Telephone Screen for Buprenorphine

Demographic Info

How did you hear about the hotline?

□ Spouse □ Friend □ Physician

□ Flyer □ Parent □ State Hotline

□ Physician Locator □ Other: _____

Are you pregnant? □ Yes □ No □ Don't Know □ N/A

Are you taking birth control pills? □ Yes □ No □ N/A

Current Address _____

Phone _____ Is it OK to leave a message? □ Yes □ No

Emergency Contact _____ Phone _____

Is the Emergency Contact aware of your addiction? □ Yes □ No

Drug Use History

What are you currently using at this time?

□ Heroin – amount:

□ Oxycontin – amount:

□ Methadone – amount:

□ Percocet, vicodin, etc. – amount:

□ Cocaine – amount:

□ Benzos (klonopin, xanax, ativan, etc.) – amount:

□ Alcohol – amount:

□ Other: _____ – amount:

□ Nothing

Have you ever overdosed? □ Yes □ No

Number of lifetime overdoses _____

Have you ever been hospitalized due to an overdose? □ Yes □ No

If yes, were you kept overnight? □ Yes □ No

If yes, were you intubated? □ Yes □ No

Have you ever purchased opiates over the Internet? □ Yes □ No

Substance Abuse Treatment History

Have you had any substance abuse treatment? □ Yes □ No

If yes, how many times to each type?

_____ Detox Program

_____ Drunken Driver Program

_____ Residential (Rehab or Halfway House)

_____ Outpatient Counseling

_____ Buprenorphine/Suboxone maintenance

_____ Methadone maintenance

_____12 step programs (NA, AA)

_____Acupuncture

_____ Other: _____

How many attempts have you made to get clean? _____

Do you attend: AA___ NA ___ Other: _____

How many meetings do you attend each week?

□ 1-2 week

□ 3-4 week

□ 5-6 week

□ Daily

□ None

□ Other: _____

Have you worked the steps, and if so, what step are you on?

Do you have a sponsor? □ Yes □ No

How often do you have contact with your sponsor? _____

Do you have any history of any other addictive behaviors? □ Yes □ No

If yes:

□ Gambling

□ Sex

□ Shopping

□ Eating disorder (over eating, bulimia, anorexia)

□ Other: _____

<u>Criminal History</u>

Have you ever been arrested? □ Yes □ No

Have you ever been incarcerated? □ Yes □ No

How many times have you been incarcerated? _____

What is the longest period of time you spent in jail/prison? _____

Are you on probation? ☐ Yes ☐ No

Are you facing any potential jail time? ☐ Yes ☐ No

Do you have any outstanding legal issues? ☐ Yes ☐ No

If yes, can you tell us about them _____

_____

_____

Clean Time History

What was the longest period of time that you have been clean? _____

When was this? _____

What has triggered relapse in the past? _____

Methadone History

Have you ever been on Methadone Maintenance? ☐ Yes ☐ No

When were you on Methadone Maintenance? _____

Where were you on Methadone Maintenance? _____

How long were you on Methadone Maintenance? _____

What was your dose? _____

Why did you stop Methadone treatment? _____

_____

Are you currently on Methadone Maintenance? ☐ Yes ☐ No

What is your dose? _____

Where are you receiving services for your Methadone treatment? _____

What is the name of your counselor at your Methadone clinic? _____

How long have you been in your current Methadone Maintenance Program?

_____

Are you receiving take-homes? ☐ Yes ☐ No

If yes, how many? _____

What has your experience been like on Methadone?

☐ Extremely positive

☐ Positive

☐ Neutral

☐ Negative

☐ Extremely negative

<u>Suboxone History</u>

Have you ever been prescribed Suboxone before? ☐ Yes ☐ No

If yes, when were you on Suboxone? _____

What was your dose? _____

Why did you stop taking the Suboxone? _____

Are you still on Suboxone? ☐ Yes ☐ No

Have you ever tried Suboxone without a prescription? ☐ Yes ☐ No

Mental Health History

Have you ever been diagnosed with any mental health condition: ☐ Yes ☐ No

If yes, please specify: _____

☐ Depression ☐ Obsessive Compulsive Disorder (OCD)

☐ Anxiety ☐ Post Traumatic Stress Disorder (PTSD)

☐ Bipolar ☐ Attention Deficit Disorder

☐ Schizophrenia ☐ Panic Attacks

☐ Other: _____

Are you currently taking any medication for this/these problem(s)? ☐ Yes ☐ No

If yes, what medications are you taking? _____

_____

Are you currently seeing a psychiatrist, psychologist or counselor for this/these problem(s)?

