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SUBOXONE MATERIALS CONFIRMATION

DOCUMENTS	INITIALS
Suboxone New Patient Introduction	_____
Suboxone Patient Information	_____
Suboxone Family Information	_____
Understanding Opioid Dependence	_____
Pharmacy Consent	RETURN THIS FORM_____
Patient Treatment Contract	RETURN THIS FORM_____
Methadone Transfer Consent	RETURN THIS FORM_____
Telephone Reminder Consent	RETURN THIS FORM_____
Release of Information Consent	RETURN THIS FORM_____
Initial Questionnaire for Suboxone® Treatment	RETURN THIS FORM_____
Questionnaire for Chronic Pain issues (as needed)	RETURN THIS FORM_____

My signature affixed below and initials by the name of each individually listed document, certifies that I fully understand and agree to the contents of each document and should I have any questions, I will ask my Buprenorphine provider.

Signature_____

Printed Name_____

Date

Return: Suboxone® Materials Confirmation (this form)
Release of Medical Records Authorization
Agreement for Treatment with Suboxone®
Initial Questionnaire for Suboxone® Treatment
Including addendum for patients with concomitant Chronic Pain Related Issues

To: Excel Pain Consultants
1000 S Mercer St,
New Castle PA, 16101
or fax (724) 656.6083

You will be promptly notified of your acceptance to the treatment program

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NEW PATIENT INTRODUCTION
(PLEASE RETAIN THIS FORM)

SUBOXONE® NEW PATIENT INTRODUCTION

Welcome to your visit step to well being and healthy life. Our clinic restricts our treatment panel to a limited number of pre-qualified patients. This program accepts only patients who are serious about overcoming opioid addiction. We do not assume general medical care of Suboxone® patients.

All patients must adhere to strict cash payment policy. Check with your insurance about Suboxone medicine coverage.

- A nurse will conduct a phone interview and physician will review your file to see if you qualify for our suboxone program. Initial office appointment will be made.
- Complete package will be mailed out to you. You can also download a copy from www.excelpainconsultants.com. Go under ***patient*** tab and go to ***suboxone***. Download forms under suboxone forms, complete and bring with you. It will save you time during initial office visit. Read the entire packet

Return the 3 required, completed forms to our office during your initial visit.

-

Suboxone instructions for initial appointment

- Arrive early to complete paperwork.
- Bring all pill bottles.
- Bring valid photo ID.
- Bring insurance card if insured.
- A separate charge for screening lab tests may be billed to your insurance.
- The initial appointment may last up to 2 hours with a return to the clinic within the first 2 days for Suboxone induction.
- Fill your prescription at the pharmacy after the initial visit

STEP ONE- INITIAL VISIT

- You will be given a comprehensive substance dependence assessment, as well as an evaluation of mental status and physical exam. The pros and cons of the medication, SUBOXONE, will be presented. Treatment expectations, as well as issues involved with maintenance versus medically supervised withdrawal will be discussed.
- After initial complete history and physical examination, you will be given initial prescription. Bring your medication with you on your induction visit.
- DO NOT TAKE THIS MEDICATION UNLESS SPECIFICALLY INSTRUCTED TO DO SO.

STEP TWO- INDUCTION

- You will be scheduled for ***induction*** visit. You should be in mild to moderate withdrawal.
- Expect to stay for 2-3 hours.
- You will be given initial dose and monitoring will be done.
- At the time of induction, you will be asked to provide a urine sample to confirm the presence of opioids and possibly other drugs. You must arrive for the first visit experiencing mild to moderate opioid withdrawal symptoms. Arrangements will be made for you to receive your first dose in your doctor's office. Your response to the initial dose will be monitored. You may receive additional medication, if necessary, to reduce withdrawal symptoms.

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- Since an individual's tolerance and reactions to SUBOXONE vary, you are advised to contact our office and medications will be adjusted until you no longer experience withdrawal symptoms or cravings.

Intake and Induction may both occur at the first visit, depending on your needs and your doctor's evaluation.

STEP THREE- STABILIZATION

- Once the appropriate dose of SUBOXONE is established, you will stay at this dose until steady blood levels are achieved. You and your doctor will discuss your treatment options from this point forward.

- Plan to begin taking Suboxone in an environment from which you will not need to travel, such as at home
- We recommend that you do not drive for at least 48-72 hours after beginning Suboxone use
- Plan not to drive for first few days after beginning Suboxone - do not drive until you feel completely
- comfortable to do so without any impairment
- Return to clinic within one to two weeks after initial uboxone dosing, per physician plan.

STEP FOUR- MAINTENANCE

- Return for frequent follow-up visits per instructions for treatment compliance and to monitor progress.
- Plan to schedule regular two week visits until stable dosing has been achieved
- Plan to schedule monthly maintenance visits thereafter.
- Expect regular as well as random urine drug screen and pill count as per policy.
- Visits may be scheduled more frequently if there are adherence issues.
- Duration of treatment is individually determined by the patient but usually lasts for one year or more
- If a visit is missed, you may be required to reapply for acceptance into the program.
- Re-acceptance is not guaranteed.

MEIDCALLY SUPERVISED WITHDRAWAL

- As your treatment progresses, you and your doctor may eventually decide that medically supervised withdrawal is an appropriate option for you. In this phase, your doctor will gradually taper your SUBOXONE dose over time, taking care to see that you do not experience any withdrawal symptoms or cravings.

