

NIDA Clinical Trials Network

Adverse Event (AD1)

Web Version: 1.0; 4.01; 05-28-19

Adverse event onset date (AEDATE):  
Event number (AESEQNO):

This adverse event has been closed by the Medical Reviewer and may no longer be updated.

1. Adverse event name:(A1DESCPT)

2. Date site became aware of the event:(A1AWARDT)

 (mm/dd/yyyy)

3. Severity of event:(A1SEVRTY)

  
 1-Grade 1 - Mild  
 2-Grade 2 - Moderate  
 3-Grade 3 - Severe  


4. Outcome of event:(A1OUTCM)

  
 1-Ongoing  
 2-Resolved without sequelae  
 3-Resolved with sequelae  
 4-Resolved by convention  
 5-Death  


Except for "None of the following", all selections in the question below will designate this as a Serious Adverse Event (SAE). The Serious Adverse Event Summary (AD2) form should be completed for all Serious Adverse Events reported.

5. Was this event associated with:(A1ASSOC)

  
 0-None of the following  
 1-Death  
 2-Life-threatening event  
 3-Inpatient admission to hospital or prolongation of existing hospitalization  
 4-Persistent or significant incapacity  
 \*Additional Options Listed Below  


a. If "Death," was it related to an overdose event?(A1DTHODE)

 0-No  1-Yes  97-Unknown

b. If "Death", date of death:(A1DTHDT)

 (mm/dd/yyyy)

Comments:(AD1COMM)

**Additional Selection Options for AD1**

**Event number (AESEQNO) (key field):**

- 01-1st Adverse Event of the day
- 02-2nd Adverse Event of the day
- 03-3rd Adverse Event of the day
- 04-4th Adverse Event of the day
- 05-5th Adverse Event of the day
- 06-6th Adverse Event of the day
- 07-7th Adverse Event of the day
- 08-8th Adverse Event of the day
- 09-9th Adverse Event of the day
- 10-10th Adverse Event of the day

**Was this event associated with:**

- 5-Congenital anomaly or birth defect
- 6-Important medical event that required intervention to prevent any of the above

NIDA Clinical Trials Network

Serious Adverse Event Summary (AD2)

Web Version: 1.0; 2.00; 10-03-17

Adverse event onset date (AEDATE):  
Event number (AESEQNO):

This adverse event has been closed by the Medical Reviewer and may no longer be updated.

1. Initial narrative description of serious adverse event:(A2SUMM)

2. Relevant past medical history:(A2SAEMHX)

Allergies, pregnancy, smoking and alcohol use, hypertension, diabetes, epilepsy, depression, etc.  
(A2MEDHX)

0-No  1-Yes  97-Unknown

3. Medications at the time of the event:(A2SAEMED)

0-No  1-Yes  97-Unknown

Medication (Generic Name)	Indication
(A2_01DNM) <input type="text"/>	(A2_01DIN) <input type="text"/>
(A2_02DNM) <input type="text"/>	(A2_02DIN) <input type="text"/>
(A2_03DNM) <input type="text"/>	(A2_03DIN) <input type="text"/>
(A2_04DNM) <input type="text"/>	(A2_04DIN) <input type="text"/>
(A2_05DNM) <input type="text"/>	(A2_05DIN) <input type="text"/>
(A2_06DNM) <input type="text"/>	(A2_06DIN) <input type="text"/>
(A2_07DNM) <input type="text"/>	(A2_07DIN) <input type="text"/>
(A2_08DNM) <input type="text"/>	(A2_08DIN) <input type="text"/>
(A2_09DNM) <input type="text"/>	(A2_09DIN) <input type="text"/>
(A2_10DNM) <input type="text"/>	(A2_10DIN) <input type="text"/>

4. Treatments for the event:(A2SAETR7)

0-No  1-Yes  97-Unknown

Treatment	Indication	Date Treated (mm/dd/yyyy)
(A2_1TNME) <input type="text"/>	(A2_1TIND) <input type="text"/>	(A2_1LTDT) <input type="text"/>
(A2_2TNME) <input type="text"/>	(A2_2TIND) <input type="text"/>	(A2_2LTDT) <input type="text"/>
(A2_3TNME) <input type="text"/>	(A2_3TIND) <input type="text"/>	(A2_3LTDT) <input type="text"/>
(A2_4TNME) <input type="text"/>	(A2_4TIND) <input type="text"/>	(A2_4LTDT) <input type="text"/>
(A2_5TNME) <input type="text"/>	(A2_5TIND) <input type="text"/>	(A2_5LTDT) <input type="text"/>

5. Labs/tests performed in conjunction with this event:(A2SAELAB)

0-No  1-Yes  97-Unknown

Lab/Test	Findings	Date of Test (mm/dd/yyyy)
(A2_1LBNM) <input type="text"/>	(A2_1LBIN) <input type="text"/>	(A2_1LBDT) <input type="text"/>
(A2_2LBNM) <input type="text"/>	(A2_2LBIN) <input type="text"/>	(A2_2LBDT) <input type="text"/>
(A2_3LBNM) <input type="text"/>	(A2_3LBIN) <input type="text"/>	(A2_3LBDT) <input type="text"/>
(A2_4LBNM) <input type="text"/>	(A2_4LBIN) <input type="text"/>	(A2_4LBDT) <input type="text"/>
(A2_5LBNM) <input type="text"/>	(A2_5LBIN) <input type="text"/>	(A2_5LBDT) <input type="text"/>

6. Follow-up:(A2FOLLUP)

Include labs/test results as they become available, clinical changes, consultant diagnosis, etc.

7. Additional information requested by the Medical Monitor:(A2ADDINF)

Have all Medical Monitor requests been addressed?(A2RQADDR)

1-Yes

**Additional Selection Options for AD2**

**Event number (AESEQNO) (key field):**

- 01-1st Adverse Event of the day
- 02-2nd Adverse Event of the day
- 03-3rd Adverse Event of the day
- 04-4th Adverse Event of the day
- 05-5th Adverse Event of the day
- 06-6th Adverse Event of the day
- 07-7th Adverse Event of the day
- 08-8th Adverse Event of the day
- 09-9th Adverse Event of the day
- 10-10th Adverse Event of the day

NIDA Clinical Trials Network

Serious Adverse Event Medical Reviewer (AD3)

Web Version: 1.0; 3.01; 05-28-19

Adverse event onset date (AEDATE):  
Event number (AESEQNO):

1. Was this determined to be a serious adverse event?(A3SAE)

0-No  1-Yes

2. Was this event expected?(A3EXPECT)

0-No  1-Yes

3. Is this a standard expedited/reportable event?  
(i.e., is it serious, unexpected and related to therapy)(A3EXPFDA)

0-No  1-Yes

If "No", is this an expedited/reportable event for other reasons?(A3EXPOTH)

0-No  1-Yes

4. Does the protocol need to be modified based on this event?(A3MPROT)

0-No  1-Yes

5. Does the consent form need to be modified based on this event?(A3MCNST)

0-No  1-Yes

6. Is the review complete?(A3REVDNE)

0-No  1-Yes

If "No", what additional information is required:(A3ADDINF)

Assessed by:(A3ASRID)

 (initials)

Reviewed by:(A3REVID)

 (initials)

Comments:(A3COMM)

**Additional Selection Options for AD3**

**Event number (AESEQNO) (key field):**

- 01-1st Adverse Event of the day
- 02-2nd Adverse Event of the day
- 03-3rd Adverse Event of the day
- 04-4th Adverse Event of the day
- 05-5th Adverse Event of the day
- 06-6th Adverse Event of the day
- 07-7th Adverse Event of the day
- 08-8th Adverse Event of the day
- 09-9th Adverse Event of the day
- 10-10th Adverse Event of the day

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Critical Action Checklist (CAC)

Web Version: 1.0; 2.00; 06-14-18

Segment (PROTSEG): C  
Visit number (VISNO):

Complete this checklist based on chart review.

- 1. Was buprenorphine administered in the ED, prescribed at discharge and/or provided for take home administration? (CAEDBUP)  0-No  1-Yes
- 2. Urine toxicology obtained: (CATOXOBT)  0-No  1-Yes
- 3. Urine toxicology documented as positive for opioids: (CATOXDOC)  0-No  1-Yes
- 4. Liver functions tests (AST, ALT) obtained: (CALFTOBT)  0-No  1-Yes
- 5. Documentation that patient met criteria for moderate to severe opioid use disorder: (CAOUDDOC)  0-No  1-Yes
- 6. Formal assessment of opioid withdrawal severity (e.g., COWS) documented: (CACOWDOC)  0-No  1-Yes
- 7. Documentation that buprenorphine education and induction instructions provided: (CAEDUDOC)  0-No  1-Yes
- 8. Direct referral for ongoing medication assisted treatment documented: (CAMATDOC)  0-No  1-Yes

Comments: (CACCOMM)

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Crime and Criminal Justice (CCJ)

Web Version: 1.0; 1.00; 03-27-17

Segment (PROTSEG): C  
 Visit number (VISNO):

1. Have you been incarcerated within the past 12 months?(CCINC12)

0-No  1-Yes

If "Yes", how many days?(CCINC12D)

(xxx)

The next questions apply only to the 30 days immediately following your ED enrollment visit.

2. Have you been incarcerated in the past 30 days?(CCINC30)

0-No  1-Yes

If "Yes", how many days?(CCINC30D)

(xx)

3. How many times in the past 30 days have you committed the following crimes?

a. Dealing narcotics:(CCNARCO)

(xxx)

b. Vandalism:(CCVANDAL)

(xxx)

c. Stolen property:(CCPROPTY)

(xxx)

d. Forgery/counterfeiting:(CCFORGE)

(xxx)

e. Fraud:(CCFRAUD)

(xxx)

f. Larceny/theft:(CCLARLEF)

(xxx)

g. Household burglary:(CCBURGLR)

(xxx)

h. Robbery:(CCROBBRY)

(xxx)

i. Rape/sexual assault:(CCRAPE)

(xxx)

j. Homicide:(CCHOMICD)

(xxx)

4. How many days in the last 30 days have you been in contact (either initiated by you or by the legal system) with the court, criminal justice system, or probation/parole officer?

a. Court:(CCNTRCT)

(xx)

b. Criminal justice system:(CCNTRCJS)

(xx)

c. Probation/parole officer:(CCNTRPRO)

(xx)

Comments:(CCJCOMM)



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Demographics (DEM)

Web Version: 1.0; 6.01; 01-07-21

1. Date of birth:(DEBRTHDT)

 (mm/dd/yyyy)

2. Age:(DEAGE)

 (xx)

3. Age:(DEAGE)

 (xx)

4. Sex:(DESEX)

 1-Male  2-Female  97-Don't know  98-Refused to answer

5. What gender do you identify with?(DEGENDER)

 01-Male  02-Female  99-Other  98-Prefer not to answer

6. Does the participant consider him or herself to be Hispanic/Latino?(DEHISPNC)

 0-No  1-Yes  97-Don't know  98-Refused to answer

If "Yes", indicate the group that represents his or her Hispanic origin or ancestry:(DEHISPS)

