Beehive Program Treatment Forms

- Beehive Program Authorization to Exchange Health Information
- Beehive Program Consent to Treatment With Buprenorphine
- Beehive Program Take-Home Dose Agreement
- Beehive Program Documentation of Clinical Eligibility
- Beehive Program Worksheet for *DSM–IV* Criteria for Diagnosis of Opioid Dependence
- Prescribers' Direct Dispensing Log Information

Beehive Program Authorization to Exchange Health Information

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

BEEHIVE PROGRAM

AUTHORIZATION TO EXCHANGE HEALTH INFORMATION

NAME*
DOB*
MRN
SS#
PCP

Patient ID / Label

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information.

I*, _____ (AKA)_____

authorize and consent to the exchange of oral, written, and computer-based information relating to my medical, substance use, mental health, and social condition among my:

Medical Provider: _____

Drug Treatment Provider: _____

Drug Treatment Counselor: _____

Pharmacist: _____

I understand that my substance abuse and treatment information may be included in my current medical record so that my medical team can have all pertinent information for my care.

By initialing in the spaces below, I specifically authorize the exchange of protected classes of information, if such information exists.

INITIAL below for protected classes of information:

☐ Mental Health Treatment ☐ Substance Abuse Treatment ☐ HIV/AIDS Treatment

☐ Sexually Transmitted Disease (City Clinic) ☐ Developmental Disabilities

In addition, I authorize the exchange of my photograph among the personnel mentioned above. I understand that access to this information will be limited to the personnel of the above-referenced agencies and that exchange of the information is necessary to improve the medical, mental health, and substance use care that I receive.

MY DPH RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I may revoke this authorization at any time. Revocation must be in writing, signed by me or on my behalf by someone with the legal authority to do so and delivered to the Beehive program. My revocation will be effective upon receipt, but will not be effective to the extent that the Beehive program may have acted in reliance upon this authorization prior to revocation. I have a right to obtain a copy of this authorization. I may not be denied treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign. I recognize that if I refuse to sign I will not be able to participate in the Beehive program but that other substance abuse services are available to me.

EXPIRATION: Unless otherwise revoked, this authorization will expire in one year or at any time that the Beehive program is no longer providing me with services.

*_____ *_____ _____
(DATE) (Signature of Patient/Client/Parent/Guardian/Conservator) (Relationship to Patient/Client)

_____
WITNESS (REQUIRED IF PATIENT/CLIENT UNABLE TO SIGN) ☐ Interpreter used _____

BEEHIVE PROGRAM
CONSENT TO TREATMENT WITH BUPRENORPHINE

NAME OF PATIENT_____ DATE _____

NAME OF PRACTITIONER EXPLAINING PROCEDURES _____

NAME OF BEEHIVE PHYSICIAN _____

I hereby authorize and give consent to the above named Beehive physician and/or any appropriately authorized assistants he/she may select, to administer or prescribe buprenorphine (Suboxone or Subutex) as an element in the treatment for my dependence on heroin or other narcotic drugs.

The procedures to treat my condition have been explained to me. I understand that it will involve my taking the prescribed buprenorphine on the schedule determined by the Beehive physician or his/her designee. This will help control my dependence on heroin or other narcotic drugs.

It has been explained to me that buprenorphine itself is an opiate, but for some individuals it may not be as strong an opiate as heroin or morphine. Buprenorphine treatment can result in physical dependence. Buprenorphine withdrawal is generally less intense than that with heroin or methadone. If buprenorphine is suddenly discontinued, some patients have no withdrawal symptoms; others have symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opiate withdrawal, buprenorphine should be discontinued gradually, usually over several weeks or more.

For my first dose, I should be in withdrawal as much as possible. If I am not already in withdrawal, buprenorphine can bring on severe opiate withdrawal. For that reason, for the first few days I will be asked to remain at the clinic or pharmacy for a period of time after I take a dose. After that, I will receive a prescription and return to the designated Beehive pharmacy to pick up the medication. I will comply with the correct dosing method for buprenorphine -- holding it under the tongue until it dissolves completely, without swallowing it. Swallowing the buprenorphine will lessen its effectiveness.