Directions:

The Suboxone Program is located within the Pain Management Clinic on the 2nd Floor.

Phone: 724.656.6086 (same number as for Pain Management) for further driving instructions.

EXPLANATION OF INDUCTION VISIT

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

Your 2ND visit is generally the longest, and may last anywhere from 1 to 4 hours.

When preparing for your Induction visit, there are a couple of logistical issues you may want to consider.

- You may not want to return to work after your visit—this is very normal, so just plan accordingly
- Because SUBOXONE can cause drowsiness and slow reaction times, particularly during the 1st few weeks of treatment, driving yourself home after the 1st visit is generally not recommended, so you may want to make arrangements for a ride home

It is very important to arrive for your Induction already experiencing mild to moderate opioid withdrawal symptoms. If you are in withdrawal, buprenorphine will help lessen the symptoms. However, if you are *not* in withdrawal, buprenorphine will "override" the opioids already in your system, which will *cause* severe withdrawal symptoms.

The following guidelines are provided to **ensure that you are in withdrawal for the visit.** (If this concerns you, it may help to schedule your first visit in the morning: some patients find it easiest to skip what would normally be their first dose of the day.)

- No methadone or long-acting painkillers for at least 24 hours
- No heroin or short-acting painkillers for at least 4 to 6 hours

Bring ALL medication bottles with you to your 1st appointment.

Before the doctor can see you, all of your paperwork must be completed, so bring all your completed forms with you or arrive about 30 minutes early. In addition, you will need to pay the doctor's fees prior to treatment.

Urine drug screening is a regular feature of SUBOXONE therapy, because it provides physicians with important insights into your health and your treatment. Your 1st visit will include urine drug screening, and may also entail a Breathalyzer®* test and blood work. If you haven't had a recent physical exam, your doctor may require one either now or soon afterwards. To help ensure that SUBOXONE is the best treatment option for you, the doctor will perform a substance dependence assessment and mental status evaluation. In addition, you and your physician will discuss SUBOXONE treatment, what it involves, and what your expectations of treatment are.

After this initial intake, your doctor will give you a dose of SUBOXONE. Your response to the medication will be evaluated after 1 hour and possibly again after 2 hours. Once the doctor is comfortable with your response, you will be allowed to go home. The doctor will schedule your next visit and give you directions for taking your medication at home. In addition, you will receive instructions on how to contact your doctor in case of emergency, as well as information about your treatment.

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CHECKLIST FOR INDUCTION VISIT:

- □ Arrive with a **full bladder**
- □ Arrive experiencing mild to moderate **opioid withdrawal** symptoms
- □ Bring completed **forms** (or come 30 minutes early)
- □ Bring **ALL medication bottles**
- □ **Fees due** at time of visit (cash or check)

FREQUENTLY ASKED QUESTIONS–PATIENTS

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

1. Why do I have to feel sick to start the medication for it to work best?

When you take your first dose of SUBOXONE, if you already have high levels of another opioid in your system, the SUBOXONE will compete with those opioid molecules and replace them at the receptor sites. Because SUBOXONE has milder opioid effects than full agonist opioids, you may go into a rapid opioid withdrawal and feel sick, a condition which is called "precipitated withdrawal."

By already being in mild to moderate withdrawal when you take your first dose of SUBOXONE, the medication will make you feel noticeably better, not worse.

2. How does SUBOXONE work?

SUBOXONE binds to the same receptors as other opioid drugs. It mimics the effects of other opioids by alleviating cravings and withdrawal symptoms. This allows you to address the psychosocial reasons behind your opioid use.

3. When will I start to feel better?

Most patients feel a measurable improvement by 30 minutes, with the full effects clearly noticeable after about 1 hour.

4. How long will SUBOXONE last?

After the first hour, many people say they feel pretty good for most of the day. Responses to SUBOXONE will vary based on factors such as tolerance and metabolism, so each patient's dosing is individualized. Your doctor may increase your dose of SUBOXONE during the first week to help keep you from feeling sick.

5. Can I go to work right after my first dose?

SUBOXONE can cause drowsiness and slow reaction times. These responses are more likely over the first few weeks of treatment, when your dose is being adjusted. During this time, your ability to drive, operate machinery, and play sports may be affected. Some people *do* go to work right after their first SUBOXONE dose; however, many people prefer to take the first and possibly the second day off until they feel better.

If you are concerned about missing work, talk with your physician about possible ways to minimize the possibility of your taking time off (eg, scheduling your Induction on a Friday).

6. Is it important to take my medication at the same time each day?

In order to make sure that you do not get sick, it is important to take your medication at the same time every day.

7. If I have more than one tablet, do I need to take them together at the same time?

Yes and no—you *do* need to take your dose at one "sitting," but you do *not* necessarily need to fit all the tablets under

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your tongue simultaneously. Some people prefer to take their tablets this way because it's faster, but this may not be what works best for *you*. The most important thing is to be sure to take the full daily dose you were prescribed, so that your body maintains constant levels of SUBOXONE.

