

Faraz Qureshi, MD
 WVU-Charleston, Department of Psychiatry
 501 Morris Street
 Charleston WV 25303
Phone: 304 341 1500
Fax: 304 341 1554
Email: fqureshi@hsc.wvu.edu

HOME DOSING RECORD

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

Patient Name _____ **Date** _____

1st Dose (time): _____ 2 mg/0.5 mg SUBOXONE tablet(s) _____ 8 mg/2 mg SUBOXONE tablet(s)

2nd Dose (time): _____ 2 mg/0.5 mg SUBOXONE tablet (s) _____ 8 mg/2 mg SUBOXONE tablet(s)

Additional SUBOXONE Disp: __ tablet (s)

	2 mg/0.5 mg	8 mg/2 mg	Describe withdrawal symptoms/ side effects below:
3rd Dose (time): _____	_____ tablet (s)	_____ tablet (s)	
4th Dose (time): _____	_____ tablet (s)	_____ tablet (s)	
5th Dose (time): _____	_____ tablet (s)	_____ tablet (s)	
	_____ total tablets	_____ total tablets	
	_____ total dose		

Other medications:	Dose/time taken	Directions for use

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FREQUENTLY ASKED QUESTIONS—PATIENTS

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

1. Why do I have to feel sick to start the medication for it to work best?

When you take your first dose of SUBOXONE, if you already have high levels of another opioid in your system, the SUBOXONE will compete with those opioid molecules and replace them at the receptor sites. Because SUBOXONE has milder opioid effects than full agonist opioids, you may go into a rapid opioid withdrawal and feel sick, a condition which is called “precipitated withdrawal.”

By already being in mild to moderate withdrawal when you take your first dose of SUBOXONE, the medication will make you feel noticeably better, not worse.

2. How does SUBOXONE work?

SUBOXONE binds to the same receptors as other opioid drugs. It mimics the effects of other opioids by alleviating cravings and withdrawal symptoms. This allows you to address the psychosocial reasons behind your opioid use.

3. When will I start to feel better?

Most patients feel a measurable improvement by 30 minutes, with the full effects clearly noticeable after about 1 hour.

4. How long will SUBOXONE last?

After the first hour, many people say they feel pretty good for most of the day. Responses to SUBOXONE will vary based on factors such as tolerance and metabolism, so each patient’s dosing is individualized. Your doctor may increase your dose of SUBOXONE during the first week to help keep you from feeling sick.

5. Can I go to work right after my first dose?

SUBOXONE can cause drowsiness and slow reaction times. These responses are more likely over the first few weeks of treatment, when your dose is being adjusted. During this time, your ability to drive, operate machinery, and play sports may be affected. Some people *do* go to work right after their first SUBOXONE dose; however, many people prefer to take the first and possibly the second day off until they feel better.

If you are concerned about missing work, talk with your physician about possible ways to minimize the possibility of your taking time off (eg, scheduling your Induction on a Friday).

6. Is it important to take my medication at the same time each day?

In order to make sure that you do not get sick, it is important to take your medication at the same time every day.

7. If I have more than one tablet, do I need to take them together at the same time?

Yes and no—you *do* need to take your dose at one “sitting,” but you do *not* necessarily need to fit all the tablets under your tongue simultaneously. Some people prefer to take their

tablets this way because it's faster, but this may not be what works best for *you*. The most important thing is to be sure to take the full daily dose you were prescribed, so that your body maintains constant levels of SUBOXONE.

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8. Why does SUBOXONE need to be placed under the tongue?

There are two large veins under your tongue (you can see them with a mirror). Placing the medication under your tongue allows SUBOXONE to be absorbed quickly and safely through these veins as the tablet dissolves. If you chew or swallow your medication, it will not be correctly absorbed as it is extensively metabolized by the liver. Similarly, if the medication is not allowed to dissolve completely, you won't receive the full effect.

9. Why can't I talk while the medication is dissolving under my tongue?

When you talk, you move your tongue, which lets the undissolved SUBOXONE "leak" out from underneath, thereby preventing it from being absorbed by the two veins. Entertaining yourself by reading or watching television while your medication dissolves can help the time to pass more quickly.

10. Why does it sometimes only take 5 minutes for SUBOXONE to dissolve and other times it takes much longer?

Generally, it takes about 5-10 minutes for a tablet to dissolve. However, other factors (eg, the moisture of your mouth) can effect that time. Drinking something before taking your medication is a good way to help the tablet dissolve more quickly.

11. If I forget to take my SUBOXONE for a day will I feel sick?

SUBOXONE works best when taken every 24 hours; however, it may last longer than 24 hours, so you may not get sick. If you miss your dose, try to take it as soon as possible, *unless* it is almost time for your next dose. If it is almost time for your next dose, just skip the dose you forgot, and take next dose as prescribed. Do not take two doses at once unless directed to do so by your physician.

In the future, the best way to help yourself remember to take your medication is to start taking it at the same time that you perform a routine, daily activity, such as when you get dressed in the morning. This way, the daily activity will start to serve as a reminder to take your SUBOXONE.

12. What happens if I still feel sick after taking SUBOXONE for a while?

There are some reasons why you may still feel sick. You may not be taking the medication correctly or the dose may not be right for you. It is important to tell your doctor or nurse if you still feel sick.

13. What happens if I take drugs and then take SUBOXONE?

You will probably feel very sick and experience what is called a "precipitated withdrawal." SUBOXONE competes with other opioids and will displace those opioid molecules from the receptors. Because SUBOXONE has less opioid effects than full agonist opioids, you will go into withdrawal and feel sick.

14. What happens if I take SUBOXONE and then take drugs?

As long as SUBOXONE is in your body, it will significantly reduce the effects of any other opioids used, because SUBOXONE will dominate the receptor sites and block other opioids from producing any effect.

15. What are the side effects of this medication?

Some of the most common side effects that patients experience are nausea, headache,

constipation, and body aches and pains. However, most side effects seen with SUBOXONE appear during the first week or two of treatment, and then generally subside. If you are experiencing any side effects, be sure to talk about it with your doctor or nurse, as s/he can often treat those symptoms effectively until they abate on their own.

