Crossroads Treatment Centers of New Mexico

ADDRESS
1711 Isleta Blvd SW ABQ NM 87105

PHONE
(505) 390-8383

FAX
(505) 390-5407

WEBSITE
ctc-nm.com

PATIENT INTAKE FORM

PLEASE READ: Welcome to CTCNM, we are excited to help you take the first step in your recovery journey, ALL NEW PATIENTS, fill out all the designated areas indicated in RED.

PATIENT INFORMATION

NAME | **DOB** (MM/DD/YYYY) | **SSN/ GOVERNMENT ID** | **GENDER**

ADDRESS | **CITY** | **STATE** | **ZIP**

MAILING ADDRESS (Leave blank if same as above) | **CITY** | **STATE** | **ZIP**

HOME PHONE: (###) ###-#### | **CELL PHONE:** (###) ###-#### | **WORK PHONE:** (###) ###-####

EMAIL: example@gmail.com | **PROBATION/PAROLE?** ☐ YES ☐ NO | **PAROLE OFFICER** | **PHONE:** (###) ###-####

INSURANCE INFORMATION

INSURANCE NAME | **POLICY #** | **GROUP #**

SUBSCRIBER NAME | **SSN** | **DOB** (MM/DD/YYYY)

RELATIONSHIP TO PATIENT | **ADDRESS IF DIFFERENT THAN PATIENT**

MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN (PCP) NAME | **PCP PHONE**

HOSPITAL NAME PREFERENCE | **HOSPITAL PHONE**

CURRENTLY UNDER MEDICAL CARE ☐ YES ☐ NO | **IF YES, WHAT IS THE REASON?**

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME (PRIMARY) | **RELATIONSHIP** (PRIMARY)

HOME PHONE: (PRIMARY) (###) ###-#### | **CELL PHONE:** (PRIMARY) (###) ###-#### | **WORK PHONE:** (PRIMARY) (###) ###-####

EMERGENCY CONTACT NAME (SECONDARY) | **RELATIONSHIP** (SECONDARY)

HOME PHONE: (SECONDARY) (###) ###-#### | **CELL PHONE:** (SECONDARY) (###) ###-#### | **WORK PHONE:** (SECONDARY) (###) ###-####

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BUPRENORPHINE/NALOXONE (SUBOXONE) MEDICATION AGREEMENT AND CONSENT

As a patient in this program, I agree and understand the following rules:

1. I will keep all scheduled appointments and arrive on time. In the case of emergency, such as hospitalization, court date or incarceration, I will provide proper documentation displaying the time, date, and reason for emergency.
2. I agree and understand that my goal is to stop using addictive drugs, and I will stop using all addictive and illegal drugs during my treatment with buprenorphine (Suboxone),
3. I agree and understand that violating this agreement may result in dismissal of this program.
4. I understand that Suboxone is an addictive medication and may, like other prescribed prescription drugs, have adverse effects. Alternative treatments have been explained to me, and I still desire treatment for my opioid addiction with the use of Suboxone due to the risk of relapse with illicit opioids.
5. I understand that Suboxone treatment through Crosspoint Treatment Centers and my physician is voluntary, and I may withdraw from this program and discontinue use of Suboxone at any time.
6. I understand that if I decrease my use of opioids (heroin, pain medication, or substituting buprenorphine (Suboxone) for these drugs) I have a higher risk of dying from an overdose if I relapse. I understand that if I relapse, I need to use smaller doses of opioids until I learn what my body can tolerate.
7. I agree not to give, sell or share my medication with another person.
8. I agree not to accumulate medication or take more than what is prescribed. I agree not to falsify information to obtain additional medication beyond my needs. I understand that I may be subjected to an investigation.
9. I understand that if I relapse while taking buprenorphine, initially I may not get high from opioids because the buprenorphine blocks their effect. I understand that if I increase my opiate use, this could result in death.
10. I agree that medication received by me is my responsibility to keep safe and secure. Medication will not be replaced if lost, damaged or stolen.
11. I understand that buprenorphine (Suboxone) is extremely dangerous for Infants and Children. They can stop breathing and die after taking in tiny amounts of this medication. I agree to keep my medication securely locked and away from others, especially infants and children. Furthermore, Crossroads Treatment Centers and my treating physician are not responsible for my medication or any effects it may have on unintended recipients.
12. I agree to not obtain the following prescriptions from any healthcare providers or pharmacies without informing your Crossroads Treatment Center provider. This includes the following: Buprenorphine (Suboxone), other opioids including methadone, benzodiazepines (Example: Valium, Klonopin, or
13. I understand, that mixing buprenorphine with other medications or substances, specifically benzodiazepines (eg.Valium, Klonopin, Xanax) Alcohol, or other sedatives, such as barbiturates, can result in
14. I understand that buprenorphine (Suboxone) by itself may not be sufficient treatment for my addiction, if recommended by my Crossroads Treatment Center provider, I will agree to attend counseling or support groups if
15. I agree to provide supervised or unsupervised urine samples for drug testing. If requested by the provider, blood alcohol levels may be
16. I will inform all of my treating medical providers outside of Crossroads Treatment Centers that I currently belong to a Suboxone
17. I agree not to deal drugs or purchase drugs at this office, in the parking lot or
18. When picking up medication at the pharmacy, I will not deal or buy drugs at that
19. I agree that my prescription/medication will only be given to me at my regular office visits and a missed appointment may result in my not being able to get my prescription/medication until the next
20. I understand that there is no guarantee of the results that I may obtain from Suboxone
21. I understand that the goal of Suboxone treatment is total rehabilitation of the patient. An eventual withdrawal from the use of Suboxone is an appropriate treatment goal. However, I also understand that opioid treatment may last for a long period of time for some
22. I understand that while in treatment certain medical conditions may make it necessary for my physician to change my course of
23. I authorize Crossroads Treatment Center staff and providers to access my New Mexico Prescription Monitoring Program
24. I understand I may be called into Crosspoint Treatment Center to verify my Suboxone medication holdings; I agree to comply with this
25. I agree to not drive or operate machinery if impaired and fully absolve Crosspoint Treatment Center and its providers of any liability associated with such activity.

I have fully read, fully understand, and fully consent to the above terms and to begin treatment with buprenorphine/Suboxone.

PATIENT NAME* _____ **DOB** (MM/DD/YYYY) * _____ **DATE** (MM/DD/YYYY)* _____ **PATIENT SIGNATURE*** _____

CTCNM STAFF

CTCNM STAFF NAME _____ **DATE** (MM/DD/YYYY) _____ **CTCNM STAFF SIGNATURE** _____

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PARTICIPANT'S RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT

Every program participant at Crossroads Treatment Center has human/civil/personal rights to be respected and honored. In addition, it is the responsibility of all program participants to act in a manner that respects the rights of others. Crossroads Treatment Center is committed to the protection of individual rights and to providing services within an environment that is characterized by dignity and respect of all persons, and is responsive to the unique needs, abilities, and characteristics of each person served by the organization.

Program Participant's Rights: As a program participant of Crossroads Treatment Centers you have a right to the following:

- Receive services that comply with all federal and state regulations.
- Have information about your treatment and your confidentiality protected to the greatest extent possible allowed by federal and state confidentiality laws and regulations.
- Be fully informed about the course of your care and decisions that may affect your treatment.
- Revoke your consent for treatment at any time.
- Timely and accurate information to assist you in making decisions pertaining to your treatment.
- Receive services that is free of all forms of abuse, including but not limited to the following: financial abuse, physical abuse and punishment, sexual exploitation, phycological abuse including humiliation, threats and exploitation and all forms of seclusion and restraint.
- File a grievance or complaint about services you receive without fear of retaliation.
- File a grievance with an outside third party if you feel that the organization has not addressed your concerns adequately.
- Be fully involved in decisions pertaining to your treatment.
- Request a change in individual direction and coordinating your treatment.
- Have family members and friends or others involved in your treatment with your consent.
- Have an individual identified in writing that will direct and coordinate your treatment.
- To request a transfer to another program if you feel Crossroads Treatment Center is not meeting your needs.
- You may also have additional rights afforded to you based on federal, state, and local regulations. Crossroads Treatment Centers representative will advise you of any additional rights that you may have.

