NALTREXONE FOR OPIOID USE DISORDER

PATIENT INFORMATION *(Please print clearly)*

Last Name: **First Name:**	**D.O.B.:** **Age:** **Gender:** **Height:** **Weight:**
Home Address:	Contact Phone:
City:	State: Zip:
Primary Care Physician:	Physician Phone:
Physician Address:	Physician Fax #:
Please state any past medical history and chronic conditions:	
Current medications:	
Allergies (please state reaction that occurs when exposed to the allergen):	
When was the last use of opioid medication (MM/DD/YYYY)?	

SCREENING QUESTIONNAIRE

	Yes	**No**	**Don't Know**
For women: Are you currently pregnant?	☐	☐	☐
For women: Have you had a negative urine pregnancy test prior to this encounter? *If yes, when?*	☐	☐	☐
Have you had liver function laboratory tests in the past 14 days?	☐	☐	☐
Do you have any allergies/hypersensitivities to Naltrexone or any component of the extended release injectable Naltrexone formulation including the diluent?	☐	☐	☐
Do you currently have acute hepatitis or liver failure?	☐	☐	☐
Do you currently have kidney impairment or history of thrombocytopenia or coagulation disorders?	☐	☐	☐
Do you have an active diagnosis of opioid dependence disorder by a healthcare provider?	☐	☐	☐
Do you currently have plans for psychosocial treatment?	☐	☐	☐
Do you currently smoke tobacco? *If yes, how many packs per day?*	☐	☐	☐
Do you currently consume alcohol? *If yes, how many drinks per day?*	☐	☐	☐
Do you currently use any recreational drugs? *If yes, please indicate which drugs and how often:*	☐	☐	☐