EXCEL MEDICAL CENTER, LLC

SUBOXONE PROGRAM PACKET

PLEASE COMPLETE PRIOR TO COMING IN FOR YOUR APPOINTMENT.

Explanation of 1st visit- No drugs are kept in this office

Suboxone will be prescription only

Your first visit is generally the longest, and may last anywhere from 1 to 2 hours.

When preparing for your first 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 arrangement for a ride home

It is very important to arrive for your first appointment on time and prepare to answer a battery of questions.

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

Before you can be seen by the doctor, all your paperwork must be completed. Please bring all your completed forms with you or arrive about 30 minutes early to complete it in office.

An observed 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 may include both urine drug screening and blood work. If you haven't had a recent physical exam, your doctor may require one. To help ensure that SUBOXONE is the best treatment option for your, your doctor will perform a substance dependence assessment and mental status evaluation. Lastly, you and your doctor will discuss Suboxone and your expectations of treatment.

After this portion of your visit is completed, your doctor will give you a SUBOXONE prescription and may add another prescription to be taken for a few days to help prevent or lessen withdrawals.

CHECKLIST

- Arrive 30 minutes prior to appointment time
- Arrive with a full bladder
- Complete forms
- Bring ALL medication bottles
- Fee due at time of visit (cash, credit, debit)

7515 Stenton Ave, Philadelphia PA Phone: 267-335-5264 Fax: 267-335-5273

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I authorize at the above address to:

Patient Name: _____

Physicians Name: _____

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

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: _____

I understand that I may withdraw this consent at any time, either verbally or in writing (preferred) except to the extent that action has been taken in reliance on it.

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 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 right.

_____ _____

Patient Name (Print) Date

_____ _____

Patient Signature Date

_____ _____

Witness Name Date

AGREEMENT FOR TREATMENT WITH SUBUTEX/SUBOXONE

Name of patient: _____

By signing below, I agree to the following:

1. Buprenorphine treatment for opiate dependence is most effective when combined with drug abuse counseling, 12-step recovery work, or a recovery support group. During my treatment with Buprenorphine, I agree to seek additional counseling and to work on a program of recovery.
2. I agree that my physician can coordinate my medication switch with the provider of methadone. This may involve exchange of medical records and discussions with the clinic physician or staff. After switching to buprenorphine, I will not take methadone.
3. I understand that on the day I start buprenorphine, I should come to the office already in opiate withdrawal. The day before induction, I will not use any opiate (heroin, methadone, codeine or other opiate containing medication). If I am not having observations signs of opiate withdrawal, induction onto Buprenorphine may be delayed a day or more
4. My first dose of Buprenorphine will be 4 mg. After a couple of hours, I may be administered additional doses of buprenorphine.
5. Take home doses and frequency of visit will be determined by how well I am doing
6. I agree to take buprenorphine as prescribed at the dosage determined be my physicians, and not to allow anyone else to take medication prescribed for me.
7. I agree not to take other medications with buprenorphine without prior permission from my doctor, I understand that overdose deaths have occurred when patients have taken other medication (particularly medications Librium, Valium or other benzodiazepines) with buprenorphine.
8. It has been explained to me that buprenorphine itself is an opiate drug and can produce physical dependence that is similar to heroin
9. The goal of treatment of opiate dependency is to learn to live without abuse of drugs. Buprenorphine treatment should continue as long as necessary to prevent relapse to opiate abuse/dependence.
10. Periodic testing for drugs of abuse is to detect early relapse and to document my progress in treatment. Initially, it will be done weekly and may be decreased in frequency as I progress in treatment.
11. Buprenorphine will be prescribed in quantities to last from visit to visit. The frequency of visits depends on how I am progressing
12. Lost prescriptions or buprenorphine tablets are a serious issue and may result in discontinuation of buprenorphine therapy from this office
13. [Language for women of childbearing potential] I agree to tell the physician if I become pregnant or even think I may be pregnant

I have read and understand these details about buprenorphine treatment. I wish to be treated with buprenorphine.

