

**Positive Recovery Solutions
Supplemental Form**

Participant Name: _____

Participant Date of Birth: _____

Coordinator Name: _____

Coordinator Phone/Extension: _____

Location to be scheduled: _____

Date of last use of substance/alcohol: _____

Allergies: _____

Participant received **Revia/Naltrexone** in the past? Yes No

Participant received **Vivitrol** in the past? Yes No

***If Yes, Date of last Vivitrol Injection:** _____

Sublocade (Buprenorphine) is a once monthly injection given in your stomach under your skin (subcutaneous) that provides a slow release of medication over 28 days.

Has Participant received Sublocade in the past? Yes No

***If Yes, Date of last Sublocade Injection:** _____

Pharmacy Information: _____

Notes: _____

With this signature, I agree to release my information to the secondary contact, confirm future appointments, and to release my information to the counselor listed below.

*Signature: _____ *Date: _____

Medication Assisted Treatment Patient Demographic Sheet
Vivitrol Referrals for Positive Recovery Solutions
Phone: (502) 749-7008
Email: PRSKentucky@gmail.com

* County of Referral _____

* Patient Name: _____ * Sex: M or F

* DOB: _____ * SS#: _____ * Valid Phone Number: _____

* Address: _____
City State Zip Code

* Drug of choice: _____

* Outpatient Drug & Alcohol Location: _____

* Name of Vivitrol Coordinator / Lead Therapist / Lead Counselor at Location: _____

* Phone Number / Email For Vivitrol Lead at Location: _____

* Patients Counselor Name: _____ * Phone Number: _____

* Person making the referral: _____ * Email/Phone # _____

* Insurance: Y or N (Attach copy of insurance card)

* Primary Insurance Company: _____ * ID/Group# _____

Secondary Insurance Company: _____ ID/Group # _____

* Patients Secondary Contact Name: _____

* Relationship to Patient: _____ * Phone Number: _____

Note(s): _____
