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Patient Intake Assessment Sheet

Name:_____ Date:_____

Personal Information:

What is your height? _____ft. _____in. What is your weight? _____

Have you ever been in detox? ☐ Yes ☐ No If yes, number of detox: _____

Last detox date and where? _____

Do you have a license to drive? ☐ Yes ☐ No

Are you currently living in an area with high drug activity? ☐ Yes ☐ No

Current Living Situation: ☐ Live alone ☐ Live with family ☐ Live with spouse ☐ Homeless

Employment Status: ☐ Part Time ☐ Full-Time ☐ Unemployed

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Household Status- How many children do you have? _____

If so, what are their ages? _____

Family Information:

Family members with history of mental illness? _____

Family members with substance abuse? _____

Is your family aware of your drug use? ☐ Yes ☐ No

Family Medical History: _____

Substance History:

Current drug of choice?

☐ Heroin ☐ Cocaine ☐ Opiate ☐ Marijuana ☐ Alcohol ☐ Other: _____

Route of Administration?

☐ Snorting ☐ Injecting ☐ Smoking ☐ IV Use ☐ Ingestion ☐ Other: _____

Current daily use? _____

Last opiate or drug use? _____

Benzodiazepine/amphetamine use? ☐ Yes ☐ No If yes: ☐ Prescribed ☐ Recreational

Have you used Suboxone in the past? ☐ Yes ☐ No If yes, how many mg? _____

Have you overdosed in the past? ☐ Yes ☐ No

If yes, number of overdoses: _____ Last overdose occurred: _____

Have you been admitted in a hospital due to drug/alcohol abuse? ☐ Yes ☐ No

History of mental illness? ☐ Yes ☐ No Hospitalized for mental illness? ☐ Yes ☐ No

Do you currently have a therapist or psychiatrist? ☐ Yes ☐ No

Last visit: _____ How often do you attend sessions: _____

Do you have any major medical issues we should be aware of? ☐ Yes ☐ No

Please specify: _____

Have you had any liver problems in the past? ☐ Yes ☐ No

Do you have any active DCF or legal cases? ☐ Yes ☐ No

Please specify: _____

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Do you need any additional recovery education or support? ☐ Yes ☐ No
If yes, what are you looking for specifically? _____

Street Suboxone ☐ Yes ☐ No If yes, how many mg? _____

Vivitrol ☐ Yes ☐ No Methadone ☐ Yes ☐ No

Shared needles ☐ Yes ☐ No Snorted drugs ☐ Yes ☐ No

IV drug use ☐ Yes ☐ No

History of mental illness? ☐ Yes ☐ No Hospitalized for mental illness? ☐ Yes ☐ No

Family members with history of mental illness? _____

Family members with substance abuse? _____

Start age and last use:

Alcohol ☐ Yes ☐ No
Last use: _____ Start age: _____

Opiate ☐ Yes ☐ No
Last use: _____ Start age: _____
(oxy, vicodin, morphine, methadone)

Heroin ☐ Yes ☐ No
Last use: _____ Start age: _____

Benzos ☐ Yes ☐ No
Last use: _____ Start age: _____

Marijuana ☐ Yes ☐ No
Last use: _____ Start age: _____

Amphetamine ☐ Yes ☐ No
Last use: _____ Start age: _____

Cocaine ☐ Yes ☐ No
Last use: _____ Start age: _____

Cigarettes ☐ Yes ☐ No How much per week? _____

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PATIENT INTAKE REGISTRATION FORM (PLEASE PRINT)

Your Preferred Treatment:	Today's Date:	Office Use Only:
○ Suboxone ○ Naltrexone ○ Vivitrol ○ Other_____		○ Northampton ○ Springfield (IO)

- *Before your intake can be sheduled, you must have active insurance, a therapist whom you see at minimum once weekly, and referrals from your pimary care doctor, if required by your insurance carrier. If you are unsure of whether you need referrals, do no hesitate to ask someone at the front desk and they will be able to help you*
- *In order to be considered for treatment all forms and contracts are to be completed, signed and dated prior to the first appointment with a medical provider*
- *The decision to start and the course of treatment will be determined after you have seen a provider*
- *Before your intake appointment you must read the ORIENTATION MANUAL*

Last Name: **First Name:** Middle: ☐Mr. ☐Miss ☐ Mrs. ☐ Ms. Marital Status (circle one) Single / Mar / Div / Sep / Wid

Preferred Name (If different from your legal first name):

Maiden Name: Date of Birth: Gender: ☐Male ☐Female ☐Other Age:

Street Address: Social Security Number: **Home Phone:** May We Leave a Message?

PO Box: City: State: Zip: **Cell Phone:** May We Leave a Message?

Employer: Work Schedule: Driver's License Number: **(Please give ID to receptionist)**

Race: ☐Asian ☐White ☐African American ☐American Indian ☐Alaska Native ☐Native Hawaiian ☐Pacific Islander ☐Other:_____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Primary Language: ☐English ☐Spanish ☐Other:_____

Hearing: ☐NOT Deaf/Hearing Impaired ☐Deaf/Hearing Impaired

Will you need Translation or Interpretive Services? ☐Yes ☐No

How did you hear of our Program? ☐Doctor ☐Friend ☐Internet Search ☐Insurance Plan ☐Hospital ☐Family ☐Close to home/work ☐Other

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Name of Primary Insurance: Card/Policy Number: Group Number:

Subscriber's Name: Date of Birth: Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child

Name of Secondary Insurance: Card/Policy Number: Group Number:

Subscriber's Name: Date of Birth: Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child

CURRENT MEDICAL CONCERNS

Medication Allergies:

Current Prescription Medications:

Surgical History:

Past Medical History (such as diabetes, high blood pressure, anxiety, bipolar, Hepatitis, PTSD, ADD, OCD, depression, etc.):

Family Medical History:

Immunization History: Do you need the HEPATITIS A or HEPATITIS B Vaccine?:
Have you been vaccinated for COVID19?:

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TREATMENT HISTORY				
Please place an "x" in the appropriate column	Yes, I am currently in another program	Yes, I was prescribed in the past	No, but I have bought on the street	No, I have never tried
Suboxone				
Naltrexone				
Vivitrol				
Methadone				

What types of treatment have you tried in the past?

