TELEPHONE SCREENING

Provider Name: ____

Provider Signature: __________________________ **Date:** _____________________________

DEMOGRAPHIC INFO

How did you hear about the hotline?

☐ 1 = Spouse
☐ 2 = Friend
☐ 3 = Medical Provider
☐ 4 = Flyer
☐ 5 = Parent
☐ 6 = State Hotline
☐ 7 = Physician Locator
☐ 8 = Other: ___________________________

Are you pregnant at this time?

☐ 1 = Yes
☐ 2 = No
☐ 3 = Don't know
☐ 4 = Tubal ligation
☐ 5 = Menopause
☐ 6 = History of hysterectomy
☐ 7 = Other: ___________________________
☐ 8 = N/A patient is male

If no, are you on birth control?

☐ 1 = Yes
☐ 2 = No

Current Address: ____

Phone: _________________________________

Phone: _________________________________

Is it ok to leave a message?

☐ 1 = Yes
☐ 2 = No

Emergency Contact: ______________________________ **Phone:** ________________________

Is the Emergency Contact aware of your substance use?

☐ 1 = Yes
☐ 2 = No

SUBSTANCE USE HISTORY

	Age of initiation	Date of most recent use	Frequency	Route of administration	Amounts used
What is your substance of choice?	0 IF NEVER USED	1=12 OR MORE MONTHS AGO (SPECIFY DATE) 2=3–11 MONTHS AGO 3=1–2 MONTHS AGO 4=1–3 WEEKS AGO 5=USED THIS WEEK	1=LESS THAN 1/MONTH 2=1–3 TIMES/MONTH 3=1–2 TIMES/WEEK 4=3–6 TIMES/WEEK 5=DAILY	1=ORAL 2=SMOKING 3=INTRANASAL 4=INTRAVENOUS INJECTION 5=SKIN POPPING 6=OTHER	
Opioid: ☐ Heroin ☐ Fentanyl ☐ Oxycodone product ☐ Buprenorphine ☐ Methadone ☐ Other opioid: ________________					
Benzodiazepines					
Alcohol					
Cocaine					
Amphetamines, including methamphetamine					
Tobacco					
Other					

What substances are you currently using at this time? Include age of first use, date of most recent use, route, frequency, and quantity.

☐ 1 = Heroin
☐ 2 = Fentanyl
☐ 3 = Buprenorphine/naloxone
☐ 4 = Methadone
☐ 5 = Oxycodone product
☐ 6 = Other opioid: ______________________
☐ 7 = Cocaine
☐ 8 = Benzodiazepines
☐ 9 = Nicotine
☐ 10 = Alcohol
☐ 11 = Amphetamines
☐ 12 = Other: ___________________________
☐ 13 = Nothing

What substances have you used in the past? Include age of first use, date of most recent use, route, frequency, and quantity.

☐ 1 = Heroin
☐ 2 = Fentanyl
☐ 3 = Buprenorphine/naloxone
☐ 4 = Methadone
☐ 5 = Oxycodone product
☐ 6 = Other opioid: ____________________
☐ 7 = Cocaine
☐ 8 = Benzodiazepines
☐ 9 = Nicotine
☐ 10 = Alcohol
☐ 11 = Amphetamines
☐ 12 = Other: __________________________
☐ 13 = Nothing

Have you ever shared needles?

☐ 1 = Yes
☐ 2 = No

Have you ever belonged to the needle exchange program?

☐ 1 = Yes
☐ 2 = No

Have you ever overdosed?

☐ 1 = Yes
☐ 2 = No

Number of lifetime overdoses: _____________

Have you ever been hospitalized due to an overdose?

☐ 1 = Yes
☐ 2 = No

Was naloxone administered?

☐ 1 = Yes
☐ 2 = No

How many times have you overdosed in the past year? ____________

Was your most recent overdose and attempt to kill yourself?

☐ 1 = Yes
☐ 2 = No

RECOVERY HISTORY

What was the longest period of time that you have been in recovery? ____________________

When was this? _______________________

ADDICTION TREATMENT HISTORY

Have you ever engaged in treatment for a substance use disorder?

☐ 1 = Yes
☐ 2 = No

If yes, how many times to each type?

_______ Detoxification Program
_______ Driving Impaired Program
_______ Residential (Rehab or Halfway House)
_______ Methadone maintenance
_______ Buprenorphine/naloxone maintenance (Suboxone, Zubsolv)
_______ Intensive Outpatient Program
_______ Naltrexone (oral or injectable) (Revia, Depade, Vivitrol)

Do you attend peer-support meetings (check all that apply):

☐ 1 = AA
☐ 2 = NA
☐ 3 = Smart Recovery
☐ 4 = Other: _______________________________

How many meetings do you attend each week?

☐ 1 = 1–2 week
☐ 2 = 3–4 week
☐ 3 = 5–6 week
☐ 4 = Daily
☐ 5 = None
☐ 6 = Other: _______________________________

Do you have a sponsor?

