statcare
Urgent & Walk-In Medical Care

Name: _____
DOB: _____
COMPLETE and RETURN

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INFORMED CONSENT AND AGREEMENT FOR TREATMENT SUBOXONE

☐ Y ☐ N I freely and voluntarily agree to accept this informed consent and treatment agreement as outlined in the following pages, by placing a checkmark next to Yes or No for each question, initialing each page and signing my name on the last page of this consent document.

☐ Y ☐ N I agree to report my history and my symptoms honestly to my treating physician and staff.

☐ Y ☐ N I also agree to inform office staff of all other physicians and dentists I see; of all prescriptions and non-prescription drugs I am taking; of any alcohol or street drugs I have recently been using. If I develop any new medical problems or am prescribed any new medications, I will notify my Suboxone doctor/staff immediately,

☐ Y ☐ N I want to be in recovery from addiction to all drugs, and I understand that any active addiction to other s**ubstances other than opiates (cocaine, methamphetamine, marijuana, etc.)** must be treated by counseling and other methods. I understand that Suboxone only treats opiate dependence.

☐ Y ☐ N I understand that Suboxone is itself a partial agonist opiate and can produce physical dependence similar to other opiates. I also understand that if an addict with opiates in their system takes Suboxone, they could experience immediate, acute, total, severe withdrawal.

☐ Y ☐ N I understand that mixing buprenorphine with other medications, especially benzodiazepines (nerve medication) (such as Valium, Klonopin, Ativan, Xanax, Librium) and/or other drugs of abuse including alcohol, can be dangerous. Accidental overdose, oversedation, coma, and death are understood risks if I abuse any other substances while on Suboxone.

☐ Y ☐ N I understand that Suboxone (buprenorphine/naloxone) treatment for opiate dependence is most effective when combined with drug abuse counseling, 12-step recovery work, or a recovery support group. During my treatment with Suboxone, I agree to seek additional counseling and to work on a program of recovery.

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☐ Y ☐ N 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.

☐ Y ☐ N I understand that I will be asked to sign a 'consent for release of information' that is very specific about with whom, why and for what period of time my Suboxone clinic can discuss my treatment. I have been assured my chemical dependence records will be vigorously protected in compliance with State and Federal laws.

☐ Y ☐ N I agree to be honest and sincere with all clinic staff and my physician, should I relapse during my recovery to drug abuse. I know this can be life-threatening. The physician should be notified before a urine screen reveals it. Trust goes a LONG way in treatment relationships,

☐ Y ☐ N I understand that Statcare does not accept insurance for my suboxone treatment, I will pay for my suboxone visit at the time of visit. Statcare will not submit any suboxone visit to my insurance company.

☐ Y ☐ N I understand that there will be random drug screens and I will be responsible for paying for the test at the time of visit.

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Our Responsibility

We here at Statcare are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition.

We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

Patient Name _____

Date _____

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Drug Abuse Screening Test (D.A.S.T.)

Check the box, if you answer yes to any of the following questions
SCORE:

- ☐ Have you ever used drugs other than those required medically?
- ☐ Have you ever abused prescription drugs?
- ☐ Do you abuse more than one drug at a time?
- ☐ I am unable to stop using drugs when I want to.
- ☐ I try to limit my drug use to certain situations.
- ☐ Do you abuse drugs on a regular basis?
- ☐ Any "blackouts" or "flashbacks" from drug use?
- ☐ Do you ever feel bad' about your drug use?
- ☐ Does your spouse or parents complain about your drugs?
- ☐ Do friends or relatives know or suspect you abuse drugs?
- ☐ Has drug abuse ever caused any problems between you/your spouse?
- ☐ Family members sought help for problems related to your drug use?
- ☐ Ever lost friends because of your use of drugs?
- ☐ Ever neglected your family or missed work because of drugs?
- ☐ Have you ever been in trouble at work because of drug use?
- ☐ Have you ever lost a job because of drug use?
- ☐ Have you gotten into fights while under influence of drugs?
- ☐ Ever arrested because of unusual behavior while using drugs?
- ☐ Ever arrested for driving under the influence of drugs?
- ☐ Have you engaged in illegal activities to obtain drugs?
- ☐ Have you ever been arrested for possession of illegal drugs?
- ☐ Ever experienced withdrawal symptoms as a result of heavy drug intake?
- ☐ Ever experience medical problems as a result of drug use?
- ☐ Have you ever gone to anyone before now for help with drug problem?
- ☐ Have you ever been hospitalized for problems related to drug issues?
- ☐ Ever involved in a treatment program specifically related to drug use?
- ☐ Ever treated as an outpatient for problems related to drug abuse?
- ☐ I cannot get through the week without using drugs?

Total:___

{Each positive response yields a point of 1. A score of greater than 5 generally positive for substance abuse problems - requires further evaluation)

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1. Is there any physical problem that makes it hard for you to give routine urine samples?

