centurion

(Attachment A)

HEALTHCARE INFORMATION WHEN PATIENT IS RELEASED

NAME: _____ ID#: _____ DOB: _____

RELEASED FROM: _____ DATE OF RELEASE: _____

Acute Healthcare Problems: _____

_____

Chronic Healthcare Problems: _____

_____

_____

Mental Health Needs: _____

_____

_____

Date of Last Physical Examination: _____ Date/Results of Last PPD: _____

Current Medication ☐ Yes ☐ No

Medication/Dosage	Instructions	Last Taken	# of Pills Provided	Prescription Provided	
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No

Pending Appointments

Date_____ Time_____ Clinic_____

Date_____ Time_____ Clinic_____

Other Follow-up Recommended:_____

_____

Address and Contact Number of Mental Health Clinic: _____

_____

Release of Information: Your doctor, clinic, or other healthcare provider can request copies of your health records by sending an appropriate signed waiver for Release of Information to the Healthcare Records Department

(Facility Name): _____

(Facility Address)_____

(Facility Contact Number): _____

I have received instructions on how to take the medication I am being provided I have had the opportunity to have my questions answered about medication side-effects and other information about my healthcare. I understand that the medications are not packaged in child-proof containers and it is my responsibility to keep the medications away from children.

_____ _____

Patient Signature Date/Time Healthcare Staff Date/Time

(Attachment B)

TCU DRUG SCREEN 5

During the last 12 months (before being locked up, if applicable) –

		Yes	No
1.	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	O	O
2.	Did you try to control or cut down on your drug use but were unable to do it?	O	O
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	O	O
4.	Did you have a strong desire or urge to use drugs?	O	O
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	O	O
6.	Did you continue using drugs even when it led to social or interpersonal problems?	O	O
7.	Did you spend less time at work, school, or with friends because of your drug use?	O	O
8.	Did you use drugs that put you or others in physical danger?	O	O
9.	Did you continue using drugs even when it was causing you physical or psychological problems?	O	O
10a.	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	O	O
10b.	Did using the same amount of a drug lead to it having less of an effect as it did before?	O	O
11a.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	O	O
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	O	O

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

O None
O Alcohol
O Cannaboids – Marijuana *(weed)*
O Cannaboids – Hashish *(hash)*
O Synthetic Marijuana *(K2/Spice)*
O Opioids – Heroin *(smack)*
O Opioids – Opium *(tar)*
O Stimulants – Powder Cocaine *(coke)*
O Stimulants – Crack Cocaine *(rock)*
O Stimulants – Amphetamines *(speed)*
O Stimulants – Methamphetamine *(meth)*
O Synthetic Cathinones *(Bath Salts)*
O Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*
O Dissociative Drugs – Ketamine/PCP *(Special K)*
O Hallucinogens – LSD/Mushrooms *(acid)*
O Inhalants – Solvents *(paint thinner)*
O Prescription Medications – Depressants
O Prescription Medications – Stimulants
O Prescription Medications – Opioid Pain Relievers
O Other (specify) _____

13. How often did you use each type of drug during the last 12 months?	Never	Only a few times	1-3 times per month	1-5 times per week	Daily
a. Alcohol	○	○	○	○	○
b. Cannaboids – Marijuana *(weed)*	○	○	○	○	○
c. Cannaboids – Hashish *(hash)*	○	○	○	○	○
d. Synthetic Marijuana *(K2/Spice)*	○	○	○	○	○
e. Opioids – Heroin *(smack)*	○	○	○	○	○
f. Opioids – Opium *(tar)*	○	○	○	○	○
g. Stimulants – Powder cocaine *(coke)*	○	○	○	○	○
h. Stimulants – Crack Cocaine *(rock)*	○	○	○	○	○
i. Stimulants – Amphetamines *(speed)*	○	○	○	○	○
j. Stimulants – Methamphetamine *(meth)*	○	○	○	○	○
k. Synthetic Cathinones *(Bath Salts)*	○	○	○	○	○
l. Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*	○	○	○	○	○
m. Dissociative Drugs – Ketamine/PCP *(Special K)*	○	○	○	○	○
n. Hallucinogens – LSD/Mushrooms *(acid)*	○	○	○	○	○
o. Inhalants – Solvents *(paint thinner)*	○	○	○	○	○
p. Prescription Medications – Depressants	○	○	○	○	○
q. Prescription Medications – Stimulants	○	○	○	○	○
r. Prescription Medications – Opioid Pain Relievers	○	○	○	○	○
s. Other (specify) _____	○	○	○	○	○

