|___|___|___|___|___|___|___|___|___|___| |___|___||___|___||___|___| |___|___|___|___|___|___| |___|___|___|___|___| |___|___|

Client ID# Today's Date Facility ID# Zip Code Administration

TCU DRUG SCREEN 5

During the last 12 months (before being locked up, if applicable) –

	Question	Yes	No
1.	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	O	O
2.	Did you try to control or cut down on your drug use but were unable to do it?	O	O
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	O	O
4.	Did you have a strong desire or urge to use drugs?	O	O
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	O	O
6.	Did you continue using drugs even when it led to social or interpersonal problems?	O	O
7.	Did you spend less time at work, school, or with friends because of your drug use?	O	O
8.	Did you use drugs that put you or others in physical danger?	O	O
9.	Did you continue using drugs even when it was causing you physical or psychological problems?	O	O
10a.	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	O	O
10b.	Did using the same amount of a drug lead to it having less of an effect as it did before?	O	O
11a.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	O	O
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	O	O

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

- O None
- O Alcohol
- O Cannaboids – Marijuana *(weed)*
- O Cannaboids – Hashish *(hash)*
- O Synthetic Marijuana *(K2/Spice)*
- O Opioids – Heroin *(smack)*
- O Opioids – Opium *(tar)*
- O Stimulants – Powder Cocaine *(coke)*
- O Stimulants – Crack Cocaine *(rock)*
- O Stimulants – Amphetamines *(speed)*
- O Stimulants – Methamphetamine *(meth)*
- O Synthetic Cathinones *(Bath Salts)*
- O Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*
- O Dissociative Drugs – Ketamine/PCP *(Special K)*
- O Hallucinogens – LSD/Mushrooms *(acid)*
- O Inhalants – Solvents *(paint thinner)*
- O Prescription Medications – Depressants
- O Prescription Medications – Stimulants
- O Prescription Medications – Opioid Pain Relievers
- O Other (specify) ____________________________

© Copyright 2017 TCU Institute of Behavioral Research, Fort Worth, Texas. All rights reserved.

Client ID#	Today's Date	Facility ID#	Zip Code	Administration
|___|___|___|___|___|___|___|___|___|	|___|___||___|___||___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|	|___|___|

13. How often did you use each type of drug during the last 12 months?	Never	Only a few times	1-3 times per month	1-5 times per week	Daily
a. Alcohol	O	O	O	O	O
b. Cannaboids – Marijuana *(weed)*	O	O	O	O	O
c. Cannaboids – Hashish *(hash)*	O	O	O	O	O
d. Synthetic Marijuana *(K2/Spice)*	O	O	O	O	O
e. Opioids – Heroin *(smack)*	O	O	O	O	O
f. Opioids – Opium *(tar)*	O	O	O	O	O
g. Stimulants – Powder cocaine *(coke)*	O	O	O	O	O
h. Stimulants – Crack Cocaine *(rock)*	O	O	O	O	O
i. Stimulants – Amphetamines *(speed)*	O	O	O	O	O
j. Stimulants – Methamphetamine *(meth)*	O	O	O	O	O
k. Synthetic Cathinones *(Bath Salts)*	O	O	O	O	O
l. Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*	O	O	O	O	O
m. Dissociative Drugs – Ketamine/PCP *(Special K)*	O	O	O	O	O
n. Hallucinogens – LSD/Mushrooms *(acid)*	O	O	O	O	O
o. Inhalants – Solvents *(paint thinner)*	O	O	O	O	O
p. Prescription Medications – Depressants	O	O	O	O	O
q. Prescription Medications – Stimulants	O	O	O	O	O
r. Prescription Medications – Opioid Pain Relievers	O	O	O	O	O
s. Other (specify) ____________________________	O	O	O	O	O

14. How many times before now have you ever been in a drug treatment program?
[DO NOT INCLUDE AA/NA/CA MEETINGS]

O *Never* O *1 time* O *2 times* O *3 times* O *4 or more times*

15. How serious do you think your drug problems are?

O *Not at all* O *Slightly* O *Moderately* O *Considerably* O *Extremely*

16. During the last 12 months, how often did you inject drugs with a needle?

O *Never* O *Only a few times* O *1-3 times/month* O *1-5 times per week* O *Daily*

17. How important is it for you to get drug treatment now?

O *Not at all* O *Slightly* O *Moderately* O *Considerably* O *Extremely*

© Copyright 2017 TCU Institute of Behavioral Research, Fort Worth, Texas. All rights reserved.

|___|___|___|___|___|___|___|___|___| |___|___||___|___||___|___| |___|___|___|___|___|___| |___|___|___|___|___| |___|___|
Client ID# Today's Date Facility ID# Zip Code Administration

TCU DRUG SCREEN 5 – Opioid Supplement

***If the response to TCU Drug Screen 5, page 2, Q13e, Q13f, or Q13r regarding opioid use is more than "Never," then complete the following questions.**

In the LAST 12 MONTHS –

1. **What types of opioids have you used?**
   a. Heroin .... O *No* O *Yes*
   b. Oxycodone (Oxycontin, Percodan, Percocet) .... O *No* O *Yes*
   c. Hydrocodone (Vicodin, Lortab, Lorcet, Norco, Zohydro) .... O *No* O *Yes*
   d. Morphine (Kadian, Avinza, MS Contin) .... O *No* O *Yes*
   e. Fentanyl (Duragesic, Fentora) .... O *No* O *Yes*
   f. Hydromorphone (Dilaudid, Exalgo) .... O *No* O *Yes*
   g. Methadone (Dolophine) .... O *No* O *Yes*
   h. Oxymorphone (Opana) .... O *No* O *Yes*
   i. Codeine (Tylenol/cough syrup with codeine) .... O *No* O *Yes*