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SAMPLE

AFTER HOURS CONTACT INFORMATION

Normal office hours are between __ AM and __PM, Monday thru Friday. For non-urgent requests, please leave a message at the phone number indicated above.

If you need to contact me at any other time, call _____ and leave your name and number with the service. The service will contact me and I will call you back. Note that my phone number is blocked, so if your phone service does not accept calls from blocked telephone numbers, I will not be able to get through to you.

If this is a true emergency, please call 911 first, and contact me second.

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FREQUENTLY ASKED QUESTIONS—FAMILY

SUBOXONE[®] (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet

1. What is an opioid?

Opioids and opiates are synthetic and natural drugs that are related to drugs found in opium; many, such as heroin, are addictive narcotics. Many prescription pain medications are opioids, such as codeine, Vicodin[®]* (hydrocodone bitartrate and acetaminophen), Demerol[®]† (meperidine hydrochloride, USP), Dilaudid[®]* (hydromorphone), morphine, OxyContin[®]‡ (oxycodone hydrochloride controlled-release), and Percodan[®]§ (oxycodone and aspirin tablets, USP). Methadone and buprenorphine are also opioids.

A small amount of naloxone is in SUBOXONE. Naloxone is added to discourage misuse of SUBOXONE. If SUBOXONE were to be crushed and injected, the naloxone would cause the person to go into withdrawal.

2. Why are opioids used to treat opioid dependence?

Many family members wonder why doctors use buprenorphine to treat opioid dependence, since it is in the same family as heroin. Some of them ask, “Isn’t this substituting one addiction for another?” But the two medications used to treat opioid dependence—methadone and buprenorphine—are not “just substitution.” Many medical studies since 1965 show that maintenance treatment helps keep patients healthier, keeps them from getting into legal troubles, and reduces the risk of getting diseases and infections that are transferred when needles are shared.

3. What is the right dose of SUBOXONE?

Dependence is a developed need to have the opioid receptors in the brain occupied by an opioid. Finding just the right amount of SUBOXONE to fill the receptors at the right rate is an important part of the induction process.

Every opioid can have stimulating or sedating effects, especially in the first weeks of treatment. The right dose of SUBOXONE is the one that allows the patient to feel and act normally. It can sometimes take a few weeks to find the right dose. During the first few weeks, the dose may be too high, or too low, which can lead to sickness, daytime sleepiness, or trouble sleeping at night. The patient may ask that family members help keep track of the timing of these symptoms, and write them down. Then the doctor can use all these clues to adjust the amount and time of day for buprenorphine doses.

Once the right dose is found, it is important to take it on time in a regular way, so the patient’s body can maintain consistent medication levels to avoid experiencing withdrawal symptoms.

4. How can the family support good treatment?

Even though maintenance treatment for opioid dependence works very well, it is not a cure. This means that the patient will continue to need the stable dose of SUBOXONE, with regular monitoring by the doctor. This is similar to other chronic diseases, such as diabetes or asthma. These illnesses can be treated, but there is no permanent cure, so patients often stay on the same medication for a long time. The best way to help and support the patient is to encourage regular medical care, encourage the patient not to skip or forget to

take the medication and most importantly, encourage the patient to partake in regular counseling sessions or support groups.

- Regular medical care

Most patients will be required to see the physician for ongoing SUBOXONE® treatment every two to four weeks, once they are stable. If they miss an appointment, they may not be able to refill the medication on time, and may even go into withdrawal, which could be dangerous.

- Counseling

Most patients who have become dependent on opioids will need formal counseling at some point in their care. The patient may have regular appointments with an individual counselor, or for group therapy. These appointments are key parts of treatment, and work together with the SUBOXONE to improve success. Sometimes family members may be asked to join in family therapy sessions to provide additional support to the patient and information to the health care provider.

- Support Groups

Most patients use some kind of support group to maintain their healthy lifestyle. It sometimes takes several visits to different groups to find a comfortable environment. In the first year of recovery from opioid dependence, some patients go to meetings every day, or several times per week. These meetings work with SUBOXONE to improve the likelihood of a patient's treatment success. Family members may have their own meetings, such as Al-Anon, or Adult Children of Alcoholics (ACA), to support them in adjusting to life with a patient who has become dependent on opioids.

- Taking the medication

SUBOXONE is an unusual medication because it is best absorbed into the bloodstream when taken "sublingually" meaning the patient must hold the tablet under his or her tongue while the medicine dissolves (swallowing SUBOXONE actually reduces its effectiveness). Please be aware that **this process takes about 5-10 minutes**. While the medication is dissolving, the patient should not speak. It is very important that the family support the patient by understanding that s/he will be "out of commission" for those 5-10 minutes intervals surrounding regular daily dosing times.

One way to support new SUBOXONE patients is by helping them to make a habit of taking their dose at the same time every day. Tying dosing to a routine, everyday activity (eg, getting dressed in the morning) is often one of the best ways to do this, because then the activity itself begins to serve as a reminder.

- Storing the medication

If SUBOXONE is lost or misplaced, the patient may skip doses or become ill, so it is very important to find a good place to keep the medication safely at home—away from children or pets, and always in the same location, so it can be easily found. The doctor may give the patient a few "backup" pills, in a separate bottle, in case an appointment has to be rescheduled, or there is an emergency of some kind. It is best if the location of the SUBOXONE is not next to the vitamins, or the aspirin, or other over-the-counter medications, to avoid confusion. If a family member or visitor takes SUBOXONE by mistake, a physician should be contacted immediately.

5. What does SUBOXONE treatment mean to the family?

It is hard for any family when a member finds out s/he has a chronic medical condition. This is true for opioid dependence as well. When chronic conditions go untreated, they often have severe complications which could lead to permanent disability or even death. Fortunately, SUBOXONE maintenance can be a successful treatment, especially if it is integrated with counseling and support for life changes.

Chronic disease means the disease is there every day, and must be treated every day. This takes time and attention away from other things, and family members may resent the effort and time and money that it takes for SUBOXONE[®] treatment and counseling. It might help to compare opioid dependence to other chronic diseases, like diabetes or high blood pressure. After all, it takes time to make appointments to go to the doctor for blood pressure checks, and it may annoy the family if the food has to be low in cholesterol, or unsalted. But most families can adjust to these changes, when they consider that it may prevent a heart attack or a stroke for their loved one.

