Client ID#	Today's Date	Facility ID#	Zip Code	Administration
|__|__|__|__|__|__|__|__|__|__|	|__|__|__|__|__|__|	|__|__|__|__|__|__|	|__|__|__|__|__|	|__|__|

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?	○	○
2.	Did you try to control or cut down on your drug use but were unable to do it?	○	○
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	○	○
4.	Did you have a strong desire or urge to use drugs?	○	○
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	○	○
6.	Did you continue using drugs even when it led to social or interpersonal problems?	○	○
7.	Did you spend less time at work, school, or with friends because of your drug use?	○	○
8.	Did you use drugs that put you or others in physical danger?	○	○
9.	Did you continue using drugs even when it was causing you physical or psychological problems?	○	○
10a.	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	○	○
10b.	Did using the same amount of a drug lead to it having less of an effect as it did before?	○	○
11a.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	○	○
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	○	○

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

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

Client ID#	Today's Date	Facility ID#	Zip Code	Administration
|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|	|___|___|

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 – 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 non-medical reasons? ..... ○ *No* ○ *Yes**

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

_____

9. Has a doctor prescribed opioid medications for you? ..... ○ *No* ○ *Yes**

***IF YES:**

a. did you have the most recent prescription filled? ..... ○ *No* ○ *Yes**
b. did you take all of the medications as prescribed? ..... ○ *No* ○ *Yes**
c. did you give or sell any of your medications to someone else? ..... ○ *No* ○ *Yes**

10. Have you taken other medications or illegal drugs 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 access to naloxone (Narcan) to reverse an overdose? ..... ○ *No* ○ *Yes*

12. How many times have you EVER overdosed after taking opioids?

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

13. In the last 12 months, how many times have you overdosed after taking opioids?

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

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

a. What types 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*