The MARC at Health Solutions

Hope. Health. Together

Thank you for your interest in becoming a patient at The Medication Assisted Recovery Center (MARC) at Health Solutions. The MARC is set up to provide medication (e.g. Suboxone, Methadone, Vivitrol), in support of your substance use recovery process. Should you be accepted into the program, we will work with you to help you successfully succeed in your recovery goals. If you are not accepted into the program, our healthcare team will work with you to identify alternative treatment options.

Please note, no appointments will be scheduled without your photo ID, insurance card/cards or number, and a completed application.

Task Check List:

- ☐ Return the completed packet to The Health Solutions Medication Assisted Recovery Center (MARC) 41 Montebello Rd., Suite 120 during open access time frame before appointment will be scheduled

In order to begin medication, the day of your history & physical/induction, please be 24-36 hours without opiates for Suboxone and 7 days without opiates for Vivitrol. If not, we will still be happy to see you for evaluation and medication planning.

Open Access Hours Monday - Friday 7 am to 2 pm
(Suboxone, Vivitrol)

Open Access Hours Monday - Friday 6 am
(Methadone)

Orientation for the MARC program is required for all patients and will be completed before your appointment with the doctor.

Please understand open access is first come first serve and based on provider availability and could take several hours please plan ahead so you can be here for the entire process. You may also be asked to return for a 2 day follow up after starting your medication.

If you have any difficulties regarding the application process, or need assistance completing the application, we are here to help. Call: **719.423.1500** – and choose option 2. Or, you can stop by the MARC to ask questions or request help with an application. We're open Monday – Friday, 7:00am – 5:00pm at 41 Montebello Road, Suite 120 in Pueblo, CO.

Mission: *Health Solutions exists to assist those in need of healthcare services who require expert care to support recovery and to successfully achieve their healthcare goals. Health Solutions is committed to offering exceptional quality services that set the standard for healthcare in Colorado. This care is provided through service excellence, innovation, compassion, and promotion of self-determination.*

Revised: 01/13/2022

MARC PATIENT APPLICATION

Name: _____ Date of Birth: _____
First, Middle, and Last Name

Insurance Information:

Insurance: Medicare Self Pay Medicaid Member #:_____

Other Insurance Information: _____

Medical History:

Who is your current Primary Care Provider? ☐ I do not currently have a Primary Care Provider

Name: _____ Phone #:_____

Are you currently pregnant? Yes No Any current prescription medications? Yes No

List all current Prescription Medications you presently use, the amount, and how often:

Medication Name	Amount/Dose	How Often

Please note, Benzodiazepine use is not allowed while in the MARC program.

Are you interested in Suboxone or Vivitrol treatment? Suboxone Vivitrol Methadone

Are you currently taking Suboxone? Yes No

If yes, please list the doctor currently prescribing it and how long you have been taking it:

_____

Are you currently employed? Yes No

Who referred you to the program/How did you hear about us: _____

Substance Use History:

List all the street drugs you presently use, the amount, and how often:

Drugs	Amount	How Often

Are you currently enrolled in residential treatment? Yes No If yes where and for how long? _____

Are you currently on probation or parole? No Yes PO's Name: _____

_____ _____
Applicant's Signature Date

MARC PATIENT APPLICATION CONT.

OFFICE USE ONLY

Treatment Enrollment? Y N Where?_____

Currently on Methadone: Y N Clinic name:_____ **Dose:** _____

How long on methadone?:_____ **Current phase level:**_____

Have you ever been diagnosed/treated for mental health? Y N
If yes what was the diagnosis:_____

Patient Information Page

Patient Name: _____
First Name. Middle Initial and Last Name (Please see page 2 for Parent/Guardian Section)

Preferred Name: _____

Patient DOB: _____

Social Security Number: _____

Mailing Address: _____

City, State, Zip Code: _____

Permanent Address: _____
(If different from above)

City, State, Zip Code: _____

Home Phone Number: _____

Cell Phone Number: _____

Email Address: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____ Check if Ok to contact in the event of an Emergency: ☐

Preferred Pharmacy: _____

Pharmacy Address: _____

Primary Insurance: _____

Member ID: _____

Subscriber Name: _____

Subscriber DOB, SSN: _____

Secondary Insurance: _____

Member ID: _____

Subscriber Name: _____

Subscriber DOB, SSN: _____

Please list Parent/Guardian Information below (If under the Age of 18):

1. Name: _____

DOB and SSN: _____

Address: _____

Home Phone Number: _____

Cell Phone Number: _____

2. Name: _____

DOB and SSN: _____

Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Please Note: Anyone other than parent(s) must provide proper documentation. Thank you

Birth Sex:
- Male
- Female
- Undifferentiated
- Unknown

Current Sex:
- Male
- Female

Gender Identity:
- Additional Gender Category or other
- Choose Not to Disclose
- Female
- Female-to-Male/Transgender Male
- Genderqueer, neither exclusively male nor female
- Male
- Male-to-Female /Transgender Female

