Addiction Medicine Patient Intake & Risk Screening

ADDICTION MEDICINE PRACTICE PACK

Patient / DOB _____

Primary substance(s) _____

Last use _____

Route / frequency _____

Prior treatment / MOUD _____

Overdose history _____

Current medications _____

Allergies _____

- ■ Opioid use
- ■ Alcohol use
- ■ Benzodiazepine use
- ■ Stimulant use
- ■ Cannabis use
- ■ Other substance use
- ■ Pregnant/breastfeeding
- ■ Seizure history
- ■ Severe liver disease
- ■ Respiratory disease
- ■ Recent overdose
- ■ Active suicidal/psychiatric crisis

Immediate safety concerns _____

Initial treatment plan / referral _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Buprenorphine Treatment Informed Consent

ADDICTION MEDICINE PRACTICE PACK

I consent to buprenorphine treatment when prescribed for opioid use disorder or another clinically appropriate indication. I understand medication treatment is individualized and may include follow-up, toxicology testing, PDMP review, counseling/support referrals, naloxone, and care coordination.

- ■ Precipitated withdrawal risk discussed
- ■ Medication storage/diversion prevention discussed
- ■ Common side effects reviewed
- ■ Overdose prevention / naloxone discussed
- ■ Sedation/respiratory risk with CNS depressants discussed
- ■ Physical dependence/withdrawal discussed
- ■ Follow-up expectations reviewed
- ■ Alternative treatments discussed

Medication/formulation _____

Induction/transition plan _____

Special risks / alternatives _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Buprenorphine Induction / Transition Checklist

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- ■ Recent opioid use documented
- ■ Methadone exposure assessed
- ■ Withdrawal status assessed
- ■ CNS depressants reviewed
- ■ Follow-up/reassessment plan established
- ■ Long-acting/short-acting opioid exposure assessed
- ■ Fentanyl exposure considered
- ■ Pregnancy status considered
- ■ Patient has instructions for first dose
- ■ Emergency contact instructions provided

Last opioid / time _____

Withdrawal assessment used / result _____

Initial dose plan _____

Reassessment plan _____

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Toxicology Testing Consent & Clinical Use Acknowledgment

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I understand toxicology testing may be used as a clinical tool to support diagnosis, medication safety, treatment planning, and recovery goals. Screening results may require confirmation or clinical interpretation.

I understand unexpected results should be discussed in context and may lead to additional assessment, confirmation testing, medication changes, increased monitoring, referral, or other clinically appropriate action.

Testing plan / frequency _____

Specimen type _____

Patient questions / limitations discussed _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Naloxone Education & Overdose Prevention Acknowledgment

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- ■ Overdose risk factors reviewed
- ■ How to recognize overdose reviewed
- ■ Call 911 / emergency response reviewed
- ■ Repeat dosing discussed
- ■ Naloxone purpose reviewed
- ■ How to administer naloxone reviewed
- ■ Rescue breathing/recovery position reviewed as appropriate
- ■ Household/support person education encouraged

Naloxone prescribed/offered _____

Education method _____

Additional harm-reduction plan _____

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Clinician/Reviewer: _____ **Date:** _____

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CNS Depressant / Benzodiazepine Risk Acknowledgment

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I understand combining opioids or buprenorphine with benzodiazepines, alcohol, sedatives, sleep medications, or other central nervous system depressants can increase sedation, impairment, respiratory depression, overdose, and death risk.

Current CNS depressants _____

Prescriber(s) / coordination plan _____

Risk-reduction plan _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Addiction Treatment Follow-Up Worksheet

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Current medication / dose _____

Adherence _____

Cravings _____

Withdrawal symptoms _____

Substance use since last visit _____

Overdose / naloxone events _____

Counseling / recovery supports _____

Housing / social stability _____

- ■ Sedation
- ■ Mood concern
- ■ Medication loss/diversion concern
- ■ New controlled medication
- ■ Constipation
- ■ Sleep concern
- ■ Pregnancy change
- ■ Other adverse event

Clinical assessment _____

Plan / follow-up _____

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Recovery & Care Coordination Authorization Worksheet

ADDICTION MEDICINE PRACTICE PACK

Use this worksheet to identify people or organizations the patient may wish to involve in care. Obtain any authorization required by HIPAA, 42 CFR Part 2, state law, or practice policy before disclosure.

Person/organization _____

Relationship / purpose _____

Information category _____

Method/contact _____

Authorization form completed / expiration _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Addiction Medicine Treatment Commitment Statement

ADDICTION MEDICINE PRACTICE PACK

- ■ Care will be respectful and evidence-informed.
- ■ Medication decisions will be based on clinical safety and patient goals.
- ■ Monitoring will be used to support care, not as punishment.
- ■ Relapse or return to use will prompt reassessment rather than automatic abandonment.
- ■ Overdose prevention and naloxone will be addressed.
- ■ Referrals will be offered when higher or different levels of care are needed.
- ■ Transitions/tapers will be handled as safely as circumstances allow.
- ■ Emergency symptoms require appropriate emergency care.

Patient goals _____

Support/referral plan _____

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