SERENITY HEALTH

Medication Management Intake

Patient Intake Information:

Patient Name: _____ Date: ___/___/_____ Primary Dr.: _____
Patient SSN: _____ DOB: ___/___/_____ Age: _____ Gender: _____
Martial Status: Single Married Divorced Separated Widowed Domestic Partner
Street Address: _____ City:_____ State/Zip:_____
Home Phone: ____-____-_____ Cell Phone: ____-____-_____
Employer: _____ Occupation: _____

Insurance Information:

Primary Insurance: _____ ID Number: _____
Name on Card: _____
Secondary Insurance: _____ ID Number: _____
Name on Card: _____

Responsible Party:

ONLY COMPLETE THIS SECTION IF YOU ARRE THE PARENT AND/OR GUARDIAN OF THE INDIVIDUAL BEING SEEN BY THE DOCTOR

Name: _____ DOB: ___/___/_____ Age: _____ SSN: _____
Gender: _____
Martial Status: □ Single □ Married□ Divorced □ Separated □ Widowed □ Domestic Partner
Street Address: _____ City:_____ State/Zip:_____
Home Phone: ____-____-_____ Cell Phone: ____-____-_____
Employer: _____ Occupation: _____

I, the undersigned, have insurance coverage with _____ and hereby assign directly to the assigned doctor and/or Serenity Mental Health, all medical benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charged not paid by the insurance.
I acknowledge that the assigned doctor has a zero-tolerance for No-call/No-show. I understand that consistent No-call/No-shows may result termination of services.
I hereby authorize the assigned doctor and/or Serenity Mental Health to release all the necessary information to secure the payment of benefits.
I authorize the use of this signature on all my insurance submissions.

_____ _____ ___/___/_____
Name Signature Date

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Does the patient have any of the following heath problems?

☐ Diabetes ☐ Stroke ☐ High Blood Pressure ☐ Allergies ☐ Cancer
☐ HIV/AIDS ☐ Heart Disease ☐ Tuberculosis ☐ Kidney Disease
☐ Other: (please specify)

_____

Patient Medications:

Please list ANY/ALL medications, vitamins, herbs or supplements the patient is currently taking. Please include the dosages and frequency of all medications, vitamins, herbs and supplements being taken by the patient.

_____

_____

_____

Please list any CHRONIC conditions. (Chronic conditions NEVER go away.)

_____

_____

_____

Please list any psychotropic medications taken in the past and the reason why they are no longer taken.

_____

_____

_____

Pharmacy Agreement

I, _____ hereby agree to adhere to the following terms:
I will only use one pharmacy to fill/obtain my medication(s). My doctor may talk with the pharmacist about my medication(s) if necessary; I also understand that while I am taking medication, I may be asked to complete a consent for release of information if my provider needs to contact other providers regarding my care and/or use of this medication.
I will inform my provider's office of any changes to my pharmacy, prescriptions from other doctors, or if receive controlled medications from other doctors (for example: a dentist, emergency room provider, etc.). I understand that if this occurs, I must bring this medicine to the office in its original bottle, even if there are no pills/capsules left.

I understand that if I break any of these rules, or my provider decides that this medication(s) is hurting me more than helping me, this medication(s) may be stopped by my provider(s) in a safe way.

I have talked about this agreement with my provider or medical staff and I understand the above rules.

_____ _____ ___/___/_____
Name Signature Date

Preferred Pharmacy

Name: _____ Phone: ____-____-_____
Street Address: _____ City: _____ State/Zip:_____

Controlled Medication Patient Agreement:

The use of controlled substances i. e. Xanax, Valium, Klonipin, and other benzodiazepines may cause addiction and may be one part of the treatments for anxiety and panic disorders.
If my treatment plan includes controlled substance the goals of these medications are:

- To improve my ability to work and function at home.
- To help my symptoms of anxiety and panic as much as possible without causing dangerous side effects. I have been told that:
    - If I drink alcohol or use street/recreational drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
    - I may get addicted to this medicine.
    - If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
    - If I need to stop this medication, I must do so slowly, or I may get very sick.

  I agree to the following:
- I am responsible for my medications. I will not share, sell, or trade my medicine. I will not take anyone else's medications.
- I will not increase my medication until I speak with my provider or the clinic nurse.
- I will keep all appointments set up by my providers (such as: primary care, pain management, mental health, physical therapy or substance abuse treatments)
- I will bring the pill bottles with any remaining pulls of this medicine to each clinic visit.
- I agree to give a blood or urine sample, if asked, to test for drug abuse. Refills will only be made at in person/telemedicine follow up appointments during regular office hours, at the provider's discretion. No refills will be authorized after business hours or on holidays. **I must make an appointment to see our providers for any refills of controlled medications. No exceptions will be made.**

_____ _____ ___/___/_____
Name Signature Date

Injectable Medication Patient Agreement

An injection is a way of administering a sterile liquid form of medication into tissues of the body that meet the skin, usually using a sharp, hollow needle or tube. Injections are usually used for drugs which need to act

quickly or do not absorb well in the digestive symptom. Some medications can be given as long-acting injections, known as depot injections which is a slow-release medication and is steadily absorbed into the body over several weeks or even months.

In the event that my medical provider suggests an injectable medication as a part of my treatment plan, I understand that the use of an injectable medication is voluntary and that my treatment plan will be left to discretion of myself and my provider.
If myself and my medical provider determine that an injectable medication is appropriate for my treatment plan, I understand I will be required to complete an additional injection consent form, and hereby agree to follow all recommendations for appropriate dosage, administration, and maintenance.

_____ _____ ___/___/_____
Name Signature Date

Lab Work Requirements & Patient Agreement

We pride ourselves at Serenity in providing the safest environment for our patients. Part of your treatment plan might include routine lab work. Usually, we will ask you to have your lab work done at a Serenity contracted lab or we occasionally will accept lab work sent to us by your PCP or specialist.

What is the importance of assessing laboratory values when prescribing medications?

Laboratory monitoring helps ensure safe and effective medication therapy, especially for medications with increased risk of drug-induced toxicity. Indeed, many potential problems are readily detectable and preventable by common laboratory assessment. Please join us in taking charge in your own patient safety and best outcome for your recommended treatment here at Serenity.

By signing below, I hereby certify that I understand and agree to comply with Serenity's routine lab work requirements to remain compliant with medication management policies.

_____ _____ ___/___/_____
Name Signature Date

Proper Use of the Controlled Substance

_____ My practitioner has discussed how to effectively use the controlled substance that is being prescribed and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner.

_____ I have discussed my treatment plan with my practitioner, and I have a good understanding of the overall treatment plan and goals of treatment. A main goal of treatment is to use the minimum amount of controlled substances to increase function.

_____ I understand my practitioner's protocol for addressing any request for refills, if my treatment for pain with the controlled substance goes beyond thirty (30) days.

_____ I understand I will be required to sign and comply with a prescription medication agreement. If treatment exceeds ninety (90) days, I realize that I will be required by Nevada law to complete further assessment regarding my risk of abuse, misuse, or diversion of the controlled substance.

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Safe Storage and Disposal of a Controlled Substance

_____ It is my responsibility to store and dispose of controlled substances in the appropriate manner. I will store controlled substances in a secure place and out of reach of children and other family members. To safely dispose of unused medications, I may return the medications to a local pharmacy, a local police station, a "drug-take back day" station, or I may safely dispose of them by dissolving them in a "Dettera" bag, which may be available for purchase at a pharmacy.

For Women in the Age Between 15 and 45

_____ It is my responsibility to tell my practitioner if I am, or have reason to believe that I am pregnant, or if I am thinking about getting pregnant during the course of my treatment with controlled substances, are there is risk to a fetus of exposure to controlled substances during pregnancy, including the risk of fetal dependency on the controlled substance and neonatal abstinence syndrome (withdrawal).

If the Controlled Substance Is an Opioid

_____ Due to the risk of possible fatal overdose resulting from the use of controlled substances, the opioid overdose antidote naloxone is available ·without a prescription at a Nevada pharmacy, I understand I can obtain this medication from a pharmacist at any time.

_____ In addition to all of the above, there are increased risks that the minor may abuse or misuse the controlled substance or divert the controlled substance for use by another person. I have been informed about ways to detect such abuse, misuse, or diversion.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I provide consent for the prescription of controlled substances for the treatment of pain.

_____ _____ ___/___/_____

Name Signature Date

For minor, or for a legal guardian:

_____ _____ ___/___/_____

Name Signature Date

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Current Opioid Misuse Measure (COMM)

The Current Opioid Misuse Measure (COMM) is a brief patient self-assessment to monitor chronic pain patient opioid therapy. The COMM was developed with guidance from a group of pain and addiction experts and input from pain management clinicians in the field. Experts and providers identified six key issues to determine if patients already on long term opioid treatment are exhibiting aberrant medication-related behaviors:

- Signs & Symptoms of intoxication
- Emotional Volatility
- Evidence of Poor Response to Medications
- Addiction
- Healthcare Use, Patterns
- Problematic Medication Behavior

The COMM will help clinicians identify whether a patient, currently on long-term opioid therapy, may be exhibiting aberrant
behavior associated with misuse of opioid medications. In contrast, the Screener and Opioid Assessment for Patient with Pain (SOAPP) is intended to predict which patients, being considered for long-term opioid therapy, may exhibit aberrant behaviors in the future. Since the COMM: examines concurrent misuse, it is ideal for helping clinicians monitor patient's aberrant medication-related behaviors over the course of treatment. The COMM is:

- A quick and easy to administer patient-self assessment
- 17 items
- Simple to score
- Completes in less than 10 minutes
- Validated with a group of approximately 500 chronic pain patients on opioid therapy
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinics.
- The COMM is for clinician use only. The toll is not meant for commercial distribution.
- The COMM is not a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with COMM scores to decide if and when modifications to a particular patient's treatment plan is needed.
- It is important to remember that all chronic pain patients deserve treatment for their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

Please Answer the questions using the following scale:	Never (0)	Seldom (1)	Sometimes (2)	Often (3)	Very Often (4)
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?					
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments).					
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e. another doctor, the Emergency Room, friends, street sources).					
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed.					

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5. In the past 30 days, how often have you seriously thought about hurting yourself?					
6. In the past 30 days, how much of your time was spent thinking about opioid medications? (having enough, taking them, dosing schedule, etc.)					
7. In the past 30 days, how often have you been in an argument?					
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?					
9. In the past 30 days, how often have you needed to take pain medication belonging to someone else?					
10. In the past 30 days, how often have you been worried about how you're handling your medications?					
11. In the past 30 days, how often have others been worried about how you're handling your medications?					
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?					
13. In the past 30 days, how often have you gotten angry with people?					
14. In the past 30 days, how often have you had to take more of your medications than prescribed?					
15. In the past 30 days, how often have you borrowed pain medication from someone else?					
16. In the past 30 days, how often have you used your pain medicine for medicine for symptoms other for pain? (e.g., to help you sleep, improve your mood, or relieve stress.					
17. In the past 30 days, how often have you had to visit the Emergency room?					

Scoring Instructions for the COMM

To score the COMM, simply add the rating of all the questions. A score of 9 or higher is considered a positive.

Sum of Questions	COMM Indication
Greater than or = 9	+
Less Than 9	-

As for any scale, the results depend on what cut off score is chosen. A score that is sensitive in detecting patients who are abusing or misusing their opioid medication v.7lll necessarily include a number of patients that are not really abusing or misusing their medication. The COMM was intended to over-identity misuse, rather than to mislabel someone as responsible when they are not. Therefore, a low cut-off score was accepted. We believe that it is more important to identify patients who have only a possibility of misusing their medications than to fail to identify those who are abusing their medication. Thus, it is possible that the COMM will result in false positives patients identified as misusing their medication when they were not.

