Skiatook Family Clinic
201 E. 2nd St.
Skiatook, OK 74070
(918) 396-1262 Fax (918) 396-4598

May 9, 2021

Re: Office-Based Opioid Treatment

Dear Prospective Patient,

Thank you for your interest in Skiatook Family Clinic's Office-Based Opioid Treatment program. We provide medication-assisted treatment for patients with Opioid Use Disorder using buprenorphine-based products and opioid antagonists. Our providers have nearly 20 years of combined experience caring for the unique needs of Opioid Use Disorder patients. We accept new patients and are excited about the successes we have seen in the past and our current patients' progress towards recovery now.

We believe substance use disorders are chronic relapsing illnesses based on our biology and triggered by our unique social circumstances, not character flaws. Our treatment approach and practice philosophy builds on the American Society of Addiction Medicine's 2020 National Practice Guideline Update and is current. We understand what you are going through and are committed to providing the best care possible.

Our goal is to help our patients stabilize their health and life and then get back on their feet to be productive and enjoy their best life. Our program requires an initial assessment and examination that includes a drug test before considering any prescriptions. Our patients must also participate and demonstrate a commitment to recovery to remain in the program. Counseling and instruction are provided directly by our providers, and we also have a licensed drug and alcohol counselor available to see patients on-site for added support.

On a case-by-case basis, we accept new patients who are committed to recovery. If you would like to enter our program, please complete the attached documents and return them to the office at your earliest convenience for consideration and scheduling your first appointment.

Sincerely,

Layne Subera DO

**** Electronic Signature Verified ****

Skiatook Family Clinic

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New Patient Intake Form

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip Code: _____

Preferred telephone number for daytime contact: _____ ☐Cell. ☐Work. ☐Home.

Please answer these questions to help us understand your situation. Be sure to identify the circumstances and substances that cause problems. Provide us enough narrative to tell your story.

Substance: _____ How long using? _____

How much? _____ How often? _____

1. Have you ever tried to quit on your own? (☐No.) If yes, explain: _____

_____

2. Have you ever been treated for a substance use disorder? (☐No.) If yes, explain: _____

_____

3. Has your drug use ever resulted in medical or legal problems? (☐No.) If yes, explain: _____

_____

4. Have you ever used buprenorphine? (☐No.) If yes, explain: _____

_____

5. Are you able or willing to attend counseling? (☐No.) If yes, explain: _____

_____

6. Do you have any medical conditions (diabetes, HIV+, epilepsy, STDs)? (☐No.) If yes, list them here: _

_____

_____

7. Are you currently taking any medications? (☐No.) If yes, list them on the medication flow sheet.

8. Are you pregnant? (☐N/A.) (☐No.) (☐Yes.) (☐Not sure.) If yes, describe your progress. How far along are you? What pregnancy care have you received? Who is your pregnancy doctor? _____

_____

_____

9. Is anyone in your family or home using substances now or have a history of substance abuse? (☐No.) If yes, explain: _____

_____

_____

10. Please describe your current living arrangement: _____

_____

_____

11. Are you currently employed? (☐No.) (☐Yes.). Occupation: _____

Employer: _____

How many hours per week do you usually work? _____

Are you at risk of losing your job? If yes, explain: _____

_____

_____

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Substance Use History Chart

INSTRUCTIONS: In the space below, mark the appropriate substances and describe how you used them in the spaces provided. If additional space is required, please continue on the back of the page.

	No	Yes	Route	How much?	How often?	Date/Time Last use?	Amount used?
Alcohol							
Benzodiazepines (Xanax, etc.)							
Caffeine							
Cocaine							
Fentanyl							
Heroin							
Inhalants							
LSD							
Marijuana							
MDMA (Ecstasy)							
Methadone							
Methamphetamine							
Opioids (Oxycodone, etc.)							
Other:							
PCP							
Stimulant pills							
Tobacco							

Current Medication List

Name:	Date of Birth:

Please help us update your medical record by listing all of your medication allergies and all of the medications that you are currently using. Include all prescriptions from other doctors. List prescriptions first and over the counter products last if space remains.

Medication Allergies				

No.	Drug Name	Dosage	Frequency	Date
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Reviewed:					

archive

5/9/2021

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Opioid Use and Safety Screener

INSTRUCTIONS: Place a checkmark in the box to the left of each sentence below if it is true.

