MARVIX AI

SAMPLE ADDICTION PSYCHIATRY SOAP NOTE

OPIOID USE DISORDER — RELAPSE AFTER OVERDOSE

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1 PATIENT INFORMATION

NAME
Shannon M. Reyes-Doyle

DATE OF SERVICE
October 8, 2026

DOB
05/16/1990 (36 yrs)

PROVIDER
Theodore Nwachukwu, MD

AGE / SEX
36 / Female

CREDENTIALS
MD, Addiction Psychiatry (ABPN)

MRN / PATIENT ID
ADP-472660

VISIT TYPE
Addiction Psychiatry Follow-Up — urgent, post-overdose

CARE SETTING
Outpatient (office-based opioid treatment)

REFERRAL SOURCE
Emergency department, St. Ambrose Medical Center, 09/29/2026

PRIMARY CARE PROVIDER, IF APPLICABLE
Dr. Alan Petrosyan, Family Medicine

THERAPIST / COUNSELOR, IF APPLICABLE
Ms. Renata Cole, LCSW — last attended 3 months ago

RECOVERY PROGRAM / CASE MANAGER, IF APPLICABLE
Bridgeway Recovery Services — case manager Devon Ames

CC CHIEF COMPLAINT

"I messed up and I almost died, and now they're saying I might lose my kids. I don't want to use — my back just hurts and nobody will help me with it." Urgent follow-up nine days after a witnessed fentanyl overdose reversed with naloxone.

S SUBJECTIVE

3a REASON FOR ADDICTION PSYCHIATRY EVALUATION

Urgent post-overdose evaluation and treatment restructuring after a return to non-prescribed fentanyl use following approximately 20 months of stability on buprenorphine. The visit must address four interlocking issues: restabilizing medication treatment after a relapse, understanding and treating the undertreated chronic pain that precipitated it, managing acute risk following a near-fatal overdose, and supporting her through active child protective proceedings that are themselves destabilizing.

3b SUBSTANCE USE HISTORY

Opioids: first exposure was prescribed oxycodone following an L4-L5 lumbar fusion in 2019 at age 29, taken as directed for post-surgical pain. When the prescription was abruptly discontinued at 4 months without taper or pain-management follow-up, she experienced withdrawal she did not recognize as such and obtained oxycodone from a friend, escalating over roughly 18 months. Transitioned to heroin in 2021 for cost, then to fentanyl as the supply changed, with intranasal use predominating and a brief period of injection use in 2022. **Longest sobriety:** 20 months on buprenorphine from January 2025 until the relapse three weeks ago — her longest ever and a genuinely significant achievement. **Other substances:** nicotine, approximately half a pack daily for 15 years. Alcohol rare and social, none in 6 months. No stimulants, cannabis, or benzodiazepines. **Stage of change:** action — she is actively help-seeking, attended this appointment voluntarily, and is distressed rather than ambivalent about the relapse.

3c PRIMARY SUBSTANCE OF CONCERN

Fentanyl, non-prescribed, obtained from the illicit supply. Used intranasally on approximately six occasions over three weeks, most recently the night of the overdose nine days ago. No use in the nine days since. Not polysubstance — no concurrent benzodiazepine, stimulant, or alcohol use, which is favorable both for withdrawal risk and for overdose risk going forward.

3d CRAVINGS AND TRIGGERS

Craving severity currently 6/10, rising to 8–9/10 during pain flares — the relationship is direct and she articulates it clearly. **The primary trigger is uncontrolled pain**, not euphoria-seeking; she describes the fentanyl use as "trying to get through a shift on my feet." Secondary triggers: the CPS investigation, conflict with her mother, and passing the corner where she previously purchased. High-risk situations are the end of a work shift and nights when she cannot sleep for pain. She has access through a former acquaintance and has not blocked that contact — discussed today. Coping strategies used successfully: calling her sister, heat packs, and leaving the house.

