Omnis Health Life
Wellness Center

MEDICAL RECORD FACE SHEET

Name:		Pt. Number:	Admission Date:
D.O.B:	Age:	Gender:	Marital Status:
Race:	Religion:	SSN:	Height:
Weight:	Hair Color:	Eye Color:	Pregnant? Yes No
Employed? Yes No		Disabled? Yes No	

PATIENT ADDRESS:	If Employed,
Street:	Employer Name:
City:	Employer Address:
State: Zip:	
Home Phone:	
Cell Phone:	Telephone:
E mail:	

PRIMARY CARE PROVIDER:	
Name:	Phone:
Address:	
Hospital of Choice:	

EMERGENCY CONTACTS:	
Name:	Relationship:
Address:	
Telephone:	

HISTORY:
Significant Medical History:
Current Medical Conditions:
Current Prescribed Medications:
Over the Counter Medications/Vitamins:
Known Allergies:
History of Mental Health Issues:
Current Mental Health Issues:

Omnis Health Life
Wellness Center

CONSENT TO MEDICATION ASSISTED TREATMENT

Name of Patient: _____

Patient ID: _____ Gender: M _____ F _____

Name of Medical Director: _____

I hereby authorize and give my voluntary consent to the above-named Medical Director, and/or any appropriate authorized assistants he/she may select, to administer or prescribe the drug Methadone or Buprenorphine as an element in the treatment for my dependence on heroin and/or narcotic drugs. I also understand that generic products of Suboxone or Subutex may be used in my treatment.

The therapies necessary to treat my condition(s) have been explained to me and I understand that it will involve my taking daily dosages of Methadone or Suboxone/Subutex, or other drugs, that are used in the treatment of dependence on heroin and/or other narcotic drugs.

It has been explained to me that Methadone or Suboxone/Subutex are a narcotic drug which can be harmful if taken without medical supervision. I further understand that Methadone and Suboxone/Subutex are addictive medications and may, like other drugs used in medical practice, produce adverse results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me and I desire to receive Methadone or Suboxone/Subutex.

I realize that for some patients, Methadone or Suboxone/Subutex treatment may continue for extended periods of time, but that periodic consideration shall be given concerning my complete withdrawal from Methadone or Suboxone/Subutex.

I understand that I may withdraw from this treatment program and discontinue the use of the medication at any time and that I shall be afforded detoxification under medical supervision.

I understand that the use of other medications/drugs/substances in conjunction with Methadone or Suboxone/Subutex may cause me harm and I agree that I shall inform any and all doctor(s), who may treat me for any medical problem/condition, that I am enrolled in a Methadone or Suboxone/Subutex treatment program.

I also understand that during the course of treatment, certain conditions may require or necessitate the use of additional or alternative therapies. I understand that these alternative therapies shall only be utilized when and if the Program or Medical Director deems it necessary, according to professional judgment.

FOR FEMALE PATIENTS OF CHILDBEARING AGE:

To the best of my knowledge, I am am not pregnant at this time. I understand the possible risks involved with long-term use of Methadone or Suboxone/Subutex. I also understand that, as with heroin and other narcotic drugs, information about the effects on pregnant women and on their unborn children is currently inadequate to guarantee that it may not produce significant or serious side effects.

It has been explained to me and I understand that Methadone and Suboxone/Subutex are transmitted to the unborn child and will cause physical dependence. I understand that if I am pregnant and suddenly stop taking Methadone or Suboxone/Subutex, I and/or the unborn child may experience withdrawal symptoms that could adversely affect my pregnancy and/or the child.

It has been explained to me and I understand that Methadone is the therapy of choice in the treatment of opioid dependence for pregnant women.

I understand that use of any other drugs/medications or substances while on Methadone or Suboxone/Subutex may adversely affect and/or harm my unborn child and/or me. I shall use no other drug/medications or substances without the Medical Director or his/her assistant's approval. I shall inform any and all doctors, who see me during this or future pregnancies, of my current and past participation in a Methadone or Suboxone/Subutex treatment program. I shall inform any and all doctor(s) who see my child after birth of my participation in a Methadone or Suboxone/Subutex treatment program during the child's pregnancy. I understand that this information will facilitate the physicians' care of me and/or the child.

I understand that, for a brief period following birth, the child may show temporary irritability or other ill effects due to my use of Methadone or Suboxone/Subutex. It is essential for my child's physician to know of my participation in a Methadone or Suboxone/Subutex treatment program so that my child can receive appropriate medical treatment. All of the above possible effects of Methadone or Suboxone/Subutex have been fully explained to me and I understand that at present, results from studies on long term use of the drug are inconclusive and cannot assure complete safety to my child. With full knowledge of this, I consent to its use and promise to immediately inform the Medical Director or one of his assistants if I become pregnant in the future.

FOR ROUTINE HIV AND HEPATITIS C SCREENING

I acknowledge that routine screening for HIV and Hepatitis C is done on all patients at Omnis Health Life Wellness Center. I have been given information regarding HIV these diseases, how they are transmitted, and potential treatments. I know that testing is voluntary that my HIV and Hepatitis related information will be kept confidential. I understand that the results will be documented in my medical chart.

Consent for HIV and Hepatitis related testing remains in effect until I revoke it, or until the following date_____
I may revoke my consent orally or in writing at any time.

_____ I do not consent to HIV testing

_____ I do not consent to Hepatitis testing

Signature of Patient _____ D.O.B _____ Date_____

Counselor Signature _____ Date _____

Agreement for Opioid Treatment

Patient: _____

The prescribing and dispensing of medication are regulated by provincial and federal guidelines, as well as by policies unique to this clinic. The purpose of this contract is both to inform you about medication maintenance therapy and to document that you agree to the rules and obligations described in this agreement.

ACKNOWLEDGMENTS

I acknowledge the following: patient MUST read

1. Methadone/Buprenorphine is an opioid. Taking it will result in physical dependence on this medication. Sudden decreases in dose or discontinuation of this medication will likely lead to symptoms of opioid withdrawal.
2. I am already (before beginning treatment) physically dependent on at least one form of opioid and have been unable to discontinue the use of opioids.
3. I have tried to the best of my ability other possible treatments for opioid dependence, and these attempts have been unsuccessful.
4. Taking my mood-altering substance with medication can be potentially dangerous. There have been reported deaths caused by combining medication with alcohol, opioids, cocaine, barbiturates and/or tranquillizers (such as Valium, Ativan, etc.)
5. I may voluntarily withdraw from the medication treatment program at any time.
6. I must inform any physician or dentist who prescribes and opioid for me that I am on medication. I understand that not doing so is considered “double doctoring” which is a criminal offense.
7. Regarding pregnancy, I understand that medications can have effects on a developing fetus, and that specialized care will be required to reduce any harm to my fetus if I am or become pregnant while on medication. I acknowledge that I may need to be transferred to another clinic in this case.
8. It may be unsafe to drive a car or other motor vehicles, or to operate machinery, during the stabilization period after starting medication and during dose adjustments.
9. Poppy seeds and certain over-the-counter medication may result in positive drug urine screens.
10. The common side effects of medication are sweating, constipation, decreased sexual function, drowsiness, increased weight, and water retention. These are usually mild and can be lessened with help from a doctor. Many of these side effects will go away on their own in time. There are no known serious long-term effects from taking medication.
11. This clinics doctor is not my family doctor. I need a family doctor while I am on the program, to deal with medical problems not related to medication maintenance.

BEHAVIOR WHILE IN THE CLINIC

I understand that the following behavior is not acceptable and may result in the termination of my treatment.

1. Any violence or threatened violence directed toward the clinic staff or other clients.
2. Disruptive behaviors in or near the clinic.
3. Any illegal activity, including selling or distributing any kind of illicit drug in or near the clinic.
4. Any behaviors that disturbs the peace in or near the clinic.

