Recovery Mobile Clinic
REDEEM. MOTIVATE. COMMIT.

Substance Abuse Medication Assisted Treatment (SAMAT) Program

Substance	Last 24 hours	Last 3 months	Last 6 months	Last 12 months
Cannabis (marijuana)				
Heroin (opiate, fentanyl)				
Prescription opiates (Norco, oxycontin, Percocet, Roxinol, Morphine, Dilaudid, Fentanyl, buprenorphine)				
Cocaine (crack, coke, ect)				
Prescription Stimulants (Ritalin, Adderall, Concerta, Vyvanse, Adipex, ect)				
Methamphetamine				
Sedatives (Xanax, valium, Ativan, Soma, Librium)				
Hallucinogens (LSD, mushrooms, ecstasy, acid, special K)				
Alcohol				
Other _____				

Has use of substances caused social, legal, personal or financial problems?

_____

_____

Have you failed to do what was normally expected of you because of your use of drugs?

_____

_____

Has a friend, relative or significant other ever expressed concern of your substance use?

_____

_____

Have you ever tried and failed to cut down, or stop using? Have you ever been in a Medication assisted treatment program previously? (Suboxone, buprenorphine, Vivitrol, naltrexone)

_____

_____

Have you ever used intravenously (IV)? If yes, when was your last blood test for HEP C, A, B and HIV?

_____

_____

Vivitrol Therapy Consent Form

I, _____, do hereby voluntarily apply and consent to participate in the Substance Abuse Medication Assisted therapy (SAMAT) Program offered by the Recovery Mobile Clinic. I am requesting Vivitrol (Naltrexone extended release injection) therapy as a treatment for alcohol and/or opiate dependence. I understand that, as far as possible, precautions will be taken to prevent any complications or ill effects on my health. I further understand that it is my responsibility to tell the medical provider in the program as much as I can about my current health status. It is my responsibility to seek medical attention immediately if any drug reaction occurs to Vivitrol or if any changes occur in my health status.

I, _____, agree to treatment with Vivitrol. I understand that Vivitrol is an intramuscular injectable medication and needs to be given in the gluteal muscle. Recovery Mobile Clinic has explained the potential risks and side effects, including but not limited to pain at the injection site, unintended precipitation of opioid withdrawal, insomnia, nausea, vomiting, abdominal pain, dry mouth, local site reaction such as redness/rash and muscle cramps with more serious but rare occurrences including abscess formation at the injection site which may need further attention, serious allergic reaction, eosinophilic pneumonia, depression, and suicidality.

Vivitrol and Alcohol Dependence

I, _____, understand that although I am receiving Vivitrol for Alcohol dependence, I am still subject to consequences of alcohol impairment. If I choose to consume alcohol while on Vivitrol, consequences including, but not limited to, alcohol poisoning, slurred speech, drowsiness, distorted vision/hearing, cognitive function impairment, DUI, impaired gait and others are still applicable while receiving Vivitrol/Naltrexone. I have discussed any questions I may have and fully understand the use of Vivitrol for my alcohol/opioid dependence.

As a participant, I freely and voluntarily, agree to adhere to the treatment protocol as follows by initiating and signing below:

_____I understand that the medication (Vivitrol) alone is not sufficient treatment for managing my substance dependence. I agree to participate in an outpatient therapy program.

_____I agree to keep, and be on time, for my appointments at the Recovery Mobile Clinic. If I cannot keep the appointment, I will call at least 24 hours ahead of time to reschedule.

_____I agree to a Urine drug screen (UDS) prior to every Vivitrol injection. I also agree to any fees associated with the Urine drug screen testing.

_____I understand that any positive results on my urine toxicology will result in not receiving my Vivitrol injection.

_____I agree to have a serum blood screen performed within 2 months of initiating the Vivitrol treatment. I also agree to pay any and all costs accrued associated with the blood testing.

_____I understand that Vivitrol is safe and well tolerated in recommended doses, but it may cause liver injury when taken in excess or in people who develop liver diseases or other causes.

_____I understand that I must inform any medical provider treating me that I am receiving Vivitrol therapy.

_____I attest that I am not using opiates at this time and understand that I cannot use opiates within 5-10 days of Naltrexone/Vivitrol.

_____I understand that I should not take Vivitrol if I am pregnant, or plan to become pregnant. It is not known how Vivitrol will affect the baby.

_____I understand that Recovery Mobile Clinic may terminate my therapy at any time if I do not comply with the treatment guidelines.

_____I understand that it is my responsibility to maintain active health insurance coverage, so that I do not have any difficulty receiving Vivitrol injections.

_____I understand that a positive urine drug screen for alcohol/and or opiates, such as heroin, methadone or Suboxone, may result in termination of Vivitrol therapy, because if these drugs are taken, may cause a serious precipitated withdrawal reaction. This reaction can be lethal.

_____I understand and agree that violation of any of the above conditions is grounds for termination from the Vivitrol program.

_____I have received verbal/written information and understand the indications, contraindications, warnings, precautions and adverse reactions pertaining to Vivitrol injections.