☐ Yes ☐ No

Where do you see your psychiatrist, psychologist or counselor? _____

_____

What is this individual's name? _____

How often do you see them? _____

How many times have you seen this person in the last six months? _____ times

Will you sign a consent to release information so that we can communicate with your psychiatrist, psychologist or counselor about your treatment plan? ☐ Yes ☐ No

If not seeing a psychiatrist, psychologist or counselor why not? _____

_____

Have you ever been hospitalized for mental health issues? ☐ Yes ☐ No

Have you ever attempted to end your life or to hurt yourself? ☐ Yes ☐ No

How many times did you try to end your life or to hurt yourself? _____

Do you currently have thoughts about hurting yourself or ending your life?

☐ Yes ☐ No (If no, skip to homicide question)

Do you currently have a plan for how you would hurt yourself or end your life?

☐ Yes ☐ No

Do you have the means to carry out your plan? ☐ Yes ☐ No

Have you ever attempted or thought about homicide (killing someone else) in the past?

☐ Yes ☐ No (If no, skip to health care)

Have you thought about how you would do it? _____

_____

Are you presently thinking about killing someone? ☐ Yes ☐ No

Do you have the means to carry this out? ☐ Yes ☐ No

Have you been hurt physically, emotionally, or verbally by anyone in the last year?

☐ Yes ☐ No

Have you ever been asked to perform sexual acts that you did not want to do?

☐ Yes ☐ No

Do you have any concerns for your personal safety at this time?

□ Yes □ No

Health Status

Have you ever been diagnosed with any other medical conditions? Mark all that apply.

□ Diabetes (specify type): _____

□ Heart disease (specify type): _____

□ Cancer (specify type): _____

□ Asthma

□ Hepatitis C □ If yes, have you been treated? □ Yes □ No

□ Tuberculosis (TB)

□ Endocarditis

□ Abscesses

□ Skin infection

□ HIV □ If yes, are you currently in care? □ Yes □ No

□ Hepatitis B

□ Hepatitis A

□ Seizure disorder □ Are you on medications? □ Yes □ No

□ High Blood Pressure

□ Head Trauma/Injuries

□ Pancreatic Problems

□ Other (specify type): _____

□ None

Are you taking any other medications? □ Yes □ No

If yes, what medications are you taking? _____

Have you been tested for HIV? □ Yes □ No

If yes, did you go back for the results? □ Yes □ No

If yes, when was the last time you were tested?

Have you ever had surgery? ☐ Yes ☐ No

If yes, why did you have surgery? _____

Do you have any pending surgeries? ☐ Yes ☐ No

What kind of medical insurance do you have? (check all that apply)

☐ Medicare

☐ Medicaid

☐ Neighborhood Health Plan

☐ Hospital/Clinic Free Care

☐ CMA

☐ Private insurance (United, Blue Cross/Blue Shield)

☐ No insurance (self pay)

☐ HDAP

☐ Don't know

☐ Other: _____

Insurance Name:

Insurance Member #:

<u>Pain</u>

Do you have problems with pain? ☐ Yes ☐ No

Has your pain lasted three months or longer? ☐ Yes ☐ No

If yes, can you tell us what about your pain (what is it from, how often do you experience it, how are you dealing with it)? _____

_____

_____

Please rate your pain, on a scale from 0 – 10, without any pain medications (prescribed or not prescribed) _____

Have you been prescribed medications for your pain? ☐ Yes ☐ No

Which medication gives you the most pain relief? _____

_____

Have you tried other treatments, that did not include medications, for your pain? ie. Acupuncture, physical therapy, steroid injections, behavioral therapy, etc.

☐ Yes ☐ No

Physician Information

Where do you get most of your health care? _____

When was the last time you saw a doctor?

☐ Last week ☐ Within the past 6 months

☐ Last month ☐ Within the past year

☐ Within the past 3 months ☐ More than 1 year ago

What is the name of your doctor? _____

Do you know his/her phone number? _____

Employment

Are you currently employed? ☐ Yes ☐ No

If yes, what do you do for work? _____

Are you working full or part time? _____

What days of the week do you work, and how many hours per day do you work?