How long were you in treatment (please give a date range for each listed)?

What was the outcome of your past treatment experience(s)?

Upon entering treatment at OnCall what are your short-term goals?

Upon entering treatment at OnCall what are your long-term goals?

HEALTH PROVIDER INFORMATION			
	NAME	ADDRESS	PHONE NUMBER
Primary Care Doctor:			
Psychiatrist:			
OBGYN:			
Pediatrician:			
Therapist (MANDATORY):			
Pharmacy:			
Other:			

MEDICAL HISTORY		
Do you exercise regularly?	☐ YES	☐ NO
History of high cholesterol?	☐ YES	☐ NO
History of high blood pressure?	☐ YES	☐ NO
History of insulin dependent diabetes?	☐ YES	☐ NO
History of liver failure or kidney failure?	☐ YES	☐ NO
Family history of heart disease?	☐ YES	☐ NO
Pregnant or breast-feeding?	☐ YES	☐ NO
Allergy to naltrexone?	☐ YES	☐ NO
Plan for upcoming surgery?	☐ YES	☐ NO
Chronic pain issue that requires opioid medication treatment?	☐ YES	☐ NO
Dental pain or ongoing oral issues?	☐ YES	☐ NO
Do you require the use of a wheelchair?	☐ YES	☐ NO
Positive PPD/TB (Tuberculosis) plant?	☐ YES	☐ NO

PLEASE FILL OUT ADULT TB RISK ASSESSMENT AND SCREENING FORM

MENTAL HEALTH		
Do you suffer from mental illness? (If yes, were you ever hospitalized for this? ☐Yes ☐No)	☐ YES	☐ NO
Do you suffer from anxiety? (If yes, were you ever hospitalized for this? ☐Yes ☐No)	☐ YES	☐ NO
Do you suffer from depression? (If yes, were you ever hospitalized for this? ☐Yes ☐No)	☐ YES	☐ NO
Have you had any past or current suicidal attempt, thoughts, and ideation? (If yes, were you ever hospitalized for this? ☐Yes ☐No)	☐ YES	☐ NO

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SOCIAL SITUATION		
Do you have a car?	☐YES	☐NO
Do you take public transportation?	☐YES	☐NO
Do you live close enough to walk?	☐YES	☐NO
Will you get a ride from a friend or family member?	☐YES	☐NO
Are you active or reserve - US armed forces?	☐YES	☐NO
Are you a US armed forces veteran?	☐YES	☐NO
Do you consider yourself homeless?	☐YES	☐NO

FAMILY SITUATION		
Are you in a relationship?	☐YES	☐NO
If yes, are they aware of your addiction?	☐YES	☐NO
Do you live alone?	☐YES	☐NO
Are you currently living with any children (younger than 18)?	☐YES	☐NO
If YES, how many children and what ages?	☐YES	☐NO
Does anyone in your family have a history of substance abuse?	☐YES	☐NO

PREGNANT OR EXPECTING WOMEN (ONLY)		
Estimated date of delivery:	Trimester: 1st 2nd 3rd	Next OBGYN visit:
Number of Pregnancies:	Number of Miscarriages:	Number of Abortions:
Recent Ultrasound Date:	NST (Non-Stress Test) Date:	
History of NAS (Neonatal Abstinence Syndrome) in previous pregnancies? ☐Yes ☐No		

LEGAL HISTORY	NO	YES	If YES, please explain
Have you ever been arrested because of drug use?			
Have you ever been incarcerated?			
Are you on Probation?			
Are you on Parole?			
Are you facing potential jail time?			
Are there any outstanding warrants for you?			
Are you currently involved with DCF?			

IN CASE OF EMERGENCY

Emergency Contact Name:	Phone Number:
Relationship to you:	Are they aware of your addiction?

Please be aware you must sign a release of information to your emergency contact listed above

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SUBSTANCE USE HISTORY

Drug/ Substance	Example	Never Used	Currently Using	Age of 1st Use	Used in the Past	Date of Last Use	Max Dose Used	I' m
Alcohol	*Beer, Wine, Hard Liquor*							
Barbiturates	*Amytal, Nembutal, Seconal, Phenobarb.: Barbs, Reds, Red Birds, Phennies, Tooies, Yellows, Yellow Jackets*							
Benzodiazepines	*Ativan, Halcion, Librium, Valium, Xanax: Benzos, Candy, Downers, Sleeping Pills, Tranks*							
Flunitrazepam	*Rohypnol: Date Rape Drug, Forget-me pill, Mexican Valium, R2, Roofies, Roofinol*							
Methaqualone	*Quaalude, Sopor, Parest:Ludes, Mandrex, Quad, Quay*							
Ketamine	*Ketalar SV: Cat Valiums, K, Special K, Vitamin K*							
PCP type drugs	*Phencyclidine: Angel Dust, Boat, Hog, Love Boat, Peace Pill*							
LSD	*Acid, Blotter, Boomers, Cubes, Microdot, Yellow Sunshines*							
Mescaline	*Buttons, Cactus, Mesc, Peyote*							
Psilocybin	*Magic Mushroom, Purple Passion, Shrooms*							
Codeine	*Fiorinal with Codeine, Robitussin AC, Tylenol with Codeine: Captain Cody, Schoolboy*							
Fentanyl	*Actiq, Duragesic, Sublimaze: Apache, China Girl, China White, Dance Fever, Friend, Goodfella, Jackpot, Murder 8, TNT*							
Heroin	*Brown Sugar, Dope H, Horse, Junk, Skag, Skunk, Smack, White Horse*							
Morphine	*Roxanol, Duramorph: M, Miss Emma, Monkey, White Stuff*							
Opium	*Laudanum, Paregoric: Big O, Black Stuff, Block, Gum, Hop*							
Oxycodone	*Oxycontin, Percocet: Oxy, O.C., Killer, Percs*							
Amphetamine	*Dexedrine, Adderall: Bennies, Black Beauties, Crosses, Hearts, LA Turnaround, Speed, Truck Drivers, Uppers*							
Cocaine	*Blow, Bump, C, Candy, Charlie, Coke, Crack, Flake, Rock, Snow, Toot*							
MDMA	*Ecstasy, Adam, Clarity, Eve, Lover's Speed, Peace, STP, X, XTC, Club Drug*							
Methamphetamine	*Meth, Chalk, Crank, Crystal, Fire, Glass, Go Fast, Ice, Speed*							
Methylphenidate	*Ritalin: JIF, MPH, R-Ball, Skippy, The Smart Drug, Vitamin R*							
Marijuana	*Weed, Dope, Grass, MaryJane, Pot, Bud*							
Nicotine	*Cigarettes, Cigars, Smokeless Tobacco, Snuff, Spit Tobacco, Bidis, Chew*							
Steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise: Roids, Juice*							
Dextromethorphan	*Found in some cough and cold medications; Robotripping, Robo, Triple C*							
Inhalants	*Solvents (paint thinners, gasoline, glues), Gases (butane, propane, aerosol propellants, nitrous oxide)*							

