Client Identification Code…….. Client DOB…….

Appendix 1: RGT DRF Data collection tool (example)

Patient Details:

Name

Address (including postcode)

Date of Birth (DD/MM/YYYY)

Gender:

☐ Male ☐ Female ☐Transgender ☐ Not stated

Employment status:

☐ Employed

☐ Unemployed and seeking work

☐ A student in full or part time education or training

☐ Long-term sick or disabled and receiving benefits

☐ Homemaker looking after the family home

☐ Not in work or actively seeking work, and not receiving benefits

☐ In prison, in care or seeking asylum

☐ Unpaid voluntary worker

☐ Retired

☐ Not stated

Relationship status:

☐ Not known

☐ Divorced/Dissolved Civil Partnership

☐ Separated

☐ Single

☐ Widowed

☐ In a relationship

☐ Married/Civil partnership

☐ Not stated

Client Identification Code…….. Client DOB…….

Ethnic Background:

☐ White British
☐ White Irish
☐ White European
☐ White: Other
☐ Black, Black British: African
☐ Black, Black British: Caribbean
☐ Black, Black British: Other
☐ Asian, Asian British: Bangladeshi
☐ Asian, Asian British: Indian
☐ Asian, Asian British: Pakistani
☐ Asian, Asian British: Chinese
☐ Asian, Asian British: Other
☐ Mixed: White and Asian
☐ Mixed, White and Black African
☐ Mixed: White and Black Caribbean
☐ Mixed: Other
☐ Any other ethnic group

Additional Client Diagnosis: (Is the client receiving treatment for any other mental health problem?)

☐ Yes - Pharmacological
☐ Yes - Psychological
☐ Yes – both psychological and pharmacological
☐ No
☐ Declined to Disclose

Client Identification Code…….. Client DOB…….

Gambling History:

What are your main types of Gambling: (Put a number '1' against the one you do most, '2' against the next and so on). You do not need to enter a number for those that do not apply

Bookmakers		Bingo Hall		Casino	
Horses	Dogs	Live draw	Terminal	Poker	Other card games
Sports or other events	Gaming Machines	Skill machines	Gaming machines	Roulette	Gaming Machines
Other (please specify)		Other (please specify)		Other (please specify)	

Live events	Adult entertainment centre (18+Arcade)	Family entertainment centre (Arcade)	Pub
Horses	Gaming Machines	Gaming Machines	Gaming Machines
Dogs	Skill prize machines	Skill prize machines	Sports
Sports or other event	Other	Other	Poker
Other			Other

Online			Miscellaneous				
Horses	Dogs	Spread betting	Private /organised card games	Lottery National / other	Football pools	Scratch cards	Service station (gaming machine)
Sports events	Bingo	Poker	Private Members Club				
Casino (Table games)	Casino (slots)	Scratchcards	Poker	Other card games	Gaming machines	Other	
Betting Exchange	Other		Other (please specify)				

Length of time gambling:

Years…….. Months……..

Job loss through gambling?

☐ Yes ☐ No ☐ Declined to respond ☐ Unknown

Relationship loss through gambling?

☐ Yes ☐ No ☐ Declined to respond ☐ Unknown

Client Identification Code…….. Client DOB…….

Age of onset of problem gambling?

Years……..

Early big win?

☐ Yes ☐ No ☐ Declined to respond ☐ Unknown

Debt due to gambling?

☐ Declined to respond
☐ No
☐ Under £5000
☐ £5000 - £9999
☐ £10,000 - £14,999
☐ £15,000 - £19,999
☐ £20,000 - £99,999
☐ £100,000 or more
☐ Bankruptcy
☐ In an IVA
☐ Don't know (some)

How many days in the last 30 would you say you have gambled?

……..

How much money do you spend on average gambling on a typical gambling day?

……

How long do you spend on average gambling on a typical gambling day?

……

How much money do you spend in a month on gambling (total gambling expenditure minus total gambling wins)?

……

Client Identification Code…….. Client DOB…….