3e WITHDRAWAL SYMPTOMS

Currently in mild withdrawal at presentation — COWS 7. Reports restlessness, yawning, mild rhinorrhea, gooseflesh, and diffuse aching that she notes is difficult to distinguish from her baseline back pain. No vomiting, diarrhea, tremor, or agitation. No history of withdrawal seizures or delirium tremens — not applicable, as she has no alcohol or benzodiazepine dependence. She had stopped her buprenorphine entirely during the relapse period, which is why she is withdrawing now.

3f RELAPSE HISTORY

This is her first relapse in 20 months. Precipitants are identifiable and largely structural: (1) her pain management clinic discharged her in July when they learned she was on buprenorphine, leaving her physical therapy and non-opioid regimen unmanaged; (2) a pharmacy prior-authorization lapse in August left her without buprenorphine for 9 days, during which she went into withdrawal; (3) she picked up additional shifts at a warehouse job that materially worsened her back pain. She used on six occasions across three weeks, culminating in the overdose. She did not tell her therapist or case manager, citing shame. Consequences: overdose, CPS notification, and lost trust with her mother.

3g TREATMENT HISTORY

2022: medically supervised detox, 5 days, followed by relapse within 2 weeks — illustrating why detox alone is inadequate for opioid use disorder. 2023: 28-day residential treatment, abstinence-only model, relapsed at 6 weeks post-discharge. January 2025: buprenorphine initiated at this clinic, with 20 months of stability, negative screens throughout, and consistent attendance until 3 months ago. Individual therapy with Ms. Cole, attended regularly for the first year, lapsed 3 months ago when her shifts changed. Attended NA irregularly; reports discomfort at meetings where members told her buprenorphine meant she was "not really clean" — a significant and unfortunately common barrier. No sober living. Case management with Bridgeway ongoing.

3h MEDICATION-ASSISTED TREATMENT / ADDICTION MEDICATIONS

Buprenorphine-naloxone 16 mg/4 mg sublingual daily from January 2025, stable and effective for 20 months. Self-discontinued approximately three weeks ago during the relapse period. Prior to that, no missed doses documented on pharmacy fill history apart from the August prior-authorization gap. No methadone history. Naltrexone not trialed. No acamprosate, disulfiram, or varenicline — nicotine treatment has not yet been addressed and remains an open opportunity. No gabapentin or topiramate.

3i MEDICATION ADHERENCE AND SIDE EFFECTS

Adherence was excellent for 20 months, which is important context — this is not a pattern of chronic non-engagement. No diversion concerns; pharmacy records and prior screens are consistent. No overuse. Tolerated buprenorphine well with only mild constipation and initial sedation that resolved. **The critical barrier is structural, not behavioral:** the August prior-authorization lapse created a 9-day gap that directly precipitated withdrawal and preceded the relapse. She did not know she could contact the clinic for a bridging supply.

3j PSYCHIATRIC SYMPTOMS

PTSD from an abusive relationship between 2016 and 2020, diagnosed in 2023 but never adequately treated. Reports nightmares 3–4 nights weekly, hypervigilance, avoidance of her former neighborhood, and exaggerated startle. Symptoms worsened markedly since the CPS involvement began. **Depression:** low mood, guilt, and hopelessness, substantially worse since the overdose and the custody proceedings, with prominent shame. **Sleep:** severely disrupted, 4–5 hours nightly, from combined pain, nightmares, and anxiety. **Anxiety:** persistent, focused on the custody hearing. No psychosis. No mania. The PTSD and the substance use are functionally intertwined and treating one without the other has repeatedly failed.

3k MEDICAL CONSEQUENCES OF SUBSTANCE USE

Hepatitis C, chronic, genotype 1a — diagnosed 2022 from the injection-use period, never treated. Most recent viral load detectable; LFTs mildly elevated. She was told she needed to be "clean for six months" before treatment would be approved, which is not current standard of care and represents another structural barrier. **One prior overdose in 2022**, plus the index overdose nine days ago — two lifetime. HIV negative, last tested 6 months ago. No endocarditis, osteomyelitis, or serious injection-related infection. Chronic low back pain with documented hardware from the 2019 fusion — **real, imaging-confirmed, and currently untreated**. Nutritionally adequate. No cognitive impairment. Not pregnant — test negative today.

