For all patients requesting PCHC’s Recovery Program for Opioid Use Disorder, please ask the following:
ALL calls for Brewer recovery interest are sent to Ashley Roberts CCMA to complete questionnaire and get scheduled for intake

- Are you asking for Suboxone because you want help relieving chronic pain or because you want to wean off prescribed pain medications?
  
  If yes, tell the patient that this particular program is not appropriate for them (Refer back to PCP for treatment options. If no PCP, offer to set them up with a PCHC PCP as a new patient)

- Do you have a safe permanent housing status?

- Are you pregnant?

  (Brewer can now see pregnant recovery patients)
  
  If yes, offer intake appointment within 24-48 hours at PCHCenter or Seaport. If no openings within that timeframe, recommend they see their OB or PCP within the next day and request a referral to Acadia Hospital or Eastern Maine Family Practice (they both treat pregnant women)

- Have you been prescribed Suboxone from another doctor or Recovery Program within the last 90 days?

  If yes, offer Hope House Recovery Program intake only, ensure patient realizes this is a daily dosing and group treatment program for patients that need a higher level of care (due to homelessness, or due to other (weekly or less) types of programs not working for them).
  
  If patient declines this service then they can re-refer when it’s been 90 days or more since discharge from last treatment. (I ask where and why they left, 90 days only applies for us if they came from different PCHC program)

In this program you must attend weekly group therapy (daily if Hope program), prescription appointments as scheduled (daily dosing for Hope, other sites do weekly prescriptions in the beginning and decrease frequency as patient stabilizes), as well as individual counseling. You will need to agree to urine drug tests and pill counts at provider discretion as well.

Can you commit to these conditions?

  If no, patient is not willing to agree to these terms, then they are NOT APPROPRIATE for this program = Refer back to PCP for treatment options

2. If patient passes pre-screening questions (no, no, no, yes), then schedule patient for a Recovery Program Intake Assessment with an LCSW/LCPC at the most appropriate site (usually meaning the site
closest to patient’s home or work, most convenient for transportation, it does not have to be the same site as pt’s PCP) and mail a Release of Information to patient, ask patient to fill it out for past and current records and send back to us as soon as possible. (At brewer Patient meets with Ashley Roberts CCMA for an intake meeting on same day as apt with LCSW/LCPC)

LCSW/LCPCs who do these assessments are:

Brewer:  Jennifer Moss, Nate McKnight, Emily Barrington, and Wally Fraser

PCHCenter: Becky McMahan

**Seaport**: Do not schedule for Seaport, instead tell patient when the next “Orientation Meeting” is scheduled, and explain that patient must attend that meeting prior to receiving an evaluation appointment. Seaport office will schedule intake with Mary Beth Leone or Denise Bouchard after patient attends that meeting, and will alert Referrals Dept. to check insurance. If no orientation meetings are scheduled that means Seaport does not have current openings, and patient should pursue other options.

**Hope House**: Do not schedule for Hope House, instead flag the Hope House Wellness Navigator Becky Churchill, and explain to patient that a Hope House staff will call them with further questions within 1-2 business days. The Navigator will ask more screening questions, and if appropriate will schedule the patient for intake with Lindsay Day.

- At the end of answering these questions I ask pt what they are currently using whether it be on the street or prescribed
What is your ACE Score?

Did you know that experiences from your childhood could affect your health today?

High ACE (Adverse Childhood Experiences) scores have been linked to serious health conditions such as anxiety, diabetes, heart disease, and even cancer.

Please complete the ACE questionnaire, found on the back of this page, to find out your score.

Then give it to your medical assistant or provider, so we can talk more about what your score might mean.
Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you? OR act in a way that made you afraid that you might be physically hurt?    If yes enter 1 ________

2. Did a parent or other adult in the household often push, grab, slap, or throw something at you? OR ever hit you so hard that you had marks or were injured?    If yes enter 1 ________

3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? OR try to or actually have oral, anal, or vaginal sex with you?    If yes enter 1 ________

4. Did you often feel that no one in your family loved you or thought you were important or special? OR your family didn’t look out for each other, feel close to each other, or support each other?    If yes enter 1 ________

5. Did you often feel that you didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? OR your parents were too drunk or high to take care of you or take you to the doctor if you needed it?    If yes enter 1 ________

6. Were your parents ever separated or divorced?    If yes enter 1 ________

7. Was your mother or stepmother often pushed, grabbed, slapped, or had something thrown at her? OR sometimes or often kicked, bitten, hit with a fist, or hit with something hard? OR ever repeatedly hit over at least a few minutes or threatened with a gun or knife?    If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?    If yes enter 1 ________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?    If yes enter 1 ________

10. Did a household member go to prison?    If yes enter 1 ________

Now add up your “Yes” answers: ________ (this is your ACE Score)

If you checked any boxes above, are any of those things bothering you now?