I agree to maintain positive, respectful behavior toward staff and other program clients at all times when in the clinic. Threats, racist or sexist remarks, physical violence, theft, property vandalism or mischief, possessing weapons and selling or buying illicit substances while in or near the clinic are extremely serious program violations that may result in immediate termination or transferred of my treatment.

Omnis Health Life
Wellness Center

OBLIGATIONS OF BEING ON THIS PROGRAM

1. I agree to take only one dose of medication a day, unless I am receiving a split dose, and have my ingestion witnessed by the dispensing nurse on those days I don't have "take home" medication.
2. I must inform any physician or dentist who treats me for any medical or psychiatric condition that I am receiving medication, so that my treatment can be tailored to prevent potentially dangerous interactions with medication. I will bring the prescriptions and/or bottles for any medications I am prescribed to the clinic and to the medical staff to check for any potential drug interactions.
3. I agree to provide a supervised urine sample when requested by program staff. If I refuse to provide this sample, the result may be that I do not receive take-home medication doses.
4. If I do not provide a urine sample, my record may be marked that this sample was assumed to contain drugs. This could further affect my level of take homes.
5. I understand that tampering with my urine sample in any way is a serious violation of the program, and it may affect my future status in the program.
6. I agree to keep all my appointments with the physician who is prescribing medication for me. I understand that if I miss appointments repeatedly, this may result in the reduction of my take home level, administrative taper, and could interfere with the doctor-client relationship.
7. I agree to inform my counselor/staff of any travel plans two weeks in advance that guest dosing can be arrange when necessary.
8. I understand and agree that the clinic will not provide me with take homes when I am unstable this includes the continuous use of illicit drugs, and other areas defined by Federal regulations.

GROUNDS FOR REFUSAL OF A DOSE

I understand that I will not be given a dose of medication in the following situations:

1. If I appear to be intoxicated or under the influence of some other substance. (I may also be requested to see a physician in this case. For the sake of my own physical safety, I may be asked to wait before receiving my dose or refused a dose for that day).
2. If I arrive late, after the end of the clinic hours.
3. If I exhibit threatening or disruptive behavior toward any staff member or another client.
4. If I miss than 3 doses of medication in a row. (To re-start treatment at this point, I may need to be seen by a physician).

My signature below indicates that I agree to follow the obligations and responsibilities outlined in this agreement. I understand that, if I fail to meet my responsibilities as a participant in this agreement, I may be discharged from the medication program or transferred to another facility.

I have had an opportunity to discuss and review this agreement with a staff member and any questions I had have been answered to my satisfaction.

_____ _____

Patient Signature Date

_____ _____

Counselor Signature Date

Omnis Health Life
Wellness Center

Patient Rights and Responsibilities

I have received and read Omnis' "Patient Rights and Responsibilities" statement and understand my rights and responsibilities as a Patient here, including a basic understanding of the Federal confidentiality law granting protection of my medical records.

_____ _____

Patient Signature Date

_____ _____

Counselor Signature Date

Omnis Health Life
Wellness Center

I_____, have received the Omnis Health Life Wellness Center patient handbook.

Signature _____ Date _____

Witness _____ Date _____

Omnis Health Life
Wellness Center

Consent to be Photographed

I, _____, consent to be photographed at Omnis Health Life.

Signature _____ Date _____

Witness _____ Date _____

Omnis Health Life
Wellness Center

FINANCIAL AGREEMENT- METHADONE/BUPRENORPHINE

ADMISSION FEE

The admission fee for methadone is $180.00 that covers the initial lab work, physicians examination, screening, bio psychosocial assessments, treatment planning, initial orientation to the program, etc. The admission fee of $250.00 for buprenorphine covers the initial lab work, physicians examination, screening, bio psychosocial assessments, treatment planning, initial orientation to the program, etc.

TREATMENT FEE

The self-pay treatment fee is $87.00 per week for methadone. Omnis Health Life permits the weekly fee to be paid at a daily rate of $13.00.

The self-pay treatment fee is $108.50 per week for dose of 8mgs buprenorphine, $98 per week of 2mgs buprenorphine. If anything, higher than 8mgs fees will be assessed at that time.

ADDITIONAL FEES

Other fees for additional services may be charged as necessary and required. These costs will be disclosed in advance of any procedure being performed.

AGREEMENT

I hereby certify that I have been made aware of the financial commitments associated with my treatment program:

Payment for services is always ***DUE IN ADVANCE***

Payment may be made with money order/credit card/debit card

Administrative withdrawal begins when a patient reaches a BALANCE DUE of $39.00 and will not be stopped until the balance is **paid in full.**

Administrative Financial Withdrawal is accomplished over a period of 21 days.

Missed days will NOT be discounted, and you **will be charged.** The fee is a PROGRAM FEE for treatment services and is not simply a medication fee.

I certify by signing this agreement that I understand this is a private program and that my continued participation demands that I take responsibility for payment of all program fees. My signature below indicates my full commitment to abide by these financial arrangements.

Patient Name: _____ Patient Number: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Omnis Health Life
Wellness Center

FINANCIAL AGREEMENT

_____ Patient financial obligation is $ 0 at this time.

_____ Patient financial obligation is $_____ co-pay.

Patient Name: _____ Patient Number: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Omnis Health Life
Wellness Center

PATIENT RIGHTS

It is the policy that each patient has the following rights:

The right to be treated with consideration and respect for personal dignity, autonomy, and privacy.

The right to service in a humane setting, which is the least restrictive feasible as defined in the treatment plan.

The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives.

The right to consent to or refuse any service, treatment or therapy upon full explanation of the expected consequences of such consent or refusal.

The right to a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.

The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan.

The right to freedom from unnecessary or excessive medication.

The right to freedom from unnecessary restrain or seclusion.

The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or another services, unless there is a valid and specific necessity which precludes and or requires the patient's participation in other services.

The right to be informed of any unusual or hazardous treatment procedures.

The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies, or photographs.

The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense.

The right to confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosures of various funding and/or certifying sources, state or federal statutes, unless release of information is specially authorized by the patient.

The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual patient for clear treatment reasons in the patient's treatment plan.

Omnis Health Life
Wellness Center

CONFIDENTIALITY OF ALCOHOL & DRUG ABUSE RECORDS

The confidentiality of patient alcohol and drug treatment records maintained by Omnis is protected by federal regulation 42-CFR, Part 2. This regulation prevents employees from disclosing any information that would identify a Patient who is receiving or has received treatment services unless:

1. The patient has provided written consent.
2. The disclosure is allowed by a court order (not a subpoena or a summons).
3. The disclosure is made to medical personnel in a medical emergency.
4. The disclosure is made to qualified persons for research, audit, or program evaluation

Violation of the regulation is a crime. Patients who believe that their protection of this regulation has been violated have the right to report such violation to the appropriate authorities in accordance with federal regulation.

This regulation does not protect information about a crime committed by a Patient on the clinic premises or against any person employed by the clinic. Information related to threats of a crime against the clinic or its employees is also not protected.

This regulation does not protect information about suspected child abuse or neglect. Under Maryland law, clinic employees with knowledge of such abuse or neglect must report this information to the appropriate authorities.

I have read or have read to me, the information about the confidentiality of treatment records at Omnis and I understand that I am obligated to keep such records confidential under 42-CRF, Part 2.

_____ _____

Patient Signature/Date: Counselor Signature/Date

Omnis Health Life
Wellness Center

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

Notice of Privacy Practices Acknowledgement

I, _____ acknowledge receipt of notice of Privacy Practices for Protected Health Information.

Patient Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

Omnis Health Life
Wellness Center

PRESCRIPTION DRUG MONITORING PROGRAM

What is the Maryland prescription drug monitoring program (PDMP)?

