Patient Name: ______________________________________ D.O.B.___________________ Date: __________________

INTAKE ASSESSMENT FORM
(Opioid-Dependent Treatment)

This questionnaire must be completed prior to your appointment with The HEAG Pain Management Center. Your careful answers will help us to understand your pain problem, and design the best treatment program for you. It is understandable that you might be concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential and no outsider is permitted to see your case record without your written permission.

NAME: ____

DOB: ____

SEX: ☐ Female ☐ Male ☐ Other

Current Address: ____

City: ____ State: _________________ Zip:__________________________

Telephone: Home: ____

Work: ____

Mobile: ____

Follow-Up

____

Patient Signature

Patient Name: ______________________________________ D.O.B.___________________ Date: __________________

Therapy Progress Report

SUBOXONE®© (buprenorphine HCl/naloxone HCl dehydrate) sublingual tablet

Please answer the questions using the following scale:					
	0 = not at all			**4 = extremely**	
NOW	**0**	**1**	**2**	**3**	**4**
1. I feel anxious	◯	◯	◯	◯	◯
2. I feel like yawning	◯	◯	◯	◯	◯
3. I am perspiring	◯	◯	◯	◯	◯
4. My nose is running and/or my eyes are watery	◯	◯	◯	◯	◯
5. I have goose bumps and/or chills	◯	◯	◯	◯	◯
6. I feel nauseated or like I may need to vomit	◯	◯	◯	◯	◯
7. I have stomach cramps and/or diarrhea	◯	◯	◯	◯	◯
8. My muscles twitch	◯	◯	◯	◯	◯
9. I feel dehydrated and/or have not had much appetite	◯	◯	◯	◯	◯
10. I am having difficulty sleeping	◯	◯	◯	◯	◯
11. I have a headache	◯	◯	◯	◯	◯
12. My muscles and bones ache	◯	◯	◯	◯	◯
13. I feel like using right now	◯	◯	◯	◯	◯
14. I would rate my overall level of withdrawal as:	◯	◯	◯	◯	◯
15. Do you feel you need a dosage change?	◯ No	◯ Yes	◯ Up	◯ Down	
16. Have you used alcohol or drugs since your last visit?	◯ No	◯ Yes			

If yes, please describe what, when and how much: ____
____

Please describe the problems or situations you found most stressful during the past week (if needed, use back of page): ____
____

Completed by Physician

S/O)	
A)	**P)**

____

Physician Signature Date

FOLLOW-UP

Patient Name: ______________________________________ D.O.B.___________________ Date: __________________

Adverse events since the last visit? ☐ Yes ☐ No Describe: ____

____

Signs of Intoxication? ☐ Yes ☐ No Describe: ____

____

Any use of unauthorized substance since last visit? ☐ Yes ☐ No

Substances used, quantity, frequency: ____

____

What were the circumstances surrounding use (i.e. what stressors or triggers)? _______________________________________

____

____

Were these triggers previously identified? ☐ Yes ☐ No

If 'no' explore new 'trigger' circumstances: ____

____

____

If 'yes' explore further how patient came to be in this situation and why use occurred: ___________________________________

____

____

How did using make the patient feel? ____

____

____

Dose adjustment necessary? ☐ Yes ☐ No New dose: ____

Other medications necessary? ☐ Yes ☐ No List: ____

____

____

Notes: ____

____

____

____

Patient Signature

Follow-Up

Patient Name: ______________________________________ D.O.B.___________________ Date: __________________

PILL COUNT

1) Please complete this form **each and every time** you make an office visit. You should also bring your pill bottles and all remaining pills with you.
2) Entries should be made for all medications prescribed by The HEAG Pain Management Center. Incomplete or partial entries will be counted as non-compliance and may result in release from the clinic. If you leave your pills in a pill organizer at home, and your count is deficient it would be counted as non-compliant.
3) **Absolutely no refill** will be allowed if this form is **not** completed and signed by the patient.
4) You are **responsible** for the **safety** of **all** your scheduled medications at **all** times. This includes when you are in the office of The HEAG Pain Management Center.
5) It is important to know that the vast majority of prescription drug crimes in the USA are felonies, making abusers subject to possible penitentiary sentences. In addition to selling prescription drugs, the act of doctor shopping, forging, or altering prescription drugs and various other pharmaceutical scams are serious felonies in North Carolina and other states. One dangerous activity is for people to give or exchange their prescription drugs with friends or family members. This activity is not only physically dangerous, but legally is the same felony offense as selling your drugs to another.
6) I have read and I clearly understand the content of this form. I certify that I have truthfully completed this form in full. I have been made aware that I will be released immediately and no scheduled drugs will be prescribed if I engage in any of the prescription drug crime discussed above. I have been told that I could be released even if it is only suspected that I have engaged in any prescription drug crime anywhere in the USA. I will also be released immediately if my pill count shows discrepancies. By signing my signature I accept the conditions for release.

Follow-Up

____

Patient Signature

Patient Name: ______________________________________ D.O.B.___________________ Date: __________________

PILL COUNT (cont'd)

Medications	**Dosage**	**How often was med *Prescribed* to be taken**	**How often did you *Actually* take medication?**	**Date and time you took the *last dose*?**	**How many pills left in bottle?**	**Total # of pills Dispensed**	**Fill Date**

If your count is deficient, please copy this statement in box below in your own handwriting or your representative's handwriting.

"My oxycodone is short by 10 pills because……."(example)

____

____

____

____

____

____

____

Patient Signature____ Date ______________________

Representative Signature ____ Date______________________

HEAG Staff:____ Date: __________________________

Witness: ____ Date: __________________________

Follow-Up

Patient Name: _______________________________________ D.O.B.___________________ Date: __________________

Patient Treatment Contract

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. 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 any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or their sources without telling my treating physician.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).
14. I agree to provide random urine samples and have my doctor test my blood alcohol level.
15. I understand that violations of the above may be grounds for termination of treatment.

Form-Up

____

Patient Signature Date

____

Physician Signature Date

Patient Name: ______________________________________ D.O.B.___________________ Date: __________________

Counseling

Counseling is a very important aspect of your treatment.

Please call 1-866-973-HERE (4373) and speak with a care coordinator who will assist you in enrolling in the counseling program.

Failure to do so may result in discontinuing your treatment.

By signing my name below, I certify that I have been given directions to help me enroll in a counseling serviced and promise to bring evidence of my enrollment to my next office visit. I also understand that not complying with this can result in my immediate release from the treatment.

____

Patient Signature Date

Follow-Up