

UF&Shands Pain Management Service  
Springhill Medical Office Building

4037 NW 86<sup>th</sup> Terrace, 3<sup>rd</sup> Floor  
Gainesville, FL 32606

Phone 352.265.4357 (HELP)  
Fax 352.265.7053

**SUBOXONE INSTRUCTIONS FOR INITIAL APPOINTMENT**

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

Prior to taking the initial dose of Suboxone® :

- A. Must be in a safe environment where you will remain for 48-72 hours so as to avoid any and all driving for the first 72 hours, and in an environment conducive to having access in contacting for prompt medical care if required.
- B. **Must be in withdrawal** prior to initiation of treatment.
- C. No methadone for at least 2 days.  
methadone dose for prior 7 days **must be less** than 31mg/day.
- D. No opioids for at least 12 hours and preferably 24 hours prior to first dose of Suboxone®

Please write in your appointment times:

Appointment 01. Time \_\_\_\_\_ Date \_\_\_\_\_

Appointment 02. Time \_\_\_\_\_ Date \_\_\_\_\_

Appointment 03. Time \_\_\_\_\_ Date \_\_\_\_\_

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## **SUBOXONE® NEW PATIENT INTRODUCTION**

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. Uninsured patients must adhere to strict cash payment policies. Privately insured patients must provide confirmation of coverage for treatment prior to acceptance. To register please complete STEP ONE.

### **STEP ONE**

- Read the entire packet
- Return the **3** required, completed forms to our office
- You will be contacted by phone before acceptance

### **STEP TWO**

- If accepted, call our office at **(325) 265-HELP(4357)**

### **STEP THREE**

- Fill your prescription at the pharmacy
- 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 Suboxone dosing, per physician plan.

### **STEP FOUR**

- Return for frequent follow-up visits per instructions
- Plan to schedule regular two week visits until stable dosing has been achieved
- Plan to schedule monthly maintenance visits thereafter.  
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.

### **Directions:**

Gainesville, Florida is located:

Between mile markers 390 and 362 in Florida on I-75.

Exit 390 on I-75 from either north or south and turn east on 39<sup>th</sup> Boulevard

Head *east* approximately 1 mile past the entrance to the **Health Park**, on the *north* side of 39<sup>th</sup> Boulevard (Montessori School across the street to the south).

The building is a new four story structure.

The parking lot is located around the building.

The **Suboxone Program** is located within the **Pain Management Clinic** on the **3<sup>rd</sup> Floor**.

Phone: **(352) 265.4357(HELP)** (same number as for **Pain Management**) for further driving instructions.

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### **SUBOXONE INFORMATION FOR PATIENTS**

**The Drug Addiction Treatment Act of 2000** made it legal to prescribe an opioid for treatment of addiction. An opioid addicted patient may receive opioid medication for detox or maintenance in a regular office setting, rather than a methadone treatment program. Suboxone® is the only allowed medication.

The restrictions of this law include requirements that the physician have training in opioid addiction treatment, be registered with the Secretary of Health and Human Services and be certified by the Drug Enforcement Administration to prescribe scheduled drugs.

**Suboxone® is a long acting opioid medication**, which binds for a long time to the opioid receptor. Suboxone® is taken sublingually (dissolved under the tongue) because it is not absorbed well by swallowing. This sublingual tablet also contains a small amount of naloxone (Narcan®) which is an opioid antagonist, or blocking/reversing agent, which will cause withdrawal if injected.

Suboxone® has a “ceiling” which makes it safer in case of accidental overdose. In large doses, Suboxone® does not suppress breathing to the point of death in the same way as opioid or methadone. These are some of the unusual qualities of this medication, which make it safer to use outside of the strict confines of a methadone clinic. After stabilization, most patients are able to self-manage Suboxone® for up to four weeks at a time.

**Suboxone® is not equivalent in maintenance strength to methadone.** In order to even try Suboxone® without going into major withdrawal, a methadone-maintained patient would have to taper down to a dose of 30 mg per day of methadone or lower.

