coös county Family Health

# MAT Intake Assessment

Name (First, MI, Last) _____

Date of Birth: _____/_____/_____

Phone (Home): _____ Phone (Cell) _____ Phone (Work) _____

Email: _____ Primary Provider: _____ Referring Provider _____

*We may wish to communicate upcoming appointment information, test results and/or other information regarding your medical care. What is the best phone number for contact where we may also leave message ☐ Home ☐ Cell ☐ Work

**Emergency Contact:** _____

Relationship: _____ Phone: _____

- Do you have reliable transportation? ☐ Yes ☐ No
- If you would like to give us permission to discuss personal information in your medical record with someone other than yourself, please fill out the **Consent for Services.**

## Health History Form

How willing/ready are you for change: ☐ very ready ☐ somewhat ready ☐ not ready ☐ unsure

**CURRENT MEDICATIONS**

| Name of Medication | Strength (ex. 500mg.) | Dosing Instructions (ex. Twice a day) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**ALLERGY HISTORY**

☐ No known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergies

| **Allergen** (ex. Food, Dust, Animals, Pollen, Medication | **Reaction** (ex. Rash, Nausea, Respiratory, Shock, etc.) |
|---|---|
| | |
| | |
| | |
| | |

**SOCIAL HISTORY** (Please circle all applicable responses)

| | | |
|---|---|---|
| Marital Status | Single Significant Other Married Divorced Widowed | |
| Living Situation | Alone Spouse/Significant other Children/Family<br>Homeless Residential Other: | |
| Females are you pregnant? | Yes / No Hysterectomy Menopause Tubal ligation | |
| Education Level | 9 10 11 12 Some college Associates Bachelors<br>GED Masters PhD | |
| Employment | Full-time Part-time Unemployed Seeking employment Disabled Retired | |
| If yes, Employer: | Occupation : # of Years | |
| Previous work experience? | Yes / No | If yes, description: |
| Military History | None / Past / Current | Army Navy Marines Coast Guard National Guard Air Force |
| Combat? | Yes / No | If yes where? |
| Discharge? | Yes / No | If yes: Honorable General Dishonorable Retired Other |
| VA Disability? | Yes / No | If yes, due to: |
| Spiritual/Religion Affiliation? | Yes / No | Practicing/ Role of Faith Past & Present |
| Receiving Benefits? | Yes / No | APTD SSI SSDI Food Stamps Fuel Asst. Section 8 Disability<br>Public Housing Pass Plan Workers comp Unemployment |

| | | | |
|---|---|---|---|
| Tobacco Use? | Yes / No | Cigarettes /Cigars / Chew | Per day: |
| If no have you ever? | Yes / No | Cigarettes /Cigars / Chew | Per day: |
| Do you drink alcohol? | Yes / No | Beer / Wine / Liquor | Per day: |
| Do you drink caffeine? | Yes / No | Coffee / Tea /Soda/ Energy Drink | Per day: |

**MEDICAL HISTORY** (Please check any of the following that you have or have had in the past)

| | | | |
|---|---|---|---|
| ☐ Acid Reflux/GERD | ☐ Chronic Cough | ☐ Hearing Loss | ☐ Seizure Disorder |
| ☐ ADHD | ☐ Chronic Pain | ☐ Heart Disease | ☐ Sexually Transmitted Disease |
| ☐ Alcoholism | ☐ COPD/Emphysema | ☐ Hepatitis | ☐ Skin Wounds/Infection |
| ☐ Anemia | ☐ Dementia | ☐ High Blood Pressure | ☐ Stroke |
| ☐ Anxiety | ☐ Dental Problems | ☐ High Cholesterol | ☐ Thyroid Disease |
| ☐ Arthritis | ☐ Depression | ☐ HIV/AIDS | ☐ Tuberculosis |
| ☐ Asthma | ☐ Diabetes | ☐ Kidney Disease | ☐ Other |
| ☐ Bleeding Disorders | ☐ Eating Disorder | ☐ Immune Disorders | |
| ☐ Bowel Problems | ☐ Glaucoma/Cataracts | ☐ Liver Disease | |
| ☐ Cancer | ☐ Headaches | ☐ Osteoporosis | |

Do you have any pending surgeries? ☐ Yes ☐ No If yes, describe _____

- Are you/do you have Obsessive Compulsive Disorder? ____ Eating disorder? ____ Panic Attacks? _____
- Have you participated in high-risk sexual practices _____ If so, please describe: _____
- Have you had Hepatitis? Yes ☐ No ☐ If yes, which type _____

  Last Hepatitis Test _____

  Results: _____

- Have you ever had a sexually transmitted disease ☐ Yes ☐ No If yes, which one(s) _____

  _____

  Last STD Test(s) _____ Results: _____

  Last HIV Test _____ Results: _____

- Do you now have, or have you ever had, seizures or convulsions? Yes ☐ No ☐
  If yes, when, and what condition caused them? _____ When was the last seizure or convulsions? _____
- Are there any problems that would make it hard for you to give routine urine specimens?

