ELITE METHADONE CLINIC

PATIENT DATA

Date: _____

A. Patient Information

Name: _____ AKA/Pronouns _____

Address: _____ City & Zip_____

Cell Phone #: _____ Other Phone #: _____

Email: _____

Date of Birth: _____ Social Security #: _____ DL#: _____

Sex: ☐ M ☐ F ☐ Other _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Pregnant: ☐Yes ☐No ☐N/A

Ethnicity: ☐ Caucasian ☐African American/Black ☐Hispanic/Latino_____

☐Native American ☐Asian ☐Bi-racial ☐Other _____

Sexual Orientation: ☐ Heterosexual ☐Homosexual ☐ Bisexual ☐Other_____

Marital Status: ☐Married ☐ Single ☐Divorced ☐Widowed

Employment: ☐Employed FT ☐Employed PT ☐ Unemployed ☐Disabled ☐Retired

☐Homemaker ☐Student

Veteran: ☐Yes ☐No ☐Family of Veteran

B. Insurance information

Insurance: _____

Insurance ID #: _____

C. Emergency Contact

In case of emergency, notify: _____

Relation: _____

Phone #: _____

How did you hear about us? ☐Current Client ☐ Radio ☐ Elite Website ☐Billboard ☐ Google

Label Here:

☐ Other: _____

SUBSTANCE USE QUESTIONNAIRE

Please check all the substances you are currently using or have a recent addiction problem with:

☐ Heroin ☐Fentanyl or Fentanyl-mixed drug ☐Other opiate _____

☐Alcohol ☐Cannabis ☐Methamphetamine ☐Cocaine ☐Benzodiazepines

☐ MDMA/Ecstasy ☐Other Substance: _____

Tell us about your drug use:

1. **Drug:** _____Amount: _____ ☐daily ☐weekly ☐monthly

   Method: ☐Smoke ☐IV ☐Inhalation (Snort) ☐Oral

   Length of use: _____ ☐ months ☐years

2. **Drug:** _____Amount: _____ ☐daily ☐weekly ☐monthly

   Method: ☐Smoke ☐IV ☐Inhalation (Snort) ☐Oral

   Length of use: _____ ☐ months ☐years

3. **Drug:** _____Amount: _____ ☐daily ☐weekly ☐monthly

   Method: ☐Smoke ☐IV ☐Inhalation (Snort) ☐Oral

   Length of use: _____ ☐ months ☐years

TB Questionnaire:

Answer Yes or No honestly

		Yes	No
I.	Do you have a cough that has lasted longer than 2 weeks?	☐	☐
II.	Do you have a cough with phlegm (white or clear mucus)?	☐	☐
III.	Do you have a cough with blood?	☐	☐
IV.	Have you ever taken medicine for Tuberculosis?	☐	☐

V. Did you complete the treatment for TB?

Label Here:

Label Here:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	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. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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 at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. 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 at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

ELITE METHADONE CLINIC

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Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Which recreational drugs have you used in the past year? (Check all that apply)

- ☐ methamphetamines (speed, crystal)
- ☐ cocaine
- ☐ cannabis (marijuana, pot)
- ☐ narcotics (heroin, oxycodone, methadone, etc.)
- ☐ inhalants (paint thinner, aerosol, glue)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ tranquilizers (valium)
- ☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse (use) more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Do you inject drugs? No ☐ Yes ☐

Have you ever been in treatment for a drug problem? No ☐ Yes ☐

I	II	III	IV
0	1-2	3-5	6

Date:_____ Patient Name:_____

Patient's Name: _____ Patient's ID# _____

Elite Methadone Clinic offers a program to all patients with one complex chronic condition that places the patient at significant risk for severe complications such as hospitalization or functional decline. The goal is to make sure you receive the best care possible from everyone that is involved with your care. Through principal care management Elite Methadone Clinic can offer the following services such as coordinating your visits with other doctors, facilities, lab, radiology, or other testing. We can talk to you on the phone about your symptoms, assist in medications, and provide you with a comprehensive care plan. These services are in addition to an office visit and can also be billed if service is provided on a non-face to face encounter.

We will continue to comply with all laws related to the privacy and security of your health information. Principal care management service will be billed to your insurance once a month You have the right to discontinue this service at any time for any reason however your signature is required to end your principal care management services.

Our goal at Elite Methadone Clinic is to offer you the best care possible, minimize your chances for unnecessary doctor's visits, emergency room visits, and hospitalizations. We know your time and health are important, so by signing below you agree to be part of our principal care management program.

Patient Signature: _____ Date_____

Date:_____ Patient Name:_____ ID#:_____

Patient DOB:_____ Aliases:_____

Label Here:

I, _____ authorize Elite Methadone Clinic and OTP clinics listed below to disclose and exchange information about my current enrollment status for opiate use disorder (OUD) treatment. This program is required by state statute NMAC 7.32.8 to contact other OTP Methadone Clinics withing a 50-mile radius, upon admission, to verify no chance of dual enrollment in methadone programs. Elite Methadone may contact these same OTP at various points throughout treatment to ensure dual enrollment has not occurred.

Information provided shall include date of last dose, name of medication, and other dosage information, if applicable. The purpose of this disclosure is to continue verification of single program enrollment.

I understand that my OUD records are protected under Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance herein.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state and federal law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Patient Signature:_____ Date:_____

Staff Signature:_____ Date:_____

PLEASE COMPLETE AND FAX OR EMAIL BACK (575-215-3427)

Name of staff completing	Clinic Name	Fax Number	Phone Number	Enrolled
	MedMark Tx Center	915-772-7275	915-772-2045	Y / N
	Aliviane, Inc.	915-779-3511	915-779-4527	Y / N
				Y / N

If enrolled please provide: Date of last methadone dose:_____

Label Here:

Amount:_____mg