Referral details:

Referral Source:

☐ GP
☐ Health visitor
☐ Other primary healthcare
☐ Self referral
☐ Carer
☐ Social Services
☐ Education Service
☐ Employer
☐ Police
☐ Courts
☐ Probation Service
☐ Prison
☐ Court Liaison and Diversion Service
☐ Independent Sector Mental Health Services
☐ Voluntary Sector
☐ Accident and Emergency Department
☐ Mental Health NHS Trust
☐ Asylum Services
☐ Drug Action Team/Drug Misuse Agency
☐ Jobcentre Plus
☐ Other service or agency

Date referral received (DD/MM/YYYY)…….

Referral Accepted?

☐ Yes ☐ No

Referral reason:

☐ Problem Gambler ☐ Affected other
☐ Person at risk of developing a gambling problem

Recurrence (Has the client been in treatment for this problem before)?

☐ Not stated ☐ Yes ☐ No ☐ Unknown

Reason for end of treatment:

ASSESSED ONLY:

☐ Not suitable for service – no action taken or directed back to referrer
☐ Not suitable for service – signposted elsewhere with mutual agreement of client
☐ Discharge by mutual agreement following advice and support
☐ Referred to another therapy service by mutual agreement
☐ Suitable for service, but client declined treatment that was offered
☐ Deceased (assessed only) ☐ Not known (assessed only)

Client Identification Code…….. Client DOB…….

ASSESSED AND TREATED:

☐ Completed scheduled treatment

☐ Dropped out of treatment (unscheduled discontinuation)

☐ Referred to other service

☐ Deceased (assessed and treated)

☐ Not known (assessed and treated)

Client Identification Code…….. Client DOB…….

Appointment Details (to be recorded for every appointment)

Date of appointment (DD/MM/YYYY) ……..

Unique caregiver code ……..

Attendance:

☐ Attended on time, or if late, before the caregiver was ready to see the client

☐ Arrived late, after the caregiver was ready to see the client, but was seen

☐ Client arrived late and could not be seen

☐ Appointment cancelled by or on behalf of the client

☐ Did not attend – no advance warning given

☐ Appointment cancelled by or on behalf of the caregiver

Contact duration: Minutes……..

Appointment purpose:

☐ Assessment

☐ Treatment

☐ Assessment and treatment

☐ Review only

☐ Review and treatment

☐ Follow-up appointment after appointment end

☐ Other

☐ Not recorded

Appointment medium:

☐ Face to face communication

☐ Web camera (e.g. Skype)

☐ Email

☐ Telephone

☐ Online chat

☐ Short Message Service (SMS)

Intervention given: (Will need service input to ensure full range of interventions covered)

☐ CBT

☐ Residential programme

☐ Other (please specify)

☐ Counselling

☐ Brief advice

Client Identification Code…….. Client DOB…….

Problem Gambling Severity Index

Thinking about the last 12 months (assessment) or last 2 weeks (post-treatment)

Have you bet more than you could really afford to lose?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Have you needed to gamble with larger amounts of money to get the same feeling of excitement?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

When you gambled, did you go back another day to try to win back the money you lost?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Have you borrowed money or sold anything to get money to gamble?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Have you felt that you might have a problem with gambling?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Has gambling caused you any health problems, including stress or anxiety?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Has your gambling caused any financial problems for you or your household?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Have you felt guilty about the way you gamble or what happens when you gamble?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Total Score …….

Score of 0 = Non-problem gambling.
Score of 1 or 2 = Low level of problems with few or no identified negative consequences.
Score of 3 to 7 = Moderate level of problems leading to some negative consequences.
Score of 8 or more = Problem gambling with negative consequences and a possible loss of control.

Client Identification Code……. Client DOB…….

CORE-10

IMPORTANT – PLEASE READ THIS FIRST

This form has 10 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time
1 I have felt tense, anxious or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2 I have felt I have someone to turn to for support when needed	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3 I have felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4 Talking to people has felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5 I have felt panic or terror	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6 I made plans to end my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7 I have had difficulty getting to sleep or staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8 I have felt despairing or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9 I have felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10 Unwanted images or memories have been distressing me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Total (Clinical Score*) ☐

* **Procedure**: Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.

Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE