RESOLUTIONS
WELLNESS GROUP

Medication - Assisted Treatment (MOUD) Intake Form

Date: _____ Chart#: _____ Page: _____

SECTION 1 - Patient Demographics

Full Legal Name (Last, First, Mi):

_____

Date of Birth: _____ Age: _____ Sex Assigned at Birth: _____Male _____Female _____Other

Gender Identity: _____ Pronouns: _____

Race / Ethnicity: _____

Primary Language: _____ Interpreter Needed? _____Yes / _____No

Address:_____

City:_____ State:_____ ZIP:_____

Phone (Primary): _____OK to call / _____OK to text

Phone (Secondary) : _____OK to call / _____OK to text

Emergency Contact Name:_____

Relationship : _____ Phone : _____

Insurance / Payor : _____

Member ID : _____ Group #: _____

Medicaid / Medicare #(If applicable) : _____

Referring Provider / Agency : _____

Primary Care Provider (PCP) _____

Phone : _____

Realease of Information on file for PCP? _____Yes _____No _____Pending

SECTION 2 - Substance Use History

2A - Primary Substance of Use

Primary substance of use:

_____ Heroin _____ Prescription Opioids _____ Fentanyl/ Illicit Fentanyl
_____Methadone _____ Buprenorphine (diverted) _____ Other: _____

Route of administration:

_____ Oral _____ Intranasal _____ IV _____ Smoked _____ Other:_____
Age of first use: _____ Age of daily / heavy use: _____

Current frequency:

_____ Daily _____ Multiple times/ Day _____ Weekly _____ Less than weekly

Last use date : _____
Amount used : _____
Longest period of abstinence: _____ When: _____

2B - Secondary / Polysubstance Use (List All Substances Used in Past 90 days)

Substance	Route	Frequency	Last Use	Notes
Alcohol				
Benzodiazepines **(Prescribed)**				
Benzodiazepines **(non-Prescribed)**				
Cocaine / Stimulants				
Cannabis				
Methamphetamine				
Tobacco / Nicotine				
Other				

2C - Prior Treatment History

Previous MAT/MOUD episodes? _____ Yes _____ No

If yes, complete below:

Medication	Clinic / Provider	Dates	Reason Discontinued

Prior detox/residential treatment: _____ Yes _____ No

Details:

Current involment in recovery support (AA/NA, sponsor, etc.) : _____ Yes _____ No

Describe:

Prior naloxone administrations (Self or witnessed) : _____ times

SECTION 3 - DMS-5 Opiod Use Disorder Diagnostic Checklist

Instructions:

Circle the number for each criterion present in the past 12 months. A minimum of 2 criteria are required for an Opioid Use Disorder diagnosis. Severity is determined by total criteria met.

1. Opioids taken in larger amounts or over a longer period than intended.
2. Persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain, use, or recover from the effects of opioids.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem likely caused or exacerbated by opioids.
10. Tolerance, as defined by either a markedly increased amount needed to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount. **(Note: does not apply to patients taking opioids solely under appropriate medical supervision.)**
11. Withdrawal, as manifested by either the characteristic opioid withdrawal syndrome, or opioids taken to relieve or avoid withdrawal symptoms. **(Note: does not apply to patients taking opioids solely under appropriate medical supervision.)**

Severity Scoring:

____ **Mild:** 2-3 criteria met ____ **Moderate:** 4-5 criteria met ____ **Severe:** 6 or more criteria met

Total Criteria Met : _____ **Clinical Signature :** _____
Date : _____

SECTION 4 - Urine Drug Screen (UDS) Documentation

Date/ Time of Collection : _____ **Collected by :** _____
Specimen temperature in range (90 -100^0 F) : _____ Yes _____ No
Point-of-care (POC) test performed : _____ Yes _____ No **Device/Brand:** _____
Confirmatory send-out ordered : _____ Yes _____ No **Lab:** _____

Observed Collection : _____ Yes _____ No
Reason if not observed: _____
_____

Substance	POC Result	Confirmator & Result	Clinician Notes
Opiates / Morphine			
Oxycodone			
Buprenorphine			
Methadone			
Benzodiazepines			
Amphetamines / Methamphetamine			
Cocaine / Benzoylecgonine			
THC / Cannabinoids			
Fentanyl			
PCP			
Alcohol (EtG)			
Other			

Overall UDS interpretation:

_____ Consistent with reported use _____ Inconsistent - **Specify**:

_____

_____

Clinician signature / initials: _____

SECTION 5 - Prescription Monitoring Program (PMP) Review

State PMP accessed: ____ Texas (PMP AWARxE) ____ Other State: _____

Date of review : _____ Reviewed by:_____

Controlled substance prescriptions identified (past 12 months)?

_____ None identified _____ Yes- complete table below:

Prescriber	Drug/Dose	Fill Date	Days Supply	Pharmacy	Concern ?