It is common for people to think of substance dependence as a weakness in character, instead of a disease. Perhaps the first few times the person used drugs it was poor judgment. However, by the time the patient became dependent, taking drugs every day, and needing medical treatment, it can be considered to be a “brain disease” rather than a problem with willpower.

In summary:

Family support can be very helpful to patients on SUBOXONE treatment. It helps if the family members understand how dependence is a chronic disease that requires ongoing care. It also helps if the family gets to know a little about how treatment with SUBOXONE works, and how it should be stored at home to keep it safe. Family life might have to change to allow time and effort for the patient to become healthy again. Sometimes family members themselves can benefit from therapy.

* Vicodin and Dilaudid are registered trademarks of Knoll Pharmaceutical.


† Demerol is a registered trademark of Sanofi-Synthelabo Inc.

‡ OxyContin is a registered trademark of Perdue Pharma L.P.

§ Percodan is a registered trademark of Endo Pharmaceuticals.

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UNDERSTANDING OPIOID DEPENDENCE

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Opioid dependence is a disease in which there are biological or physical, psychological, and social changes. Some of the physical changes include the need for increasing amounts of opioid to produce the same effect, symptoms of withdrawal, feelings of craving, and changes in sleep patterns. Psychological components of opioid dependence include a reliance on heroin or other drugs to help you cope with everyday problems or inability to feel good or celebrate without using heroin or opioids. The social components of opioid dependence include less frequent contact with important people in your life, and an inability to participate in important events due to drug use. In extreme cases, there may even be criminal and legal implications

The hallmarks of opioid dependence are the continued use of drugs despite their negative affect, the need for increasing amounts of opioids to have the same effect and the development of withdrawal symptoms upon cessation.

There are a variety of factors than can contribute to the continued use of opioids. Among these are the use of heroin to escape from or cope with problems, the need to use increasing amounts of heroin to achieve the same effect, and the need for a “high.”

Treatment

Treatment for opioid dependence is best considered a long-term process.

Recovery from opioid dependence is not an easy or painless process, as it involves changes in drug use and lifestyle, such as adopting new coping skills. Recovery can involve hard work, commitment, discipline, and a willingness to examine the effects of opioid dependence on your life. At first, it isn't unusual to feel impatient, angry, or frustrated.

The changes you need to make will depend on how opioid dependence has specifically affected your life. The following are some of the common areas of change to think about when developing your specific recovery plan:


Physical – good nutrition, exercise, sleep and relaxation.

Emotional – learning to cope with feelings, problems, stresses and negative thinking without relying on opioids.

Social – developing relationships with sober people, learning to resist pressures from others to use or misuse substances, and developing healthy social and leisure interests to occupy your time and give you a sense of satisfaction and pleasure.

Family – examining the impact opioid dependence has had on your family, encouraging them to get involved in your treatment, mending relationships with family members, and working hard to have mutually satisfying relationships with family members.

Spiritual – learning to listen to your inner voice for support and strength, and using that voice to guide you in developing a renewed sense of purpose and meaning.


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During the treatment process, SUBOXONE will help you avoid many or all of the physical symptoms of opioid withdrawal. These typically include craving, restlessness, poor sleep, irritability, yawning, muscle cramps, runny nose, tearing, goose-flesh, nausea, vomiting and diarrhea. Your doctor may prescribe other medications for you as necessary to help relieve these symptoms.

You should be careful not to respond to these withdrawal symptoms by losing patience with the treatment process and thinking that the symptoms can only be corrected by using drugs. To help you deal with the symptoms of withdrawal, you should try to set small goals and work towards them.

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EXPLANATION OF TREATMENT

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Intake

You will be given a comprehensive substance dependence assessment, as well as an evaluation of mental status and physical exam. The pros and cons of the medication, SUBOXONE, will be presented. Treatment expectations, as well as issues involved with maintenance versus medically supervised withdrawal will be discussed.

Induction

You will be switched from your current opioid (heroin, methadone or prescription painkillers) on to SUBOXONE. At the time of induction, you will be asked to provide a urine sample to confirm the presence of opioids and possibly other drugs. You must arrive for the first visit experiencing mild to moderate opioid withdrawal symptoms. Arrangements will be made for you to receive your first dose in your doctor's office. Your response to the initial dose will be monitored. You may receive additional medication, if necessary, to reduce withdrawal symptoms.

Since an individual's tolerance and reactions to SUBOXONE vary, daily appointments may be scheduled and medications will be adjusted until you no longer experience withdrawal symptoms or cravings. Urine drug screening is typically required for all patients at every visit during this phase.

Intake and Induction may both occur at the first visit, depending on your needs and your doctor's evaluation.

Stabilization

Once the appropriate dose of SUBOXONE is established, you will stay at this dose until steady blood levels are achieved. You and your doctor will discuss your treatment options from this point forward.

Maintenance

Treatment compliance and progress will be monitored. Participation in some form of behavioral counseling is strongly recommended to ensure best chance of treatment success. You are likely to have scheduled appointments on a weekly basis, however, if treatment progress is good and goals are met, monthly visits will eventually be considered sufficient. The Maintenance phase can last from weeks to years—the length of treatment will be determined by you and your doctor, and, possibly, your counselor. Your length of treatment may vary depending on your individual needs.

Medically Supervised Withdrawal

As your treatment progresses, you and your doctor may eventually decide that medically supervised withdrawal is an appropriate option for you. In this phase, your doctor will gradually taper your SUBOXONE dose over time, taking care to see that you do not experience any withdrawal symptoms or cravings.

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EXPLANATION OF 1ST VISIT—Using In-Office Supply
SUBOXONE[®] (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet

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

When preparing for your 1st office visit, there are a couple of logistical issues you may want to consider.

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

It is very important to arrive for your 1st visit already experiencing mild to moderate opioid withdrawal symptoms. If you are in withdrawal, buprenorphine will help lessen the symptoms. However, if you are *not* in withdrawal, buprenorphine will “override” the opioids already in your system, which will *cause* severe withdrawal symptoms.

