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

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*