  Yes ☐ No ☐ If yes, describe _____

  _____

- Do you have any disabilities that make it hard for you to read labels or count pills?

  Yes ☐ No ☐ If yes, describe _____

  _____

**For Women Only:**

At what age did you start to menstruate? _____

Do you now have, or have you had problems with your menstrual period? Yes ☐ No ☐

If yes, please describe these problems? _____

Contraception use? Yes ☐ No ☐ If yes what type:_____

If no, what is the reason _____

Have you had any:

Pregnancies? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Miscarriages? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Abortions? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Menopausal symptoms or treatment? If yes, when? _____

**For Men Only:**

Do you now have, or have you had, problems with your prostate, difficult or painful urination, or impotence?

Yes ☐ No ☐ If yes, please describe those problems: _____

_____

**Family History** (Please tell us about your immediate family)

**CHILDREN** ☐ None

| First Name | Last Name | Age | Living With? | Custody? | Quality of Relationship |
|---|---|---|---|---|---|
| | | | Yes / No | Yes / No | |
| | | | Yes / No | Yes / No | |
| | | | Yes / No | Yes / No | |
| | | | Yes / No | Yes / No | |

**SPOUSE/SIGNIFICANT OTHER** ☐ None

| Name | Age | Occupation | Quality of Relationship |
|---|---|---|---|
| | | | |

| Relationship | Age | Marital Status | Occupation | Living with? | Quality of Relationship |
|---|---|---|---|---|---|
| Mother | | | | Yes / No | |
| Father | | | | Yes / No | |
| Sibling: | | | | Yes / No | |
| Sibling: | | | | Yes / No | |
| Sibling: | | | | Yes / No | |
| Other: | | | | Yes / No | |
| **Family is:** | Intact | Parents are Separated/Divorced | | Parents Remarried | |
| **Resided with:** | Mother | Father | Adopted | Orphaned | Other: |

| Health History | Father | Mother | Sibling | Children | Other |
|---|---|---|---|---|---|
| Age of Death | | | | | |
| Cause of Death | | | | | |
| Heart Disease/Stroke | | | | | |
| High Blood Pressure | | | | | |
| Diabetes | | | | | |
| Cancer (type) | | | | | |
| Epilepsy | | | | | |
| Asthma | | | | | |
| Blood Disease | | | | | |
| Depression | | | | | |
| Anxiety | | | | | |
| Bi-Polar | | | | | |
| Schizophrenia | | | | | |
| Other: | | | | | |

**Contact with Family** (check all that apply)

☐ Visit at least monthly
☐ Supportive
☐ Non-supportive
☐ Not satisfied with family relationship/contact
☐ Involved with treatment providers
☐ Knowledgeable about mental health
☐ Involved in National Alliance on Mental Illness (NAMI) or other support groups
☐ Family is available locally
☐ Family members not available
☐ Satisfied with family relationship/contact

What family member or significant others will be supportive to you during your treatment? _____

**SUBSTANCE ABUSE HISTORY**

**Family Substance Abuse** (Please check any family that apply, and list substance abused)

☐ None ☐ Parents _____ ☐ Siblings _____ ☐ Extended Family _____

☐ Significant other/spouse _____

Do you or your family think you have a problem with:

Shopping? ☐ Yes ☐ No Barbiturates? ☐ Yes ☐ No Internet? ☐ Yes ☐ No

Sex Addiction? ☐ Yes ☐ No Gambling? ☐ Yes ☐ No

Have you had any previous rehab or treatment for substances abuse? Yes ☐ No ☐

| Where? | Reason there? | How Long? | Inpatient/Outpatient | Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Has your significant other/spouse had any previous rehab or treatment for substance abuse? Yes ☐ No ☐

| Where? | Reason there? | How Long? | Inpatient/Outpatient | Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Have you had an adverse reaction to any substance use disorder medications? Yes ☐ No ☐