Signature of Patient: _____ Date: _____

Signature of provider obtaining consent: _____Date: _____

SUBOXONE Procedure Policy

The handling of excel medical center SUBOXONE patients will follow the following guidelines. It is the goal of this practice to avoid or eliminate confusion and upset in relation to the treatment of drug addiction.

The following will take place with patient desiring treatment for drug addiction:

1. Concierge will speak to you about:
   - An appointment
   - Ask them you to fill out intake medical history form; by printing it off the website or coming by the office and picking up the forms. They should be filled out completely prior to your first appointment
   - Give you the explanation of first visit handout, via the same method as the form distribution
2. The receptionist will make the first appointment, allowing at least 30-minute slot for this appointment.

3. The nurse will:
   - Assess the patient
   - Go over the medical intake form
   - Collect urine for drug screen
   - Go over the contract and have the patient ready to sign it when the doctor comes in

Urine drug screens will be done on each patient, after that, they will be randomized by the screening lab or when here is suspicion among the staff of miss-use of the SUBOXONE. It patient has dirty urine, there will always be random urine to follow. Dirty urine is defined as: Urine that is negative SUBOXONE or positive for illegal substances.

All randomized urine screening will follow the same procedure, whether it is for dirty urine or just a random screen.

1. The patient will be notified at the time of the appointment to give a urine sample. The patient will not be allowed to, leave the facility until the sample is given. If the patient refuses to do so, then the patient will not be seen on that day of the visit, they will be given another appointment date which would also be followed by a urine sample.

No further prescriptions will be written until the random urine is collected. Two dirty urines will result in automatic dismissal.

It is imperative that this clinic has functioning contact phone numbers; it is the responsibility of the patient to notify the clinic in any changes to their contact numbers. The clinic will make two attempts to contact the patient for the collection of random urine screens and NO messages will be left on the recorder. The patient will need to make sure they can be reached. Failure to respond to the call for random urine screening will be considered dirty urine. The patient will not be allowed to arrange a time to come the office for the random urine screen.

If primary care services are needed, we can aid with other medical problems during the SUBOXONE appointment. If the addiction therapy patient is an established medical patient, they will need another appointment scheduled for other complaints. If they are not an established medical patient, they must satisfy all the requirements and be taken under consideration before they are accepted by this practice as medical patient.

Please read the patient contract and it will shed light on what is acceptable behavior and what is not tolerated.

Confidentiality of Alcohol and drug dependence patient records

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

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

Violation of the federal laws and regulations by a practice /program is a crime. Suspicious violations may be reported to appropriate authorities authorizes 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.

Suboxone Medication Agreement

Suboxone (a tablet with buprenorphine and naloxone) is an FDA approved medication for treatment of people with heroin or other opioid addiction. Buprenorphine can be used for detoxification of for maintenance therapy. Maintenance therapy can continue as long as medically necessary. There are other treatments for opiate addiction, including methadone, naltrexone, and some treatments medication that including counseling, groups, and meetings.

If you are dependent on opiates- any opiates- you should be in as much withdrawal as possible when you take the first dose of buprenorphine. It you are not in withdrawal, buprenorphine can cause severe opiate withdrawal. For that reason, you should take the first dose in the office and remain in the office for at least 2 hours. We recommend that you arrange not to drive after your first dose, because some patients get drowsy until the correct dose is determined for them.

Some patients find that it takes several days to get used to the transition from the opiate they had been using to buprenorphine. During that time, any use of other opiates may casuse an increase in symptoms. After you become stabilized on buprenorphine, it is expected that other opiates will have less effect. Attempts to override the buprenorphine by taking more opiate could result in an opiate overdose. You should not take anuy other medication with discussing it with the physician fist.

Combining buprenorphine with alcohol or other sedating medications is dangerous. The combination of burprenorphine with benzodiazepines (such as Valium, Librium, Ativan, Xanax, Klonopin, etc.) has resulted in death.