☐ Yes  ☐ No  ☐ Not Sure

For office use only: Was patient referred for treatment?    ☐ Yes  ☐ No

If yes, did patient accept referral?    ☐ Yes  ☐ No  ☐ N/A
Readiness to Change

Do you feel that you will ever be “normal” without drugs (even Suboxone)?

1. No, I will always need drugs to feel whole and happy.
2. Possibly, but I am a long way from that goal now.
3. Probably, and I can imagine myself getting there.
4. Definitely. I am ready to start tapering.
5. Definitely. I am making steady progress in tapering to zero.

Please write your answer ________
Name___________________________DOB________

Induction date/Time______________________________

The following task must be completed before you come for your induction appointment:

- Complete mental health evaluation
- Complete lab work (non-fasting)
- Give pharmacy your insurance information
- Females must make arrangements for long-term effective birth control
Induction day Instructions:

• You must be in withdrawals for 24-48 hours prior to apt
  o If you have used within 24 hours you WILL NOT receive medication that day
• arrive 20 minutes early to pick up your prescription from our pharmacy
• Do not open medication without provider present
PCHC Brewer Recovery Program

Agreement and Statement of Understanding

__ I want to be in recovery and my goal is to become free of addiction. I will strive to gain the skills to lead a drug-free life and understand that recovery involves being honest with oneself and others, and being eager to change.
__ I understand that Suboxone is itself an addictive drug and I will work to taper off of it.
__ I will not use other addicting medications/drugs while in the program, whether prescribed or not, including marijuana, alcohol, benzodiazepines, some prescription sleeping medications, opiates, or stimulants
__ If I use nicotine products I will strive to become nicotine free
__ I understand that if I do not show engagement in group therapy I will be required to pick my prescription up at group sessions.
__ I will be honest with myself and others during group sessions.
__ I agree to random urine drug samples, which may be witnessed.
__ I agree to present all Suboxone in my possession when requested for pill/film counts.
If I cannot be reached, then I have failed my pill/film count. I may be asked to leave the program if I fail pill/film counts.
__ I agree to schedule regular office visits with my medication provider, and my individual therapist
__ I agree to have a working phone at all times, with working voicemail checked at least once daily, and to notify the program of any changes.
__ I understand that keeping my medications secure is my responsibility; lost or stolen prescriptions will not be replaced.
__ I understand that I will be asked to leave the program if I share, sell, or give away any of my medication.
__ I understand that I will be asked to leave the program if I threaten, assault, or harass the staff at Brewer Medical Center.
__ If I am female, I understand I must be on effective, long acting birth control while on Suboxone.
__ I understand payment is expected at time of service, and I will be required to pay any co-pays for medication if it applies.
__ I agree to pick up my prescription at the same pharmacy, and to tell the program staff if I need to use a different pharmacy then I usually do.

Patient Signature __________________________ Date ______________
Patient Name ______________________________ Date ______________
Witness Signature __________________________ Date ______________
Patient Information

RE: Ima Test  DOB: 06/21/1973

Agreement and Informed Consent for SUBOXONE Treatment

Medications I take that may cause addiction:
1. ______________________
2. ______________________
3. ______________________
4. ______________________

These medications are being prescribed for one or more of the following conditions:
1. Opiate Withdrawal
2. Opiate Dependency for short and long-term maintenance using Suboxone
3. Alcohol and/or benzodiazepine withdrawal

My goals for using these medications are:

1) To improve my ability to work and function independent of the use of addictive illegal and prescription drugs.
2) To safely suppress opiate withdrawal symptoms as rapidly as possible.
3) To be taken in a safe and responsible manner

I have been told that:

1) If I drink alcohol or use mood altering drugs, I may not be able to think clearly and I could become at risk for personal injury. My provider may take me off Suboxone if he/she feels that my use of alcohol/other substances places me at risk.
2) If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction
3) If I need to stop this medication, I will contact my provider before simply stopping it on my own.
4) In some cases, my ability to drive may be impaired while I take my medication, and it will be my responsibility not to drive if impaired.
5) The control of pain and treatment of mental illnesses are a significant part of all medical practices. All of the providers in the office strive to provide adequate pain relief and appropriate treatment of symptoms of mental illnesses to all of those who need it.
6) Reasons to use controlled substances include: (1) acute, short-term problems such as a toothache or kidney stone (2) terminal cancer or other terminal conditions (3) chronic conditions that have no definitive treatment (4) conditions that
Patient Information

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Agreement and Informed Consent for SUBOXONE Treatment

may have no obvious cause (5) mental illness

7) **PCHC has a ZERO tolerance policy.** Any violation of the rules can result in tapering or discontinuing of all scheduled medications. PCHC has the right to review this policy at their discretion.