The prescription drug monitoring program (PDMP) is a core component of Maryland's comprehensive strategy for reducing prescription drug abuse throughout the state. Expanding provider access to and use of PDMP data is also a major goal of the Maryland Opioid Overdose Prevention Plan and many local overdose prevention plans developed by Maryland's jurisdiction.

What does the PDMP do?

The PDMP monitors the prescribing and dispensing of drugs that contain controlled dangerous substance (CDS). CDS dispensers, including pharmacy and healthcare practitioners, report information on Schedules II through V CDS dispensed to a patient or a patient's agent in Maryland. This information is securely stored in an electronic database and is disclosed only to a persons or agencies that are specifically authorized under State Law. Data disclosure to healthcare providers and public health and law enforcement agency investigators is conducted through secure, web based applications. The PDMP requires that these systems users be authenticated and credentialed before they may submit requests for and receive PDMP data.

Which prescription drugs are monitored?

The PDMP monitors only the prescribing and dispensing of drugs that contain Schedules II through V controlled dangerous substance (CDS). State and federal law defines CDS as substance that have abuse potential. Drugs listed in CDS Schedules II, III, IV and V also have accepted medical uses. This includes opioid- pain relievers like Oxycodone (Oxycontin, Percocet, Percodan, Roxicet), Hydrocodone (Vicodin, Lortab) and Methadone prescribed for pain; antianxiety and sedative medications like alprazolam (Xanax) and Diazepam (Valium); and stimulants like Adderall and Ritalin. The complete list of CDS in Maryland is found in Criminal Law Article, Title 5, Subtitle 4, Annotated Code of Maryland.

The treatment program's obligation to report

The program is not obligated and will not report the Methadone or Bupernorphine/Suboxone you are dispensed from the program.

The treatment program's access to the PDMP

From time to time, the program may access the PDMP; in order to verify the prescription medications that as a patient are receiving.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Omnis Health Life
Wellness Center

Notice of privacy practices:

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "output" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and controlled dangerous substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Notice of Privacy Practices Acknowledge Page:

We participate in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at www.crisphealth.org.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Warning on Benzodiazepine Use

I have been informed by the staff at Omnis Health Life of the dangers related to ingesting any Benzodiazepine medications, whether prescribed or illicitly obtained, while taking Methadone or Suboxone. This includes medications such as Alprazolam (Xanax), Lorazepam (Ativan), Diazepam (Valium), Clonazepam (Klonopin).

The ingestion of Methadone or Suboxone in combination with these medications can be dangerous and may greatly impair my thinking and behavior. This combination can be deadly and can lead to death by stopping me from breathing normally,

Therefore, I understand the policy regarding the use of any Benzodiazepine, whether prescribed or illicitly obtained. If I am currently being prescribed this medication, I agree to allow Omnis Health Life to contact the prescribing physician for the purpose of possibly finding a safer alternative as well as the coordination of care. If I am obtaining a Benzodiazepine from any other source I agree to discontinue doing so immediately. Otherwise, I am aware that the continued use of a Benzodiazepine of will result in the requirement for additional counseling I am also aware that If I continue to test positive for illicit Benzodiazepine medication that I may be subject to the reduction of my current medication/dose level and/or the possible dismissal from the clinic and/or transfer to a more appropriate level of care.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Omnis Health Life
Wellness Center

2200 Garrison Blvd. Baltimore, MD 21216;
Ph: 240-204-5594; Fax: 667-260-6267

Request/Authorization for Release of Client of Information

I (last name, first name: _____, DOB _____) hereby authorize the release of the following information to be disclosed and released to and from Omnis Health Life Wellness and:

Name/Program: _____ Phone: _____

Address: _____ Fax: _____

Specific types of information to be disclosed:		
Medical, mental health and substance use history and progress (include the below)		
Dose Verification	Emergency Contact	Discharge Summary
Treatment Summary, Progress	Recommendations/Prognosis	Physical Exam
Drug Screens	Other	

The purpose of this disclosure is: _____ **Continuity of Care;** _____ **Other** _____

PLEASE DO NOT FAX INFORMATION; NOT NEEDED AT THIS TIME OR

PLEASE FAX INFORMATION AT THIS TIME

Method of release: Verbal/Phone and/or Fax Email Mail Any of these

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THIS CONSENT IS SUBJECI' TO REVOCATION AT ANY TIME EXCEPT TOTHE EXTENT THAT THE PROGRAM HAS ALREADY TAKEN RELIANCE ON IT. IFNOTPREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE WITHIN ONE CALENDAR YEAR OR _____ (specify date, even, condition).

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written agreement with person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for release of medical. Or other information is not sufficient for this purpose, The Federal rules restrict any use of the attached information to criminally investigate or prosecute any substance use disorder client.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

This client information release authorization is prepared in accordance with the authority specified in Public Act 56 of 1973. This form is in compliance with Title 42 of the Code of Federal Regulations Part 2.

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Wellness Center

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TAKE HOME RESPONSIBILITY AGREEMENT

This agreement is to inform you and ensure that you understand your responsibility when you are given take-home medication. To earn and maintain take-home privileges, you must implement and ensue that certain practices are always in place. It is your responsibility to make sure that your medication is stored in a metal locked box and not accessible to anyone at any time.

WHEN CHILDREN ARE INVOLED, YOU SHOULD PRATICE EVERY POSSIBLE PRECAUTION TO PREVENT THAT CHILDREN FROM COMING IN CONTACT WITH YOUR BUPRENORPHINE/METHADONE MEDICATION

BUPRENORPHINE/METHADONE IS FA· AL TO CHILDREN

KEEP YOUR BUPRENORPHINE/METHDONE MEDICATION OUT OF REACH OF CHILDREN

If children reside in your home, you MUST advise your counselor upon applying for take-home privileges. Be aware that a recall of your take-home medication by our medical staff can occur at any time. You must have your most recent phone number on file to be contacted. Once called, you must follow all instructions given by the medical staff.

Please be reminded that your take-home privileges may be rescinded for the following reasons:

- Positive urinalysis or unacceptable breathalyzer readings
- Arrest for criminal activity
- Falsifying a urine specimen or negative urine result for medication
- Failure to return take-home bottles
- Failure to provide a urine specimen when requested
- Failure to report other prescribed medication
- Failure to pay program fees
- Not having correct phone number on file with the program

By signing below, I acknowledge that I have read this notice and fully understand my responsibility to have take-home privileges.

Patient Name: _____ ID Number: _____

Patient Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

Omnis Health Life
Wellness Center

AGREEMENT FOR RECALL/RECEIVING TAKE-HOME MEDICATION

I, _____ agree to adhere to the following conditions when I receiver take-home medication from Omnis Health Life Wellness Center:

1. I will not GIVE or SELL my medication to any individual.
2. I will NOT open the medication bottle prior to the date indicate on the label.
3. I will NOT tamper with the BOTTLE or alter the LABEL in any way.
4. I will REATAIN and HAND IN all empty take-home bottles upon my return to the program.
5. I will comply with my FINANCIAL AGREEEMENT and any ADDENDUM written

In response to a RECALL of take-home medication by OMNIS HEALTH LIFE, I will return all take-home medications to the program at the program at the time instructed by the program Nurse.

I may be reached by telephone at the number(s) listed below, and I understand that messages cannot be left with third parties or on message devices.

CWLL/HOME: _____ Hours: _____

WORK: _____ OTHER: _____

I understand that it is my responsibility to notify OMNIS HEALTH LIFE of changes in the telephone numbers or services listed above.

I understand that upon return of my take-home medication to OMNIS HEALTH LIFE, the Medical Director and/or Charge Nurse will decide whether I am eligible to receive replacement take-home medication.

