

NURSING FOLLOW-UP: NALTREXONE

Provider Name: _____

Provider Signature: _____ Date: _____

NALTREXONE NURSING FOLLOW-UP VISIT

Visit type:

- Scheduled
- Call-back
- Walk-in
- Random call-back

Patient Receives:

- Oral naltrexone
- Extended-release injectable naltrexone

Last injection date: _____

Last injection location: Right side Left side

Length of time on injectable naltrexone: _____

Is patient experiencing:

- Cravings
- Medication side effects
- Medication adverse reactions
- Other: _____
- Patient denies cravings/withdrawal symptoms/adverse effects

OBAT Provider Name: _____

Was the last OBAT provider visit within 4 months? _____

Female Patients: Any chance that you are pregnant at this time?

- 1 = Yes
- 2 = No
- 3 = Don't know
- 4 = Tubal ligation
- 5 = Menopause
- 6 = History of hysterectomy
- 7 = Other: _____

If no, are you on birth control?

- 1 = Yes
- 2 = No

If yes, which method of birth control are you currently on? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Relying on male condoms | <input type="checkbox"/> Patch |
| <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Female barrier method (e.g., diaphragm, female condom) |
| <input type="checkbox"/> Shot (e.g., Depo-Provera) | <input type="checkbox"/> Rhythm/Fertility Awareness Methods/Withdrawal |
| <input type="checkbox"/> Hormonal implant | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Intrauterine device/contraception (IUD or IUC) | |
| <input type="checkbox"/> Vaginal ring | |

Has patient used any substances?

- | | |
|--|--|
| <input type="checkbox"/> Opioids | <input type="checkbox"/> Prescribed controlled substance |
| <input type="checkbox"/> Cocaine | Reason for prescription: _____ |
| <input type="checkbox"/> THC | <input type="checkbox"/> Patient denies all drug use |
| <input type="checkbox"/> ETOH | <input type="checkbox"/> None |
| <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Amphetamines | |

Patient reports the following medical issues:

Is patient engaged in counseling?

- 1 = Yes
- 2 = No

Location of counseling: _____

What is the name of your counselor? _____

How often is the patient going to counseling?

- 1 = Once a week
- 2 = Every other week
- 3 = Once a month
- 4 = Every 2–3 months
- 5 = Other: _____

Has the patient missed any counseling appointments?

- 1 = Yes
- 2 = No

What is the reason for the missed appointments?

Is the patient seeing a psychiatrist?

- 1 = Yes
- 2 = No

Name of psychiatrist: _____

How often is the patient seeing a psychiatrist?

- 1 = Once a week
- 2 = Every other week
- 3 = Once a month
- 4 = Every 2–3 months
- 5 = Other: _____

Are you attending peer-support meetings?

- 1 = Yes
- 2 = No

If yes, which meetings do you attend? (check all that apply)

- 1 = AA
- 2 = NA
- 3 = Smart Recovery
- 4 = Other: _____

If yes, how many meetings do you attend each week?

- 1 = 1–2 week
- 2 = 3–4 week
- 3 = 5–6 week
- 4 = Daily
- 5 = Other: _____

The following portions of the patient's history were reviewed and updated as appropriate:

- Medication List
- Recent Lab Results
- Allergies
- Problem List
- Other: _____

Today's injection was given on the:

- Right side
- Left side

Are there any changes in your housing status?

- 1 = Yes
- 2 = No

Recovery education/support conducted during this session?

- 1 = Yes
- 2 = No

Educated/supported the patient in:

- | | |
|---|---|
| <input type="checkbox"/> 1 = Attending meetings | <input type="checkbox"/> 6 = Relationship/family issues |
| <input type="checkbox"/> 2 = Attending counseling | <input type="checkbox"/> 7 = Obtaining a sponsor |
| <input type="checkbox"/> 3 = Addiction behavior | <input type="checkbox"/> 8 = Job training |
| <input type="checkbox"/> 4 = Recovery issues | <input type="checkbox"/> 9 = School/vocational training |
| <input type="checkbox"/> 5 = Relapse prevention | <input type="checkbox"/> 10 = Other: _____ |

Treatment plan reviewed?

- 1 = Yes
- 2 = No

Urine toxicology screen sent?

- 1 = Yes
- 2 = No

Urine sample sent for confirmatory testing?

- 1 = Yes
- 2 = No

RTC:

- 1 = Scheduled
- 2 = Random call-back

Comments:

After completion, scan form into patient record and provide a copy to the patient.