

Buprenorphine Treatment Intake History and Physical

Name: _____ **DOB:** _____ **Date:** _____

Chief Complaint: _____

Opiate use history:

Type of opiates _____ Route _____ Current Amount/Freq _____

Current length of continuous use _____ Yrs/mos of use _____

Present symptoms _____

History of substance use disorder treatment (outpatient/inpatient/residential)

History of: Methadone _____ Naltrexone-XR _____ Buprenorphine _____ Overdose _____

Other drug abuse history:

Cocaine/stimulant: Route: _____ Current amount: _____ Mos/Yrs of Use: _____ Last Use: _____
Complications of Use: _____

Alcohol: Current amount: _____ Mos/Yrs of Use: _____ Last Use: _____
Complications of Use: _____

Benzodiazepines: Route: _____ Current amount: _____ Mos/Yrs of Use: _____ Last Use: _____
Complications of Use: _____

Cannabis: Route: _____ Current amount: _____ Mos/Yrs of Use: _____ Last Use: _____
Complications of Use: _____

Nicotine/cigarettes: Current amount: _____ Pack years _____

Other: _____

Medical history:

Medical/psychiatric problems _____

Hospitalizations/surgeries _____

Psychiatric treatment _____

Allergies _____ Current meds _____

Hepatitis _____ SBE _____ HIV _____ TB _____ STD _____
(women) LMP _____ G _____ P _____ TAB _____ SAB _____ Contraception _____

ROS: _____

Routine screening history (pap, chol, TB, Hep Panel, HIV, ECG, Pregnancy test, etc.):

**Buprenorphine Treatment
Intake History and Physical (continued)**

Physical Examination:

T____ P____ BP_____ R ____ WT_____ HT_____ Gen. Appearance_____

HEENT

Thyroid/neck

Heart

Lungs

Chest/breast

ABD_____

Neuro_____

Extrem_____

Skin_____

Tracks/scars_____

Signs of Opioid Withdrawal:

Time of last use: _____

- | | |
|---|---|
| <input type="checkbox"/> Pupillary dilation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Rhinorrhea | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Lacrimation | <input type="checkbox"/> Myalgia/Joint Pain |
| <input type="checkbox"/> Diaphoresis | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Piloerection | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Increase temp. | <input type="checkbox"/> Yawning |
| <input type="checkbox"/> Increase BP | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Goosebumps |
| <input type="checkbox"/> Vomiting | |

COWS Score_____

Screening Laboratory Results:

Urine Drug Screen Results: _____

Liver function Test Results: _____

Other Labs (CBC, chemistries): _____

Assessment and Plan:

Opioid Use Disorder: mild____ moderate____ severe____ not present____

withdrawal degree: none____ minimal____ moderate____ severe____

Other Diagnoses: _____

**Buprenorphine Treatment
Intake History and Physical (continued)**

Initial Treatment Plan:

Screening for Appropriateness for Buprenorphine Treatment:

Initial Orders:

Laboratory testing:

- CBC
- Chem Panel
- Urine Drug Screen (expanded panel for opioids)
- other: Hepatitis Panel _____ HIV antibody _____ Pregnancy Test (Urine/Serum) _____ ECG _____
- Breathalyzer
- TB test: placed date _____ to be read date _____

Admit to buprenorphine maintenance/medical withdrawal treatment. Induction instructions and treatment contract given to patient.

Induction dose orders: _____

Urine drug screen schedule: _____

Counseling plans: _____

Next visit: _____

Maintenance Buprenorphine/Naloxone Dose: _____

Signed _____ Date _____