05.13

BUPRENORPHINE/NALOXONE MAINTENANCE TREATMENT
INTAKE QUESTIONNAIRE FOR PATIENT
TREATMENT-PLANNING QUESTIONS

2594 Highway 34 East #B Newnan, GA 30265
Phone: (770) 252-3760 Fax: (678) 298-7637 Email: office@curecounseling.com

NAME_____DATE_____

PLEASE ANSWER THE FOLLOWING QUESTIONS WHICH WILL HELP US DESIGN YOUR PLAN OF TREATMENT:

WHAT IS THE BEST TIME OF DAY AND DAY OF THE WEEK FOR YOU FOR CLINIC VISITS?

_____

ARE THERE ANY MONTHS OUT OF THE YEAR WHEN YOU MAY HAVE DIFFICULTY MAKING IT IN FOR APPOINTMENTS?

_____

IS THERE ANY PROBLEM THAT MAKES IT HARD FOR YOU TO GIVE ROUTINE URINE SPECIMENS?

_____

DO YOU HAVE ANY DISABILITIES THAT MAKE IT HARD FOR YOU TO READ LABELS OR COUNT PILLS?

_____

WHAT ARE YOUR REASONS FOR BEING INTERESTED IN BUPRENORPHINE/NALOXONE TREATMENT?

_____

_____

_____

WHAT 'TRIGGERS' DO YOU KNOW WHICH HAVE PUT YOU IN DANGER OF RELAPSE IN THE PAST OR WHICH MIGHT IN THE FUTURE?

_____

_____

_____

WHAT COPING METHODS HAVE YOU DEVELOPED TO DEAL WITH THESE TRIGGERS TO RELAPSE?

_____

_____

_____

WHAT PLANS DO YOU HAVE FOR THE COMING YEAR?
WORK?_____
HOME?_____
OTHER?_____

WHAT KINDS OF HELP WOULD YOU LIKE FROM YOUR COUNSELOR?

_____
_____

WHAT ARE YOUR STRENGTHS AND SKILLS TO HANDLE TAKE-HOME BUPRENORPHINE/NALOXONE (SUBOXONE)?

_____
_____

WHAT WORRIES DO YOU HAVE ABOUT EXTENDED TAKE-HOMES?

_____

IS ANYONE IN YOUR HOME ACTIVELY ADDICTED TO DRUGS OR ALCOHOL? _____

WHAT ARE THE MAJOR SOURCES OF STRESS IN YOUR LIFE?

_____

WHAT FAMILY OR SIGNIFICANT OTHERS WILL BE SUPPORTIVE TO YOU DURING YOUR TREATMENT?

_____

WOULD YOU BE WILLING TO SIGN A RELEASE SO THAT THE PERSON(S) IDENTIFIED ABOVE CAN BE SPOKEN TO REGARDING YOUR TREATMENT?

_____

WHAT MEDICAL CARE WILL YOU HAVE IN THE COMING YEAR?

_____

HOW WILL YOU COMPLY WITH THE ANNUAL PHYSICAL EXAMINATION AND LABORATORY AND URINE TESTING REQUIREMENTS?_____

_____

HAVE YOU EVER BEEN TREATED FOR A PSYCHIATRIC PROBLEM OR MENTAL ILLNESS OR PRESCRIBED PSYCHIATRIC MEDICATIONS?

_____

BUPRENORPHINE TREATMENT
INTAKE HISTORY AND PHYSICAL

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NAME: _____ DATE: _____

Chief Complaint:

_____

***Opiate use History*:**

Yrs./mos. of use: _____ Route of Admin.: _____

Current length of continuous use: _____

Amount of current use: _____ Last use date/time: _____

Present symptoms:

_____

_____

History of drug abuse treatment:

_____

_____

***Medical History*:**

Allergies: _____

Current meds: _____

Medical/ psychiatric problems: _____

_____

Hospitalizations/surgery: _____

_____

Psychiatric treatment: _____

_____

Hepatitis: _____ SBE: _____ HIV: _____ TB: _____ STD: _____

(Women) LMP: _____ G: ___ P: ___ TAB: ___ SAB: ___ Contraception:_____

ROS: _____

_____

Other Drug Abuse History:

Cocaine/Stimulant: _____ Current amount:_____ Mos/Yrs of Use:___ Last Use:___

Route:____ Medical/Psychiatric Complications of Use:_____

_____

Alcohol: Current amount:_____ Mos/Yrs of Use:_____ Last

Use:_____ Medical/Psychiatric Complications of Use:_____

_____

Benzodiazepines: _____ Current amount:_____ Mos/Yrs of Use:_____

Last Use:___ Route:____ Medical Complications of Use:_____

_____

Marijuana: _____ Current amount:_____ Mos/Yrs of Use:___ Last Use:___

Medical/Psychiatric Complications of Use:_____

_____

Caffeine: Current use:_____ Mos/Yrs of Use:_____

Nicotine/Cigarettes: _____ Pack years:_____

Nutrition History: _____

_____

_____

_____

BUPRENORPHINE/NALOXONE TREATMENT AGREEMENT

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Patient Name:_____ MR#: _____

I am requesting that my doctor provide buprenorphine/naloxone treatment for opioid _____ addiction. I freely and voluntarily agree to accept this treatment
list drug(s)
agreement, as follows:

(1) I agree to keep, and be on time to, all my scheduled appointments with the doctor and his/her assistant.

