MISSISSIPPI OPIOID TREATMENT CENTER

Patient Name: _____ Date of Birth: _____ Date of Service: _____

PATIENT DEMOGRAPHICS

Patient Name:		Referring Doctor:	
Date of Birth:		Home Phone Number:	
Email Address:		Cell Phone Number:	
Preferred Method of Communication:			
PATIENT PORTAL ACCESS : For Access to Your Personal Health Record ☐ I approve to receive notifications regarding my personal health records via ☐ Mobile Text Notification ☐ Voice Notification			
Address:			
City:	State:	Zip Code:	
Social Security Number:	Age:		
Race:	Ethnicity:	Sex: ☐ Male / ☐ Female	Marital Status:

EMERGENCY CONTACT

Name:	Relationship to Patient:
Home Phone Number:	Cell Phone Number:

EMPLOYMENT

Employer:	Position:
Address:	Phone Number:

INSURANCE

Policy Holder Name:		Date of Birth:
Medicare Number:	Medicaid Number:	
Other Insurance:		Policy Number:
Group Name:		Group Number:

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PRETREATMENT SCREENING

Patient Age: _____ Sex: ( ) M ( ) F

Reason for seeking treatment

Substance: _____ How long using? _____

How much? _____ How often? _____

Has your drug use ever resulted in medical or legal problems? ( ) N ( ) Y (Please describe) _____

_____

Have you ever been treated for substance dependence or misuse (eg, detoxification program)? ( ) N ( ) Y

(Please describe setting and length) _____

_____

_____

Have you ever tried to quit on your own? ( ) N ( ) Y (Please describe) _____

_____

Have you ever been treated by a psychiatrist? ( ) N ( ) Y (Please describe treatment reason, setting, and length)

_____

_____

Does anyone in your family (mother, father, brother/sister, child, aunt/uncle, or grandparent) have a history of substance abuse? ( ) N ( ) Y (Please describe) _____

_____

_____

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Do you have any medical conditions (eg, diabetes, HIV+, epilepsy, STDs)? ( ) N ( ) Y (Please list all conditions)

_____

_____

Are you currently taking any medication(s) to treat these conditions? ( ) N ( ) Y [Please list medication(s) and dosage(s)] _____

_____

Are you pregnant? **( )** N/A **( )** N **( )** Y **( )** Not Sure

Are there any current legal issues we should be aware of (eg, probation or parole)? ( ) N ( ) Y (Please describe)

_____

Are you currently employed? **( )** N **( )** Y How many hours per week (avg)? _____

Please describe your current living arrangements: -

_____

_____

_____

Other: _____

_____

_____ Date: _____
Patient Signature

299 Highway 51- Suite F1 ** Ridgeland MS 39157 ** 601-790-9266 (Phone)
601 Renaissance Way – Suite B ** Ridgeland, MS 39157 ** 601-605-9914 (Phone) ** 601-605-9904 (Fax)

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OPIOID RISK TOOL (ORT)

MARK EACH BOX THAT APPLIES	FEMALE	MALE
FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	**1**	**3**
Illegal Drugs	**2**	**3**
Prescription Drugs	**4**	**4**
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	**3**	**3**
Illegal Drugs	**4**	**4**
Prescription Drugs	**5**	**5**
AGE BETWEEN 16-45 YEARS	**1**	**1**
HISTORY OF PREADOLESCENT SEXUAL ABUSE	**3**	**0**
PSYCHOLOGIC DISEASE		
ADD, OCD, Bipolar, Schizophrenia	**2**	**2**
Depression	**1**	**1**
SCORING TOTALS		

SCORING (RISK) : 0-3 (Low) ; 4-7 (Moderate); ≥ 8 (High)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction

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