- 1-Puerto Rican
- 2-Dominican (Republic)
- 3-Mexican/Mexican American
- 5-Chicano
- 6-Cuban/Cuban American
- \*Additional Options Listed Below

7. What race does the participant consider him or herself to represent? (Check all that apply)

American Indian or Alaska Native:(DEAMEIND)

 1-

Asian:(DEASIAN)

 1-

Asian Indian:(DEASAIND)

 1-

Chinese:(DECHINA)

 1-

Filipino:(DEFILIPN)

 1-

Japanese:(DEJAPAN)

 1-

Korean:(DEKOREA)

 1-

Vietnamese:(DEVETNM)

 1-

Specify other Asian:(DEASIAOT)

 1-

Black or African American:(DEBLACK)

 1-

Native Hawaiian or Pacific Islander:(DEHAWAII)

 1-

Native Hawaiian:(DENATHAW)

 1-

Guamanian or Chamorro:(DEGUAM)

 1-

Samoa:(DESAMOAN)

 1-

Specify other Pacific Islander:(DEPACISO)

White:(DEWHITE)

 1-

Some other race:(DERACEOT)

 1-

-or-

Don't know:(DERACEDK)

 1-

Refused:(DERACERF)

 1-

8. What is the highest grade or level of school the participant has completed or the highest degree they have received? (DEEDUCTN)

- 00-Never attended / kindergarten only
- 01-1st grade
- 02-2nd grade
- 03-3rd grade
- 04-4th grade
- \*Additional Options Listed Below

9. We would like to know about what the participant does -- is he/she working now, looking for work, retired, keeping house, a student, or what?(DEJOB)

- 01-Working now
- 02-Only temporarily laid off, sick leave, or maternity leave
- 03-Looking for work, unemployed
- 04-Retired
- 05-Disabled, permanently or temporarily
- \*Additional Options Listed Below

If "Other", specify:(DEJOBSP)

10. Is the participant currently married, widowed, divorced, separated, never married, or living with a partner?(DEMARTL)

- 01-Married
- 02-Widowed
- 03-Divorced
- 04-Separated
- 05-Never married
- \*Additional Options Listed Below

Comments:(DEMCOMM)

**Additional Selection Options for DEM**

**If "Yes", indicate the group that represents his or her Hispanic origin or ancestry:**

- 8-Central or South American
- 9-Other Latin American
- 99-Other Hispanic or Latino
- 98-Refused
- 97-Don't know

**What is the highest grade or level of school the participant has completed or the highest degree they have received?**

- 05-5th grade
- 06-6th grade
- 07-7th grade
- 08-8th grade
- 09-9th grade
- 10-10th grade
- 11-11th grade
- 12-12th grade, no diploma
- 13-High school graduate
- 14-GED or equivalent
- 15-Some college, no degree
- 16-Associate's degree: occupational, technical, or vocational program
- 17-Associate's degree: academic program
- 18-Bachelor's degree (e.g., BA, AB, BS, BBA)
- 19-Master's degree (e.g., MA, MS, MEng, MEd, MBA)
- 20-Professional school degree (e.g., MD, DDS, DVM, JD)
- 21-Doctoral degree (e.g., PhD, EdD)
- 98-Refused
- 97-Don't know

**We would like to know about what the participant does -- is he/she working now, looking for work, retired, keeping house, a student, or what?**

- 06-Keeping house
- 07-Student
- 99-Other

**Is the participant currently married, widowed, divorced, separated, never married, or living with a partner?**

- 06-Living with partner
- 98-Refused
- 97-Don't know

NIDA Clinical Trials Network

Additional Demographics (DM1)

Web Version: 1.0; 2.00; 06-18-18

Segment (PROTSEG): C  
 Visit number (VISNO):

1. Are you currently covered by health insurance or health coverage plans?  0-No  1-Yes  
*This does not include plans that pay for only one type of service (such as, nursing home care, accidents, family planning, or dental care) and plans that only provide extra cash when hospitalized. (DMHEALTH)*

If "Yes" indicate the type of plan:

a. Insurance through a current or former employer or union (of yours or another family member's);  1-Covered  2-Not covered  3-Not sure  
*This would include COBRA coverage. (DMINSEMP)*

b. Insurance purchased directly from an insurance company (by you or another family member);  1-Covered  2-Not covered  3-Not sure  
*This would include coverage purchased through an exchange or marketplace, such as HealthCare.gov. (DMINSCOM)*  
 If "Covered", does the coverage have a state-specific program name? (DMSTCO)  0-No  1-Yes  2-Not sure  
 If "Yes", specify the name: (DMSTCOSP)

c. Medicare, for people 65 and older, or people with certain disabilities: (DMINSCAR)  1-Covered  2-Not covered  3-Not sure  
 If "Covered", does the coverage have a state-specific program name? (DMSTCR)  0-No  1-Yes  2-Not sure  
 If "Yes", specify the name: (DMSTCRSP)

d. Medicaid, Medical Assistance (MA), the Children's Health Insurance Program (CHIP), or any kind of state or government-sponsored assistance plan based on income or a disability: (DMINSCAI)  1-Covered  2-Not covered  3-Not sure  
 If "Covered", does the coverage have a state-specific program name? (DMSTCD)  0-No  1-Yes  2-Not sure  
 If "Yes", specify the name: (DMSTCDSP)

e. TRICARE or other military health care, including VA health care: (DMINSTRI)  1-Covered  2-Not covered  3-Not sure

f. Indian Health Service: (DMINSIHS)  1-Covered  2-Not covered  3-Not sure

g. Any other type of health insurance coverage or health coverage plan: (DMINSOTH)  1-Covered  2-Not covered  3-Not sure  
 If "Covered" by another type, specify: (DMOTSP)

2. What has been your usual employment pattern in the past 12 months? (DMEMPLOY)

1-Full time (35+ hrs)   
 2-Part time (regular hours)   
 3-Part time (irregular hours)   
 4-Student   
 5-Military service   
 \*Additional Options Listed Below

3. What is your combined household income? (DMINCOME)

1-<\$35,000   
 2-\$35,001-\$50,000   
 3-\$50,001-\$75,000   
 4-\$75,001-\$100,000   
 5-\$100,001-\$250,000   
 \*Additional Options Listed Below

4. In the last 12 months have you spent at least one night in any of the following places? (DMNIGHT)  0-No  1-Yes  
 If "Yes", select all that apply:

(DMSHLTR1)  A shelter for homeless persons.  
 (DMSTRET1)  On the street or in a public place not intended for sleeping (e.g., abandoned building, subway, or car).  
 (DMSRO1)  In a welfare hotel or single room occupancy (SRO).  
 (DMHLFWY1)  In any emergency, temporary, or transitional housing program, or a halfway house.  
 (DMSMELS1)  Doubled up with others, in someone else's house/apartment.

5. Are you currently living in any of the places listed above? (DMLIVING)  0-No  1-Yes  
 a. If "Yes", select all that apply:

(DMSHLTR2)  A shelter for homeless persons.  
 (DMSTRET2)  On the street or in a public place not intended for sleeping (e.g., abandoned building, subway, or car).  
 (DMSRO2)  In a welfare hotel or single room occupancy (SRO).  
 (DMHLFWY2)  In any emergency, temporary, or transitional housing program, or a halfway house.  
 (DMSMELS2)  Doubled up with others, in someone else's house/apartment.

b. How many months have you lived there? (DMMONTHS)

1-Less than a month   
 2-1-2 months   
 3-3-4 months   
 4-5-6 months   
 5-More than 6 months

Comments: (DM1COMM)

**Additional Selection Options for DM1**

**What has been your usual employment pattern in the past 12 months?**

- 6-Retirement/disability
- 7-Unemployment
- 8-In controlled environment
- 9-Service (volunteer)

**What is your combined household income?**

- 6->\$250,000

NIDA Clinical Trials Network

ED Visit Review (EDR)

Web Version: 1.0; 5.03; 01-05-21

Segment (PROTSEG): C  
 Visit number (VISNO):

Date of ED admission:(EDRASMDT)

 (mm/dd/yyyy)

1. How was this patient identified?(ERPPTID)

01-Screening by Emergency Department (ED) staff  
 02-Health quiz by research staff  
 03-Electronic health record (EHR) chief complaint  
 04-Emergency Department (ED) staff referral  
 99-Other

If "Other", specify:(ERPPTIDSP)

2. What was the chief complaint as written in the Emergency Department (ED) chart or ED provider notes?(ERCOMPL)

3. What was the discharge diagnosis?(ERDSCDG)

4. What are the ICD 10 code(s) for the discharge diagnosis?

a. Code 1:(ERICDCD1)

b. Code 2:(ERICDCD2)

c. Code 3:(ERICDCD3)

d. Code 4:(ERICDCD4)

e. Code 5:(ERICDCD5)

f. Code 6:(ERICDCD6)

g. Code 7:(ERICDCD7)

h. Code 8:(ERICDCD8)

i. Code 9:(ERICDCD9)

j. Code 10:(ERICDC10)

5. What was the date of discharge?(ERDISCDT)

 (mm/dd/yyyy)

6. Did the patient come to the ED specifically for a referral to substance abuse treatment?(EREDREFR)

 0-No  1-Yes

7. Which RA consented patient and completed assessment forms?(ERRACNST)

01-SP  
 02-YSAS  
 03-EC  
 04-MKL  
 05-EPR  
 \*Additional Options Listed Below

8. Which RA consented patient and completed assessment forms?(ERRACNST)

06-AM  
 07-DGa  
 08-DGr  
 09-KV  
 10-KW  
 \*Additional Options Listed Below

9. Which RA consented patient and completed assessment forms?(ERRACNST)

16-AR  
 17-BP  
 18-DE  
 19-HR  
 20-RH  
 \*Additional Options Listed Below

10. Which RA consented patient and completed assessment forms?(ERRACNST)

23-SG  
 24-CH  
 25-CM  
 26-TN  
 27-LW  
 \*Additional Options Listed Below

11. Who was the discharge attending?(ERDISATT)

01-Bayram, J.  
 02-Bright, L  
 03-Cattlett, C.  
 04-Chanmugam, A.  
 05-de Ramirez, S.  
 \*Additional Options Listed Below

12. Was an addiction related consult performed?(ERCONSUL)

 0-No  1-Yes

If "Yes", who performed the consult?(ERCONSPR)

01-Social work  
 02-Substance Use Counselor/Health Promotion Advocate (on-site hospital employee)  
 03-Recovery Coach/Peer Consult (not on-site hospital employee)  
 04-General psychiatrist  
 05-Addiction MD specialist  
 \*Additional Options Listed Below

13. Did the ED practitioner document that any of the following were provided:

a. Brief intervention:(ERPRVB)

 0-No  1-Yes

b. Advice:(ERPRVADV)

 0-No  1-Yes

c. Overdose education:(ERPRVODE)

 0-No  1-Yes

14. Were any of the following tests performed:

- a. HIV:(*ERHIVTST*)  0-No  1-Yes
- b. Hepatitis C:(*ERHCVTST*)  0-No  1-Yes

15. Were any of the following medications administered in the ED, prescribed at discharge, and/or given a take home dose?