I understand that it may take several days to get used to the transition from the opiate I had been using to buprenorphine. I understand that using any other opiates (like heroin) will complicate the process of stabilization on buprenorphine. I also understand that other opiates will have less effect once I become stabilized on buprenorphine. Taking more opiates to try to override the effect of buprenorphine can result in an opiate overdose. In addition, I understand that intravenous use of buprenorphine can produce serious problems including severe withdrawal, overdose, and even death.

I understand that I will not take any other medication without first discussing it with my Beehive primary physician because combining buprenorphine with other medications or alcohol may be hazardous. The combination of buprenorphine with Valium, Librium, or Ativan has **resulted in death.**

BEEHIVE PROGRAM
CONSENT TO TREATMENT WITH BUPRENORPHINE

I understand that during the course of treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me.

The goal of narcotic treatment is total recovery of the patient. I realize that for some patients, narcotic treatment may continue for relatively long periods of time, but that periodic consideration shall be given concerning my complete withdrawal from the use of all narcotic drugs. I understand that I may withdraw from the Beehive pilot program and discontinue use of buprenorphine at any time. I shall be transferred to detoxification under medical supervision or a traditional ORT program.

I will not allow any other individual to use my buprenorphine. It is dangerous for an individual not on buprenorphine to ingest the medication. Doing so may result in serious injury or even death for that individual.

For Female Patients of Child-Bearing Age:
Information on the effects of buprenorphine on pregnant women and their unborn children is inadequate to guarantee that it may not produce significant or serious side effects. Therefore, pregnant women or women trying to become pregnant will not be allowed into buprenorphine treatment on Beehive and will be referred to alternate treatment. Women may be required to take a pregnancy test.

To the best of my knowledge,

- ☐ I am pregnant at this time.
- ☐ I am not pregnant at this time.

While on buprenorphine, I will practice an acceptable form of birth control (i.e. abstinence, condoms, spermicide, birth control pills). If I do become pregnant, I will inform my Beehive physician or one of his/her assistants *immediately*. I will be transferred to a methadone treatment program for pregnant women or another treatment modality.

For All Patients:
Alternative methods of treatment, the potential benefits of treatment, possible risks involved, and the possibility of complications have been explained to me. I certify that no guarantee or assurance has been made as to the results that may be obtained from narcotic addiction treatment. I consent to buprenorphine treatment since I realize that I would otherwise continue to be dependent on heroin or other narcotic drugs.

Printed Name of Patient_____ Patient DOB_____

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____

BEEHIVE PROGRAM

BUPRENORPHINE TAKE-HOME DOSE AGREEMENT

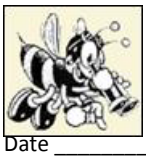
I,_____understand that any take-home doses granted to me, by the Beehive Program are a privilege. This privilege can be revoked at any time, due to illicit drug or alcohol use, unexcused clinic absences, or when my safety or the safety of others is an issue. The Beehive staff will make the determination of whether a take-home dose is appropriate on a case-by-case basis. I agree to take only the dose of buprenorphine prescribed each day, and I will keep my buprenorphine in a safe place, out of reach of children. I realize that buprenorphine can be fatal to children or other individuals for whom it is not prescribed. **Transfer, distribution or sale of buprenorphine is prohibited by state and federal law.** I understand that buprenorphine can be dangerous when taken with certain other drugs or alcohol. Failure to comply with any of the above requirements may result in the loss of take-home privileges and possible termination from treatment.

_____
Patient Signature

_____
Date

_____
Staff Signature

_____
Date



BEEHIVE PROGRAM
Documentation of Clinical Eligibility

Date _____ MRN_____

Patient's initials _____

Primary Care Provider: _____ Ever on Buprenorphine? (Y / N)

In-Person (1) or Phone (2): _____ Contact info/phone:_____Repeat screener? (Y / N)

Referred by:_____ Homeless? (Y / N) MediCal? (Y / N)

A. Demographics

1. Age: _____ _____

2. Gender: [ ] female [ ] male [ ] transgender

3. Hispanic/Latino: [ ] no [ ] yes [ ] don't know

4. Race/Ethnicity:
   [ ] White
   [ ] African American/Black
   [ ] Asian
   [ ] Native American/Alaskan Native
   [ ] Native Hawaiian or other Pacific Islander
   [ ] Other (please specify):_____