_____

Name of medication/when used/reaction

| Substances | Age at first use | How often you use | How much you use | Method(s) you use | How long since last use |
|---|---|---|---|---|---|
| Alcohol | | | | | |
| Methamphetamine | | | | | |
| Amphetamine | | | | | |
| Barbiturates | | | | | |
| Cocaine (powder) | | | | | |
| Cocaine (crack) | | | | | |
| Hallucinogens | | | | | |
| Hashish | | | | | |
| Heroin | | | | | |
| Methadone | | | | | |
| Morphine | | | | | |
| Opioids (Narcotics) | | | | | |
| Inhalants | | | | | |
| Marijuana | | | | | |
| PCP (Angel Dust) | | | | | |
| Ketamine (Special K) | | | | | |
| Ecstasy (x) | | | | | |
| Fentanyl | | | | | |
| Suboxone | | | | | |
| Other: _____ | | | | | |

Did/do you go to group meetings? _____ Do you have a sponsor? _____

Do you see a psychiatrist and if so who and how long? _____

Do you see a therapist or counselor and if so who and how long? _____

Have you ever been treated for depression if so when? _____

Do you have a Narcan Kit available at home? _____

Have you had any overdoses in the past ☐ Yes ☐ No

If yes was it accidental or planned? _____

_____

**Legal History** (Please report any and all illegal issues using the space provided on the following page to comment, if necessary)

| | | | |
|---|---|---|---|
| Legal or Criminal Involvement? | Yes / No | *Court order Probation Parole Restraining Order* | |
| *Found not competent to stand trial Homicide or attempted homicide Sexual Assault Arson Assault Felony* | | | |
| **Probation/Parole Office** | Current / Past | Name: | County: |
| **DUI** (date): | **Warrants (**date): | | **Violent Crime (**date): |
| **Incarceration (**date): | | How long: | Reason: |
| Do you have firearms at home? | Yes / No | If yes, Are they locked? | Yes / No |

Comments: _____

_____

_____

**MENTAL HEALTH**

**Stressful events over the last year:**

- ☐ Recent Hospital Discharge
- ☐ Death/ Divorce / Separation
- ☐ Relationship problems
- ☐ Move
- ☐ Educational Problems
- ☐ Housing Problems
- ☐ Access to Healthcare
- ☐ Witness/Victim of Violence
- ☐ History/Current Abuse
- ☐ Disability (self or family)
- ☐ Parent Issues
- ☐ Job Loss
- ☐ Financial Problems
- ☐ Legal Problems
- ☐ Social/Environmental Problems
- ☐ Other Family Problems
- ☐ Health Problem: _____
- ☐ Other: _____

**Please check symptoms experienced in the last 4 weeks:**

| | | |
|---|---|---|
| **MOOD**<br>☐ Depression<br>☐ Anxiety<br>☐ Hopelessness | ☐ Mood Changes<br>☐ Sadness<br>☐ Elation (happier than normal)<br>☐ Anger/Rage | ☐ Overwhelming guilt/shame<br>☐ Difficulty enjoying life<br>☐ Irritability |
| **BEHAVIORS**<br>☐ Hurting yourself<br>☐ Doing the same thing repeatedly | ☐ Uncontrolled spending/gambling<br>☐ Increased alcohol/drug use | ☐ Reckless behavior<br>☐ Social Isolation |
| **PHYSICAL**<br>☐ Increased Sleep<br>☐ Decreased Sleep<br>☐ Difficult Sleeping | ☐ Panic/Anxiety Attacks<br>☐ Increased Appetite/ weight gain<br>☐ Decreased Appetite/ weight loss<br>☐ Disturbing nightmares/dreams | ☐ Agitation/Restlessness<br>☐ Unusual sensory experience (smell, taste)<br>☐ Other (specify): |
| **THINKING**<br>☐ Wanting to take your life<br>☐ Wanting to hurt someone else<br>☐ Seeing/Hearing things that aren't there<br>☐ Difficulty concentrating | ☐ Intrusive negative thoughts<br>☐ Flashbacks<br>☐ Irrational fear<br>☐ Racing thoughts<br>☐ Paranoia | ☐ Low self-esteem<br>☐ Academic/work problems<br>☐ Easily distracted<br>☐ Thinking same thoughts repeatedly<br>☐ Memory problems |
| **INTERPERSONAL**<br>☐ Increased conflict w/others<br>☐ Increased family conflict<br>☐ Difficult making/keeping friends | ☐ Socially withdrawn/isolation<br>☐ Increased sexual problem/concerns<br>☐ Increased social anxiety<br>☐ Problems with intimacy | ☐ Increased difficulty tolerating others<br>☐ Trouble with law/authority figures |