	^2 Medications Administered		^2 Medications Prescribed		^2 Medications Provided for Take Home Administration	
	No	Yes	No	Yes	No	Yes
a. Opioids:	( <i>EROPIMED</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>EROPIRX</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>EROPITH</i> ) <input type="checkbox"/>	<input type="checkbox"/>
b. Benzodiazepines:	( <i>ERBZOMED</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>ERBZORX</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>ERBZOTH</i> ) <input type="checkbox"/>	<input type="checkbox"/>
c. Methadone:	( <i>ERMTDMED</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>ERMTDRX</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>ERMTDTH</i> ) <input type="checkbox"/>	<input type="checkbox"/>
d. Buprenorphine:	( <i>ERBUPMED</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>ERBUPRX</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>ERBUPTH</i> ) <input type="checkbox"/>	<input type="checkbox"/>
e. Naltrexone:	( <i>ERNALTMED</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>ERNALTRX</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>ERNALTTH</i> ) <input type="checkbox"/>	<input type="checkbox"/>
f. Naloxone:	( <i>ERNALXMD</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>ERNALXRX</i> ) <input type="checkbox"/>	<input type="checkbox"/>	( <i>ERNALXTH</i> ) <input type="checkbox"/>	<input type="checkbox"/>

If a naloxone prescription was received, did the patient receive a kit or a prescription?(*ERKITRX*)  1-Kit  2-Prescription

16. Did the patient receive a referral to opioid use disorder (OUD) treatment?(*EROPIREF*)

- a. Was the referral for a specific time and location?(*ERREFSP*)  0-No  1-Yes
- 0-No  1-Yes

If "Yes", answer the following:

- b. Site name of the OUD specific referral:(*ERREFSIT*)
- c. Location type of OUD specific referral:(*ERREFLOC*)

1-Office-based provider  
 2-Opioid treatment program  
 3-Residential program  
 99-Other

If "Other", specify:(*ERLOCSP*)

17. Did the patient receive a psychiatric evaluation during the ED visit?(*ERPSYCH*)

- 0-No  1-Yes

18. Was the patient evaluated for ED-initiated buprenorphine and given a direct referral for medication assisted treatment within 24 hours? (no induction or prescription needed.)(*EREVAL*)  0-No  1-Yes

If "No direct referral", what was noted in the discharge instructions?

- General pamphlets/information regarding OUD services:(*ERPAMPH*)  1-
- Indirect referral (i.e., advice to go to specific place without appointment) for OUD services:(*ERINDREF*)  1-
- Nothing specific to OUD:(*ERNOOUD*)  1-

If "Indirect referral", select the type of place:(*ERREFNOT*)

01-Opioid treatment program  
 02-Office-based provider  
 99-Other

If "Other", specify:(*ERREFNTSP*)

Comments:(*EDRCOMM*)

PI signature to indicate form review:(*ERPISIGN*)

Date of PI review:(*ERPISGDT*)

 (mm/dd/yyyy)

**Additional Selection Options for EDR**

**Which RA consented patient and completed assessment forms?**

- 21-BK
- 22-PJ
- 33-GH
- 34-TM
- 54-RK
- 37-AH
- 55-RP
- 56-BM
- 45-KJ
- 46-SK
- 47-AE
- 48-48NA

**Which RA consented patient and completed assessment forms?**

- 11-BT
- 12-SR
- 13-NM
- 14-WR
- 15-AW
- 32-MB
- 38-BV
- 41-SV
- 42-FE
- 43-AL
- 57-57NA
- 58-58NA
- 59-59NA
- 60-60NA
- 61-61NA
- 62-62NA
- 63-63NA
- 64-64NA
- 65-65NA

**Which RA consented patient and completed assessment forms?**

- 35-DD
- 36-NQ
- 40-Aho
- 44-HRo
- 49-SRe
- 52-AV
- 53-Hry
- 72-72NA
- 73-73NA
- 74-74NA
- 75-75NA
- 76-76NA
- 77-77NA
- 78-78NA
- 79-79NA
- 80-80NA

**Which RA consented patient and completed assessment forms?**

- 39-DA
- 50-LK
- 51-RC
- 84-SM
- 85-85NA
- 86-86NA
- 87-87NA
- 88-88NA
- 89-89NA
- 90-90NA
- 91-91NA
- 92-92NA
- 93-93NA
- 94-94NA
- 95-95NA

**Who was the discharge attending?**

- 06-Dugas, A.
- 07-Ehmann, M.
- 08-Euster, C.
- 09-Fong, T.
- 10-Hansoti, B.
- 11-Hile, D.
- 12-Hile, L.
- 13-Hill, P.
- 14-Hill, T.
- 15-Hinson, J.
- 16-Hsu, E.
- 17-Jung, J.
- 18-Kane, E.
- 19-Kelen, G.
- 20-King, M.
- 21-Kirsch, T.
- 22-Kozen, J.
- 23-Levy, J.
- 24-Levy, M.
- 25-Margolis, A.
- 26-Millin, M.
- 27-Morton, M.
- 28-Omron, R.
- 29-Peterson, S.
- 30-Putman, S.
- 31-Qureshi, A.
- 32-Razzak, J.
- 33-Regan, L.
- 34-Rice, J.
- 35-Rothman, R.
- 36-Satheed, M.
- 37-Shah, S.
- 38-Shelton, E.
- 39-Stolbach, A.
- 40-Tang, N.
- 41-Vu, A.
- 42-Wilson, C.
- 43-Woltman, N.
- 44-Abdelsamad, D.
- 45-Carmody, S.
- 46-Davis, M.
- 47-Dsouza, M.
- 48-Figueroa, S.
- 49-Ghazarian, S.
- 50-Haley, E.
- 51-Huntley, B.
- 52-Jackson, A.
- 53-Jokl, J.
- 54-Juhaszova, K.
- 55-Jones, T.
- 56-Lewis, A.
- 57-Masterson, M.
- 58-Milch, L.
- 59-Pomeroy, A.
- 60-Ridenour, P.
- 61-Roane, Y.
- 62-Robinson, S.
- 63-Scott, C.
- 64-Smith, T.
- 65-Steiner, L.
- 66-Tobar, M.
- 67-Updike, M.

If "Yes", who performed the consult?  
99-Other



### ED Visits and Hospitalization (EDV)

Segment (PROTSEG): C

Visit number (VISNO):

ED visit hospitalization (EDHOSPDT):

Document sequence number (SEQNUM):

#### ED Index Visit

- 1. ED enrollment date:(EDEDENRL)
- 2. Chief complaint:(EDICOMPL)
- 3. Discharge date:(EDDISDT)
- 4. Discharge diagnosis:(EDDISDG)
- 5. ICD 10 code(s) for the discharge diagnosis:
  - a. Code 1:(ED1ICD10)
  - b. Code 2:(ED2ICD10)
  - c. Code 3:(ED3ICD10)
  - d. Code 4:(ED4ICD10)
  - e. Code 5:(ED5ICD10)
  - f. Code 6:(ED6ICD10)
  - g. Code 7:(ED7ICD10)
  - h. Code 8:(ED8ICD10)
  - i. Code 9:(ED9ICD10)
  - j. Code 10:(ED10ICD)

(mm/dd/yyyy)

(mm/dd/yyyy)

#### ED Visit or Hospitalization After the ED Index Visit

- 6. Has the patient visited the ED or been hospitalized between the screening and follow-up visits?(EDVVISIT)
- 7. ED visit or hospitalization:(EDVHOSP)
- 8. Chief complaint:(EDVCOMPL)
- 9. Discharge date:(EDVDISDT)
- 10. Discharge diagnosis:(EDVDISDG)
- 11. ICD 10 code(s) for the discharge diagnosis:
  - a. Code 1:(EDV1ICD10)
  - b. Code 2:(EDV2ICD)
  - c. Code 3:(EDV3ICD)
  - d. Code 4:(EDV4ICD)
  - e. Code 5:(EDV5ICD)
  - f. Code 6:(EDV6ICD)
  - g. Code 7:(EDV7ICD)
  - h. Code 8:(EDV8ICD)
  - i. Code 9:(EDV9ICD)
  - j. Code 10:(EDV10ICD)
- Comments:(EDVCOMM)

0-No  1-Yes

00-ED visit  01-Hospitalization

(mm/dd/yyyy)

**Additional Selection Options for EDV**

Document sequence number (*SEQNUM*) (key field):

01-1  
02-2  
03-3  
04-4  
05-5  
06-6  
07-7  
08-8  
09-9  
10-10  
11-11  
12-12  
13-13  
14-14  
15-15  
16-16  
17-17  
18-18  
19-19  
20-20

EQ-5D-3L (EQD)

Web Version: 1.0; 3.00; 03-28-18

Segment (PROTSEG): C  
Visit number (VISNO):



Health Questionnaire

English version for the USA

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Under each heading, please tap the ONE box that best describes your health TODAY.

Mobility  
(EQ5MBTLY)

- MB1-I have no problems in walking about
- MB2-I have some problems in walking about
- MB3-I am confined to bed

Self-Care  
(EQ5SLFCR)

- SC1-I have no problems with self-care
- SC2-I have some problems washing or dressing myself
- SC3-I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family, or leisure activities)  
(EQ5ACTIV)

- UA1-I have no problems with performing my usual activities
- UA2-I have some problems with performing my usual activities
- UA3-I am unable to perform my usual activities

Pain / Discomfort  
(EQ5PAIND)

- PD1-I have no pain or discomfort
- PD2-I have moderate pain or discomfort
- PD3-I have extreme pain or discomfort

Anxiety / Depression  
(EQ5ANXDE)

- AD1-I am not anxious or depressed
- AD2-I am moderately anxious or depressed
- AD3-I am extremely anxious or depressed

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- We would like to know how good or bad your health is TODAY.
- This scale is numbered 0 to 100.
- 100 means the best health you can imagine.
- 0 means the worst health you can imagine.
- Please tap on the scale to indicate how your health is TODAY.

(xxx)  
 The best health you can imagine  
 The worst health you can imagine

YOUR HEALTH TODAY(EQ5HLTTD)

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NIDA Clinical Trials Network

Engagement in Treatment: Facility (ETF)

Web Version: 1.0; 3.02; 09-23-19

Segment (PROTSEG): C

Visit number (VISNO):

Facility name (FACPRLC):

Date of assessment:(ETDATE)

(mm/dd/yyyy)

- 1-Office-based provider
- 2-Opioid treatment program
- 3-Residential program
- 99-Other

0-No  1-Yes

1. What type of Provider/Program is this?(ETPROGRAM)

If "Other", specify:(ETPROGSP)

2. On [Enter 30day Target Date] was this patient engaged in a program at your facility or being treated at your office for their opioid use disorder?(ETENGAGE)

If "Yes", review and answer the following questions:

a. Indicate the type(s) of treatment they were receiving for their opioid use disorder on [Enter 30day Target Date]:

	No	Yes
Methadone:	(ETMTD) <input type="checkbox"/>	<input type="checkbox"/>
Buprenorphine:	(ETBUP) <input type="checkbox"/>	<input type="checkbox"/>
Naltrexone:	(ETNAL) <input type="checkbox"/>	<input type="checkbox"/>
Short-term detoxification:	(ETSTDETX) <input type="checkbox"/>	<input type="checkbox"/>
Inpatient:	(ETINPT) <input type="checkbox"/>	<input type="checkbox"/>
Outpatient counseling:	(ETOTPT) <input type="checkbox"/>	<input type="checkbox"/>
Other, specify:(ETOTRSP) <input type="text"/>	(ETOTHER) <input type="checkbox"/>	<input type="checkbox"/>

b. On [Enter 30day Target Date], how would you categorize the level of treatment received by this patient?(ETCATGTR)

- 0-No care received
- 1-Level I: Outpatient treatment
- 2-Level II: Intensive outpatient treatment (including partial hospitalization)
- 3-Level III: Residential/inpatient services
- 4-Level IV: Medically managed intensive inpatient treatment
- \*Additional Options Listed Below

(mm/dd/yyyy)

0-No  1-Yes

(mm/dd/yyyy)

If "Other", specify:(ETCATSP)

c. What was the date of their admission into your program or, if office-based, when did their care begin?(ETADMSDT)

d. Was the patient discharged?(ETDISCH)

If "Yes", date of discharge from your care:(ETDSCDT)

Comments:(ETFCOMM)

**Additional Selection Options for ETF**

On [Enter 30day Target Date], how would you categorize the level of treatment received by this patient?  
99-Other

Engagement in Treatment: Patient (ETP)

Segment (PROTSEG): C  
Visit number (VISNO):

The next questions ask about the medical care you have received for an opioid use disorder on [insert 30day Target Date].

1. On [insert 30day Target Date] are/were you receiving treatment for opioid use disorder? (ETMEDTRT)

0-No  1-Yes

	Program/Provider #1	Program/Provider #2	Program/Provider #3
a. <sup>1</sup> Where are/were you receiving this treatment?			
<sup>2</sup> Program/provider name:	(ETPRLC01) <input type="text"/>	(ETPRLC02) <input type="text"/>	(ETPRLC03) <input type="text"/>
c. <sup>3</sup> What type(s) of treatment are/were you receiving? <small>Only include formal treatment (e.g., do not include NA, AA, or faith-based).</small>			
Methadone:	(ETMETH1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETMETH2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETMETH3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
Buprenorphine:	(ETBUP1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETBUP2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETBUP3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
Naltrexone:	(ETNALTR1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETNALTR2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETNALTR3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
Short-term detoxification:	(ETDETOX1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETDETOX2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETDETOX3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
Inpatient:	(ETINPAT1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETINPAT2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETINPAT3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
Outpatient counseling:	(ETOTPAT1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETOTPAT2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETOTPAT3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
Other:	(ETOTHER1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETOTHER2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(ETOTHER3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
If "Other", specify:	(ETOTHSP1) <input type="text"/>	(ETOTHSP2) <input type="text"/>	(ETOTHSP3) <input type="text"/>
d. <sup>4</sup> Who is/was your counselor/clinician?			
e.	(ETCOCLI1) <input type="text"/>	(ETCOCLI2) <input type="text"/>	(ETCOCLI3) <input type="text"/>
f. <sup>5</sup> Was this service covered by:			
g.	(ETCOVRD1) <input type="text"/>	(ETCOVRD2) <input type="text"/>	(ETCOVRD3) <input type="text"/>

2. On [insert 30day Target Date] are/were you: (ETLIVE)

If "Other", specify: (ETLIVESP)

Comments: (ETPCOMM)

0069C (ENR)

Date eligibility confirmed:(STARTDT)

(mm/dd/yyyy)

Patient date and time to bed in Emergency Department:(R5EDDT)

Date:  (mm/dd/yyyy) (R5EDTM) Time:  (hh:mm)

Inclusion Criteria

In order to meet eligibility ALL Inclusion answers must be "Yes".

- 1. Participant is 18 years of age or older:(R5PTAGE)  0-No  1-Yes  97-Unknown
- 2. Participant presented to the Emergency Department during study screening hours:(R5SCHOUR)  0-No  1-Yes  97-Unknown
- 3. Participant meets DSM-5 diagnostic criteria for moderate to severe opioid use disorder:(R5DSMOUD)  0-No  1-Yes  97-Unknown
- 4. Participant has a urine toxicology test, taken prior to any Emergency Department provided opioid medication, that is positive for opioids:(R5URIOP)  0-No  1-Yes  97-Unknown

Exclusion Criteria

In order to meet eligibility ALL Exclusion answers must be "No".

- 1. Participant has a medical or psychiatric condition that requires hospitalization at the index Emergency Department visit:(R5HOSPTL)  0-No  1-Yes  97-Unknown
- 2. Participant is actively suicidal or severely cognitively impaired:(R5SUICDE)  0-No  1-Yes  97-Unknown
- 3. Participant presents from extended care facility (e.g., skilled nursing facility):(R5EXCARE)  0-No  1-Yes  97-Unknown
- 4. Participant requires continued prescription opioids for a pain condition:(R5RXOPI)  0-No  1-Yes  97-Unknown
- 5. Participant is a prisoner or is in police custody at the time of index Emergency Department visit:(R5PRISON)  0-No  1-Yes  97-Unknown
- 6. Participant currently has (past 30 days) enrolled in formal addiction treatment, including by court order:(R5ADDTRT)  0-No  1-Yes  97-Unknown
- 7. Participant is unable to provide reliable locator information including 2 contact numbers:(R5LOCATE)  0-No  1-Yes  97-Unknown
- 8. Participant is unwilling to follow study procedures (e.g., unwilling to provide permission to contact referral provider/program or to return for 30-day assessment):(R5UNSTDY)  0-No  1-Yes  97-Unknown
- 9. Participant has prior participation in the current study:(R5PRIOR)  0-No  1-Yes  97-Unknown
- 10. Participant is not able to speak English sufficiently to understand the study procedures and provide written informed consent to participate in the study:(R5ENGLSH)  0-No  1-Yes  97-Unknown

Eligibility for Enrollment

- 1. Is the participant eligible for the study?(R5ELGSTY)  0-No  1-Yes
- 2. Will the participant be enrolled?(R5BEENR)  0-No  1-Yes

If "No", specify:(R5NENRSP)

2-Declined study participation  
 3-Left prior to completion  
 99-Other

If "Other", specify:(R5OTJGSP)

Comments:(R5COMM)

Timeline Followback Page 2 (F69)

TFB week start date (TFWKSTDT):

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date	(TLDATE1) <input type="text"/>	(TLDATE2) <input type="text"/>	(TLDATE3) <input type="text"/>	(TLDATE4) <input type="text"/>	(TLDATE5) <input type="text"/>	(TLDATE6) <input type="text"/>	(TLDATE7) <input type="text"/>
1. Have any pain relievers, pain medications, sedatives, alcohol, methamphetamine, cocaine, heroin, or other illicit substances been used on this day?	(TLSUBAL1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
2. Pentazocine (Talwin):							
Route:	(TLPENZ1) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLPENZ2) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLPENZ3) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLPENZ4) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLPENZ5) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLPENZ6) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLPENZ7) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below
Prescribed:	(TLPENZ1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPENZ2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPENZ3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPENZ4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPENZ5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPENZ6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPENZ7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTPENZ1) <input type="text"/> (xxx)	(TLTPENZ2) <input type="text"/> (xxx)	(TLTPENZ3) <input type="text"/> (xxx)	(TLTPENZ4) <input type="text"/> (xxx)	(TLTPENZ5) <input type="text"/> (xxx)	(TLTPENZ6) <input type="text"/> (xxx)	(TLTPENZ7) <input type="text"/> (xxx)
3. Codeine:							
Route:	(TLCODE1) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCODE2) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCODE3) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCODE4) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCODE5) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCODE6) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCODE7) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below
Prescribed:	(TLCODE1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLCODE2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLCODE3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLCODE4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLCODE5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLCODE6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLCODE7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTCODE1) <input type="text"/> (xxx)	(TLTCODE2) <input type="text"/> (xxx)	(TLTCODE3) <input type="text"/> (xxx)	(TLTCODE4) <input type="text"/> (xxx)	(TLTCODE5) <input type="text"/> (xxx)	(TLTCODE6) <input type="text"/> (xxx)	(TLTCODE7) <input type="text"/> (xxx)
4. Benzodiazepines (Valium, Serpax, Ativan, Xanax, Librium, Rohypnol):							
Route:	(TLBZO1) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLBZO2) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLBZO3) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLBZO4) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLBZO5) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLBZO6) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLBZO7) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below
Prescribed:	(TLPBZO1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPBZO2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPBZO3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPBZO4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPBZO5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPBZO6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPBZO7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTBZO1) <input type="text"/> (xxx)	(TLTBZO2) <input type="text"/> (xxx)	(TLTBZO3) <input type="text"/> (xxx)	(TLTBZO4) <input type="text"/> (xxx)	(TLTBZO5) <input type="text"/> (xxx)	(TLTBZO6) <input type="text"/> (xxx)	(TLTBZO7) <input type="text"/> (xxx)
5. Methamphetamine (speed, crystal meth, ice):							
Route:	(TLMET1) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMET2) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMET3) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMET4) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMET5) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMET6) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMET7) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below
Prescribed:	(TLPMET1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMET2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMET3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMET4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMET5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMET6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMET7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTMET1) <input type="text"/> (xxx)	(TLTMET2) <input type="text"/> (xxx)	(TLTMET3) <input type="text"/> (xxx)	(TLTMET4) <input type="text"/> (xxx)	(TLTMET5) <input type="text"/> (xxx)	(TLTMET6) <input type="text"/> (xxx)	(TLTMET7) <input type="text"/> (xxx)
6. Cocaine (coke, crack):							
Route:	(TLCOC1) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCOC2) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCOC3) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCOC4) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCOC5) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCOC6) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLCOC7) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below
Prescribed:	(TLTCOC1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLTCOC2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLTCOC3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLTCOC4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLTCOC5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLTCOC6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLTCOC7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTCOC1) <input type="text"/> (xxx)	(TLTCOC2) <input type="text"/> (xxx)	(TLTCOC3) <input type="text"/> (xxx)	(TLTCOC4) <input type="text"/> (xxx)	(TLTCOC5) <input type="text"/> (xxx)	(TLTCOC6) <input type="text"/> (xxx)	(TLTCOC7) <input type="text"/> (xxx)
7. Alcohol:							
# Times Used Each Day:	(TLTALCH1) <input type="text"/> (xxx)	(TLTALCH2) <input type="text"/> (xxx)	(TLTALCH3) <input type="text"/> (xxx)	(TLTALCH4) <input type="text"/> (xxx)	(TLTALCH5) <input type="text"/> (xxx)	(TLTALCH6) <input type="text"/> (xxx)	(TLTALCH7) <input type="text"/> (xxx)
8. Cannabis (marijuana, pot, grass, hash):							