Multiple prescriber concern identified? _____ Yes _____ No

Multiple pharmacy concern identified? _____ Yes _____ No

PMP consistent with patient report? _____ Yes _____ No - explain:

_____

Action taken:

_____

_____

SECTION 6 - Medical History

Active medical diagnoses (list all): _____

_____

Relevant past medical history: _____

_____

Surgeries/hospitalizations: _____

_____

Hepatitis C Status :

____ Never Tested ____ Negative (date ____/____/____) ____ Positive -treatment status:_____

____SVR achived

VIH Status :

____ Never Tested ____ Negative (date ____/____/____) ____ Positive-ON art? :____ Yes ____ No

Tuberculosis (TB) screening :

____ Never Tested ____ Negative (date ____/____/____) ____ Positive-LTBI treatment: _____

Hepatitis B Status :

____ Inmmune ____ Non-inmune / unvaccinated ____ Active infection

Cardiac history (QTc prolongation risk — especially relevant for methadone):

Last EKG (if applicable): _____ QTc interval: _____

Respiratory: ____ Sleep apnea (CPAP? ____ Yes ____ No) ____COPD ____Asthma ____None

Liver disease/cirrhosis: ____ Yes ____ No Child-Pugh class: _____

Pregnancy status (if applicable):

____ Not pregnant ____Pregnant (EGA: ____ weeks) ____ Unknown— test ordered

OB provider (if pregnant):

Last labs: ____ CBC: ____ CMP: ____ LFTs: ____ HbA1c: ____ Other: _____

SECTION 7 - Psychiatric History

Active psychiatric diagnoses: _____

_____

Prior psychiatric hospitalizations: ____ Yes ____ No Dates/facilities: _____

History of suicide attempts: ____ Yes ____ No Most recent: _____

Current suicidal ideation: ____ Yes ____ No Plan: _____ Intent: _____

Current homicidal ideation:____ Yes ____ No

Current mental health provider: _____ Phone: _____

Psychiatric Condition	Present?	Additional Notes / Screening Score
PST / Trauma history	☐ Yes ☐ No	
Anxiety disorder	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	PHQ-9 score (if completeed today):
ADHD	☐ Yes ☐ No	
Bipolar disorder	☐ Yes ☐ No	
Psychotic disorder / Schizophrenia	☐ Yes ☐ No	

Prior benzodiazepine prescriptions for psychiatric diagnosis ____ Yes ____ No

Prescribe by : _____

SECTION 8 - Current Medications and Allergies

8A - Current Medication List

Medication Name	Dose	Frequency	Prescriber	Indication

Vitamins / Suplements / OT medications: _____

_____

8B - Allergies and Adverse Reactions

NKDA (No Known Drug Allergies) If allergies exist, complete table below:

Drug / Substance	Reaction Type	Severity

SECTION 9 - Risk Assessments

9A - Overdose Risk Assessment

History of non-fatal overdose: ____ Yes ____ No
How many: _____ Most recent date: _____

Witnessed overdose (of another person): ____ Yes ____ No

Naloxone (Narcan) currently in possesion?: ____ Yes ____ No
Prescribe today?: ____ Yes ____ No

Lives alone: ____ Yes ____ No
High-risk use behaviors (sharing needles, unknown drug supply)?: ____ Yes ____ No

Fentanyl test strip education provided?: ____ Yes ____ No
Overdose Prevention Education documented in visit note? ____ Yes ____ No

9B - Opioid Risk Tool (ORT)

Instructions:
Place a checkmark next to any item that applies to the patient. Use the appropriate scoring column (Female / Male). Sum the scores to determine risk category.

Item	Present?	Score (Female)	Score (Male)
1.- Family History os Substance Abuse			
Alcohol	☐	1	3
Illegal drugs	☐	2	3
Prescription drugs	☐	4	4
2.- Personal History of Substance Abuse			
Alcochol	☐	1	3
Illegal drugs	☐	2	3
Prescription drugs	☐	4	4
3.- Age 16-45	☐	1	3
4.- History of preadolescent sexual abuse	☐	2	3
5.- Psychological Disease			
ADD, OCD, Bipolar disorder or Schizophrenia	☐	1	3
Depression	☐	2	3

ORT Total Score: _____ **Risk Category:** ☐ **Low** (0-3) ☐ **Moderate** (4-7) ☐ **High** (8+)

9C - DAST-10 (Drug Abuse Screening Test)

Instructions:

Ask the patient each question. Circle **YES** or **NO**. Score1 point for each **YES** answer ***(except item 3, which scores 1 point for NO.)*** Total score determines risk level.

Question — "In the past 12 months..."	Response
Have you used drugs other than those required for medical reasons?	☐ Yes ☐ No
Do you abuse more than one drug at a time?	☐ Yes ☐ No
Are you always able to stop using drugs when you want to? (Score 1 for NO)	☐ Yes ☐ No
Have you had "blackouts" or "flashbacks" as a result of drug use?	☐ Yes ☐ No
Do you ever feel bad or guilty about your drug use?	☐ Yes ☐ No
Does your spouse (or parents) ever complain about your involvement with drugs?	☐ Yes ☐ No
Have you neglected your family because of your use of drugs?	☐ Yes ☐ No
Have you engaged in illegal activities in order to obtain drugs?	☐ Yes ☐ No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐ Yes ☐ No
Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?	☐ Yes ☐ No