3l OVERDOSE AND HARM REDUCTION HISTORY

Index overdose 09/29/2026: found unresponsive in her bathroom by her sister, who administered two doses of intranasal naloxone from a kit obtained at this clinic and called emergency services. She required bag-valve-mask ventilation en route and was observed in the emergency department for 6 hours before discharge. **Her sister's naloxone use almost certainly saved her life** — the value of that prior harm-reduction step cannot be overstated. Prior overdose 2022, also naloxone-reversed. Fentanyl exposure risk is extreme in the current local supply. She has not used fentanyl test strips and was unaware they are available. No current injection use; when she did inject in 2022 she reports never sharing needles. She has one naloxone kit at home, now expired.

3m LEGAL / OCCUPATIONAL / SOCIAL CONSEQUENCES

Active child protective services investigation opened after the emergency department overdose report; her two children, ages 9 and 5, are temporarily residing with her sister under a safety plan, with a court review in 6 weeks. This is the dominant stressor in her life and she is highly motivated by it. No criminal charges from the overdose. One prior DUI in 2021, completed probation. Employment: warehouse associate, currently on unpaid leave; her employer is unaware of the overdose. Housing: renting a room from her mother, with the relationship badly strained since the CPS involvement — her mother has threatened to ask her to leave. Financially precarious with no income during leave.

3n RECOVERY SUPPORTS

Her sister is her strongest support — she administered the naloxone, is currently caring for her children, and attended the clinic waiting room today. Case manager Devon Ames at Bridgeway remains engaged. Therapist Ms. Cole is available but contact lapsed 3 months ago. No sponsor. NA attendance stopped after the negative experiences regarding her medication. No sober living. Her mother is a support in principle but currently a source of conflict. **Barriers to engagement:** transportation (no car, two buses to clinic), work-shift conflicts, shame after the relapse, and the anti-medication attitudes she encountered in mutual-help settings.

3o SAFETY CONCERNS

Overdose risk is the dominant safety concern and is currently high: recent overdose, reduced tolerance after nine days of abstinence, ongoing access to an acquaintance who supplies, extreme fentanyl contamination in the local supply, and unresolved pain as a driver. **Passive suicidal ideation** endorsed — "If I lose the kids I don't know what the point is" — occurring several times since the CPS notification, without plan or intent, and she is clear that her children are the reason she will not act. No self-harm history. No homicidal ideation. No aggression. Withdrawal risk mild and manageable. No impaired driving — she has no vehicle. Access to lethal means: no firearms; her remaining medications are limited. No current domestic violence — the abusive partner is no longer in contact and there is a protective order. No abuse or neglect of the children identified beyond the supervision concern that triggered the CPS report.

3p PERTINENT NEGATIVES

Denies use in the past nine days. Denies benzodiazepine, alcohol, stimulant, or cannabis use. Denies current injection use or needle sharing. Denies active suicidal ideation with plan or intent, homicidal ideation, self-harm, hallucinations, delusions, and severe intoxication. Not currently in severe withdrawal — COWS 7. Denies fever, chills, injection-site infection, chest pain, or dyspnea. Pregnancy test negative. Denies diverting or selling her buprenorphine.

ROS ADDICTION PSYCHIATRY REVIEW OF SYSTEMS

CRAVINGS / WITHDRAWAL

Positive — cravings 6/10 rising to 8–9/10 with pain; mild withdrawal (COWS 7); no use in 9 days

AUTONOMIC / GI

Positive for restlessness, yawning, rhinorrhea, gooseflesh, diffuse aching; denies vomiting, diarrhea, tremor

DEPRESSION

Positive — low mood, guilt, hopelessness, prominent shame since overdose and CPS involvement

ANXIETY / TRAUMA / SLEEP

Positive — PTSD nightmares 3–4 nights weekly, hypervigilance, startle; sleep 4–5 hours; custody-focused anxiety

PSYCHOSIS

Negative — no hallucinations, paranoia, delusions, or disorganized thinking

PAIN / CONSTITUTIONAL

Positive — chronic low back pain 7/10, fatigue, poor sleep; appetite and weight stable; no cognitive concerns

OVERDOSE / NEUROLOGIC

Positive — overdose 9 days ago requiring naloxone and ventilatory support; denies blackouts or seizures

INFECTIOUS

Positive — chronic untreated hepatitis C; denies fever, chills, wounds, or injection-site infection; HIV negative

SAFETY

Positive for passive suicidal ideation without plan or intent; denies self-harm, HI, or aggression

O OBJECTIVE / MENTAL STATUS EXAMINATION

5a VITALS, IF OBTAINED

TEMPERATURE
36.9 °C

RESPIRATORY RATE
18 / min

BLOOD PRESSURE
138/86 mmHg

OXYGEN SATURATION
98% on room air

HEART RATE
96 bpm, regular — consistent with mild withdrawal

WEIGHT / BMI IF RELEVANT
61 kg; BMI 22.4 — stable

5b MENTAL STATUS EXAMINATION

GENERAL APPEARANCE
Casually dressed, adequately groomed, appears her stated age; mildly uncomfortable, shifting position frequently in a manner consistent with genuine back pain; in mild withdrawal with visible gooseflesh and intermittent yawning; no signs of intoxication

BEHAVIOR
Cooperative, engaged, and notably forthcoming — volunteered the full relapse account without minimization, including details not in the emergency department record. Good eye contact. Restless with frequent repositioning. Mild psychomotor activation consistent with withdrawal. No guardedness, sedation, or abnormal movements. Tearful twice when discussing her children.

SPEECH
Normal rate, volume, and fluency; clearly articulated with no slurring; coherent and spontaneous; no pressured or slowed speech; no latency

MOOD
“Terrified — and ashamed of myself” (patient-reported)

AFFECT
Anxious and dysphoric, congruent with mood, full range with appropriate reactivity, tearful but not labile

THOUGHT PROCESS
Linear, logical, and goal-directed. No circumstantiality, tangentiality, disorganization, flight of ideas, perseveration, or slowing.

THOUGHT CONTENT
Cravings acknowledged openly without preoccupation dominating the interview. Prominent guilt and shame regarding the overdose and its effect on her children. Passive suicidal ideation as described — no plan or intent. No homicidal ideation, delusions, or paranoia. Realistic and appropriate concern regarding custody.

PERCEPTION
No hallucinations, illusions, or dissociation. No intoxication- or withdrawal-related perceptual disturbance. Reality testing intact.

COGNITION
Alert and fully oriented. Attention and concentration intact throughout an extended interview. Memory intact with a detailed and internally consistent account. Fund of knowledge appropriate. No intoxication- or withdrawal-related cognitive impairment.

INSIGHT

JUDGMENT

Good — she identifies the pain–craving relationship precisely, recognizes the pharmacy gap and the pain clinic discharge as precipitants rather than blaming herself alone, and understands that stopping buprenorphine preceded the relapse. This is a sophisticated and accurate self-formulation.

Improving — impaired during the relapse period, but she presented voluntarily for urgent follow-up, disclosed fully, accepted naloxone and monitoring, and is engaging with the treatment plan

IMPULSE CONTROL

Currently adequate; compromised during acute pain flares, which is the specific vulnerability the plan must address

SAFETY

No acute intoxication and no severe withdrawal requiring inpatient management. Overdose risk high and actively addressed. Passive ideation without plan or intent, with strong protective factors. Outpatient management with intensified support is appropriate; escalation criteria reviewed.

AS SUBSTANCE USE ASSESSMENT TOOLS

AUDIT-C / AUDIT

AUDIT-C 1 — low risk; no alcohol use in 6 months

DAST

DAST-10 score 8 — substantial, consistent with severe substance use disorder

COWS

7 — mild opioid withdrawal (restlessness, yawning, rhinorrhea, gooseflesh, aching)

CIWA-AR

Not applicable — no alcohol or sedative dependence

PHQ-9

18 — moderately severe depression (item 9 endorsed as “several days”)

GAD-7

15 — severe anxiety, custody-focused

C-SSRS

Positive item 2 (passive ideation); items 3–5 negative; no lifetime attempt

PCL-5

52 — well above the clinical threshold; PTSD symptoms markedly elevated

URINE DRUG SCREEN

Today: positive fentanyl (declining), negative buprenorphine (consistent with discontinuation), negative for benzodiazepines, cocaine, amphetamines, and alcohol

BREATHALYZER OR ALCOHOL TESTING

0.00 — negative

PRESCRIPTION DRUG MONITORING PROGRAM REVIEW

Reviewed today — no opioid or benzodiazepine prescriptions from any prescriber; buprenorphine fills consistent through August, with the documented 9-day gap and no fills for the past 3 weeks

OTHER SUBSTANCE-SPECIFIC OR FUNCTIONAL ASSESSMENT TOOLS

Brief Pain Inventory administered — pain severity 7/10, interference 8/10, indicating severe functional impact

Interpretation and limitations:

The PDMP is corroborative and important — it confirms no diversion, no doctor-shopping, and objectively documents the 9-day buprenorphine gap that preceded the relapse, supporting her account and locating the failure in the system rather than in her adherence. The urine screen pattern (fentanyl positive and declining, buprenorphine absent) is consistent with her reported nine days of abstinence and complete discontinuation. A PCL-5 of 52 with a PHQ-9 of 18 indicates that untreated PTSD is a major and probably primary driver, and that treating the opioid use disorder without treating the trauma is unlikely to hold. Limitation: PHQ-9 and GAD-7 are inflated by an acute and genuine situational crisis (a near-fatal overdose and possible loss of her children), so these should be re-administered once the acute stressors settle rather than treated as a stable baseline.

RA RISK ASSESSMENT

Overdose risk, prior overdose history, fentanyl exposure risk, naloxone access, and harm reduction needs:

High — the single most urgent risk. Two lifetime overdoses, the most recent nine days ago requiring naloxone and ventilatory support. Tolerance is now substantially reduced after nine days of abstinence, which paradoxically raises the lethality of any return to use. The local fentanyl supply is heavily contaminated and unpredictable. She retains contact with a supplying acquaintance. Her only naloxone kit is expired. She has never used fentanyl test strips. Pain remains uncontrolled, and pain is her documented primary trigger. Every one of these is modifiable and each is addressed in the plan.

Withdrawal risk, including alcohol, benzodiazepine, opioid, or polysubstance withdrawal risk:

Mild opioid withdrawal only, COWS 7 — uncomfortable but not dangerous and manageable outpatient. No alcohol or benzodiazepine dependence, so no seizure or delirium risk. The withdrawal is itself clinically useful today, as a COWS of 7 means she is appropriately positioned for buprenorphine re-induction without meaningful precipitated-withdrawal risk.

Suicidal ideation, plan, intent, means, prior attempts, and protective factors:

Passive ideation tied specifically to the possibility of losing custody — “If I lose the kids I don’t know what the point is” — occurring several times since the CPS notification. No plan, no intent, no preparatory behavior, and no lifetime attempt. She is explicit that her children are the reason she will not act, and that her focus is on regaining custody. Protective factors: her two children, her sister, active engagement in treatment, and a concrete goal with a defined timeline. Note that the overdose itself was not a suicide attempt — this was explored directly and she is clear it was not.

Self-harm thoughts, urges, behaviors, triggers, frequency, and intent:

None. No history of self-injurious behavior at any point.

Homicidal ideation, threats, aggression, target, means, and protective factors:

None. No violent ideation and no history of violence toward others.

Intoxication-related risk, impaired driving, unsafe behavior, or impulsive risk:

Not intoxicated today. No vehicle and no driving, so impaired-driving risk is minimal. Impulsive risk concentrated during acute pain flares, which is the specific and targetable vulnerability.

Psychosis-related safety concerns:

None — no psychotic symptoms and reality testing intact.

Substance-related medical risk, including seizure, delirium, infection, pregnancy-related risk, or severe medical complication:

No seizure or delirium risk. **Untreated chronic hepatitis C** with detectable viral load and mildly elevated transaminases represents ongoing hepatic risk and is treatable — the prior "six months clean" requirement she was given is not current standard of care and constitutes an unjust barrier. No active infection. Pregnancy test negative. Prior anoxic risk from the overdose with no apparent residual cognitive deficit.

Abuse, neglect, exploitation, or domestic violence concerns:

No current domestic violence — the abusive former partner has no contact and a protective order is in place. Historical DV is the source of her PTSD. Child protective services involvement is active and appropriate given an overdose in the home; the children are safe with her sister. No exploitation identified. Housing instability with her mother is a genuine vulnerability.

OVERALL RISK LEVEL

High

CLINICAL RATIONALE FOR RISK LEVEL

High is driven overwhelmingly by overdose risk, not by suicide risk. An overdose nine days ago, reduced tolerance, retained supply access, expired naloxone, an unpredictable fentanyl supply, and an unresolved pain trigger together create substantial mortality risk in the coming weeks. Suicide risk is separately low-to-moderate — passive ideation with strong protective factors. She is highly engaged and the risks are addressable, which is why intensified outpatient care rather than inpatient admission is appropriate.

Safety plan, crisis resources, naloxone plan, lethal means restriction, withdrawal precautions, emergency instructions, or higher level of care:

Written safety plan completed collaboratively, with a copy for her and, with consent, for her sister. **Naloxone: two fresh kits dispensed in clinic today**, with a further kit prescribed for her sister and refresher training given to both; expired kit collected and replaced. **Fentanyl test strips provided** with instruction on use, and the reasoning explained non-judgmentally as harm reduction rather than permission. Never-use-alone counseling delivered, including the national overdose prevention line. Discussed blocking her supplier contact; she agreed and did so during the visit. Crisis resources including 988 provided in writing. Emergency instructions for overdose, active suicidal ideation, and severe withdrawal reviewed. Inpatient admission considered and discussed openly; she declined and, given her engagement, mild withdrawal, intact cognition, supportive sister, and the fact that admission would complicate the custody process, intensive outpatient management was judged appropriate with explicit escalation criteria and a 3-day follow-up.

L LABORATORY AND DIAGNOSTIC RESULTS

Toxicology / Substance Monitoring:

Urine drug screen today: fentanyl positive with declining concentration, buprenorphine and norbuprenorphine absent, negative for benzodiazepines, cocaine, amphetamines, methadone, and oxycodone. Confirmatory LC-MS sent. Breathalyzer 0.00. Ethyl glucuronide negative. PDMP reviewed and documented above.

Medication Monitoring Labs:

CMP with LFTs: AST 68, ALT 74 (mildly elevated, consistent with chronic hepatitis C), bilirubin and albumin normal, synthetic function preserved. CBC unremarkable. Creatinine 0.8 with normal renal function. **Pregnancy test negative.** Hepatitis C RNA detectable at 1.2 million IU/mL, genotype 1a. Hepatitis B surface antigen negative with surface antibody positive (immune). HIV antigen/antibody negative today with consent.

Withdrawal / Medical Risk Labs:

Electrolytes, magnesium, and phosphorus within normal limits. Glucose 92. CK normal — no rhabdomyolysis following the period of unresponsiveness. Thiamine not indicated in the absence of alcohol use. ECG performed given the buprenorphine re-induction and baseline documentation: normal sinus rhythm, QTc 412 ms.

Infectious Disease Screening:

HIV negative. Hepatitis B immune. **Hepatitis C chronic and untreated — actionable.** STI screening offered and accepted, results pending. TB testing not indicated. No blood or wound cultures required — no infectious signs.

