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 Homeless Residential Other:	
Females are you pregnant?	Yes / No Hysterectomy Menopause Tubal ligation	
Education Level	9 10 11 12 Some college Associates Bachelors 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 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 ☐ Depression ☐ Anxiety ☐ Hopelessness	☐ Mood Changes ☐ Sadness ☐ Elation (happier than normal) ☐ Anger/Rage	☐ Overwhelming guilt/shame ☐ Difficulty enjoying life ☐ Irritability
BEHAVIORS ☐ Hurting yourself ☐ Doing the same thing repeatedly	☐ Uncontrolled spending/gambling ☐ Increased alcohol/drug use	☐ Reckless behavior ☐ Social Isolation
PHYSICAL ☐ Increased Sleep ☐ Decreased Sleep ☐ Difficult Sleeping	☐ Panic/Anxiety Attacks ☐ Increased Appetite/ weight gain ☐ Decreased Appetite/ weight loss ☐ Disturbing nightmares/dreams	☐ Agitation/Restlessness ☐ Unusual sensory experience (smell, taste) ☐ Other (specify):
THINKING ☐ Wanting to take your life ☐ Wanting to hurt someone else ☐ Seeing/Hearing things that aren't there ☐ Difficulty concentrating	☐ Intrusive negative thoughts ☐ Flashbacks ☐ Irrational fear ☐ Racing thoughts ☐ Paranoia	☐ Low self-esteem ☐ Academic/work problems ☐ Easily distracted ☐ Thinking same thoughts repeatedly ☐ Memory problems
INTERPERSONAL ☐ Increased conflict w/others ☐ Increased family conflict ☐ Difficult making/keeping friends	☐ Socially withdrawn/isolation ☐ Increased sexual problem/concerns ☐ Increased social anxiety ☐ Problems with intimacy	☐ Increased difficulty tolerating others ☐ 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**

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Substance Use Disorder Treatment Agreement

Patient Name: _____ **Date of Birth**: _____

Purpose: The purpose of this agreement is to outline the responsibilities and expectations for you and your recovery team 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. 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 patient/recovery team relationship and that the recovery team will provide health care services to me based on this agreement.
- I understand that the information I provide helps to determine my plan of care.
- I am aware that if I am not honest with my recovery team I understand it may have a negative effect on my recovery.
- I understand that medication for my substance use disorder is being prescribed as a part of a comprehensive treatment plan for my substance use disorder.

Appointments

- I understand that if I am a prenatal patient in the program, I will be encouraged to meet with the OB nurses at AVH at 34 weeks into pregnancy to discuss the infant plan of care
- I understand that the frequency of visits will be determined by the recovery team based on an individualized plan of care.
- As I progress in my recovery, my visits may extend out to four weeks, at treatment team discretion. Prenatal patients may not extend out to more than two weeks.
- I understand that if I miss scheduled appointments this may alter my initial plan of care, including violation of this agreement and discontinuation of prescribed medication for SUD.

- I must call 24 hours prior to cancelling an appointment.
- If I miss an appointment:
    - I may be asked to return to more frequent visits
    - Medication refills are at the discretion of my recovery team
    - If I miss more than two appointments with my recovery team in six months, I may be dismissed from the program.
- If I move outside of the CCFHS service area this agreement will be terminated within 30 days.

Compliance Urines

- 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 that I will submit to random blood or urine tests and pill/strip counts when requested by the recovery team within 24 hours from the time of the call.
- I understand that repeated positive drug screens for unexpected/nonprescribed substances may result in a change to my treatment plan, including discharge from the SUD program or recommendation for a higher level of care.
- I understand that if I am unable or refuse to prove a urine or blood sample for scheduled or random drug testing it is considered an unexpected finding.
- I understand that if the treatment team is unable to reach me or leave a message to come in for a random/scheduled urine drug screen it is considered an unexpected finding

I understand that if I am discharged from the SUD program for noncompliance with this treatment agreement, I will be offered medications to minimize withdrawal symptoms while being tapered off of my medication over 30 days with weekly appointments with a provider.

If you have left or have been dismissed from the CCFHS program you are welcome to speak with a member of our Recovery Team for reconsideration.

Handouts Given to Patient:

- Buprenorphine handout given and reviewed with patient
- Precipitated withdrawal handout given and reviewed with patient
- Naltrexone handout given and reviewed with patient
- Narcan handout given and reviewed with patient

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Family Health

Patient Signature: _____ Date:_____

I certified that I have reviewed this agreement with the above signed individual

Recovery Team Member Signature: _____Date:_____

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

Witnessed by: _____Date: _____

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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:_____

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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: _____

Symptoms of Precipitated Withdrawal

Precipitated withdrawal happens when buprenorphine removes and then replaces the opioid molecules that have already attached to the person's opioid receptors in the brain. When this happens the person is deprived of the full opioid agonist effect and replaced by a partial opioid agonist (buprenorphine) that can trigger withdrawal symptoms in a person

When the body is forced to go without those drugs, it cannot adjust to the sudden deprivation, and it experiences a number of unpleasant effects as a result:

- Muscle aches and pains
- Fever
- Cramping
- Sweating
- Insomnia
- Dilated pupils

If the person has been using opioids for a long time and has developed significant physical dependence, the symptoms can be severe. They include:

- Depression
- Diarrhea
- Suicidal thoughts
- Rapid heart beat
- High blood pressure

If a person has developed a high tolerance the buprenorphine/naloxone can still induce withdrawal symptoms.