**So remember the following tips.** If you are offered Suboxone® by a “friend” and you are taking other opioids, the Suboxone® will force the other opioids off the receptor site and you may go into withdrawal and become very sick. If you dissolve and inject the Suboxone® sublingual tablet, it may induce severe withdrawal because of the naloxone, which is an antagonist and reverses opioids effect when injected. If you wish to transfer to Suboxone® from methadone, your dose has to be at or below 30 mg per day.

There have been deaths reported when Suboxone® is combined with benzodiazepines. (This family of drugs includes Klonopin, Ativan, Halcion, Valium, Xanax, Librium, Serax, etc.) If you are taking any of these drugs, either by prescription or on your own, Suboxone® is not a good treatment for you and should not be taken.

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**SUBOXONE MATERIALS CONFIRMATION**

<b>DOCUMENT</b>	<b>INITIALS</b>
Suboxone Information for Patients	_____
Suboxone Patient Responsibilities	_____
Follow-up Appointment Protocol	_____
Suboxone Treatment Informed Consent	_____
Suboxone Treatment Maintenance	_____
<b>Release of Medical Records Authorization</b>	RETURN THIS FORM _____
<b>Agreement for Treatment with Suboxone®</b>	RETURN THIS FORM _____
<b>Initial Questionnaire for Suboxone® Treatment</b>	RETURN THIS FORM _____
<b>Questionnaire for Chronic Pain issues (as needed)</b>	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:**           **Shands-UF Suboxone Program**  
 4037 NW 86<sup>th</sup> Terrace, 3<sup>rd</sup> Floor  
 Gainesville, FL 32606  
 or fax (352) 265.7053

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

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### **SUBOXONE PATIENT RESPONSIBILITIES**

**I agree to store medication properly.** Medication may be harmful to children, household members, guests, and pets. The pills should be stored in a safe place, out of the reach of children. If anyone besides the patients ingests the medication, the patient must call the Poison Control Center or 911 immediately.

**I agree to take the medication only as prescribed.** The indicated dose should be taken daily, and the patient must not adjust the dose on his/her own.

**I agree to comply with the required pill counts and urine tests.** Urine testing is a mandatory part of office maintenance. The patient must be prepared to give a urine sample for testing at each clinic visit and to show the medication bottle for a pill count, including any reserve medication.

**I agree to promptly make another appointment in case of a lost or stolen medication and I will bring a document to the office visit confirming that a police report has been made for the incident in question.**

**I agree to notify the clinic in case of relapse to drug use or abuse.** An appropriate treatment plan must be developed as soon as possible. The physician should be informed of a relapse **before** it is revealed by random urine testing.

**I agree to the guidelines of office operations.** I understand the procedure for making appointments and cancellations. I have the phone number of this clinic and I understand the office hours. I understand that no medications will be prescribed by phone or on weekends. I understand that I am required to abide by these responsibilities in order to remain on the Suboxone treatment panel of this office. I understand that this treatment program does not provide medical or surgical care outside the scope of routine Suboxone maintenance.

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### **SUBOXONE TREATMENT FOLLOW-UP APPOINTMENT PROTOCOL**

**Follow up appointments will be *at least* monthly.**

The visits are focused on evaluating adherence and the possibility of relapse.

They may include:

- Pill counts
- Urine testing for drug abuse
- An interim history of any new medical problems or social stressors
- Prescription of medication
- **Suboxone will be prescribed during clinic - office visits**
- Appointments do not include evaluation or care for other problems

**Dangerous behavior, relapse and relapse prevention.**

The following behavior will be addressed with the patient as soon as they are noticed:

- Missing appointments
- Running out of medication too soon
- Taking medication off schedule
- Refusing urine testing
- Neglecting to mention new medication or outside treatment
- Agitated behavior
- Frequent or urgent inappropriate phone calls
- Outbursts of anger
- Lost or stolen medication
- Non-payment of visit bills as agreed, missed appointments or cancellations within 24 hours of your appointment
- **Treatment may be discontinued if these behaviors occur**

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### **SUBOXONE TREATMENT INFORMED CONSENT**

Please read this information carefully. Suboxone® (buprenorphine + naloxone) is an FDA approved medication for treatment of people with opioid (narcotic) dependence. It can be used for detoxification or for maintenance therapy when prescribed by qualified physicians.

