NOVA Addiction Treatment Center

8551 Rixlew Lane, Suite 140, Manassas, VA 20109 | Ph: 1-877-241-3596 | info@altmedfirst.com | www.altmedfirst.com

ADAPTED SUBJECTIVE OPIATE WITHDRAWAL SCALE

Suboxone / Medication-Assisted Treatment (MAT)

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____ **Date:** _____

1. HOW DO YOU FEEL RIGHT NOW?

Select the number that best fits • 0 = Not at all • 10 = Extremely

Symptom	0	1	2	3	4	5	6	7	8	9	10
1. I feel anxious	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. I feel like yawning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. I am perspiring	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. My nose is running and/or my eyes are watery	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. I have goose bumps and/or chills	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. I feel nauseated or like I may need to vomit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. I have stomach cramps and/or diarrhea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. My muscles twitch	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. I feel dehydrated and/or have little appetite	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. I am having difficulty sleeping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. I have a headache	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. My muscles and bones ache	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. I feel like using right now	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Overall, I would rate my withdrawal as	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Symptom score (items 1–13, auto-calculated): _____ out of 130 *Score updates automatically as items are selected*

2. DOSE & SUBSTANCE USE

Do you feel you need a dosage change? ☐ No ☐ Yes If yes: ☐ Up ☐ Down

Used alcohol or other drugs since your last visit? ☐ No ☐ Yes

If yes, describe what, when, and how much:

Life changes, triggers, or stressors since your last visit:

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RECOVERY CHECK-IN

Suboxone / Medication-Assisted Treatment (MAT)

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____ **Date:** _____

3. RECOVERY SUPPORT

Since your last visit, have you relapsed? ☐ No ☐ Yes

If yes, substance and when: _____

Attended any AA / NA meetings since your last visit? ☐ No ☐ Yes

If yes, dates and location: _____

Do you have a support network (family, sober friends)? ☐ No ☐ Yes

If yes, who: _____

4. MEDICATION CHANGES

Any medication changes since your last visit? ☐ No ☐ Yes

Medication name	Dose	Frequency / day	Prescribing doctor

5. SIDE EFFECTS / SYMPTOMS SINCE LAST VISIT

Check all that apply

☐ Fever ☐ Chills ☐ Sweats ☐ Sedation / sleepy

☐ Dizziness ☐ Heart fluttering ☐ Blurred vision ☐ Abdominal pain

☐ Nausea ☐ Constipation ☐ Headache ☐ Trouble sleeping

Other symptoms not listed above:

Patient Signature: _____ **Date:** _____

PROVIDER REVIEW

Office use only

☐ VA PMP reviewed ☐ UDS collected today (p. 3) ☐ Naloxone prescribed / on hand

Current buprenorphine dose: _____ **Plan:** ☐ Continue ☐ Increase ☐ Decrease ☐ Refer

Notes:

Next visit: _____ **Provider Signature:** _____ **Date:** _____

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DRUG SCREEN RESULT FORM – CONTROLLED SUBSTANCE

Suboxone / Medication-Assisted Treatment (MAT) **Specimen ID #** _____

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____ **SSN / ID #:** _____

PATIENT VITALS

BP: _____ **Pulse:** _____ **Height:** _____ **Weight:** _____

O2: _____ **Smoke:** _____ **Drink:** _____ **LMP:** _____

Allergies: _____

REASON FOR TEST & COLLECTION

☐ Follow-Up Visit ☐ Random ☐ Reasonable Suspicion ☐ Periodic

Date of Collection: _____ **Time of Collection:** _____ ☐ AM ☐ PM

Specimen Type: ☑ Urine **Temperature 90–100°F:** ☐ Yes ☐ No

Test Lot #: DOA2507040 **Exp. Date:** 2027-06 **Remarks:** _____

CERTIFICATION AND CONSENT

I certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for the presence of drugs and/or alcohol. I also give permission for the release of these results to my treating provider and/or their authorized healthcare professional.

Donor Signature: _____ **Date:** _____

I certify that I collected the specimen provided by the aforementioned donor and that it was not substituted or adulterated to the best of my knowledge.

Collector Signature: _____ **Date:** _____

TEST RESULTS

ALL NEG | CLEAR

ClearRapids™ 12 Panel Drug Test Cup • CLIA Waived • Cutoffs in ng/mL

Drug	Cutoff	POS	NEG	Quant. Confirm
Amphetamine (AMP)	1000	☐	☐	☐
Barbiturates (BAR)	300	☐	☐	☐
Buprenorphine (BUP)	10	☐	☐	☐
Benzodiazepines (BZO)	300	☐	☐	☐
Cocaine (COC)	300	☐	☐	☐
Methamphetamine (MET)	1000	☐	☐	☐

Drug	Cutoff	POS	NEG	Quant. Confirm
Ecstasy (MDMA)	500	☐	☐	☐
Methadone (MTD)	300	☐	☐	☐
Morphine (MOP)	300	☐	☐	☐
Oxycodone (OXY)	100	☐	☐	☐
Phencyclidine (PCP)	25	☐	☐	☐
Marijuana (THC)	50	☐	☐	☐

Result Remarks:

Result Read By: _____ **Date / Time Read:** _____