Sexual Orientation:
- Bisexual
- Decline
- Gay/Lesbian/Homosexual
- Straight/Heterosexual
- Other

Preferred Pronoun:
- Decline
- He, Him, His
- Other
- She, Her, Hers
- They, Them, Theirs
- Ze, Hir

Marital Status:
- Divorced
- Married
- Married, Separated
- Never Married
- Widowed

Race:
- American Indian/Alaska Native
- Asian
- Black/African American
- Decline
- Native Hawaiian/Other Pacific Islander
- White/Caucasian

Ethnicity:
- No Hispanic
- Decline
- Yes, Hispanic (Other)
- Yes, Hispanic (Mexican)
- Yes, Hispanic (Puerto Rican)
- Yes, Hispanic (Cuban)

Preferred Contact:
- Case Worker
- Cell Phone
- Confidential
- Don't Call Home Phone
- Don't Call Work Number
- Don't Leave Message
- Email
- Home Phone
- OK To Leave Message
- Other
- Patient Portal
- Work Phone

Notifications:
- Opt out
- Email
- SMS (Text)
- Voice Reminders

Transportation Needed:

- Yes
- No

Highest Education:

- College Degree
- Doctoral Degree
- Master's Degree
- Some College
- Grade 12 or GED
- Grade 11
- Grade 10
- Grade 9
- Grade 8
- Grade 7
- Grade 6
- Grade 5
- Grade 4
- Grade 3
- Grade 2
- Grade 1
- Kindergarten
- Less than Kindergarten

Primary Role/employment/school:

- Disabled
- Employed Full Time (35 Hours +/week)
- Employed Part Time (<35 Hours/week)
- Homemaker
- Inmate
- Military
- Retired
- Student
- Supported Employment
- Unemployed
- Volunteer

Smoker:

- Current Smoker – Tobacco User - Periodically
- Current Smoker/tobacco User – Every Day
- Former Smoker/Tobacco User
- Never Smoker/Tobacco User
- Smoker/Tobacco User – current Status Unknown
- Unknown If Ever Smoked/Used

Place of Residence:

- Assisted Living
- ATU, Adults Only
- Boarding Home (Adult)
- Correctional Facility/Jail
- Foster Home (Youth)
- Group Home (Adult)
- Halfway House
- Homeless
- Independent Living
- Inpatient
- Nursing Home
- Residential Facility (MH Adult)
- Residential Facility (Other)
- Sober Living
- Supporting Housing

Current Living Arrangement:

- Alone
- Children
- Father
- Foster Parent(s)
- Guardian
- Mother
- Partner/Significant Other
- Relatives
- Siblings
- Spouse
- Unrelated Person

Veteran:

- Yes
- No

Pregnant:

- Yes
- No

How did you hear about us?

- Billboard
- Direct Mailing
- Facebook
- Health Solutions Behavioral Health
- Insurance Referral
- Newspaper
- Patient Referral
- Provider Referral
- Radio/TV
- Twitter
- Unknown
- WebSearch
- Yellow Pages

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

AUDIT - C

Health SOLUTIONS

Hope. Health. Together

Client Name: _____ **Client DOB:** _____ **Assessment Date:** _____

How often do you have a drink containing alcohol?

- ○ **Never**
- ○ **Monthly or less**
- ○ **2/4 times per month**
- ○ **2/3 times a week**
- ○ **4 or more times a week**

How many standard drinks containing alcohol do you have in a typical day?

- ○ **0 to 2**
- ○ **3 or 4**
- ○ **5 or 6**
- ○ **7 to 9**
- ○ **10 or more**

How often do you have six or more drinks on one occasion?

- ○ **Never**
- ○ **Less than monthly**
- ○ **Monthly**
- ○ **Weekly**
- ○ **Daily or almost daily**

AUDIT-C TOTAL **AUDIT-C DESCRIPTION**

NAME: _____ **DATE:** _____

DRUG USE QUESTIONNAIRE (DAST – 20)

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question. In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Adult Version

These questions refer to the past 12 months.	Circle Your Response	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Have you abused prescription drugs?	Yes	No
3. Do you abuse more than one drug at a time?	Yes	No
4. Can you get through the week without using drugs?	Yes	No
5. Are you always able to stop using drugs when you want to?	Yes	No
6. Have you had "blackouts" or "flashbacks" as a result or drug use?	Yes	No
7. Do you every feel bad or guilty about your drug use?	Yes	No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10. Have you lost friends because of your use of drugs?	Yes	No
11. Have you neglected your family because of your use of drugs?	Yes	No
12. Have you been in trouble at work (or school) because of drug abuse?	Yes	No
13. Have you lost your job because of drug abuse?	Yes	No
14. Have you gotten into fights when under the influence of drugs?	Yes	No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16. Have you been arrested for possession of illegal drugs?	Yes	No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19. Have you gone to anyone for help for drug problem?	Yes	No
20. Have you been involved in a treatment program specifically related to drug use?	Yes	No