_____
_____

2. Do you have any disabilities that make it hard for you to read labels or instructions?

_____
_____

3. What are your reasons for being interested in Suboxone therapy?

_____
_____

4. What "triggers' do you have which put you in danger of relapse?

_____
_____

5. How do you deal with those triggers when they occur?

_____
_____

6. What plans do you have for the coming year? *W*ork? Home? Family? Other?

_____
_____

7. How do you feel you will handle the responsibilities of Suboxone at home? (Keeping your medication, safe, secure)

_____
_____

8. Is anyone you live with also actively addicted to any drugs or alcohol?

_____
_____

9. Close friends or co-workers actively addicted?

_____
_____

10. What are the major sources of stress in your life?

_____
_____

11. Any other avenues to relieve stress other than chemical use? Hobbies etc?

_____
_____

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12. What do you plan to replace your drug-seeking / intoxicated time with?

_____
_____

13. Anything you feel *we* as a treatment staff need to know before going forward?

_____
_____

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SUBOXONE PATIENT INFORMATION

Last name	First name	
Phone number (☐ ☐ ☐) ☐ ☐ ☐ - ☐ ☐ ☐ ☐	DOB / /	Gender ☐ M ☐ F ☐ Alt

Address Street	Address	City
City	Zip Code	Can we send mail? ☐ Yes ☐ No

Social Security Number ☐ ☐ ☐ - ☐ ☐ ☐ - ☐ ☐ ☐ ☐	Cell phone (☐ ☐ ☐) ☐ ☐ ☐ - ☐ ☐ ☐ ☐
Email Address	Alt. phone (☐ ☐ ☐) ☐ ☐ ☐ - ☐ ☐ ☐ ☐

Family Physician:	Phone number (☐ ☐ ☐) ☐ ☐ ☐ - ☐ ☐ ☐ ☐

Allergies to medication: ☐ NKDA _____ _____	Past surgeries: _____ _____
Current medications _____ _____ _____	Past medical history _____ _____ _____
Psychiatric History _____	Hospitalization _____

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REASON FOR SEEKING SUBOXONE TREATMENT

☐ I desire treatment for high risk of relapse, no current narcotic use.

☐ I desire treatment due to current addiction / physical dependence

DRUG USE HISTORY

Select your opiate drug of choice and the dose taken (mg, gram)

☐ Hydrocodones: _____ ☐ Tramadol: _____

☐ Methadone: _____ ☐ Heroin: _____

☐ Oxycodones: _____

Route of opiate usage (check all that apply):

☐ Ingested ☐ Snorted ☐ Smoked ☐ Injected

Current Opiate Habits

Number of times per day used:_____

Number of years, months, days you have used drugs at this frequency_____

Total length of time in opiate drug addiction: _____

Usual monthly expense for opiates: $ _____

Legal problems from drug use: _____

Have you ever used any of the following?

☐ Cocaine ☐ Marijuana ☐ Alcohol ☐ Methamphetamine ☐ Nicotine ☐ Caffeine

Are you currently using any of the following?

☐ Cocaine ☐ Marijuana ☐ Alcohol ☐ Methamphetamine ☐ Nicotine ☐ Caffeine

Are you currently prescribed any Benzodiazepines, such as (Xanax, Klonopin, Valium, Lorzepam, etc.)?

Name of Benzodiazepine you are prescribed: _____,

If so at what dose mg: _____

How often do you use it _____per (day/week/month)

☐ ☐ ☐

When was the last time you used any opiates? Date: _____Time:_____

Name of opiate last used _____How much did you use_____ (*pill*/*mg*)

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HISTORY OF OPIATE THERAPY:

1. Have yo*u,* or are you, currently using Suboxone/Subutex/Zubsolv/Bunavail? ***Y /N***
2. Have you ever been prescribed Suboxone/Subutex/Zubsolv/Bunavail? ***Y/N***
3. If so how much have you used in a 24 hour period:
   _____
4. Any problems from taking Suboxone/Subutex/Zubsolv/Bunavai?
   _____
   _____
5. History of drug abuse treatments (names of facilities, types of treatment, year you went, and for how long):_____
   _____
6. Have you ever overdosed from opiate drug use? If so when:
   _____

MEDICAL HISTORY:

Have you had any blood tests in last 6 months?
☐ Hepatitis ☐ HIV/AIDS ☐ Abnormal Liver Enzymes

Any other blood tests in last 6 months? ☐ Y ☐ N If so what kind?:
_____

PSYCHIATRIC HISTORY

History of suicidal thoughts or suicide attempts: ☐ Y ☐ N
If yes, when was the last time you had thoughts of suicide:_____
Family history of substance abuse: ☐ Y/ ☐ N Who?_____
Personal history of physical or sexual abused as child: ☐ Y ☐ N
Personal history of physical or sexual abuse as an adult: ☐ Y ☐ M

WOMEN

Any chance at all that you might be **Pregnant**? **Y/N** (very important)
Last period: _____ #pregnancies_____ #children: _____