**TREATMENT QUESTIONNAIRE**

Have you had any previous **psychiatric hospitalizations?** Yes ☐ No ☐

| Where | When | Reason |
|---|---|---|
| | | |
| | | |
| | | |

Have you had any previous **outpatient mental health treatment?** Yes ☐ No ☐

| **Where** | **When** | **Reason** |
|---|---|---|
| | | |
| | | |
| | | |

Have you had any previous **prescribed psychiatric medications?** Yes ☐ No ☐

| **Medications** | **Prescribing Provider** | **Dates** |
|---|---|---|
| | | |
| | | |
| | | |

Have any family members had a history of **mental illness?** Yes ☐ No ☐

| **Persons** | **Diagnosis of Symptoms** | **Treatments** |
|---|---|---|
| | | |
| | | |
| | | |

Have you ever experienced any **trauma?** Yes ☐ No ☐

If yes, have you been

☐ Neglected ☐ Physically Abused
☐ Emotionally Abused ☐ Sexually Abused ☐ Don't know
☐ Acts of War ☐ Witnessed/Victim of violence
☐ Serious Accidents ☐ Fire
☐ Other _____

---

What **leisure or stress reduction activities/coping methods** do you use?

What is your **motivation for treatment?**

What **"triggers"** are you aware of that may put you at risk of a relapse?

**What kind of help** would you like from your counselors or nurse?

Do symptoms interfere with your ability to work or get things done? Yes ☐ No ☐ If yes, Explain

_____

_____

Additional Comments/Information:

**The above information is thorough and accurate to the best of my knowledge.**

_____ _____

**Patient Signature (or Guardian)** **Date**

coös county Family Health

54 Willow Street
Berlin, NH 03570-1800
Ph: 1-603-752-3669
Fax: 1-603-752-3027

133 Pleasant Street
Berlin, NH 03570-2006
Ph: 1-603-752-2040
Fax: 1-603-752-7797

2 Broadway Street
Gorham, NH 03581-1597
Ph: 1-603-466-2741
Fax: 1-603-466-2953

59 Page Hill Road
Berlin, NH 03570-3568
Ph: 1-603-752-2900
Fax: 1-603-752-3727

# Suboxone/Subutex/Vivitrol Treatment Agreement

## Medication Assisted Therapy Program (MAT)

Patient Name: _____ Date of Birth: _____

Purpose:

The purpose of this agreement is to outline the responsibilities and expectations for you and your healthcare provider and to prevent any potential misunderstanding about the medications that Coos County Family Health Services (CCFHS) will be prescribing for management of your condition. The agreement provides for resolution of problems, and if necessary, termination of services due to noncompliance. This agreement is written to improve the quality of services delivered to you and to comply with the policies and procedures governed by Coos County Family Health Services.

It is agreed that:

I understand that CCFHS is under no obligation to prescribe these medications to me.

I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that the medical provider will provide health care services to me based on this Agreement.

I understand that I must be completely honest with my providers at all times, so they may treat me to the best of their ability. I understand that if I am not completely honest with providers, it may cause negative effects to my recovery.

I voluntarily apply and consent to participate in the Medication Assisted Therapy (MAT) Program. I am requesting therapy for substance use disorder (SUD). I understand that, as far as possible, precautions will be taken to prevent any complications or ill effects on my health. I further understand that it is my responsibility to tell the provider/nurse in the program as much as I can about my health. It is my responsibility to seek medical attention immediately if any reaction occurs to any medication prescribed for me or if any changes occur in my health status. As a patient, I freely and voluntarily agree to adhere to the treatment protocol.

I understand that, as a patient of the MAT Program, I must inform my MAT Provider of any inpatient hospital stay, prior to being discharged or within 30 days of discharge.

I understand that, if I break this Agreement, the medical provider may stop prescribing medications for my substance use disorder. In order to minimize withdrawal symptoms the provider may taper

me off the medication over a period of several days as necessary. Also, a drug-dependence treatment program may be recommended/required.

I understand that medication for my substance use disorder is being prescribed as part of a comprehensive treatment plan for my substance use disorder.

I agree to actively participate in individual counseling sessions and other treatment requirements prior to beginning and during medication therapy. I agree to attend visits without others present in the room. (i.e.: parents, significant other, friends etc.)

