St Matthews Community Pharmacy
Open Mon to Fri 9 am – 6 pm & Sat 10 am – 3 pm
Phone: 502.690.4462

Vivitrol® New Patient Enrollment Form

Patient Information

Name				Date of Birth	
Address		City		State	Zip Code
Primary Phone Number	Secondary Phone Number				Sex M F
Social Security Number		Weight		Height	
Prescription Insurance Information RxBIN RxPCN ID Group					
Emergency Contact Name Relationship Phone Number					
Primary Care Provider Name Office Number					

Past Medical History

Please check all that apply

Anemia	Depression	Liver Dysfunction
Arthritis	Diabetes	Migraines
Asthma	Epilepsy	Parkinson's Disease
Cancer	GERD	Renal Dysfunction
Cerebrovascular Disease	Glaucoma	Thyroid Disease
Congestive Heart Failure	High Blood Pressure	Tuberculosis
Coagulation Disorders	High Cholesterol	Urinary Retention/Frequency
Coronary Artery Disease	HIV/AIDS	Other ________________

Please list any relevant hospitalizations and surgical procedures with dates

Please list all medication and food allergies, along with the reaction experienced

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Vaccination History

Vaccine	Frequency	Yes/No
Flu Shot	one time every year	
Pneumonia Shot	one time over the age of 65 and one time under 65 if you are high risk	
Shingles	one time over the age of 50	
Tdap (Tetanus/Diphtheria/Pertussis)	one time dose	
Hepatitis A	one time dose	
Hepatitis B	3 dose series per lifetime	

Current Medications

Please include any prescription, over-the counter, and herbal/dietary supplements

Baseline Assessment

Have you previously been diagnosed with an opioid use disorder? Yes No

Do you currently have naloxone rescue therapy available (i.e. Narcan, Evzio)? Yes No

If no, would you be interested in obtaining one at no additional cost to you? Yes No

Previously Tried and Failed Medication Assisted Therapies

Check all that apply	Date of Therapy
Vivitrol	
Naltrexone Tablets	
Suboxone	
Subutex	
Methadone	

What psychosocial support program are you currently engaged in (i.e. recovery meetings, counseling sessions)?

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Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself…or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

To be completed by the pharmacy: ____ + ____ + ____

TOTAL: ____

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult

By signing the line below, I attest that all above information is accurate and complete to the best of my knowledge.

(Signature) (Date)