EVALUATION OF RISK

When was your last drug use?: What did you use and how much?:

Have you used drugs IV?	☐Yes	☐No	
Have you ever shared needles?	☐Yes	☐No	
Have you ever snorted drugs?	☐Yes	☐No	
Have you ever overdosed? If yes, which drug did you use?	☐Yes	☐No	If yes, # of times:
Have you ever overdosed while on Vivitrol? If yes, what drug did you use?	☐Yes	☐No	If yes, # of times
Have you ever witnessed an overdose?	☐Yes	☐No	If yes, how many?

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How much money did or do you spend per week on drugs/alcohol?	☐Yes	☐No	
Have you ever tried to stop using substances on your own?	☐Yes	☐No	were you successful? ☐Yes ☐No
Have you not been able to cut down or stop (repeated failed attempts)?	☐Yes	☐No	
Have you not been able to stick to drinking limits (repeatedly gone over)?	☐Yes	☐No	
Have you shown tolerance (needed to drink or use more drug to get the same effect)?	☐Yes	☐No	
Have you shown signs of withdrawal (tremors, sweating, nausea, or insomnia when trying to quit or cut down)?	☐Yes	☐No	
Have you kept using despite problems (recurrent psychological or physical problems)?	☐Yes	☐No	
Have you spent a lot of time using substances (trying to get, using, or recovering from using substances)?	☐Yes	☐No	
Have you spent less time on other matters (activities that had been important or pleasurable)?	☐Yes	☐No	
Have you had run-ins with the law (arrests or other legal problems)?	☐Yes	☐No	
Have you had relationship trouble (with family or friends)?	☐Yes	☐No	
Have you experienced risk of bodily harm (drinking and driving, operating machinery or swimming while impaired)?	☐Yes	☐No	
Have people annoyed you by criticizing your substance use?	☐Yes	☐No	
Have you felt bad or guilty about your substance use or drinking behavior?	☐Yes	☐No	
Do you currently live in a place where drug use happens around you on a regular basis?	☐Yes	☐No	
Do you attend AA or NA meetings? - If yes, approximately how many meetings do you attend each week? - If yes, do you have a sponsor?	☐Yes	☐No	
Have you been a victim of physical abuse?	☐Yes	☐No	
Have you been a victim of sexual assault?	☐Yes	☐No	
Have you been a victim of mental/emotional abuse?	☐Yes	☐No	
Do you have a history of childhood trauma?	☐Yes	☐No	
Are you a member of the LGBTQ community? *If you don't feel comfortable answering this question on this form and would like to speak to someone instead please check this box ☐	☐Yes	☐No	
How do you sexually orient? ☐Heterosexual ☐Bi-sexual ☐Homosexual ☐Pansexual ☐Asexual ☐Other:____			
Do you consider yourself "out"?	☐Yes	☐No	
Have you faced discrimination? If yes, check all that apply: ☐Racial ☐heterosexism ☐homophobia ☐bi-phobia ☐trans-phobia ☐sexism	☐Yes	☐No	
Have you ever been diagnosed with Hepatitis C?	☐Yes	☐No	
If yes, when were you treated for Hepatitis C and what medication was used?:			
Have you ever been diagnosed with HIV/AIDs?	☐Yes	☐No	
If yes, when were you treated for HIV/AIDSs and what medication was used?			
Do you need any additional information on HIV/AIDS or Hepatitis C?	☐Yes	☐No	
Have you ever had unprotected sex?	☐Yes	☐No	
Are you concerned about currently having a sexually transmitted disease (STD) or a sexually transmitted infection (STI)	☐Yes	☐No	
Have you already been treated for a STD or STI?	☐Yes	☐No	If yes, when?
Do you engage in gambling?	☐Yes	☐No	How many times a week?
Do you currently smoke cigarettes? If yes, what age did you start using?	☐Yes	☐No	How many packs a week?
Do you currently use a vape? If yes, what age did you start using?	☐Yes	☐No	How many times a day?
Do you currently drink alcohol? If yes, what age do you start?	☐Yes	☐No	How many drinks per week?
Do you have a support system?	☐Yes	☐No	
Who or what do you consider to be your support system?			

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Therapy Requirement Notification

OnCall Medication Assisted Treatment (MAT) locations:
51 Locust Street Northampton, MA 01060
568 Main Street Indian Orchard, MA 01151

As a patient enrolled in OnCall HLP's MAT program it is important to understand that therapy is a required portion of treatment.

