PCSS MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Buprenorphine/Naloxone Maintenance Treatment
Intake Questionnaire for Patient Treatment-Planning Questions

Name:_____ **Date:**_____

Please answer the following questions which will help us design your plan of treatment:

What is the best time of day and day of week for you for clinic visits?

_____

Are there any months of the year when you may have difficulty making it in for appointments?

_____

Is there any problem that makes it hard for you to give routine urine specimens?

_____

Do you have any disabilities that make it hard for you to read labels or count pills?

_____

What are your reasons for being interested in Buprenorphine/Naloxone treatment?

_____

_____

_____

What "triggers" do you know which have put you in danger or relapse in the past or which might in the future?

_____

_____

_____

What coping methods have you developed to deal with these triggers to relapse?

What plans do you have for the coming year?

Work?

Home?

Other?

What kinds of help would you like from your counselor?

What are your strengths and skills to handle take-home Buprenorphine/Naloxone (Suboxone)?

What worries do you have about extended take homes?

Is anyone in your home actively addicted to drugs or alcohol?

What are the major sources of stress in your life?

What family or significant others will be supportive to you during your treatment?

Would you be willing to sign a release so that the person(s) identified above can be spoken to regarding your treatment?

What medical care will you have in the coming year?

How will you comply with the annual physical examination and laboratory and urine testing requirements?

Have you ever been treated for a psychiatric problem or mental illness or prescribed psychiatric medications?