☐ 1 = Yes
☐ 2 = No

Do you have any history of any other addictive behaviors such as?

☐ 1 = Gambling
☐ 2 = Sex
☐ 3 = Shopping
☐ 4 = Eating disorder (overeating, bulimia, anorexia)
☐ 5 = Other: ______________________________
☐ 6 = No

Comments:

CRIMINAL HISTORY

Have you ever been incarcerated?

☐ 1 = Yes
☐ 2 = No

What is the longest period of time you spent in jail/prison? ______________________________

Are you on probation?

☐ 1 = Yes
☐ 2 = No

Are you on parole?

☐ 1 = Yes
☐ 2 = No

Are you facing any potential jail time?

☐ 1 = Yes
☐ 2 = No

Do you have any outstanding legal issues?

☐ 1 = Yes
☐ 2 = No

If yes, can you tell us about them?

METHADONE HISTORY

Have you ever engaged in a Methadone Maintenance program?

☐ 1 = Yes
☐ 2 = No

Are you currently on Methadone Maintenance?

☐ 1 = Yes
☐ 2 = No

If yes to currently engaged in Methadone treatment:

Where are you engaged in Methadone Maintenance? ________________________________

What is the name of your counselor at your Methadone clinic? ________________________

How long have you been in your current Methadone Maintenance Program? ____________

What is your dose? _____________________

Are you receiving take-homes?

☐ 1 = Yes
☐ 2 = No

If yes, how many? ______________

If not currently engaged in methadone treatment:

When were you on Methadone Maintenance? ______________________________________

Where were you on Methadone Maintenance? _____________________________________

How long were you on Methadone Maintenance? ___________________________________

What was your dose? ___________________

Why did you stop Methadone treatment?

BUPRENORPHINE HISTORY

Have you ever been prescribed buprenorphine/naloxone (Suboxone, Zubsolv) before?

☐ 1 = Yes
☐ 2 = No

If yes:

Where were you prescribed buprenorphine/naloxone? ______________________________

When were you prescribed buprenorphine/naloxone? ______________________________

What was your dose? ____________________

Why did you stop taking buprenorphine/naloxone?

NALTREXONE HISTORY

Have you ever been prescribed naltrexone (Revia, Depade, Vivitrol) before?

☐ 1 = Yes
☐ 2 = No

If yes:

Where were you prescribed naltrexone? ____

When were you prescribed naltrexone? ____

Did you ever receive an extended-release naltrexone injection? ______________________

Why did you stop naltrexone treatment?

MENTAL HEALTH HISTORY

Are you currently seeing a psychiatrist, psychologist, or counselor for a mental health issue?

☐ 1 = Yes
☐ 2 = No

Where do you see your psychiatrist, psychologist, or counselor? ___________________________

What is this individual's name? ____

How often do you see them? ____

How many times have you seen this person in the last six months? __________ Times.

Are you willing to sign a consent for release of information so that we can communicate with your psychiatrist, psychologist, or counselor about your treatment plan?

☐ 1 = Yes
☐ 2 = No

Have you ever been hospitalized for mental health issues?

☐ 1 = Yes
☐ 2 = No

Have you ever attempted to end your life or to hurt yourself?

☐ 1 = Yes
☐ 2 = No

How many times did you try to end your life or to hurt yourself? __________ Times.

Do you currently have thoughts about hurting yourself or ending your life?

☐ 1 = Yes
☐ 2 = No (If no, skip to homicide question)

If yes: Do you currently have a plan for how you would hurt yourself or end your life?

☐ 1 = Yes
☐ 2 = No

Do you have the means to carry out your plan?

☐ 1 = Yes
☐ 2 = No

Have you ever attempted or thought about homicide (killing someone else)?

☐ 1 = Yes
☐ 2 = No (If no, skip to health status)

If yes: Are you presently thinking about killing someone?

☐ 1 = Yes
☐ 2 = No

Do you have the means to carry this out?

☐ 1 = Yes
☐ 2 = No

Are you willing to sign a Contract for Safety, call 911, etc., per program protocol?

☐ 1 = Yes
☐ 2 = No

HEALTH STATUS

Have you ever been diagnosed with any medical conditions? Mark all that apply.

☐ 1 = Diabetes (specify type): ___________________________________
☐ 2 = Heart disease (specify type): _______________________________
☐ 3 = Cancer (specify type): _____________________________________
☐ 4 = Asthma
☐ 5 = Tuberculosis (TB)
☐ 6 = Endocarditis
☐ 7 = Skin infection
☐ 8 = HIV→ If yes, are you currently in care? ☐ 1 = Yes ☐ 2 = No
☐ 9 = Hepatitis A
☐ 10 = Hepatitis B → If yes, have you been treated? ☐ 1 = Yes ☐ 2 = No
☐ 11 = Hepatitis C → If yes, have you been treated? ☐ 1 = Yes ☐ 2 = No
☐ 12 = Seizure disorder → Are you on medications? ☐ 1 = Yes ☐ 2 = No
☐ 13 = Head Trauma/Brain Injury
☐ 14 = Pancreatic Problems
☐ 15 = Other (specify type): _____________________________________
☐ 16 = None

Have you ever been tested for HIV?