The Massachusetts State Bureau of Substance Abuse Services (BSAS) mandates that all patients of any certified outpatient substance abuse treatment program must do the following:

1. **See a qualified substance abuse counselor or therapist that specializes in addiction as provided by the outpatient treatment program.**
2. **Therapists who do not specifically specialize in substance abuse are not eligible.**

Therefore, all patients enrolled in treatment at OnCall HLP will be required to see one of the two in house therapists or attend a group meeting, as provided by OnCall HLP **in addition to having a qualified outside therapist.**

All patients with an established outside therapist (who meets qualifications) are encouraged to continue this relationship. A signed consent to release will be required for communication purposes.

Outside Therapy Information/Requirements
Patients will be required to bring in proof of attendance, minimally monthly, with a therapy verification form that must be given to the receptionist at check-in.

The program director will communicate with the outside therapist periodically, if the patient is doing well, these communications will remain periodic. If the relapse or therapeutic recommendations occur, the communication will be more frequent.

Non-compliance with a qualified outside therapist will result in an immediate in-house therapist appointment (Northampton) or required attendance at a monthly group therapy session (offered at both Northampton and Indian Orchard locations) to meet program requirements dictated by the state of Massachusetts.

In-House Therapy Information/Requirements
There are two individual licensed therapists (referred to as in-house clinicians) available at the Northampton location and additional referral resources can be provided to assist patients in finding qualified substance abuse counselors as well as more intensive services when they are indicated.

Patients at the Northampton location will be assigned an in-house clinician based on their preference or by insurance coverage.

Patients at the Indian Orchard location will be offered group meetings, to be held at least twice a monthly at that location or the ability to schedule with either of the two clinicians at the Northampton location.

Patients who have in-house therapists are scheduled with each maintenance visit, changes may apply. Attendance with group therapies are documented in the EMR.

Patient Signature: _____ Date: _____

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I understand, & give consent (please initial)	I don't give consent (please initial)	TREATMENT POLICY AND CONSENTS Please read each consent and initial either the right or left column
		HEALTHCARE INSURANCE WAIVER
		I attest that at the inception of my opioid addiction treatment with OnCall HLP, if I **do not have active HEALTH INSURANCE that covers outpatient Suboxone/Vivitrol treatment I am electing to receive this treatment and I am willing to pay for this treatment myself.** I understand that the cost of this treatment is no less than that which is billed to any insurer contracted with OnCall HLP and I agree to pay for my treatment at the time of service.
		ACKNOWLEDGEMENT OF PRIVACY PRACTICES
		OnCall HLP provides information about how protected health information may be disclosed; including disclosure or information about substance abuse treatment records protected under the Code of Federal Regulation 42 Part 2; psychological and social service records, including communications made to a social worker or psychologist. I understand that the terms of the Notice may change and that I may obtain a revised Notice by contacting OnCall HLP.
		VOLUNTARY PARTICIPATION
		Treatment services are provided on a voluntary basis, all patients/clients have the right to discharge themselves form treatment at any time. If treatment has been mandated, there may be consequences for leaving treatment prematurely, but patient participation remains a voluntary choice.
		INFORMED CONSENT OF HIV TESTING
		I agree to be tested for HIV. I have been given information about the test. All my questions about the test have been answered. I understand that this consent will expire one year from the date it is signed. I understand that I may withdraw my consent at any time. My decision to be tested is completely voluntary. If testing reveals presence of disease, I will be referred for appropriate treatment as deemed necessary by my treating provider.
		APPOINTMENT REMINDERS THOUGH TEXTS
		Please send me a text message reminder before any appointment I may have at the OnCall HLP. I agree to pay any service charges or fees associated with these reminders. I realize that this service is a courtesy and I agree that keeping all appointments are my responsibility and that if I do not receive a test message before a scheduled appointment, I will call to confirm the appointment.
		SCHEDULED APPOINTMENTS
		I agree to keep and be on time for my scheduled appointments understanding that if I cannot make my appointment, I must give at least 24-hour notice or be charged a fee of $25. Appointments that are cancelled due to an emergency must be rescheduled with proof provided of the emergency.
		INFORMED CONSENT FOR HEPATITIS C TESTING
		I agree to be tested for Hepatitis C. I have been given information about the test. All my questions about the test have been answered. I understand that this consent will expire one year from the date it is signed. I understand that I may withdraw my consent at any time. My decision to be tested is completely voluntary. If testing reveals presence of disease, I will be referred for appropriate treatment as deemed necessary by my treating provider.
		INFORMED CONSENT FOR SEXUALLY TRANSMITTED DISEASES
		I agree to be tested for RPR (Syphilis), Chlamydia, and Gonorrhea. I have been given information about the test. All my questions about the test have been answered. I understand that this consent will expire one year from the date it is signed. I understand that I may withdraw my consent at any time. My decision to be tested is completely voluntary. If testing reveals presence of disease, I will be referred for appropriate treatment as deemed necessary by my treating provider.
		INFORMED CONSENT FOR TUBERCULOSIS TESTING
		I agree to be tested for Tuberculosis. I have been given information about the test. All my questions about the test have been answered. I understand that this consent will expire one year from the date it is signed. I understand that I may withdraw my consent at any time. My decision to be tested is completely voluntary. If testing reveals presence of disease, I will be referred for appropriate treatment as deemed necessary by my treating provider.
		INFORMED CONSENT OF PHARMACY COMMUNICATION
		OnCall HLP provides information about how protected health information may be disclosed; including disclosure or information about substance abuse treatment records protected under the Code of Federal Regulation 42 Part 2; psychological and social service records, including communications made to a pharmacist about dose of medication prescribed any contraindicated medications that may be filled while receiving treatment at OnCall HLP. I understand that the terms of the Notice may change and that I may obtain a revised Notice by contacting OnCall HLP.
		OBSERVED URINE DRUG AND ALCOHOL TESTING
		I agree to submit to a supervised urine drug screen at each of my appointment and at every random urine drug and alcohol screen as requested by any member of the staff at the OnCall HLP. If I am unable to submit a urine sample, I agree I will follow the shy bladder protocol as described and educated by the OnCall HLP staff/collector until I am able to provide the sample. I agree that if a member of the staff of OnCall HLP asks me to produce additional samples at any scheduled appointment or random urine drug/alcohol screen and I will comply with the request. I agree not to tamper with ANY urine drug screens and if I do so, I understand this will be grounds for immediate discharge from the Vivitrol/Suboxone program with referral to a more extensive treatment program. I agree to cooperate with unannounced urine or serum toxicology screens as may be requested. I understand that once I am called, I will have 24 (twenty-four) hours to come to the

