



## YOU ARE IN THE RIGHT PLACE.

At Angels of America, our purpose is to deliver the best individualized comprehensive outpatient treatment for drug and alcohol addiction in Columbus, Ohio.

By completing the following forms, you are declaring that you are ready to be free from the challenges, pain and problems that brought you to us. Please answer each form completely and honestly so that we can fully support you with the plan that best serves you without fear of judgment.

This is your time. You deserve the best. Our team is here to be sure you get it.

## LET'S GET STARTED



## **Angels of America New Patient Packet**

### **Buprenorphine/Naloxone Agreement**

*The agreement will (1) define the terms and conditions within the Angels of America doctor-patient relationship, (2) provide basic information about medications you will be taking to manage Opioid Dependence (OD) and (3) review how Angels of America physicians must comply with state and federal regulations when prescribing buprenorphine/naloxone (B/N) using best practices. Our treatment team's goal is to help you have the best quality of life possible given the reality of your clinical condition.*

*The success of your treatment depends on mutual trust and honesty in the physician/patient relationship, following physician orders, and attending required counseling and any other modalities, i.e., psychiatric care, that may be required. It is imperative to read and understand all documents given to you while you are an Angels of America patient.*

#### **WHILE UNDER THE CARE OF ANGELS OF AMERICA (AA/A)PHYSICIANS:**

- 1. I will use only Angels of America physicians to prescribe and monitor B/N and adjunctive medications.** If my primary care physician (PCP) has already prescribed adjunctive medications (muscle relaxants, antidepressants, or other non-narcotics), it is my responsibility to obtain my Primary Care Physician's permission in writing in order to have an AA/A doctor continue these medications.
- 2. I will use one pharmacy to obtain all my prescriptions prescribed.** I will sign a separate pharmacy agreement and it will be added to my chart. I understand that pharmacy is defined as same location; not one chain or string of stores with the same name.
- 3. I have been instructed to attend mandatory substance abuse counseling.** I agree to obtain my initial assessment from my counseling facility ***within the first 4 weeks*** of my first B/N prescription. I will sign an information release form for my ANGELS OF AMERICA physician so s/he can follow this progress.
- 4. I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment.** I understand that my B/N must be approved by my insurance company (if I have/use insurance) before I can fill my prescription. If prior approval/pre-authorization (PA) is not made in a timely fashion, I will either have to personally pay for B/N to take until my next appointment or wait without B/N until my PA has been authorized by my insurance company.
- 5. Prescriptions for B/N or any other prescriptions will be handled only during an office visit.** No refills of any medications will be written or called in during the evening or on weekends. Emergencies will be considered on a case-by-case basis.

Patient Initials: \_\_\_\_\_

*The ANGELS OF AMERICA staff will expedite the PA as quickly as possible. We do not, however, have control over how quickly your insurance company will act, especially if it is Friday afternoon. We try to avoid scheduling new appointments during this time.*

**6. I will bring back any medications prescribed by my physician in their original containers when:**

- *I am requested to do so OR*
- *I voluntarily stop taking my medication for ANY reason*

These medications will be destroyed upon their return after their amounts are reconciled. This destruction will be witnessed by the AA/A staff and I will sign a medication reconciliation form at such time. If I (or anyone else) dispose of my medication(s) I have stopped taking (i.e., flushing them down the toilet) that prevents me from returning my medications to AA/A, I will be immediately discharged from the practice.

**7. I am responsible for keeping my medication in a safe and secure place**, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. Stolen medications should be reported to the police and to my physician immediately. If my medication is lost, misplaced or stolen, your physician will NOT replace them (even if a police report is filed).

**8. I may not give or sell my medications to any other person under any circumstances.** If I do, I may endanger that person's health. Since it is against the law, I will be discharged from A/AA as a patient and reported to the proper authorities.

**9. Any evidence of drug hoarding, obtaining other opioid medication or adjunctive analgesia from other physicians (which include emergency depts.) or other persons, uncontrolled dose escalation or reduction, sale of prescription(s), or failure to follow any of my AA/A agreements will result in termination.**

**10. I will communicate fully to my physician to the best of my ability** at the initial and all follow-up visits my withdrawal symptoms and functional activity along with any side effects of medications. This information allows my physician to adjust my treatment plan accordingly.

**11. I will not use any illicit drugs, such as cocaine, marijuana, etc. while taking my medications.** This will place my treatment in jeopardy. Either a safe discontinuation schedule of my medication will be used or a one-to-four week supply of medicine will be provided until a complete termination of the doctor/patient relationship occurs.

**12. The use of alcohol is also UNACCEPTABLE.** If it is discovered I am using alcohol, my treatment as a B/N patient will be jeopardized. My AA/A physician will determine if I will continue as a patient. This also applies to the use of other drugs mentioned above in number 11.