The following guidelines are provided to **ensure that you are in withdrawal for the visit**. (If this concerns you, it may help to schedule your first visit in the morning: some patients find it easiest to skip what would normally be their first dose of the day.)

- No methadone or long-acting painkillers for at least 24 hours
- No heroin or short-acting painkillers for at least 4 to 6 hours

Bring ALL medication bottles with you to your 1st appointment.

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

Urine drug screening is a regular feature of SUBOXONE therapy, because it provides physicians with important insights into your health and your treatment. Your 1st visit will include urine drug screening, and may also entail a Breathalyzer^{®*} test and blood work. If you haven't had a recent physical exam, your doctor may require one either now or soon afterwards. To help ensure that SUBOXONE is the best treatment option for you, the doctor will perform a substance dependence assessment and mental status evaluation. In addition, you and your physician will discuss SUBOXONE treatment, what it involves, and what your expectations of treatment are.

After this initial intake, your doctor will give you a dose of SUBOXONE. Your response to the medication will be evaluated after 1 hour and possibly again after 2 hours. Once the doctor is comfortable with your response, you will be allowed to go home. The doctor will schedule your next visit and give you directions for taking your medication at home. In addition, you will receive instructions on how to contact your doctor in case of emergency, as well as information about your treatment.

CHECKLIST FOR 1ST VISIT:



- Arrive with a **full bladder**

- Arrive experiencing mild to moderate **opioid withdrawal** symptoms
- Bring completed **forms** (or come 30 minutes early)
- Bring **ALL medication bottles**
- **Fees due** at time of visit (cash or check)

*Breathalyzer is a registered trademark of Indiana University Foundation.

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APPOINTED PHARMACY CONSENT

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

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

Patient Name (Print)

- Authorize _____ at the above address to disclose my treatment for opioid

Physician Name (Print)

dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine prescriptions directly to the pharmacy.

- Agree to allow pharmacist to contact physician listed above to discuss my treatment if necessary so that my buprenorphine prescriptions can be filled and either delivered to the office addressed given above or picked-up by employees of the same.

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

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

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

Patient Signature

Date

Parent/Guardian Signature

Parent/Guardian Name (Print)

Date

Witness Signature

Witness Name (Print)

Date

Appointed Pharmacy: Name _____ Phone

Address

Confidentiality of Alcohol and Drug Dependence Patient Records

The confidentiality of alcohol and drug dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol or drug dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

FARAZ QURESHI, MD
WVU-CHARLESTON, DEPARTMENT OF PSYCHIATRY
501 MORRIS STREET
CHARLESTON WV 25303
PHONE: 304 341 1500
FAX: 304 341 1554
EMAIL: FQURESHI@HSC.WVU.EDU

PATIENT TREATMENT CONTRACT

Patient Name _____ **Date** _____

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium[®], Klonopin^{®†}, or Xanax^{®‡}), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.

13.

I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).

14. I agree to provide random urine samples and have my doctor test my blood alcohol level.
15. I understand that violations of the above may be grounds for termination of treatment.

_____ Date
Patient Signature _____

*Valium® is a registered trademark of Roche Products Inc.

†Klonopin® is a registered trademark of Roche Laboratories Inc.

‡Xanax® is a registered trademark of Pharmacia & Upjohn Company

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METHADONE TRANSFER CONSENT

I _____ authorize

Patient Name (Print)

Physician Name

(Print)

practicing at the above address to disclose my treatment for opioid dependence to the outpatient treatment program specified below in order to obtain my medical history, methadone treatment, and any other of my patient information pertinent to the office-based treatment with buprenorphine. I understand that the physician mentioned above may need to discuss my medical and treatment history with the physicians and other staff at the outpatient treatment program specified below.

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

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

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

Patient Signature

Date

Parent/Guardian Signature

Parent/Guardian Name (Print)

Date

Witness Signature

Witness Name (Print)

Date

Outpatient treatment program: Name

Phone

Address

Confidentiality of Alcohol and Drug Dependence Patient Records

The confidentiality of alcohol and drug dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol or drug dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Faraz Qureshi, MD
WVU-Charleston, Department of Psychiatry
501 Morris Street
Charleston WV 25303
Phone: 304 341 1500
Fax: 304 341 1554
Email: fqureshi@hsc.wvu.edu

TELEPHONE APPOINTMENT REMINDER CONSENT

I _____ give _____
Patient Name (Print) Physician Name (Print)

and members of his/her staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):
 Home _____
 Work _____
 Cell _____

Yes, this office may leave (check all that apply):
 Voice mail at my Home Voice mail at my Work Voice mail on my Cell
 Messages with people at my Home Messages with people at my Work

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

Patient Signature

Date

Parent/Guardian Signature

Parent/Guardian Name (Print) Date

Witness Signature

Witness Name (Print) Date

Faraz Qureshi, MD
WVU-Charleston, Department of Psychiatry
501 Morris Street
Charleston WV 25303
Phone: 304 341 1500
Fax: 304 341 1554
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CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize _____ at the above address to:
Patient Name (Print) Physician Name (Print)

MD check all that apply

- Receive my medical history information from the following physicians:
(name, address) _____
(name, address) _____
- Receive my treatment records from the following therapist
Therapist (name, address) _____
- Release my treatment information/records to the following healthcare professional
(name, address) _____
- Release my treatment information to the health insurance company listed below for billing purposes
Insurance Provider (name, address) _____

This information is for the following purposes (any other use is prohibited): _____

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

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

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

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

Witness Signature

Witness Name (Print)

Date

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Faraz Qureshi, MD
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501 Morris Street
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FAX COVER SHEET

SUBOXONE[®] (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet

Date: _____

From: Dr. _____

DEA No. _____

DATA No. _____

Lic. No. _____

To: _____

Phone: _____ **FAX:** _____

Please notify the doctor's office as soon as possible if you do NOT currently have a signed pharmacy consent form on file for the patient listed below.

