**PREMIER HEALTH CENTER**

**409 WAKE CHAPEL RD,**

**FUQUAY VARINA, NC 27526**

**PHONE: 919-567-9001 FAX: 919-557-5540**

# EXPLANATION OF FIRST VISIT

Your first visit is generally the longest, and may last anywhere from 1 to 4 hours.

When preparing for your first office visit, there are a couple of logistical issues you may want to consider:

- You may not want to return to work on the day of your visit—this is very normal, so just plan accordingly
- Because the medication can cause drowsiness and slow reaction times, particularly during the first few weeks of treatment, driving yourself home after the first visit is generally not recommended, so you may want to make arrangements for a ride home

It is very important to arrive for your first visit already experiencing moderate opioid withdrawal symptoms. If you are in withdrawal, the medicine is supposed to help lessen the symptoms. However, if you are *not* in withdrawal, the medicine will "override" the opioids already in your system, which will *cause* severe withdrawal symptoms.

The following guidelines are provided to **ensure you are in withdrawal for the visit**. (If this concerns you, it may help to schedule your first visit in the morning; some patients find it easiest to skip what would normally be their first dose of the day.)

- No methadone or long-acting painkillers for at least 24 hours
- No heroin or short-acting painkillers for at least 4 to 6 hours

Bring ALL medication bottles with you to your first appointment.

Before you can be seen by the doctor, all of the paperwork your doctor provided must be completed. If your doctor provided the paperwork to you prior to this visit, bring it completed or arrive about 30 minutes early to fill it out.

Urine drug screening is a regular procedure of treatment, because it provides physicians with important insights into your health and your treatment. Your first visit will include urine drug screening, and may also entail a Breathalyzer®* test and blood work. If you haven't had a recent physical exam, your doctor may require one. To help ensure that this medicine is the best treatment option for you, your doctor will perform a substance dependence assessment and mental status evaluation. Lastly, you and your doctor will discuss the medicine and your expectations of treatment.

After this portion of your visit is completed, your doctor will administer your first dose. Your doctor may have you fill the prescription at the pharmacy and return to the doctor's office so you can take the medication in a safe place where the medical staff can monitor your response.

Once you take your first dose, you should begin to feel better within 30 minutes. Your doctor may choose to give you additional doses while you are in the office. It's important that you are honest about how you are feeling during induction so your doctor can find the appropriate dose for you.

When you leave the office, the doctor will likely give you a prescription that will last until your next appointment. The doctor may also want to discuss counseling with you, since medication plus counseling has been shown to produce better results. At the same time, your doctor may suggest enrolling in the Here to Help® Program, which can provide you with an added support system.

Your doctor may ask you to keep a record of any medications you take at home to control withdrawal symptoms. You will also receive instructions on how to contact your doctor in an emergency, as well as additional information about treatment.

**CHECKLIST FOR FIRST VISIT:**

- □ Arrive experiencing moderate **opioid withdrawal** symptoms
- □ Arrive prepared to give a urine sample for screening
- □ Bring completed **forms** (or come 30 minutes early)
- □ Bring **ALL medication bottles**
- □ **Fees due** at time of visit (cash or check)



**Please see your doctor or pharmacist for full Product Information for your medicine**

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# EXPLANATION OF TREATMENT

## Intake

You will be given a comprehensive substance dependence assessment, as well as an evaluation of mental status and physical exam. The pros and cons of the medication, will be presented. Treatment expectations, as well as issues involved with maintenance and medically supervised tapering off the medication will be discussed.

## Induction

Treatment begins here. You will be switched from your current opioid of misuse (heroin, methadone, or prescription painkillers) to your treatment medication. You are asked to arrive at the doctor's office in a moderate state of withdrawal. Being in a state of moderate withdrawal is vital to having the medication work well. If you are not in moderate withdrawal, the medication might actually make you feel worse rather than better (intensifying withdrawal symptoms). This is called **precipitated withdrawal**.

It is really important to be truthful with your doctor about the last time you used an opioid, which opioid it was, how much you took, and which other drugs or medications you used. Your doctor needs this information to determine the timing of your first dose.

Once you take your first dose, you should begin to feel better within 30 minutes. Your doctor may choose to give you additional doses while you are in the office. Be sure to tell your doctor about how you are feeling during induction so your doctor can find the appropriate dose for you.

When you leave the office, the doctor will likely give you a prescription that will last until your next appointment. The doctor may also want to discuss counseling with you, since medication plus counseling has been shown to produce better results. At the same time, your doctor may suggest enrolling in the Here to Help® Program, which can provide you with an added support system.

Since an individual's tolerance and reactions to the medicine vary, daily appointments may be scheduled and medications will be adjusted until you no longer experience withdrawal symptoms or cravings. Urine drug screening is typically required for all patients at every visit during this phase.