SUBOXONE® (buprenorphine HCl/naloxone HCl dihydrate)Ⓒ sublingual tablet

8. Why does SUBOXONE need to be placed under the tongue?

There are two large veins under your tongue (you can see them with a mirror). Placing the medication under your tongue allows SUBOXONE to be absorbed quickly and safely through these veins as the tablet dissolves. If you chew or swallow your medication, it will not be correctly absorbed as it is extensively metabolized by the liver. Similarly, if the medication is not allowed to dissolve completely, you won't receive the full effect.

9. Why can't I talk while the medication is dissolving under my tongue?

When you talk, you move your tongue, which lets the undissolved SUBOXONE "leak" out from underneath, thereby preventing it from being absorbed by the two veins. Entertaining yourself by reading or watching television while your medication dissolves can help the time to pass more quickly.

10. Why does it sometimes only take *5* minutes for SUBOXONE to dissolve and other times it takes much longer?

Generally, it takes about 5-10 minutes for a tablet to dissolve. However, other factors (eg, the moisture of your mouth) can effect that time. Drinking something before taking your medication is a good way to help the tablet dissolve more quickly.

11. If I forget to take my SUBOXONE for a day will I feel sick?

SUBOXONE works best when taken every 24 hours; however, it may last longer than 24 hours, so you may not get sick. If you miss your dose, try to take it as soon as possible, *unless* it is almost time for your next dose. If it is almost time for your next dose, just skip the dose you forgot, and take next dose as prescribed. Do not take two doses at once unless directed to do so by your physician.

In the future, the best way to help yourself remember to take your medication is to start taking it at the same time that you perform a routine, daily activity, such as when you get dressed in the morning. This way, the daily activity will start to serve as a reminder to take your SUBOXONE.

12. What happens if I still feel sick after taking SUBOXONE for a while?

There are some reasons why you may still feel sick. You may not be taking the medication correctly or the dose may not be right for you. It is important to tell your doctor or nurse if you still feel sick.

13. What happens if I take drugs and then take SUBOXONE?

You will probably feel very sick and experience what is called a "precipitated withdrawal." SUBOXONE competes with other opioids and will displace those opioid molecules from the receptors. Because SUBOXONE has less opioid effects

than full agonist opioids, you will go into withdrawal and feel sick.

14. What happens if I take SUBOXONE and then take drugs?

As long as SUBOXONE is in your body, it will significantly reduce the effects of any other opioids used, because SUBOXONE will dominate the receptor sites and block other opioids from producing any effect.

15. What are the side effects of this medication?

Some of the most common side effects that patients experience are nausea, headache, constipation, and body aches and pains. However, most side effects seen with SUBOXONE appear during the first week or two of treatment, and then generally subside. If you are experiencing any side effects, be sure to talk about it with your doctor or nurse, as s/he can often treat those symptoms effectively until they abate on their own.

Confidentiality of Alcohol and Drug Dependence Patient Records

The confidentiality of alcohol and drug dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol or drug dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

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FREQUENTLY ASKED QUESTIONS—FAMILY

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

1. What is an opioid?

Opioids and opiates are synthetic and natural drugs that are related to drugs found in opium; many, such as heroin, are addictive narcotics. Many prescription pain medications are opioids, such as codeine, Vicodin®* (hydrocodone bitartrate and acetaminophen), Demerol®† (meperidine hydrochloride, USP), Dilaudid®* (hydromorphone), morphine, OxyContin®‡ (oxycodone hydrochloride controlled-release), and Percodan®§ (oxycodone and aspirin tablets, USP). Methadone and buprenorphine are also opioids.

A small amount of naloxone is in SUBOXONE. Naloxone is added to discourage misuse of SUBOXONE. If SUBOXONE were to be crushed and injected, the naloxone would cause the person to go into withdrawal.

2. Why are opioids used to treat opioid dependence?

Many family members wonder why doctors use buprenorphine to treat opioid dependence, since it is in the same family as heroin. Some of them ask, "Isn't this substituting one addiction for another?" But the two medications used to treat opioid dependence—methadone and buprenorphine—are not "just substitution." Many medical studies since 1965 show that maintenance treatment helps keep patients healthier, keeps them from getting into legal troubles, and reduces the risk of getting diseases and infections that are transferred when needles are shared.

3. What is the right dose of SUBOXONE?

Dependence is a developed need to have the opioid receptors in the brain occupied by an opioid. Finding just the right amount of SUBOXONE to fill the receptors at the right rate is an important part of the induction process.

Every opioid can have stimulating or sedating effects, especially in the first weeks of treatment. The right dose of SUBOXONE is the one that allows the patient to feel and act normally. It can sometimes take a few weeks to find the right dose. During the first few weeks, the dose may be too high, or too low, which can lead to sickness, daytime sleepiness, or trouble sleeping at night. The patient may ask that family members help keep track of the timing of these symptoms, and write them down. Then the doctor can use all these clues to adjust the amount and time of day for buprenorphine doses.

Once the right dose is found, it is important to take it on time in a regular way, so the patient's body can maintain consistent medication levels to avoid experiencing withdrawal symptoms.

4. How can the family support good treatment?

Even though maintenance treatment for opioid dependence works very well, it is not a cure. This means that the patient will continue to need the stable dose of SUBOXONE, with regular monitoring by the doctor. This is similar to other chronic diseases, such as diabetes or asthma. These illnesses can be treated, but there is no permanent cure, so patients often stay on the same medication for a long time. The best way to help and support the patient is to encourage regular medical care, encourage the patient not to skip or forget to take the medication and most importantly, encourage the patient to partake in regular counseling sessions or support groups.