14. How many times before now have you ever been in a drug treatment program?
[DO NOT INCLUDE AA/NA/CA MEETINGS]

○ *Never* ○ *1 time* ○ *2 times* ○ *3 times* ○ *4 or more times*

15. How serious do you think your drug problems are?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*

16. During the last 12 months, how often did you inject drugs with a needle?

○ *Never* ○ *Only a few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

17. How important is it for you to get drug treatment now?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*

TCU Drug Screen 5 (v.Aug17)

(Attachment C)

TCU DRUG SCREEN 5 – Opioid Supplement

***If the response to TCU Drug Screen 5, page 2, Q13e, Q13f, or Q13r regarding opioid use is more than "Never," then complete the following questions.**

In the LAST 12 MONTHS –

1. **What types of opioids have you used?**

a.	Heroin	○ *No*	○ *Yes*
b.	Oxycodone (Oxycontin, Percodan, Percocet)	○ *No*	○ *Yes*
c.	Hydrocodone (Vicodin, Lortab, Lorcet, Norco, Zohydro)	○ *No*	○ *Yes*
d.	Morphine (Kadian, Avinza, MS Contin)	○ *No*	○ *Yes*
e.	Fentanyl (Duragesic, Fentora)	○ *No*	○ *Yes*
f.	Hydromorphone (Dilaudid, Exalgo)	○ *No*	○ *Yes*
g.	Methadone (Dolophine)	○ *No*	○ *Yes*
h.	Oxymorphone (Opana)	○ *No*	○ *Yes*
i.	Codeine (Tylenol/cough syrup with codeine)	○ *No*	○ *Yes*

2. **How many times did you inject an opioid?**

○ *Never* ○ A *few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

3. **How many times did you take an opioid in another way (e.g., ground pills and sniffed it, put a film in your mouth)?**

○ *Never* ○ A *few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

4. **How many times did you take an opioid prescribed for you?**

○ *Never* ○ A *few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

5. **How many times did you take an opioid prescribed for someone else?**

○ *Never* ○ A *few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

6. **From whom did you get the opioids you took?**

a.	Medical doctor/pharmacy?	○ *No*	○ *Yes*
b.	Family member?	○ *No*	○ *Yes*
c.	Friend?	○ *No*	○ *Yes*
d.	Someone else (e.g., "on the street")?	○ *No*	○ *Yes*

7. **Have you taken opioids for medical reasons?** ○ *No* ○ *Yes**

***IF YES,** briefly describe the reasons:

_____

8. **Have you taken opioids for <u>non-medical reasons</u>?** ..... ○ *No* ○ *Yes**

***IF YES,** briefly describe the reasons:

_____

9. **Has a <u>doctor prescribed</u> opioid medications for you?** ..... ○ *No* ○ *Yes**

***IF YES:**

a. did you have the most recent <u>prescription filled</u>? ..... ○ *No* ○ *Yes**

b. did you <u>take all of the medications</u> as prescribed? ..... ○ *No* ○ *Yes**

c. did you <u>give or sell any of your medications</u> to someone else? ..... ○ *No* ○ *Yes**

10. **Have you taken <u>other medications or illegal drugs</u> for medical reasons (e.g., to treat pain)?** ..... ○ *No* ○ *Yes**

***IF YES,** please list:

Drug/medication: _____ Reasons for taking: _____

Drug/medication: _____ Reasons for taking: _____

Drug/medication: _____ Reasons for taking: _____

11. **Do you or someone close to you (e.g., family, friend) have <u>access to naloxone (Narcan)</u> to reverse an overdose?** ..... ○ *No* ○ *Yes*

12. **How many times have you <u>EVER overdosed</u> after taking opioids?**

○ *Never* ○ *Once* ○ *Twice* ○ *3 times* ○ *4 or more times*

13. **<u>In the last 12 months</u>, how many times <u>have you overdosed</u> after taking opioids?**

○ *Never* ○ *Once** ○ *Twice** ○ *3 times** ○ *4 or more times**

***IF MORE THAN "NEVER," in the last 12 months:**

a. <u>What types</u> of opioids did you use?