B. Beehive Program Eligibility Questions

5. Is this patient **HIV positive**?
   [ ] no
   [ ] yes*, receives HIV primary care outside of Ward 86 and unwilling/able to transfer*
   [ ] yes, *receives or willing to receive HIV primary care at Ward 86*

   Notes:_____

   _____

6. Does this patient **use opioids**? [*CHECK ALL THAT APPLY*]
   [ ] no current use
   [ ] prescribed use only *(may or may not meet DSM IV criteria for dependence)*
   [ ] other than prescribed use, does not meet DSM IV criteria for dependence
   [ ] meets DSM IV criteria for dependence

   Notes:_____

   _____

7. Is this patient **currently on buprenorphine**?
   [ ] no
   [ ] yes

   Notes:_____

   _____

Date _____ MRN_____

8. Has this patient used **benzodiazepines** in last 6 months? [*CHECK ALL THAT APPLY*]
   [ ] no use
   [ ] prescribed use only *(may or may not meet DSM IV criteria for dependence or abuse)*
   [ ] other than prescribed use, does not meet DSM IV criteria for dependence or abuse
   [ ] meets DSM IV criteria for dependence or abuse

   Notes:_____

   _____

9. Has this patient used **alcohol** in the last 6 months?
   [ ] no use
   [ ] use, does not meet DSM IV criteria for dependence
   [ ] meets DSM IV criteria dependence or abuse

   Notes:_____

   _____

10. Is this patient participating & dosing in a **methadone program?**
    [ ] not in a methadone program
    [ ] low dose and/or tapering down to transfer (ideal: ≤ 35 mg.)
    [ ] in a methadone program, not suitable for transfer

    Notes:_____

    _____

11. Is this patient **pregnant or trying to become pregnant**?
    [ ] no
    [ ] yes
    [ ] not applicable (*i.e. biological male)*

    Notes:_____

    _____

12. What is the patient's liver function? **AST _____ ; ALT _____** (date should be in last 3 months:_____)
    [ ] normal transaminase levels
    [ ] transaminase elevated, <= 5 times normal
    [ ] transaminase > 5 times normal

    Notes:_____

    _____

Date _____ MRN_____

13. Is this patient **actively suicidal or with suicidal ideation**?
    [ ] no
    [ ] yes

    Notes:_____

    _____

14. Does this patient have any **other psychiatric conditions** affecting his or her ability to consent *to treatment* (e.g., dementia, delusional, actively psychotic)?
    [ ] no
    [ ] yes

    Notes:_____

    _____

15. Inappropriate according to clinical judgment of clinician *(specify reason below)*
    [ ] no
    [ ] yes, *patient requires high-dose prescription opioids for pain syndrome (#19a.)*
    [ ] yes, *other reason, specify below:*

    Notes:_____

    _____

SUMMARY: Is this patient eligible for the Beehive Program? (Circle one): YES/ NO

☐ **IF PATIENT IS CLINICALLY ELIGIBLE, BUT DECLINES TREATMENT (check reason below):**
_____ Did not want to go on any opiate substitution therapy
_____ Inquiry only, not ready
_____ Prefers methadone
_____ Prior negative experience with buprenorphine
_____ Visit frequency with buprenorphine
_____ Does not wish to decrease opioid pain medications
_____ Don't know
_____ Other, specify: _____

Notes:_____

_____

_____

_____

_____

_____

Beehive Program Worksheet for *DSM–IV* Criteria for Diagnosis of Opioid Dependence

Patient's Name:

BEEHIVE PROGRAM

Worksheet for DSM-IV criteria for diagnosis of opioid dependence

Diagnostic Criteria* (Dependence requires meeting 3 or more criteria)	Meets criteria Yes	No	Notes/supporting information
(1) Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of the substance to achieve intoxication of desired effect			
(b) markedly diminished effect with continued use of the same amount of the substance			
(2) Withdrawal, as manifested by either of the following: (a) the characteristic withdrawal syndrome			
(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms			
(3) The substance is often taken in larger amounts or over a longer period of time than intended			
(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use			
(5) A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects			
(6) Important social, occupational, or recreational activities are given up or reduced because of substance use			
(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance			

Signature _____ Date _____

Criteria from American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev., p. 197). Washington, DC: Author.

