OBAT Nurse Intake

Nursing Summary: review and confirm screener information. Obtain any missing info.

Additional information to include:

Do you use any method to ensure family planning or protective sex?
☐ 1 = Yes ☐ 2 = No

If yes, which method are you currently utilizing? (Check all that apply)
☐ Condoms
☐ Oral contraceptives
☐ Injection (e.g., Depo-Provera)
☐ Hormonal implant
☐ Intrauterine device/contraception (IUD or IUC)
☐ Vaginal ring
☐ Patch
☐ Rhythm/fertility awareness methods/withdrawal
☐ None
☐ Trying to conceive
☐ Other: ____________________

Would you like to learn more about family planning options? ☐ 1 = Yes ☐ 2 = No

Substance Use History

What substances are you currently using?
Includes quantity, most recent use, route, and frequency.
☐ 1 = Heroin
☐ 2 = Fentanyl
☐ 3 = Buprenorphine
☐ 4 = Methadone
☐ 5 = Oxycodone product
☐ 6 = Other opioid: _______________
☐ 7 = Cocaine/crack cocaine
☐ 8 = Benzodiazepines
☐ 9 = Alcohol
☐ 10 = Amphetamines
☐ 11 = Crystal meth
☐ 12 = Nicotine
☐ 13 = Cannabis
☐ 14 = Pharmaceutical (e.g., gabapentin, quetiapine, promethazine, etc.)
☐ 15 = None
☐ 16 = Other: ____________________

Comments:
____

Are you seeking resources or treatment for any process addictions (examples below)?
☐ 1 = Gambling
☐ 2 = Sex
☐ 3 = Shopping
☐ 4 = Eating disorder (over-eating, bulimia, anorexia)
☐ 5 = Other: ___________________
☐ 6 = No

Comments: ____

Prior Substance Use Disorder Treatment History

Methadone

Have you ever been on methadone maintenance? ☐ 1 = Yes ☐ 2 = No

Where were you on methadone maintenance? _____________________

What was your most recent dose? ________________________________

When was your most recent dose? ________________________________

Why did you/are you seeking to discontinue methadone treatment?

____

Buprenorphine

Have you ever been prescribed buprenorphine before?
☐ 1 = Yes ☐ 2 = No

If yes, who was prescribing your medication (prescriber and practice location)?

____

Are you currently prescribed buprenorphine or taking it illicitly?
☐ 1 = Prescribed ☐ 2 = Illicit ☐ 3 = Both

What is your daily dose of buprenorphine? ________________________________

When was your most recent dose of buprenorphine? ________________________

Have you ever received an extended-release buprenorphine injection? ___________

If yes, when was your most recent injection? ___________________________

If applicable, why did you stop taking buprenorphine?

____

NALTREXONE

Have you ever been prescribed naltrexone before?
☐ 1 = Yes ☐ 2 = No

If yes, who was prescribing your medication (prescriber and practice location)?

____

Are you currently prescribed naltrexone?
☐ 1 = Yes ☐ 2 = No

If yes, are you receiving the oral or injectable formulation?
☐ 1 = Oral ☐ 2 = Injectable

When was your most recent dose of naltrexone? ________________________

If applicable, why did you stop naltrexone treatment?

____

Mental Health History

Have you ever been diagnosed with any of the following mental health conditions?
☐ 1 = Depression
☐ 2 = Anxiety
☐ 3 = Bipolar disorder
☐ 4 = Schizophrenia
☐ 5 = Obsessive Compulsive Disorder (OCD)
☐ 6 = Post-Traumatic Stress Disorder (PTSD)
☐ 7 = Attention Deficit Hyperactivity Disorder (ADHD)
☐ 8 = Other: ______________

Are you currently taking any medication for this/these conditions(s)?
☐ 1 = Yes ☐ 2 = No

If yes, what medications are you taking? ____

Who is prescribing your psychiatric medications? __________________________________

Are you willing to sign a consent for release of information so that we can communicate with your psychiatrist, psychologist, or counselor about your treatment plan?
☐ 1 = Yes ☐ 2 = No

Have you ever been hospitalized for mental health issues?
☐ 1 = Yes ☐ 2 = No

Have you ever attempted to end your life or to hurt yourself?
☐ 1 = Yes ☐ 2 = No

How many times did you try to end your life or to hurt yourself? _________

***Do you currently have thoughts about hurting yourself or ending your life?**
☐ 1 = Yes ☐ 2 = No (If no, skip to homicide question)

If yes:
Do you currently have a plan for how you would hurt yourself or end your life?
☐ 1 = Yes ☐ 2 = No

Do you have the means to carry out your plan?
☐ 1 = Yes ☐ 2 = No

Have you ever attempted or thought about homicide (killing someone else)?
☐ 1 = Yes ☐ 2 = No (If no, skip to health status)