Patient Name: _____

Patient Address: _____

___ **Copy of insurance card enclosed** ___ **Payment arrangements already made**

Credit Card No. and Expiration _____

			Quantity (tablets)
SUBOXONE	2 mg/0.5 mg	___ Daily	_____
SUBOXONE	8 mg/2 mg	___ Daily	_____

___ Please deliver SUBOXONE to doctor's office (see address above) by ___:___ AM/___:___ PM

___ The prescription will be picked up by _____ from the above-named physician's office

Physician Signature

Date

FARAZ QURESHI, MD

WVU-CHARLESTON, DEPARTMENT OF PSYCHIATRY

501 MORRIS STREET

CHARLESTON WV 25303

PHONE: 304 341 1500

FAX: 304 341 1554

EMAIL: FQURESHI@HSC.WVU.EDU

Call Date _____

Call Time _____

PRETREATMENT SCREENING

Completed prior to call

Name _____

Phone no. _____ Best time to contact _____

Address _____

DOB _____ Age _____ Sex () M () F

Insurance co. _____ Insurance member # _____

Do you plan to submit a claim? () Yes () No

Reason for seeking treatment

Substance _____ How long using? _____

How much? _____ How often? _____

Has your drug use ever resulted in medical or legal problems? () N _____

Have you ever been treated for substance dependence or misuse (eg, detoxification program)? () N

(Please describe setting, length) _____

Have you ever tried to quit on your own? () N (Please describe)

Have you ever been treated by a psychiatrist? () N (Please describe treatment reason, setting, and length)

Does anyone in your family (mother, father, brother/sister, child, aunt/uncle or grandparent) have a history of substance abuse? () N _____

Do you have any medical conditions (diabetes, HIV+, epilepsy, STDs)? () N

Are you currently taking any medications to treat these conditions? () N (List medication and dosage)

Are you pregnant? () N/A () N () Y () Not Sure

Are there any current legal issues we should be aware of (probation, parole)? () N

Are you currently employed? () N () Y How many hours/week (avg.)?

Please describe your current living arrangements _____

Other _____

Patient Interviewer Signature

Date: _____

Office Assessment

Patient accepted for treatment () N () Y

If “no”

Describe why: _____

Alternate treatment recommendations:

() NA () AA () OTP () Other (list below):

Patient was called to discuss the above: _____ Date _____ Caller Initials

If “yes”

Patient was called to schedule 1st visit: _____ Date _____ Caller Initials

1st visit requirements discussed with patient:

- Arrive with full bladder (urine drug screening will be performed)
- Arrive experiencing mild to moderate opioid withdrawal symptoms (average abstinence periods: methadone or long-acting pain killers: 24 hrs; heroin or short-acting pain killers: 4 to 6 hrs)
- Bring ALL medication bottles
- Bring completed Pretreatment Paperwork or come 30 minutes early
- Payment will be required in advance

Pretreatment Paperwork explained to patient: _____ Caller Initials

Pretreatment Paperwork mailed or given to patient: _____ Date _____ Caller Initials

Faraz Qureshi, MD
 WVU-Charleston, Department of Psychiatry
 501 Morris Street
 Charleston WV 25303
Phone: 304 341 1500
Fax: 304 341 1554
Email: fqureshi@hsc.wvu.edu

PATIENT INTAKE: PHYSICAL EXAM

Patient Name _____ **Date** _____ **Date of last physical**

T _____ P _____ BP _____ R _____ WT _____ HT _____ Appearance

TB _____ HIV _____ STD (specify) _____ Hep-C _____ Hep-B _____

BAL _____

Skin	GI	Lymph
HEENT	GU	Neuro
Neck	GYN	Locomotor
CVS	Musculoskeletal	Psych
Resp	Extremities	Nutrition/hydration

Signs of intoxication? () N

NOTES

BUN & Cr___ Urine Drug Screen Other _____

PPD placed _____ To be read _____ Other TB status checks

(date) (date)

Signed _____ Date

Faraz Qureshi, MD
WVU-Charleston, Department of Psychiatry
501 Morris Street
Charleston WV 25303
Phone: 304 341 1500
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Email: fqureshi@hsc.wvu.edu

INITIAL PATIENT CONTACT

1. When a potential patient calls seeking treatment for dependence on opioids, such as pain killers (eg, oxycodone), methadone, or heroin use this form to record that person's contact information. It is important to treat these callers with understanding: they are looking for help and may often feel vulnerable. At the same time, if a caller is inappropriate or makes you uncomfortable for any reason, tell that person you are ending the call and why.
2. In general, if a caller has questions about treatment, tell them that you are not the best person to talk to about treatment, but that the person who will be calling him or her for the telephone interview (see # 6) will be able to answer any questions that caller has.
3. Let the caller know that all information they give you is completely confidential.

4. Contact Information

First Name _____ Last Name _____

Phone Number _____ Ok to leave voice messages at this number? () N

() Y

Insurance provider _____ Reason seeking

treatment _____

Referred by?

Interview time *OR* best date/times to be called back to schedule interview

Fill in date/ circle time

<input type="checkbox"/>	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
--------------------------	------------	------------	------------	--------------	------------	------------	------------

#1	AM	9	10	11	PM	12	1	2	3	4	5	6	7	8	9	
		:15	:30	:45				:15	:30	:45						
	Mon	Tue	Wed	Thurs	Fri	Sat	Sun									
#2	AM	9	10	11	PM	12	1	2	3	4	5	6	7	8	9	
		:15	:30	:45				:15	:30	:45						

5. Confirm (read back) caller's **phone number** and **best time to be reached** ONLY.

6. After confirming the caller's phone number and contact time, **mention** the following:
 - The caller/patient will be contacted by someone on the medical staff at the times just specified to conduct/arrange for a confidential telephone interview
 - If the patient misses this call, s/he will need to reinitiate contact with the office to arrange another time for the interview
 - The telephone interview is short, usually **under 20 minutes**
 - During the call, the patient will be asked basic questions about his/her current condition and medical history
 - If the patient can be accepted for treatment, then someone from the office will call him or her to schedule the first appointment and describe what is required for the first visit
 - If for some reason the patient cannot be accepted for treatment at this time, then someone from the office will call him or her to explain why and recommend alternate treatment options