Route:

(TLTHC1)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLTHC2)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLTHC3)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLTHC4)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLTHC5)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLTHC6)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLTHC7)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

Prescribed:

(TLPTHC1)  0-No  1-Yes

(TLPTHC2)  0-No  1-Yes

(TLPTHC3)  0-No  1-Yes

(TLPTHC4)  0-No  1-Yes

(TLPTHC5)  0-No  1-Yes

(TLPTHC6)  0-No  1-Yes

(TLPTHC7)  0-No  1-Yes

# Times Used Each Day:

(TLTTHC1)  (xxx)

(TLTTHC2)  (xxx)

(TLTTHC3)  (xxx)

(TLTTHC4)  (xxx)

(TLTTHC5)  (xxx)

(TLTTHC6)  (xxx)

(TLTTHC7)  (xxx)

9. Other drug 1 use:

Route:

(TLOT11)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT12)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT13)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT14)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT15)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT16)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT17)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

Prescribed:

(TLPOT11)  0-No  1-Yes

(TLPOT12)  0-No  1-Yes

(TLPOT13)  0-No  1-Yes

(TLPOT14)  0-No  1-Yes

(TLPOT15)  0-No  1-Yes

(TLPOT16)  0-No  1-Yes

(TLPOT17)  0-No  1-Yes

# Times Used Each Day:

(TLTOT11)  (xxx)

(TLTOT12)  (xxx)

(TLTOT13)  (xxx)

(TLTOT14)  (xxx)

(TLTOT15)  (xxx)

(TLTOT16)  (xxx)

(TLTOT17)  (xxx)

Specify other drug 1:

(TLOTSP11)

(TLOTSP12)

(TLOTSP13)

(TLOTSP14)

(TLOTSP15)

(TLOTSP16)

(TLOTSP17)

10. Other drug 2 use:

Route:

(TLOT21)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT22)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT23)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT24)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT25)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT26)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

(TLOT27)  
 0-00-No use  
 1-01-Oral  
 2-02-Nasal  
 3-03-Smoking  
 4-04-Non-IV Injection  
 \*Additional Options Listed Below

Prescribed:

(TLPOT21)  0-No  1-Yes

(TLPOT22)  0-No  1-Yes

(TLPOT23)  0-No  1-Yes

(TLPOT24)  0-No  1-Yes

(TLPOT25)  0-No  1-Yes

(TLPOT26)  0-No  1-Yes

(TLPOT27)  0-No  1-Yes

# Times Used Each Day:

(TLTOT21)  (xxx)

(TLTOT22)  (xxx)

(TLTOT23)  (xxx)

(TLTOT24)  (xxx)

(TLTOT25)  (xxx)

(TLTOT26)  (xxx)

(TLTOT27)  (xxx)

Specify other drug 2:

(TLOTSP21)

(TLOTSP22)

(TLOTSP23)

(TLOTSP24)

(TLOTSP25)

(TLOTSP26)

(TLOTSP27)

Comments:(TFBCOMM)

**Additional Selection Options for F69**

**D1 pentazocine**  
5-05-IV Injection  
99-99-Other

NIDA Clinical Trials Network

Follow-Up Visit Scheduling (FVT)

Web Version: 1.0; 2.01; 07-02-18

Segment (PROTSEG): C  
Visit number (VISNO):

Please schedule the follow up visit date and time with this participant. The target date range for the 30 day follow-up visit is from  $j\_edate+30$  to  $j\_edate+44$

1. Date of 30 day follow-up visit:(FVAPPTDT)

 (mm/dd/yyyy)

2. Appointment time:(FVAPPTM)

 (hh:mm) (24-hour time)

Comments:(FVTCOMM)

Health Services Utilization Page 1: Inpatient (HS1)

Web Version: 1.0; 1.01; 10-03-18

Segment (PROTSEG): C  
Visit number (VISNO):

Now I would like to review, in detail, any facilities in which you have been hospitalized overnight for any reason (physical, emotional, or substance abuse) during the past 30 days. Please include residential detox facilities but do not include sober houses or halfway house stays.

Were any inpatient services used in the past 30 days?(HS1SU)

0-No  1-Yes

If "Yes", how many inpatient facilities were utilized in the past 30 days?(HS1FAC)

(xx) facilities

Health Services Utilization Page 1: Outpatient (HS2)

Web Version: 1.0; 1.01; 08-20-18

Segment (PROTSEG): C  
Visit number (VISNO):

Next, I want to ask you about when you were an outpatient. Please include regular doctor visits, visits to Emergency Departments/Rooms (ED), and any treatment centers (e.g., methadone maintenance centers). Let's review, in detail, each practitioner or community service you received as an outpatient for any reason (physical, emotional, or substance abuse) during the past 30 days.

Next, I want to ask you about when you were an outpatient. Please include regular doctor visits, visits to Emergency Departments/Rooms (ED), not including ED enrollment visit, and any treatment centers (e.g., methadone maintenance centers). Let's review, in detail, each practitioner or community service you received as an outpatient for any reason (physical, emotional, or substance abuse) during the past 30 days.

Were any outpatient services used in the past 30 days?(HS2SU)

0-No  1-Yes

If "Yes", how many outpatient facilities were utilized in the past 30 days?(HS2FAC)

(xx) facilities

Were any outpatient services used in the 30 days prior to the follow up visit target date?(HS2SU)

0-No  1-Yes

If "Yes", how many outpatient facilities were utilized in the 30 days prior to the follow up visit target date?(HS2FAC)

(xx) facilities

Health Services Utilization: Inpatient (HSI)

Segment (PROTSEG): C

Visit number (VISNO):

Facility name (FACPLC):

Sequence number (SEQNUM2):

Please describe your stay including the type of inpatient service that was provided.

1. Provider code:
Note to RA: If patient endorses 'Inpatient substance abuse treatment (residential)', then refer back to eligibility criteria. (HSPRCODE)

Dropdown menu with options: 1-Medical hospital, 2-Psychiatric hospital, 3-Inpatient substance abuse treatment (residential), 4-Skilled nursing/extended care facility, 99-Other inpatient facility

If "Other inpatient facility", specify:(HSOTHISP)

Text input field

2. Service type:
Note to RA: If patient endorses 'Substance abuse' or 'Psychiatric and substance abuse', then refer back to eligibility criteria. (HSSRTYPE)

Dropdown menu with options: 1-Medical/surgical, 2-Psychiatric (non-substance abuse), 3-Substance abuse, 4-Psychiatric and substance abuse

3. What was the reason for the hospitalization?(HSHSPRSN)

Text input field

4. Number of nights stayed this visit:
Include all days in the facility, including days arising from a stay which began prior to the start of the 30 DAY period. (HSNITNUM)

Text input field (xxx)

5. Number of admissions in PAST 30 days:
Include any admission during the 30 DAYS (e.g., if a patient was hospitalized continuously there would have been no admissions in 30 DAYS). Consider transfers as new admissions if they involve a different kind of service (i.e., service type). (HSADMNUM)

Text input field (xx)

6. Visit(s) paid for by:(HSVSPAID)

Radio buttons: 1-Insurance, 2-Self-pay, 3-No-cost

Comments:(HSICOMM)

Text input field for comments

**Additional Selection Options for HSI**

Sequence number (SEQNUM2) (key field):

- 01-1
- 02-2
- 03-3
- 04-4
- 05-5
- 06-6
- 07-7
- 08-8
- 09-9
- 10-10

Health Services Utilization: Outpatient (HSO)

Segment (PROTSEG): C

Visit number (VISNO):

Facility name (FACPRLC):

Please describe the type of outpatient service that was provided and about your stay.

1. Provider code:(HSPVCODE)

1-Hospital-based clinic  
 2-Federally-qualified (community) health center  
 3-Private doctor's office  
 4-Emergency department  
 5-Urgent care center/walk-in facility  
 \*Additional Options Listed Below

If "Other", specify:(HSPVOTSP)

2. Service type:(HSSERVTP)

1-Medical/surgical  
 2-Psychiatric (non-substance abuse)  
 3-Substance abuse  
 4-Psychiatric and substance abuse

3. Provider type:(HSPVTYPE)

1-Doctor  
 2-Nurse  
 3-Nurse practitioner  
 4-Physician's Assistant (PA)  
 5-Chiropractor  
 \*Additional Options Listed Below

If "Other", specify:(HSPVOTH)

4. Number of visits in PAST 30 days:(HNUMVIS)

(xx)

5. Number of visits in the 30 days prior to your follow up visit target date:(HNUMVIS)

(xx)

6. Average minutes per visit:

Include time spent with the provider.(HSAVGMIN)

(xxxx)

7. Visit(s) paid for by:(HSPAIDBY)

1-Insurance  2-Self-pay  3-No-cost

8. Medications received/amount in the past 30 days:

Include substance abuse medications.

9. Medications received/amount in the 30 days prior to your follow up visit target date:

Include substance abuse medications.