8) PCHC reserves the right to stop writing prescriptions for any individual when the Provider for any reason does not feel comfortable doing so.

9) Prescriptions of Schedule II Controlled Substances cannot be written for "refills".

10) It is critical that I am honest with my providers at all times. My failure to be truthful with respect to my prior drug use may result in unexpected severe withdrawal symptoms when Suboxone is started, and/or an increased risk of seizure when medications are started for alcohol or benzodiazepine withdrawal.

11) I know that having these drugs may increase my risk of being the victim of a crime.

12) I know that the use of certain anxiety drugs, known as benzodiazepines ("benzos"), along with opioids is dangerous and that my provider and I should avoid the use of these drugs while I am receiving Suboxone prescriptions. Examples of **benzodiazepines** include alprazolam, clonazepam, diazepam, and lorazepam.

13) I know that side effects of these drugs include sedation, constipation, reduced hormone levels and reduced sex drive, personality changes, falls, and osteoporosis.

14) I know that my provider will be checking on all of my controlled drug prescriptions through the Prescription Monitoring Program of the Office of Substance Abuse.

I agree to the following:

1) I am responsible for my medications. I will not share, sell, or trade my medication. I will not take anyone else's medicine. I will not use any controlled substances that are not prescribed for me.

2) My medicine is a matter between PCHC and myself. I will not discuss my medication or doses with third parties. I understand that calls to PCHC by third parties discussing my medications may be seen by PCHC as evidence that this confidentiality has been violated by me.

3) I recognize that medical/psychiatric care is a matter of trust between Patient and Provider and that if for any reason my Provider loses trust in me, he/she may stop my medicine in a safe way. In such cases it is also the option of the Provider to discharge me from the practice.

4) I will not increase the dose of my medicine(s) until I communicate with my provider or medical assistant for authorization to do so.

5) I will not request an early refill; early refills of Suboxone will not be provided.

6) I will safeguard my medication(s) from loss or theft.

7) My medicine(s) will not be replaced if it is lost, stolen, or used up sooner than prescribed.
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8) I will report any stolen or misused medications to the proper authorities.

9) I will keep all appointments set up by my provider including primary care, physical therapy, osteopathic manipulation therapy, mental health consultation, substance abuse treatment or counseling, pain management, addiction medicine consultation etc. Refusal to follow through may result in discontinuation of prescriptions for controlled substances.

10) I will bring the pill bottles with any remaining pills of all medicine(s) to each clinic visit, and agree to have my pills counted at that time. Any discrepancy between the actual pill count and that expected may be considered a sign of drug diversion and will be handled appropriately.

11) I agree to give a blood or urine sample, if asked. I will be expected to provide a urine drug screen with each clinic visit. Use of any street drugs, including marijuana, will absolutely be a violation of this contract, and will not be tolerated. I understand that prior long-term use of marijuana may result in a positive urine drug screen for marijuana for up to eight weeks, and this will be taken into account when urine drug screens are performed.

12) I will not use any illegal substances or any illegally obtained street or prescription drugs with my medication.

13) A photo ID is required to pick up any prescription picked up patient and must be provided if requested by staff.

14) Any alteration of or forgery of a prescription will result in discharge from the practice and notification of the police or other authorities. Such conduct is not confidential health care information and will be reported.

15) The combination of alcohol with my medications will make it dangerous for me to drive a motor vehicle or to operate machinery.

16) Group therapy is very important and integral part of your treatment. It is the cornerstone of your treatment program. Weekly group meetings as discussed with you during your evaluation will be mandatory. Unexcused absences from group therapy meetings will not be tolerated, and may result in your termination from this program and taken off Suboxone.

Penobscot Community Health Care Refills:

Refills will be made only during regular office hours—Monday through Friday, 8:00 am-5:00 pm. No refills on nights, holidays, or weekends. PCHC Walk-In Service will not refill controlled substance prescriptions. I must call at least two (2) working days ahead (M-F) to ask for a refill of my medicine(s). No exceptions will be made. I will not come to Penobscot Community Health Care for my refill until I am called by the nurse or medical assistant. Courteous behavior is expected at all times. (Providers will also fill your medication(s) at scheduled 15-minute appointments.) I must keep track of my medications. No early or emergency refills will be made. Multiple requests for the same medication on the same day will not be tolerated.

