LIFE BALANCE, PLLC

COMPACT MEDICATION-ASSISTED TREATMENT (MAT) INTAKE

Buprenorphine / Suboxone Program for Opioid Use Disorder | 405 Galleria Drive, Suite E · Oxford, MS 38655 | 662.640.4004

CONFIDENTIAL: Your answers are used to guide safe treatment. Substance use disorder records receive special privacy protections under HIPAA and 42 CFR Part 2. Completing this form does not guarantee admission or a prescription.

1 PATIENT & CONTACT INFORMATION

Full legal name: _____	DOB: _____ / _____ / _____
Phone: _____ Email: _____ Address: _____ _____ _____	Preferred contact: ☐ Phone ☐ Text ☐ Email

Emergency contact (optional): _____ Relationship: _____

Phone: _____

Referral source/provider (if any): _____ Phone: _____

2 OPIOID & OTHER SUBSTANCE USE

Opioids used now/recently: ☐ Fentanyl ☐ Heroin ☐ Prescription opioids ☐ Kratom ☐ Other:

_____

Usual route: ☐ Oral ☐ Snort ☐ Smoke ☐ Injection/IV ☐ Other: _____ Frequency: ☐ Daily ☐ Weekly ☐ Intermittent

Typical amount: _____ LAST opioid use — Date: ____ / ____ / _____ Time: _____

☐ Unsure

Other current/recent use: ☐ Alcohol ☐ Benzodiazepines ☐ Methamphetamine ☐ Cocaine ☐ Cannabis ☐ Other: _____

For any checked above, substance/amount/frequency/last use: _____

3 TREATMENT, OVERDOSE & NALOXONE

Prior substance-use treatment: ☐ None ☐ Outpatient ☐ Inpatient ☐ Counseling ☐ MOUD Prior MOUD: ☐ Buprenorphine ☐ Methadone ☐ Naltrexone

Program/provider & approximate dates:

_____

_____

_____

_____

Reason treatment ended:

_____

_____

Prior opioid overdose: ☐ No ☐ Yes Number: _____ Most recent: _____

Naloxone/Narcan currently available: ☐ Yes ☐ No ☐ Unsure

Naloxone today: ☐ Offered/prescribed ☐ Patient already has current supply ☐ Declined ☐ To discuss with clinician

Overdose education: ☐ Completed ☐ Pending

4 MEDICAL, MENTAL HEALTH & INFECTIOUS-DISEASE SCREEN

Current medical conditions/hospitalizations / major surgeries: _____

Current medications (include controlled medicines):

_____

Allergies & reaction: □ None known □ Yes: _____

Pregnant, possibly pregnant, or breastfeeding: □ No □ Yes □ Not applicable □ Prefer to discuss Pregnancy test if indicated: □ Clinician to assess

Mental health history/current symptoms: □ Depression □ Anxiety □ Bipolar □ PTSD □ Psychosis □ ADHD □ Other: _____ □ None known

Current/recent thoughts of suicide or self-harm: □ No □ Yes □ Prefer to discuss

Prior suicide attempt/psychiatric hospitalization: □ No □ Yes

HIV: □ Negative □ Positive □ Unknown/not tested

Hepatitis B: □ Negative □ Positive □ Unknown

Hepatitis C: □ Negative □ Positive □ Treated □ Unknown

Would you like testing/referral for HIV/hepatitis/STIs? □ Yes □ No □ Discuss with clinician

Injection-related wounds/infections now? □ No □ Yes

5 RECOVERY SUPPORTS & PRACTICAL NEEDS

Housing: □ Stable □ Unstable □ Homeless

Transportation barrier: □ No □ Yes

Employment/school: □ Working □ School □ Neither □ Prefer not to answer

Recovery/support person or program: _____ Counseling/recovery support desired? □ Yes □ No □ Unsure

Other barrier that may affect treatment (cost, childcare, legal, pharmacy, safety, etc.):

_____

6 PROGRAM EXPECTATIONS & MEDICATION SAFETY — INITIAL EACH

_____ I will take buprenorphine only as prescribed and will not change the dose or route without my clinician.

_____ I will not sell, share, trade, inject, or otherwise misuse/divert medication; I will store it securely away from children and others.

_____ I understand alcohol, benzodiazepines, opioids, and other sedatives can increase sedation, breathing problems, overdose, and death.

_____ I understand benzodiazepine or other substance use does not automatically exclude me from treatment, but may require coordination and closer monitoring.

_____ I agree to required clinical monitoring, which may include prescription-monitoring review and scheduled or random toxicology testing.

_____ I will tell the clinic about pregnancy, hospitalization, relapse, medication changes, other prescribers/pharmacies, and procedures requiring pain treatment.

_____ I understand lost/stolen medication may not automatically be replaced and missed visits may affect safe prescribing and follow-up.

7 BUPRENORPHINE INFORMED CONSENT & PRIVACY

Buprenorphine can reduce opioid withdrawal/craving and support recovery, but does not eliminate relapse or overdose risk. Risks can include precipitated withdrawal, sedation, constipation, nausea/headache, physical dependence, misuse/diversion, dental/oral problems with transmucosal products, and potentially fatal respiratory depression—especially with other sedatives. Alternatives include methadone, naltrexone, behavioral treatment, and no treatment.

_____ I have had or will have the opportunity to discuss benefits, risks, alternatives, safe storage, overdose prevention/naloxone, and questions with my clinician before treatment begins.

_____ I acknowledge I was offered the clinic Notice of Privacy Practices. Separate authorization is required for optional disclosures/coordination of care when applicable.

Optional communication: □ Text □ Email □ Neither Optional telehealth consent (if used): □ Yes □ No I understand these methods have privacy/technology limitations.

8 PATIENT ATTESTATION & SIGNATURE

I certify that the information I provided is accurate to the best of my knowledge. I understand this intake is part of a clinical evaluation and does not guarantee a prescription.

Patient name (print): _____

Signature: _____

Date: ____ / ____ / _____

FOR CLINICIAN USE — INITIAL MOUD ASSESSMENT

OUD diagnosis: □ Confirmed □ Not confirmed / further assessment needed

DSM-5 severity: □ Mild □ Moderate □ Severe

Withdrawal/COWS when applicable: _____

Vitals/exam completed as clinically indicated: □ Yes

Toxicology: □ Obtained □ Reviewed □ Deferred/not indicated today

Pregnancy test when indicated: □ Negative □ Positive □ Pending □ N/A

MS PMP reviewed: □ Yes Date/time: _____ Findings: □ Consistent □ Concern identified

Relevant labs/testing ordered/reviewed: □ HIV □ HBV □ HCV □ CMP/LFTs □ Other: _____ □ Not needed today

Naloxone: □ Prescribed/offered □ Has supply □ Declined Acute psychiatric/safety concern: □ No □ Yes → disposition/plan:

_____

Clinical assessment: □ OUD criteria reviewed □ Current/last opioid use reviewed □ CNS depressants/controlled meds reviewed □ Diversion risk assessed □ Naloxone/overdose education addressed

PMP concern/action or clinical rationale (if applicable): _____

Induction/continuation strategy & treatment plan: _____

Follow-up: _____

Counseling/recovery supports discussed: □ Yes

Higher level of care/referral needed: □No □ Yes: _____

Clinician: _____ Credentials: _____

Signature: _____ Date: _____