1. Heroin ..... ○ *No* ○ *Yes*
2. Oxycodone (Oxycontin, Percodan, Percocet) ..... ○ *No* ○ *Yes*
3. Hydrocodone (Vicodin, Lortab, Lorcet, Norco, Zohydro) ..... ○ *No* ○ *Yes*
4. Morphine (Kadian, Avinza, MS Contin) ..... ○ *No* ○ *Yes*
5. Fentanyl (Duragesic, Fentora) ..... ○ *No* ○ *Yes*
6. Hydromorphone (Dilaudid, Exalgo) ..... ○ *No* ○ *Yes*
7. Methadone (Dolophine) ..... ○ *No* ○ *Yes*
8. Oxymorphone (Opana) ..... ○ *No* ○ *Yes*
9. Codeine (Tylenol/cough syrup with codeine) ..... ○ *No* ○ *Yes*

b. How many times did you go to the <u>hospital or emergency room</u> because of an overdose on opioids?

○ *Never* ○ *Once* ○ *Twice* ○ *3 times* ○ *4 or more times*

c. How many times were <u>you given naloxone (Narcan)</u> because of an overdose?

○ *Never* ○ *Once* ○ *Twice* ○ *3 times* ○ *4 or more times*

d. Have you <u>received any follow-up treatment</u> after the most recent overdose? ..... ○ *No* ○ *Yes*

14. Have you <u>received Medication Assisted Treatment (MAT) in the last 12 months</u>? ..... ○ *No* ○ *Yes*

15. Are you <u>currently receiving Medication Assisted Treatment (MAT)</u>? ..... ○ *No* ○ *Yes*

***IF YES,** what type?

a. Methadone (Dolophine or Methadone) ..... ○ *No* ○ *Yes*
b. Buprenorphine (Subutex, Suboxone) ..... ○ *No* ○ *Yes*
c. Oral naltrexone (Depade, Revia) ..... ○ *No* ○ *Yes*
d. Depot natrexone (Vivitrol) ..... ○ *No* ○ *Yes*
e. Other, specify: _____ ..... ○ *No* ○ *Yes*

16. Have you <u>obtained</u> any of these medications <u>without a prescription</u>? ..... ○ *No* ○ *Yes*

17. Have you <u>taken more</u> of these medications <u>than were prescribed</u>? ..... ○ *No* ○ *Yes*

(Attachment D)

Clinical Opiate Withdrawal Scale (COWS) Assessment
For each item, mark the number that best describes the patient's signs or symptom.
Patient should be at rest prior to evaluation.

Resting pulse rate _____ beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120 **Score:** _____	**Gastrointestinal upset** *Over last half hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting **Score:** _____
Sweating *Over past half hour not accounted for by room temperature or inmate activity* 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 **Score:** _____	**Tremor** *Observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching **Score:** _____
Restlessness *Observation 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 **Score:** _____	**Yawning** *Observation 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 **Score:** _____
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 rim of the iris is visible **Score:** _____	**Anxiety or irritability** 0 None 1 Inmate reports increasing irritability or anxiousness 2 Inmate obviously irritable or anxious 4 Inmate so irritable or anxious that participation in the assessment is difficult **Score:** _____
Bone or joint aches *If patient was having pain previously, only additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Inmate reports severe diffuse aching joints/muscles 4 Inmate is rubbing joints or muscles and is unable to sit because of discomfort **Score:** _____	**Gooseflesh skin** 0 Skin is smooth 3 Piloerection* of skin can be felt or hairs standing up on arms 5 Prominent piloerection *Piloerection is gooseflesh or goose bumps **Score:** _____

Runny nose or tearing *Not accounted for by cold symptoms 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 **Score:** _____	**Total COWS Score** The total score is the sum of both columns. Note score on flow sheet **> 36 = Severe:** Notify physician or designee immediately **25 - 36 = Moderately Severe:** Notify physician or designee immediately. **13 - 24 = Moderate:** Notify physician or designee immediately. **5 - 12 = Mild:** Notify physician or designee for orders **< 5 =** Notify physician or designee of initial evaluation

(Attachment E)

VCMAT Treatment Adjustment Form

Patient Name: _____ Patient DOB: _____

Date: _____

Current Buprenorphine Dose:_____mg

Date of admission to MAT:_____

Why is a MAT Treatment Evaluation requested?