Suboxone® itself is a weak opioid and reverses actions of other opioids! It can cause a withdrawal reaction from standard opioids or methadone while at the same time having a mild opioid pain relieving effect from the Suboxone®.

The use of Suboxone® can result in physical dependence of the buprenorphine, but withdrawal is much milder and slower than with either opioids or methadone. If Suboxone® is discontinued suddenly, you will have withdrawal symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opioid withdrawal, Suboxone® may be discontinued gradually, usually over several weeks or more.

Because of its opioid-reversing effect, if you are dependent on opioids, **you should be in established opioid withdrawal when you take the first dose of Suboxone®**. You must be off methadone for at least 24 hours or off of other opioids for at least 12 hours **and showing signs of withdrawal before starting Suboxone®**. If you are not in withdrawal at the time of your first visit, you may **not** be given Suboxone®, as it can cause severe opioid withdrawal while you are still experiencing the effect of other opioids. You will be given further instructions and a prescription for Suboxone® that can be filled at the pharmacy of your choice.

Some patients find that it takes several days to get used to the transition to Suboxone® from the opioid they had been using. After stabilized on Suboxone®, other opioids will have virtually no effect. Attempts to override the Suboxone® by taking more opioids could result in an opioid overdose. Do not take any other medication without discussing it with you physician first.

Combining Suboxone® with alcohol or some other medications may also be hazardous. The combination of Suboxone® with **any sedative**, such as alcohol, barbiturates or benzodiazepine mediations such as Valium, Librium, Ativan, Xanax, Serax, or Klonopin has **resulted in deaths**.

The form of Suboxone® given in this program is a combination of *buprenorphine* with a short-acting opioid blocker, *naloxone*. If the Suboxone® tablet was dissolved and injected by someone taking opioid or another strong opioid it would cause severe opioid withdrawal.

Suboxone® tablets must be held under the tongue, and film held on the tongue or in the mouth until completely dissolved. It is then absorbed from the tissue under the tongue and in the mouth (oral mucosa) over the following 30-120 minutes. If swallowed, Suboxone® is not well absorbed from the stomach and the desired benefit will **not** be experienced.

**We do not prescribe, under any circumstances, opioids, methadone, or sedatives for patients desiring maintenance or detoxification from opioids.**

We also recommend that patient remain alcohol-free.

All Suboxone® must be purchased at private pharmacies. We will not supply any Suboxone®.

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### **SUBOXONE TREATMENT MAINTENANCE**

Suboxone® treatment may be discontinued for several reasons:

- Suboxone controls withdrawal symptoms and is an excellent maintenance treatment for many patients. If you are unable to stop your opioid abuse, or if you continue to feel like using opioids, even at the top doses of Suboxone, the doctor may discontinue treatment with Suboxone, or you may be required to enter into a higher level of addiction treatment, or you may be required to seek help elsewhere
- There are certain rules and patient agreements that are part of Suboxone treatment. All patients are required to read and acknowledge these agreements by signature upon admission to the treatment panel. If you do not abide by these agreements you may be discharged from the Suboxone treatment program.
- If appointments cannot be kept as agreed, your status as an active patient will be cancelled - no exceptions.
- Obviously, in the rare case of an allergic reaction to medication, Suboxone must be discontinued.
- Dangerous or inappropriate behavior that is disruptive to our clinic or to other patients may result in your discharge from the Suboxone treatment clinic. This includes patients who present in an intoxicated or impaired state or present themselves while on other opioids, alcohol, Valium, barbiturates, sedatives, or any mood altering substance or medication.
- In the case of dangerous, or intoxicated or impaired behavior, you may be subject to physical restraint or compelled to admission to a psychiatric or detoxification treatment unit. You may also be immediately, and summarily discharged from the clinic.



