**BUPRENORPHINE REFERRAL FORM FOR OPIOID USE DISORDER**

***Instructions:*** Buprenorphine/naloxone (brand name: Suboxone) helps treat opioid use disorder by decreasing cravings and suppressing withdrawal symptoms. When appropriate, patients with opioid use disorder should receive a prescription or first dose of buprenorphine in the hospital, along with a direct referral for buprenorphine maintenance. For referrals, please complete and fax this form to local treatment centers listed below.

**Patient’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of birth**: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_

**Phone number**: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ **Date of ED visit:** \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

**Insurance:**  € Medicaid/Medicare € Commercial € Self-pay

**Presented to ED with opioid overdose:** € Yes € No

**Opioid Use History:**

Age of first use: \_\_\_\_\_\_\_\_\_ Primary type of opioid used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pattern of opioid use (average daily amount and frequency): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Use History** (other than opioids): Is the patient **CURRENTLY** using any of the following?

€ cocaine

€ alcohol

€ benzodiazepines

€ PCP

€ synthetic marijuana

€ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical/Psychiatric History:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Critical actions required by the Emergency Department prior to buprenorphine induction:**

Urine drug screen (list positive): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Liver function test (must be < 5x normal): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DSM 5 Score for opioid dependence (Score must be ≥3): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
COWS Score (Score must be ≥8): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Buprenorphine started in ED**: € - Yes € - No **Date first dose given in ED:** \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

Dose given: \_\_\_\_\_ Rx dose\_\_\_\_\_\_\_\_\_\_\_\_ Sig: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of days given (Rx):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of referring ED provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact number:** (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Completed form sent by EHR, faxed etc to (please check one): {List frequent referrals sites}

Note: For all treatment options include information on what insurance types are accepted and appointment times, availability or contact. Include walk in hours if available

**Opioid Treatment Programs (list all in area)**

**Opioid Treatment Providers (list all in area)**

**Opioid Treatment Clinics (list all in area)**

Some examples:

[ ]  **Opioid Treatment Program:** 203-733-1234 (phone), 203-788-5555 (fax). Note: Takes walk-ins Monday-Friday before noon; all insurance types.

[ ]  **Primary Care Center-** Call 204-123-3333 and leave message, note and upload form into EPIC. Patient will be seen within 3 business days, takes all insurance types

[ ]  **Southland Addiction Treatment Center:** Send EPIC inbox to Margaret Taft or John Page (clinic directors). Patient will be contacted with 24 hours, Medicaid or no insurance ONLY

**Provide any relevant follow up capabilities** e.g. Check Nurse follow up discharge box in EHR if available