_____

_____

Continued use of illicit drugs?: YES NO
If yes, please describe:

Drug	Amount used and route	Frequency in last week	Date of last use

Any patient/staff reports of sedation or impairment on current dose? YES NO

If yes, describe: _____

Drug Screens:	Side effects/toxicity:
Date:_____Results:_____ Date:_____Results:_____ Date:_____Results:_____	Sedation: yes / no Description: _____ Constipation: yes / no Description: _____ Sweating: yes / no Description: _____ Other: yes / no Description: _____

Medical/psych history: _____

Any known active patient med/behavioral issues: _____

New stressors: _____

Medications: _____

Allergies: _____

For dose adjustment requests only:
Symptoms 3-4 hrs after medicating:_____
Progression of symptoms and timeline:_____
_____
Sx 24 hrs after medicating (if reporting withdrawal, do pre-dose COW):_____

Compliance with counseling/ monthly check-ins/treatment plan:
_____

Nursing impression: _____
_____

For behavioral concerns only:
Current behavioral interventions on treatment plan: _____
_____

Compliance with behavioral interventions on treatment plan: _____

MAT Team assessment/recommendation:
_____

***For non-compliance with treatment plan*:**
Nature of non-compliance: _____

Nursing impression: _____
_____

Staff filling out form: _____

MAT Medical Director assessment/plan: _____

(Attachment F)

Impairment Assessment Tool

Patient Name: _____ PID: _____

Date of assessment: _____

Medication Utilized and current dose: _____ Date dose began:___

Reason for sedation/impairment concerns (describe): _____

_____

Reports of any illicit drug use (describe): _____

History of benzodiazepine use: _____

Point of Care Urine Drug Screen Results:

BZD	+	-
MTD	+	-
BUP	+	-
OPI	+	-

OXY	+	-
COC	+	-
AMPH	+	-

Presentation:	_____ _____ _____
Mental Status:	Oriented___ Disoriented___ Time___ Place___ Person___ Alert___ Drowsy___ Lethargic___ Inattentive___ Forgetful___ Stuporous___ Cooperative___ Combative___
Mood / Emotional Status:	Normal ___ Angry ___ Elation___ Calm___ Friendly___ Evasive___ Fearful___ Anxious___ Irritable___ Withdrawn___ Euphoric___ Hostile___
Speech:	Spontaneous___ Sudden Silences___ Slow and deliberate___ Rapid___ Content clear___ Content not clear___ Logical progression___ Slurring___
Eyes:	Nystagmus___ Poor eye contact___ Drooping eyelids___ Pupils constricted/pinpoint___ Dilated___ Equal___ Unequal___
Gait:	Heel to toe steady___ Unsteady___ Finger to nose good___ Finger to nose poor___
Vital Signs:	Temperature___ Pulse___ BP___ Respirations___ %O2_____
General Impression:	

(Attachment G)

Vermont Corrections Medication Assisted Treatment (VCMAT)
Patient Agreement

*See separate attachment –final to be inserted upon official approval of document

Centurion of Vermont
5430 Waterbury-Stowe Road
Building 1, Ground Floor
Waterbury Center, VT 05677
Phone: 802-221-4726 Fax: 802-244-1935

Hub Transfer of Care Request for Incarcerated Patient

The purpose of this form is to request Hub dosing and admission for a patient who is being released from incarceration

☐ If box is checked, request is **urgent** as patient is pending release within 24 hours.

Requesting Agency: _____

Contact: _____ Telephone number: _____

Hub where dosing/admission is requested: _____

Contact: _____ Telephone number: _____

Patient Name: _____ Date of Birth: _____

Patient's current insurance carrier_____ Policy #_____

Date incarceration began: _____ MAT med utilized and dose: _____

If MAT med was started during incarceration, date commenced:_____

If patient was already receiving MAT prior to incarceration, dates of treatment:_____

Planned release date: _____ Requested date to begin dosing at hub: _____

All current Medications/Dosages: _____

Active Medical Problems: _____

Allergies (including documented allergy for naloxone): _____

_____ _____ _____ _____

Medical from Sending Facility Date MD from accepting Hub Date

Enclosures:
Consent to Release Information signed by patient
DSM5 diagnosis sheet
Centurion MAT Admission Assessment/progress notes
Lab results for tb, hep c, hiv if available

Form revised 10/12/2018