**Fill-in Name & Contact Information of Primary Care Provider, then Sign and Return This Form**

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**Shand-UF Authorization for Release of Medical Records**

Patient's Name	Date of Birth	Verification of Identity (Driver's License, ID Card, Passport, etc.)
Patient's Address	Medical Record Number	

\*\* Complete the following only if the person authorizing the use or disclosure is not the patient:

Representative's Name	Relationship to Patient	Legal Authority
Representative's Address	Verification of Identity	Verification of Authority

**By signing this form, I authorize the following:**

Disclosure of the patient's PHI <b>from</b> :		Disclosure of the patient's PHI <b>to</b> :	
<i>Person, class of persons, or organization</i>		<i>Person, class of persons, or organization</i>	
Address		Address	
Attn:	<i>Phone</i>	Attn:	<i>Phone</i>

The following protected health information may be disclosed:

**I further authorize** the disclosure of the following information which may be included in the protected health information listed above. *(Check all that are approved.)*

<input type="checkbox"/> Mental Health	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Records created by non-UF/Shands providers
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The purpose of the disclosure is:

I understand that, by federal law, the University of Florida may not use or disclose protected health information without authorization except as provided in the University's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

I understand that I may be charged a fee of up to \$1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by Florida law.

This authorization expires automatically one (1) year from the date signed, if no other date or event is specified.	<i>Expiration Date or Event</i>
This authorization may be used to disclose protected health information of the same type described above, which may be created in the future, until the expiration date.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>I have read and understand the information in this authorization form.</b>	
Signature of Patient or Legal Representative:	<i>Date</i>

**Fill-in Name & Contact Information of Family or Friend Contact, then Sign and Return This Form**

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<i>Person, class of persons, or organization</i>		<i>Person, class of persons, or organization</i>	
Address		Address	
Attn:	<i>Phone</i>	Attn:	<i>Phone</i>

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This authorization may be used to disclose protected health information of the same type described above, which may be created in the future, until the expiration date.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>I have read and understand the information in this authorization form.</b>	
Signature of Patient or Legal Representative:	<i>Date</i>

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**Agreement for Treatment with Suboxone (Buprenorphine/Naloxone)**

**I understand that Suboxone is a medication to treat opioid addiction (for example: opioid, prescription opioids such as oxycodone, hydrocodone, methadone). Suboxone contains the opioid analgesic medication, *buprenorphine*, and the opioid antagonist drug, *naloxone*, in a 4 to 1 (buprenorphine to naloxone) ratio. The naloxone is present in the tablet to prevent diversion to injected abuse of this medication. Injection of Suboxone® by a person who is addicted to opioids will produce severe opioid withdrawal.**

- Yes No 1. I agree to keep appointments and let staff know if I will be unable to show up as scheduled.
- Yes No 2. I agree to report my history and my symptoms honestly to my physician, nurses, and counselors involved in my care. I also agree to inform staff of all other physicians and dentists who I am seeing; of all prescription and non-prescription drugs I am taking; of any alcohol or street drugs I have recently been using; and whether I have become pregnant or have developed hepatitis.
- Yes No 3. I agree to cooperate with urine drug testing (UDT) whenever requested by medical staff, to confirm if I have been using any alcohol, prescription drugs, or street drugs. If indicated, I will agree to same-sex witnessed urine drug testing. If in question, the UDT may require supervision.
- Yes No 4. I have been informed that buprenorphine is an opioid analgesic, and thus it can produce a "high"; I know that taking Suboxone regularly can lead to physical dependence and addiction, and that if I were to abruptly stop taking Suboxone after a period of regular use, I could experience symptoms of opioid withdrawal. I also understand that combining Suboxone with benzodiazepine (sedative or tranquilizer) medications (including but not limited to Valium, Klonopin, Ativan, Xanax, Librium, Serax) has been associated with severe adverse events and even death. I also understand that I should not drink alcohol with Suboxone since it could possibly interact with Suboxone to produce medical adverse events such as reduced breathing or impaired thinking. I agree not to use benzodiazepine medications or to drink alcohol while taking Suboxone and I understand that my doctor may end my treatment with buprenorphine if I violate this term of the treatment agreement.
- Yes No 5. I have been informed that Suboxone is to be placed under the tongue for it to dissolve and be absorbed, and that it should never be injected. I have been informed that injecting Suboxone after taking Suboxone or any other opioid regularly could lead to sudden and severe opioid withdrawal.
- Yes No 6. I have been informed that Suboxone is a powerful drug and that supplies of it must be protected from theft or unauthorized use, since persons who want to get high by using it or who want to sell it for profit, may be motivated to steal my take-home prescription supplies of Suboxone.
- Yes No 7. I have a means to store take-home prescription supplies of Suboxone safely, where it cannot be taken accidentally by children or pets, or stolen by unauthorized users. I agree that if my Suboxone pills are swallowed by anyone besides me, I will call 911 or Poison Control at 1-800-222-1222 immediately and I will take the person to the doctor or hospital for treatment.
- Yes No 8. I agree that if my doctor recommends that my home supplies of Suboxone should be kept in the care of a responsible member of my family or another third party, I will abide by such recommendations.
- Yes No 9. I will be careful with my take-home prescription supplies of Suboxone, and agree that I have been informed that if I report that my supplies have been lost or stolen, that

