



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: _____

ADULT QUESTIONNAIRE (18-64 years)
OUTCOMES MEASUREMENT SYSTEM (OMS)
[Version 3; December 13, 2014]

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

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

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

*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 life, such as your living situation and daily activities.

***1. Where are you 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) _____

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

2. In general, how satisfied are you with where you currently live? Ψ

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

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

- No
- Yes

(continued on next page)

RECOVERY AND FUNCTIONING

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 #1 with response options]

<i>Please note that Questions 4-13¹ are all Ψ (Client Opinion Only)</i>	Not at all	A little bit	Somewhat	Quite a bit	Very much
4. I am confident that I can make positive changes in my life.					
5. I am hopeful about the future.					
6. I believe I make good choices in my life.					
7. I am able to set my own goals in life.					
8. I feel accepted as who I am.					
9. I do things that are meaningful to me.					
10. I am able to take care of my needs.					
11. I am able to handle things when they go wrong.					
12. I am able to do things that I want to do.					
13. My symptoms bother me. (see OMS Interview Guide for definition of "symptoms")					

¹ Items 4-8 are from the Maryland Assessment of Recovery Scale-Short Form; used with permission (Drapalski, et. al, 2012).

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

14. Overall, how satisfied are you with your recovery? Ψ (description of "recovery" in italics below)

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

["Recovery from Mental Disorders and/or Substance Use Disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2011)]

PSYCHIATRIC SYMPTOMS

For the next several questions, please tell me your answer based on the past MONTH.

INTERVIEWER: (do not read aloud) For items 15-38, you must either show the designated Response Card, give the client a copy of the questionnaire to follow along, or read all of the response options for each question to the client.
(Questionnaire Items 15-38 comprise the BASIS-24; ©McLean Hospital. Used and modified with permission.)

During the PAST MONTH, how much difficulty did you have...

15. Managing your day-to-day life? Ψ [CARD #2 with response options]

- No difficulty
- A little difficulty
- Moderate difficulty
- Quite a bit of difficulty
- Extreme difficulty

16. Coping with problems in your life? Ψ [CARD #2]

- No difficulty
- A little difficulty
- Moderate difficulty
- Quite a bit of difficulty
- Extreme difficulty

17. Concentrating? Ψ [CARD #2]

- No difficulty
- A little difficulty
- Moderate difficulty
- Quite a bit of difficulty
- Extreme difficulty

During the PAST MONTH, how much of the time did you...

18. Get along with people in your family? Ψ [CARD #3 with response options]

- None of the time
- A little of the time
- Half of the time
- Most of the time
- All of the time

19. Get along with people outside your family? Ψ [CARD #3]

- None of the time
- A little of the time
- Half of the time
- Most of the time
- All of the time

20. Get along well in social situations? Ψ [CARD #3]

- None of the time
- A little of the time
- Half of the time
- Most of the time
- All of the time

21. Feel close to another person? Ψ [CARD #3]

- None of the time
- A little of the time
- Half of the time
- Most of the time
- All of the time

22. Feel like you had someone to turn to if you needed help? Ψ [CARD #3]

- None of the time
- A little of the time
- Half of the time
- Most of the time
- All of the time

23. Feel confident in yourself? Ψ [CARD #3]

- None of the time
- A little of the time
- Half of the time
- Most of the time
- All of the time

During the PAST MONTH, how much of the time did you...

24. Feel sad or depressed? Ψ [CARD #3]

- None of the time
- A little of the time
- Half of the time
- Most of the time
- All of the time

25. Think about ending your life? Ψ [CARD #3]

- None of the time
- A little of the time
- Half of the time
- Most of the time
- All of the time

26. Feel nervous? Ψ [CARD #3]

- None of the time
- A little of the time
- Half of the time
- Most of the time
- All of the time

During the PAST MONTH, how often did you...

27. Have thoughts racing through your head? Ψ [CARD #4 with response options]

- Never
- Rarely
- Sometimes
- Often
- Always

28. Think you had special powers? Ψ [CARD #4]

- Never
- Rarely
- Sometimes
- Often
- Always

29. Hear voices or see things? Ψ [CARD #4]

- Never
- Rarely
- Sometimes
- Often
- Always

30. Think people were watching you? Ψ [CARD #4]

- Never
- Rarely
- Sometimes
- Often
- Always

31. Think people were against you? Ψ [CARD #4]

- Never
- Rarely
- Sometimes
- Often
- Always

During the PAST MONTH, how often did you...

32. Have mood swings? Ψ [CARD #4]

- Never
- Rarely
- Sometimes
- Often
- Always

33. Feel short tempered? Ψ [CARD #4]

- Never
- Rarely
- Sometimes
- Often
- Always

34. Think about hurting yourself? Ψ [CARD #4]

- Never
- Rarely
- Sometimes
- Often
- Always

During the PAST MONTH, how often...

35. Did you have an urge to drink alcohol or take street drugs? Ψ [CARD #4]

- Never
- Rarely
- Sometimes
- Often
- Always

36. Did anyone talk to you about your drinking or drug use? Ψ [CARD #4]

- Never
- Rarely
- Sometimes
- Often
- Always

37. Did you try to hide your drinking or drug use? Ψ [CARD #4]

- Never
- Rarely
- Sometimes
- Often
- Always

38. Did you have problems from your drinking or drug use? Ψ [CARD #4]

- Never
- Rarely
- Sometimes
- Often
- Always

LEGAL SYSTEM INVOLVEMENT

***39. In the past six months have you been arrested?**

- No
- Yes

***40. In the past six months have you been in either jail or prison?**

- No
- Yes

EMPLOYMENT

Now let's talk a little bit about your work situation.

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

- No *(continue to #42)*
- Yes *(skip to #43)*

***42. Have you been employed in the past six months?** *[mandatory only if Question 41 is "No"]*

- No *(skip to #45)*
- Yes *(continue to #43)*

INTERVIEWER: (do not read aloud) If the person held more than one job in the past six months, please ask him or her to answer the following questions in terms of the most recent job.

43. How many hours a week (do/did) you usually work?

- 1-10 hours
- 11-20 hours
- 21-30 hours
- 31-40 hours
- 40+ hours

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

44. In general, how satisfied (are/were) you with this job? Ψ

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

SOMATIC HEALTH

***45. Do you smoke cigarettes?**

- No (*skip to #47*)
- Yes (*continue to #46*)

46. How many cigarettes do you 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)

***47. In the past month did you 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

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

48. Would you say in general your health is: Ψ

- Excellent
- Very good
- Good
- Fair
- Poor

49. How tall are you?

_____ (feet) _____ (inches) [*please write legibly*]

50. How much do you currently weigh?

_____ pounds [*whole numbers only; please write legibly*]

- Don't Know*
- Refused*

Clinician's Notes (Optional)

A large, empty rectangular box with a thin black border, intended for the clinician to write their notes. The box occupies most of the page's vertical space.

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
<i>Add the score for each column</i>	+	+	+	
Total Score (<i>add your column scores</i>) =				

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 Intern Med.* 2006;166:1092-1097.

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

Patient Name		Today's Date				
<p>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.</p>		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						