Buprenorphine

Buprenorphine is an opioid partial agonist. It produces effects such as euphoria or respiratory depression at low to moderate doses. With buprenorphine, however, these effects are weaker than full opioid agonists such as methadone and heroin. When taken as prescribed, buprenorphine is safe and effective.

Buprenorphine has unique pharmacological properties that:

- Diminish the effects of physical dependency to opioids, such as withdrawal symptoms and cravings
- Increase safety in cases of overdose
- Lower the potential for misuse

Buprenorphine Safety Precautions

- Because of buprenorphine's opioid effects, it can be misused, particularly by people who do not have an opioid dependency. Naloxone is added to buprenorphine to decrease the likelihood of diversion and misuse of the combination drug product.
- Use the following precautions when taking buprenorphine:
- Do not take other medications without first consulting your doctor.
- Do not use illegal drugs, drink alcohol, or take sedatives, tranquilizers, or other drugs that slow breathing. Mixing large amounts of other medications with buprenorphine can lead to overdose or death.
- Ensure that a physician monitors any liver-related health issues that you may have.
- Tell your doctor if you are pregnant or plan to become pregnant.
- Prevent children and pets from accidental Ingestion by storing it out of reach. For more information, visit CDC's Up and Away educational campaign.
- Dispose of unused buprenorphine safely. Talk to your MOUD practitioner for guidance, or for information on the safe disposal of unused medications, visit FDA's disposal of unused medicines or DEA's drug disposal webpages
- Do not share your buprenorphine with anyone even if they have similar symptoms

Buprenorphine Side Effects

Common side effects of Buprenorphine include headache, diarrhea, constipation, and nausea. In addition, some people become attached to the relaxation Suboxone can cause, and that can lead to addiction and/or drug relapse.

Buprenorphine treatment can include a number of side effects, the most severe of which are caused by its status as a partial opioid agonist. According to the drug manufacturer, common side effects of can include:

- Nausea and vomiting
- Headache
- Sweating
- Numb mouth
- Constipation
- Painful tongue
- Dizziness and fainting
- Problems with concentration
- Irregular heartbeat
- Insomnia
- Blurry vision
- Back pain
- Drowsiness
- Respiratory Depression – shallow or slow breathing resulting in decreased oxygen in the body

Behavioral Health common side effects of the drug are incidences of:

- Anxiety
- Depression
- Nervousness

Narcan

BE PREPARED TO RECOGNIZE AN OPIOID EMERGENCY

Knowing the signs and symptoms of an opioid overdose is essential to responding quickly.

How to administer Nasal Naloxone

1. Call 911 right away
2. Identify an Opioid emergency
    a. They may include:
        i. UNUSUAL SLEEPINESS OR UNRESPONSIVENESS
        ii. BREATHING WILL BE SLOW OR ABSENT
        iii. SLOW HEARTBEAT OR LOW BLOOD PRESSURE
        iv. SKIN FEELS COLD AND CLAMMY
        v. PUPILS ARE TINY
        vi. NAILS AND LIPS ARE BLUE
3. Open package and take out the nasal Naloxone
    a. Put the nozzle int the nostril and push the plunger
4. Evaluate and Support
    a. Watch the person closely and if no response in 3 minutes, administer another dose
    b. Move the person on their side
    c. Wait for emergency services to arrive

Naltrexone (oral and intramuscular)

Naltrexone, an opioid antagonist, blocks the effects of opioid drugs (such as morphine, heroin, and oxycodone) in the brain and decreases the craving for alcohol by reducing the intoxicating effects. It can help to eliminate cravings for alcohol or opioids to prevent relapse. It is an effective, yet underutilized, medication that can help individuals remain abstinent from alcohol and opioids.

Individuals must be completely opioid-free before taking naltrexone. Using naltrexone while on opioids can precipitate severe withdrawal symptoms.

Naltrexone has many positive characteristics, including:

- no associated intoxication
- no potential for abuse
- does not cause physical dependence
- when stopped, it does not cause withdrawal symptoms
- an unlikely candidate for black market sales or other unintended uses

Naltrexone is currently available in two forms:

- pills taken orally on a daily basis, generally for weeks to months
- long-acting formulation of the medication, given monthly by intramuscular injection, administered by a health care professional

Side effects

- Nausea or vomiting.
- Stomach cramps.
- Joint or muscle pain.
- Headache.
- Dizziness.
- Nervousness, anxiety, restlessness.
- Tiredness.
- Trouble sleeping.

Naltrexone should not be taken by:

- persons currently using, or unable to abstain from opioids
- persons using opioids for the treatment of acute or chronic pain
- persons with severe liver or kidney damage