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my doctors will not be requested or expected to provide me with make-up supplies. This means that if I run out of my medication supplies it could result in my experiencing symptoms of opioid withdrawal. Also, I agree that if there has been a theft of my medications, I will report this to the police and will bring a copy of the police report to my next visit.

- Yes No 10. I agree to bring my bottle of Suboxone in with me for every appointment with my doctor so that remaining supplies can be counted.
- Yes No 11. I agree to take my Suboxone as prescribed, to not skip doses, and that I will not adjust the dose without talking with my doctor about this so that changes in orders can be properly communicated by to my pharmacy.
- Yes No 12. I agree that I will not drive a motor vehicle or use power tools or other dangerous machinery during my first days of taking Suboxone or after a dosage increase, to make sure that I can tolerate taking it without becoming sleepy or clumsy as a side effect of taking it.
- Yes No 13. I understand that I may not be able to drive a car or operate any form of heavy machinery during the induction phase with buprenorphine because of possible psychomotor impairment that I may have during this induction phase. I will assume all responsibility for determining the method of my transportation to and from the treatment facility during my first days of taking Suboxone. I hereby vacate any and all responsibility for any transportation issues from the treating physician, facility and staff.
- Yes No 14. I want to be in recovery from addiction to all drugs, and I have been informed that any active addiction to other drugs besides opioid and other opioids must be treated by counseling and other methods. I have been informed that buprenorphine, as found in Suboxone, is a treatment designed to treat opioid dependence, not addiction to other classes of drugs.
- Yes No 15. I agree that medication management of addiction with buprenorphine, as found in Suboxone, is only one part of the treatment of my addiction, and I agree to participate in a regular program of professional counseling while being treated with Suboxone.
- Yes No 16. I agree that professional counseling for addiction has the best results when patients also are open to support from peers who are also pursuing recovery.
- Yes No 17. I agree to participate in a regular program of peer/self-help while being treated with Suboxone.
- Yes No 18. I agree that the support of loved ones is an important part of recovery, and I agree to invite significant persons in my life to participate in my treatment.
- Yes No 19. I agree that a network of support, and communication among persons in that network, is an important part of my recovery. I will be asked for my authorization, to allow telephone, email, or face-to-face contact, as appropriate, between my treatment team, and outside parties, including physicians, therapists, probation and parole officers, and other parties, when the staff has decided that open communication about my case, on my behalf, is necessary.
- Yes No 20. I agree that I will be open and honest with my counselors and inform staff about cravings, potential for relapse to the extent that I am aware of such, and specifically about any relapse which has occurred before a drug test result shows it.
- Yes No 21. I have been given a copy of clinic procedures, including hours of operation, the clinic phone number, and responsibilities to me as a recipient of addiction treatment services, including buprenorphine treatment with Suboxone.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Signature/Title: \_\_\_\_\_