I understand that each take-home does returned in response to RECALL will undergo laboratory analysis, and must contain at least 90% of the amount dispensed.

I have read or had read to me the conditions outlined above for receiving take-home medication privileges and understand and agree to abide by this agreement. I understand that I will be subject to disciplinary action for failure to comply with any of its conditions, and that such action may include loss of my take-home privileges and/or discharge from treatment at OMNIS HEALTH LIFE.

Patient Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

Omnis Health Life
Wellness Center

CO-OCCURRING SSI SCREENING FORM

Directions: Read each question below and the responses to the right exactly as they appear, Circle the number in the box that indicates the extent of the symptoms or experiences.	0 Not at all	1 Rarely	2 Sometimes	3 A Lot
SYMPTOMS Consider each symptom below over the past 3-6 months				
DEPRESSION				
1. Does your future seem lonely or hopeless?				
2. Do you feel you are not as good as other people?				
3. Do you feel sad or empty inside?				
ANXIETY				
4. Do you feel tense, restless, nervous or upset even when no using drugs or alcohol?				
5. Do you feel fearful or afraid?				
6. Do you feel like you worry a lot?				
PSYCHOSIS: When not using drugs or alcohol…				
7. … do you hear noises or voices that other people say they don't hear?				
8. … do you believe others are against you are watching you?				
9. … do you feel out of touch or very different from other people?				
10. … do you feel as if someone or something else controls you or your thoughts?				
SUICIDE HISTORY/THOUGHTS				
11. Do you feel life is not worth living or your better off dead?				
12. Do you ever think about hurting yourself?				
13. Have you ever tried to hurt you or kill yourself?				
TRAUMA				
14. Are you jumpy or easily startled by noises or movement?				
15. Do you have nightmares or flashbacks of the same event over and over?				
16. Do you have periods of time in your life that you can't remember?				
17. Have you ever been through an event that involved a physical threat or harm to you?				
18. Do you ever feel numb, apart, or without much feeling at all?				
MANIA: When not using drugs or alcohol…				
19. …do you have feelings of being super up and full of energy?				
20. …do your thoughts seem to race or go to fast?				
21. …do you ever go without sleep because you have so much energy?				
22. …do you act impulsively or without thinking?				
23. …do you sometimes feel very powerful?				
24. …do you move from task to task quickly, sometimes without finishing what you started?				

_____

ANY positive score on suicide history/thoughts requires immediate discussion with a supervisor. These questions address suicidal plans and thoughts. Immediate intervention may be required.

Omnis Health Life
Wellness Center

HIV/STD/TB/Hepatitis Education Sheets

I, _____, have reviewed the HIV/STD/TB/Hepatitis education sheets with a counselor.

Patient Name: _____ Patient Number: _____

Signature: _____ Date: _____

Witness: _____Date: _____

Omnis Health Life
Wellness Center

TB ELIMINATION
TUBERCULOSIS; GENERAL INFORMATION

WHAT IS TB?

Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually effect the lungs, but it can also affect the other part of the body, such as the brain, the kidneys, or the spine. A person with TB can die if they do not get treatment.

WHAT ARE THE SYMPTOMS OF TB?

The general symptoms of TB disease include feelings of sickness or weakness, weight loss, fever and night sweats. The symptoms of TB disease of the lungs also include coughing, chest pain, and the coughing up of blood. Symptoms of TB disease in other parts of the body depend on the area affected.

HOW IS TB SPREAD?

TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These germs can stay in the air for several hours, depending on the environment. Persons who breathe in the air containing these TB germs can become infected; this is called latent TB infection.

WHAT IS THE DIFFERENCE BETWEEN LATENT TB INFECTION AND TB DISEASE?

People with latent TB infection have TB germs in their bodies, but they are not sick because the germs are not active. These people do not have symptoms of TB disease, and they cannot spread the germs to other. However, they may develop TB disease in the future. They are often prescribed treatment to prevent them from developing TB disease.

People with TB disease are sick from TB germs that are active, meaning that they are multiplying and destroying tissue in their body. They usually have symptoms of TB disease. People with TB disease of the lungs or throat are capable of spreading germs to others. They are prescribed drugs that can treat TB disease.

WHAT SHOULD I DO IF I HAVE SPENT TIME WITH SOMEONE WITH LATENT TB INFECTION?

A person with latent TB infection cannot spread germs to other people. You do not need to be tested if you have spent time with someone with latent TB infection. However, if you have spent time with someone with TB disease or someone with symptoms of TB, you should be tested.

WHAT SHOULD I DO IF I HAVE BEEN EXPOSED TO SOMEONE WITH TB DISEASE?

People with TB disease are most likely to spread the germs to people they spend time with every day, such as family members or coworkers. If you have been around someone who has TB disease, you should go to your doctor or your local health department for tests.

HOW DO YOU GET TESTED FOR TB?

These are tests that can be used to help detect TB infection: a skin test or TB blood tests. The Mantoux tuberculin skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin in the lower part of the arm. A person given the tuberculin skin test must return within 48 to 72 hours to have a trained health care worker look for a reaction on the arm. The TB blood tests measures how the patient's immune system reacts to the germs that cause TB.

Omnis Health Life
Wellness Center

HEPATITIS C

WHAT IS HEPATITIS?

"Hepatitis" means inflammation of the liver. The liver is a vital organ that process nutrients, filters the blood, and fight infections. When the liver is inflamed or damaged, its function can be affected.

Heavy alcohol use toxin, some medications, and certain medical conditions can cause Hepatitis. However, hepatitis is most often caused by a virus. In the United States, the most common types of viral hepatitis are Hepatitis A, Hepatitis B, and Hepatitis C.

WHAT IS HEPATITIS C?

Hepatitis C is an infection of the liver that results from the Hepatitis C virus. **Acute** Hepatitis C refers to the first several months after someone is infected. Acute infection can range in severity from a very mild illness with few or no symptoms to a serious condition requiring hospitalization. For reasons that are not known, about 20% of people are able to clear, or get rid of the virus without treatment in the first 6 months.

Unfortunately, most people who get infected are not able to clear the Hepatitis C virus and develop a chronic, or lifelong infection. Over time, chronic Hepatitis C can cause a serious health problems including liver disease, liver failure and even liver cancer.

WHAT ARE THE SYMPTOMS OF HEPATITIS C?

Many people with Hepatitis C do not have symptoms and do not know they are infected. If symptoms occur, they can include: fever, feeling tired, not wanting to eat, upset stomach, throwing up, dark urine, grey colored stool, joint pain, and yellow skin and eyes.

HOW IS HEPATITIS C SPREAD?

Hepatitis C is usually spread when blood from a person infected with the Hepatitis C virus enters the body of someone who is not infected. Today, most people become infected with Hepatitis C by sharing needles, syringes, or any other equipment to inject drugs. Before widespread screening of the blood supply in 1992, Hepatitis C was also spread through blood transfusions and organ transplant. While uncommon, poor infection control has resulted in outbreaks in healthcare settings.

While rare, sexual transmission of Hepatitis C is possible. Having a sexual transmitted disease or HI, sex with multiple partners, or rough sex appears to increase a person's risk for Hepatitis C.

Hepatitis C can also be spread when getting tattoos and body piercing in unlicensed facilities, informal settings, or with non-sterile instruments. Also, approximately 6% of infants born to infected mothers will get Hepatitis C. Still, some people don't know how or when they got infected.

WHEN DO SYMPTOMS OCCUR?

If symptoms occur with an acute infection, they can appear anytime from 2 weeks to 6 months after infection. If symptoms occur with chronic Hepatitis C, they can take decades to develop. When symptoms appear with chronic Hepatitis C, they often are a sign of advanced liver disease.

HOW WOULD YOU KNOW IF YOU HAVE HEPATITIS C?