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		clinic for my drug screen and alcohol testing. I understand that my medical records, course of treatment, and urine drug screen reports will be kept at the OnCall HLP offices in a medical record system that is confidential and locked. The notes will be available to any other healthcare professional involved in my care. For providers located outside of OnCall HLP, I will be asked to sign consents so that my other health care providers can have access to, and be involved in, my medical care. I understand that OnCall HLP's Vivitrol/Suboxone Program will not release the results of my urine toxicology screens and alcohol testing (breathalyzer, ETG-urine alcohol metabolite) to any other agency, program, or institution without a signed release. The purpose of these tests is for my treatment at OnCall HLP only.
		TRANSPORTATION OF MEDICATION
		Buprenorphine, also known as Suboxone, is a powerful medication that can cause severe injury and possible death if it is ingested by any person for whom it is not prescribed, including adolescent and adults. Children are especially at risk for severe injury including but not limited to difficulty breathing, blindness, overdose and death. Serious medical complications have been reported in children who have licked, tasted, sucked or swallowed even small amounts of the medication. Due to these risks, Massachusetts Department of Public Health (MDPH) recommends that this medication be kept in its original container form the pharmacy with a child proof cap and cotton to lessen the risk of unintentional ingestion. Additionally, MDPH recommends that this medication be kept in a locked box at all times and out of the reach of children. I understand that the ingestion of this medication by a person for whom this medication is not prescribed may result in the person's overdose or death. I further understand that if this medication is ingested by someone for whom it is not prescribed, I should immediately call 911 for assistance, even if there are no obvious signs of distress.
		THERAPY PARTICIPATION
		I understand that I am required to participate in substance abuse counseling as part of my participation in Suboxone/Vivitrol Program at **OnCall HLP.** To meet this requirement, I will be doing the following: ☐Weekly counseling ☐Weekly attendance at group therapy

IMPORTANT MEDICATION INFORMATION ABOUT VIVTROL

Vivitrol is a FDA approved medication for treatment of people with opioid and alcohol dependence. Vivitrol is a prescription injectable medicine used as a replacement prevention strategy to opioid dependence, after opioid detoxification. Vivitrol is injected by a healthcare provider once per month into the muscle in your buttocks. The injection is done using a special needle that comes with Vivitrol and is suited to your body type. Once Vivitrol in injected, it lasts for a month and cannot be removed from body.

IMPORTANT MEDICATION INFORMATION ABOUT BUPRENORPHINE

Buprenorphine is a FDA approved medication for treatment of people with opiate dependence. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary, it is estimated that one will be on Buprenorphine for at least 6 months to one year. Buprenorphine treatment can result in physical dependence of an opioid. Withdrawal from Buprenorphine is generally less intense than with heroin or methadone. If Buprenorphine is suddenly discontinued, some patients have no withdrawal symptoms; others may have symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opioid withdrawal, Buprenorphine should be discontinued gradually over several weeks or more, If you are not in withdrawal, buprenorphine can cause severe opioid withdrawal. It may take several days to get used to the transition from the opioid that has been taken and using Buprenorphine. During this time, any use of other opioids may cause an increase in symptoms. After becoming stabilized on Buprenorphine, the use of other opioids will have less effect. Attempts to override the Buprenorphine by taking more opioids could results in an opioid overdose. You should not take any other medications without first discussing with your health care provider. Combining Buprenorphine with alcohol or other medications may be hazardous. Combining Buprenorphine with medications such as Klonopin, Valium, Haldol, Librium, Ativan has a resulted in deaths. The form of Buprenorphine that you will be taking (Suboxone) is a combination of Buprenorphine with a short acting opioid blocker (Naloxone). If a Suboxone were dissolved and injected by someone taking heroin or another strong opioid (i.e. Morphine), it would cause severe opioid withdrawal. Buprenorphine film must be held under the tongue until they completely dissolve, Buprenorphine will not be absorbed from the stomach if swallowed.

Patient Registration Form Signature

I attest that the information answered on this form is truthful to the best of my knowledge and understand that this information will be used to assess and determine if OnCall HLP's medication assisted treatment program is the appropriate level of care for my needs.

Patient Signature:	Date:
Patient Name (PRINT) :	Date:
Staff/Witness Signature:	Date:

OnCall
Healthy Living Program

51 Locust Street Northampton MA 01060 T: 413-584-7425 F: 413-584-7440
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CONSENT FOR TREATMENT WITH BUPRENORPHINE OR VIVITROL AT ONCALL HEALTHY LIVING PROGRAM

The four most common medications used to treat opioid addictions are:

- Buprenorphine with Naloxone (Suboxone)
- Buprenorphine without Naloxone (Subutex)
- Injectable Naltrexone (Vivitrol)
- Methadone

OnCall HLP's medication assisted treatment program prescribes the following:

- Suboxone (buprenorphine/naloxone)
- Subutex (for pregnant women & naloxone allergy)
- Vivitrol for opioid or alcohol dependence (NOT for pregnant women)
- Sublocade (monthly buprenorphine injection)

Buprenorphine is a FDA approved medication for treatment of people with opiate dependence. Buprenorphine can be used for detoxification or for maintenance therapy. Detoxification is typically for a period not less than 30 days or not more than 180 days. Maintenance therapy can continue as long as medically necessary, it is estimated that one will be on Buprenorphine maintenance at least 6 months. Methadone is another medication available for detoxification typically in an inpatient setting or for maintenance in a Methadone clinic. Each drug comes with different risks and benefits. People on methadone can be at a high risk for overdose and death, especially when combined with alcohol or benzodiazepines, therefore methadone is typically dosed daily. The risk to overdose on Buprenorphine or Vivitrol is much less, however you are always at greater risk after a period of abstaining due to lower tolerance.