7. Does the caller have any questions about the telephone interview?

8. Thank the caller and end the call.

Faraz Qureshi, MD

WVU-Charleston, Department of Psychiatry

501 Morris Street

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PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

Use the opposite side of the page as necessary to complete your answers. **Please print legibly.**

Name

Address

Phone (w) _____ (h) _____ (c)

DOB _____ Age _____ SS#

Emergency Contact

Relationship to patient _____ Phone

Primary care physician _____ Phone

Date of last physical _____ Have you ever had an EKG? () N Date

Current or past medical conditions (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma/respiratory | <input type="checkbox"/> Cardiovascular (heart attack, high cholesterol, angina) | |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Epilepsy or seizure disorder | <input type="checkbox"/> GI disease |
| <input type="checkbox"/> Head trauma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Pancreatic problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> STDs | <input type="checkbox"/> Abnormal Pap smear | <input type="checkbox"/> Nutritional deficiency |

Other (Please describe)

-

If there a family history of any of the illnesses listed above, **please put an "F" next to that illness**

MD NOTES

Is there a family history of anything NOT listed here? (Please explain)

MD NOTES

Have you ever had **surgery** or been **hospitalized**? (Please describe)

MD NOTES

Childhood Illnesses

Measles ()N ()Y Mumps ()N ()Y Chicken Pox ()N ()Y

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**?

(Please describe)

Have you ever taken or been prescribed **antidepressants**? ()N For what reason

Medication(s) and dates of use _____ Why stopped

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later)

Please list all current **herbal medicines, vitamin supplements**, etc. and how often you take them

MD NOTES

Please list any **allergies** you have (penicillin, bees, peanuts)

MD NOTES

Tobacco History

Cigarettes: Now? () N () Y In the past? () N () Y

How many per day on average?

For how many years? _____

Pipe: Now?

() N () Y

In the past?

() N () Y

How often per day on average?

For how many years? _____

Have you ever been **treated for substance misuse**? () N (Please describe when, where and for how long)

How long have you been **using substances**? _____

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth- Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							

Other							
-------	--	--	--	--	--	--	--

Did you ever stop using any of the above because of dependence? () N (Please list)

What was your longest period of abstinence?

MD NOTES

FARAZ QURESHI, MD

WVU-CHARLESTON, DEPARTMENT OF PSYCHIATRY

501 MORRIS STREET

CHARLESTON WV 25303

PHONE: 304 341 1500

FAX: 304 341 1554

EMAIL: FQURESHI@HSC.WVU.EDU

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name

(Circle one) Married Single Long-term relationship Divorced/Separated

Years married/ in long-term relationship _____ Times Married _____ Times Divorced

Children? () N () Y Current ages (list)

Residing with you? () N () Y If no, where?

Where are you currently living?

Do you have family nearby? () N (Please describe)

Education (check most recent degree):

() Graduate school () College () Professional or Vocational School

() High School Grade _____

Are you currently employed? () N Where (if "no," where were you last employed?)

What type of work do/did you do? _____ How long have/did you work (ed) there?

Have you ever been arrested or convicted? () N

() DWI () Drug-related () Domestic violence () Other

Have you ever been abused? () N

() Physically () Sexually (including rape or attempted rape) () Verbally ()

Emotionally

Have you ever attended:

AA () Current () Past **NA** () Current () Past **CA** () Current () Past

ACOA () Current () Past **OA** () Current () Past

If you are not currently attending meetings, what factors led you to stop?

Have you ever been in counseling or therapy? () N (Please describe)

Faraz Qureshi, MD
WVU-Charleston, Department of Psychiatry
501 Morris Street
Charleston WV 25303
Phone: 304 341 1500
Fax: 304 341 1554
Email: fqureshi@hsc.wvu.edu

CAGE QUESTIONNAIRE

Cut down—Have you ever felt you ought to cut down on your drinking or drug use? () **Y** () **N**

Annoyed—Have people annoyed you by criticizing your drinking or drug use? () **Y** () **N**

Guilty—Have you ever felt bad or guilty about your drinking or drug use? () **Y** () **N**

Eye-opener—Have you ever had a drink or used drugs first thing in the morning, to steady your nerves or get rid of a hangover? () **Y** () **N**

There are no formal cut-off scores. Any positive score suggests the need for further evaluation.

Ewing J. Detecting alcoholism: The CAGE questionnaire. *JAMA*. 252(14):905-1907, 1984.

Faraz Qureshi, MD

WVU-Charleston, Department of Psychiatry

501 Morris Street

Charleston WV 25303

Phone: 304 341 1500

Fax: 304 341 1554

Email: fqureshi@hsc.wvu.edu

DRUG ABUSE SCREENING TEST (DAST)

1. Have you used drugs other than those required for medical reasons? ()Y ()N
2. Have you misused prescription drugs? ()Y ()N
3. Do you misuse more than one drug at a time? ()Y ()N
4. Can you get through the week without using drugs (other than those required for medical reasons)? ()Y ()N
5. Are you always able to stop using drugs when you want to? ()Y ()N
6. Do you misuse drugs on a continuous basis? ()Y ()N
7. Do you try to limit your drug use to certain situations? ()Y ()N
8. Have you had "blackouts" or "flashbacks" as a result of drug use? ()Y ()N
9. Do you ever feel bad about your drug misuse? ()Y ()N
10. Does your spouse (or parents) ever complain about your involvement with drugs? ()Y ()N
11. Do your friends or relatives know or suspect you misuse drugs? ()Y ()N
12. Has drug misuse ever created problems between you and your spouse? ()Y ()N
13. Has any family member ever sought help for problems related to your drug use? ()Y ()N

Have you ever:

14. Lost friends because of your use of drugs? ()Y ()N
15. Neglected your family or missed work because of your use of drugs? ()Y ()N
16. Been in trouble at work because of drug misuse? ()Y ()N
17. Lost a job because of drug misuse? ()Y ()N
18. Gotten into fights when under the influence of drugs? ()Y ()N
19. Been arrested because of unusual behavior while under the influence of drugs? ()Y ()N
20. Been arrested for driving while under the influence of drugs? ()Y ()N
21. Engaged in illegal activities to obtain drugs? ()Y ()N
22. Been arrested for possession of illegal drugs? ()Y ()N
23. Experienced withdrawal symptoms as a result of heavy drug intake? ()Y ()N
24. Had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, or bleeding)? ()Y ()N
25. Gone to anyone for help for a drug problem? ()Y ()N
26. Been in hospital for medical problems related to your drug use? ()Y ()N
27. Been involved in a treatment program specifically related to drug use? ()Y ()N

28. Been treated as an outpatient for problems related to drug dependence or misuse? () Y
() N

Scoring: Each positive response yields 1 point, except for questions 4, 5, and 7 which yield 1 point for a negative response or false direction.