The only way to know if you have Hepatitis C is to get tested. Doctors use a blood test, called a Hepatitis C Antibody test, which looks for antibodies to the Hepatitis C virus. Antibodies are chemicals released into the bloodstream when someone gets infected. Antibodies remain in the bloodstream, even if the person clears the virus.

A positive or reactive Hepatitis C Antibody Test means that a person has been infected with the Hepatitis C virus at some point in time. However, a positive antibody test does not necessarily mean a person still has Hepatitis C. An additional test called a RNA test is needed to determine if a person is currently infected with Hepatitis C.

Omnis Health Life
Wellness Center

HEPATITIS C

Can Hepatitis C be treated?

Yes. However, treatment depends on many different factors, so it is important to see a doctor experienced in treating Hepatitis C. new and improved treatments are available that can cure Hepatitis C for many people.

How can Hepatitis C be prevented?

Although there is currently no vaccine to prevent Hepatitis C, there are ways to reduce the risk of becoming infected with the Hepatitis C virus.

- Avoid sharing or reusing needles, syringes or any other equipment to prepare and inject drugs, steroids hormones, or other substance.
- Do not use personal items that may have come into contact with an infected person's blood, even in amounts too small to see, such as razors, nail clippers, toothbrushes, or glucose monitors.
- Do not get tattoos or body piercing from an unlicensed facility or in an informal setting.

For More Information

Talk to your health professional, call your health department, or visit www.cdc.gov/hepatitis.

Omnis Health Life
Wellness Center

HEPATITIS B

WHAT IS HEPATITIS?

"Hepatitis" means inflammation of the liver. The liver is a vital organ that process nutrients, filters the blood, and fight infections. When the liver is inflamed or damaged, its function can be affected. Heavy alcohol use toxin, some medications, and certain medical conditions can cause Hepatitis. However, hepatitis is most often caused by a virus. In the United States, the most common types of viral hepatitis are Hepatitis A, Hepatitis B, and Hepatitis C.

WHAT IS HEPATITIS B?

Hepatitis B can be a serious liver disease that results from infection with the Hepatitis B Virus. Acute Hepatitis B refers to a short term infection that occurs within the first 6 months after someone is infected with the virus. The infection can range in severity from a mild illness with few or no symptoms to a serious condition requiring hospitalization. Some people, especially adults, are able to clear, or get rid of the virus without treatment. People who clear the virus become immune and cannot get infected with the Hepatitis B Virus again.

Chronic Hepatitis B refers to a lifelong infection with the Hepatitis B virus. The likelihood that a person develops a chronic infection depends on the age at which someone becomes infected. Up to 90% of infants infected with the Hepatitis B Virus will develop a chronic infection. In contrast, about 5% of adults will develop chronic Hepatitis B. over time, chronic Hepatitis B can cause serious health problem, including liver damage, cirrhosisi, liver cancer, and even death.

HOW IS HEPATITIS B SPREAD?

The Hepatitis B virus is spread when blood, semen, or other body fluids from an infected person enters the body of someone who is not infected. The virus can be spread through:

- **Sex with an infected person:** Among adults, Hepatitis B is often spread through sexual contact.
- **Injection drug use:** Sharing needles, syringes and any other equipment to inject drugs with someone infected with Hepatitis B can spread the virus.
- **Outbreaks:** while uncommon, poor infection control has resulted in outbreaks of Hepatitis B in healthcare settings.
- **Birth:** Hepatitis B can be passed from an infected mother to her baby at birth. Worldwide, most people with Hepatitis B were infected with the virus as an infant.

Hepatitis B is not spread through breastfeeding, sharing eating utensils, hugging, kissing, holding hands, coughing or sneezing. Unlike some forms of hepatitis, Hepatitis B is also not spread by contaminated food or water.

WHAT ARE THE SYMPTOMS OF HEPATITIS B?

Many people with Hepatitis B do not have symptoms and do not know they are infected. If symptoms occur, they can include: fever, feeling tired, not wanting to eat, upset stomach, throwing up, dark urine, grey colored stool, joint pain, and yellow skin and eyes.

WHEN DO SYMPTOMS OCCUR?

If symptoms occur with an acute infection, they usually appear within 3 months of exposure and can last up to 6 months. If symptoms occur with chronic with chronic Hepatitis B, they can take years to develop and can be a sign of advanced liver disease.

HOW WOULD YOU KNOW IF YOU HAVE HEPATITIS B?

The only way to know if you have Hepatitis B is to get tested. Blood tests can determine if a person has been infected and cleared the virus, is currently infected, or has never been infected.

Omnis Health Life
Wellness Center

HEPATITIS B

HOW IS HEPATITIS B TREATED?

For those with acute Hepatitis B, doctors usually recommend rest, adequate nutrition, fluids, and close medical monitoring. Some people may need to be hospitalized. People living with chronic Hepatitis B should be evaluated for liver problems and monitored on a regular basis. Treatments are available that can slow down or prevent the effects of liver disease.

CAN HEPATITIS B BE PREVENTED?

Yes. The best way to prevent Hepatitis B is by getting vaccinated. The Hepatitis B vaccine is typically given as a series of 3 shots over a period of 6 months. The entire series is needed for long-term protection.

WHO SHOULD GET VACCINATED AGAINST HEPATITIS B?

All infants are routinely vaccinated for Hepatitis B at birth, which has led to dramatic declines of new Hepatitis B cases in the US and many parts of the world. The vaccine is also recommended for people living with someone infected with Hepatitis B, travelers to certain countries, and healthcare and public safety workers exposed to blood.

People with high risk sexual behaviors, men who have sex with men, people who inject drugs, and people who have certain medical conditions, including diabetes, should talk to their doctor about getting vaccinated.

For More Information

Talk to your health professional, call your health department, or visit www.cdc.gov/hepatitis.

Omnis Health Life
Wellness Center

HIV 101

Without treatment, HIV (human immunodeficiency virus) can make a person very sick and even cause death. Learning the basics about HIV can keep you healthy and prevent transmission.

HIV can be transmitted by

Sexual Contact	Sharing Needles to Inject Drugs	Mother to Baby During Pregnancy, Birth, or Breastfeeding

HIV is not transmitted by

Air or Water	Saliva, Sweat, Tears, or Closed-Mouth Kissing	Insects or Pets	Sharing Toilets, Food, or Drinks

Protect yourself from HIV

- Get tested at least once or more often if you are at risk.
- Use condoms the right way every time you have anal or vaginal sex.
- Choose activities with little to no risk like oral sex.
- Limit your number of sex partners.
- Don't inject drugs, or if you do, don't share needles or works.
- If you are at high risk for HIV, ask your health care provider if pre-exposure prophylaxis (PrEP) is right for you.
- If you think you have been exposed to HIV within the last 3 days, ask a health care provider about post-exposure prophylaxis (PEP) right away. PEP can prevent HIV, but it must be started within 72 hours.
- Get tested and treated for other STDs.

Keep yourself healthy and protect others if you are living with HIV

- Find HIV care. It can keep you healthy and help reduce the risk of transmitting HIV to others.
- Take your HIV medicines as prescribed.
- Stay in HIV care.
- Tell your sex or drug-using partners that you are living with HIV. Use condoms the right way every time you have sex, and talk to your partners about PrEP.
- Get tested and treated for other STDs.

Omnis Health Life
Wellness Center

STDs and HIV-CDC Fact Sheet

People who have STDs are most likely to get HIV, when compared to people who do not have STDs

Are some STDs associated with HIV?
Yes. In the United States, people who get syphilis, gonorrhea, and herpes often also have HIV, or are more likely to get HIV in the future.