☐ 1 = Yes
☐ 2 = No

If yes, what was the result of your most recent test?

☐ 1 = Positive
☐ 2 = Negative
☐ 3 = Don't Know

If yes, what was the date of your most recent test? _________________________________

Have your ever been tested for Hepatitis C?

☐ 1 = Yes
☐ 2 = No

If yes, what was the result of your most recent test?

☐ 1 = Positive
☐ 2 = Negative
☐ 3 = Don't Know

If yes, what was the date of your most recent test? _________________________________

Have you ever had surgery?

☐ 1 = Yes
☐ 2 = No

If yes, why did you have surgery?

Do you have any pending surgeries?

☐ 1 = Yes
☐ 2 = No

If yes, please briefly explain:

PAIN

Do you have chronic pain?

☐ 1 = Yes
☐ 2 = No

If yes, please rate your pain, on a scale from 0 to 10, WITHOUT any pain medications (by medications we mean any medications prescribed to you in addition to any medications not prescribed to you)

☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10

If yes, please rate your pain, on a scale from 0 to 10, WITH pain medications (by medications we mean any medications prescribed to you in addition to any medications not prescribed to you)

☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10

HEALTH CARE PROVIDER INFORMATION

Where do you get most of your health care? ____________________

When was the last time you saw a health care provider?

☐ 1 = Last week
☐ 2 = Last month
☐ 3 = Within the past 3 months
☐ 4 = Within the past 6 months
☐ 5 = Within the past year
☐ 6 = More than 1 year ago

What is the name of your provider? ____________________

EMPLOYMENT

Are you currently employed?

☐ 1 = Yes
☐ 2 = No

If yes, what do you do for work? ____________________

Are you working full or part time? ____________________

What days of the week do you work, and how many hours per day do you work?

SOCIAL SUPPORT

What is your relationship status?

☐ 1 = Single (skip the next questions)
☐ 2 = Married
☐ 3 = Long-term relationship
☐ 4 = Divorced
☐ 5 = Other ______________________________

Do you live with your partner/significant other?

☐ 1 = Yes
☐ 2 = No

Does your partner have a history of substance use disorder?

☐ 1 = Yes
☐ 2 = No

Is your partner/significant other currently in treatment?

☐ 1 = Yes
☐ 2 = No

How satisfied are you with the support you get from your partner/significant other?

☐ 1 = Very satisfied
☐ 2 = Satisfied
☐ 3 = Fairly satisfied
☐ 4 = Not satisfied
☐ 5 = N/A

FAMILY HISTORY

Do any other family members have a history of substance use disorder?

☐ 1 = Yes
☐ 2 = No

TRANSPORTATION

How do you get around?

☐ 1 = I drive → Do you have your own car? ☐ 1 = Yes ☐ 2 = No
☐ 2 = Public Transportation
☐ 3 = Walk
☐ 4 = I get a ride from a family/friend
☐ 5 = Other ______________________________

Do you have a valid form of government issued identification?

☐ 1 = Yes
☐ 2 = No

How would you get to this office if you needed to get here?

☐ 1 = I would drive
☐ 2 = Public Transportation
☐ 3 = I would walk
☐ 4 = I would get a ride from a family/friend
☐ 5 = Other ______________________________

HOUSING

Have you spent one or more weeks on the street or in a shelter in the last three months?

☐ 1 = Yes
☐ 2 = No

What type of place are you living in now?

☐ 1 = In a house or apartment you own or rent
☐ 2 = In a house or apartment owned or rented by family or friends
☐ 3 = Hotel
☐ 4 = Alcohol or substance use treatment program
☐ 5 = Shelter
☐ 6 = Street or car
☐ 7 = Other (specify other) ______________________________
☐ 8 = Don't know

Who do you live with at this time?

☐ 1 = I live alone.
☐ 2 = I live with my partner/significant other
☐ 3 = I live with family members
☐ 4 = I live with friends
☐ 5 = Other ____

Can you tell me what your goals are for treatment?

After completion, scan form into patient record and provide a copy to the patient.

This document has been reproduced with permission from Boston Medical Center© and is excerpted from: *LaBelle, C. T.; Bergeron, L. P.; Wason, K.W.; and Ventura, A. S. Policy and Procedure Manual of the Office Based Addiction Treatment Program for the use of Buprenorphine and Naltrexone Formulations in the Treatment of Substance Use Disorders. Unpublished treatment manual, Boston Medical Center, 2016.* This manual or any documents therein are not a substitute for informed medical decision making by an appropriate, licensed provider.