

**STRONG: Statement of Treatment Requested, Ongoing Needs and Goals.**

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**PART 1- ME,**

Name:	Date of Birth:
Best contact number:	Address:
Other phone number(s):	
Email Address:	Postcode:

What I want you to know about me;

**PART 2- THE PROBLEM,**

The problem I am looking for help with is;

What I want to achieve with this help is;

The most important thing to me right now is;

**PART 3- HOW YOU CAN HELP ME,**

How I would like you to treat me, what helps me and what I am proud of;

What does not help me, what sets me back and what I would like you to avoid doing;

Signed:

Date:

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**PART 4- I REQUEST THE FOLLOWING MEDICAL ASSISTANCE (circle Yes or No as appropriate).**

1. I request a prescription for opioid substituting medication	Yes/No	
- I would like to be prescribed a specific medication (if yes, pick one of the below)	Yes/No	
a) Methadone	Yes/No	
b) Buprenorphine Pills (i.e Subutex/Suboxone)	Yes/No	
c) Injected Buprenorphine (i.e Buvidal)	Yes/No	
d) Another opioid substituting medication (please specify below)	Yes/No	
- I feel that this medication suits me best because;		
- I would like my medication to begin on a specific date or timeframe if possible;		Yes/No
2. I request a prescription for another medication (or other medications) which I believe would be of benefit to me or would like to talk to a doctor about (if yes please specify below);	Yes/No	
- I feel that this medication would help me because;		
3. I request specific arrangements about where/how/how often I pick up medication (if yes please specify below);	Yes/No	
4. I request that the reasoning behind any decision that is taken about what medication(s) are appropriate to prescribe to me is explained to me by a doctor.	Yes/No	
5. I request residential rehabilitation.	Yes/No	
- I want to go to a specific rehabilitation service (if yes, please specify below);	Yes/No	
6. I request abstinence only treatment.	Yes/No	
7. I request a referral to mental health services for assessment.	Yes/No	
- I have specific mental health difficulties which I need help with (if yes, please specify below);	Yes/No	
8. I request medical assistance with the following physical health difficulties (if yes, please specify below);	Yes/No	
9. I request Naloxone to take home with me.	Yes/No	
- I request training in how to use Naloxone to prevent accidental overdose.	Yes/No	
10. I request additional harm reduction supplies/training (if yes, please specify below);	Yes/No	

Signed:

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**PART 5- I REQUEST THE FOLLOWING ADDITIONAL SUPPORT FOR MY TREATMENT/RECOVERY (circle Yes or No as appropriate).**

1. I request advice and/or support and/or training to help me support my current employment or to help me find employment; - The problems I am having are;	Yes/No
2. I request advice and/or support to help me care for my child/children; - The problems I am having are;	Yes/No
3. I request advice and/or support to help me care for another adult/ other adults; - The problems I am having are;	Yes/No
4. I request advice and/or support with housing issues; - The problems I am having are;	Yes/No
5. I request advice and/or support with domestic or family abuse; - These issues are still ongoing; - The problems I am having are;	Yes/No Yes/No
6. I request advice and/or support around benefits; - The problems I am having are;	Yes/No
7. I request legal advice and/or support; - The problems I am having are;	Yes/No
8. There is something else that I want to ask for advice and/or support about; - The problems I am having are;	Yes/No

Signed:

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**PART 6- I REQUEST THAT THE FOLLOWING PEOPLE BE INVOLVED IN MY TREATMENT AND/OR RECOVERY.**

Name;	Relationship to me:
Telephone Number:	Postal Address:
Alternate Number:	
Email address:	Post Code:
Please contact this person - Yes/No	
Name;	Relationship to me:
Telephone Number:	Postal Address:
Alternate Number:	
Email address:	Post Code:
Please contact this person - Yes/No	
Name;	Relationship to me:
Telephone Number:	Postal Address:
Alternate Number:	
Email address:	Post Code:
Please contact this person - Yes/No	
Name;	Relationship to me:
Telephone Number:	Postal Address:
Alternate Number:	
Email address:	Post Code:
Please contact this person - Yes/No	

**PART 7- I REQUEST THAT THE FOLLOWING PEOPLE NOT BE INVOLVED IN MY TREATMENT AND/OR RECOVERY, BUT I FEEL THAT YOU NEED TO KNOW ABOUT THEM.**

Name;	Why you need to know about them;
I believe this person is a threat to my safety - Yes/No	
Name;	Why you need to know about them;
I believe this person is a threat to my safety - Yes/No	
Name;	Why you need to know about them;
I believe this person is a threat to my safety - Yes/No	
Name;	Why you need to know about them;
I believe this person is a threat to my safety - Yes/No	

Signed:

Date:

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## PART 8 – WHAT I GIVE MY CONSENT FOR YOU TO DO WITH THIS DOCUMENT.

1. This document is a record of my personal information, including information about my health and medical treatment. It is protected under the General Data Protection (GDPR) act (2018) under the category of sensitive information. This document, in almost all circumstances, must not be shared without my consent.

In all cases where I give consent for my information to be shared, stored and processed, I request that it be shared, stored and processed in line with GDPR regulations regarding sensitive information.

I consent to this document being shared with, stored and processed by NHS organisations, as necessary to facilitate my treatment and inform relevant medical professionals about my needs.	Yes / No
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I consent to this document being shared with, stored and processed by third sector support organisations (such as Turning Point Scotland or Change Grow Live) as necessary to facilitate their support and inform relevant professionals about my needs.	Yes / No
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I consent to this document being shared with, stored and processed by the local authority and organisations employed by the local authority to carry out statutory duties of care (such as social work or housing associations) as necessary to facilitate my treatment and inform relevant professionals about my needs.	Yes / No
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I consent to this document being shared with, stored and processed by advocacy organisations (such as AdvoCard or Partners in Advocacy) who I have engaged to work on my behalf, as necessary to act on my instructions.	Yes / No
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I consent to this document being shared with, stored and processed by lawyers, solicitors or other legal organisations who I have engaged to work on my behalf, as necessary to act on my instructions.	Yes / No
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I consent to this document being shared with, stored and processed by third sector advice organisations (such as Citizen's Advice or Shelter) as necessary to facilitate their support and inform relevant professionals about my needs.	Yes / No
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I completed this form with assistance; -I received assistance from;	Yes / No
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Name:	Relationship to me:
Telephone Number:	Postal Address:
Alternate Number:	
Email address	Post Code:
This person gave their permission to be contacted regarding this document – Yes/No	

Please treat the requests that I have made, and the views that I have expressed, in this document as you would treat requests I had made or views I had expressed to your organisation in person, in writing or by any other means of communication.

Signed:

Date: