Public Health
Prevent. Promote. Protect.
Harford County
Health Department

DIVISION OF BEHAVIORAL HEALTH
ELIGIBILITY, SCREENING AND ENROLLMENT

Buprenorphine Treatment Program

Buprenorphine: Buprenorphine (Zubsolv®/Suboxone) is used to treat opioid withdrawal and dependence.

Buprenorphine Treatment: The Buprenorphine Treatment Program is overseen by the Division's Medical Director. Individuals enrolled in Buprenorphine Treatment must follow all recommendations from their treatment team. Buprenorphine Treatment is a short term treatment program designed to minimize symptoms of withdraw by tapering an individual off the buprenorphine while under the care of a trained professional.

No Same Day Dosing: At intake dosing will **NOT** occur. Buprenorphine will not be prescribed or dispensed until the eligibility criterion has been met and an examination has been completed by the Division's Medical Director.

Eligibility Criteria: At a minimum, the following must be met to be considered for enrollment into the Buprenorphine Treatment program:

1. As recommended by the treatment team, the individual shall enroll in an appropriate level of addictions treatment. To ensure continuity of care, this treatment must be completed at the Division;
2. The individual must comply with all treatment recommendations. This includes participation in all groups and individual counseling sessions; and
3. The individual's toxicology screen(s) are:
    a. **Negative** for benzodiazepines (Ativan, Xanax, Valium, Klonopin, etc.), cocaine and alcohol; and marijuana (THC) levels are decreasing or absent.

Final Consideration: The Division's prescriber makes the final decision regarding clinical appropriateness, eligibility and enrollment.

Methadone Recipients: Until further notice, individuals enrolled in an Opioid Treatment Program (i.e. Methadone Treatment) cannot be enrolled in Division services.

Referrals: Upon request, referrals to an alternative treatment provider can be provided.

Questions: For further information, please contact the Division's Enrollment and Referral Specialists at 410-877-2340

Signature: _____ Date: _____

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DIVISION OF BEHAVIORAL HEALTH
REGISTRATION FORM

Today's Date:

CLIENT INFORMATION **PATAGONIA#** _____

Client's Last Name : First: Middle Initial:

Legal Name: Former/Maiden Name(s):

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Birth Date: Is the client a United States Citizen Yes / No

Gender (Please Check):
☐ Male ☐ Female ☐ Declined

Please check: ☐Married ☐Never Married ☐Divorced ☐Separated ☐Widowed

Race: _____ Ethnicity: _____ ☐ Decline to Answer

Does client have a Legal Representative? YES / NO

If yes, complete below: Name of Representative: _____

Relationship: _____ Contact Number: _____

Address: _____

Documented Verification of Legal Representation Received Y / N

If document was not received, explain: _____

Primary Address: _____

Preferred Mailing Address (if different then above): _____

Home phone # ___ ___ ___-___ ___ ___-___ ___ ___ ___ Cell phone#: ___ ___ ___-___ ___ ___-___ ___ ___ ___ Text: Y / N

Email Address: Preferred Method of Contact: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Contact Number: _____ Address: _____

Name: _____ Relationship: _____

Contact Number: _____ Address: _____

DIVISION OF BEHAVIORAL HEALTH
REGISTRATION FORM

Services Requested: Check all that Apply	Referred By:
☐ Mental Health ☐ Addictions ☐ Methadone ☐ Residential ☐ Detox ☐ Suboxone/Vivitrol ☐ Other (Please Specify): Have you received services here before? Yes / No	☐ Friend/Family ☐ Hospital: Name: _____ ☐ Treatment Provider/Other Please Specify:_____

Are you currently enrolled in another drug, alcohol or mental health program, is so please indicate

Name of Program: Type of Service:

What language does client feel most comfortable speaking in with their counselor?

Reasonable accommodations needed (interpreter, etc.)?