Although sublingual buprenorphine has not been shown to be liver damaging, your doctor will monitor your liver while you are taking buprenorphine. (This is a blood test)

The form buprenorphine (Suboxone) you will be taking is a combination of buprenorphine with a short acting opiate blocker (Naloxone). It will maintain physical dependence and if you discontinue it suddenly, you will likely experience withdrawal. If you are not already dependent, you should not take buprenorphine, it could eventually cause physical dependence.

Buprenorphine tablets must be held under the tongue until they dissolve completely. You will be given your first dose at the clinic, and you will have to wait as it dissolves, and for two hours after it dissolve, to see how you react. It is important not to talk or swallow until the tablet dissolves. This takes up to ten minutes. Buprenorphine is then absorbed over the next 30 to 120 minutes from the tissue under the tongue. Buprenorphine will not be absorbed from the stomach if it is swallowed. If you swallow the tablet, you will not have the important benefits of the medication, and it may not relieve your withdrawal.

Most patients end up at a daily dose of 16mg to 24mg of buprenorphine. (This is roughly equivalent to 60mg of methadone maintenance) Beyond that dose, the effect of buprenorphine plateau, so there may not be any more benefit to increase the dose. It may take several weeks to determine just the right dose for you. The first dose is usually 2mg

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If you are transferring to Suboxone from methadone maintenance, you dose has to be tapered until you have been below 30mg for at least a week. There must be at least 24 hours (preferably longer) between the time you take your late methadone dose and the time you are given your first dose of buprenorphine. Your doctor will examine you for clear signs of withdrawal, and you not be given buprenorphine until you are in withdrawal.

I have read and understand these details about buprenorphine treatment. I wish to be treated with buprenorphine.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

EXCEL MEDICAL CENTER, LLC.

AGREEMENT FOR OPIOID MAINTENANCE THERAPY FOR NON-CANCER/CANCER PAIN

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physicians comply with all state federal regulations concerning the prescribing of controlled substances. A trail of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

1. You should use one physician to prescribe and monitor all opioid medications and adjunctive analgesics.
2. You should use one pharmacy to obtain all opioids prescriptions and adjunctive analgesics prescribed by your physician.
   Pharmacy: _____ Number: _____

3. You should inform your physician of all medications you taking, including herbal remedies, since opioid medications can interact with over-the-counter- medication and other prescribed medications, especially cough syrup that contain alcohol, codeine, hydrocodone.

4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, plus usually two to three days extra. The extra medication is not to be used without explicit permission of the physician unless an emergency requires your appointment to be deferred one or two days.

5. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medication will be done during the evening or on weekends.

6. You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original bottles.

7. You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your physician immediately. If your medications are lost, misplaced or stolen, your physician may choose not to replace the medications or to taper and discontinue the medications

8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health. It is also against the law.

9. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

10. You will communicate fully to your physician to the best of your ability at the initial and all follow-up visits your pain level and functional activity along with any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.

11. You should not use any illicit substances, such as cocaine, marijuana, etc. While taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or termination of the doctor/patient relationship.

12. The use of alcohol and opioid medications in contraindicated.

13. You agree and understand that your physician reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool and in accordance with certain level and regulatory materials on the use of controlled substances to treat pain.

14. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).

15. Physical dependence and/or tolerance can occur with the use of opioid medications.
    - Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating nervousness, abdominal cramps, diarrhea, goose bumps, and alternations in one's mood.
    - It should be noted that physical dependence down not equal addiction. One can be dependent on insulin to treat to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone
    - Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing it development and manifestation it is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. This means the drug decreases one's quality of life
    - Tolerance mean a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug effects over time. The dose of the opioid

may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

16. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instance, disqualify one for opioid treatment of pain, but staring or continuing a program for recovery is a must.

17. You agree to allow your physician to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions if the physician feels it necessary

18. You agree to a family conference or a conference with a close friend or significant other if the physician feels it necessary.

The above agreement has explained to me by Dr. John Michel. I agree to its terms so that Dr. John Michel can provide quality pain management using opioid therapy to decrease my pain and increase my function.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date_____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: EXCEL MEDICAL CENTER

Address: _____

City: PHILADELPHIA State: PA Zip Code: _____

Fax: _____ Phone: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. (Make Change when necessary)

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive,to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatmentto the person(s) listed above.

