TCU DRUG SCREEN 5 – Opioid Supplement

*If the response to TCU Drug Screen 5, page 2, Q13e, Q13f, or Q13r regarding opioid use is more than “Never,” then complete the following questions.

In the LAST 12 MONTHS –

1. **What types of opioids** have you used?
   a. Heroin ................................................................. ○ No ○ Yes
   b. Oxycodone (Oxycontin, Percodan, Percocet) ........................ ○ No ○ Yes
   c. Hydrocodone (Vicodin, Lortab, Loracet, Norco, Zohydro) ........ ○ No ○ Yes
   d. Morphine (Kadian, Avinza, MS Contin) .............................. ○ No ○ Yes
   e. Fentanyl (Duragesic, Fentora) ........................................ ○ No ○ Yes
   f. Hydromorphone (Dilaudid, Exalgo) ................................... ○ No ○ Yes
   g. Methadone (Dolophine) ................................................ ○ No ○ Yes
   h. Oxymorphone (Opana) .................................................. ○ No ○ Yes
   i. Codeine (Tylenol/cough syrup with codeine) ....................... ○ No ○ Yes

2. **How many times did you inject** an opioid?
   ○ Never ○ A few times ○ 1-3 times/month ○ 1-5 times per week ○ Daily

3. **How many times did you take** an opioid in another way (e.g., ground pills and sniffed it, put a film in your mouth)?
   ○ Never ○ A few times ○ 1-3 times/month ○ 1-5 times per week ○ Daily

4. **How many times did you take** an opioid prescribed for you?
   ○ Never ○ A few times ○ 1-3 times/month ○ 1-5 times per week ○ Daily

5. **How many times did you take** an opioid prescribed for someone else?
   ○ Never ○ A few times ○ 1-3 times/month ○ 1-5 times per week ○ Daily

6. **From whom** did you get the opioids you took?
   a. Medical doctor/pharmacy? ............................................. ○ No ○ Yes
   b. Family member? ....................................................... ○ No ○ Yes
   c. Friend? ..................................................................... ○ No ○ Yes
   d. Someone else (e.g., “on the street”)? .............................. ○ No ○ Yes

7. **Have you taken opioids** for medical reasons? .................................. ○ No ○ Yes*
   *IF YES, briefly describe the reasons:

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8. Have you taken opioids for **non-medical reasons**? ........................................... ○ No ○ Yes*  
*IF YES, briefly describe the reasons:  

9. Has a **doctor prescribed** opioid medications for you? ........................................... ○ No ○ Yes*  
*IF YES:  
a. did you have the most recent prescription filled? ........................................... ○ No ○ Yes*  
b. did you take all of the medications as prescribed? ........................................... ○ No ○ Yes*  
c. did you give or sell any of your medications to someone else? ........................ ○ No ○ Yes*  

10. Have you taken other **medications or illegal drugs** for medical reasons (e.g., to treat pain)? ................................................................. ○ No ○ Yes*  
*IF YES, please list:  

Drug/medication: ___________________________ Reasons for taking: ___________________________  
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11. Do you or someone close to you (e.g., family, friend) have access to **naloxone (Narcan)** to reverse an overdose? .................................................. ○ No ○ Yes  

12. How many times have you **EVER** overdosed after taking opioids?  
○ Never ○ Once ○ Twice ○ 3 times ○ 4 or more times  

13. In the last 12 months, how many times **have you overdosed** after taking opioids?  
○ Never ○ Once* ○ Twice* ○ 3 times* ○ 4 or more times*  
*IF MORE THAN “NEVER,” in the last 12 months:  
a. **What types of opioids** did you use?  
   1. Heroin .......................................................................................................... ○ No ○ Yes  
   2. Oxycodone (Oxycontin, Percodan, Percocet) ............................................. ○ No ○ Yes  
   3. Hydrocodone (Vicodin, Lortab, Lorcan, Nnorco, Zohydro) ...................... ○ No ○ Yes  
   4. Morphine (Kadian, Avinza, MS Contin) .................................................... ○ No ○ Yes  
   5. Fentanyl (Duraesic, Fentora) ..................................................................... ○ No ○ Yes  
   6. Hydromorphone (Dilaudid, Exalgo) ........................................................... ○ No ○ Yes  
   7. Methadone (Dolophine) ............................................................................. ○ No ○ Yes  
   8. Oxymorphone (Opana) ............................................................................... ○ No ○ Yes  
   9. Codeine (Tylenol/cough syrup with codeine) ............................................ ○ No ○ Yes
b. How many times did you go to the hospital or emergency room because of an overdose on opioids?
   ○ Never  ○ Once  ○ Twice  ○ 3 times  ○ 4 or more times

c. How many times were you given naloxone (Narcan) because of an overdose?
   ○ Never  ○ Once  ○ Twice  ○ 3 times  ○ 4 or more times

d. Have you received any follow-up treatment after the most recent overdose? ................................................................. ○ No  ○ Yes

14. Have you received Medication Assisted Treatment (MAT) in the last 12 months? ................................................................. ○ No  ○ Yes

15. Are you currently receiving Medication Assisted Treatment (MAT)? .......... ○ No  ○ Yes
   *IF YES, what type?
   a. Methadone (Dolophine or Methadone) .................................................. ○ No  ○ Yes
   b. Buprenorphine (Subutex, Suboxone) .................................................. ○ No  ○ Yes
   c. Oral naltrexone (Depade, Revia) .................................................. ○ No  ○ Yes
   d. Depot natrexone (Vivitrol) ........................................................ ○ No  ○ Yes
   e. Other, specify: ____________________________________________________ ○ No  ○ Yes

16. Have you obtained any of these medications without a prescription? .......... ○ No  ○ Yes

17. Have you taken more of these medications than were prescribed? .......... ○ No  ○ Yes