Are you a HURRICANE victim? Yes / No

Have you **OVERDOSED** recently? Yes / No When:_____

Priority services:

Are you an IV Drug Users? Yes / No

Have you been diagnosed with HIV or AIDS? Yes / No

Are you Pregnant? Yes / No

INSURANCE INFORMATION **UNINSURED: YES / NO**

Have you or your immediate family member ever served in Military? Yes / No

Do you have health benefits through Veterans Administration (VA)? Yes / No

Referred: Yes / No Referral Number: 800-827-1000

Please indicate primary insurance carrier:		Subscriber's name:
Subscriber's S.S. number: ___-___-____	Subscriber's Birth date: __/__/____	MA/Policy Number:

Relationship to subscriber:

Name of secondary insurance carrier (if applicable):		Subscriber's name:
Subscriber's S.S. number: ___-___-____	Subscriber's Birth date: __/__/____	MA/Policy Number:

Relationship to subscriber:

CHILD AND ADOLESCENT QUESTIONNAIRE (6-17 years)
OUTCOMES MEASUREMENT SYSTEM (OMS)
[Version 3; December 13, 2014]

Child/Adolescent Name: _____
(pre-populated in online system)

Interviewer Name: _____
(pre-populated in online system)

***Date of Current Interview:** _____ / _____ / _____
MM DD YYYY

PRIMARY RESPONDENT DETERMINATION
(person to whom questions are addressed and whose responses are recorded if there is disagreement)

Guidelines (clinician discretion overrides):
Ages 6-11 → Caregiver (adjust grammar as needed).
Ages 12-17 → Youth (use "you" when reading questions).

***Please indicate below who will be the Primary Respondent for this interview:**

☐ Youth *(1)* *OR* ☐ Caregiver *(2)*

*A companion **OMS Interview Guide** for this questionnaire is available at **www.maryland.valueoptions.com**.*

The symbol (Ψ) denotes a client opinion only question.

An asterisk (*) denotes a question that is mandatory for submission.

Underlined questions indicate that a definition is available for a term within the questionnaire. Click on the hyperlink that appears in order to access the definition.

LIVING SITUATION

I'm going to ask you some questions today about different areas of (your/your child's) life, such as school and other daily activities.

***1. Where are (you/your child) living now?** *(see OMS Interview Guide for more specific definitions)*

- ○ Independent (Private Residence, Boarding House/Rooming House)
- ○ Community (Residential Rehabilitation Program, Group Home/Therapeutic Group Home, Halfway House, Recovery Residence, School or Dormitory, Foster Home, Crisis Residence)
- ○ Institutional (Assisted Living, Skilled Nursing Facility, Residential Treatment Center for Children, Hospital, Jail/Correctional Facility/Detention Center)
- ○ Homeless (Homeless or Emergency Shelter)
- ○ Other (specify) _____

2. Have (you/your child) been homeless at all in the past six months? *(see OMS Interview Guide for definition of "homeless")*

- ○ No
- ○ Yes

PSYCHIATRIC SYMPTOMS[1]

INTERVIEWER: (do not read aloud) Please remember that if the Primary Respondent (PR) is the caregiver, use "your child" as appropriate.

Next I will ask you to answer questions about (your/your child's) feelings and behaviors. There is no right or wrong answer to any of the questions. Try to answer all of the questions even if you are not totally sure of how (you/your child) feel. These questions ask about how you have been feeling during the past week. As I read the question to you, let me know how many days in the past week you have been feeling that way.

In the <u>past week</u>, on how many days ... [CARD #1 with response options]

Please note that Questions 3-23 are all Ψ (Client/Caregiver Opinion Only)	Never (0 days)	A few days (1-2 days)	About every other day/half of the time (3-4 days)	Almost every day (5-6 days)	Every day (7 days)
3. Did you have trouble falling asleep or staying asleep?					
4. Did you feel depressed or sad?					
5. Did you have trouble relaxing?					
6. Were you nervous, uptight, or worried?					
7. Did you worry about your safety?					
8. Were you irritable or grouchy?					
9. Did you cry a lot?					
10. Were you afraid of things?					
11. Did you feel like you had no energy?					
12. Did you want to be by yourself instead of with others?					
13. Were you happy one minute and then sad or angry the next minute?					
14. Did you have stomachaches, headaches, or other aches and pains?					
15. Did you think or worry about bad things that you have seen or have happened to you?					
16. Did you want to hurt yourself?					
17. Did you want to hurt someone else?					
18. Did you have a hard time paying attention?					
19. Were you angry?					
20. Did you have a hard time sitting still?					
21. Were you mean, threatening or bullying to others?					
22. Did you get in arguments or fights?					
23. Did you have trouble following rules?					

[1] Items developed by Dr. Laurel Kiser; © Univ. of Maryland, Baltimore 2005

FUNCTIONING

Now I am going to read a series of statements. For each of these statements, please indicate whether (you/your child) strongly agree, agree, are undecided, disagree or strongly disagree. *[if Primary Respondent is a caregiver, read questions as "your child"]*

[see OMS Interview Guide for definitions of response options and "handle" (#24), "family" (#25),"cope" (#28), and "satisfied" (#29)]

[CARD #2 with response options]

Please note that Questions 24-30 are all Ψ (Client/Caregiver Opinion Only)	**Strongly Agree**	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**
24. I am able to handle daily life.					
25. I get along with family members.					
26. I get along with friends and other people.					
27. I am doing well in school and/or work.					
28. I am able to cope when things go wrong.					
29. I am satisfied with our family life right now.					
30. I am able to do things I want to do (and am allowed to do).					

SCHOOL PERFORMANCE

Next let's talk about school.

***31. Do (you/your child) attend school when it is in session, <u>including</u> home schooling?**

- O No
- O Yes

***32. In the past six months have (you/your child) had problems with school attendance?**

- O No *(skip to #34)*
- O Yes *(continue to #33)*

***33. In the past six months would you say (your/your child's) problems with school attendance have increased, stayed the same, or decreased?** *[mandatory only if Question 32 is "Yes"]*

- O Increased
- O Stayed the same
- O Decreased

***34. In the past six months were (you/your child) suspended from school? This includes in- and out-of-school suspensions.**

- ○ No
- ○ Yes

***35. In the past six months were (you/your child) expelled from school?**

- ○ No
- ○ Yes

SOMATIC HEALTH

(INTERVIEWER: Read all the answer options to the client)

36. Would you say in general (your/your child's) health is... Ψ

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

INTERVIEWER: (do not read aloud)
Is child/adolescent 11 years or older?
□ Yes *(continue)*
□ No *(end of interview)*

***37. Do (you/your child) smoke cigarettes?**

- ○ No *(skip to #39)*
- ○ Yes *(continue to #38)*

38. How many cigarettes do (you/your child) smoke per day? *[One pack = 20 cigarettes]*

- ○ Do not smoke every day
- ○ 1-10
- ○ 11-20
- ○ 21-30
- ○ 30+

(INTERVIEWER: Read all the answer options to the client and check all that apply)

***39. In the past month did (you/your child) use any of the following tobacco products?**

- ○ Cigars (e.g., cigarillos, little cigars)?
- ○ Smokeless tobacco (e.g., chewing tobacco, dip, snuff)?
- ○ Electronic-cigarettes (e.g., e-cigarettes, vaporizer cigarettes, vapes)?
- ○ Pipes (e.g., hookah, water pipes)?
- ○ Other tobacco product (e.g., bidis, kreteks, clove cigarettes)?
- ○ None

LEGAL SYSTEM INVOLVEMENT

***40. In the past six months have (you/your child) been arrested?**

- ○ No
- ○ Yes

ALCOHOL AND SUBSTANCE USE [2]

During the PAST SIX MONTHS, did you:

Please note that Questions 41-43 are all Ψ (Client/Caregiver Opinion Only)	**No**	**Yes**
41. Drink any *alcohol* (more than a few sips)?		
42. Smoke any *marijuana or hashish*?		
43. Use *anything else* to *get high*?		

INTERVIEWER: (do not read aloud) If the respondent answered NO to ALL (#41, 42, 43), ask only #44 and skip to gray box after #49.
If the respondent answered YES to ANY (#41, 42, 43), ask #44-49.

During the PAST SIX MONTHS:

Please note that Questions 44-49 are all Ψ (Client/Caregiver Opinion Only)	**No**	**Yes**
44. Have you ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?		
45. Did you use alcohol or drugs to relax, feel better about yourself, or fit in?		
46. Did you use alcohol or drugs while you were by yourself (alone)?		
47. Did you forget things you did while using alcohol or drugs?		
48. Did your family or friends tell you that you should cut down on your drinking or drug use?		
49. Have you gotten into trouble while you were using alcohol or drugs?		

[2] CRAFFT Substance Abuse Screening tool, 2009.

INTERVIEWER: (do not read aloud)
Is child/adolescent 14 years or older?
□ Yes *(continue)*
□ No *(end of interview)*

EMPLOYMENT

50. Are you currently employed? *(see OMS Interview Guide for definition of "employment")*

- ○ No *(continue to # 51)*
- ○ Yes *(skip to # 52)*

51. Have you been employed in the past six months?

- ○ No
- ○ Yes

RESILIENCE

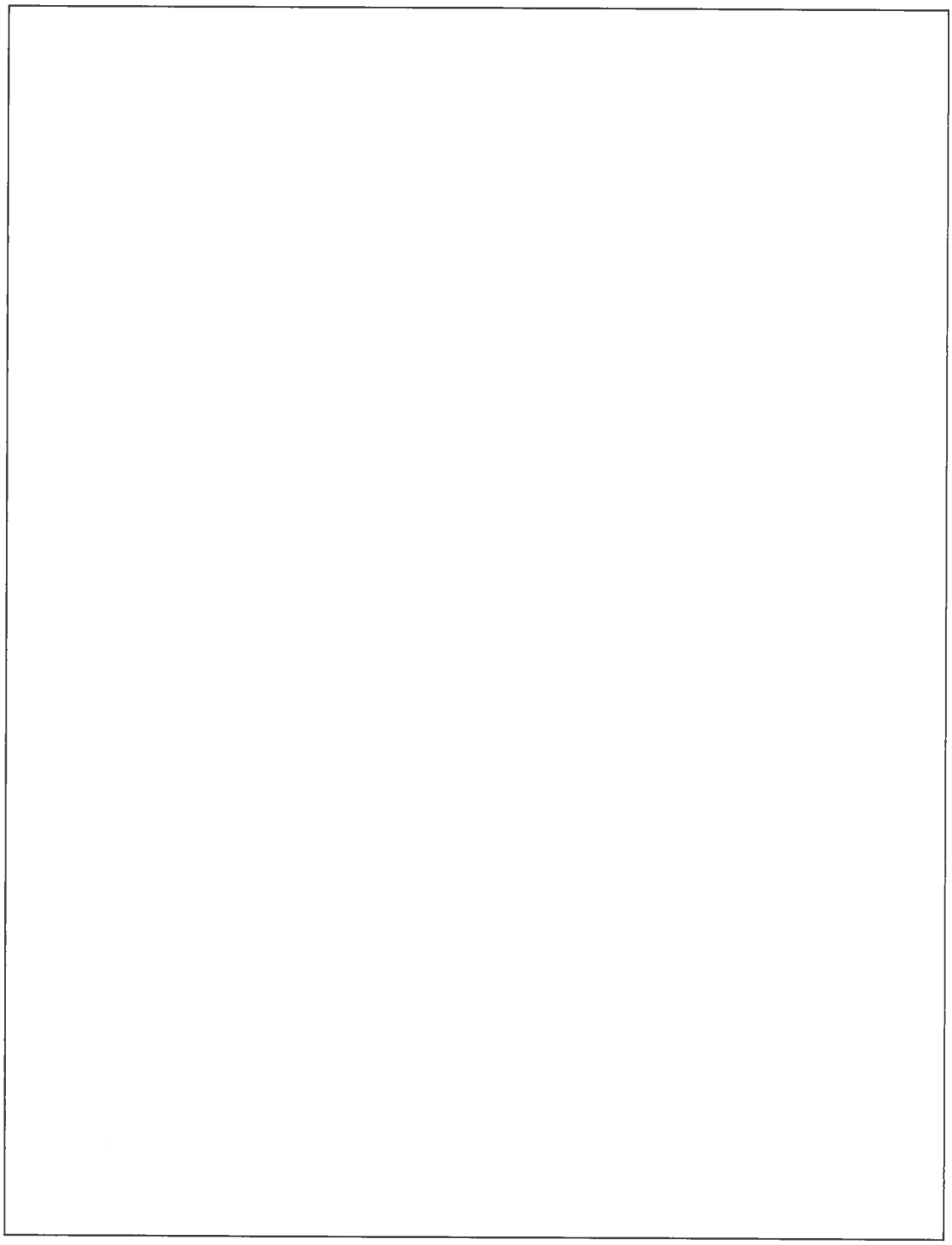
Now I am going to read a series of statements. As I read each statement, please indicate how much you agree with it: Not at all, A little bit, Somewhat, Quite a bit, or Very much.

[CARD #3 with response options]

Please note that Questions 52-56[1] are all Ψ (Client Opinion Only)	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
52. I am confident that I can make positive changes in my life.					
53. I am hopeful about the future.					
54. I believe I make good choices in my life.					
55. I am able to set my own goals in life.					
56. I feel accepted as who I am.					

[1] Items 52-56 are from the Maryland Assessment of Recovery Scale-Short Form; used with permission (Drapalski, et. al, 2012).

Clinician's Notes (Optional)



Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.