Date: \_\_\_\_\_

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**Substance Use Disorder Evaluation**  
**Initial Questionnaire for Suboxone Treatment**

Patient name: \_\_\_\_\_

Age: \_\_\_\_\_

**Identifying Information:**

**Emergency Contact(s) Information:**

*Name(s) and number(s)*

Address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Phone Number : \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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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Fax 352.265.7053

**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**

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

**Bath Salts**

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

**Psychiatric and Substance Treatment History:**

Inpatient Psychiatric: \_\_\_\_\_

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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 \_\_\_\_\_ Obsessive Compulsive Disorder \_\_\_\_\_

Bipolar Disorder \_\_\_\_\_ Schizophrenia \_\_\_\_\_

Post-Traumatic Stress Disorder \_\_\_\_\_ 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 \_\_\_\_\_

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**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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 \_\_\_\_\_



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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

**Developmental History:**

Where born/raised? \_\_\_\_\_

**Family of origin information:**

Father	alive or dead	age	_____	occupation	_____	divorced?	_____
Mother	alive or dead	age	_____	occupation	_____	divorced?	_____
Siblings	alive or dead	age	_____	occupation	_____	divorced?	_____
	alive or dead	age	_____	occupation	_____	divorced?	_____
Children:	son / daughter	age	_____	son / daughter	age	_____	
	son / daughter	age	_____	son / daughter	age	_____	
	son / daughter	age	_____	son / daughter	age	_____	

**Spiritual Beliefs:**

Raised in Faith: \_\_\_\_\_  
 Current Practice: \_\_\_\_\_

**Recovery Activities:**

Meetings: \_\_\_\_\_

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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: \_\_\_\_\_

\_\_\_\_\_

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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?

\_\_\_\_\_  
\_\_\_\_\_

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**For patients with concomitant Chronic Pain Related Issues**

**Current opioid (Chronic Opioid Agonist Therapy) treatment:**

**What opioid(s) are you currently using?**

Medication	Dosage (mg)	Number of times per day	Route (PO, IM, IV, Patch)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How much **pain relief** do they provide?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How much **improvement in your function** do they provide?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How much **improvement in your mood** do they provide?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How much **improvement in energy** do they provide?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Do you keep them in a **safe place**?    Y     N

If yes, where? \_\_\_\_\_

Please list the **pain-related medications** you have **received in the past**:

Medication	Dosage (mg)	Took for how long?	Why did you stop taking it?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Please indicate the **pain-related injections** or **other procedures** you have received:

	Approximate dates (mo, yr)	Pain Improved? (mark Y/N)
Epidural steroid injection (neck)	_____	_____
Epidural steroid injection (low back)	_____	_____
Facet joint injection(s)	_____	_____
Trigger point injection(s)	_____	_____
Sacroiliac injection	_____	_____
Spinal cord stimulator	_____	_____
Spinal pain pump	_____	_____
Others (specify) :	_____	_____
	_____	_____

Please indicate **any diagnostic tests** you have had for your pain problem(s):

	Body part(s)	Approximate dates (mo, yr)
X-rays	_____	_____
MRI	_____	_____
CAT scan	_____	_____
EMG/NCV	_____	_____

**Other things that you use to manage your pain include** (circle all that apply):

- |             |           |                       |              |                   |
|-------------|-----------|-----------------------|--------------|-------------------|
| distraction | alcohol   | relaxation techniques | meditation   | hypnosis          |
| massage     | TENS unit | cold/warm compresses  | chiropractic | pain psychologist |

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### **INFORMATION FOR FAMILY MEMBERS**

Family members of patients who have been prescribed Suboxone® for treatment of addiction often have questions.

#### **What is an opioid?**

Opioids are addictive opioids in the same family as opium and opioid. This includes many prescription pain medications such as Codeine, Vicodin, Demerol, Dilaudid, Morphine, Oxycontin, and Percodan, methadone, and Suboxone.

