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, Lorcet, 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:
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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   Drug/medication: _____________________ Reasons for taking: _____________________

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, Lorcet, Norco, Zohydro) ......................... ○ No   ○ Yes
      4. Morphine (Kadian, Avinza, MS Contin) ..................................................... ○ No   ○ Yes
      5. Fentanyl (Duragesic, 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