The table below presents several statistics that describe how effective the COMM is at different cutoff values. These values suggest that the COMM is a sensitive test. This confirms that the COMM is better at identifying who is misusing their medication than identifying who is not misusing. Clinically, a score of 9 or higher will identify 77% of those who turn out to be at high risk. The Negative Predictive Values for a cutoff score of 9 is .95, which means

that most people who have a negative COMM are likely not misusing their medication. Finally, the positive likelihood ratio suggests that a positive COMM score (at a cutoff of 9) is nearly 3 times (3.48 times) as likely to come from someone who is misusing their medication (note that by using a cutoff score of 9 will ensure that the provider is least likely to miss someone who is really misusing their prescription opioids. However, one should remember that a low COMM score suggests the patient is really at low risk, while a high COMM score will contain a larger percentage of false positives (about 34%) while at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more those who do show aberrant behavior.]

COMM Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ratio
Score 9 or above	.77	.66	.66	.95	3.48	.08

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Prescription Opioid Misuse Index

1. Do you ever use MORE of your medication, that is, take a higher dosage, than is prescribed for you?
   ☐ YES ☐ NO
2. Do you ever use your medication MORE OFTEN, that is, shorten the time between doses?
   ☐ YES ☐ NO
3. Do you ever feel high or get a buzz after using your pain medication?
   ☐ YES ☐ NO
4. Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain?
   ☐ YES ☐ NO
5. Have you ever gone to multiple physicians including emergency room doctors, seeking more of your pain medication?
   ☐ YES ☐ NO
6. Do you ever need early refills for your pain medications?
   ☐ YES ☐ NO

Patient's Name: _____

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Controlled Substance Questionnaire

	Yes	No	N/A
1. Have you ever used a controlled substance in a way other than prescribed			
2. Have you ever diverted a controlled substance to another person?			
3. Have you ever taken a controlled substance that did not have the desired effect?			
4. Are you currently using any drugs, including alcohol or marijuana?			
5. Are you using any drugs that may negatively interact with a controlled substance?			
6. Are you using any drugs that were not prescribed by a practitioner that is treating you?			
7. Have you ever attempted to obtain an early refill of a controlled substance?			
8. Have you ever made a claim that a controlled substance was lost or stolen?			
9. Have you ever been questioned about your pharmacy report or PMP report?			
10. Have you ever had blood or urine tests that indicate inappropriate usage of meds?			
11. Have you ever been accused of inappropriate behavior or intoxication?			
12. Have you ever increased the dose or frequency of meds without telling your provider?			
13. Have you ever had difficulty with stopping the use of a controlled substance?			
14. Have you ever demanded to be prescribed a controlled substance?			
15. Have you ever refused to cooperate with any medical testing or examinations?			
16. Have you ever had a history of substance abuse of any kind?			
17. Has there been any change in your health that might affect your medications?			
18. Have you misused or become addicted to a drug or failed to comply with instructions?			
19. Are there any other factors that your practitioner should consider before prescribing?			

_____ _____ ___/___/_____

Name Signature Date

For minor, or for a legal guardian:

_____ _____ ___/___/_____

Name Signature Date

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Clinical Opioid Withdrawal Scale (COWS) INTERVAL	0 mins	30 mins	2 hours	4 hours
Date: TIME				
	Score	Score	Score	Score
Resting Heart Rate (measure after lying or sitting for 1 minute): 0 HR 80 or below 1 HR 81-100 2 HR 101-120. 4 HR greater thana 120				
Sweating (preceding 30 minutes and not related to room temp/ 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness (observe during assessment): 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds				
Pupil size: 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rm of the iris is visible				
Bone or joint aches (not including existing joint pains): 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints / muscles plus unable to sit still due to discomfort				
Runny nose or tearing (not related to URTI or allergies): 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				
GI upset (over last 30 minutes): 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of vomiting or diarrhea				
Tremor (observe outstretched hands): 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning (observe during assessment): 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute				
Anxiety or irritability				

0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 Patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin 0 skin is smooth 3 piloerections (goosebumps) of skin can be felt or hairs standing up on arms 5 prominent piloerections				
SCORE INTERPRETATION: 5-12 = MILD 13-24 = MODERATE 25-36 = MODERATELY SEVERE >36 SEVERE WITHDRAWAL	**TOTAL** **INITIALS**	**TOTAL** **INITIALS**	**TOTAL** **INITIALS**	**TOTAL** **INITIALS**