Patient Signature: _____ Date Signed: _____

This signature will expire 12 months after the date above.

EXCEL MEDICAL CENTER, LLC.

BUPRENORPHINE MAINTENANCE TREATMENT
INTAKE HISTORY AND PHYSICAL EXAMINATION FORM

Patients Name: _____ Date: _____

CC: _____

OPIOID ABUSE HISTORY

Opioid of choice: _____ Current # times per day used: _____

Current amount spent per use: _____ Current months of continuous use_____

Months of lifetime use: _____ Late use date/time: _____

Present symptoms: _____

_____

History of drug abuse treatment: _____

_____

MEDICAL HISTORY

Allergies: _____ Current meds: _____

Medical/psychiatric problems: _____

Hospitalization/Surgery: _____

Hepatitis: _____ SBE: _____ HIV: _____ TB: _____ STD: _____

(Women)LMNP: _____ G: _____ P: _____ TAB: _____ SAB: _____ Contraception: _____

ROS: _____

Other Drug abuse history:

Cocaine: _____ Alcohol: _____ Valium/Sedatives: _____

Caffeine: _____ Marijuana: _____ Nicotine/Cigarettes: _____ quit/cut down? _____

Nutrition History: _____

Routine screening history (pap, chol, etc.): _____

_____

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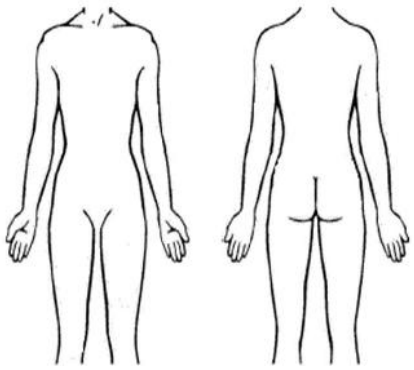
PHYSICAL EXAMINATION (For Provider Use)

T:_____ P: _____ BP: _____ R: _____ WT. _____ Gen. Appearance:

_____

HEENT:	ABD
Thyroid/neck	BACK
Heart	Neuro
Lungs	Extremities.
Chest/breast	Skin
Signs Withdrawal	Sketch of tracks, needle marks and scars:
Pupils Rhinorrhea Lacrimation Perspiration Piloerection Increase Temp Increase BP Tachycardia Vomiting Diarrhea	 

Office based opioid maintenance assessment:

_____ Opioid Dependence

_____Withdrawal: Degree: _____

_____

_____

PLAN:

_____Admit to maintenance treatment, Initial dose order: _____

_____Routine labs; other labs: _____

_____TB test; placed date: _____To be read date: _____

Other TB status checks: _____

_____Drug screen schedule: _____

Next Visit: _____

Counseling Plans: _____

_____

Patient Signature: _____ Date:

Physician's Signature: _____ _____

Name/Practice name: Excel Medical Center
Address: 7515 Stenton Ave
City, State, Zip: Philadelphia PA, 19150
Phone: 267-335-5264
Fax: 267-335-5273

APPOINTED PHARMACY CONSENT

I, _____ do hereby; (MD check all that apply)
Patient name (Print)

☐ Authorize _____ at the above address to disclose my treatment for opioid Dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacies, 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 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 in 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 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	Patient Name (print)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Name (Print)	Date
_____	_____	_____
Witness Signature	Witness Name (print)	Date

Appointed Pharmacy: Name: _____ Phone: _____

Address: _____

CAGE

Name:_____ Date:_____
DOB:_____/_____/_____

Instructions: Place an X on the line indicating the right answer.

	Yes	No
1. Have you ever felt you should cut down on your drinking?	____	____
2. Have People annoyed you by criticizing your drinking?	____	____
3. Have you ever felt bad or guilty about your drinking?	____	____
4. Have you had an eye opener (Alcoholic beverage) first thing in the morning to steady your nerves or get rid of a hangover?	____	____

Name: _____

DOB: _____

Social Needs Screening Tool

PATIENT FORM (short version)

Please answer the following.