Buprenorphine treatment can result in physical dependence of an opioid. Withdrawal from Buprenorphine is generally less intense than with heroin or methadone. If Buprenorphine is suddenly discontinued, most patients will have withdrawal symptoms; symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days, general malaise can linger longer. To minimize the possibility of opioid withdrawal, Buprenorphine should be discontinued gradually over several weeks or more.

If you are dependent on opioids, you should be in as much withdrawal as possible when you take the first dose of Buprenorphine. If you are not in withdrawal, Buprenorphine can cause severe precipitated withdrawal. You must be fully detoxed off opioids for seven to ten days to get Vivitrol, your levels will be verified by a urine drug screen before the dose is given.

It may take several days for you to acclimate from the prior opioid used to taking Buprenorphine. During this time, any use of other opioids may cause an increase in symptoms of withdrawal which include, but are not limited to, nausea, vomiting, tremor, diaphoresis, goose flesh, head ache. After becoming stabilized on Buprenorphine, the use of other opioids will have less effect. Attempts to override the Buprenorphine by taking more opioids could result in an opioid overdose. Buprenorphine tablets and film must be held under the tongue until they completely dissolve, Buprenorphine will not be absorbed from the stomach if it is swallowed.

You should not take any other medications without first discussing it with your health care provider, as well as disclose any medical conditions. Combining Buprenorphine with alcohol or other medications may be hazardous. The form of Buprenorphine that you will be taking (Suboxone) is a combination of Buprenorphine with a short acting opioid blocker (Naloxone). If the Suboxone tablet were dissolved and injected by someone taking heroin or another strong opioid (i.e. Morphine), it would cause severe opioid withdrawal.

Vivitrol is a medication available and can treat both opiate and alcohol addiction. It blocks other opioids from acting on the receptors in the brain and can also help ease drug cravings. By blocking the effects of other opioids, it takes away the pleasurable effect, which can help with preventing relapse. Although it is not fully understood as to why an opioid antagonist works in treating alcoholism, it is believed that Vivitrol blocks the pleasurable effects of alcohol by blocking the release of endorphins caused by alcohol. This treatment can help you stop misusing opioids and alcohol and, when combined with counseling, can help you rebuild your life. Vivitrol is a monthly injection. It is recommended that you stay on Vivitrol six months to a year. Termination of Vivitrol does not cause withdrawal.

The goal of Medication assisted treatment at OnCall HLP (buprenorphine or Vivitrol) is to treat substance use disorders and prevent overdose and the negative health and social related effects of substance use disorder.

For women of child-bearing age, medication-assisted treatment continues to be the recommended therapy for pregnant women with an opioid use disorder. Methadone or Buprenorphine are used to treat opioid use disorder in pregnant women. Methadone is currently the standard of care due to more studies and information of neonatal effects. It is critical that you inform the program if you should become pregnant, so buprenorphine can be prescribed. Concern about medication-assisted treatment must be weighed against the negative effects of ongoing misuse of opioids, which can be much more detrimental to mom and baby. A possible problem of taking any opioid (heroin, methadone or buprenorphine) during pregnancy is that after birth, the child may suffer a withdrawal syndrome called Neonatal Abstinence Syndrome. This can may cause the baby to suffer from sleep disturbances, feeding difficulties, tremor, sneezing, irritability, vomiting, weight loss, and seizures. A large proportion of these children will require hospitalization, often for long periods of time. The use of heroin during pregnancy is life threatening to both mom and baby because of the risks of infection, overdose, and intrauterine withdrawal.

Treatment at the OnCall HLP is voluntary and you may withdraw at any time. The program may terminate treatment in certain circumstances (see orientation manual). Options for medically supervised withdrawal, if necessary, will be determined upon decision to terminate services.

Patient Name (print):_____ Patient Signature:_____ Date:_____

OnCall
Healthy Living Program

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568 Main Street Indian Orchard MA 01151 T: 413-301-7759 F: 413-301-7871

Notice of Privacy Practices

YOU ARE RECEIVING THIS NOTICE BECAUSE YOU ARE A PATIENT OF ONCALL. THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
Get an electronic or paper copy of your medical record
▪ You can ask to see or get an electronic or paper copy of your medial record and other health information we have about you. Ask us how to do this. ▪ We will provide a copy or a summary of your health information, usually within 30 days of your written request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record
▪ You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. ▪ We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications
▪ You can ask us to contact you in a specific way (for example, home or office phone, or not to contact you) or to send mail to a different address. ▪ We will say "yes" to your requests.
Ask us to limit what we use or share
▪ You can ask us not to use or share certain health information for treatment, payment, or our operations. ▪ If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information
▪ You can ask for a list (accounting) of the ties we've shared your health information for six years prior to the date you ask, who we shared it with, and why ▪ We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice
▪ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you
▪ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

▪ We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated
▪ You can complain if you feel we have violated your rights by contacting us: **OnCall Healthy Living Program** **Kate Sorensen** **Tele: 413-584-7425 x304** **Online form: www.yourhealthylivingprogram.com**
▪ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: **200 Independence Avenue, S.W.** **Washington, D.C. 20201** **Calling 1-877-696-6775, or** **Visiting www.hhs.gov/ocr/privary/hipaa/complaints/.**
▪ We will not retaliate against you for filing a complaint.
YOUR CHOICES
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: ▪ Share information with your family, close friends, or others involved in your care ▪ Share information in a disaster relief situation If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.
ONCALL RESPONSIBILITIES
▪ We are required by law to maintain the privacy and security of your protected health information.
▪ We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
▪ We must follow the duties and privacy practices described in this notice and give you a copy of it.
▪ We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
▪ For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
OTHER INFORMATION / THINGS YOU SHOULD KNOW
We typically use of share your health information in the following ways.
Treat you
▪ Once you sign consent to treatment, we can use your health information and share it with other professionals who are treating you. Example: ▪ *We may need to disclose your health information to a case manager coordinating your care.*

