

## 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: \_\_\_\_\_

### Criminal History

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

### Suboxone History

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 #:

### Pain

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?

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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

### Family History

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

### Transportation

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 (including methamphetamine)							
Tobacco							
Other							

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