^2Drug	Use	Number of Days	
a. ^2Methadone:	(HSMETHAD) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(HSMETDAY) <input type="text"/> (xx)	
b. ^2Buprenorphine:	(HSBUPREN) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes		
Oral:	(HSBUPORL) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(HSBPORDY) <input type="text"/> (xx)	
@2	@2Implant: (HSBUPIMP) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(HSBPIMDY) <input type="text"/> (xx)	Implant date:(HSIMPDT) <input type="text"/> (mm/dd/yyyy)
		Removal date:(HSREMDT) <input type="text"/> (mm/dd/yyyy)	
Other:	(HSBUPOT) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(HSBPOTDY) <input type="text"/> (xx)	
c. ^2Naltrexone:	(HSXRNTX) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes		
Oral:	(HSNALORL) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(HSNAORDY) <input type="text"/> (xx)	
Injectable:	(HSNALINJ) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes		Injection date:(HSINJDT) <input type="text"/> (mm/dd/yyyy)
			Date of second injection:(HSINJ2DT) <input type="text"/> (mm/dd/yyyy)
Other:	(HSNALOT) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(HSNAOTDY) <input type="text"/> (xx)	
d. ^2Naloxone (Narcan):	(HSNARCAN) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes		Number of doses:(HSNLNDOS) <input type="text"/> (xx)
e. ^2Other medication:	(HSOTHER) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(HSOTHDY) <input type="text"/> (xx)	^2Specify medication:(HSOTHSP) <input type="text"/>

Comments:(HSOCOMM)



**Additional Selection Options for HSO**

**Provider code:**

- 6-Day surgery
- 7-Opioid treatment program
- 99-Other

**Provider type:**

- 6-Dentist
- 7-Counselor/psychologist
- 8-Self-help (e.g., NA, AA)
- 99-Other

Health Status (HST)

Segment (PROTSEG): C  
 Visit number (VISNO):

- 1. Did you come to the Emergency Department today primarily to receive treatment or a referral for your opioid use? (HSEDRSN)
- 2. Do you have a medical care provider whom you usually see? (HSMEDPRO)
- 3. Where do you usually or most often go for medical care? (HSMEDLOC)

0-No  1-Yes

0-No  1-Yes

1-Hospital-based clinic  
 2-Federally-qualified (community) health center  
 3-Private doctor's office  
 4-Emergency department  
 5-Urgent care center/walk in facility  
 \*Additional Options Listed Below

0-No  1-Yes  2-Never tested

0-Negative  1-Positive

0-No  1-Yes  2-Never tested

0-Negative  1-Positive

If "Other", specify: (HSLOCSP)

- 4. Do you know your HIV status? (HSKNOHIV)

If "Yes", what is your HIV status? (HSSTAHIV)

- 5. Do you know your Hepatitis C status? (HSKNOHEP)

If "Yes", what is your Hepatitis C status? (HSSTAHEP)

The following questions are about your sexual and drug use behaviors, things that happened, or that you have done in the past month. Think back over this time about the places you have been, the things that you have done, and the people that you have been with. The most important thing is that you respond HONESTLY and ACCURATELY. OK, let's start.

Drug Use Section

- 6. How many times have you hit up (i.e., injected yourself with any drugs or were injected by someone else) in the last month? (HSHITUP)

0-No times  
 1-Once  
 2-More than once  
 3-Once a day  
 4-2-3 times a day  
 5-More than 3 times a day

- 7. How many times in the last month have you used a needle after someone else had already used it? Please include the number of times you used a needle after your partner in addition to the number of times you used a needle after others. (HSYOUAFT)

0-No times  
 1-One time  
 2-Two times  
 3-3-5 times  
 4-6-10 times  
 5-More than 10 times

- 8. How many different people (including your partner) have used a needle before you in the last month? (HSPPLBEF)

0-None  
 1-One person  
 2-Two people  
 3-3-5 people  
 4-6-10 people  
 5-More than 10 people

- 9. How many times in the last month has someone else used a needle after you used it? (HSPPLAFT)

0-No times  
 1-One time  
 2-Two times  
 3-3-5 times  
 4-6-10 times  
 5-More than 10 times

- 10. How often, in the last month, have you cleaned needles before re-using them? (HSLCNEED)

0-Doesn't re-use  
 1-Every time  
 2-Often  
 3-Sometimes  
 4-Rarely  
 5-Never

- 11. Before using needles again, how often in the last month did you use bleach to clean them? (HSCBLEC)

0-Doesn't re-use  
 1-Every time  
 2-Often  
 3-Sometimes  
 4-Rarely  
 5-Never

Sexual Behavior Section

- 12. How many people, including any regular partners, casual acquaintances and clients, have you had sex with in the last month? (HSPPLSEX)

0-None  
 1-One person  
 2-Two people  
 3-3-5 people  
 4-6-10 people  
 5-More than 10 people

- 13. How often, in the last month, have you used condoms when having sex with your regular partner(s)? (HSCONREG)

0-No regular partners / No penetrative sex  
 1-Every time  
 2-Often  
 3-Sometimes  
 4-Rarely  
 5-Never

- 14. How often, in the last month, have you used condoms when you had sex with casual partners (acquaintances)? (HSCONCAS)

0-No casual partners / No penetrative sex  
 1-Every time  
 2-Often  
 3-Sometimes  
 4-Rarely  
 5-Never

- 15. How often, in the last month, have you used condoms when you have been paid for sex with money or drugs or when you have paid for sex with money or drugs? (HSCONPAD)

0-No paid sex / No penetrative sex  
 1-Every time  
 2-Often  
 3-Sometimes  
 4-Rarely  
 5-Never

0-No times  
 1-One time  
 2-Two times  
 3-3-5 times  
 4-6-10 times  
 5-More than 10 times

0-No regular partners / No penetrative sex  
 1-Every time  
 2-Often  
 3-Sometimes  
 4-Rarely  
 5-Never

16. How many **times** have you had anal sex in the last month?(HSANALSX)

17. How **often** have you used condoms during anal sex in the last month?(HSCONANL)

**Pain Section**

Please use the range of 0 to 10 to answer the following questions.

18. What number best describes your pain on average in the past week?(HSPAINAV)

19. What number best describes how, during the past week, pain has interfered with your enjoyment of life?(HSENGJOY)

20. What number best describes how, during the past week, pain has interfered with your general activity?(HSACTVTY)

(0 = No pain, 10 = Pain as bad as you can imagine)

(0 = Pain has not interfered at all, 10 = Pain has interfered extremely)

(0 = Pain has not interfered at all, 10 = Pain has interfered extremely)

**Psychological Section**

21. In your lifetime, have you ever been treated for any psychological or emotional problems in a hospital or inpatient setting? (HSHOSP)

0-No  1-Yes

22. In your lifetime, have you ever been treated for any psychological or emotional problems as an outpatient/private patient? (HSOUTPT)

0-No  1-Yes

23. In the past 30 days, have you been treated for any psychological or emotional problems with counseling or medication? (HSCNMED)

0-No  1-Yes

24. Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

a. Little interest or pleasure in doing things:

Not at All      Several Days      More Than Half the Days      Nearly Every Day

(HSINTPL)                  

b. Feeling down, depressed, or hopeless:

(HSDEPR)                  

c. Trouble falling or staying asleep, or sleeping too much:

(HSSLEEP)                  

d. Feeling tired or having little energy:

(HSTIRED)                  

e. Poor appetite or overeating:

(HSEAT)                  

f. Feeling bad about yourself-or that you are a failure or have let yourself or your family down:

(HSFAIL)                  

g. Trouble concentrating on things, such as reading the newspaper or watching television:

(HSCONCEN)                  

h. 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:

(HSMOVE)                  

i. Thoughts that you would be better off dead, or of hurting yourself in some way:

(HSDEAD)                  

25. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?(HSDIFFC)

0-Not difficult at all  
 1-Somewhat difficult  
 2-Very difficult  
 3-Extremely difficult

**Additional Selection Options for HST**

Where do you usually or most often go for medical care?  
6-No place  
99-Other

NIDA Clinical Trials Network

Healthcare Visit Logistics (HVL)

Web Version: 1.0; 1.01; 05-23-17

Segment (PROTSEG): C  
Visit number (VISNO):

Please answer the following questions about the time it takes to travel to your usual healthcare provider.  
If you are unsure about this information, give your best estimate.

1. About how many miles do you travel **ONE WAY** to get to your usual health care provider (e.g., medical doctor)?  
(If you have more than one usual provider, choose one.)(HVDISTSP)

 (xxx.xx) miles

2. About how long does it typically take to travel **ONE WAY** to your provider?(HVTMHRSP)

Hours:  (xx) (HVTMMNSP) Minutes:  (xx)

Comments:(HVLCOMM)

**Missed Visit (MVF)**

Segment (PROTSEG): C  
Visit number (VISNO):

Reason for missed visit:(MVREASON)

1-Participant failed to return to site and unable to contact  
2-Participant unable to attend visit (e.g., no childcare, transportation, schedule conflict)  
3-Participant on vacation  
4-Participant illness  
5-Participant in hospital, in-patient, or residential treatment  
\*Additional Options Listed Below

If "Other", specify:(MVOTHRSP)

Comments:(MVFCOMM)

**Additional Selection Options for MVF**

- Reason for missed visit:**  
6-Participant moved from area  
7-Participant incarcerated  
8-Site closed  
9-Participant withdrew consent  
10-Participant deceased  
99-Other

National Death Index (NDI)

Web Version: 1.0; 1.00; 05-11-20

Enter death information on this form only if it has returned from the National Death Index (NDI) submission.

1. Is this record reported as an exact match?(NDEXTMCH)

0-No  1-Yes

2. Date of death per NDI:(NDDTHDT)

(mm/dd/yyyy)

3. NDI primary cause of death:(NDNDICOD)

4. Is there any additional information provided concerning secondary cause of death or other contributing factors?(NDADDINF)

0-No  1-Yes

a. NDI secondary cause of death, if applicable:(NDNDISEC)

(NDSECNA)  96-N/A

b. NDI contributing factors to cause of death, if applicable:(NDCONFAC)

(NDCNTNA)  96-N/A

Comments:(NDICOMM)



Overdose Events (ODE)

Segment (PROTSEG): C  
Visit number (VISNO):

All questions relating to past 30 days refer to Days 1-30, post ED enrollment visit (Day 0).

1. On how many days in the past 30 days do you think you overdosed on opioids (you used more opioids than you should have used and were more sedated, drugged, or high than you wanted to be)?(ODTHINK)  (xx) day(s)
2. On how many days in the past 30 days did you or someone else call for medical assistance because you were more sedated, drugged, or high than you should be after you used opioids?(ODMED)  (xx) day(s)

Comments:(ODECOMM)

Other Substance Use (OSU)

Segment (PROTSEG): C  
Visit number (VISNO):

These questions ask about psychoactive substances in the PAST 3 MONTHS ONLY.