I understand that, if I am a prenatal patient in the MAT Program, I am required to meet with the OB nurses at AVH at 34 weeks into pregnancy to discuss the infant plan of care

I understand the frequency of visits will be at least weekly at first and then biweekly. Increased frequency may be necessary as required by my provider. As my recovery progresses, with the completion of individual and/or group therapy and maintenance of personal psychotherapy, my visits may extend out to 4 weeks, at providers discretion. If I am a prenatal patient, my visits will not extend out more than two (2) weeks. I understand that, if I relapse or miss appointments, then I will return to weekly visits until assurance in my recovery is re-established. I must call 24 hours prior to canceling an appointment. If I miss an appointment without contacting my provider:

- I may be asked to return to more frequent visits.
- I may not have my medication refilled until I am seen again.
- I may be discharged from the program.
- If I miss more than 2 appointments with my provider or therapist in 6 months, I may be dismissed from the Medication Assisted Therapy Program.

If I use an illegal substance and/or alcohol, the provider may terminate this Agreement because of the risk of mixing illegal substances and/or alcohol with medication prescribed to treat my substance use disorder (SUD). The provider will determine if I am still a candidate for the MAT Program.

I understand that mixing my medication, especially benzodiazepines (such as Valium) and other drugs of abuse, can be dangerous. I also understand that a number of deaths, injuries, coma and other long-term health conditions have been reported among individuals mixing medications, alcohol or illegal substances.

I will give the provider a copy of my card for therapeutic marijuana, if I have one.

I will not attempt to obtain any controlled medication, including narcotic pain medication, controlled stimulants, or anti-anxiety medications, from any other source without discussing with my medical provider at CCFHS.

I will notify the provider immediately if I am prescribed a controlled substance by another provider, hospital, psychiatrist, emergency room physician, etc.

If my medication or prescription is stolen, I will report this incident promptly to the police and fully cooperate with such authorities. I will safeguard my medicine from loss, theft, or destruction. I will safeguard my medication from children, pets and others to prevent accidental ingestion of these medications.

**I understand that lost, stolen, or altered medication will not be replaced.** I may be provided with a medication pack for treatment of withdrawal symptoms, until my next refill is due.
If I am a pregnant patient who reports lost or stolen medication, I may be allowed a replacement refill one time.

I understand that I will receive no more than 28 days per refill of medications.

I will not arrive at the office intoxicated or under the influence of drugs. If I do, the medical provider/nurse will not see me, and I will not be given any medication until my next scheduled appointment, and this will count as a missed appointment.

I understand that my prescriptions/refills can be given to me only during my regular daytime office visits (Monday-Friday) between the hours of 8 a.m. and 4:00 p.m., and that there is no after hour coverage to be prescribed medication. Any missed office visits may result in my not being able to get medication until the next scheduled visit.

I will be responsible for noting when I will run out of medication and plan accordingly. I will notify the provider within 2-3 business days prior to needing a refill.

I understand that my prescription will need to be filled immediately following my appointment, while our staff is still available to take care of any questions or issues at the pharmacy.

I understand that I must provide a viable contact number at all times (and will update the office of any changes) or my provider may not prescribe medications. Failure to do so may result in my dismissal from the program.

I understand the required commitment to the program and appointments. Therefore, I will not use transportation challenges as a reason for short-notice cancellations or no show appointments.

If I move outside of the CCFHS service area (30 miles from the Pleasant St. office), this Agreement will be terminated in 30 days.

I understand that my failure to comply with any of the components of the MAT Program may lead to termination of the Agreement.

I understand that, based on the clinical judgment of the provider, treatment with medications provided may be discontinued at any time, including a violation of this agreement.

I understand that random and scheduled urine drug screens are used as a therapeutic tool to assist in my recovery. Urine screens may be observed or unobserved. I agree that I will submit to random blood or urine tests and pill/strip counts when requested by the provider/nurse to determine my compliance with the use of my medication and to evaluate the use of any illegal or non-prescribed controlled substances, within 2 hours from the time of the call.

I understand that a positive drug screen for alcohol, opiates, other non-prescribed medications, or illegal substances, such as heroin, Methadone, Marijuana etc., may result in discontinuation of medication therapy. Repeated positive drug screens will lead to a referral to a higher level of care such as mandatory individual therapy, intensive outpatient or inpatient care. Refusal of higher level of care will result in dismissal of the program. I will have the opportunity to speak privately with my provider about anything that might be in my urine.

I understand that if I am unable or refuse to provide urine or blood for scheduled or random drug testing, it will be considered a positive screen. I understand if MAT providers are unable to reach me, or leave a message to come in for a random/scheduled UDS, it will be considered a positive screen. If I miss a random UDS, it will result in weekly provider visits. If I miss three (3) random or scheduled drug screens it will result in dismissal from the program.