Why does having an STD put me more at risk for getting HIV?
If you get an STD you are more likely to get HIV than someone who is STD-free. This is because the same behaviors and circumstances that may put you at risk for getting an STD can also put you at greater risk for getting HIV. In addition, having a sore or break in the skin from an STD may allow HIV to move easily enter your body.

What activities can put me at risk for both STDs and HIV?

- Having anal, vaginal, or oral sex without a condom;
- Having multiple sex partners;
- Having anonymous sex partners;
- Having sex while under the influence of drugs or alcohol can lower inhibitions and result in greater sexual risk-taking.

What can I do to prevent getting STDs and HIV?
The only way to avoid STDs is not have vaginal, anal or oral sex. If you are sexually active, you can do the following things to lower your chances of getting STDs and HIV:

- Choose less risky sexual behaviors;
- Use condoms consistently and correctly;
- Reduce the number of people with hum you have sex;
- Limit or eliminate drug and alcohol use before and during sex;
- Have an honest and open talk with your health care provider and ask whether you should be tested for STDs and HIV;
- Talk to our health care provider and find out if pre-exposure prophylaxis, or PrEP, is good option for you to prevent HIV infection

Omnis Health Life
Wellness Center

If I already have HIV, and then I get an STD, does that put my sex partner(s) at an increased risk for getting HIV?

It can, If you already have HIV, and then get another STD, It can put your HIV-negative partners at greater risk for getting HIV from you.

You sex partners are less likely to get HIV from you

- Use antiretroviral therapy (ART). ART reduces the amount of virus (viral load) in your blood and body fluids. ART can keep you healthy for many years, and greatly reduce your chance for transmitting HIV to sex partners, if taken consistently.
- Choose less risky sexual behaviors.
- Use condom consistently and correctly.

The risk of getting HIV may also be reduced if your partner take pre-exposure prophylaxis, or PrEP, after discussing this option with his or her healthcare provider and determining whether it is appropriate.

Will treating STDs prevent me from getting HIV?

No. It's is not enough,

If you get treated for an STD. this will help to prevent its complications, and prevent spreading STDs to your sex partner. Treatment for an STD other than HIV does not prevent the spread of HIV.

If you are diagnosed with an STD, talk to your doctor about ways to protect yourself and your partners from getting reinfected with the same STD, or getting HIV.

Where can I get more information?

HIV/AIDS and STDs

PrEP (pre-exposure prophylaxis)

Division of STD Prevention
(DSTDP)
Center for Disease Control and Prevention

CDC-INFO Contact Center
1-800-CDC-INFO
(1-800-232-4636)

CDC National Prevention Information Network (NPIN)

P.O. Box 6003
Rockville, MD 20849-6003
Email:

American Sexual Health Association (ASHA)

P.O. Box 13827
Researching Triangle Park
27709-3827
1-800-783-9877

Omnis Health Life
Wellness Center

PATIENT ASSESMENT OF PERSONAL, STRENGTHS, NEEDS, ABILITIES & PREFERENCES (SNAP)

Patient Name _____ ID# _____

Please take some time to complete the following questions. By assessing you strengths, needs, abilities and preferences, a personal treatment plan can be developed with you to assist you in being successful in your treatment experience. Thank you.

STRENGTHS	
What are some of the things about you that will help you be successful in your treatment and recovery? Check all that apply and fill in the "other" box if you do not see your strength reflected in the following list:	
	I belong to a self-help group (AA. NA. DT. Recovery Support Group)
	I believe in a higher power or something greater than my self
	I have support from my family (parent(s), siblings, extended family members
	I have support from my spouse/life partner/significant other
	I have a positive and supportive sponsor/recovery specialist/peer specialist
	Connection to a religious group
	A counselor or Case Manager who helped me into treatment
	A judge or probation officer who gave me a chance to go to treatment
	An employer or teacher who helped me into treatment
	Financial assistance and insurance
	A safe place to live
	A stable job
	I go to school regularly
	I volunteer regularly
	A positive, structured daily routine
	Healthy recreational activates which I enjoy
	Other
NEEDS	
What do you believe you will need to be successful in this treatment experience and in your recovery? Check all that apply and fill in the "other" box if you do not see your strength reflected in the following list:	
	Education about substance use disorder
	Education about mental illness and use of alcohol and drugs
	Education about mental illness symptoms
	Education about relapse triggers and relapse prevention
	A better understanding of "higher power"
	Explanations of my diagnosis
	Education about effects of alcohol and drug use on my health
	Better skills in relating of other people
	Better skills in communicating/talking with other people
	A safe place to live
	I need help with reading
	I cannot read or write
	A stable job
	Getting along with my family
	Getting along with any spouse/life partner/significant other
	Other

AGE 2

ABILITIES	
Please check off the phrases that best describe your personal qualities. Skills, or talents that will help you be successful in treatment or recovery.	
	I can be honest
	I can be cooperative
	I am willing to work in order to change and be in recovery
	I am trustworthy
	I am determined
	I have a good sense of humor
	I am able to ask for help
	I accept criticism from other people
	I care about myself
	I can respect other people's privacy
	I do not gossip
	Other
PREFERENCES	
Which of the following activities do you think would help you most?	
	Individual Counseling
	Group Counseling
	Mental Health Counseling
	Addictions Counseling
	Family Education
	Parenting Skills
	Self Help Group (please check all that apply to you)
	• Alcoholics Anonymous
	• Narcotics Anonymous
	• Self-Help Recovery Group
	• Self-Help Mental Health Recovery Support Group
	• Faith Based Recovery Self Help Group
	• Other Support
	Other Preferences not listed
Would like to work on the following goals while in this program:	
1.	
2.	
3.	
4.	

Omnis Health Life
Wellness Center

SOUTH OAKS GAMBLING SCREEN (SOGS)

Patient Name _____ ID# _____

Date _____

1. Please indicate which of the following types of gambling you have done in your lifetime. For each type, mark one answer: “Not at all”, “Less than once per week”, or “Once per week or more”.

Please check one answer for each statement:	Not at all	Less than once per week	Once per week or more
a. Played cards for money			
b. Bet on horses, dogs, or other animal (at OTB, the track or with a bookie)			
c. Bet on sports (parlay cards, with bookie, at Jai Alai)			
d. Played dice games, including craps, over & under or other dice games			
e. Went to casinos (legal or otherwise)			
f. Played the numbers or bet on lotteries			
g. Played bingo			
h. Played the stock and/or other commodities markets			
i. Played slot machines, poker machines, or other gambling machines			
j. Bowled, shot pool, played golf, or some other game of skill for money			
k. Played pull tabs or “paper” games other than lotteries			
l. Some form of gambling not listed above			

2. What is the largest amount of money you have gambled with on any one day?		
Never gambled $1.00 or less	More than $1 up to $10	More than $10 up to $100
More than $100.00 up to $1,000	More than $1.000 up to $10.000	More than $10.000

3. Check which of the following people in your life has (or had) a gambling problem:			
Father	Mother	Brother/Sister	Spouse/Partner
My Child (ren)	Another Relative	A friend or someone important in your life	

4. When you gamble, how often you go back another day to win back money you have lost?		
Never	Most of the time	Some of the time

5. Have you ever claimed to be winning money gambling, but weren’t really? In fact, you lost?		
Never	Yes, Less than half the time I lost	Yes, most of the time

6. Do you feel you ever had a problem with betting or money gambling?		
No	Yes	Yes, in the past but not now

7. Did you ever gamble more than you intended?	Yes	No
8. Have you criticized your betting or told you that you had a problem, regardless of whether or not you thought it was true?	Yes	No
9. Have you ever felt guilty about the way you gamble, or what happens when you gamble?	Yes	No
10. Have you ever felt like you would like to stop betting money or gambling, but did not think that you could?	Yes	No

