Hospital Initiated Buprenorphine Program

Screening and Referral Instructions

(THIS FORM NOT TO BE GIVEN TO THE PATIENT)

Identifying Patients/Screening:

- No absolute contraindications
- Patient agrees to medication assisted treatment and follow up plan
- Check iStop for buprenorphine RX written by emergency provider within past 6 months
- Patients exhibiting signs/symptoms of opioid withdrawal
    - Give 8mg buprenorphine/naloxone now, followed by a prescription for 7 days
- Patients arriving after overdose
    - Provide buprenorphine/naloxone 4mg BID for 7 days
- *May consider buprenorphine 4mg without naloxone for pregnant patients*

PLEASE WRITE RX FOR 7 DAYS

ALLOWS CLINIC FLEXIBILITY AND DECREASES LIKELIHOOD FOR MEDICATION LAPSE

- Please write your "X" DEA number in the comments section when you e-prescribe
- Patients do NOT have to receive a RX to be referred
- Be aware that Medicare typically does not cover outpatient addiction services including most clinics on this list (patients will essentially be treated like self-pay)

Referral Process:

- Provide patient with the Opiate Dependence Screening Form (with clinic locations)
- Instruct the patient to complete the form
- Have patient choose their top two clinic choices (located on the bottom)
- Secretary/counselor (or the physician/PA/NP) will:
    - Using opioid dependence screening form – call centralized scheduling number

(716) XXXXXXXXX

THIS NUMBER NOT TO BE DISTRIBUTED OR GIVEN TO PATIENTS

    - Call taker will place patient into an appointment dates (clinic will call patient to set exact time)
- Patient should be informed that the clinic will call them to arrange time for appointment
- Place Opiate Dependence Screening form in HIPPA lock box (located in each ED)
- Provide patient with "Hospital initiated buprenorphine D/C instruction sheet"

NEW YORK MATTERS
Medication Assisted Treatment & Emergency Referrals

Rapid Assessment and Hospital Initiated Buprenorphine Program
Opiate Dependence Screening Form

You are being asked to complete this form to assist the providers in facilitating appropriate substance abuse treatment follow up and to monitor the effectiveness of our care. This information will be shared with the agency you are referred to for treatment if applicable.

Today's Date _____ First Name _____ Last Name _____

Date of Birth _____/_____/_____ Phone #1 _____

Street Address _____Alt Phone #2 _____

City/Town, Zip _____,_____

Insurance ☐ Independent Heath ☐ Univera ☐ Blue Cross ☐ Medicare ☐ Medicaid ☐ None
☐ United ☐ Tricare ☐ Other _____

In the past month have you used any of the following? (check all that apply)
☐ Prescription Opiates that were prescribed to you ☐ Benzodiazepines that were prescribed to you
☐ Prescription Opiates that were not prescribed to you ☐ Benzodiazepines that were not prescribed to you
☐ Illegal Opiates (such as heroin) ☐ Crack or Cocaine
☐ Alcohol ☐ Other drugs (specify) _____

Do you have any history of mental health issues? (check all that apply)
☐ Anxiety ☐ Depression ☐ Bipolar ☐ Other (specify)_____
☐ Schizophrenia ☐ Prior Suicide Attempts

Do you have any of the following medical problems? (check all that apply)
☐ Coronary Artery Disease ☐ Asthma/COPD ☐ Currently Pregnant
☐ Hepatitis ☐ Hypertension ☐ Diabetes ☐ Other (specify) _____

Have you ever undergone any of the following treatments for opiate dependence in the past? (check all that apply)
☐Outpatient Treatment ☐ Inpatient Treatment ☐ Buprenorphine (Suboxone) ☐ Methadone ☐ Vivitrol

TO BE COMPLETED BY PHYSICIAN, PA, OR NP ONLY
Name of **prescribing** provider _____
Where was the patient care encounter? ☐ ED (outpatient) ☐ Inpatient
Was a dose of Buprenorphine given in the ED/hospital? ☐ Yes ☐ No
Was an outpatient prescription for Buprenorphine given? ☐ Yes ☐ No
(For the following question – answer based on the time of initial presentation)
Reason for hospital visit ☐ Overdose ☐ Acute Withdrawal ☐ Neither overdose nor acute withdrawal

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PARTICIPATING CLINICS (Select your TOP TWO choices)
THE CLINIC WILL CONTACT YOU SHORTLY AFTER DISCHARGE

Clinic Organization A	Location 1	Location 2	Location 3
Clinic Organization B	Location 1	Location 2	
Clinic Organization C	Location 1	Location 2	Location 3
Clinic Organization D	Location 1	Location 2	
Clinic Organization E	Location 1		