

TCU DRUG SCREEN 5

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

	Yes	No
1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	<input type="radio"/>	<input type="radio"/>
2. Did you try to control or cut down on your drug use but were unable to do it?	<input type="radio"/>	<input type="radio"/>
3. Did you spend a lot of time getting drugs, using them, or recovering from their use?	<input type="radio"/>	<input type="radio"/>
4. Did you have a strong desire or urge to use drugs?	<input type="radio"/>	<input type="radio"/>
5. Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	<input type="radio"/>	<input type="radio"/>
6. Did you continue using drugs even when it led to social or interpersonal problems? ...	<input type="radio"/>	<input type="radio"/>
7. Did you spend less time at work, school, or with friends because of your drug use?	<input type="radio"/>	<input type="radio"/>
8. Did you use drugs that put you or others in physical danger?	<input type="radio"/>	<input type="radio"/>
9. Did you continue using drugs even when it was causing you physical or psychological problems?	<input type="radio"/>	<input type="radio"/>
10a. Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	<input type="radio"/>	<input type="radio"/>
10b. Did using the same amount of a drug lead to it having less of an effect as it did before?	<input type="radio"/>	<input type="radio"/>
11a. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	<input type="radio"/>	<input type="radio"/>
11b. Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	<input type="radio"/>	<input type="radio"/>
12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]		
<input type="radio"/> None		
<input type="radio"/> Alcohol		
<input type="radio"/> Cannaboids – Marijuana (<i>weed</i>)		
<input type="radio"/> Cannaboids – Hashish (<i>hash</i>)		
<input type="radio"/> Synthetic Marijuana (<i>K2/Spice</i>)		
<input type="radio"/> Natural Opioids – Heroin (<i>smack</i>)		
<input type="radio"/> Synthetic Opioids – Fentanyl/Iso		
<input type="radio"/> Stimulants – Powder Cocaine (<i>coke</i>)		
<input type="radio"/> Stimulants – Crack Cocaine (<i>rock</i>)		
<input type="radio"/> Stimulants – Amphetamines (<i>speed</i>)		
<input type="radio"/> Stimulants – Methamphetamine (<i>meth</i>)		
<input type="radio"/> Synthetic Cathinones (<i>Bath Salts</i>)		
<input type="radio"/> Club Drugs – MDMA/GHB/Rohypnol (<i>Ecstasy</i>)		
<input type="radio"/> Dissociative Drugs – Ketamine/PCP (<i>Special K</i>)		
<input type="radio"/> Hallucinogens – LSD/Mushrooms (<i>acid</i>)		
<input type="radio"/> Inhalants – Solvents (<i>paint thinner</i>)		
<input type="radio"/> Prescription Medications – Depressants		
<input type="radio"/> Prescription Medications – Stimulants		
<input type="radio"/> Prescription Medications – Opioid Pain Relievers		
<input type="radio"/> Other (specify) _____		

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

14. 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*

15. How serious do you think your drug problems are?

Not at all *Slightly* *Moderately* *Considerably* *Extremely*

16. 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*

17. How important is it for you to get drug treatment now?

Not at all *Slightly* *Moderately* *Considerably* *Extremely*

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:

<input type="text"/> Client ID#	<input type="text"/> Today's Date	<input type="text"/> Facility ID#	<input type="text"/> Zip Code	<input type="text"/> Administration
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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: _____

Drug/medication: _____ Reasons for taking: _____

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*

<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Client ID#	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Today's Date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Facility ID#	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Zip Code	<input type="text"/> <input type="text"/> <input type="text"/> Administration
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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 naltrexone (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