**13. I agree and understand that my physician will perform urine drug testing at each office visit.** I agree to cooperate in providing a urine sample which includes the possibility of collecting a directly observed specimen. If I do not provide a urine sample, I understand that my doctor will consider this a "positive test" unless an oral drug screen is performed. If not, this may result in complete termination of the doctor/patient relationship. The presence of any unprescribed drug(s) or illicit drug(s) in my urine is grounds for my termination; this is at the discretion of my physician.

**14. There are side effects with B/N therapy** which may include, but is not exclusively limited to, skin rash, itching, constipation, sexual dysfunction, sleeping abnormalities, sweating, and other signs of withdrawal. I understand most side-effects occur during the first week due to the dose of B/N being up-titrated. The likelihood of overdosing with B/N is small; however, there still exists a small overdose danger if I abuse such medications.

Patient Initials: \_\_\_\_\_

- 15. I will inform my physician of all medications I am taking.** This includes herbal remedies, over-the-counter medications, and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.
- 16. I understand that although B/N contains a narcotic, it also contains naloxone which helps prevent the full effect of the opioid component.** While unlikely to cause significant drowsiness which may delay my response/reaction times, I will still exercise care if and when driving or operating any machinery while on B/N, especially if my dose has just been increased.
- 17. If I suddenly stop or decrease the medication, I could have withdrawal symptoms** (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that withdrawal is quite uncomfortable, but not a life-threatening condition.
- 18. If I have a history of alcohol or drug misuse/addiction, I must notify the AA/A physician of such history.**
- 19. I agree to allow my physician to contact anyone:** health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if the physician feels it is necessary.
- 20. I agree to a family conference or a conference with a close friend or significant other if the physician feels it is necessary.**
- 21. I agree to be pregnancy tested should my physician deem this necessary.** I understand that if I am pregnant or become pregnant while taking B/N medications, this will alter my care and I will be referred to another specialist immediately.
- 22. I understand that it is the primary goal of AA/A physicians in using B/N medications is to treat my opioid dependence and NOT necessarily my pain condition (if I have one).**
- 23. My dose will NOT be raised to accommodate pain issues, rather only to augment the suppression of withdrawal signs and symptoms, should they be present.**
- 24. I understand and agree that I MUST have a primary care provider (PCP) while a patient at AA/A Clinic.** If I do not have a PCP, I understand I have 60 days to find AND visit my PCP. If I do not establish a doctor-patient relationship with a PCP within 60 days, I will be discharged as a patient from AA/A.
- 25. I understand I will receive B/N medication at my initial visit as part of an up-titration schedule.** I also understand I may not obtain a dose that I think will be the best for me or a dose that I was getting previously or “off the street”.
- 26. I agree to random pill counts.** It is my responsibility to supply AA/A with functional phone numbers and a correct address where I live so I can be contacted for a pill count. Also, I agree to all conditions related to pill counts at AA/A outlined elsewhere.
- 27. I agree to store my prescribed medication safely** out of sight and reach of all children. Buprenorphine can cause severe, possibly fatal, respiratory depression in children.

Patient Initials: \_\_\_\_\_

***I have read each page of this Buprenorphine/Naloxone agreement and my initials on each page testifies to this. All of my questions have been explained to me. I agree to its terms and conditions fully and I understand that these terms and conditions are set forth in this agreement so that I may be provided a responsible opioid dependence management experience when using B/N therapy to help increase my daily function and to improve my life.***

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

## Pharmacy Agreement

I, \_\_\_\_\_, the undersigned and patient of Angels of America of America (AA/A), have been instructed to use only **ONE pharmacy** while I am under the care of the physicians at AA/A.

**One pharmacy** is defined as *a single location*, not a chain of stores having a pharmacy such as Kroger, Walgreens, or CVS, where multiple locations exist and may be used.

The Pharmacy I will use is: \_\_\_\_\_.

The Address is: \_\_\_\_\_.

The Phone Number is: \_\_\_\_\_.

There may be circumstances when my pharmacy has either run out of my medicine or does not have the strength of medication prescribed by my doctor. ***If this is the case, I will ask the pharmacist to call AA/A and immediately report this problem to uphold the transparency required of me as part of my doctor-patient relationship concerning the prescribing of my medications.*** The pharmacist can then let AA/A staff know if I was sent to another pharmacy for my medicine.

I will be subject to random pill counts where I will receive a call from AA/A and I will be instructed to take my medication(s) I receive from AA/A -that day -to either my selected pharmacy above (preferred), to another pharmacy, or bring them to in to AA/A by the end of business to be counted and reconciled. If I go to a pharmacy, the pharmacist there will call AA/A to disclose the count verbally. If AA/A is closed (after 6pm), I will ask the pharmacist to fax this information to (614) 396-9265 by 10pm (the fax must be time-stamped by 10pm).

If, for any reason, I change my pharmacy indicated on this form, I must inform AA/A of this change as soon as possible (within 72 hrs.) and I am obligated to report the reason I changed my current pharmacy. I accept the responsibility that I may be discharged from care if it is discovered that I have used more than one pharmacy for my medications.