If I am dismissed from the MAT Program for non-compliance, I understand that I may be tapered off prescription Buprenorphine and I will be scheduled for weekly appointments with a provider until completion of tapering. Rapid detoxification is not recommended and should occur over 30 days, possibly longer. In the alternative, my provider may provide a bridge prescription for no more than 2 weeks, while another MAT provider is secured.

I agree to have lab tests to monitor the effects of the medication being prescribed.

I understand that, whether or not I have insurance coverage, I am responsible for lab test fees, including confirmation of positive urine screens.

I understand that the medication in the recommended doses is usually well tolerated, but it may cause liver injury when taken in excess. If I experience excessive tiredness, unusual bleeding or bruising, pain in upper right part of my stomach that last more than a few days, light colored bowel movements, dark urine, or yellowing of the skin or eyes, I will notify the medical provider/nurse immediately.

I understand that I must inform any medical provider, including ER providers treating me, that I am receiving medication therapy for my substance use disorder.

I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate may result in my being without medication for a period of time and may lead to termination of this agreement.

I agree to treat all CCFHS providers and staff in a respectful and professional manner at all times. I will not use foul language, threaten or abuse any CCFHS provider or staff member. If I demonstrate disrespectful behavior, use foul language or threaten any staff or CCFHS employees, the agreement will be terminated, and the proper authorities (police) will be notified.

**If this Agreement is terminated by my provider, I understand that I cannot participate in the MAT Program at CCFHS.**

I will not share, sell or trade my medication with anyone. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal as well as report to local authorities or DEA.

I authorize the medical provider and the pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medicine. I authorize the medical provider to provide a copy of this Agreement to the pharmacy and, as appropriate, to other health care personnel involved in my care. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree consents will be signed and kept on file for each provider and will be kept updated and current. Failure to comply may lead to dismissal from program.

I authorize the medical provider to fully disclose information regarding my treatment to Northern Human Services, DCYF, pharmacist, specialists, and other providers involved in my care (release to be signed and not revoked).

I agree to use_____ Pharmacy, located at

_____, telephone number

_____ , for filling my suboxone prescription.

If I need to change the pharmacy listed above, I will contact my provider with this request along with the reason for requested change. I understand that, only by approval by my provider, will a change be made to my pharmacy.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment and this agreement have been adequately answered. A copy of this signed document has been given to me.

**WARNING: <u>IF I ATTEMPT TO SELF-ADMINISTER LARGE DOSES OF ALCOHOL, HEROIN, OR ANY OTHER NARCOTIC (OPIOID) OR BENZODIAZEPINES – (LIKE XANAX, KLONOPIN, VALIUM, LIBRIUM, ETC.) WHILE ON MEDICATION TO TREAT MY SUBSTANCE USE DISORDER, I MAY DIE OR SUSTAIN SERIOUS INJURY, INCLUDING COMA.</u>**

- ☐ Suboxone handout given and reviewed with patient
- ☐ Subutex handout given and reviewed with patient
- ☐ Vivitrol handout given and reviewed with patient
- ☐ Narcan handout given and reviewed with patient

Patient signature: _____Date: _____

I certify that I have reviewed this Agreement with the above signed individual.

Provider Signature: _____ Date: _____

I certify that the above-signed patient has knowingly and willingly signed this Agreement.

Witnessed by: _____ Date: _____

coös county Family Health

## MAT Program Drug Testing Consent Form

I, _____, consent to allow Coos County Family Health to collect urine and/or blood specimens from me, for testing of drugs and controlled substances. I also give my consent for the release of the test results to appropriate personnel.

I understand that the drugs being tested are as follows: Amphetamine, Barbituates, Buprenorphine, Benzodiazepines, Cocaine, Ecstasy, Methamphetamine, Morphine, Methadone, Opiates, Phencyclidine, Propoxyphene, Tricyclic Antidepressants, Cannabis and Fentanyl. I understand that other illicit drugs, misused prescription drugs and other mind altering substances can also be tested for.

I understand that I will be asked to leave the following items in a designated space prior to entering the bathroom—Jacket, hats and scarfs, sweatshirt, bulky sweaters, contents of pockets, purses, bags, backpacks, etc. No other persons, including children, may accompany me into the bathroom while I provide urine.

I understand the urine drug screen may be observed by the MAT Program nurse and/or another available trained staff member. I understand that an unused specimen collection unit will be placed on the toilet and I will be instructed to sit (not stand), keeping my hands in full view for the duration of the urine drug screen (UDS), and will refrain from urinating until my hands are in full view of the observer.