INDICATIONS

For the prevention of relapse to opiate/alcohol dependence, following opiate/alcohol detoxification.

As part of a comprehensive management program that includes psychological support.

Contraindications

- Patients receiving opiate analgesics.
- Patients who have failed the naltrexone tolerance test
- Patients in acute opiate withdrawal
- Patients with a positive Urine Drug screen (UDS)
- Patients with an allergy to Naltrexone
- Patients with acute hepatitis
- Patients with severe renal impairment (GFR <50)
- Abnormal LFT >3x the Normal levels
- Pregnancy or breastfeeding

WARNINGS AND PRECAUTIONS

Vulnerability to opiate overdose: following VIVITROL treatment opiate tolerance is reduced from pretreatment baseline, and patients are vulnerable to potentially fatal overdose at the end of a dosing interval, after missing a dose, or after discontinuing VIVITROL, treatment. Attempts to overcome a blockade may result in a fatal overdose.

1. Injection site reactions: In some cases, injection site reactions may be severe. Some cases of injection site reactions may be severe and can possibly require surgical intervention.
2. Precipitation of opiate withdrawal: Opiate dependent and opiate using patients, including those being treated for Alcohol dependence, should be opiate free before starting VIVITROL treatment and should notify healthcare providers of any recent opiate use. An

opiate free duration of 7-10 days is recommended by Vivitrol and will be modified to 5 days with the provision of a naltrexone (Revia) tolerance test in office. This is required to prevent a precipitation of opiate withdrawal that is severe and may warrant hospitalization.

3. Hepatotoxicity: Cases of Hepatitis and clinically significant Liver dysfunction were observed with use of Vivitrol treatment during the clinical trial and in the post marketing period. Discontinuation of Vivitrol will be recommended in the presence of acute hepatitis symptoms.
4. Depression and suicidality: Monitor patients for risk of depression and suicidal thoughts.
5. When reversal of VIVITROL blockade is required, for ACUTE PAIN MANAGEMENT, In an emergency situation in patients receiving Vivitrol, suggestions for pain management include regional anesthesia, and use of non-opiate analgesics.

ADVERSE REACTIONS

1. The adverse reactions most frequently seen in association with VIVITROL Opiate -treatment were: hepatic enzyme abnormalities, injection site pain, nasopharyngitis (cold symptoms), insomnia and toothache.
2. The adverse reactions most frequently seen in association with VIVITROL Alcohol-treatment were: nausea/vomiting, injection site pain (induration, pruritus, nodules and swelling), muscle cramps, dizziness/syncope, somnolence or sedation, anorexia, decreased appetite or other appetite disorders.
3. To report a suspected adverse reaction, contact Alkermes, inc at 1-800-Vivitrol (1-800-848-4876) and/or email: usmedinfo@alkermes.com or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

DRUG INTERACTIONS

Naltrexone antagonizes the effects of the opiate -containing medications, such as cough and cold remedies, antidiarrheal remedies and opiate analgesics.

WARNING

IF I ATTEMPT TO USE LARGE DOSES OF ALCOHOL, HEROIN, OR ANY OTHER NARCOTIC WHILE ON VIVITROL, I MAY DIE OR SUSTAIN SERIOUS INJURY INCLUDING, BUT NOT LIMITED TO, COMA.

_____ _____

Patient Signature Date

I, the undersigned, have defined and fully explained the above information to this individual.

_____ _____

Medical Provider Signature Date

Nursing staff to review this informed consent again prior to administering the first dose.

_____ _____

Provider Signature **Date**

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Dear Valued Patient,

For any patient who has a total of three no-shows/cancellations, Recovery Mobile Clinic will consider this a breach of the patient contract and consider the patient to have abandoned treatment. In this event, Recovery Mobile Clinic will call in a two-week script of oral naltrexone, and attempt to help facilitate placement in another Vivitrol provider program. We will recommend that you follow up for treatment with your Primary care provider and utilize the Vivitrol provider locator to find another provider. The Recovery Mobile Clinic will inform the patient of other resources that Recovery Mobile clinic is aware of in their specific community that they may contact as well.

Print Patient Name: _____

Patient Signature: _____Date: ___ / ___ / ___

Policies Regarding Discharge from Treatment

Recovery Mobile Clinic strives to provide compassionate care for our patients. In the interest of ensuring that our patients receive appropriate care from Recovery Mobile Clinic, there are guidelines that the patient must adhere to, or be immediately discharged from treatment.

_____Any threat or act of violence (including verbal) towards staff or other patients will be a cause for immediate discharge.

_____Any submission of urine specimen that is not your own or altered in any way is a cause for immediate discharge.

_____In the event the urine specimen is not the appropriate temperature at time of submission, the patient agrees to resubmit a specimen with the supervision of Recovery Mobile clinic staff. If the patient refuses, Recovery Mobile Clinic will consider the first specimen altered and the patient will be discharged.

_____If patient is unable to test urine for any reason, an oral swab will be administered. The Vivitrol injection will NOT be provided after an oral Swab. The patient will be provided a 1-week Supply of Oral Naltrexone (Revia) and an appointment for an injection will be rescheduled for 1-week. The patient WILL be required to give a UDS sample again prior to Vivitrol injection in a week. The patient WILL be financially responsible for all costs incurred.