HOUSING

1. What is your housing situation today?[1]
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☐ I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[1]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)[1]
   - ☐ Yes, it has kept me from medical appointments or getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[1]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

8. How often does anyone, including family, insult or talk down to you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

9. How often does anyone, including family, threaten you with harm?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

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Striving for a Healthier Community

10. How often does anyone, including family, scream or curse at you?[1]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Fairly often
    - ☐ Frequently

ASSISTANCE

11. Would you like help with any of these needs?
    - ☐ Yes
    - ☐ No

Questions 1-10 are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

REFERENCE:

1. Billioux A, Verlander K, Anthony S, and Alley D. National Academy of Medicine. Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool. National Academies Press. Washington, D.C. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf. Accessed November 14, 2017.

_____

Patient Signature

_____

Provider Signature

EXCEL MEDICAL CENTER, LLC.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ **DOB:** _____

Date of visit: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle answer)	Not at all	Several Days	More than half	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling Down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thought that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add Columns				
			Total Score:	

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	_____ Not difficult _____ Somewhat Difficult _____ Very Difficult _____ Extremely Difficult

**Interpretation of Total Score*

Total Score	Depression Severity
0-4	None
5-9	Mild Depression
10-14	Moderate Depression
15-19	Moderate to severe Depression
20-27	Severe Depression

Signature: _____ **Date:** _____

Circle Credentials: MD, DO, NP, or PA

Providers Name: _____ Health Risk Assessment
Insurance:_____
Patient Name: _____
Patient DOB: _____
Completion Date: _____

General Questions

1. In general, how would you rate your health? _____
2. Do you exercise regularly or take part in a physical exercise program? _____

Your Health

3. Which of the following are you currently receiving treatment for? (Please indicate yes/no for allthat apply)

	Response		Response		Response
Anxiety		Depression		Schizophrenia	
Asthma		Diabetes		Stroke	
Bi-Polar disorder		Hearing problems		None	
Cancer		Heart Failure		Vision Problems	
COPD/emphysema		Hypertension		Other	
Coronary heart disease		Organ transplant			
Dementia		Renal/kidney failure			

4. How often do you take medication? _____
5. Do you find that you sometimes have to choose between buying groceries or medication? _____
6. Have you fallen in the past 6 months ? (A fall is when your body goes to the ground without being pushed.) _____
7. In the past 3 months, how many times did you go to the Emergency Room? _____
8. In the past 6months, how many time have you had unplanned overnight stays in a patient hospital? _____
9. In the past 2 weeks, have you experiences a change in the amount you normally eat, either poor appetite or overeating? _____
10. When was the last time you smoked or used any tobacco products? _____
11. In the past 2 weeks, have you had little interest or pleasure in doing things that you normally like to do? _____
12. In the past 2 weeks, have you been feeling downhearted, depressed or “blue” more than usual? _____

13. Are you using any street drugs or abusing medications? _____
14. Do you drink Alcohol? _____
15. In the past 4 weeks, how much body pain have you had? _____

Do you need help with any of the following?

	Yes/No
16. Standing up from a sitting position?	
18. Walking outside of the house?	
20. Eating a meal?	
22. Bathing?	

	Yes/No		
17. Walking in the house?			
19. Getting dressed?			
21. Using the toilet?			
23. Driving or getting to places?			

24. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? _____

Advanced care planning

25. Do you have a medical Power of Attorney? _____
26. Do you have a living will/Advance directive? _____

About you

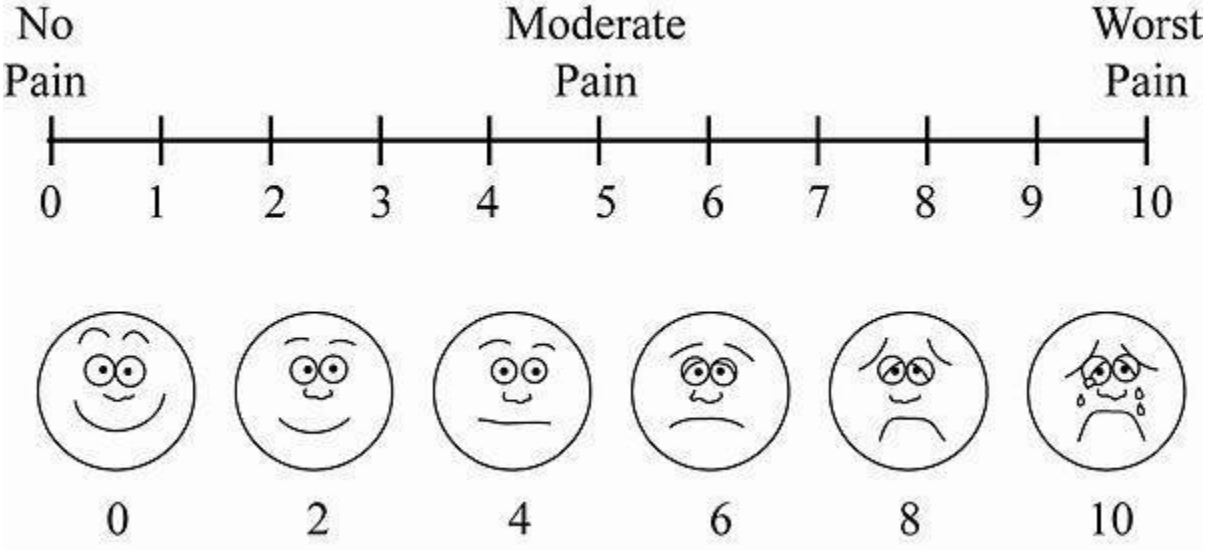
27. Do you live with other family members? _____
28. What is your primary language? _____
29. Do you ever choose not to seek medical care because of religious or personal beliefs?

_____

30. During the past 4 weeks, how has your health impacted your ability to work or caused you to be absent from activities you enjoy? _____

Pain Assessment

Rate your pain on a scale from 0 (no pain) to 10(worse pain imaginable).



EXCEL MEDICAL CENTER, LLC.
Striving for a Healthier Community

TOBACCO SCREENING FORM

Patient Name: _____ Date of Birth: _____/_____/_____
Month Day Year

Date: _____/_____/_____
Month Day Year

Race/Ethnicity: _____ PCP: _____

CO Value _____ PPM _____(date)

□ Initial Screening □ Second Screening □ Follow-up Screening	CO Range: □ Low □ Medium □ High

1. Which statement best describes your current tobacco use? (choose all that apply)
    a. I have never smoked cigarettes. (Mark here if you have only tried smoking) Skip to Question 9
    b. I stopped smoking within the past year – I am not smoking Skip to Question 9
    c. I dip, chew, or use smokeless tobacco.
    d. I smoke e-cigarettes/vapor
    e. I smoke regularly now

Number of cigarettes I smoked yesterday: _____

2. How long have you used tobacco (or nicotine products) recently? _____
3. Are there any changes in your use of tobacco (or nicotine products) recently? □ Yes □ No
4. How soon after you wake up do you usually use tobacco? (choose only one)

□ 5 minutes □ 6 to 30 minutes □ 31 to 59 minutes □ 1 to 2 hours □ Greater than 2 hours

5. How many attempts to quit have you made? _____
6. If you have tried quitting before what worked to help you:
    _____
7. Have you ever tried using nicotine replacement products: □ Yes □ No

If yes, what product(s) _____; how much did you use _____

how long did you use it? _____

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8. How ready do you feel now to quit?

□ Not thinking about it
□ Thinking about it, not ready
□ Ready to quit (if ready, how confident do you feel about your ability to quit on a 1-10 scale with 1 being low) _____

9. How many cigarette smokers live in the same house with you? (choose only one)

   □ None
   □ 1
   □ 2 or more

10. How is a cigarette smoking handled where you live? (choose only one)

    □ No one smokes where I live – they smoke outside
    □ People may only smoke in certain rooms where I live
    □ People may smoke anywhere I live
    □ I do not know
    □ I refuse to say

11. How many of your family and friends are cigarette smokers? (choose only one)

    □ None □ A few □ Some □ Most

BUPRENOPHONE INITIAL VISIT QUESTIONAIRE

Name:_____ Date: _____

1) Have you been taking opioids longer or in higher does than intended?