Pharmacy:

1) I will only use one pharmacy to get my medicine(s). My Primary Care/Mental Health Provider or his/her staff may talk with the pharmacist about my medicine(s).

2) The name/location of my pharmacy is _________________________________.

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Prescriptions from other Providers:

1) I will not attempt to obtain/seek controlled medications(s) from any other provider, pharmacy, or hospital unless directed by my Primary Care Provider or other Penobscot Community Health Care provider (for example, a dentist, a provider in the Emergency Room, or another provider). If so, I must bring this medicine to Penobscot Community Health Care in the original bottle, even if there are no pills left.

Privacy:

1) While I am taking this medicine(s), my Primary Care Provider or his/her staff may need to contact other providers, hospitals, or pharmacists to get information about my care and/or use of this medicine(s).

2) I authorize the Primary care/Mental Health Provider or his/her staff and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of the possible misuse, sale, or other diversion of my medicines.

3) I authorize my Primary care/Mental Health provider or his/her staff to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

Termination of Agreement:

1) If I break any of the rules, or if my provider decides that this medicine(s) is hurting me more than helping me, this medicine(s) may be stopped at any time by my Primary Care/Mental Health Provider in a safe way.

2) I have talked about this agreement with my provider, and I understand the above rules.

3) As discussed above, addiction counseling, including group therapy, will be a requirement for this agreement. Failure to comply with this important requirement may result in my safe discontinuation off my medication, and termination from participation in this program.

Penobscot Community Health Care and PCHC Provider Responsibilities:

1) As your provider, I agree to schedule regular office visits to see how well the medicine(s) is working and to offer other forms of treatment, when applicable.

2) Assessments will be made for overall usefulness and safety of this medicine(s).

3) I agree to provider medical, mental health care, individual and/or group addiction counselling for you even if you are no longer getting controlled medicines from me, unless your actions have caused you to be discharged from the practice.

Patient Responsibilities for Patient Safety:

1) Being responsible for your medications(s) and how you take them is essential to your treatment. If you are unable to fulfill your responsibilities in regards to this treatment plan, or do not follow the instructions of your provider, then your
Patient Information

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provider has the right and responsibility to discontinue or change your treatment plan as clinically indicated.

2) My signature indicates that I have read or had read to me this agreement and fully understand it. I have been given the opportunity to ask questions to clarify any part of it I do not understand. It also indicates that I participated in the development of my treatment plan including a discussion of the risks, benefits, and other options for treatment.

________________________________________  __________________________
Patient's Signature                         Date

________________________________________  __________________________
Primary Care/Mental Health Provider Signature  Date
Patient Information

RE:  Ima Test  DOB: 06/21/1973

Suboxone Recovery Program Intake

1. How many ounces of caffeinated drinks do you drink daily?
   ___ None
   ___ 8 oz or less
   ___ 9-16 oz
   ___ 16 oz or more

2. How many packs of cigarettes do you smoke daily?
   ___ None
   ___ 1/2 pack or less
   ___ ½ to 1 pack
   ___ 1-2 packs
   ___ 2 packs or more

3. When did you start smoking?
   ___ never smoked
   ___ elementary school
   ___ middle school
   ___ high school
   ___ after high school

4. How many alcoholic beverages do you drink each day?
   ___ None
   ___ 1
   ___ 2
   ___ 3
   ___ 4
   ___ 5 or more

5. When did you start drinking alcohol?
   ___ never drank
   ___ elementary school
   ___ middle school
   ___ high school
   ___ after high school

6. Have you ever had an OUI?
   ___ yes
Patient Information

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Suboxone Recovery Program Intake

___ no

7. Do you smoke marijuana now?
   ___ yes
   ___ no

8. When did you start using marijuana?
   ___ never smoked
   ___ elementary school
   ___ middle school
   ___ high school
   ___ after high school

9. When did you start abusing narcotics?
   ___ elementary school
   ___ middle school
   ___ high school
   ___ after high school

10. Have you ever used cocaine?
    ___ yes
    ___ no

11. Have you ever used IV drugs?
    ___ yes
    ___ no

12. Have you ever had an accidental drug overdose?
    ___ yes
    ___ no

13. How many times before now have you been in a treatment for addiction?
    ___ none
    ___ 1
    ___ 2
    ___ 3
    ___ 4
Patient Information

