END OF CAP TREATMENT PATIENT EVALUATION FORM

COUNSELLOR NAME: _____

PATIENT NAME: _____

TRIAL ID: _____

DATE OF DISCHARGE: _____ **(DD/MM/YYYY)**

1. Reason for discharge (Tick ONLY ONE response)

1.1 Planned discharge □
1.2 Drop out (i.e. 3 missed appointments) □
1.3 Change in place of residence□
1.4 Death of patient□
1.5 Referral out of the program (specify to whom and for what reason) □

1.6 Refusal to continue with treatment (specify reason for refusal) □

1.7 Other (Please specify) □

2. What was the overall response of the patient to the treatment? (Tick ONLY ONE response)

2.1 Recovered□

2.2 Partly improved□

2.3 No change□

2.4 Worsened□

2.5 Explain your rating in the box below

3. What strategies were the most helpful? (Tick all that apply)

3.1 Personalized feedback□

3.2 Problem solving□

3.3 Drink refusal skills□

3.4 Handling emotions□

3.5 Handling drinking urges□

3.6 Developing motivation for change□

3.7 Involving the SO□

3.8 Any other (Please give details below) □

3.9 Explain why these were the most useful strategies

4. What were the barriers to successfully delivering the treatment? (Tick all that apply)

4.1 Patient did not respond to the treatment□

4.2 Patient did not follow through on the treatment expectations, e.g. homework□

4.3 Patient did not have time□

4.4 Patient was not cooperative□

4.5 Family was not cooperative□

4.6 Patient could not understand a concept or strategy □

4.7 Patient had a physical illness□

4.8 Counsellor related issues (Please specify) □

4.9 Any other (Please specify)

4.10 Please elaborate your response below