PRESCRIBERS' DIRECT DISPENSING LOG INFORMATION

Newly enacted legislation within the prescription law requires all practitioners and prescribers, including veterinarians, to report directly dispensed controlled substances to the Department of Justice, CURES program.

Effective January 1, 2005, pursuant to Health and Safety Code Section 11190 and Business and Professions Code Section 4170, all licensees who dispense Schedule II and III controlled substances must provide the dispensing information to the Department of Justice on a monthly basis by using the Prescribers' Direct Dispensing Log. For veterinarians, please use the direct dispense form for Veterinarians' Use Only. The Department of Justice will also be able to receive in electronic format the direct dispense data by following the Direct Dispense Data Specifications.

The Prescribers' Direct Dispensing Log, Direct Dispensing Logs for Veterinarians Use Only, and the Direct Dispense Data Specifications were designed to aid physicians/prescribers and veterinarians in fulfilling Business and Professions Code Section 4170 as well as the Health and Safety Code reporting requirements. Information must be mailed via CD-Rom or by hard copy to: CURES Program, P.O. Box 160447, Sacramento, California 95816.

The prescibers' log contains the following information:

- The prescriber's name, address, telephone number, category of licensure and license number, and federal controlled substance registration (DEA#).
- Date of dispensing.
- Numeric quantity of controlled substance dispensed.
- Drug name.
- NDC (National Drug Code) number of the controlled substance dispensed.
- Strength of the prescription.
- Patient's full name.
- Date of birth.
- Rx number.
- Gender Code.(Code: male =1/female=2).
- ICD-9 Code (diagnosis code), if available.
- Patient's address.
- Date submitted.

The veterinarians' log contains the following information:

- The prescriber's name, address, telephone number, license number, and federal controlled substance registration (DEA#).
- Date of dispensing.
- Numeric quantity of controlled substance dispensed.
- Drug name.
- NDC (National Drug Code) number of the controlled substance dispensed.
- Strength of the prescription.
- Client's full name.
- Client's gender (Code: male =1/female =2).
- Client's date of birth (if available).
- Client's address.
- Animal patient's name
- Date submitted.

When submitting your data electronically, please note there are two separate Direct Dispense Data Specifications formats, one is exclusively formatted for Veterinarians use only and the other one is for general (physicians/prescriber's) who direct dispense. Also, when submitting your data the direct dispense data must be in a text file format and the record layout must be in the order as specified in the Direct Dispense Data Specifications.

Practitioners/prescribers are not responsible for reporting to CURES if they only administer Schedule II and III controlled substances.

For further information please contact the CURES Program at (916) 319-9062.

STATE OF CALIFORNIA

DEPARTMENT OF JUSTICE

PRESCRIBER'S DIRECT DISPENSING LOG

BNE 1179 (1/05)

Prescriber/Dispenser Name: ________________________________ Medical Lic. Number: ___________________

Address: ____ Telephone: ___________________________

DEA #: ____ Category of Licensure: ___________________

Date of Dispensing	Numeric Quantity	Drug Name	NDC Number	Strength of Rx

Patient First Name	MI	Patient Last Name	Patient Date of Birth	Rx Number

Gender Code Male=1/Female=2	ICD Code	Patient Address	City	State	Zip

Date of Dispensing	Numeric Quantity	Drug Name	NDC Number	Strength of Rx

Patient First Name	MI	Patient Last Name	Patient Date of Birth	Rx Number

Gender Code Male=1/Female=2	ICD Code	Patient Address	City	State	Zip

Date of Dispensing	Numeric Quantity	Drug Name	NDC Number	Strength of Rx

Patient First Name	MI	Patient Last Name	Patient Date of Birth	Rx Number

Gender Code Male=1/Female=2	ICD Code	Patient Address	City	State	Zip

Reporting Month/Year: _______/_______

Date submitted: _______/_______/_______