I understand that, if I am unable to fill the specimen container with an appropriate amount of urine, or cannot produce a sample, I will be provided with fluids and wait 15-30 minutes before attempting UDS again. I understand that if I refuse to leave a sample or leave the facility without providing a sample, such action will be considered a positive drug screen.

I understand that, if my urine is positive for any substance(s) other than what I am prescribed, the urine will be sent to a lab for confirmation testing. I understand that, this will result in substantial additional expenses, which I will be responsible to pay. I understand that, if I am honest with the staff about using any substance which may be positive in my urine, my urine may not have to be sent for confirmation, saving me from the added expenses.

I understand that, if I refuse to sign this consent, I will not be enrolled in the MAT Program, nor will I be prescribed any medication.

I have read and understand the terms of this consent form.

Patient Signature:_____ Date: _____

Witness Signature: _____ Date:_____

coös county Family Health

54 Willow Street
Berlin, NH 03570-1800
Ph: 1-603-752-3669
Fax: 1-603-752-3027

133 Pleasant Street
Berlin, NH 03570-2006
Ph: 1-603-752-2040
Fax: 1-603-752-7797

2 Broadway Street
Gorham, NH 03581-1597
Ph: 1-603-466-2741
Fax: 1-603-466-2953

59 Page Hill Road
Berlin, NH 03570-3568
Ph: 1-603-752-2900
Fax: 1-603-752-3727

# SUBSTANCE USE DISORDER SERVICES:
## AUTHORIZATON AND CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I understand Coos County Family Health Services will be providing me care and treatment and will need to share private health information about my referral, diagnosis and/or treatment for substance use disorder and mental health with my treatment team, with other treating providers, with entities responsible for payment and with others listed below as authorized by me or by law.

**Treating Providers**
I authorize Coos County Family Health Services (CCFHS) to access, use, disclose and communicate both verbally and in writing my health information, including my private substance use disorder and mental health information, which is maintained as part of my integrated electronic health record to and from my past, current and/or future treating providers at CCFHS for the purpose of my ongoing treatment an recovery and helping me manage my care, including but not limited to:
[Check all that apply]

- ☐ Coos County Family Health Services treating providers and team
- ☐ Coos County Family Health Services MAT Team
- ☐ Androscoggin Valley Hospital, AVH ER, Inpatient and Androscoggin Specialty Associates
- ☐ Northern Human Services – Mental Health Counselors
- ☐ My Care Coordinator(s) at: Coos County Family Health Services MAT Coordinator
- ☐ Other: Specify _____
- ☐ Other: Specify _____

The purpose of disclosure:

- ☐ Ongoing treatment for substance use.
- ☐ Ongoing treatment for mental/behavioral health and substance use counseling.
- ☐ _____

This information is to be used for:

- ☐ My attendance and compliance in substance use treatment.
- ☐ My mental/behavioral health counseling treatment.
- ☐ My substance use counseling/group counseling.
- ☐ _____

**Non-treating providers**
I also authorize Coos County Family Health to access, use, disclose and communicate both verbally and in writing the following private substance use disorder and mental health information [which is maintained as part of integrated electronic health record], including: [check all that apply]

- ☐ My medical events, care management plan and medication list
- ☐ My attendance at my recovery program
- ☐ Information confirming my compliance with my care and recovery plan
- ☐ Other: _____
- ☐ Other: _____

To and from the following individuals involved in my well-being and recovery:

- ☐ Agency: (Title/Name of individual/Tel#) Coos County Family Health Services 752-2040
- ☐ Agency: Title/Name of Individual/Tel#) CCFHS Dental Office 752-2424
- ☐ Agency: (Title/Name of individual/Tel#) Aegis Sciences Corporation 1-800-533-7052
- ☐ Agency: (Title/Name of individual/Tel#) _____
- ☐ Other: _____
- ☐ Other: _____

For the purpose of: [check all that apply]

- ☐ Monitoring and supporting my ongoing recovery:
- ☐ Assessing/evaluating my readiness/ability to participate in housing/employment/vocational training
- ☐ Confirming compliance with court ordered treatment, probation or parole
- ☐ For the purpose of the care and treatment of my children
- ☐ Other: _____
- ☐ Other: _____

**Payment and Healthcare Operations**
I authorize Coos County Family Health to use, disclose and communicate both verbally and in writing my health information including substance use and mental health information to and from my health insurance company or other entity responsible for my medical bills for the purpose of eligibility, payment and health care operations per CCFHS payment policies.