#### **Why are opioids used to treat addiction?**

Many family members wonder why Suboxone is used to treat opioid addiction since it is in the same family as opioid. Isn't this substituting one addiction for another? Suboxone is not "just substitution". It is *blocking the opioid sites in the body* and *preventing any response to any opioids taken*.

#### **What is the right dose of Suboxone®?**

The "right" dose of Suboxone is the dose that prevents any response to opioids.

#### **How can the family support treatment?**

Even though maintenance treatment for opioid addiction works very well, it is NOT a cure by itself. This means that the patient may continue to need the *blocking opioid dose* of Suboxone with regular monitoring by our clinic. This is similar to other chronic disease, such as diabetes, or asthma, which requires long term treatment. The best way to help support the patient is to encourage regular medical care and encourage the patient not to skip or forget to take medication. **It is our goal to encourage the patient to learn to live independent of Suboxone.** This will take counseling and time.

**Regular Medical Care:** Most patients will be required to see us for ongoing Suboxone treatment every two to four weeks once stabilized. If the patient misses an appointment s/he may not be able to refill the medication on time and may even go into withdrawal. The patient will be asked to bring the medication and prescription bottles / boxes to the office on regular visits.

**Special Medical Care:** Some patients may also need care for other medical problems, such as hepatitis or HIV(AIDS) disease. They will need to see other physicians for these illnesses. We will not provide HIV treatment in our clinic. The patient will need to seek the assistance of specialists elsewhere for this problem.

**Counseling:** Patients who are recovering from addiction usually need counseling at some point in their care. We encourage patients to keep any other regular appointments with an individual counselor or group therapy. These appointments are key parts of treatment and work together with the Suboxone program to improve success in addiction treatment.

Sometimes family members may be asked to join in family therapy sessions, which also are geared to improve addiction care. It is our belief that successful withdrawal from opioid use will only come when there has first been a substantial change of heart and mind about God's purpose in the patient's life.

**Meetings:** Most patients use some kind of recovery group to maintain sobriety. In the first year of recovery some patients go to meetings every day or several times per week. These meetings work

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toward improving success in treatment, in addition to taking Suboxone®. Family members may have their own meetings, such as Al-Anon or ACA, to support them in adjusting to life with a loved one who has an addiction.

**Taking the medication:** Suboxone® is unusual because it must be dissolved under the tongue, rather than swallowed. Please be aware that **this takes a few minutes**. While the medication is dissolving, the patient will not be able to answer the phone, or the doorbell, or speak very easily. This means that the family will get used to the patient being “out of commission” for a few minutes whenever the regular dose is scheduled.

**Storing the medication:** If Suboxone is lost or misplaced, or should one skip doses, one may go into withdrawal. 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. To avoid confusion, it is best if the location of the Suboxone is NOT next to the vitamins, aspirin, or other over-the-counter medications. If a family member or visitor takes Suboxone by mistake, s/he should be checked by a physician immediately.

### **What does Suboxone treatment mean to the family?**

When chronic diseases progress untreated, they may lead to severe complications, which can lead to disability and death. Fortunately, Suboxone maintenance can be a successful treatment, especially if it is integrated *with counseling and support for life changes* that the patient has to make to remain clean and sober.

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

It is our hope that we can assist the patient in becoming drug free. Research is showing that some persons have more risk for becoming addicted than others, and that some of the risk is genetic. So, when one member develops opioid addiction, it means that other blood relatives should consider themselves at risk of developing addiction or alcoholism. It is especially important for young people to know they are especially at risk, even with alcohol, of becoming addicted.

Sometimes when the patient improves and starts feeling “normal”, the family has to get used to the “new” person. The family interactions (sometimes called “family dynamics”) might have been all about trying to help this person in trouble. Now s/he is no longer in so much trouble. Some families can use some help themselves during this change and might ask for **family therapy** for a while.

**In summary:** Family support can be very helpful to patients on Suboxone® treatment. It helps if the family members understand how addiction is a chronic disease that requires ongoing care and heart/spiritual change for it to be successful. In addition to understanding a little about how the medication works it is important for the family to also come to understand the spiritual side of this struggle. Often, the family members can greatly benefit from a change of heart as well.