- 1. Did you smoke a cigarette containing tobacco?(OSSMKCIG)  0-No  1-Yes
  - a. Did you usually smoke more than 10 cigarettes each day?(OSSMK10)  0-No  1-Yes
  - b. Did you usually smoke within 30 minutes after waking?(OSSMK30)  0-No  1-Yes
- 2. Did you have a drink containing alcohol?(OSALCOH)  0-No  1-Yes
  - a. On any occasion, did you drink more than 4 standard\* drinks of alcohol? (\*1 standard drink is about 1 small glass of wine, or one can of medium strength beer, or one single shot of spirits.)(OSALBING)  0-No  1-Yes
  - b. Have you tried and failed to control, cut down or stop drinking?(OSALSTOP)  0-No  1-Yes
  - c. Has anyone expressed concern about your drinking?(OSALCNR)  0-No  1-Yes
- 3. Did you use cannabis?(OSCANAB)  0-No  1-Yes
  - a. Have you had a strong desire or urge to use cannabis at least once a week or more often?(OSCANDES)  0-No  1-Yes
  - b. Has anyone expressed concern about your use of cannabis?(OSANCNR)  0-No  1-Yes
- 4. Did you use an amphetamine-type stimulant, or cocaine, or a stimulant medication not as prescribed?(OSSTMULN)  0-No  1-Yes
  - a. Did you use a stimulant at least once each week or more often?(OSSTMOFT)  0-No  1-Yes
  - b. Has anyone expressed concern about your use of a stimulant?(OSSTMENR)  0-No  1-Yes
- 5. Did you use a sedative or sleeping medication not as prescribed?(OSSEDUSE)  0-No  1-Yes
  - a. Have you had a strong desire or urge to use a sedative or sleeping medication at least once a week or more often? (OSSEDES)  0-No  1-Yes
  - b. Has anyone expressed concern about your use of a sedative or sleeping medication?(OSSEDSNR)  0-No  1-Yes
- 6. Did you use any other psychoactive altering substance?(OSPSYCH)  0-No  1-Yes
 

If "Yes", what did you take?(OSPSYSP)

Comments:(OSUCOMM)

Protocol Deviation Review (PDR)

Date of deviation (PDDATE):

Protocol deviation number (PDSEQNO):

Completed by Protocol Specialist:

1. What section of the protocol does this deviation refer to?(PDSECTN)

Text input field for PDSECTN

2. Does the report of this deviation require site staff retraining?(PDTRAIN)

0-No  1-Yes

If "Yes", specify plan for retraining:(PDPLATRA)

Text input field for PDPLATRA

3. Date deviation was discussed with Lead Investigative Team:(PDDISCDT)

(mm/dd/yyyy)

4. Deviation is categorized as:(PDCATGRY)

2-Major  1-Minor

5. Deviation assessment by Protocol Specialist complete:(PDPSCMP)

0-No  1-Yes

Protocol Specialist reviewer:(PDPSRVID)

(initials)

Protocol Specialist comments:(PDRCOMM2)

Text input field for PDRCOMM2

Completed by Protocol Monitor:

6. Deviation requires review by Protocol Monitor:(PDPREVV)

0-No  1-Yes

7. Corrective action for this deviation was completed and documented on-site as described:(PDACTDOC)

0-No  1-Yes

If "No", specify reason:(PDSITESP)

Text input field for PDSITESP

8. Deviation was reported to the IRB as required:(PDIRBRPT)

0-No  1-Yes

If "No", specify reason:(PDIRBSP)

Text input field for PDIRBSP

9. Preventive action plan related to this event was completed and documented on-site as described:(PDPREVNT)

0-No  1-Yes

10. Review by Protocol Monitor is complete:(PDPMCMP)

0-No  1-Yes

Protocol Monitor reviewer:(PDPMRVID)

(initials)

Protocol Monitor comments:(PDRCOMM)

Text input field for PDRCOMM

**Additional Selection Options for PDR**

**Protocol deviation number (PDSEQNO) (key field):**

- 01-1st Protocol Deviation of the day
- 02-2nd Protocol Deviation of the day
- 03-3rd Protocol Deviation of the day
- 04-4th Protocol Deviation of the day
- 05-5th Protocol Deviation of the day
- 06-6th Protocol Deviation of the day
- 07-7th Protocol Deviation of the day
- 08-8th Protocol Deviation of the day
- 09-9th Protocol Deviation of the day
- 10-10th Protocol Deviation of the day

Protocol Deviation (PDV)

Date of deviation (PDDATE):

Protocol deviation number (PDSEQNO):

1. Is this deviation related to one or more participants?(PDPPTREL)

If "Yes", how many participants?(PDPRELNO)

0-No  1-Yes

01-1

02-2

03-3

04-4

05-5

\*Additional Options Listed Below

Select related participants:

Participant ID 1:(PDPPT01)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 2:(PDPPT02)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 3:(PDPPT03)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 4:(PDPPT04)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 5:(PDPPT05)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 6:(PDPPT06)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 7:(PDPPT07)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 8:(PDPPT08)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 9:(PDPPT09)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 10:(PDPPT10)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 11:(PDPPT11)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 12:(PDPPT12)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 13:(PDPPT13)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 14:(PDPPT14)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 15:(PDPPT15)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 16:(PDPPT16)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 17:(PDPPT17)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 18:(PDPPT18)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 19:(PDPPT19)

9999999999-DUMMYPARTICIPANTID ▲

Participant ID 20:(PDPPT20)

9999999999-DUMMYPARTICIPANTID ▲

2. Date deviation identified:(PDVDATE)

(mm/dd/yyyy)

3. Deviation type:(PDTYPE)

010-INFORMED CONSENT/ASSENT PROCEDURES

01A--- No consent/assent obtained

01B--- Invalid/incomplete informed consent/assent form

01C--- Unauthorized assessments and/or procedures conducted prior to obtaining informed consent/assent

01D--- Non IRB approved/outdated/obsolete informed consent/assent documents used

\*Additional Options Listed Below

If "Other", specify:(PDYSPSP)

4. Is this deviation related to COVID-19?(PDCVD19)

0-No  1-Yes

5. Brief description of what occurred:(PDESCPT)

6. Brief description of the actual or expected corrective action for this event:(PDACTION)

7. Brief description of the plan to prevent recurrence:(PDPREVRE)

8. Is this deviation reportable to your IRB?(PDIRBREP)

0-No  1-Yes

If "Yes", will the IRB be notified at the time of continuing review?(PDIRBCON)

0-No  1-Yes

If "Yes", date of planned submission:(PDIRBPDT)

(mm/dd/yyyy)

If "No", date of actual submission:(PDIRBADT)

(mm/dd/yyyy)

Comments:(PDVCOMM)

**Additional Selection Options for PDV****Protocol deviation number (PDSEQNO) (key field):**

01-1st Protocol Deviation of the day  
 02-2nd Protocol Deviation of the day  
 03-3rd Protocol Deviation of the day  
 04-4th Protocol Deviation of the day  
 05-5th Protocol Deviation of the day  
 06-6th Protocol Deviation of the day  
 07-7th Protocol Deviation of the day  
 08-8th Protocol Deviation of the day  
 09-9th Protocol Deviation of the day  
 10-10th Protocol Deviation of the day

**If "Yes", how many participants?**

06-6  
 07-7  
 08-8  
 09-9  
 10-10  
 11-11  
 12-12  
 13-13  
 14-14  
 15-15  
 16-16  
 17-17  
 18-18  
 19-19  
 20-20

**Deviation type:**

01E--- Informed consent/assent process not properly conducted and/or documented  
 01Z--- Other informed consent/assent procedures issues (specify)  
 020-INCLUSION/EXCLUSION CRITERIA  
 02A--- Ineligible participant randomized/inclusion/exclusion criteria not met  
 02B--- Ineligible participant enrolled/inclusion/exclusion criteria not met  
 02Z--- Other inclusion/exclusion criteria issues (specify)  
 040-LABORATORY ASSESSMENTS  
 04A--- Biologic specimen not collected/processed as per protocol  
 04Z--- Other laboratory assessments issues (specify)  
 050-STUDY PROCEDURES/ASSESSMENTS  
 05A--- Protocol required visit/assessment not scheduled or conducted  
 05B--- Study assessments not completed/followed as per protocol  
 05C--- Inappropriate unblinding  
 05Z--- Other study procedures/assessments issues (specify)  
 060-ADVERSE EVENT  
 06A--- AE not reported  
 06B--- SAE not reported  
 06C--- AE/SAE reported out of protocol specified reporting timeframe  
 06D--- AE/SAE not elicited, observed and/or documented as per protocol  
 06E--- Safety assessment (e.g. labs, ECG, clinical referral to care) not conducted per protocol  
 06Z--- Other adverse events issues (specify)  
 070-RANDOMIZATION PROCEDURES  
 07A--- Stratification error  
 07Z--- Other randomization procedures issues (specify)  
 080-STUDY MEDICATION MANAGEMENT  
 08A--- Medication dispensed to ineligible participant  
 08B--- Medication dispensed to incorrect participant  
 08C--- Medication dosing errors (protocol specified dose not dispensed)  
 08D--- Participant use of protocol prohibited medication  
 08Z--- Other study medication management issues (specify)  
 090-STUDY BEHAVIORAL INTERVENTION  
 09A--- Study behavioral intervention was not provided/performed as per protocol  
 09Z--- Other study behavioral intervention issues (specify)  
 100-STUDY DEVICES  
 10A--- Study devices dispensed to ineligible participant  
 10Z--- Other study devices issues (specify)  
 110-SAFETY EVENT  
 11A--- Safety event not reported  
 11B--- Safety event reported out of protocol specified reporting timeframe  
 11C--- Safety event not elicited, observed and/or documented as per protocol  
 11D--- Safety event assessment not conducted per protocol  
 11Z--- Other safety event issues (specify)  
 990-OTHER SIGNIFICANT DEVIATIONS  
 99A--- Destruction of study materials without prior authorization from sponsor  
 99B--- Breach of Confidentiality  
 99Z--- Other significant deviations issues (specify)

NIDA Clinical Trials Network

Study Completion (STC)

Web Version: 1.0; 8.00; 03-15-19

Segment (PROTSEG): C

1. Did the participant complete the 30 day follow-up visit within 14 days of [insert enrollment date + 30d]?(STCOMPLT)

0-No  1-Yes

a. If "No," did the participant complete the 30 day follow-up visit at a later date?(STLTFEUP)

0-No  1-Yes

b. If "No", select the primary reason for not completing the follow-up visit:(STEARLY)

- 1-Participant failed to return to clinic and unable to contact
- 2-Participant stopped participation due to practical problems (e.g., no childcare or transportation)
- 3-Participant moved from area
- 4-Participant incarcerated
- 5-Participant terminated due to AE/SAE
- \*Additional Options Listed Below

If "Participant terminated for other clinical reasons", "Participant terminated for administrative issues", or "Participant terminated for other reason", specify:(STCMPOSP)

2. Date of last data collection or date of withdrawn consent:(STCOMPDT)

 (mm/dd/yyyy)

Comments:(STCCOMM)

Investigator's Signature

With this act of signing, I confirm that all data collected for this participant was under my guidance and the data submitted to Advantage eClinical are complete and accurate to the best of my knowledge.

