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
FAX to: (614) 604-8312 / Phone: (614) 604-8231

* 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):_____

_____