Participant Responsibilities: As a patient at Crosspoint Treatment Centers you have a responsibility to the following:

- Attend all appointments required by Crossroads Treatment Centers to meet treatment goals.
- Notify any outside providers (Doctors, case workers, counselors etc) of participation in our services should your treatment impact or compromise the provision of those services.
- Refrain from all forms of physical violence or abuse toward other program participants, staff, visitors and volunteers.
- Refrain from abusive language, disruptive behavior and overt sexual conduct.
- Refrain from loitering outside the organization's facilities and property.
- Refrain from bringing any type of weapon into a Crossroads Treatment Center facility or property.
- Refrain from bringing or using any illegal drugs or alcohol onto Crossroads Treatment Center property.
- Refrain from using illegal drugs or alcohol while participating in services provided by Crosspoint Treatment Centers.
- If smoking, stay a reasonable distance (20 feet) from the front door.
- Treat all program participants, staff, visitors and volunteers in a respectable manner.By my signature below, I acknowledge that I have read and understand my rights and responsibilities as a participant in Crossroad Treatment Center. Failure to comply would allow immediate dismissal from the program and possible local, state or federal charges against me.

PATIENT NAME* | **DOB** (MM/DD/YYYY) * | **DATE** (MM/DD/YYYY)* | **PATIENT SIGNATURE***

CTCNM STAFF

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PATIENT AGREEMENT FOR AT HOME SUBOXONE

Crossroads patients are solely responsible for their take home medication doses. Crossroads Treatment Centers are not responsible for the security of your medication doses or liable for any adverse events associated with their unintended use.

Crossroads Treatment Centers mandates use of a medication lock box. A Very low dose of Suboxone can seriously harm a child, adult, or pets. It is extremely important that patients store their doses securely and safely such that no one besides the patient has access to them.

Selling or giving your take home doses to another person is illegal and against Crossroads Treatment Centers policy. These actions will result in dismissal from this program and potential legal action against you.

It is the responsibility of the patient to report any stolen or missing take-home doses to the proper authorities (police or sheriff's department) Crossroads Treatment Centers will require a copy of the police report.

You, the patient, are liable for the safety of the take home doses once they are obtained by you and by signing below you agree that you have read this document and fully understand and agree with the statements written above and agree to abide by this document.

PATIENT NAME * _____

DOB (MM/DD/YYYY) * _____

DATE (MM/DD/YYYY) * _____

PATIENT SIGNATURE * _____

CTCNM STAFF

CTCNM STAFF NAME _____

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PATIENTS OF CHILD-BEARING AGE

Please select an option

- ☐ I am a biological Male, this section of the form does not apply.
- ☐ To the best of my knowledge, I am currently NOT Pregnant.
- ☐ To the best of my knowledge, I AM Pregnant.
- ☐ I am currently breast feeding.
- ☐ I am NOT breast feeding.

Suboxone Safety during Pregnancy and Nursing:

Buprenorphine/naloxone (Suboxone) is a FDA class C medication. There are no adequate and well-controlled studies of Suboxone in pregnant women according to the manufacturer. Limited published data on use of buprenorphine in pregnancy, have not shown an increased risk of major malformations. However, reproductive, and developmental studies in rats and rabbits identified adverse events at clinically relevant doses. Pre- and postnatal development studies in rats demonstrated dystocia, increased neonatal deaths, and developmental delays. In a few studies, some events such as acephalous, omphalocele, and skeletal abnormalities were observed but these findings were not clearly treatment related. Embryofetal death was also observed in both rats and rabbits. Potential adverse effects on the unborn child from the drug or from the underlying material condition could be seen.

Opioid dependence in pregnancy is associated with adverse obstetrical outcomes such as low birth weight, preterm birth, and fetal death. Neonatal abstinence syndrome may occur in newborn infants of mothers who were on buprenorphine maintenance treatment. As with all opioids, use of buprenorphine prior to delivery may result in respiratory depression in the newborn.

Buprenorphine and its metabolite norbuprenorphine are present in low levels in human milk and infant urine, and available data have not shown adverse reaction in breast-fed infants. There is no data on the combination product buprenorphine/naloxone in breast feeding. For this reason, potential adverse effects on the breastfed child from the drug or from the underlying maternal condition could be seen.