Name: _____

**Authorization to Discuss Health Status with Family, Friends or Advocate Members**
If I am not present or available, I authorize CCFHS affiliated treating providers and staff to discuss my relevant health information, including my substance use disorder [and mental health] treatment, with the family members, friends and/or advocates named below.

Authorized individuals (please provide full names):

Name: _____ Tel# _____
Name: _____ Tel# _____
Name: _____ Tel# _____
Name: _____ Tel# _____
Name: _____ Tel# _____
Name: _____ Tel# _____

**Acknowledgment of Rights/Responsibilities**
I understand that my substance use disorder treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act 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 if my treating providers disclose my substance use disorder treatment records pursuant to this consent, the recipient will be provided a notice of non-disclosure.

- I understand there are no limitations placed on history of illness with diagnostic and therapeutic information including HIV testing or disease, substance abuse, psychiatric care or mental health information and genetic testing.

- I agree to release my records via FAX machine. I accept the risk of mis-directed information via mis-dialed phone number and mis-directed information within the receiving facility/company. A photocopy of this authorization shall be accepted with the same authority as the original.

- I understand I have a right to request a list of treating providers who have received my substance use disorder information from Coos County Family Health pursuant to 42 CFR Part 2.

- I also understand that I may revoke this consent, orally or in writing by contacting the MAT Coordinator at CCFHS at 603-752-2040 at any time except to the extent that action has been taken in reliance on it. We are unable to take back any disclosures we have already made with your consent and we are required to retain as records of the care we provided to you.

- If not already revoked, this consent will remain in effect. Upon request, I can inspect or obtain a copy of the information I am authorizing to be released.

- I understand that I may be denied services if I refuse to consent to a disclosure for purposes of my treatment or payment. I will not be denied services if I refuse to consent to a disclosure for other purposes.

- I understand that I am responsible to update the MAT Coordinator with any changes or updates to this authorization.

Exception to 42 CFR Part 2 can be made under the following circumstances:

- No consent needed for disclosure to medical personnel to respond to a bona fide medical emergency.
- No consent needed for disclosure made under a Qualified Service Organization Agreement.
- No consent necessary for disclosure if pursuant to valid court order and subpoena.
- No consent necessary for disclosure for "audit and evaluation".

If I have any questions about disclosure of my private health information, I can contact the MAT Coordinator at 603-752-2040. I have received a copy of this authorization and consent form.

_____ _____

Signature/legal representative or guardian Date and Time

_____ _____

Authority/Relationship of representative to patient (attach copy) Date and Time

_____ _____

MAT Coordinator Date and Time

**Group Counseling Agreement**

**Confidentiality**

As a member of this group, I agree not to disclose to anyone outside the group any information that may help to identify another group member. This includes, but is not limited to, names, physical descriptions, and specifics to the content of interactions with other group members.

What you share in the group will be shared with other members of the treatment team when we feel that it is important to your treatment to do so.

Your group counselor is bound by law to maintain confidentiality. Only under the following conditions will information be shared:

1. If you sign a release for exchange of information with a third party.
2. Therapists are required by law to report to the appropriate agency if there is suspicion of child or elder abuse.
3. Therapists are required to intervene appropriately with the threats of serious harm to yourself or others. This could require reporting to police or other appropriate agency.
4. The Court of law subpoenas information for a legal proceeding.

**Group agreements**

- I agree to come to group on time. If I am unable to attend group, I will call to inform the group leader of this at least one hour before group.
- Group meetings will always begin and end on time.
- I will attend group with an open attitude and willingness to participate and be part of the group.
- I understand the importance of being sober during group. I will not attend the group under the influence of any substances and will inform the group leader of any current substance use in my daily life.
- I agree that cell phones will be turned off during group time.
- I will allow others to express their thoughts and feelings without trying to solve their problems, interrupt them or change the subject in order to avoid uncomfortable topics.
- As group members, we may disagree, but we will accept and respect each other. We understand the importance of maintaining an atmosphere of trust and respect for each individual in the group.

Participants need to be to group on time. If participants are late, they may not come to group due to the disruption this causes. Participants will be moved to weekly provider visits for four (4) weeks. If participant is a no-call/no-show to group, this will also result in being moved to weekly provider visits.

By signing below, I indicate that I have read carefully and understand the Group Counseling Agreement and that I agree to its terms and conditions. I have asked and had answered any questions I have concerning the agreement and am aware that signing the agreement is required for my admission to group.

Patient Signature: _____ Date _____

Patient DOB: _____

Counselor Signature: _____ Date: _____