

BUPRENORPHINE OFFICE FLOW SHEET

NAME: _____

AGE: _____

SEX: _____

OTHER CARE CLINICIANS: _____

	✓	DATE:
Complete History and Physical		
Lab work-up (LFT's, Viral Hep Profile, etc.)		
Dose of Buprenorphine:		
Other Medications:		
Blood Pressure/Pulse		
Signs of Opiate Withdrawal:		
Restless sleep		
Dilated pupils		
Anorexia		
Gooseflesh		
Irritability		
Tremor		
Increase in heart rate		
Increase in blood pressure		
Nausea and vomiting		
Diarrhea		
Abdominal cramps		
Labile mood		
Depression		
Muscle spasm		
Weakness		
Bone pain		
History of craving?		
Change in mood?		
High risk behaviors:		
Alcohol use		
Sedative use		
Tobacco use		
Urine Drug Screen ordered?		
Involvement in Behavioral Treatment?		
Provider:		
Schedule of visits?		
Compliant with visits?		
Assessment:		
Dose adjustment:		
Behavioral Treatment Change?		

Date of next visit: _____

Physician's signature: _____