Opioid Treatment Court

Please complete the survey below.

Thank you!

Date of Assessment	_____
NYSID	_____
Referral Source	◯ Law Enforcement ◯ Defense ◯ DA ◯ Treatment ◯ Probation ◯ Parole ◯ Other Court (eg. town and village court or other treatment courts) ◯ Pre-trial Services ◯ Self-referral ◯ Other
Location	_____
Full Name	_____
SS#	_____
Address	_____
Do you have insurance?	◯ Yes ◯ No
Please provide your insurance information (name of insurance company, insurance number)	_____
Name of emergency contact	_____
Phone number of emergency contact	_____
Relationship to emergency contact	_____
What are your charges?	_____
Do you have an attorney?	◯ Yes ◯ No

Name of attorney

_____

Originating Court

_____

Please complete the following table

	Primary	Secondary	Tertiary
Drug	_____	_____	_____
Amount (in $)	_____	_____	_____
Frequency	_____	_____	_____
Last Use (in days)	_____	_____	_____

Are you currently in treatment?

◯ Yes
◯ No

Where are you in treatment?

_____

When was the last time you were in treatment

◯ I have never been in treatment
◯ This is my first time in treatment
◯ Other _____

Have you ever overdose?

◯ Yes
◯ No

How many times have you overdosed?

◯ Once
◯ Twice
◯ Three or more times
◯ I don't remember

Do you have any major medical issues?

◯ Yes
◯ No

What medical issues do you have?

_____

Do you have any mental health diagnosis?

◯ Yes
◯ No

What is your diagnosis?

_____

Do you take any medications?

◯ Yes
◯ No

What medications are you taking?

_____

Referred by

_____

Prepared by

_____

Have you ever taken any of the following drugs?

	Yes	No
Heroin	◯	◯
Methadone	◯	◯
Suboxone	◯	◯
Morphine	◯	◯
MS Contin	◯	◯
Oxycontin	◯	◯
Oxycodone	◯	◯
Other Opioid	◯	◯

Did you ever need to use more opioids to get the same high as when you first started using opioids?
◯ Yes
◯ No

Did the idea of missing a fix or dose ever make you anxious or worried?
◯ Yes
◯ No

In the morning, did you ever use opioids to keep from feeling dope sick or did you ever feel dope sick?
◯ Yes
◯ No

Did you ever worry about your use of opioids?
◯ Yes
◯ No

Have others in your life ever worried about your opioid use?
◯ Yes
◯ No

Did you find it difficult to stop or not use opioids?
◯ Yes
◯ No

Did you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high?
◯ Yes
◯ No

Did you ever miss out on important things like doctors' appointments, family/friend activities, or other things because of opioids?
◯ Yes
◯ No

Thank you for completing the screen. This person is opioid dependent

Thank you for completing the screen. This person is not opioid dependent

Sum for questions 2-8 _____