A score greater than 5 requires further evaluation for substance misuse problems.

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior* 7(4): 363-371, 1982.

Faraz Qureshi, MD
WVU-Charleston, Department of Psychiatry
501 Morris Street
Charleston WV 25303
Phone: 304 341 1500
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Email: fqureshi@hsc.wvu.edu

BRIEF MICHIGAN ALCOHOL SCREENING TEST (MAST)

Points

- (2) 1. Do you feel you are a normal drinker?*
- (2) 2. Do friends or relatives think you are a normal drinker?*
- (5) 3. Have you ever attended a meeting of Alcoholics Anonymous?
- (2) 4. Have you ever lost friends or girlfriends/boyfriends because of drinking?
- (2) 5. Have you ever gotten into trouble at work because of drinking?
- (2) 6. Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking?
- (2) 7. Have you ever had delirium tremens (DTs), severe shaking, heard voices, seen things that weren't there after heavy drinking?
- (5) 8. Have you ever gone to anyone for help about your drinking?
- (5) 9. Have you ever been in a hospital because of drinking?
- (2) 10. Have you ever been arrested for drunk driving or driving after drinking?

*Negative responses are alcoholic responses.

Scoring

- < 3 points, nonalcoholic
- 4 points, suggestive of alcoholism
- 5 or more, indicates alcoholism

1. Selzer ML. The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiatry* 27(12): 1653-1658, 1971. 2. Pokorny AD; Miller BA; Kaplan HB. The Brief MAST: A shortened version of the Michigan Alcoholism Screening Test. *American Journal of Psychiatry* 129(3): 342-345, 1972.

Faraz Qureshi, MD
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DSM-IV CRITERIA FOR OPIOID DEPENDENCE DIAGNOSIS: WORKSHEET

Patient Name:			
Diagnostic Criteria* (Dependence requires meeting 3 or more criteria)	Meets criteria		Notes/supporting information
	Yes	No	
(1) Tolerance, as defined by either of the following: (a) need for markedly increased amounts of the substance to achieve intoxication or desired effect			
(b) markedly diminished effect with continued use of the same amount of the substance			
(2) Withdrawal, as manifested by either of the following: (a) the characteristic withdrawal syndrome			
(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms			
(3) The substance is often taken in larger amounts or over a longer period of time than intended			
(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use			
(5) A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects			
(6) Important social, occupational, or recreational activities are given up or reduced because of substance use			
(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance			

Physician Signature

Date

*Criteria from American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association page 197.

Faraz Qureshi, MD
 WVU-Charleston, Department of Psychiatry
 501 Morris Street
 Charleston WV 25303
Phone: 304 341 1500
Fax: 304 341 1554
Email: fqureshi@hsc.wvu.edu

DSM-IV CRITERIA FOR SUBSTANCE DEPENDENCE AND ABUSE

Once a thorough patient assessment has been performed, a formal diagnosis of either opioid dependence or abuse can be made. A substance dependence or abuse diagnosis, according to current DSM-IV diagnostic schema, is based on clusters of behaviors and physiological effects occurring within a specific time frame. ***A diagnosis of dependence always takes precedence over that of abuse***, eg, a diagnosis of abuse is made only if DSM-IV criteria for dependence have never been met.

DEPENDENCE	ABUSE
3 or more in a 12-month period	1 or more in a 12-month period (Symptoms must never have met criteria for dependence.)
Tolerance (marked increase in amount; marked decrease in effect)	Recurrent use resulting in failure to fulfill major role obligation at work, home or school
Characteristic withdrawal symptoms; substance taken to relieve withdrawal	Recurrent use in physically hazardous situations
Substance taken in larger amount and for longer period than intended	Recurrent substance related legal problems
Persistent desire or repeated unsuccessful attempt to quit	Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by substance
Much time/activity to obtain, use, recover	
Important social, occupational, or recreational activities given up or reduced	
Use continues despite knowledge of adverse consequences (e.g., failure to fulfill role obligation, use when physically hazardous)	

In using the DSM-IV criteria, one should specify whether substance dependence is with physiologic dependence (ie, there is evidence of tolerance or withdrawal) or without physiologic dependence (ie, no evidence of tolerance or withdrawal). In addition, patients may be variously classified as currently manifesting a pattern of abuse or dependence or as in remission. Those in remission can be divided into four subtypes—full, early partial, sustained, and sustained partial—on the basis of whether any of the criteria for abuse or dependence have been met and over what time frame. The remission category can also be used for patients receiving agonist therapy (eg, methadone maintenance) or for those living in a

controlled drug-free environment.

* Criteria from American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association page 197.

FARAZ QURESHI, MD

WVU-CHARLESTON, DEPARTMENT OF PSYCHIATRY

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SUBSTANCE DEPENDENCE ASSESSMENT

(For complete substance use history, see Patient Intake: Medical History)

Patient Name _____ **Date** _____

BP _____ Pulse _____ BAL _____ Urine Drug Screening _____

Has patient experienced withdrawal symptoms in the past (check all that apply):

Blackouts	()	Anxiety	()
ETOH Seizures	()	Diarrhea	()
Tremors	()	Nausea/vomiting	()
DTs	()	Body cramps	()
Sweats	()	Body aches	()

Has patient ever been treated for substance misuse? () N (Please describe when, where and for how long)

MD NOTES _____

Presenting problem

Substance _____ Route _____

Quantity/Dose _____ Frequency _____

Last Usage _____

Faraz Qureshi, MD
 WVU-Charleston, Department of Psychiatry
 501 Morris Street
 Charleston WV 25303
Phone: 304 341 1500
Fax: 304 341 1554
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OPIOID WITHDRAWAL RECORD (Induction Form)
 (Adapted from Clinical Opioid Withdrawal Scale)