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Run our organization
▪ We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: ▪ *We use health information about you to manage your treatment, evaluate practitioners, and improve quality.*
Bill for your services
▪ We can use and share your health information to bill and get payment from health plans or other entities. Example: ▪ *We give information about you to your health insurance plan so it will pay for your services.*
We will not market or sell your health information
▪ We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as research. We have to meet many conditions in the law before we can share you information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html http://www.healthinfolaw.org/federal-law/42-cfr-part2
Do research
▪ We can use or share your information for health research.
Comply with the law
▪ We will share information about you if the law allows or requires it.
Address government requests
▪ We can use or share health information about you: ▪ With health oversight agencies for activities authorized by law
Respond to legal actions
▪ We can share health information about you in response to a court order and subpoena. (See Health Insurance Portability and Accountability Act of 1996 (HIPAA) & 42 CFR Part 2)) ▪ If you have any questions about any of the notices above: **ONCALL HEALTHY LIVING PROGRAM** **51 Locust Street** **Northampton MA 01060** **T: 413-584-7425 x304** **F: 413-584-7440**

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Notice of Privacy Practices
Signature Page

This sheet is to confirm that the client listed below received a copy of the Notice of Privacy Practice, which explains how the patient's medical information may be used and disclosed and how they can get access to this information.

We understand that health care information is personal and sensitive. Only the use of appropriate authorizations filled out and signed by the patient allow us to disclose medical information. Re-disclosure cannot occur without additional patient authorization. Unauthorized re-disclosure or failure to maintain the confidentiality of patient information is punishable under Federal and/or State Law.

Your medical record is protected by federal confidentially rules (42 C.F.R part 2). The federal rules prohibit OnCall from making any further disclosure of your information unless further disclosure is expressly permitted in writing by you or as otherwise permitted by 42 C.F.R part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

Please sign below that you understand the information that has been provided to you and had the chance to ask any questions regarding the protection and disclosure of your medical information.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

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I have received a copy of the newly updated (as of September 2018) OnCall HLP Patient Policy Manual. I have read and understand the changes and information presented. I am aware that a copy will be available in the waiting room for review at any time or an additional copy can be obtained for a fee.

Patient Name: _____Date Signed: _____

Patient Signature: _____

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EMERGENCY CONTACT

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Birthdate (DOB): _____

I hereby give consent and authorize ***OnCall Healthy Living Program*** to verbally release and exchange information to:

_____ _____
(list emergency contact name and phone here)

_____ (Patient initials) Specific TYPE OF INFORMATION to be disclosed is limited to emergency situations and rescheduling information.

_____ (Patient initials) This authorization will remain in effect until (date):_____. If date not specified it will remain in effect for one year or until termination of treatment, whichever occurs first.

_____ (Patient initials) The specific PURPOSE AND NEED for such disclosure would be in the case of emergency or to reschedule or change an appointment when client is not available.

_____ (Patient initials) I understand that my records are protected under the Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical, mental and/or emotional illness, including treatment of psychiatric, alcohol or chemical dependency for any admission; diagnosis, prognosis, testing for and/or treatment for HIV infection, Acquired Immunodeficiency Syndrome (AIDS) or Acquired Immunodeficiency Syndrome Related Complex (ARC).

_____ (Patient initials) I understand that this consent may be revoked at any time by submitting a written and dated notice of revocation to the agency releasing this information. (Unless release of information has taken place.)

X _____

Patient Signature Date
(or personal representative, state relationship to patient)

This information has been disclosed from records protected by federal confidentially rules (42 CFR part 2). The federal rules prohibit the authorized above from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. (42 CFR § 2.32)

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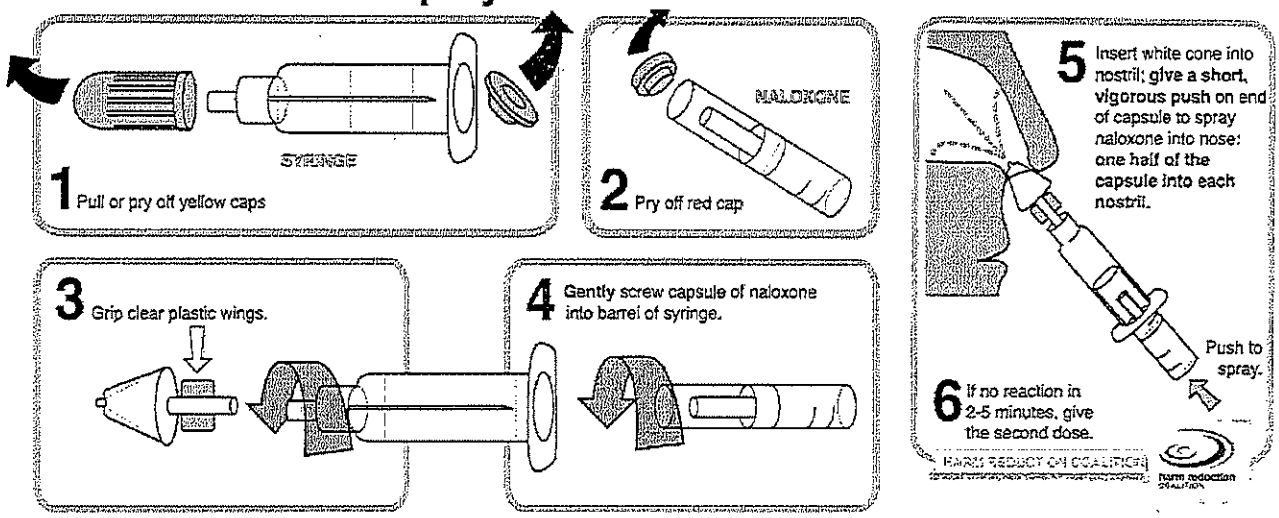
Narcan is an opioid antagonist used for the complete or partial reversal of opioid overdose, including respiratory depression.
Narcan is also used for diagnosis of suspected or known acute opioid overdose.
Narcan has been made available upon request at your local pharmacy. The cost is that of your regular prescription copay.
Use of **Narcan** should be immediately followed by a visit to your local emergency room for further evaluation