2. **How many times did you inject an opioid?**
   O *Never* O *A few times* O *1-3 times/month* O *1-5 times per week* O *Daily*

3. **How many times did you take an opioid in another way (e.g., ground pills and sniffed it, put a film in your mouth)?**
   O *Never* O *A few times* O *1-3 times/month* O *1-5 times per week* O *Daily*

4. **How many times did you take an opioid prescribed for you?**
   O *Never* O *A few times* O *1-3 times/month* O *1-5 times per week* O *Daily*

5. **How many times did you take an opioid prescribed for someone else?**
   O *Never* O *A few times* O *1-3 times/month* O *1-5 times per week* O *Daily*

6. **From whom did you get the opioids you took?**
   a. Medical doctor/pharmacy? .... O *No* O *Yes*
   b. Family member? .... O *No* O *Yes*
   c. Friend? .... O *No* O *Yes*
   d. Someone else (e.g., "on the street")? .... O *No* O *Yes*

7. **Have you taken opioids for medical reasons?** .... O *No* O *Yes**
   ***IF YES,** briefly describe the reasons:
   ____

© Copyright 2017 TCU Institute of Behavioral Research, Fort Worth, Texas. All rights reserved.

|___|___|___|___|___|___|___|___|___|	|___|___||___|___||___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|	|___|___|
Client ID#	Today's Date	Facility ID#	Zip Code	Administration

8. Have you taken opioids for <u>non-medical reasons</u>? .... O *No* O *Yes**

***IF YES,** briefly describe the reasons:

____

9. Has a <u>doctor prescribed</u> opioid medications for you? .... O *No* O *Yes**

***IF YES:**

a. did you have the most recent <u>prescription filled</u>? .... O *No* O *Yes**

b. did you <u>take all of the medications</u> as prescribed? .... O *No* O *Yes**

c. did you <u>give or sell any of your medications</u> to someone else? .... O *No* O *Yes**

10. Have you taken <u>other medications or illegal drugs</u> for medical reasons (e.g., to treat pain)? .... O *No* O *Yes**

***IF YES,** please list:

Drug/medication: ____________________ Reasons for taking: ____________________________

Drug/medication: ____________________ Reasons for taking: ____________________________

Drug/medication: ____________________ Reasons for taking: ____________________________

11. Do you or someone close to you (e.g., family, friend) have <u>access to naloxone (Narcan)</u> to reverse an overdose? .... O *No* O *Yes*

12. How many times have you <u>EVER overdosed</u> after taking opioids?

O *Never* O *Once* O *Twice* O *3 times* O *4 or more times*

13. <u>In the last 12 months</u>, how many times <u>have you overdosed</u> after taking opioids?

O *Never* O *Once** O *Twice** O *3 times** O *4 or more times**

***IF MORE THAN "NEVER," in the last 12 months:**

a. <u>What types</u> of opioids did you use?

1. Heroin .... O *No* O *Yes*
2. Oxycodone (Oxycontin, Percodan, Percocet) .... O *No* O *Yes*
3. Hydrocodone (Vicodin, Lortab, Lorcet, Norco, Zohydro) .... O *No* O *Yes*
4. Morphine (Kadian, Avinza, MS Contin) .... O *No* O *Yes*
5. Fentanyl (Duragesic, Fentora) .... O *No* O *Yes*
6. Hydromorphone (Dilaudid, Exalgo) .... O *No* O *Yes*
7. Methadone (Dolophine) .... O *No* O *Yes*
8. Oxymorphone (Opana) .... O *No* O *Yes*
9. Codeine (Tylenol/cough syrup with codeine) .... O *No* O *Yes*

© Copyright 2017 TCU Institute of Behavioral Research, Fort Worth, Texas. All rights reserved.

b. How many times did you go to the <u>hospital or emergency room</u> because of an overdose on opioids?

O *Never* O *Once* O *Twice* O *3 times* O *4 or more times*

c. How many times were <u>you given naloxone (Narcan)</u> because of an overdose?

O *Never* O *Once* O *Twice* O *3 times* O *4 or more times*

d. Have you <u>received any follow-up treatment</u> after the most recent overdose? .... O *No* O *Yes*

14. Have you <u>received Medication Assisted Treatment (MAT) in the last 12 months</u>? .... O *No* O *Yes*

15. Are you <u>currently receiving Medication Assisted Treatment (MAT)</u>? .... O *No* O *Yes*

***IF YES,** what type?

a. Methadone (Dolophine or Methadone) .... O *No* O *Yes*
b. Buprenorphine (Subutex, Suboxone) .... O *No* O *Yes*
c. Oral naltrexone (Depade, Revia) .... O *No* O *Yes*
d. Depot natrexone (Vivitrol) .... O *No* O *Yes*
e. Other, specify: ______________________________........ O *No* O *Yes*

16. Have you <u>obtained</u> any of these medications <u>without a prescription</u>? .... O *No* O *Yes*

17. Have you <u>taken more</u> of these medications <u>than were prescribed</u>? .... O *No* O *Yes*

© Copyright 2017 TCU Institute of Behavioral Research, Fort Worth, Texas. All rights reserved.