Patient Name _____ **Treatment Start Date** _____

Circle the number/description which best corresponds to your patient's present symptoms

Parameter	Baseline Observation Administer 1st Dose ___mg Time given ___am/pm	1st Dose Observation _____min. after 1st dose	1st Dose, 2nd Dose Observation (if needed) _____min. After 1st dose	2nd dose (if needed) _____mg Time given ___am/pm	2nd Dose Observation _____min. After 2nd dose
Resting pulse rate ____beats/min <i>Measure after patient is sitting lying for 1 minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	0 1 2 4	0 1 2 4	0 1 2 4	0 1 2 4	0 1 2 4
Sweating <i>Over past 30 minutes; not accounted for by room temperature or patient activity</i> 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Restlessness <i>Observation during assessment</i> 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or	0 1 3	0 1 3	0 1 3	0 1 3	0 1 3

extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	5	5	5	5	5
--	---	---	---	---	---

Tremors <i>Observation of outstretched hands</i> 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching	0 1 2 4	0 1 2 4	0 1 2 4	0 1 2 4	0 1 2 4
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	0 1 2 5	0 1 2 5	0 1 2 5	0 1 2 5	0 1 2 5
	Baseline Observation	1st Dose Observation	1st Dose, 2nd Observation	2nd Dose	2nd Dose Observation
GI upset <i>Over last 30 minutes</i> 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting	0 1 2 3 5	0 1 2 3 5	0 1 2 3 5	0 1 2 3 5	0 1 2 3 5
Anxiety or irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable/anxious 4 patient so irritable/anxious that participation in assessment is difficult	0 1 2 4	0 1 2 4	0 1 2 4	0 1 2 4	0 1 2 4
Bone or joint aches <i>If patient was having pain previously, gauge the additional component attributed to opioid withdrawal only</i>	0	0	0	0	0

0 not present	1	1	1	1	1
1 mild diffuse discomfort					
2 patient reports severe diffuse aching of joints/ muscles	2	2	2	2	2
4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	4	4	4	4	4

Yawning <i>Observation during assessment</i>					
0 no yawning	0	0	0	0	0
1 yawning once or twice during assessment	1	1	1	1	1
2 yawning three or more times during assessment	2	2	2	2	2
4 yawning several times/minute	4	4	4	4	4
Runny nose or tearing <i>Not accounted for by cold symptoms or allergies</i>					
0 not present	0	0	0	0	0
1 nasal stuffiness or unusually moist eyes	1	1	1	1	1
2 nose running or tearing	2	2	2	2	2
4 nose constantly running or tears streaming down cheeks	4	4	4	4	4
Gooseflesh skin					
0 skin is smooth	0	0	0	0	0
3 skin piloerection can be felt or hairs standing up on arms	3	3	3	3	3
5 prominent piloerection	5	5	5	5	5
Total Score _____ Total score is the sum of all 11 items <ul style="list-style-type: none"> • 5-12 = mild • 13-24 = moderate • 25-36 = moderately severe • >36 = severe withdrawal 	_____	_____	_____	_____	_____

FARAZ QURESHI, MD
 WVU-CHARLESTON, DEPARTMENT OF PSYCHIATRY
 501 MORRIS STREET
 CHARLESTON WV 25303
PHONE: 304 341 1500
FAX: 304 341 1554
EMAIL: FQURESHI@HSC.WVU.EDU

THERAPY PROGRESS REPORT

SUBOXONE® (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet
 (Adapted from Subjective Opiate Withdrawal Scale)

Patient Name _____ **SUBOXONE dose** _____ mg/day **Date** _____

COMPLETED BY PATIENT
 now

Circle the answer that best fits the way you feel

I feel anxious	(Not at all) 0 - 1 - 2 - 3 - 4 (Extremely)
I feel like yawning	0 - 1 - 2 - 3 - 4
I am perspiring	0 - 1 - 2 - 3 - 4
My nose is running and/or my eyes are watery	0 - 1 - 2 - 3 - 4
I have goosebumps and/or chills	0 - 1 - 2 - 3 - 4
I feel nauseated or like I may need to vomit	0 - 1 - 2 - 3 - 4
I have stomach cramps and/or diarrhea	0 - 1 - 2 - 3 - 4
My muscles twitch	0 - 1 - 2 - 3 - 4
I feel dehydrated and/or have not had much appetite	0 - 1 - 2 - 3 - 4
I am having difficulty sleeping	0 - 1 - 2 - 3 - 4
I have a headache	0 - 1 - 2 - 3 - 4
My muscles and bones ache	0 - 1 - 2 - 3 - 4
I feel like using right now	0 - 1 - 2 - 3 - 4
I would rate my overall level of withdrawal as	0 - 1 - 2 - 3 - 4
Do you feel you need a dosage change?	() No () Yes () Up () Down
Have you used alcohol or drugs since your last visit?	() No () Yes
If "yes," please describe what, when, and how much	
Please describe the problems or situations you found most stressful during the past week (if needed, use back of page)	

Handelsman L, Cochrane KJ, Aronson MJ, Ness R, Rubinstein KJ, Kanof PD. (1987). Two new rating scales for opiate withdrawal. *Am J Drug Alcohol Abuse*. 13(3):293-308.

COMPLETED BY PHYSICIAN (OR OTHER MEDICAL PROFESSIONAL)

S/O

A)	P)
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Physician Signature _____ Date _____

Adverse events since the last visit? () N (Describe) _____

Any signs of **intoxication**? () N (Describe) _____

Any use of unauthorized substances since last visit? () N (Substances used, quantity, frequency)

What were the circumstances surrounding use (ie, what stressors or triggers)?

Were these triggers previously identified?

If “no,” explore new “trigger” circumstances _____

If “yes,” explore further how patient came to be in this situation and why use occurred _____

How did using make the patient feel? _____

Dose adjustment necessary? () N New dose _____

Other medications necessary? () N (list) _____

NOTES _____