- Regular medical care

Most patients will be required to see the physician for ongoing SUBOXONE® treatment every two to four weeks, once they are stable. If they miss an appointment, they may not be able to refill the medication on time, and may even go into withdrawal, which could be dangerous.

- Counseling

Most patients who have become dependent on opioids will need formal counseling at some point in their care. The patient may have regular appointments with an individual counselor, or for group therapy. These appointments are key parts of treatment, and work together with the SUBOXONE to improve success. Sometimes family members may be asked to join in family therapy sessions to provide additional support to the patient and information to the health care provider.

- Support Groups

Most patients use some kind of support group to maintain their healthy lifestyle. It sometimes takes several visits to different groups to find a comfortable environment. In the first year of recovery from opioid dependence, some patients go to meetings every day, or several times per week. These meetings work with SUBOXONE to improve the likelihood of a patient's treatment success. Family members may have their own meetings, such as Al-Anon, or Adult Children of Alcoholics (ACA), to support them in adjusting to life with a patient who has become dependent on opioids.

- Taking the medication

SUBOXONE is an unusual medication because it is best absorbed into the bloodstream when taken "sublingually" meaning the patient must hold the tablet under his or her tongue while the medicine dissolves (swallowing SUBOXONE actually reduces its effectiveness). Please be aware that **this process takes about 5-10 minutes.** While the medication is dissolving, the patient should not speak. It is very important that the family support the patient by understanding that s/he will be "out of commission" for those 5-10 minutes intervals surrounding regular daily dosing times.

One way to support new SUBOXONE patients is by helping them to make a habit of taking their dose at the same time every day. Tying dosing to a routine, everyday activity (eg, getting dressed in the morning) is often one of the best ways to do this, because then the activity itself begins to serve as a reminder.

- Storing the medication

If SUBOXONE is lost or misplaced, the patient may skip doses or become ill, so it is very important to find a good place to keep the medication safely at home—away from children or pets, and always in the same location, so it can be easily found. The doctor may give the patient a few "backup" pills, in a separate bottle, in case an appointment has to be rescheduled, or there is an emergency of some kind. It is best if the location of the SUBOXONE is not next to the vitamins, or the aspirin, or other over-the-counter medications, to avoid confusion. If a family member or visitor takes SUBOXONE by mistake, a physician should be contacted immediately.

5. What does SUBOXONE treatment mean to the family?

It is hard for any family when a member finds out s/he has a chronic medical condition. This is true for opioid dependence as well. When chronic conditions go untreated, they often have severe complications which could lead to permanent disability or even death. Fortunately, SUBOXONE maintenance can be a successful treatment, especially if it is integrated with counseling and support for life changes.

Chronic disease means the disease is there every day, and must be treated every day. This takes time and attention away from other things, and family members may resent the effort and time and money that it takes for SUBOXONE® treatment and counseling. It might help to compare opioid dependence to other chronic diseases, like diabetes or high blood pressure. After all, it takes time to make appointments to go to the doctor for blood pressure checks, and it may annoy the family if the food has to be low in cholesterol, or unsalted. But most families can adjust to these changes, when they consider that it may prevent a heart attack or a stroke for their loved one.

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It is common for people to think of substance dependence as a weakness in character, instead of a disease. Perhaps the first few times the person used drugs it was poor judgment. However, by the time the patient became dependent, taking drugs every day, and needing medical treatment, it can be considered to be a "brain disease" rather than a problem with willpower.

In summary:

Family support can be very helpful to patients on SUBOXONE treatment. It helps if the family members understand how dependence is a chronic disease that requires ongoing care. It also helps if the family gets to know a little about how treatment with SUBOXONE works, and how it should be stored at home to keep it safe. Family life might have to change to allow time and effort for the patient to become healthy again. Sometimes family members themselves can benefit from therapy.

UNDERSTANDING OPIOID DEPENDENCE

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Opioid dependence is a disease in which there are biological or physical, psychological, and social changes. Some of the physical changes include the need for increasing amounts of opioid to produce the same effect, symptoms of withdrawal, feelings of craving, and changes in sleep patterns. Psychological components of opioid dependence include a reliance on heroin or other drugs to help you cope with everyday problems or inability to feel good or celebrate without using heroin or opioids. The social components of opioid dependence include less frequent contact with important people in your life, and an inability to participate in important events due to drug use. In extreme cases, there may even be criminal and legal implications

The hallmarks of opioid dependence are the continued use of drugs despite their negative affect, the need for increasing amounts of opioids to have the same effect and the development of withdrawal symptoms upon cessation.

There are a variety of factors than can contribute to the continued use of opioids. Among these are the use of heroin to escape from or cope with problems, the need to use increasing amounts of heroin to achieve the same effect, and the need for a "high."

Treatment

Treatment for opioid dependence is best considered a long-term process.

Recovery from opioid dependence is not an easy or painless process, as it involves changes in drug use and lifestyle, such as adopting new coping skills. Recovery can involve hard work, commitment, discipline, and a willingness to examine the effects of opioid dependence on your life. At first, it isn't unusual to feel impatient, angry, or frustrated.