Failure to fulfill any of these conditions above will more than likely result in my discharge from care at AA/A. I understand the above and I am in agreement with the conditions as mentioned. ***I have been given a copy of this agreement for my records and will take this with me when I have a pill count to show the pharmacist I am under this contract.***

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## Adjunctive Medication Agreement

Occasionally, medicines referred to as “adjunctive” are prescribed with primary medications for an additional benefit. However, these are short-term medications and should be discontinued after one month. These medications include benzodiazepines (such as Valium®), the muscle relaxer Soma®, and sleep aid drugs as Ambien®.

AA/A physicians will not be prescribing these agents, even if you previously received adjunctive medicines from other physicians.

There are multiple reasons for this AA/A policy including:

- These medications, in some, can be dangerous when combined with certain opioids, especially buprenorphine.
- These medications should be used short term (1-4 weeks) in acute situations, depending upon what is needed, i.e., muscle relaxer or a sleep aid medicine;
- These medications should only be used long-term by psychiatrists due to their side effect profile and high addiction potential;
- Benzodiazepine can be used for severe anxiety and this diagnosis must be established by a psychiatrist and then these medications can be prescribed by that same doctor who will manage your severe anxiety problem;
- If any of these medicines are being used for sleep, you must be seen by a sleep specialist for an evaluation of why you cannot sleep and what part of your sleep is being affected.

Every patient using these medications is required to have a psychiatrist prescribe these medications if necessary. The medications listed above are NOT allowed in our program. Exceptions will not be considered unless written consent and explanation has been given by the prescribing psychiatrist and/or sleep specialist.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Printed: \_\_\_\_\_

Witness Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Printed: \_\_\_\_\_



## Angels of America of America Initial Visit Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Substance Abuse History:**

I originally started my use of narcotics in (month/year) \_\_\_\_\_ at age \_\_\_\_\_

I started using opioids like oxycodone:  To Get High     To treat pain     After Surgery

Fill out all that apply ((Please write (C) for current and (P) for past))

Substance (C) or (P)	How Used	Amount	Last use
Heroin		Grams/day	
Cocaine		/day	
Opioids		Mg/ Day	
Marijuana		Joints/Day	
Alcohol		Drinks/Day	
Tobacco		Packs/Day	
Other Drugs			

**Substance Abuse Counseling (SAC) History:** (Check what applies)

- I am not attending SAC currently.
- I am trying to set up SAC currently
- I am attending SAC currently at: \_\_\_\_\_
  - I attend \_\_\_\_\_/ week for individual counseling
  - I attend \_\_\_\_\_/week for group counseling
- I have attended SAC in the past. Last attended (mo./yr.): \_\_\_\_\_/\_\_\_\_\_ at \_\_\_\_\_
- I have NEVER attended any kind of SAC

**Have you ever been to Individual Counseling:** ( ) N ( ) Y

If you are not currently in counseling what made you stop attending or to never seek counseling?

\_\_\_\_\_  
\_\_\_\_\_

**Living Arrangements:**

(Circle one)

I live in: An Apartment House Trailer Other \_\_\_\_\_

I live with: Spouse My Children Significant Other Friend Other

I live with "users" currently I do NOT live with "users" currently

**Employment History:**

I am currently working  FT  PT at \_\_\_\_\_.

I am not working now but I will be seeking:  Employment  Disability

I am already disabled due to \_\_\_\_\_.

**PATIENT INTAKE: MEDICAL HISTORY**

(To be completed by patient)

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

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (w) \_\_\_\_\_ (h) \_\_\_\_\_ (c) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Have you ever had an EKG? ( ) N ( ) Y Date: \_\_\_\_\_

Have you ever had **surgery** or been **hospitalized**? ( ) N ( ) Y (please describe) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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 seizures 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):

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

Is there a family history of anything NOT listed here?  N  Y (please explain)\_\_\_\_\_

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**Childhood Illnesses**

Measles  N  Y                      Mumps  N  Y                      Chicken Pox  N  Y

Have you or a family member even been diagnosed with psychiatric or mental illness?  N  Y

(Please describe) \_\_\_\_\_

Have you ever taken or been prescribed antidepressants?  N  Y

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):

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Please list all herbal medications, vitamin supplements, etc. and how often you take them:

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Please list any allergies you have (e.g., penicillin, bees, and/or peanuts):

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**PATIENT INTAKE: SOCIAL/FAMILY HISTORY**

(To be completed by patient)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Years married/ in long-term relationship: \_\_\_\_\_ Times Married: \_\_\_\_\_ Times Divorced: \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

Where are you currently living?

\_\_\_\_\_

Do you have family nearby? ( ) N ( ) Y (please describe)

\_\_\_\_\_

Education (check most recent degree):

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

( ) High School Grade \_\_\_\_\_

Are you currently employed? ( ) N ( ) Y 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 ( ) Y (Check all that apply)

( ) DWI ( ) Drug-related ( ) Domestic violence ( ) other \_\_\_\_\_

Have you ever been abused? ( ) N ( ) Y

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

Please explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_