How to Give Nasal Spray Naloxone



Directions For Use:

- Step 1: Check to see if the person breathing, if not, do rescue breathing for a few quick breaths.
- Step 2: Affix the nasal atomizer (applicator) to the needleless syringe and then assemble the glass cartridge of naloxone (see diagram).
- Step 3: Tilt the head back and spray half of the naloxone up one side of the nose (1cc) and half up the other side of the nose (1cc).
- Step 4: If there is no breathing or breathing continues to be shallow, continue to perform rescue breathing for them while waiting for the naloxone to take effect.

Step 5: If there is no change in 3-5 minutes, administer another dose of naloxone and continue to breathe for them. If the second dose of naloxone does not revive them, something else is wrong—either it has been too long and the heart has already stopped, there are no opioids in their system, or the opioids are unusually strong and require more naloxone (such as Fentanyl, for example).

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I have been provided *understandable* information on how to obtain and use Narcan safely in the event of an overdose. The Healthy Living Program expressed they were available for questions regarding the use of Narcan should I have any now or in the future. I have been provided copy of the diagram and directions for safe Narcan use. I understand that in the event of an overdose, once able to, myself or someone nearby, should contact 911 immediately.

_____ _____

Patient Printed Name Patient Signature

_____

Date

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Dear OnCall HLP Patient,

Please be aware the Department of Public Health's Bureau of Substance Abuse Services is requiring all state certified substance abuse programs to provide certified substance abuse therapy to all patients. We understand that many of our patients already have an established outside therapist.

If you currently have an outside therapist or counselor, we understand the relationship of trust already established with a therapist is important and integral to the behavioral health portion of your treatment. Therefore, we encourage you to continue seeing and attending all scheduled outside therapy appointments.

However, due to our obligation to provide therapy to all patients, OnCall HLP will offer monthly group therapy and automatically schedule all patients who have outside therapy. It will be the patient's decision whether to attend or not.

Group therapy will be offered at each location.

David Lemke, LMHC/CADC-II, will be running the Northampton group once a month from 5pm – 6pm. The monthly date will be posted at the Northampton office.

Karen Caraker, LICSW, will be running the Indian Orchard group once or twice a month from 8am – 9am. The monthly dates will be posted at the Indian Orchard office.

If you have any questions about this new required service please contact the Practice Manager, Kate Sorensen, at your earliest convenience, 413-584-7425 x304. Please leave a message and your call will be returned.

Please sign the acknowledgement form to verify you understand the information provided.

Thanks

OnCall HLP Staff

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I, _____(print name) have received a copy of the letter explaining the new OnCall HLP Group Therapy Services. I have read and understand the changes and information presented. I am aware that I can attend, in addition to individual therapy, the group therapy sessions offered at each OnCall HLP location.

Patient Name:_____Date Signed:_____

Patient Signature_____

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APPOINTED PHARMACY CONSENT

I _____ by signing this Appointed Pharmacy Consent form, the patient authorizes a provider to disclose to the pharmacy that he or she is being treated for opioid or alcohol dependence the pharmacy is also authorized to contact the provider to discuss treatment.

Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my prescriptions directly to the pharmacy. I also agree to allow the pharmacist to contact the provider to discuss my treatment if necessary so that my buprenorphine prescriptions can be filled. The patient also agrees to allow pharmacist to contact provider listed above to discuss my treatment if necessary so that my prescription can be filled.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

If not revoked this authorization will terminate on _____, 20 (exp. Date) or _____ (exp. Event)

(The consent will expire 365 days after initiating my treatment, unless the provider specified above is otherwise notified by me.

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 (Circle One)

Walgreens Pharmacy- 70 Main St, Florence, MA 01062 Phone: 413-586-1190

Stop & Shop Pharmacy- 228 King St, Northampton, MA 01060 Phone: 413-584-9700

Serios Pharmacy – 63 State St, Northampton, MA 01060 Phone: 413-584-8980

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Click to Save
Click to Print

Adult TB Risk Assessment and Screening Form
(For Patient Record)

Name: _____ DOB: _____ Date: _____

TB Risk Assessment	Yes	No
1) Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East? In what country were you born? _____	☐	☐
2) In the past 5 years, have you lived or traveled in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East for more than one month?	☐	☐
3) In the last 2 years, have you lived with or spent time with someone who has been sick with TB?	☐	☐
4) Do you have (or have you had) any of these medical conditions? Diabetes; Kidney disease; HIV infection; Colitis; Cancer; Stomach or intestine surgery; Rheumatoid arthritis	☐	☐
5) Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections?	☐	☐
6) In the past 1 year, have you injected drugs that your doctor did not prescribe?	☐	☐
7) Have you ever lived or worked in a prison, jail, homeless shelter or long-term care facility? (example: nursing home, substance abuse treatment, rehabilitation facility)	☐	☐

Symptom Screening – At this time, do you have any of these symptoms?	Yes	No
1) Coughing for more than 2-3 weeks?	☐	☐
2) Coughing up blood?	☐	☐
3) Weight loss of more than 10 pounds for no known reason?	☐	☐
4) Fever of 100°F (or 38°C) for over 2 weeks?	☐	☐
5) Unusual or heavy sweating at night?	☐	☐
6) Unusual weakness or extreme fatigue?	☐	☐

If you answer "yes" to any of the questions above, you may be atincreased risk for TB infection. Please give this form to your medical provider.