   YES ☐ NO ☐

2) Do you have a persistent desire, or unsuccessful efforts to cut down or control opioid use?

   YES ☐ NO ☐

3) Are you spending a great deal of time obtaining, using, or recovering from using opioids?

   YES ☐ NO ☐

4) Are you craving opioids?

   YES ☐ NO ☐

5) Do you repeatedly fail to fulfill obligations at work, school, or home due to opioid use?

   YES ☐ NO ☐

6) Do you continue to use opioids even though it causes or exacerbates social or interpersonal problems?

   YES ☐ NO ☐

7) Do you five up or reduce important, occupational, or recreational activities because of opioids use?

   YES ☐ NO ☐

8) Do you repeatedly use opioids in situations which it is physically hazardous?

   YES ☐ NO ☐

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QUALITY CARE

THERAPY PROGRESS REPORT

PATIENT NAME: _____ MEDICAION DOSE: _____MB/DAY DATE:_____

CIRCLE THE ANSWER THAT BEST FITS WAY FEEL NOW

	NOT AT ALL				EXTREMELY
I FEEL ANXIOUS	0	1	2	3	4
I FEEL LIKE YAWNING	0	1	2	3	4
I AM PARSPIRING	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	0	1	2	3	4
APPETITE I AM HAVE DIFFICULTY SLEEPING	0	1	2	3	4
I HAVE A HEADACHE	0	1	2	3	4
MY MUSCLE 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 IS	0	1	2	3	4
DO YOU FEEL YOU NEED A DOSAGE CHANGE?	NO	YES		UP	DOWN
HAVE YOU USED ALCOHOL OR OTHER DRUGS SINCE YOUR	NO	YES			
LAST VISIT? IF "YES" PLEASE DESCRIBE WHAT, WHEN, AND HOW MUCH:					

PLEASE DESCRIBE ANY LIFE CHANGES, TRIGGERS, OR STRESSORS THAT HAVE OCCURRED SINCE YOUR LAST VISITS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

1. LIST YOUR IDEA AND PLAN TO COPE WITH THESE LIFE CHANGES, TRIGGERS, OR STRESSORS:

_____

_____

2. WHAT ARE THE NEW SKILLS YOU LEARNED IN COUNSELING SINCE YOUR LAST APPOINMENT:

_____

_____

3. HAVE YOU APPLIED THESE NEW SKILLS IN YOUR LIFE? IF YES ARE THEY HELPING?:

_____

_____

4. WHAT IS YOUR NEXT SHORT-TERM GOAL?:

_____

_____

COMPLETED BY COUNSELOR

HOW OFTEN HAS THE PATIENT BEEN ATTENDING COUNSELING?:

_____

_____

DESCRIBE PATIENT'S PROGRESS SINCE HIS/HER LAST DOCTOR'S APPOINTMENT:

_____

COUNSELOR SIGNATURE: _____ DATE: _____

TELEPHONE: _____

S/O)

A)	P)

COMPLETED BY PHYSICIAN

OTHER MEDICAL CONDITIONS THAT NEED TREATMENT:

_____

DOSE ADJUSTMENT NECESSARY? __N __ Y NEW DOSE _____

OTHER MEDICATIONS NECESSARY? __N __Y (LIST)

IS THE PATIENT RECEIVING THE PSYCHOSOCIAL SUPPORT CONSIDERED NECESSARY? __N __Y

DO THE BENEFITS OF TREATMENT OUT WEIGHT THE RISKS OF ACCIDENTAL OVERDOSE, MISUSE, AND ABUSE? __N __Y

IS THE PATIENT MAKING ADEQUATE PROGRESS TOWARD TREATMENT GOAL? __N __Y

PHYSICIAN SIGNATURE: _____ DATE: _____