Principal Investigator:(STPISIGN)

Date:(STPISGDT)

 (mm/dd/yyyy)

**Additional Selection Options for STC**

If "No", select the primary reason for not completing the follow-up visit:

- Participant failed to return to site and unable to contact
- Participant moved from area
- Participant incarcerated
- Participant terminated due to AE/SAE
- 8 Participant withdrew consent/assent
- 9 Participant deceased
- 12 Participant feels treatment no longer necessary, cured
- 13 Participant feels treatment no longer necessary, not working
- 14 Participant in hospital, in-patient, or residential treatment (not for substance use treatment)
- 20 Participant became pregnant
- 21 Participant reports intolerable symptoms or side effects
- 23 Clinical deterioration: New onset of psychiatric or medical condition
- 28 Participant is in detox, residential, or intensive outpatient treatment for substance use treatment
- 33 Participant met criteria for prisoner status
- 35 Contraindicated concomitant medication
- 36 Participant refused, non-specific
- 37 Physical illness or condition that precludes taking study medication
- 99 Participant terminated for other reason



Timeline Followback Page 1 (T69)

TFB week start date (TFWKSTDT):

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date	(TLDATE1) <input type="text"/>	(TLDATE2) <input type="text"/>	(TLDATE3) <input type="text"/>	(TLDATE4) <input type="text"/>	(TLDATE5) <input type="text"/>	(TLDATE6) <input type="text"/>	(TLDATE7) <input type="text"/>
1. Have any pain relievers, pain medications, sedatives, alcohol, methamphetamine, cocaine, heroin, or other illicit substances been used on this day?	(TLSUBAL1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLSUBAL7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
2. Heroin:							
Route:	(TLHERR1) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHERR2) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHERR3) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHERR4) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHERR5) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHERR6) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHERR7) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below
# Times Used Each Day:	(TLHERR1) <input type="text"/> (xxx)	(TLHERR2) <input type="text"/> (xxx)	(TLHERR3) <input type="text"/> (xxx)	(TLHERR4) <input type="text"/> (xxx)	(TLHERR5) <input type="text"/> (xxx)	(TLHERR6) <input type="text"/> (xxx)	(TLHERR7) <input type="text"/> (xxx)
3. Oxycodone (Percocet, Percodan, Roxicet, Oxycotin, Roxicodone, Endocet, Tylox):							
Route:	(TLOXYC1) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLOXYC2) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLOXYC3) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLOXYC4) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLOXYC5) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLOXYC6) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLOXYC7) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below
Prescribed:	(TLPOXYC1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYC2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYC3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYC4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYC5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYC6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYC7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTOXYC1) <input type="text"/> (xxx)	(TLTOXYC2) <input type="text"/> (xxx)	(TLTOXYC3) <input type="text"/> (xxx)	(TLTOXYC4) <input type="text"/> (xxx)	(TLTOXYC5) <input type="text"/> (xxx)	(TLTOXYC6) <input type="text"/> (xxx)	(TLTOXYC7) <input type="text"/> (xxx)
4. Hydrocodone (Vicodin, Lorcet, Lortab, Hycodan, Norco, Vicoprofen):							
Route:	(TLHYDC1) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHYDC2) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHYDC3) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHYDC4) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHYDC5) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHYDC6) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLHYDC7) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below
Prescribed:	(TLPHYDC1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYDC2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYDC3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYDC4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYDC5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYDC6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYDC7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTHYDC1) <input type="text"/> (xxx)	(TLTHYDC2) <input type="text"/> (xxx)	(TLTHYDC3) <input type="text"/> (xxx)	(TLTHYDC4) <input type="text"/> (xxx)	(TLTHYDC5) <input type="text"/> (xxx)	(TLTHYDC6) <input type="text"/> (xxx)	(TLTHYDC7) <input type="text"/> (xxx)
5. Fentanyl (Duragesic, Actiq, Sublimaze):							
Route:	(TLFENT1) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLFENT2) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLFENT3) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLFENT4) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLFENT5) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLFENT6) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLFENT7) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below
Prescribed:	(TLPFENT1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPFENT2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPFENT3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPFENT4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPFENT5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPFENT6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPFENT7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTFENT1) <input type="text"/> (xxx)	(TLTFENT2) <input type="text"/> (xxx)	(TLTFENT3) <input type="text"/> (xxx)	(TLTFENT4) <input type="text"/> (xxx)	(TLTFENT5) <input type="text"/> (xxx)	(TLTFENT6) <input type="text"/> (xxx)	(TLTFENT7) <input type="text"/> (xxx)
6. Morphine (MS Contin, Kadian, Duramorph):							
Route:	(TLMORH1) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMORH2) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMORH3) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMORH4) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMORH5) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMORH6) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below	(TLMORH7) 0-00-No use 1-01-Oral 2-02-Nasal 3-03-Smoking 4-04-Non-IV Injection *Additional Options Listed Below
Prescribed:	(TLPMORH1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMORH2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMORH3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMORH4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMORH5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMORH6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMORH7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTMORH1) <input type="text"/> (xxx)	(TLTMORH2) <input type="text"/> (xxx)	(TLTMORH3) <input type="text"/> (xxx)	(TLTMORH4) <input type="text"/> (xxx)	(TLTMORH5) <input type="text"/> (xxx)	(TLTMORH6) <input type="text"/> (xxx)	(TLTMORH7) <input type="text"/> (xxx)
7. Hydromorphone (Dilaudid, Palladone):							
Route:	(TLHYMR1)	(TLHYMR2)	(TLHYMR3)	(TLHYMR4)	(TLHYMR5)	(TLHYMR6)	(TLHYMR7)

	<div style="border: 1px solid gray; padding: 2px;">                     0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>
Prescribed:	(TLPHYMR1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYMR2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYMR3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYMR4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYMR5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYMR6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPHYMR7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTHYMR1) <input type="text"/> (xxx)	(TLTHYMR2) <input type="text"/> (xxx)	(TLTHYMR3) <input type="text"/> (xxx)	(TLTHYMR4) <input type="text"/> (xxx)	(TLTHYMR5) <input type="text"/> (xxx)	(TLTHYMR6) <input type="text"/> (xxx)	(TLTHYMR7) <input type="text"/> (xxx)
8. Meperidine (Demerol):							
Route:	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEPR1)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEPR2)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEPR3)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEPR4)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEPR5)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEPR6)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEPR7)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>
Prescribed:	(TLPMEPR1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEPR2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEPR3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEPR4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEPR5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEPR6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEPR7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Taken Each Day:	(TLTMEPR1) <input type="text"/> (xxx)	(TLTMEPR2) <input type="text"/> (xxx)	(TLTMEPR3) <input type="text"/> (xxx)	(TLTMEPR4) <input type="text"/> (xxx)	(TLTMEPR5) <input type="text"/> (xxx)	(TLTMEPR6) <input type="text"/> (xxx)	(TLTMEPR7) <input type="text"/> (xxx)
9. Methadone (Dolophine, Methadose):							
Route:	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEDN1)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEDN2)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEDN3)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEDN4)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEDN5)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEDN6)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLMEDN7)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>
Prescribed:	(TLPMEDN1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEDN2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEDN3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEDN4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEDN5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEDN6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPMEDN7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTMEDN1) <input type="text"/> (xxx)	(TLTMEDN2) <input type="text"/> (xxx)	(TLTMEDN3) <input type="text"/> (xxx)	(TLTMEDN4) <input type="text"/> (xxx)	(TLTMEDN5) <input type="text"/> (xxx)	(TLTMEDN6) <input type="text"/> (xxx)	(TLTMEDN7) <input type="text"/> (xxx)
10. Buprenorphine (Suboxone, Zubsolv, Bunavail):							
Route:	<div style="border: 1px solid gray; padding: 2px;">                     (TLBUPR1)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLBUPR2)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLBUPR3)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLBUPR4)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLBUPR5)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLBUPR6)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLBUPR7)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>
Prescribed:	(TLBPUR1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLBPUR2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLBPUR3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLBPUR4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLBPUR5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLBPUR6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLBPUR7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTBUR1) <input type="text"/> (xxx)	(TLTBUR2) <input type="text"/> (xxx)	(TLTBUR3) <input type="text"/> (xxx)	(TLTBUR4) <input type="text"/> (xxx)	(TLTBUR5) <input type="text"/> (xxx)	(TLTBUR6) <input type="text"/> (xxx)	(TLTBUR7) <input type="text"/> (xxx)
11. Oxycodone (Opana):							
Route:	<div style="border: 1px solid gray; padding: 2px;">                     (TLOXYM1)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLOXYM2)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLOXYM3)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLOXYM4)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLOXYM5)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLOXYM6)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>	<div style="border: 1px solid gray; padding: 2px;">                     (TLOXYM7)                      0-00-No use                      1-01-Oral                      2-02-Nasal                      3-03-Smoking                      4-04-Non-IV Injection                      *Additional Options Listed Below                 </div>
Prescribed:	(TLPOXYM1) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYM2) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYM3) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYM4) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYM5) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYM6) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes	(TLPOXYM7) <input type="checkbox"/> 0-No <input type="checkbox"/> 1-Yes
# Times Used Each Day:	(TLTOXYM1) <input type="text"/> (xxx)	(TLTOXYM2) <input type="text"/> (xxx)	(TLTOXYM3) <input type="text"/> (xxx)	(TLTOXYM4) <input type="text"/> (xxx)	(TLTOXYM5) <input type="text"/> (xxx)	(TLTOXYM6) <input type="text"/> (xxx)	(TLTOXYM7) <input type="text"/> (xxx)

Comments: (TFBCOMM)

**Additional Selection Options for T69**

**D1 heroin**  
5-05-IV Injection  
99-99-Other

NIDA Clinical Trials Network

TLFB Assessment Period (TAP)

Web Version: 1.0; 4.01; 02-07-19

Segment (PROTSEG): C  
Visit number (VISNO):

Target day for 30 day followup:(TAPASMDT)

(mm/dd/yyyy)

1. Assessment period:(TATFSTDY)

From:  (mm/dd/yyyy)

(TATFENDY)

To:  (mm/dd/yyyy)

The following substances were indicated by the participant as used during the past 30 days on the ED Health Quiz:[insert reported names of substances indicated on Q7 and Q9 on EHQ]

The following days were indicated by the participant as days any prescription opioids, pain relievers or heroin were used during the past 7 days on the ED Health Quiz:[insert reported days of use from EHQ]

2. Have any substances, alcohol, cigarettes, or e-cigarettes been used during this assessment period?(TASUBALC)  0-No  1-Yes

3. Does the participant have a prescription for any substances including opiates and marijuana for any days in this assessment period?(TAPRXSUB)  0-No  1-Yes

Comments:(TAPCOMM)

Urine Drug Screen (UDS)

Segment (PROTSEG): C  
 Visit number (VISNO):

1. Was a urine drug screen performed?(UDTEST1)

If "No", reason:(UDNORSN1)

If "Other", specify:(UDNOSP1)

0-No  1-Yes

- 1-Participant reported being unable to provide sample
- 2-Participant refused to provide sample
- 3-Study staff error
- 99-Other

2. Date urine specimen collected:(UDCOLDT)

 (mm/dd/yyyy)

3. Urine Drug Screen Result(s):

Drug Name (Abbreviation)	Negative	Positive	Invalid
Benzodiazepines (BZO):	(UDBZO1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamine (AMP):	(UDAMP1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana (THC):	(UDTHC1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine (MET):	(UDMET1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opiates (2000 ng) (OPI):	(UDOPH1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (COC):	(UDCOC1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy (MDMA):	(UDMDA1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxycodone (OXY):	(UDOXY1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone (MTD):	(UDMTD1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturate (BAR):	(UDBAR1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opiates (300 ng) (OPI):	(UDOP131) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buprenorphine (10 ng) (BUP):	(UDBUP1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentanyl (FEN):	(UDFEN1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:(UDSCOMM)