The changes you need to make will depend on how opioid dependence has specifically affected your life. The following are some of the common areas of change to think about when developing your specific recovery plan:

Physical – good nutrition, exercise, sleep and relaxation.

Emotional – learning to cope with feelings, problems, stresses and negative thinking without relying on opioids.

Social – developing relationships with sober people, learning to resist pressures from others to use or misuse substances, and developing healthy social and leisure interests to occupy your time and give you a sense of satisfaction and pleasure.

Family – examining the impact opioid dependence has had on your family, encouraging them to get involved in your treatment, mending relationships with family members, and working hard to have mutually satisfying relationships with family members.

Spiritual – learning to listen to your inner voice for support and strength, and using that voice to guide you in developing a renewed sense of purpose and meaning.

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During the treatment process, SUBOXONE will help you avoid many or all of the physical symptoms of opioid withdrawal. These typically include craving, restlessness, poor sleep, irritability, yawning, muscle cramps, runny nose, tearing, goose-flesh, nausea, vomiting and diarrhea. Your doctor may prescribe other medications for you as necessary to help relieve these symptoms.

You should be careful not to respond to these withdrawal symptoms by losing patience with the treatment process and thinking that the symptoms can only be corrected by using drugs. To help you deal with the symptoms of withdrawal, you should try to set small goals and work towards them.

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PHARMACY CONSENT
(PLEASE BRING THIS FORM BACK)

APPOINTED PHARMACY CONSENT

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SUBUTEX® © (buprenorphine HCl) sublingual tablet

I _____ do hereby: **(MD check all that apply)**
Patient Name (Print)

□ Authorize _____ at the above address to disclose my treatment for opioid
Physician Name (Print)
dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine prescriptions directly to the pharmacy.

□ Agree to allow pharmacist to contact physician listed above to discuss my treatment if necessary so that my buprenorphine prescriptions can be filled and either delivered to the office addressed given above or picked-up by employees of the same.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

Appointed Pharmacy:

Name _____ Phone _____

Address _____

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PATIENT TREATMENT CONTRACT

Patient Name: _____ **Date:** _____

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 other 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.

_____ Date _____
Patient Signature

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METHADONE CONSENT
(PLEASE BRING THIS FORM BACK)

METHADONE TRANSFER CONSENT

I _____ authorize _____
Patient Name (Print) Physician Name (Print)

practicing at the above address to disclose my treatment for opioid dependence to the outpatient treatment program specified below in order to obtain my medical history, methadone treatment, and any other of my patient information pertinent to the office-based treatment with buprenorphine. I understand that the physician mentioned above may need to discuss my medical and treatment history with the physicians and other staff at the outpatient treatment program specified below.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

Outpatient treatment program: Name _____

Phone _____

Address _____

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TELEPHONE CONSENT
(PLEASE BRING THIS FORM BACK)

TELEPHONE APPOINTMENT REMINDER CONSENT

I _____ give _____
Patient Name (Print) Physician Name (Print)

and members of his/her staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):

□ Home _____

□ Work _____

□ Cell _____

Yes, this office may leave (check all that apply):

□ Voice mail at my Home □ Voice mail at my Work □ Voice mail on my Cell

□ Messages with people at my Home □ Messages with people at my Work

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

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CONSENT TO RELEASE INFORMATION
(PLEASE BRING THIS FORM BACK)

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize_____ at the above address to:
Patient Name (Print) Physician Name (Print)

MD check all that apply

□ Receive my medical history information from the following physicians:
(name, address)_____
(name, address)_____

□ Receive my treatment records from the following therapist
Therapist (name, address)_____

□ Release my treatment information/records to the following healthcare professional
(name, address)_____

□ Release my treatment information to the health insurance company listed below for billing purposes
Insurance Provider (name, address) _____
_____

This information is for the following purposes (any other use is prohibited): _____
_____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

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INITIAL QUESTIONNAIRE
(PLEASE BRING ALL PAGES)

Substance Use Disorder Evaluation
Initial Questionnaire for Suboxone Treatment

Patient name: _____ Sex: _____ Age: _____

Identifying Information:

Address: _____
_____
Phone Number : _____
Occupation: _____

Emergency Contact(s) Information:
Name(s) and number(s)

_____ _____
_____ _____
_____ _____
_____ _____

What specifically brings you to treatment :

_____
_____

Opioid Use History :

Age of very First Use _____ Age it began to become a Problem for you _____
What is your Average Use _____ _____ Route: Oral Nasal Injection
What has been your Maximal Use _____ _____ Route: Oral Nasal Injection
Length of Continuous Use _____ _____ Last Use _____
What are your current symptoms _____
_____ _____
What treatment have you had for opioid dependence _____
_____
Have you ever gotten pain or other prescription medicines other than from a doctor? _____
_____
Was there ever a time in your life when you had a drug or alcohol problem? _____
_____
Have you ever had a drug overdose? _____
_____

Have you ever been arrested for selling drugs? _____
_____

Have you ever received substance abuse treatment? If so, what were the dates and locations? _____
_____

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Other Substance Use History:

Alcohol (including beer, wine, hard liquor)
Substance _____
Very First use _____
Beginning problem use _____
Recent average use _____
Highest-Maximal Use _____
Last Use _____