(2) I agree to conduct myself in a courteous manner in the physician's or clinic's office.

(3) I agree to pay all office fees for this treatment at the time of my visits. I will be given a receipt that I can use to get reimbursement from my insurance company if this treatment is a covered service. I understand that the medication cost is separate from the office visit charge.

(4) I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not see me and I will not be given any medication until my next scheduled appointment.

(5) I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.

(6) I understand that the use of buprenorphine/naloxone by someone who is addicted to opioids could cause them to experience severe withdrawal.

(7) I agree not to deal, steal, or conduct any other illegal or disruptive activities in the vicinity of the doctor's office or anywhere else.

(8) I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.

(9) I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.

(10) I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine/naloxone with other medications, especially benzodiazepines

(sedatives or tranquilizers), such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), and/or other drugs of abuse including alcohol, can be dangerous. I also understand that a number of deaths have been reported in persons mixing buprenorphine with benzodiazepines. I also understand that I should not drink alcohol while taking this medication as the combination could produce excessive sedation or impaired thinking or other medically dangerous events.

(11) I agree to take my medication as the doctor has instructed, and not to alter the way I take my medication without first consulting the doctor.

(12) I understand that medication alone is not sufficient treatment for my disease and I agree to participate in weekly counseling, in the recommended patient education and relapse prevention program, to assist me in my recovery.

(13) I understand that my buprenorphine/naloxone treatment may be discontinued and I may be discharged from the clinic if I violate this agreement.

(14) I understand that there are alternatives to buprenorphine/naloxone treatment for opioid addiction including:

a. medical withdrawal and drug-free treatment
b. naltrexone treatment
c. methadone treatment

My doctor will discuss these with me and provide a referral if I request this.

_____ _____

Patient's Signature Date

_____ _____

Witness Signature Date

INITIAL PATIENT CONTACT ABOUT BUPRENORPHINE

2594 Highway 34 East #B Newnan, GA 30265

Phone: (770) 252-3760 Fax: (678) 298-7637 Email: office@curecounseling.com

(For use by treatment program personnel who answer inquiries about buprenorphine/naloxone treatment)

Intake Form for Opiate Patients

Name: _____ **Date**: :_____/_____/20____

Sex: Male __ Female __ Age: _____ Date of Birth: ___/___/_____

Home Address: _____

City: _____ State: _____ Zip: _____

Please provide all contact numbers:

Cell Phone:(_____)_____-_____ Home Phone:(_____) _____-_____

Work phone:(_____)_____-_____Email:_____

REQUIREMENTS: ***(check if discussed with patient)***

The following are required of patients who are admitted to a buprenorphine/naloxone treatment slot:

__ Actively addicted to heroin or prescription opioids or currently taking methadone (methadone dose 30 mg daily or less)

__ You need to be in withdrawal to be seen by the physician

__ One time blood work to be performed at an outside lab/Patient responsible for payment at that time

__ Initial visit: Evaluation, Assessment and Physical Exam performed on site - $250

__ Requirement - Initial visit and every visit: Urine Drug Screen performed on site - $35

__ Monthly visits are required after initial consult - $175. Monthly visit fee does not include the cost of medication.

__ Requirement: Weekly attendance in substance abuse counseling, which can be scheduled here.

__ Agrees to sign a release of information to talk to all other doctors and counselors

__ Payment is always made before service is rendered at each visit. Physician does not accept insurance. Cash, money order and credit cards are accepted. Insurance may be utilized for counseling services.

INITIAL PATIENT CONTACT ABOUT BUPRENORPHINE

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(For use by treatment program personnel who answer inquiries about buprenorphine/naloxone treatment)

__ Appointment cancellation requires a 48-hour advance notice. Not showing up for an appointment without sufficient notice is grounds for discharge from the program, as space is limited. After that, new patient enrollment will be necessary to begin treatment again.

__ Complete Registration Pak for Dr. Solomon can be downloaded from the CURE Website at www.curecounseling.com. Downloads, Opiate Registration Pak. Or arrive 30 minutes early for completion of paperwork in office.

QUESTIONS:

1. What kind of Opioids/Narcotics medication are you using/taking?
   __Lortab __Lorcet __Hydrocodone __Oxycodone __Roxycodone __Vicodin
   __Methadone __other _____

2. Are you taking any benzodiazepine? __No __Yes (If yes, what kind?)
   __Valium __Xanax ___Ativan ___Klonopin __Other _____

3. Do you use other drugs? __Cocaine __Meth __Heroine __Alcohol __Other _____

CONFIDENTIALITY: ***(check if discussed with patient)*** ___Patient confidentiality discussed

INSTRUCTIONS FOR INITIAL APPOINTMENT:

(check when discussed with patient)

__ Arrive with a full bladder as a urine drug test will be taken

__Bring completed forms or come early to complete

__Withdrawal, (if methadone, more than 24 hours since dose); heroin or short acting opioids at least 12 hours since last use; withdrawal symptoms must be observable by staff before induction can take place

__Bring ALL pill bottles

__Valid photo ID

Appointment: Date: _____ 20____ Time:_____:_____ AM PM