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: (412) 660-7064
Email To: JDetillo@prs-cares.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 Emergency Contact Name:_____

*Relationship to Patient:_____ *Phone Number:_____

Note(s):_____

_____