Sedatives (incl. benzodiazepines,barbiturates, Z-drugs)
Substance Name(s) _____
Very First use _____
Beginning problem use _____
Recent average use _____
Highest-Maximal Use _____
Last Use _____

Stimulants (including cocaine, amphetamines)
Substance Name(s) _____
Very First use _____
Beginning problem use _____
Recent average use _____
Highest-Maximal Use _____
Last Use _____

Marijuana/Spice/Synthetic Marijuana
Substance Name(s) _____
Very First use _____
Beginning problem use _____
Recent average use _____
Highest-Maximal Use _____
Last Use _____

Hallucinogens/LSD/Mushrooms
Substance Name(s) _____
Very First use _____
Beginning problem use _____
Recent average use _____
Highest-Maximal Use _____
Last Use _____

Inhalants (glues, anesthetics, etc)
Substance Name(s) _____
Very First use _____
Beginning problem use _____
Recent average use _____
Highest-Maximal Use _____
Last Use _____

Club Drugs Bath Salts
Substance Name _____
Very First use _____
Recent average use _____
Highest-Maximal Use _____
Last Use _____

Substance Name _____
Very First use _____
Recent average use _____
Highest-Maximal Use _____
Last Use _____

Psychiatric and Substance Treatment History:

Inpatient Psychiatric: _____
Outpatient Psychiatric: _____
Inpatient Substance: _____
Outpatient Substance: _____

Please report any Psychiatric Conditions with which you may have been diagnosed:
(please check any appropriate disorders)

Attention Deficit Disorder _____
Bipolar Disorder _____
Post-Traumatic Stress Disorder _____
Obsessive Compulsive Disorder _____
Schizophrenia _____
Depression _____ Anxiety _____

Do you suffer from any visual or auditory hallucinations? Y _ N _
(please explain) : _____

Do you suffer from Suicidal thoughts? Y _ N _ from Homicidal thoughts? Y _ N _
(please explain) : _____
Do you have any Eating Disorder? Y _ N _
(please explain) : _____
Do you suffer from a Personality Disorder? Y _ N _
(please explain) : _____

Past Medical History: **(please circle any conditions you suffer from)**

Heart: angina heart attack congestive heart failure high blood pressure arrhythmia
pacemaker heart murmur other _____
Lungs: asthma emphysema supplemental oxygen sleep apnea CPAP
COPD other _____
CNS: seizure(s) stroke headache disorder head injury
other _____
GI: ulcer gastritis liver disease cirrhosis hepatitis A B C
other _____
Blood: anemia bleeding dis sickle cell disease
other _____
Endocrine: thyroid disease diabetes
other _____
Infectious: HIV-AIDS endocarditis soft tissue infection(s)
osteomyelitis other _____
Musculoskeletal: arthritis fibromyalgia rheumatoid arthritis injury(ies)
other _____
Chronic pain: chronic pain issues _____
_____
_____

Past Surgical History: (please list operations and dates below)

_____ _____
_____ _____

Medications:(please list medications/doses below)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies: (please list allergies below)

_____ _____
_____ _____
_____ _____

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Social and Occupational History:

Were you the victim of any abuse when you were growing up? _____
What is the highest level of education you have attained? _____
Current marital status (circle) single separated divorced widowed If divorced, how many times? _____
Are you currently employed outside the household? _____
If you are employed, what do you do? _____
If not employed, how long have you been out of work? _____
If not employed, how do you spend your day? _____
Are you on disability? _____
If not, have you applied or are you applying for disability? _____
Are you involved with Worker's Compensation? _____
Is there any active litigation (lawsuit) pending against an employer or individual related to an accident or injury? Y _ N _
If yes, please explain _____
Are you having trouble keeping up with paying bills? If yes, please explain _____
_____

Review of Systems: (please circle all that apply)

General: Recent weight loss, recent weight gain, weakness, fatigue, night sweats, fevers
Eyes: Double vision, blurred vision
Ears, nose, throat: Dry mouth, hoarseness or other voice change, difficulty swallowing
Respiratory: Cough, sputum (color: _____ ; quantity _____), shortness of breath at rest, shortness of breath with activity
Cardiovascular: Heart trouble, chest pain or discomfort, palpitations, shortness of breath while lying flat, swelling in legs or ankles
Gastrointestinal: Ulcer, trouble swallowing, heartburn, change in appetite, nausea, diarrhea, constipation, rectal bleeding or dark or tarry stools
Urinary: Increased frequency of urination, incontinence, reduced caliber or force of urinary stream, hesitancy, dribbling
Musculoskeletal: Muscle or joint pain or stiffness, joint pain, redness, swelling
Psychiatric: Anxiety, depression, changes in mood, thoughts of suicide
Neurologic: Headaches, dizziness, vertigo, fainting, blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tingling or "pins and needles," tremors or other involuntary movements, seizures

Recovery Activities:

Meetings: _____
_____
Sponsor: _____
Step Work: _____
Activities: _____
_____

Legal Problems: (reports any and all legal issues including DUI - DWI)

_____
_____

_____
Housing Problems: _____
Emotional Support: _____

Family History: (please note any psychiatric or substance-related issues in blood relatives)

Please report any positive findings for the following issues: (please circle any that apply)
Schizophrenia Bipolar Disorder Depression Anxiety Suicide or Suicide Attempt