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Beck's Depression Inventory

The depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

		(score)
1.	0. I do not feel sad 1. I feel sad 2. I am sad all the time and I cannot snap out of it 3. I am so sad and unhappy that I cannot stand it	
2.	0. I am not particularly discouraged about the future 1. I feel discouraged about the future 2. I feel I have nothing to look forward to 3. I feel the future is hopeless and that things cannot improve	
3.	0. I do not feel like a failure 1. I feel I have failed more than the average person 2. As I look back on my life, all I can see is a lot of failures 3. I feel I am a complete failure as a person	
4.	0. I get as much satisfaction out of things as I used to 1. I do not enjoy things the way I used to 2. I do not get real satisfaction out of anything anymore 3. I am dissatisfied or bored with everything	
5.	0. I do not feel particularly guilty 1. I feel guilty a good part of the time 2. I feel quite guilty most of the time 3. I feel guilty all of the time	
6.	0. I do not feel I am being punished 1. I feel I may be punished 2. I expect to be punished 3. I feel I am being punished	
7.	0. I do not feel disappointed in myself 1. I am disappointed in myself 2. I am disgusted with myself 3. I hate myself	
8.	0. I do not feel I am any worse than anybody else 1. I am critical of myself for my weaknesses or mistakes 2. I blame myself all the time for my faults 3. I blame myself for everything bad that happens	
9.	0. I do not have any thoughts of killing myself 1. I have thoughts of killing myself, but I would not carry them out 2. I would like to kill myself 3. I would kill myself if I had the chance	
10.	0. I do not cry any more than usual 1. I cry more now than I used to 2. I cry all the time now 3. I used to be able to cry, but now I cannot cry even though I want to	
11.	0. I am no more irritated by things than I ever was	

	1. I am slightly more irritated now than usual 2. I am quite annoyed or irritated a good deal of time 3. I feel irritated all the time	
12.	0. I have not lost interest in other people 1. I am less interested in other people than I used to be 2. I have lost most of my interest in other people 3. I have lost all of my interest in other people	
13.	0. I make decisions about as well as I ever could 1. I put off making decision more than I used to 2. I have greater difficulty in making decisions more than I used to 3. I cannot make decisions at all anymore	
14.	0. I do not feel that I look any worse than I used to 1. I am worried that I am looking old or unattractive 2. I feel there are permanent changes in my appearance that make me look unattractive 3. I believe that I look ugly	
15.	0. I can work about as well as before 1. It takes an extra effort to get started at doing something 2. I have to push myself very hard to do anything 3. I cannot do any work at all	
16.	0. I can sleep as well as usual 1. I do not sleep as well as I used to 2. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep 3. I wake up several hours earlier than I used to and cannot get back to sleep	
17.	0. I do not get more tired than usual 1. I get tired more easily than I used to 2. I get tired from doing almost anything 3. I am too tired to do anything	
18.	0. My appetite is no worse than usual 1. My appetite is not as good as it used to be 2. My appetite is much worse now 3. I have no appetite at all anymore	
19.	0. I have not lost much weight, if any, lately 1. I have lost more than five pounds 2. I have lost more than ten pounds 3. I have lost more than fifteen pound	
20.	0. I am no more worried about my health than usual 1. I am worried about physical problems like aches, pains, upset stomach, or constipation 2. I am very worried about physical problems, and it is hard to think of much else 3. I am so worried about my physical problems that I cannot think of anything else	
21.	0. I have not noticed any recent change in my interest in sex 1. I am less interested in sex than I used to be 2. I have almost no interest in sex 3. I have lost interest in sex completely	

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Interpreting the Beck's Depression Inventory

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circle zero on each question. You can evaluate your depression according to the Table below.

Total Score _____ Levels of Depression

Use the guide below to see the range that corresponds with your total score.

1-10 _____ These ups and downs are considered normal
11- 16 _____ Mild mood disturbance
17-20 _____ Borderline clinical depression
21-30 _____ Moderate depression
31- 40 _____ Severe depression
Over-40 _____ Extreme depression