11. Have you ever hidden betting slips, lottery tickets, gambling money, IOUs, or other signs of betting or gambling from your spouse, children or other important people in your life?	Yes	No
12. Have you ever argued with people you live with over how you handle money?	Yes	No
13. (If you answered "yes" to question 12: have money arguments ever centered on your gambling?)	Yes	No
14. Have you borrowed from someone and not paid them back as a result of your gambling?	Yes	No
15. Have you ever lost time from work (or school) due to betting money or gambling?	Yes	No
16. If you borrowed money to gamble or to pay gamble debts, who and where did you borrow from? *Check Yes or No for each:*		
a. From household money	Yes	No
b. From your spouse/partner	Yes	No
c. From relatives or in-laws	Yes	No
d. From banks, loan companies, or credit unions	Yes	No
e. From credit card	Yes	No
f. From loan sharks	Yes	No
g. You cashed in stock, bonds or other securities	Yes	No
h. You sold personal or family property	Yes	No
i. You borrowed on you checking accounts (passes bad checks)	Yes	No
j. You have (had) a credit line with a bookie	Yes	No
k. You have (had) a credit line with a casino	Yes	No

Patient Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

Omnis Health Life
Wellness Center

SMOKING ASSESSMENT QUESTIONNAIRE

Patient Name _____ ID# _____ Date _____

SMOKING HISTORY	
1. What age did you begin to smoke?	
2. How many cigarettes do you smoke before starting the work day?	
3. How many cigarettes do you smoke during the work day?	
4. How many cigarettes do you smoke after the work day?	
5. What is the total number cigarettes smoked per day?	
6. What is the total number cigarettes smoked per day during the weekend?	
7. How many cigarettes have you smoked per day during your heaviest smoking period?	

8. How many times have you tried to stop smoking? (Please check one)	
	Never
	Once
	Twice
	Three times
	Four times
	Five times
	Six times
	Never

9. What is the longest period of time you have gone without smoking since your first started working regularly?	
	1 week or less
	1 week – 1 month
	Less than 1 month – 6 months
	Less than 6 months – 1 year
	Longer than 1 year

10. Have you ever tried to stop smoking before using the following methods? (Check all that apply)		
Clinic or group	Written materials	Cold turkey
Gradual reduction	1 week or less	Special Filters
Stop with a friend (buddy system)	Hypnosis	Self-help program
Medications	List medications	

CURRENT PLAN TO STOP SMOKING				
1. How interested are you in stopping smoking? (Please check one)				
Strongly	Very	somewhat	a little	not at all

Patient Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

Omnis Health Life
Wellness Center

FAMILY AND RECOVERY ENVIRONMENT ASSESSMENT

	YES	NO
1. Would you like to receive information about how chemical dependency effects families?		
2. Did you grow up in a household where 1 or more family member's alcohol use had a negative effect on the family?		
3. Would you like to receive information about Al-Anon and/or other 12 steps and other self-help programs?		
4. Do you have family member in need of substance use treatment		
5. Do you believe that the support of your family members can help you refrain from alcohol and/or drug use?		
6. Would you be interested in setting up a meeting with your primary counselor and family member about their substance use?		
7. Would you like to receive information about how to deal with family issues in recovery?		
8. Did you grow up in a household where 1 or more family member's drug use had a negative impact on the family?		
9. Do you currently reside with a family member or relative whose active drug and/or alcohol use has a negative impact on your efforts to maintain abstinence or sobriety?		
10. Are you family members supportive of your efforts to abstain from alcohol and/or drug use?		
11. Can you talk to your family about participation in substance use and/or medication maintenance treatment?		
12. Have you ever suffered any type of physical, emotional or sexual abuse by a family member that would make you unsafe for you to involve them in your treatment?		
13. Would you like to setup a meeting with a family members to discuss how substance use can impact a family?		
14. Would you like to bring in a family members to discuss how substance use can impact them?		
15. If you have children under the age of 18, are you comfortable discussing your involvement in treatment?		
16. Could you primary counselor of treatment team be helpful in talking to your family members about your current involvement in treatment?		
17. Are you currently interested in receiving some family counseling and/or therapy?		
18. Do you have any concerns about a family member's current drug or alcohol use?		
19. Do you want your family, or a member of your family involved in any aspect of your treatment?		
20. Is there a need for an interpreter and/or supports for special services needed to engage your family member in treatment?		

Patient Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

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FAMILY AND RECOVERY ENVIRONMENT ASSESSMENT

Patient Name _____ ID# _____ Date _____

Family and relationships with significant others can be important factor in treatment success, Please Completer the following questionnaire, which will assist us in determining and meeting your needs as it relates to family and relationships.

MY FAMILY/SIGNIFICANT OTHER		
Is supportive	True	False
Is very critical	True	False
Argues often	True	False
Listen to my opinion	True	False
Does not really know me	True	False
I have a little or no contact with my children	True	False
I would like to make the following changes in the way my family relates to each other:		

OMNIS OFFERS THE FOLLOWING SERVICES, INDICATE YOUR INTEREST IN ANY OR ALL		
Family Counseling	Yes	No
Education Group for family	Yes	No
Patient Education on Family issues	Yes	No

At this time, I am opting to:	
	Involve my family and/or significant other than my treatment
	Not involve my family and/or significant others at this time with the understanding that I can change my decision at any time.

Are you willing to grant permission so that we can contact your significant other or another family member for the purpose of gaining their perspective concerning your use of alcohol and drugs? _____ Yes _____ No
(If Yes, we will request that you sign a consent form which you may retract at any time).

Patient Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

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PATIENT SAFETY PLAN

Warning signs (thought, images, mood, situation, behavior) that a crisis may be developing:	
1.	
2.	
3.	
Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, Physical activity)	
1.	
2.	
3.	
People and social settings that provide positive support:	
1.	Phone Number:
2.	Phone Number:
3.	Phone Number:
What staff will do to help me stay safe (staff responsibility):	
1.	
2.	
3.	
Professionals of agencies I can contact during a crisis:	
1.	Phone Number:
2.	Phone Number:
3. Suicide Prevention Lifeline Phone 1-800-273 TALK (8255) **These are the people I want contacted if I am hospitalized:**	
1. Name	
Telephone number:	
Is Release of information signed:	Yes No
2. Name	
Telephone number:	
Is Release of information signed:	Yes No
Making the environment safe (i.e., remove weapons, knives, rope…)	
1.	
2.	
3.	

I agree to follow the above plan to ensure safety for myself and others.

Patient Signature _____ Staff Signature _____

Patient was provided a follow up appointment for: Date _____ Time _____

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ASAM ADMISSION CRITERIA FOR OPIATE MAINTENANCE TREATMENT (OMT)