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Suboxone Recovery Program Intake

____ 5 or more

14. Have you ever been in a detox or residential addiction program?
   ____ yes
   ____ no

15. Have you ever received medication from a psychiatrist or psychiatric nurse practitioner?
   ____ yes - in past
   ____ yes - currently
   ____ no

16. Have you ever been hospitalized for a psychiatric illness?
   ____ yes
   ____ no

17. Have you ever been in therapy for a mental health condition?
   ____ yes - in past
   ____ yes - currently
   ____ no

18. Have you ever had Hepatitis B?
   ____ yes
   ____ no
   ____ unsure

19. Have you ever had Hepatitis C?
   ____ yes
   ____ no
   ____ unsure

20. Have you been diagnosed with HIV?
    ____ yes
    ____ no
    ____ unsure

21. Have you ever been diagnosed with attention deficit disorder?
    ____ yes
    ____ no
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Suboxone Recovery Program Intake

___ unsure

22. Have you ever been diagnosed with bipolar disorder?
   ___ yes
   ___ no
   ___ unsure

23. Have you ever been diagnosed with PTSD?
   ___ yes
   ___ no
   ___ unsure

24. Do you have chronic pain?
   ___ yes - in past
   ___ yes - currently
   ___ no

25. Are you on birth control?
   ___ yes
   ___ no
   ___ N/A

26. Are you pregnant?
   ___ yes
   ___ no
   ___ N/A

27. Have you ever been diagnosed with a sexually transmitted disease?
   ___ yes - in past
   ___ yes - currently
   ___ no

28. Do you live at a permanent safe address?
   ___ yes
   ___ no

29. Do you have reliable transportation?
Patient Information

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Suboxone Recovery Program Intake

___ yes
___ no

30. Are you employed?
   ___ full-time
   ___ part-time
   ___ homemaker
   ___ unemployed
   ___ student
   ___ disabled

31. How many children (under 18 yrs) live with you (including shared custody)?
   ___ none
   ___ 1
   ___ 2
   ___ 3
   ___ 4
   ___ 5 or more

32. Are you contesting child custody with a partner or the state?
   ___ yes
   ___ no

33. Are you facing criminal charges?
   ___ yes
   ___ no

34. Have you ever been convicted of a violent crime?
   ___ yes
   ___ no

35. Do you have a felony conviction?
   ___ yes
   ___ no

36. Have you ever been in jail or prison?
   ___ yes
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Suboxone Recovery Program Intake

___ no

37. How many in your household use drugs?
   ___ none
   ___ 1
   ___ 2
   ___ 3
   ___ 4
   ___ 5 or more

38. How many sober friends do you socialize with regularly?
   ___ none
   ___ 1
   ___ 2
   ___ 3
   ___ 4
   ___ 5 or more

39. Do you have contact with supportive family members?
   ___ yes
   ___ no

40. How much money do you owe your family-creditors-IRS:
   ______

41. How do you plan to pay for your treatment?
   ___ insurance
   ___ self pay
   ___ unsure

42. Can we verify your working cell phone
   ___ yes
   ___ no
Patient Information

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Suboxone Recovery Program Intake
Recovery Program Group Rules

- Urine Drug Tests & Pill/Film Counts
  - You will be subject to random drug tests and pill or film counts; positive urine drug tests or missing films or pills are grounds for dismissal from the program.
  - You must have a working cell phone with functioning messaging AT ALL TIMES. We will be contacting you for pill/film counts. If we cannot reach you (for example, your voice mailbox is full or not set up), or if you do not respond to our message within 24 hours, then you have failed the pill/film count.
  - You must provide a urine sample when requested by your prescribing provider.

- Attendance
  - Missing more than one meeting each month is grounds for dismissal from the program. Being more than 20 minutes late means you have missed the group.

- Confidentiality
  - What happens in the group stays in the group. Breaking confidentiality is grounds for dismissal from the program.

- Honesty
  - The group is a place to practice honesty. Accepting responsibility for what is happening to you here and now is part of being honest. You will get the most out of the group if you give as much as you can to the discussion, and if you are as honest as you can be.

- Respect
  - Avoid interrupting or talking over other group members, or having side conversations while someone else is speaking.

- Setting your agenda
  - There is a lot of experience in this room, and you can learn from those around you. The goal is change. We will work with you, one-on-one and together as a group, to set real, practical, recovery goals that you can reach.

2016-10-17