MedPro

PATIENT DATA SUMMARY SHEET

Treatment Status: ____*New Patient*
____*Transfer Patient (from which Clinic?*_____)
____*Re-Admission*

First Name _____ **MI**_____**Last Name**_____

Social Security #_____

Gender: *M F* (if female, pregnant?) Y N

Race/Ethnic: *Caucasian African American Native American Asian Spanish*

*Other*_____

Martial Status: *M S D Other*_____

Birthdate_____

Employment Status: *FT PT Student Homemaker Disabled*

Drivers License # _____**State Issued** _____

Living Arrangements: *Apartment House Relative Other* _____

Address _____

City/State_____**Zip Code**_____

Work #_____**Home #**_____

I DO _____ **/ DO NOT** _____
consent to being called using these numbers or other contact numbers provided without prior notice.

*Emergency Contact Name*_____ *PH#*_____
(By providing this information I am providing consent to contact this person in a situation considered an emergency by clinic staff and/or if you leave the clinic against medical advice)

Relationship of emergency contact_____

Primary Care Physician_____**Phone#**_____

Dr.'s Address_____ **Preferred Hospital**_____

Patient Signature_____Date_____

MTC Representative_____Date_____

PATIENT NAME_____***PID#***_____

MedPro Treatment Centers
405 N. McDonald Street, Ste. B
McKinney, TX 75069

972-542-4144

Screening Form

CRITERIA FOR ACCEPTANCE TO METHADONE OR BUPRENORPHINE TREATMENT

There are specific State and Federal regulations regarding admissions to a Methadone Maintenance Treatment Center. Please answer the following questions to the best of your knowledge.

Name: _____ Date: _____

Phone Number: _____ O.K. to call and/or leave a message? Y N

Age: _____(please stop if you are under 18) Referred by: _____

If Internet: Which Search Engine or Website Used: _____

What Search Term(s) or Ad Clicked On: _____

☐ New Patient ☐ Transferring Patient ☐ Re-admitting Patient

1. Please list any and all narcotic drugs that you have ever used and the length of time you have used each drug _____

   How long has the patient been addicted to opiates? (Must be at least one year) _____

   Date of Last Narcotic Use: _____

   Please check all symptoms of withdrawal that you are currently experiencing:

Runny Nose	[ ]	Dilated Pupils	[ ]	Tearing (eyes)	[ ]
Sweating	[ ]	Chills	[ ]	Diarrhea	[ ]
Yawning	[ ]	Nausea	[ ]	Gooseflesh	[ ]

2. Please check all signs and behaviors that apply.

   Can't stop or control use? [ ]
   Spend a lot of time obtaining drugs? [ ]
   Keep using despite harmful effects? [ ]
   Obtain opiates on the street? [ ]
   Using opiates inappropriately? [ ]
   Having problems with work, family, legal system, or friends because of using? [ ]

3. What would you most like to receive from MTC to assist in your recovery? _____

   _____

4. Appears appropriate for treatment? Y N

5. Intake appointment scheduled for ____/____/____ Time: _____

_____ _____
Signature Date

New Patient Demographics

PID # _____

Screen Date: _____

Admit Date or Reason not Admitted: _____

Referred By: _____

Search Engine: _____

Search Term Used: _____

City of Residence: _____

Number of years addicted: _____

Risk Reduction Intake

1. Are you currently using opiate-based drugs? Y N
2. Are you currently employed, a student or a full time Homemaker at this time? Y N
3. Have you had any new legal problems in the past 90 days? Y N
4. Have you practiced safe sex 100% of the time in the past 90 days? Y N
5. Have you remained free from needle sharing in the past 90 days? Y N
6. Are you currently drinking alcohol excessively? Y N
7. Did you begin taking opiates due to an accident or injury? Y N
8. What is your drug of choice? _____