DAST-10 Total Score: _____

Risk Level: ☐ **Low** (0-2) ☐ **Moderate** (3-5) ☐ **Substantial** (6-8) ☐ **Severe** (9-10)

9D - Audit-C (Alcohol Use Disorders Identification Test -Consumption)

Question	Response Options (Select One)
How often do you have a drink containing alcohol?	☐ (0-Never) ☐ (1-Monthly or less) ☐ (2-2-4x /Month) ☐ (3-2-3x /week) ☐ (4-4+x /week)
How many standard drinks containing alcohol do you have on a typical day when drinking?	☐ (0-1 or 2) ☐ (1-3 or 4) ☐ (2-5 or 6) ☐ (3-7-9) ☐ (4-10 or more)
How often do you have 6 or more drinks on one occasion?	☐ (0-Never) ☐ (1-Less than Monthly) ☐ (2-Monthly) ☐ (3-weekly) ☐ (4-Daily or almost daily

AUDIT-C Total Score: _____ Positive screen ? ☐ **Yes** (≥ 3 Female / ≥ 4 Male) ☐ **No**

9E - Columbia Suicide Severity Rating Scale (C-SSRS) — Screener Version

Instructions:
Ask questions in order. A "YES" to any question warrants clinical response per protocol.

Question (Past Month unless otherwise noted)	Response
Have you wished you were dead or wished you could go to sleep and not wake up?	☐ Yes ☐ No
Have you had any thoughts of killing yourself?	☐ Yes ☐ No
Have you been thinking about how you might kill yourself?	☐ Yes ☐ No
Have you had any intention of acting on these thoughts?	☐ Yes ☐ No
Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	☐ Yes ☐ No
Have you done anything, started to do anything, or prepared to do anything to end your life? (Lifetime)	☐ Yes ☐ No

C-SSRS Outcome:

☐ No ideation reported ☐ Passive ideation only (Q1 Yes, Q2 No) ☐ Active ideation without intent or plan

☐ Ideation with plan or intent - Safety plan initiaded: ☐ Yes ☐ No

SECTION 10 - Social and Legal History

Housing:

____ Stable (own/rent) ____Living with family ____Transitional/soberliving ____Shelter ____Unsheltered

Employment:

____ Employed full-time ____ Employed part-time ____ Unmployed ____ Disability

____ Student ____Other

Highest education level complete: _____

Children/dependents: _____ Ages:_____

CPS involvement? ____ Yes ____ No Current active case? ____Yes ____No

Primary support system: _____

Current legal involvement: ____ None ____ Probation ____ Parole ____ Drug court ____
Pending charges — describe: _____

Probation/parole officer name and contact: _____

Drug court participation? ____ Yes ____ No Court:_____ Case manager:_____

Domestic violence / intimate partner violence screening:
____ Negative ____ Positive — referral made: ____ Yes

Transportation to clinic:
____ Self ____ Family ____ Bus/transit ____ Rideshare ____ Other:_____

SECTION 11 - Treatment Plan-Initial

11A - MOUD Selection and Rationale

____ Buprenorphine/naloxone (Suboxone/generic) — Rationale:_____

____ Buprenorphine monoproduct (Subutex) — Rationale: _____

____ Extended-release naltrexone (Vivitrol) — Rationale:_____

____ Methadone (OTP/clinic-based) — Rationale: _____

____ Extended-release buprenorphine injectable (Sublocade) — Rationale: _____

Starting dose/plan: _____

Induction setting: ____ Office-based ____ Home induction (patient given written instructions) ____ OTP

COWS score at induction (if applicable): _____

11B - Goals of Treatment (Patient-Stated)

1.) _____
2.) _____
3.) _____

11C - Problem List and Intervention Plan

Problem	Goal	Intervention	Target Date

Counseling/Behavioral Health referral: ____ Yes — agency: ____ Declined ____ Integrated on-site

UDS monitoring frequency: ____ Weekly ____ Biweekly ____ Monthly ____ Per protocol

PMP review frequency: ____ Each visit ____ Monthly ____ Quarterly

Follow-up appointment: _____

SECTION 12 - Consents and Signatures

Instructions:

All items below must be completed and acknowledged prior to initiating MOUD treatment. Place a checkmark to confirm each item has been reviewed with and acknowledged by the patient.

Completed	Question (Past Month unless otherwise noted)	Notes/Exceptions
☐	Patient Rights and Notice of Privacy Practices reviewed and provided to patient	
☐	HIPAA Authorization form reviewed and acknowledged	
☐	Release of Information (ROI) signed for:	
☐	MOUD Treatment Agreement reviewed, discussed and signed by patient	
☐	Informed consent for MOUD (medication-specific risks, benefits, alternatives) reviewed and signed	
☐	Overdose prevention education provided; naloxone prescribed or dispensed if indicated	
☐	UDS monitoring policy and PMP review policy explained to patient	

Patient Signature: _____ Date: _____

Printed Name: _____

Clinician / Provider Signature: _____

Supervising Medical Provider (If applicable): _____

This form was completed at Resolutions Wellness Group, an outpatient Medication-Assisted Treatment / MOUD program operating in Texas.

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