0-None | 1-Mild | 3-Severe

Six-Dimensional Criteria Worksheet

Date: _____ Pt. ID#_____

1. Acute intoxication and/or withdrawal problem: (Patient must meet A and B, or one of C, D or E)	
A)	Physiological dependence on opiated for a period of at least one year (if no, skip to C)
B)	Dependence verified by positive opiate urine screen, vital signs, track marks, self/family report
C)	Patient recently (last 6 months) released from penal/chronic care setting, presenting without physiological dependence Indicators – other than self-report
D)	Pregnant woman, with or without evidence of physiological dependence
E)	Person who has previously been in OMT in last 2 years
2. Biomedical conditions and complications: (Patient status in this dimension is characterized by one of the following)	
A)	Patient meets biomedical criteria for opiate dependence, requiring care
B)	Patient has concurrent biomedical condition or pregnancy, which can be treated in OP basis
C)	Patient has other medical problem manageable in OMT: liver disease, hepatic decompensates, pancreatitis, gastrointestinal problems, cardiovascular problems, HIV/AIDS, STDs, concurrent psychiatric illness requiring medication tuberculosis
3. Emotional/Behavioral or Cognitive conditions and complications: (Patient status in this dimension is characterized by one of the following)	
A)	Patient behavioral/emotional problems if present are manageable in OMT
B)	Patient requires OMT to reduce risk of negligent/abusive behaviors
C)	Patient has a mental health diagnosis, on medication management, requiring OMT to remain sable
D)	Patient demonstrates mild risk of posing harm to self/others, is without suicidal and homicidal ideation/behavior and is manageable in OMT
E)	Patient demonstrates emotional/behavioral stability but requires OMT to prevent opiate use
4. Readiness to Change (Patient status in this dimension is characterized by one of the following)	
A)	Patient requires OP treatment, (pharmacotherapy) to promote treatment progress and recovery
B)	Patient attributes problems to other persons or external events, instead of addictive disorder; patient lacks motivation without OP clinical intervention
5. Relapse/Continual Use or Continue Problem Potential (Patient status in this dimension is characterized by one of the following)	
A)	Patient attributes relapses to physiological craving/need, requiring OMT
B)	Without OMT intervention, patient has continued high risk behaviors, deteriorating functions
C)	Patient has lack of awareness of relapse triggers, exhibits resistance to treatment
6. Recovery / Living Environment (Patient status in this dimension is characterized by one of the following)	
A)	Patients psychosocial environment make MMT feasible (family support, transportation, etc.)
B)	Patients support system requires professional intervention to promote patient OMT
C)	Patient does not have a positive support system but demonstrates motivation to acquire one
D)	Patient has home environment manageable in MMT

Counselor Signature _____

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ASAM ADMISSION CRITERIA FOR OPIATE MAINTENANCE TREATMENT (OMT)

AUTHORIZATION TO DISCLOSE SUBSTANCES USE TREATMENT INFORMATION FOR COORDINATION OF CARE

Name of Patient: _____ DOB: _____

Address: _____ Phone Number: _____

Medical Assistance Number: _____

SECTION 1: PURPOSE OF AUTHORIZATION

This Authorization to disclose is for the purpose of permitting the Maryland Medical Assistance Program (the Medicaid program), my substance use treatment provider and any other providers identified in this form for healthcare operations and payment purposes, including but not limited to care coordination, so that it is more beneficial to me. By giving my consent, my Medical Managed Care Organization and any other providers specifically identified on this form will have access to information about substance use treatment I am receiving, which will help avoid conflicts in medication or treatment and improve the care I am receiving. By giving this consent, I may also gain access to other case management services offered through the Medicaid program.

SECTION 2: ENTITIES AUTHORIZED TO DISCLOSE MY SUBSTANCE USE DISORDER RECORDS

My Substance Use Disorder Provider(s), or if indicated, the provider listed below:

Omnis Health Life Address: 2200 Garrison Blvd Baltimore Md 21216

SECTION 3: DURATION AND REVOCATION OF AUTHORIZATION

This authorization will expire one year from the date I sign it. I may revoke this authorization at any time by notifying the Maryland Medicaid Program's Administrative Services Organization, Optum Maryland, either orally or in writing at the address below; however the revocation will not have an effect on any actions taken prior to the date my revocation is receive and processed. To revoke the authorization, notify Optum at:

Optum Maryland
P.O. Box 30631
Salt Lake City, UT 84130
Phone: 800.888.1965
Fax: 855-293-5407

SECTION 4: AUTHORIZATION

I hereby authorize my substance use treatment provider(s) to disclose to the Maryland Medicaid Program {Including Its administrative services organization, Optum Maryland), claims and authorization data resulting from my treatment, for purposes of healthcare operations and payment purposes, not limited to coordination of my care . If you want to identify the kind or amount of information that you are authorizing for disclosure, you may do so here:

I also authorize the Maryland Medicaid Program (including Optum Maryland) to re-disclose my claims and authorization data to the Medicaid Managed Care Organization (MCO} in which I am enrolled, and with any additional health care providers listed on this form below, for purposes of coordinating my health care.

I further authorize my substance use treatment provider(s) to disclose medical records requested by my MCO's patient care coordination team, for purposes of coordinating my care.

Section 5 (OPTIONAL): I authorize the Maryland Medicaid Program, Optum Maryland, my MCO, and my substances use disorder treatment providers to disclose all substances use disorder treatment records to the additional health care providers specified below for treatment purposes:

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I do not want to have my SUD treatment records shared with additional providers.

Name: _____

Address: _____

Name: _____

Address: _____

If you want to identify the kind or amount of information that you are authorizing for disclosure, you may do so here:

_____

I also understand that, for two years following the date of my signature, I have the right to find out who in the MCO actually saw my information.
I have been provided a copy of this Authorization.

Patient Signature_____ Date _____

Parent or Guardian Signature* (if applicable) _____ Date _____

**** NOTE: If you are signing as the member's Legally Authorized Representative, attach a copy of the legal document(s) granting you the authority to do so, Examples are health care power of attorney, a court order, guardianship papers, etc. The following are the Maryland Medical Managed Care Organizations (MCOs).***

FAX completed form to Optum Maryland: 1-855-293-5407 or
Mail to: Optum Maryland, Attn: ROI P.O.
Box 30531
Salt Lake City, UT 84130

Aetna

Compliance Officer
509 Progress Drive, Suite 117
Linthicum, MD 21209
866-827-2710

WellPoint Maryland

Compliance Officer
7550Teague Road, Suite 500
Hanover, MD 21076
410-859-5800

Jal Medical Systems, Inc.

301International Circle
Hunt Valley, MD 21030
888-524-1999

Maryland Physicians Care

1201Winterson Road, Suite 170
Linthicum, MD 21090
800-953-8854

MedStar Family Choice

Compliance Officer
5233 King Avenue, Suite 400 Baltimore, MD
21237
800-905-1722

Priority Partners

Compliance Officer
7231 Parkway Drive
Hanover, MD 21076

CareFirst BlueCross Blue Shield Community Health Plan (formerly University of Maryland Health Partners)

1966 Greenspring Drive, Suite 600

Timonium, MD 21093
410-878-7709

United Healthcare

10175 Little Patuxent Parkway
Colombia, MD 20144
800-487-7391

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PATIENT ORIENTATION CHECKLIST

	Rights and responsibilities of the person served
	Grievance and appeal procedures
	Ways in which input is given (i.e Suggestion box, focus groups, surveys, follow up calls)
	Describe our services, activities, hours of operation, doing hours, after hours number
	Code of conduct and confidentiality policy
	Explain any and all financial obligations, fees and financial arrangements for services
	Tour of facility: Identify location of emergency exits, fire extinguishers, first aid kits
	Provide brief training on fire detection, warning of fire hazards, and suppression (P.A.S.S.)
	Review the ways to discuss doing issues with appropriate staff
	Review policies on: Restraint, smoking, illegal drugs/legal drugs and weapons brought onto the property
	Identify the program Sponsor and/or Clinical Supervisor
	Describe the rules regarding take home privileges: what events, behaviors, attitude that lead to loss in take home privileges, and how to regain take homes, if they are lost
	Provide education on Advance Directive (and handout if needed)
	Describe the purpose and process of the assessment (ASI or psychosocial history)
	Describe how the individual plan will be developed and the person's participation in it
	Provide information about the prevention and control of infections and communicable diseases: AIDS/HIV/Hep C/TB
	Education regarding importance of family involvement
	Describe program rules re: voluntary termination (withdrawal), criteria for involuntary/immediate termination (Non-compliance) and Discharge Procedures
	Overdose education and prevention
	Review requirement of lock boxes, if applicable
	Begin referrals for pregnant patients, if application
	Emergency Procedures, Exits and Equipment location(s)

Patient ID#: _____

Patient Signature: _____ Date: _____

Counselor Signature: _____ Date: _____