**Intake and Induction may both occur at the first visit, depending on your needs and your doctor's evaluation. Call your doctor if you have any questions or concerns.**

## Stabilization & Maintenance

This is the second phase of treatment. During this phase, your doctor may continue to adjust your dose until you find, and continue on, the dose that works for you. It is important to take your medication as directed. To evaluate the effectiveness of your dose, your doctor may request urine samples from time to time.

During this phase is when you may also begin working on your treatment goals with your doctor and counselor. At times when you feel stressed, or experience triggers or cravings, your doctor may suggest a dose adjustment, or there may be a need to change the frequency of counseling and/or behavioral therapy.

Occasionally, as you achieve your treatment goals and feel confident about your progress, your physician may suggest a dose decrease. During these times, you are "restabilized." This is why stabilization and maintenance go together.

**Tapering Off**

There are no time limits for treatment with this medicine. Length of therapy is up to your doctor, you, and sometimes your therapist or counselor. If you and your doctor agree that the time is right for a medical taper, he or she will slowly lower your dose (also known as a taper), taking care to minimize withdrawal symptoms. If you feel at risk for relapse during a taper, let your doctor know. You can be restabilized and continue maintenance if needed.

**Please note:** This medicine is a narcotic medication indicated for the maintenance treatment of opioid dependence, available only by prescription, and must be taken under a doctor's care as prescribed. It is illegal to sell or give away your medicine.



**Please see your doctor or pharmacist for full Product Information and Medication Guide**

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# PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

Use the opposite side of the page as necessary to complete your answers. **Please print legibly.**

Name: _____

Address: _____

Phone: (w) _____ (h) _____ (c) _____

DOB: _____ Age: _____SS no.: _____

Emergency contact: _____

Relationship to patient: _____ Phone: _____

Primary care physician: _____ Phone: _____

Date of last physical: _____ Have you ever had an EKG? **( )** N **( )** Y Date: _____

**Current or past medical conditions** (check all that apply) :

| | | |
|---|---|---|
| **( )** Asthma/respiratory | **( )** Cardiovascular (heart attack, high cholesterol, angina) | |
| **( )** Hypertension | **( )** Epilepsy or seizure disorder | **( )** GI disease |
| **( )** Head trauma | **( )** HIV/AIDS | **( )** Diabetes |
| **( )** Liver problems | **( )** Pancreatic problems | **( )** Thyroid disease |
| **( )** STDs | **( )** Abnormal Pap smear | **( )** Nutritional deficiency |

Other (Please describe) : _____

_____

_____

If there a family history of any of the illnesses listed above, **please put an "F" next to that illness**.

**MD NOTES:** _____

_____

Is there a family history of anything NOT listed here? **( )** N **( )** Y (Please explain) _____

_____

_____

**MD NOTES:** _____

_____

Have you ever had **surgery** or been **hospitalized**? **( )** N **( )** Y (Please describe) _____

_____

_____

**MD NOTES:** _____

_____

**Childhood Illnesses**

Measles **( )** N **( )** Y Mumps **( )** N **( )** Y Chicken Pox **( )** N **( )** Y

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? **( )** N **( )** Y (Please describe) _____

Have you ever taken or been prescribed **antidepressants**? **( )** N **( )** Y For what reason _____

Medication(s) and dates of use: _____ Why stopped: _____

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).
DO NOT include medications you may be currently misusing (that information is needed later): _____

_____

_____

Please list all current **herbal medicines**, **vitamin supplements**, etc, and how often you take them: _____

_____

**MD NOTES:** _____

_____

Please list any **allergies** you have (eg, penicillin, bees, or peanuts): _____

_____

**MD NOTES:** _____

**Tobacco History**

**Cigarettes**: Now? **( )** N **( )** Y In the past? **( )** N **( )** Y

How many per day, on average? _____ For how many years? _____

**Pipe**: Now? **( )** N **( )** Y In the past? **( )** N **( )** Y

How often per day, on average? _____ For how many years? _____

Have you ever been **treated for substance misuse**? **( )** N **( )** Y (Please describe when, where and for how long)

_____

How long have you been **misusing substances?** _____

**Substance Use History**

| | No | Yes/Past or Yes/Now | Route | How Much | How Often | Date/Time of Last Use | Quantity Last Used |
|---|---|---|---|---|---|---|---|
| Alcohol | | | | | | | |
| Caffeine (pills or beverages) | | | | | | | |
| Cocaine | | | | | | | |
| Crystal Meth-Amphetamine | | | | | | | |
| Heroin | | | | | | | |
| Inhalants | | | | | | | |
| LSD or Hallucinogens | | | | | | | |
| Marijuana | | | | | | | |
| Methadone | | | | | | | |
| Pain Killers | | | | | | | |
| PCP | | | | | | | |
| Stimulants (pills) | | | | | | | |
| Tranquilizers/ Sleeping Pills | | | | | | | |
| Ecstasy | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Other | | | | | | | |