If yes:
Are you presently thinking about killing someone?
☐ 1 = Yes ☐ 2 = No

Do you have the means to carry this out?
☐ 1 = Yes ☐ 2 = No

****If patient screens positive to any of the above questions, the OBAT nurse must implement institutional protocols regarding acute suicidal ideation or homicidal ideation***

Health Status

Have you ever been diagnosed with any medical conditions? (Mark all that apply)
☐ 1= Head Trauma/Brain Injury (specify type): _________________________________
☐ 2= Seizure disorder ➔ Are you on medications? ☐ 1 = Yes ☐ 2 = No
☐ 3= Endocarditis
☐ 4= Skin infection
☐ 5= HIV ➔ If yes, are you currently in care? ☐ 1 = Yes ☐ 2 = No
☐ 6= Hepatitis A
☐ 7= Hepatitis B ➔ If yes, have you been treated? ☐ 1 = Yes ☐ 2 = No
☐ 8= Hepatitis C ➔ If yes, have you been treated? ☐ 1 = Yes ☐ 2 = No
☐ 9= Tuberculosis (TB) ➔ If yes, have you been treated? ☐ 1 = Yes ☐ 2 = No
☐ 10=Diabetes (specify type): ___________________________________

☐ 11 = Heart disease (specify type): ______________________________
☐ 12 = Asthma (specify type): ___________________________________
☐ 13 = Cancer (specify type): ___________________________________
☐ 14 = Pancreatic Problems
☐ 15 = Other (specify): ____________________________________
☐ 16 = None

Who are your health care providers?

____

Are you willing to sign a consent for release of information to external health care providers listed above?
☐ 1 = Yes ☐ 2 = No

Past Medical History:

____

Current Medications:

____

Allergies:

____

Have you been tested for HIV? ☐ 1 = Yes ☐ 2 = No

If yes, did you go back for the results? ☐ 1 = Yes ☐ 2 = No

If yes, when was the last time you were tested? _______________

Have you been tested for Hepatitis C? ☐ 1 = Yes ☐ 2 = No

If yes, did you go back for the results? ☐ 1 = Yes ☐ 2 = No

If yes, when was the last time you were tested? _______________

Do you have any pending surgeries? ☐ 1 = Yes ☐ 2 = No

Pain

Do you have chronic pain? ☐ 1 = Yes ☐ 2 = No

If yes, please explain:

____

____

If yes:
PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity)

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

1) **What number best describes you pain on average in the past week? _________**

2) **What number best described how, during the past week, pain has interfered with your enjoyment of life? _________**

3) **What number best describes how, during the past week, pain has interfered with your general activity? _________**

Total PEG Score: ___________

Treatment Goals

What are your goals for addiction treatment?

____

____

Check all appropriate boxes:

☐ OBAT program reviewed with patient including contact information, treatment goals, frequency of OBAT appointments, and indications for laboratory monitoring.

☐ OBAT treatment agreement and relevant consents reviewed with the patient. Patient voluntarily agreed to and/or signed and dated consents. A copy was given to the patient and the original was placed in the chart. Opportunity for questions provided.

☐ Provided counseling to keep medications in a safe undisclosed place, out of reach of children and visitors.

☐ Patient has been informed that buprenorphine, buprenorphine/naloxone, and naltrexone are Category C medications. Patient will inform treatment team if becomes pregnant.

☐ Labs sent (if indicated) may include complete blood count (CBC); Hepatitis A, B, and C serologies; and comprehensive metabolic panel. Standard testing is recommended to include human chorionic gonadotropin (hCG) for women of childbearing age, urine toxicology screen, and HIV testing.

☐ Overdose education provided. Patient has access to a naloxone rescue kit through their preferred pharmacy and has received instructions on how to use it.

Buprenorphine:

☐ Provided education about buprenorphine including indications; contraindications; administration; dosing; interactions; and potential side effects or adverse reactions such as: elevations in transaminases, sedation, constipation, dry mouth, and headache. Written information also provided. Patient verbalizes understanding and wishes to continue for further treatment.

☐ Contact numbers of treatment team and buprenorphine information given to patient. Patient instructed to give this information to family and friends in case patient is hospitalized.

Naltrexone:

☐ Provided education about naltrexone including indications; contraindications; administration; dosing; interactions; and potential side effects or adverse reactions such as injection site reactions, increased transaminases, depressed mood, opioid blocking effects, and decreased opioid tolerance.

☐ Provided counseling about the importance of being fully withdrawn from opioids prior to initiating naltrexone to mitigate the risk of precipitated or spontaneous withdrawal. Written info provided to patient. Patient verbalized understanding and wishes to initiate naltrexone treatment.

☐ Contact numbers of treatment team and naltrexone information given to patient. Patient instructed to give this information to family and friends in case patient is hospitalized. Patient also advised to carry on their person naltrexone medical identification such as a bracelet and/or dog tag.

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