment

Prior History: Refer to Social Assessment

_____

_____

Are you currently being treated for any mental health diagnosis, either voluntary or court ordered? Yes No

If yes, what is the diagnosis? What treatment are you receiving?

_____

_____

Have you ever had thoughts of hurting yourself or committing suicide? Yes No

Do you currently have thoughts of hurting yourself or someone else? Yes No

(If suicidal or homicidal, immediately proceed to procedure for crisis situations.)

Comments:

_____

_____

_____

Outcome:

O Positive Assessment to Readiness *O Negative Assessment to Readiness*

Goals:

_____

_____

Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition, American Psychiatric Washington, DC. 1994, p.327

Substance Use Assessment

Is there a history of substance use in the past? (obtain from social work assessment)

_____

_____

Do you drink alcohol (beer/wine/liquor)? _____ How much do you consume? _____

Do you use drugs?_____ Which drug(s) do you use? Heroin/crack/cocaine/marijuana/other_____

How much and how often do you use?_____

Stage I: Readiness Assessment

Are you currently being treated for a substance –induced disorder either voluntarily or court ordered? Yes No

If yes, what substance? What treatment are you receiving?

_____

_____

CAGE Tool – Assessment of Alcohol Use

In the past six months:

1. How many drinks do you consume per week? _____
2. What is the maximum number of drinks on one occasion you have consumed in the past month? _____
3. CAGE Questions (Score 1 point for each positive response)

- Have you ever tried to **C**ut down on your drinking? Y N
- Do you get **A**nnoyed when people talk about your drinking? Y N
- Do you feel **G**uilty about your drinking? Y N
- Have you ever had an **E**ye-opener? (Drink first thing in the morning) Y N
- Total score _____

Screen is positive if:

- Consumption is greater than 14 drinks per week (males) or 7 drinks per week (females)
  OR
- Maximum number of drinks consumed is greater than 4 drinks per occasion (males) or 3 drinks per occasion (females)
  OR
- CAGE score is greater than 1

If drug or alcohol abuse is suspected, then ask…

1. Do you believe that you need treatment for your use of alcohol and/or drugs? Yes No
2. Medication treatment for HIV is affected by alcohol and/or drug use...
   Would you consider changing your behavior related to alcohol and/or drugs? Yes No
3. Would you consider a treatment program? Yes No

Stage I: Readiness Assessment

Comments:

_____

_____

_____

Outcome:

O Positive Assessment to Readiness *O Negative Assessment to Readiness*

Goals:

_____

_____

Environmental Assessment

1) *HOUSING*

Do you have stable housing? (mortgage, lease and rent)	Yes	No
How long have you lived at your current address?	_____	
Do you plan to move in the next 2-3 months?	Yes	No
Do you have a refrigerator in you home?	Yes	No
Do you have an adequate supply of food & water there?	Yes	No
Where do you keep your medication(s)?	_____	
Do you believe they are safe?	Yes	No

Housing Status	Permanent	Non Permanent	Institution

Comments:

_____

_____

2) *FAMILY/HOUSEHOLD*

Who lives there?

_____

_____

Are they aware of your diagnosis?	Yes	No	N/A
Are they supportive of your treatment?	Yes	No	N/A
Would they be supportive if you began medications?	Yes	No	N/A
Would you feel the need to hide your medications from anyone?	Yes	No	N/A
If children are present in the home at any time, will the medications be in a safe place?	Yes	No	N/A

Could anyone who lives with you assist you in taking medication? Yes No N/A

Do you believe you have an adequate support system? Yes No N/A

(family, friends, neighbors, peers, support groups, etc.)

Comments:

_____

_____

_____

3) *EMPLOYMENT*

Do you work? Yes No N/A

Is your employer aware of your diagnosis? Yes No N/A

Are your co-workers aware of your diagnosis? Yes No N/A

Do you have a regular work schedule? Yes No N/A

If "no," please explain how varied your schedule might be:

_____

_____

If you had to take medication at work, would this be difficult? Yes No N/A

_____

_____

Comments:

_____

_____

_____

4) *LEGAL*

Are there any divorce/separation concerns? Yes No N/A

Is there any other relationship issues (i.e., restraining order)? Yes No N/A

Are there any issues of child custody/child support? Yes No N/A

Any civil/criminal concerns (including drug related)? Yes No N/A

Any other legal issues that would involve the courts? Yes No N/A

Comments:

_____

_____

_____

Stage I: Readiness Assessment

5) *DAILY ROUTINE*

What is your weekday (M-F) routine that includes meals and sleep?

