



**RREACT/HOPE OPIATE OUTREACH VISIT SHEET** Staff Name: \_\_\_\_\_

RREACT OC Request Time: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Start Time: \_\_\_\_\_  
Patient ID #: \_\_\_\_\_ Patient Name: \_\_\_\_\_ End Time: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Zip Code or Homeless: \_\_\_\_\_  
Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

**O/D Location:**

Community: \_\_\_\_\_ Public Facility: \_\_\_\_\_  
Home Car Friend's House Unknown

Narcan: Choose an item. Inpatient Referral: Choose an item. Pregnant: \_\_\_\_\_

Emergency Department: \_\_\_\_\_ Type of Visit: \_\_\_\_\_

Was the patient admitted? No Yes, if yes, describe when follow-up is needed: \_\_\_\_\_

**Contact Information**

Homeless: \_\_\_\_\_ Franklin County Resident: \_\_\_\_\_

Living Arrangements: Self Spouse Parent(s) Other \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: OH Zip Code: \_\_\_\_\_

Main Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Can a message be left with emergency contact? \_\_\_\_\_

Family Supports Provided: Yes No, who? \_\_\_\_\_

Narcan Kit Provided: Yes, Kit # \_\_\_\_\_ No, if no, reason: \_\_\_\_\_

**Referral: Outcome**

Results: \_\_\_\_\_ Same Day? Yes No, if no, Date: \_\_\_\_\_

Maryhaven Addiction Stabilization Center (MASC)

Bridge Program – Franklin Station Mat (Agency \_\_\_\_\_)

Other (Provider \_\_\_\_\_) Disposition \_\_\_\_\_

**Insurance Information:**

Primary Insurance Provider: \_\_\_\_\_

Employed: No Yes, if yes, who: \_\_\_\_\_

Military Service: \_\_\_\_\_

Assistance with hearing, vision, or mobility: No Yes, if yes, explain: \_\_\_\_\_

**Visit Notes:**