

## SI MAT for OUD Learning Collaborative Patient Case Presentation Form

Please complete the case presentation form and email to [Vnjoku-anokam@statenislandpps.org](mailto:Vnjoku-anokam@statenislandpps.org) a week before the monthly Monday session. **DO NOT SHARE any protected health information** about the patient (i.e. name, date of birth, or unique identifiers).

### **Section 1: Provider Information**

**Date:** \_\_\_\_\_ **Case Presenter (Last, First; email):** \_\_\_\_\_  
**Clinical Degree:**  MD  DO  PA  NP  PharmD  RN  SW  Other:  
**Clinical Specialty:**  IM  FM  Psych  Ob/Gyn  Peds  Emergency Med  Other:  
**Practice Type:**  Primary Care  Specialty Care  Drug Treatment Program  Mental Health Program  ED/Hospital  
**Buprenorphine Waivered?**  Yes, prescribing  Yes, not prescribing  No, planning for waiver  No, unsure of waiver

### **Section 2: Brief clinical history / history of present illness (please limit to 3 sentences)**

### **Section 3: Patient Demographic Information**

**Age:** \_\_\_\_\_ **Gender:** \_\_\_\_\_  
**Race/Ethnicity:** \_\_\_\_\_  
**Insurance Status:**  Medicaid  Medicare  Commercial/Private  Uninsured/Self-pay  
**Contributing Factors:**  Undomiciled  Unemployed  Criminal Justice (i.e. parole, probation)  Child Custody Issues  
**Treatment Status:**  New to treatment (go to section 4)  Already in treatment (go to section 5)

### **Section 4: If patient is new to treatment, tell us about substance use and previous treatment**

**Opioids used in the last year:**  
 Heroin  Illicit Buprenorphine  Illicit Methadone  Illicit Opioid Analgesics  Prescribed Opioid Analgesics  
**Opioid use routes in the last year:**  Oral  Intranasal  Intravenous  Intramuscular  Subcutaneous  
**Other substances used in the last year:**  
 Alcohol  Amphetamines  Benzodiazepines  Cocaine  Cannabis  Other:  
**History of overdose:**  Yes  No  Unsure  
**Previous treatment for substance use disorder:**  
 Buprenorphine Maintenance, Dose(mg): \_\_\_\_\_  Methadone Maintenance, Dose(mg): \_\_\_\_\_  Naltrexone  
 Detox  28-Day Rehab  Residential Treatment  Outpatient Treatment  Other:

### **Section 5: If patient is already in treatment, tell us about current treatment**

**Medication Treatment:**  Buprenorphine, Dose(mg): \_\_\_\_\_  Methadone, Dose(mg): \_\_\_\_\_  Naltrexone  
**Behavioral Health Treatment:**  Individual Counseling  Group Counseling  Psychiatry  Other:

### **Section 6: Any other information you would like to share about this case?**

**Past Medical History:**  
 HIV  Chronic HCV  Severe Hepatic Disease  Severe Renal Disease  
 Acute Pain  Chronic Pain  Anticipated Surgery  Current or Anticipated Pregnancy

**Past Mental Health History:**  
 Depression  Anxiety  Suicide Ideation  Psychosis  History of Trauma

### **Relevant Medications & Allergies:**

**Most Recent Urine Drug Test (check if positive):**  No recent urine drug test  
 Opiates  Oxycodone  Methadone  Buprenorphine  Alcohol  Amphetamines  Benzodiazepines  
 Cocaine  Cannabinoids

### **Section 7: DISCUSSION: What is your primary clinical question?** Please Identify Patient Strengths/Challenges