- ☐ I am using opioids in larger amounts or for a more extended period of time than I planned.
- ☐ I have a persistent desire to cut down on my opioid use but have been unsuccessful.
- ☐ I spend a lot of time trying to obtain opioids, use them or recover from using them.
- ☐ I crave opioids or have strong urges to keep using them.
- ☐ My opioid use keeps causing me to fail to meet significant obligations at work, school, or home.
- ☐ I continue to use opioids even though I know they are causing persistent social or interpersonal problems in my life.
- ☐ I have given up important social, occupational, or recreational activities because of my opioid use.
- ☐ I frequently use opioids in physically hazardous situations like driving or using tools.
- ☐ I keep using opioids despite knowing they are causing me physical or psychological problems.
- ☐ I keep increasing the amounts of opioids I use because I do not get the same effect from the lower doses I used to get.
- ☐ If I run out of opioids, I get sick or have to find something else to take.
- ☐ None of these statements are true.

Signed: _____. Date: _____

Adapted from the DSM-V criteria for Opioid Use Disorder.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

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EXPLANATION OF SUBOXONE INDUCTION VISIT

SUBOXONE® (buprenorphine HCl/naloxone HCl dihydrate)Ⓒ sublingual tablet

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

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

- You may not want to return to work after your visit—this is very normal, so just plan accordingly
- Because SUBOXONE can cause drowsiness and slow reaction times, particularly during the 1st few weeks of treatment, driving yourself home after the visit is generally not recommended, so you may want to make arrangements for a ride home

It is very important to arrive for your visit already experiencing mild to moderate opioid withdrawal symptoms. If you are in withdrawal, buprenorphine will help lessen the symptoms. However, if you are *not* in withdrawal, buprenorphine 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 appointments.

Before you can be seen by the doctor, all of your paperwork must be completed, so bring all your completed forms with you or arrive about 30 minutes early. In addition, you will need to pay the doctor's fees prior to treatment.

CHECKLIST FOR SUBOXONE INDUCTION VISIT:

- ☐ Arrive experiencing mild to moderate **opioid withdrawal** symptoms
- ☐ Arrive with a **full bladder**
- ☐ Bring completed **forms**
- ☐ Bring **ALL medication bottles**
- ☐ **Fees due** at time of visit (cash or check)

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APPOINTED PHARMACY CONSENT

SUBOXONE® (buprenorphine HCl/naloxone HCl dihydrate) C sublingual tablet
SUBUTEX® (buprenorphine HCl) sublingual tablet

I _____ do hereby: (**MD check all that apply**)
Patient Name (Print)

☐ Authorize _____ at the above address to disclose my treatment for opioid
Physician Name (Print)
dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine prescriptions directly to the pharmacy.

☐ Agree to purchase all SUBOXONE, SUBUTEX, and any other medications related to my treatment from the pharmacy specified below.

☐ Agree not to use any pharmacy other than the one specified below for the duration of my treatment with the physician specified above, unless specific arrangements have been made with the physician.

☐ Agree to make payment arrangements with the pharmacy specified below *in advance* of treatment, so that my buprenorphine prescriptions can be filled and either delivered to the office addressed given above or picked-up by employees of the same.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

Appointed Pharmacy: Name_____ Phone_____

Address_____

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PATIENT INFORMATION

NAME:_____
Last First Middle Nickname

ADDRESS:_____
P.O. Box/Street City State ZIP

EMPLOYER:_____EMPLOYER Phone_____

HOME PHONE:_____ CELL PHONE_____

SSN:_____BIRTHDATE_____ RACE:_____

LANGUAGE_____ ETHNICITY_____ MALE FEMALE

Who referred you to us?_____

Emergency contact OUTSIDE home:_____

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY:_____ SSN:_____

HOME PHONE:_____ CELL PHONE:_____

EMPLOYER:_____ PHONE:_____

INSURANCE INFORMATION

PRIMARY INS:_____ SECONDARY INS:_____

ADDRESS:_____ ADDRESS:_____

CITY/STATE/ZIP:_____ CITY/STATE/ZIP:_____

POLICYHOLDER:_____ POLICYHOLDER:_____

BIRTHDATE:_____ BIRTHDATE:_____

SSN:_____ SSN:_____

GROUP/PLAN#_____GROUP PLAN#_____

SELF SPOUSE PARENT CHILD SELF SPOUSE PARENT CHILD

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CONSENT TO RELEASE RECORDS CONTAINING SUBSTANCE ABUSE INFORMATION 42 CFR

I, _____, authorize Skiatook Family Clinic to disclose the following information:

- ☐ Psychiatric/medical/alcohol/drug abuse records.
- ☐ Progress notes.
- ☐ Lab studies.
- ☐ Medical tests/studies.
- ☐ Psychological testing.
- ☐ Other: _____.

To (Name of recipient): _____

for the purpose of (be specific as possible): _____.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows (describe date or circumstance.): _____.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

- ☐ I have been provided a copy of this form.

Signature of Patient: _____ *Dated*: _____

Signature of person signing form if not patient: _____

Relationship: _____

Describe authority to sign on behalf of patient: _____