In the following family members: (blood relatives only) _ Mark if adopted and do not know
Paternal-Grandfather: _____
Paternal-Grandmother: _____
Maternal-Grandfather: _____
Maternal-Grandmother: _____
Father: _____
Mother: _____
Siblings: _____
_____
Child or Children: _____
_____
Do you have any family members who are in recovery? Y _ N _
If yes, what are their relationship(s) to you and for how long have they been in recovery?
_____
_____
_____
_____

What specific goals could you accomplish if opioid dependence treatment was successful?
1. _____
2. _____
3. _____
4. _____
5. _____
Routine urine specimens are a requirement. Are you able to comply with these? Y _ N _
Do you have any disabilities that make it hard for you to read labels or count pills? Y _ N _
What are your reasons for being interested in Suboxone treatment?
_____
_____
What "triggers" do you know which have put you in danger of relapse in the past or which might do so 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 : _____

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Home : _____
Other : _____
What are your strengths and skills to handle take-home Suboxone?

_____
_____
What worries do you have about extended take-home medications?

_____
_____
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? Y _ N _
What medical care will you have in the coming year?

_____
_____
How will you comply with the annual physical examination; periodic laboratory and frequent urine testing requirements?

_____
_____

CAGE QUESTIONNAIRE

Cut down—Have you ever felt you ought to cut down on your drinking or drug use? **( ) Y ( ) N**

Annoyed—Have people annoyed you by criticizing your drinking or drug use? **( ) Y ( ) N**

Guilty—Have you ever felt bad or guilty about your drinking or drug use? **( ) Y ( ) N**

Eye-opener—Have you ever had a drink or used drugs first thing in the morning, to steady your nerves or get rid of a hangover?

( ) Y ( ) N

There are no formal cut-off scores. Any positive score suggests the need for further evaluation.

Ewing J. Detecting alcoholism: The CAGE questionnaire. *JAMA.* 252(14):905-1907, 1984.

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DRUG ABUSE SCREENING TEST (DAST)

1. Have you used drugs other than those required for medical reasons? **( ) Y ( ) N**
2. Have you misused prescription drugs? **( ) Y ( ) N**
3. Do you misuse more than one drug at a time? **( ) Y ( ) N**
4. Can you get through the week without using drugs (other than those required for medical reasons)? **( ) Y ( ) N**
5. Are you always able to stop using drugs when you want to? **( ) Y ( ) N**
6. Do you misuse drugs on a continuous basis? **( ) Y ( ) N**
7. Do you try to limit your drug use to certain situations? **( ) Y ( ) N**
8. Have you had "blackouts" or "flashbacks" as a result of drug use? **( ) Y ( ) N**
9. Do you ever feel bad about your drug misuse? **( ) Y ( ) N**
10. Does your spouse (or parents) ever complain about your involvement with drugs? **( ) Y ( ) N**
11. Do your friends or relatives know or suspect you misuse drugs? **( ) Y ( ) N**
12. Has drug misuse ever created problems between you and your spouse? **( ) Y ( ) N**
13. Has any family member ever sought help for problems related to your drug use? **( ) Y ( ) N**

Have you ever:

14. Lost friends because of your use of drugs? **( ) Y ( ) N**
15. Neglected your family or missed work because of your use of drugs? **( ) Y ( ) N**
16. Been in trouble at work because of drug misuse? **( ) Y ( ) N**
17. Lost a job because of drug misuse? **( ) Y ( ) N**
18. Gotten into fights when under the influence of drugs? **( ) Y ( ) N**
19. Been arrested because of unusual behavior while under the influence of drugs? **( ) Y ( ) N**
20. Been arrested for driving while under the influence of drugs? **( ) Y ( ) N**
21. Engaged in illegal activities to obtain drugs? **( ) Y ( ) N**
22. Been arrested for possession of illegal drugs? **( ) Y ( ) N**
23. Experienced withdrawal symptoms as a result of heavy drug intake? **( ) Y ( ) N**
24. Had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, or bleeding)? **( ) Y ( ) N**
25. Gone to anyone for help for a drug problem? **( ) Y ( ) N**
26. Been in hospital for medical problems related to your drug use? **( ) Y ( ) N**

27. Been involved in a treatment program specifically related to drug use? **( ) Y ( ) N**

28. Been treated as an outpatient for problems related to drug dependence or misuse? **( ) Y ( ) N**

Scoring: Each positive response yields 1 point, except for questions 4, 5, and 7 which yield 1 point for a negative response or false direction.

A score greater than 5 requires further evaluation for substance misuse problems.

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior* 7(4): 363-371, 1982.

BRIEF MICHIGAN ALCOHOL SCREENING TEST (MAST)

Points

(2) 1. Do you feel you are a normal drinker?*

(2) 2. Do friends or relatives think you are a normal drinker?*

(5) 3. Have you ever attended a meeting of Alcoholics Anonymous?

(2) 4. Have you ever lost friends or girlfriends/boyfriends because of drinking?

(2) 5. Have you ever gotten into trouble at work because of drinking?

(2) 6. Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking?

(2) 7. Have you ever had delirium tremens (DTs), severe shaking, heard voices, seen things that weren't there after heavy drinking?

(5) 8. Have you ever gone to anyone for help about your drinking?