_____

Are you satisfied with your job? □ Yes □ No

Social Support

What is your relationship status?

□ Single (skip the next question)

□ Married

□ Long term relationship

□ Divorced

□ Other: _____

Do you live with your partner/significant other? □ Yes □ No

Has your partner or your significant other ever used drugs? □ Yes □ No

Is your partner/significant other currently in treatment? □ Yes □ No

If yes, what kind of treatment are they in?

□ Suboxone

□ Methadone

□ Abstinence

□ Other: _____

How satisfied are you with the support you get from your partner?

□ Very satisfied

□ Satisfied

□ Fairly satisfied

□ Not satisfied

□ N/A

Do you, or have you ever used at home? ☐ Yes ☐ No

If yes, who have you used with? _____

Is there someone whom you can turn to if you needed help in an emergency situation or got sick?

☐ Yes ☐ No

How is this person related to you?

☐ Partner/Spouse

☐ Friend

☐ Social Worker

☐ Other family member:

☐ Other: _____

Does this person know about your history of substance abuse?

☐ Yes ☐ No ☐ Don't know

Overall, how satisfied are you with the support you get from your friends?

☐ Very satisfied

☐ Satisfied

☐ Fairly satisfied

☐ Not satisfied

☐ N/A

<u>Family History</u>

Do any other family members have a history of substance use/abuse? ☐ Yes ☐ No

If yes, which family members?

☐ Father

☐ Mother

☐ Sibling

☐ Grandparent

☐ Other: _____

Are they currently using drugs or alcohol? ☐ Yes ☐ No

If yes, what are they using?

☐ Alcohol

☐ Heroin

☐ Cocaine

☐ Benzos

☐ Amphetamines/Methamphetamine

☐ Marijuana

☐ Other: _____

Overall, how satisfied are you with the support you get from your family members?

☐ Very satisfied

☐ Satisfied

☐ Fairly satisfied

☐ Not satisfied

☐ N/A

<u>Transportation</u>

How do you get around?

☐ I drive ☐ Do you have your own car? ☐ Yes ☐ No

☐ Public Transportation

☐ Walk

☐ I get a ride from a family/friend

☐ Other: _____

Do you have a drivers license? ☐ Yes ☐ No

How would you get to the office if you needed to get here?

□ I would drive

□ Public Transportation

□ I would walk

□ I get a ride from a family/friend

□ Other: _____

Would you be able to come into the office with 48 hours notice? □ Yes □ No

Housing

Have you spent one or more weeks on the street or in a shelter in the last three months?

□ Yes □ No

What type of place are you living in now?

□ In a house or apartment you own.

□ In a house or apartment you rent

□ In a house or apartment owned or rented by family or friends

□ Hotel

□ Alcohol or drug treatment program

□ Shelter

□ Street or car

□ Other:_____

□ Don't know

How long have you been staying where you currently live?

_____ years _____ months

Where were you living before this?

□ In a house or apartment you own.

□ In a house or apartment you rent

□ In a house or apartment owned or rented by family or friends

□ Hotel

□ Alcohol or drug treatment program

□ Shelter

□ Street or car

□ Other:_____

□ Don't know

How many different places have you lived in the past 12 months?

□ One place only

□ Two places

□ Three places

□ Four places

□ Five or more places

What are your goals for this treatment? _____

_____

_____

_____

_____

Appointment booked for RN Intake?

□ Yes □ No

	Age of first use	Last use	How often used?	Route of admin.	Amt. used	Needle Sharing History	Belong to NEP?
What is your drug of choice?*	0 if never used	1=12 or more months ago (specify date) 2=3-11 months ago 3=1-2 months ago 4=1-3 weeks ago 5= used this week	1=less than 1/month 2=1-3 times/month 3=1-2 times/week 4=3-6 times /week 5=Daily	1=Oral 2=Smoking 3=Intranasal 4=Intravenous Injection 5=Skin Popping 6=Other		Has patient ever shared needles? 1=Yes 2=No If yes, how often did you share needles? 1=sometimes 2=always	1=Yes 2=No
Opioid __Heroin __Oxycontin __Other oxycodone containing product __Methadone __Other_____							
Benzodiazepine							
Alcohol							
Cocaine							
Amphetamines (ncluding methamphetamine)							
Tobacco							
Other							

Adapted from materials produced by Colleen LaBelle, RN at Boston Medical Center