I have read and understand the above information. I agree to inform my Crossroads Treatment Center provider if I suspect that I am pregnant or trying to get pregnant. I understand my care may be transferred to UNM ASAP Milagro program in such cases.

PATIENT NAME* _____ **DOB** (MM/DD/YYYY) * _____ **DATE** (MM/DD/YYYY)* _____ **PATIENT SIGNATURE*** _____

CTCNM STAFF

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CONFIDENTIAL LOCATOR AND FOLLOW-UP CONSENT

I authorize Crossroads Treatment Centers to contact the below listed individuals if I have lost contact with the substance abuse treatment program:

NAME _____ RELATIONSHIP _____ PHONE: (###) ###-#### _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

- Is it ok for this person to know about your substance abuse treatment? ☐ YES ☐ NO
- May this person be used as an additional emergency contact? ☐ YES ☐ NO

NAME _____ RELATIONSHIP _____ PHONE: (###) ###-#### _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

- Is it ok for this person to know about your substance abuse treatment? ☐ YES ☐ NO
- May this person be used as an additional emergency contact? ☐ YES ☐ NO

☐ **No one may be contacted for this purpose.**

- I consent to personal contact by Crossroads Treatment Centers after discharge from the program for the purposes of assessing the quality of the services provided and inquiry into my well-being and sobriety.
- I understand my confidentiality will be strictly maintained during this process.
- I understand this is not for research purposes.
- I understand I have the right to refuse this service now or revoke this authorization at any time.

This form has been explained to me, I have full understanding, and I have been offered a copy of this form.

PATIENT NAME* _____ DOB (MM/DD/YYYY)* _____ DATE (MM/DD/YYYY)* _____ PATIENT SIGNATURE* _____

CTCNM STAFF

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CONFIDENTIALITY OF ALCOHOL AND DRUG PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by Crossroads Treatment Centers is protected by Federal Laws and Regulations. Crossroads Treatment Centers may not disclose to anyone outside the program that a patient is getting treatment at our facility or disclose any information identifying a patient as an alcohol or drug abuser. The following are exceptions to this rule:

1. The patient consents in writing.
2. The disclosure is allowed by a special court order.
3. The disclosure is made to medical personnel for research, audit, or program evaluation.
4. The disclosure is made to the Department of Health and Human Services if test results are positive of a sexually transmitted disease.

Violation of the Federal Law and Regulations by the program is a crime. Suspected violations may be reported to the appropriate authorities in accordance with Federal Regulations. Federal Law and Regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal Law and Regulations do not protect any information about suspected child abuse or neglect from being reported under State or Local authorities.

I understand that my records are protected under the Federal Regulations governing confidentiality of alcohol and drug abuse patients records,42 CFR, Part 2, and cannot be disclosed without written consent unless otherwise provided for the regulations. I understand and acknowledge that a copy of this form is available to me as attested to by my signature below.

PATIENT NAME * _____

DOB (MM/DD/YYYY) * _____

DATE (MM/DD/YYYY) * _____

PATIENT SIGNATURE * _____

NOTICE REQUIRED TO ACCOMPANY

This information has been disclosed to you from records protected by the Federal Confidentiality Rule (42 CFR Part 2). The Federal rules prohibit you from making any further discourse of this information without the specific written consent of the person to whom it pertains as otherwise permitted by (42 CFR Part 2). A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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CTCNM STAFF NAME _____

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PRIOR AUTHORIZATION REQUIREMENTS

PATIENT NAME* _____ DOB (MM/DD/YYYY)* _____ DATE (MM/DD/YYYY)* _____ PATIENT SIGNATURE* _____

Board of Pharmacy Prescription Drug Monitoring Program (PDMP): New Mexico report obtained; does not contain opiates, tramadol, benzodiazepines or sedative-hypnotic agents.

Medical Justification: Patient has F11.20 Opioid Dependence, unspecified and desires buprenorphine treatment.

Psychosocial Program: Therapy with a counselor and or by the treating provider.