_____

What is your routine on the weekends? _____

_____

Comments:

_____

_____

**Barriers identified in sections 1-4 determine outcome. Section 5 is informational only.*

Comments:

_____

_____

_____

Outcome:

○ Positive Assessment to Readiness *○ Negative Assessment to Readiness*

Goals:

_____

_____

Stage I: Readiness Assessment

Cognitive Assessment (Functional) *

Intellectual/Medication History

Skill	Goal	Process	Assessment	
1. Ability to manage own medicine.	Determine if client or family member has managed medication in the past.	Ask client, "Do you take your own medications? Do you fill your own pillbox?	Yes	No
2. Ability to read prescriptions	Standard CCHS 10 points font label. 6 lines peer label	Are you able to read this label?	Yes	No
3. Ability to open/close child resistant cap	Determine if client can open and close a **non**-child resistant resistant cap on a pill bottle.	"Can you open this bottle?"	Yes	No
4. Ability to open/close non child resistant cap	Determine if client can open and close a child resistant cap on a pill bottle.	"Can you open this bottle?"	Yes	No
5. Ability to remove pills from bottle	Determine if client can remove 2 dipyridamole 50mg tablets from a bottle containing 6 tablets	"Can you remove 2 tablets from this bottle?"	Yes	No
6. Ability to describe a TID regimen	Determine dosing interval	"If you had to take pills three times a daily how would you take them?"	Yes	No
7. Ability to differentiate tablets by color	Determine if client can discern pills by color. Using Levothyroxine various strengths and colors ask client to remove specific color pill.	" Can you remove the purple pill from this bottle?"	Yes	No
8. Ability to obtain refills on medication from pharmacy	Standard CCHS 10 point font label. 6 lines label.	What phone number do you call when you need more medicine? Can you recognize the prescription number? Can you locate the number of refills listed on the RX label?"	Yes	No

If any of the above answers are "no" please address skill/goal setting:

_____

_____

_____

_____

_____

_____

Modified Meyer Assessment

- Meyer ME, Schuna AA. Assessment of Geriatric clients' Functional Ability to take Medication. DICP 1989,23: 171-4

Stage I: Readiness Assessment

Intellectual Assessment

re: Literacy & School (refer to Social Work/ assessment form for details)

Medication History

Do you have trouble swallowing pills?	Yes	No
Have you ever taken antibiotics?	Yes	No
If yes, did you take it as prescribed and finish all of the medication?	Yes	No
Have you, or do you, take medication for any health condition?	Yes	No
Did you, or do you take the medication as prescribed?	Yes	No
Have you taken care of an ill family member or child?	Yes	No
Were you able to give medicine as prescribed?	Yes	No

Comments:

How important are the following things to you in taking medication:

	Important	Neutral	Not Important
How many times I have take the medicines (2 vs.3 x/day)			
How many pills I have to take			
How I have to store the medicines (refrigerator)			
Whether I need to take them with or without food			
How much the medicines cost			
Whether I need to change my current medicines to avoid possible drug interactions			
Whether I can tolerate possible uncomfortable side effects			
Whether or not the medicine will work			

Outcome: ○Positive Assessment to Readiness ○ Negative Assessment to Readiness

Stage I: Readiness Assessment

Attitudinal Assessment/Belief System

Disease

Do you believe:

HIV is the virus that causes AIDS and you have HIV?	Yes	No
HIV/AIDS is a serious health problem and may lead to death?	Yes	No
HIV is affecting your body even though you don't feel it?	Yes	No
Treatment for HIV is necessary to stay well?	Yes	No
Do you try to forget your HIV infection?	Yes	No

Comments:

_____

_____

_____

Healthcare Provider

Do you feel comfortable telling the staff here your health concerns?	Yes	No
The staff here is primarily white; do you feel that we care about and/or give equal treatment to? … Persons of all races?	Yes	No
people with different sexual orientations?	Yes	No
persons with substance use problems?	Yes	No
Do you feel there would be any repercussions if you told us you did not think you were able to do, or did not want to do what we recommend?	Yes	No
Are you aware that if you chose not to take medication for HIV that we will follow your other health care needs?	Yes	No
Are you aware of Tuskegee or "Bad Blood" study?	Yes	No
If so, do you think that could happen again or happen here?	Yes	No

Comments:

_____

_____

_____

Medication

What are your memories and/or experiences of taking medicines in the past?

_____

_____

Stage I: Readiness Assessment

Do you know any one who has HIV and has taken medication? Yes No

If yes, what is your understanding of their experience with medicines?

_____

_____

_____

Do you want to take medicine for HIV? Yes No

If yes; are you willing to take AZT? Yes No

Are any family members/significant others encouraging you to take medicines? Yes No

Do you feel you have to take the medicine either for yourself or someone else? Yes No

Are you taking medicine to please someone else? Yes No

Will taking medicine everyday remind you of your HIV? Yes No

If yes, do you think this will be helpful or harmful?

_____

_____

_____

Wanting to do and able to do are two completely different things; do you think you are able to do this?

Yes No

_____

_____

_____

Comments:

_____

_____

_____

Outcome:

O Positive Assessment to Readiness *O Negative Assessment to Readiness*

Goals:

_____

_____