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| Client ID# Today’s Date | Facility ID# | Zip Code Administration |

TCU DRUG SCREEN 5

During the last 12 months (before being locked up, if applicable) –

1. Did you use larger amounts of drugs or use them for a longer time

**Yes No**

than you planned or intended? .......................................................................................  

1. Did you try to control or cut down on your drug use but were unable to do it? ............  
2. Did you spend a lot of time getting drugs, using them, or recovering

from their use? ................................................................................................................  

4. Did you have a strong desire or urge to use drugs? .......................................................  

1. Did you get so high or sick from using drugs that it kept you from

working, going to school, or caring for children? ..........................................................  

1. Did you continue using drugs even when it led to social or interpersonal problems? ...  
2. Did you spend less time at work, school, or with friends because of your drug use? ....  
3. Did you use drugs that put you or others in physical danger? .......................................  
4. Did you continue using drugs even when it was causing you

physical or psychological problems? .............................................................................  

10a. Did you need to increase the amount of a drug you were taking so that you

could get the same effects as before? .............................................................................  

10b. Did using the same amount of a drug lead to it having less of an effect

as it did before? ..............................................................................................................  

11a. Did you get sick or have withdrawal symptoms when you quit or missed

taking a drug? .................................................................................................................  

11b. Did you ever keep taking a drug to relieve or avoid getting sick or having

withdrawal symptoms? ...................................................................................................  

1. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]
   * None
   * Alcohol
   * Cannaboids – Marijuana *(weed)*
   * Cannaboids – Hashish *(hash)*
   * Synthetic Marijuana *(K2/Spice)*
   * Natural Opioids – Heroin *(smack)*
   * Synthetic Opioids – Fentanyl/Iso
   * Stimulants – Powder Cocaine *(coke)*
   * Stimulants – Crack Cocaine *(rock)*

* Stimulants – Methamphetamine *(meth)*
* Synthetic Cathinones *(Bath Salts)*
* Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*
* Dissociative Drugs – Ketamine/PCP *(Special K)*
* Hallucinogens – LSD/Mushrooms *(acid)*
* Inhalants – Solvents *(paint thinner)*
* Prescription Medications – Depressants
* Prescription Medications – Stimulants
* Prescription Medications – Opioid Pain Relievers
  + Stimulants – Amphetamines *(speed)*  Other (specify)

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| Client ID# | Today’s Date | Facility ID# | Zip Code Administration |

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| 13. How often did you use each type of drug during the last 12 months? | Only a few  Never times | 1-3 1-5  times per times per month week | Daily |
| a. Alcohol .......................................................................... |   |   |  |
| b. Cannaboids – Marijuana *(weed)* .................................... |   |   |  |
| c. Cannaboids – Hashish *(hash)* ........................................ |   |   |  |
| d. Synthetic Marijuana *(K2/Spice)* .................................... |   |   |  |
| e. Natural Opioids – Heroin *(smack)* ................................. |   |   |  |
| f. Synthetic Opioids – Fentanyl/Iso ................................. |   |   |  |
| g. Stimulants – Powder cocaine *(coke)* ............................. |   |   |  |
| h. Stimulants – Crack Cocaine *(rock)* ............................... |   |   |  |
| i. Stimulants – Amphetamines *(speed)* ............................. |   |   |  |
| j. Stimulants – Methamphetamine *(meth)* ......................... |   |   |  |
| k. Synthetic Cathinones *(Bath Salts)* ................................. |   |   |  |
| l. Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)* ......... |   |   |  |
| m. Dissociative Drugs – Ketamine/PCP *(Special K)* .......... |   |   |  |
| n. Hallucinogens – LSD/Mushrooms *(acid)* ...................... |   |   |  |
| o. Inhalants – Solvents *(paint thinner)* .............................. |   |   |  |
| p. Prescription Medications – Depressants ....................... |   |   |  |
| q. Prescription Medications – Stimulants .......................... |   |   |  |
| r. Prescription Medications – Opioid Pain Relievers ....... |   |   |  |
| s. Other (specify) ...... |   |   |  |

1. How many times before now have you ever been in a drug treatment program? [DO NOT INCLUDE AA/NA/CA MEETINGS]
   * *Never*  *1 time*  *2 times*  *3 times*  *4 or more times*
2. How serious do you think your drug problems are?
   * *Not at all*  *Slightly*  *Moderately*  *Considerably*  *Extremely*
3. During the last 12 months, how often did you inject drugs with a needle?
   * *Never*  *Only a few times*  *1-3 times/month*  *1-5 times per week*  *Daily*
4. How important is it for you to get drug treatment now?
   * *Not at all*  *Slightly*  *Moderately*  *Considerably*  *Extremely*

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| Client ID# Today’s Date | Facility ID# | Zip Code Administration |

**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*

# How many times did you inject an opioid?

* + *Never*  A *few times*  *1-3 times/month*  *1-5 times per week*  *Daily*

# 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*

# 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*

# 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*

# 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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| Client ID# Today’s Date | Facility ID# | Zip Code Administration |

**8. Have you taken opioids for non-medical reasons?** .............................................  *No*  *Yes\**

**\*IF YES,** briefly describe the reasons:

1. **Has a doctor prescribed opioid medications for you?** .......................................  *No*  *Yes\**

# \*IF YES:

* 1. did you have the most recent prescription filled? ..........................................  *No*  *Yes\**
  2. did you take all of the medications as prescribed? ........................................  *No*  *Yes*\*
  3. did you give or sell any of your medications to someone else? .....................  *No*  *Yes*\*

# 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: Drug/medication: Reasons for taking: Drug/medication: Reasons for taking:

# Do you or someone close to you (e.g., family, friend) have access to

**naloxone (Narcan) to reverse an overdose?** ........................................................  *No*  *Yes*

# How many times have you EVER overdosed after taking opioids?

* *Never*  *Once*  *Twice*  *3 times*  *4 or more times*

# 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:

* 1. **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*

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| Client ID# Today’s Date | Facility ID# | Zip Code Administration |

# 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*

# How many times were you given naloxone (Narcan) because of an overdose?

* + - *Never*  *Once*  *Twice*  *3 times*  *4 or more times*

# Have you received any follow-up treatment after the most recent

**overdose?** ..............................................................................................................  *No*  *Yes*

# Have you received Medication Assisted Treatment (MAT)

**in the last 12 months?** ...................................................................................................  *No*  *Yes*

1. **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*

1. **Have you obtained any of these medications without a prescription?** .............  *No*  *Yes*
2. **Have you taken more of these medications than were prescribed?** ..................  *No*  *Yes*