Treatment Plan:

1. Initial Assessment by treating provider with counseling and prescription for Suboxone.
2. Patient returns for office based observed Suboxone induction or begins home-based induction.
3. Suboxone dose titrated as needed until stabilized.
4. Once stable dose is reached, maintenance stage is entered, and patient returns to clinic at least monthly for urine drug screen, Physician evaluation, and psychosocial counseling.
5. On-going reassessment for patient ability to titrate off of Suboxone.
6. Eventual complete discontinuation of Suboxone therapy without relapse of substance abuse.

Pregnancy: Patient is either a male, or female that certifies she is not pregnant or breastfeeding.

Safety: Patient consents Suboxone administration; it is contraindicated with concurrent use of opiates, tramadol, benzodiazepines, sedatives, hypnotics, carisoprodol, meprobamate, and alcohol. Acknowledges use of any of these substances at the same time as Suboxone could result in adverse effects including, but not limited to, death.

Suboxone Film:	Suboxone Tablets:	Subutex Tablets:	Zubsolv Tablet:
☐ 2mg/0.5mg	☐ 2mg/0.5mg	☐ 2mg	☐ 5.7/1.4
☐ 4mg/1mg	☐ 8mg/2mg	☐ 8mg	
☐ 8mg/2mg			
☐ 12mg/3mg			

☐ QD ☐ BID

DOSING/SIG: _____ DISP: # _____ DURATION: _____

☐ Jose Tepe Campos, PA ☐ Paul Romo, MD

MEDICAL PROVIDER _____

CTCNM STAFF

CTCNM STAFF NAME _____ DATE (MM/DD/YYYY) _____ CTCNM STAFF SIGNATURE _____

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PATIENT INFORMATION

PATIENT NAME* _____ DOB (MM/DD/YYYY)* _____ DATE (MM/DD/YYYY)* _____ PATIENT SIGNATURE* _____

MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL ISSUES:

Alcoholism	☐ YES	☐ NO
Alzheimer's	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Blood Clots	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Emphysema/COPD	☐ YES	☐ NO
Heart Disease Heart Attack	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
High Cholesterol	☐ YES	☐ NO
HIV/AIDS	☐ YES	☐ NO
Seizures/Epilepsy	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Thyroid Disease	☐ YES	☐ NO
Ulcers	☐ YES	☐ NO

OTHER _____

LIST DETAILS OF ANY MEDICAL PROBLEMS YOU HAVE ANSWERED YES TO:

_____

_____

_____

_____

_____

_____

_____

_____

LIST ANY SURGERIES YOU HAVE HAD AND THE YEAR THEY WERE PERFORMED.

_____

_____

_____

_____

_____

_____

PSYCHIATRIC/MENTAL HEALTH

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING ISSUES:

ADHD	☐ YES	☐ NO
Antisocial Disorder	☐ YES	☐ NO
Anxiety	☐ YES	☐ NO
Bipolar Disorder	☐ YES	☐ NO
Borderline Personality	☐ YES	☐ NO
Depression	☐ YES	☐ NO
Eating Disorder	☐ YES	☐ NO
Panic Disorder	☐ YES	☐ NO
PTSD	☐ YES	☐ NO
Schizophrenia	☐ YES	☐ NO

PLEASE LIST ANY OTHER MENTAL HEALTH ISSUES

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING ISSUES:

Blackouts, Falling	☐ YES	☐ NO
Blood Clots	☐ YES	☐ NO
Chest Pain, Heart Problems	☐ YES	☐ NO
Constipation, Diarrhea	☐ YES	☐ NO
Eyes, Ears	☐ YES	☐ NO
Fever, Chills	☐ YES	☐ NO
Joint Pain, Joint Stiffness	☐ YES	☐ NO
Migraines, Headaches	☐ YES	☐ NO
Nose, Throat	☐ YES	☐ NO
Psychological Problems	☐ YES	☐ NO
Skin Rash, Lesions	☐ YES	☐ NO
Shortness of Breath, Lungs	☐ YES	☐ NO
Teeth, Mouth	☐ YES	☐ NO
Urinary System, Genitalia	☐ YES	☐ NO
Abnormal Weight Loss, Weight Gain	☐ YES	☐ NO

OTHER SYMPTOMS YOU ARE EXPERIENCING.

_____

_____

_____