_____Discontinuing recommended Behavioral Health treatment as required by a patient's insurance coverage will be a cause for discharge.

_____A PATIENT WHO HAD THREE POSITIVE URINE DRUG SCREENS DURING THEIR TREATMENT TO BE AN INAPPROPRIATE CANDIDATE FOR CONTINUED TREATMENT ON VIVITROL/NALTREXONE. PATIENTS WILL BE CONSIDERED HIGH RISK FOR OVERDOSE/DEATH AND WILL BE REFERRED OUT TO ALTERNATIVE TREATMENT.

By signing this agreement, the patient agrees that they understand the practices and policies regarding discharge from treatment as well as side effects and potential risks from the treatment of Vivitrol/Naltrexone. All questions have been asked and answered by the staff of Frenchtown Urgent Care.

Patient Signature: _____

Date: _____/_____/_____

Recovery Mobile Clinic Staff Signature: _____

Date: _____/_____/_____

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Medical Information Release Form

(HIPAA Release Form)

Patient's Name: _____ Date of Birth: ____/____/_____

Social Security Number: _____-_____-_____

Address:

_____

City: _____ State: _____ Zip Code: _____

Phone Number (Home/cell) _____

Email _____

Consent to Deliver Appointment Reminders by (circle all that apply): 1. Voicemail 2. Email or 3. Text

Contact in case of Emergency/relationship:

_____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and information of claims. This information may be released to:

Name/relationship/contact information

_____

_____

RELEASE OF INFORMATION FOR MEDICAL ENTITIES

Behavioral Health: _____Phone Number: _____-_____-_____

Caseworker: _____Phone Number _____-_____-_____

Drug/Alcohol group: _____ Phone Number: _____-_____-_____

RELEASE OF INFORMATION FOR PROBATION/PAROLE

Probation/Parole Officer: _____

County: _____ Drug Court Liaison: _____

PRIMARY Insurance Company:

_____

Medicaid Medicare Commercial Other _____

Policy Holder Name: _____

Relationship to Policy Holder (other than self) _____

POLICY NUMBER: _____GROUP NUMBER: _____

Phone Number (Listed on Back of Card) _____-_____-_____

SECONDARY Insurance Company:

_____

Policy Number: _____ GROUP NUMBER: _____

Assignment of benefits: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical and private insurance and any other health plans to Frenchtown Urgent Care. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Patient Signature: _____

Date: _____/_____/_____

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Patient Medical History

Patient Name: _____ Date of Birth: _____/_____/_____

Primary Medical History:

_____

_____

Known Medical History

Hepatitis A Yes No

Hepatitis B Yes No

Hepatitis C Yes No

Elevated Liver Enzymes Yes No

HIV and/or AIDS Yes No

Allergies: _____

_____

Medications:

_____

_____

_____

Recent Hospitalizations: _____

_____

Primary Care provider _____

Phone number _____ Fax number _____

Clinic address_____

Counselor _____

Phone number _____ Fax Number _____

Patient Signature: _____ Date: _____/_____/_____

Staff Signature: _____ Date: _____/_____/_____

Vivitrol Supplemental Form

Date: _____

Participant name: _____ DOB: _____

Coordinator Name: _____ phone/fax: _____

Location First Injection: _____

Provider of First Injection: _____

Last dose of Oral naltrexone/Revia _____

Date of last Vivitrol Injection _____

Date of last substance abuse: _____

Pharmacy Information: _____

Notes:

_____

_____

_____

_____

_____

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HIPAA Authorization Form

Recovery Mobile Clinic has taken measures to protect all of our patients' private medical information. We will **NOT** release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy & Accountability Act) does allow us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment, your insurance company when trying to get your claims paid, your pharmacy or hospital. Please see the receptionist with any questions prior to signing this authorization form.

I, _____, am authorizing the person/people listed below to obtain medical information about myself. I understand that Recovery Mobile Clinic is not responsible for the information provided as long as it is given to a person that I have listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name:_____ Date of Birth: _____
Name:_____ Date of Birth: _____
Name:_____ Date of Birth: _____
Patient Signature:_____ Date: _____
****

I, _____, do not authorize Recovery Mobile Clinic to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient Signature:_____Date:_____

Consent to Use & Disclosure of Protected Health Information (HIPAA) Your protected health information will be used by Recovery Mobile Clinic or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. You may also request a copy of the Notice of Privacy Practices for your own records.

Recovery Mobile Clinic may or may not agree to restrict the use or disclosure of your protected health information. If Recovery Mobile Clinic agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards. You may revoke this consent to the use and disclosure of your protected health information. You must revoke consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Recovery Mobile Clinic reserves the right to modify the Privacy Practices outlined in the notice. I have reviewed this consent form & give my permission to Recovery Mobile Clinic to Use & Disclose my health information in accordance of the Federal Privacy Standards.

Patient Name (Printed) _____

Signature of Patient _____ Date: _____