Did you ever stop using any of the above because of dependence? **( )** N **( )** Y (Please list) _____

_____

_____

What was your longest period of abstinence? _____

_____

Are you receiving, or have you ever received counseling support? **( )** N **( )** Y (Please describe when and for how long) _____

_____

**MD NOTES:** _____

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# PATIENT INTAKE: PHYSICAL EXAM

**Patient Name: _____ Date:_____ Date of last physical: _____**

T_____ P_____ BP_____ R_____ WT_____ HT_____ Appearance _____

TB_____ HIV_____ STD (specify)_____ Hep-C_____ Hep-B_____ BAL_____

| | | |
|---|---|---|
| Skin | GI | Lymph |
| HEENT | GU | Neuro |
| Neck | GYN | Locomotor |
| CVS | Musculoskeletal | Psych |
| Resp | Extremities | Nutrition/hydration |

**Signs of intoxication?** ( ) N ( ) Y _____

**NOTES:** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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# PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

**Patient Name:** _____

(Circle one) Married Single Long-term relationship Divorced/Separated

Years married/in long-term relationship: _____Times married: _____Times divorced: _____

Children? **( )** N **( )** Y Current ages (Please list) _____

Residing with you? **( )** N **( )** Y If no, where? _____

Where are you currently living? _____

Do you have family nearby? **( )** N **( )** Y (Please describe) _____

**Education** (check most recent degree):

**( )** Graduate School **( )** College **( )** Professional or Vocational School

**( )** High School Grade _____

Are you currently employed? **( )** N **( )** Y Where (if no, where were you last employed)? _____

What type of work do/did you do? _____ How long have/did you work(ed) there? _____

Have you ever been arrested or convicted? **( )** N **( )** Y (Check all that apply)

**( )** DWI **( )** Drug-related **( )** Domestic violence **( )** Other _____

Have you ever been abused? **( )** N **( )** Y

**( )** Physically **( )** Sexually (including rape or attempted rape) **( )** Verbally **( )** Emotionally

Have you ever attended:

**AA:** **( )** Current **( )** Past **NA:** **( )** Current **( )** Past **CA:** **( )** Current **( )** Past

**ACOA:** **( )** Current **( )** Past **OA:** **( )** Current **( )** Past

If you are not currently attending meetings, what factors led you to stop? _____

Have you ever been in counseling or therapy? **( )** N **( )** Y (Please describe) _____

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# PATIENT TREATMENT CONTRACT

**Patient Name: _____ Date: _____**

As a participant in medication treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep, and be on time to, all my scheduled appointments.

2. I agree to adhere to the payment policy outlined by this office.

3. I agree to conduct myself in a courteous manner in the doctor's office.

4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.

6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.

7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.

8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.

9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.

10. I understand that mixing this medicine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).

11. I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events.

12. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.

13. I agree to bring my empty and full strip packets on each visit to the office. If I do not bring these packets, it may result in my not being able to get my medication/prescription until the next scheduled visit.

14. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.

15. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine).

16. I agree to provide random urine samples and have my doctor test my blood alcohol level.

17. I understand that violations of the above may be grounds for termination of treatment.

_____ _____

Patient Signature Date

*Valium® is a registered trademark of Roche Products Inc.

†Klonopin® is a registered trademark of Roche Laboratories Inc.

‡Xanax® is a registered trademark of Pharmacia & Upjohn Company.

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# SUBSTANCE DEPENDENCE ASSESSMENT

(For complete substance use history, see Patient Intake: Medical History)

**Patient Name: _____ Date: _____**

BP _____ Pulse _____ BAL _____ Urine Drug Screening _____

**Has patient experienced withdrawal symptoms in the past** (check all that apply)**:**

| | | | |
|---|---|---|---|
| Blackouts | **( )** | Anxiety | **( )** |
| ETOH Seizures | **( )** | Diarrhea | **( )** |
| Tremors | **( )** | Nausea/vomiting | **( )** |
| DTs | **( )** | Body cramps | **( )** |
| Sweats | **( )** | Body aches | **( )** |

**Has patient ever been treated for substance misuse**? **( )** N **( )** Y (Please describe when, where, and for how long)

_____

**MD NOTES:** _____

_____

_____

_____

**Presenting problem**

Substance: _____ Route: _____

Quantity/Dose: _____ Frequency: _____

Last Usage: _____

**MD NOTES:** _____

_____

_____

**Present illness:**

_____

_____

_____

_____

_____

**Family history of substance abuse:** _____

_____

_____

_____

_____

**Treatment plan** (including recommended psychosocial support): _____

_____

_____

_____

_____

_____

_____

_____