(5) 9. Have you ever been in a hospital because of drinking?

(2) 10. Have you ever been arrested for drunk driving or driving after drinking?

*Negative responses are alcoholic responses.

Scoring

- < 3 points, nonalcoholic
- 4 points, suggestive of alcoholism
- 5 or more, indicates alcoholism

1. Selzer ML. The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiarty* 27(12): 1653-1658, 1971. 2. Pokorny AD; Miller BA; Kaplan HB. The Brief MAST: A shortened version of the Michigan Alcoholism Screening Test.*American Journal of Psychiatry* 129(3): 342-345, 1972.

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DSM-IV CRITERIA FOR OPIOID DEPENDENCE DIAGNOSIS: WORKSHEET

Patient Name:			
Diagnostic Criteria* (Dependence requires meeting 3 or more criteria)	Meets criteria Yes	No	Notes/supporting information
(1) Tolerance, as defined by either of the following: (a) need for markedly increased amounts of the substance to achieve intoxication or desired effect			
(b) markedly diminished effect with continued use of the same amount of the substance			
(2) Withdrawal, as manifested by either of the following: (a) the characteristic withdrawal syndrome			
(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms			
(3) The substance is often taken in larger amounts or over a longer period of time than intended			
(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use			
(5) A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects			
(6) Important social, occupational, or recreational activities are given up or reduced because of substance use			
(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance			

Physician Signature

Date

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DSM-IV CRITERIA FOR SUBSTANCE DEPENDENCE AND ABUSE

Once a thorough patient assessment has been performed, a formal diagnosis of either opioid dependence or abuse can be made. A substance dependence or abuse diagnosis, according to current DSM-IV diagnostic schema, is based on clusters of behaviors and physiological effects occurring within a specific time frame. ***A diagnosis of dependence always takes precedence over that of abuse***, eg, a diagnosis of abuse is made only if DSM-IV criteria for dependence have never been met.

DEPENDENCE 3 or more in a 12-month period	**ABUSE** 1 or more in a 12-month period (Symptoms must never have met criteria for dependence.)
Tolerance (marked increase in amount; marked decrease in effect)	Recurrent use resulting in failure to fulfill major role obligation at work, home or school
Characteristic withdrawal symptoms; substance taken to relieve withdrawal	Recurrent use in physically hazardous situations
Substance taken in larger amount and for longer period than intended	Recurrent substance related legal problems
Persistent desire or repeated unsuccessful attempt to quit	Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by substance
Much time/activity to obtain, use, recover Important social, occupational, or recreational activities given up or reduced	
Use continues despite knowledge of adverse consequences (e.g., failure to fulfill role obligation, use when physically hazardous)	

In using the DSM-IV criteria, one should specify whether substance dependence is with physiologic dependence (ie, there is evidence of tolerance or withdrawal) or without physiologic dependence (ie, no evidence of tolerance or withdrawal). In addition, patients may be variously classified as currently manifesting a pattern of abuse or dependence or as in remission. Those in remission can be divided into four subtypes—full, early partial, sustained, and sustained partial—on the basis of whether any of the criteria for abuse or dependence have been met and over what time frame. The remission category can also be used for patients receiving agonist therapy (eg, methadone maintenance) or for those living in a controlled drug-free environment.

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THERAPY PROGRESS REPORT

(Adapted from Subjective Opiate Withdrawal Scale)

Patient Name_____ **SUBOXONE dose** _____mg/day **Date** _____

COMPLETED BY PATIENT Circle the answer that best fits the way you feel now

(Not at all) 0 - 1 - 2 - 3 4 **(Extremely)**

I feel anxious	0 - 1 - 2 - 3 - 4
I feel like yawning	0 - 1 - 2 - 3 - 4
I am perspiring	0 - 1 - 2 - 3 - 4
My nose is running and/or my eyes are watery	0 - 1 - 2 - 3 - 4
I have goosebumps and/or chills	0 - 1 - 2 - 3 - 4
I feel nauseated or like I may need to vomit	0 - 1 - 2 - 3 - 4
I have stomach cramps and/or diarrhea	0 - 1 - 2 - 3 - 4
My muscles twitch	0 - 1 - 2 - 3 - 4
I feel dehydrated and/or have not had much appetite	0 - 1 - 2 - 3 - 4
I am having difficulty sleeping	0 - 1 - 2 - 3 - 4
I have a headache	0 - 1 - 2 - 3 - 4
My muscles and bones ache	0 - 1 - 2 - 3 - 4
I feel like using right now	0 - 1 - 2 - 3 - 4
I would rate my overall level of withdrawal as	0 - 1 - 2 - 3 - 4
Do you feel you need a dosage change?	( ) No ( )Yes ( ) Up ( ) Down

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 (OR OTHER MEDICAL PROFESSIONAL)

S/O)

A)	P)

Physician Signature_____ Date_____

Adverse events since the last visit? ( ) N (Describe) _____

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_____

Any signs of **intoxication**? ( ) N (Describe) _____

_____

Any use of unauthorized substances since last visit? ( ) N (Substances used, quantity, frequency)

_____

_____

_____

What were the circumstances surrounding use (ie, what stressors or triggers)?

_____

_____

_____

Were these triggers previously identified?

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? ( ) N New dose _____

Other medications necessary? ( ) N (list) _____