Psychiatric / Medical Workup:

TSH 1.8 (normal). B12 and folate normal. Vitamin D 19 ng/mL (deficient). No sleep study indicated — insomnia is clearly attributable to pain, nightmares, and anxiety. Lumbar spine imaging from 2024 reviewed: intact L4-L5 fusion hardware with adjacent-segment degenerative change at L3-L4 — **objective confirmation that her pain has a genuine structural basis**, which matters both clinically and for how she is treated by other services.

Prior Records Reviewed:

Emergency department record from 09/29/2026 documenting the overdose, naloxone administration, bag-valve-mask ventilation, and 6-hour observation. Complete buprenorphine treatment record from this clinic since January 2025 including all prior negative screens. Pharmacy fill history confirming the 9-day August gap. Pain management clinic discharge letter from July 2026, which explicitly cited buprenorphine as the reason for discharge. 2023 residential treatment discharge summary. 2022 detox record. Therapy notes from Ms. Cole through her last attendance. Bridgeway case management notes. CPS safety plan documentation provided by the patient. 2024 lumbar imaging report.

A ASSESSMENT

Opioid use disorder, severe, in early remission on medication until three weeks ago — now with relapse to fentanyl and a naloxone-reversed overdose nine days ago (second lifetime overdose). She had achieved 20 months of documented stability on buprenorphine, her longest ever, with consistent negative screens and no diversion. That context matters enormously: this is not treatment failure or chronic non-engagement, it is a relapse with identifiable, largely structural precipitants.

The relapse was structurally driven, and naming that accurately is essential to preventing the next one. Three system failures converged. Her pain management clinic discharged her in July *because* she was on buprenorphine — penalising her for being in evidence-based treatment and leaving genuine, imaging-confirmed pain unmanaged. A pharmacy prior-authorization lapse in August left her without medication for nine days, and she did not know a bridging supply was available. She then increased warehouse shifts, worsening her pain. Framing this as a failure of willpower would be both clinically wrong and actively harmful; the interventions that matter are re-securing medication access and treating the pain.

Overdose risk is high and is the immediate clinical priority. Recent overdose, tolerance now reduced by nine days of abstinence, retained supply access, an expired naloxone kit, an extremely contaminated local fentanyl supply, and an unresolved pain trigger. Mortality risk over the next several weeks is real. Every component is modifiable and each is addressed today.

Untreated PTSD is probably the deeper driver. PCL-5 of 52 from an abusive relationship between 2016 and 2020, diagnosed in 2023 but never adequately treated, with symptoms sharply worse since the CPS involvement. Repeated abstinence-only episodes have failed while the trauma went untreated. With PHQ-9 at 18 and GAD-7 at 15, both substantially inflated by the acute crisis, the psychiatric comorbidity is not incidental — it is central, and sustained recovery is unlikely without addressing it.

Chronic pain with a documented structural basis — intact L4-L5 fusion with adjacent-segment degeneration at L3-L4, Brief Pain Inventory severity 7/10 and interference 8/10. Her pain is real, objectively substantiated, and currently untreated. Treating opioid use disorder while ignoring the pain that drives it has already failed once.

Chronic hepatitis C, genotype 1a, untreated with a detectable viral load, deferred on the basis of an outdated "six months clean" requirement that contradicts current guidance — direct-acting antivirals are indicated regardless of ongoing use and are curative. **Active CPS proceedings** with children temporarily placed with her sister and a court review in six weeks; this is simultaneously her greatest stressor and her strongest motivator. **Housing instability** and loss of income compound the picture. **Nicotine dependence** remains entirely unaddressed. **Protective factors** are genuine and substantial: 20 months of prior success proving the treatment works for her, excellent insight, voluntary help-seeking after the relapse, a sister who administered naloxone and is caring for her children, no polysubstance use, and a concrete time-bound goal.

P PLAN

Medication-assisted treatment plan:

Re-induce buprenorphine-naloxone today — COWS of 7 places her appropriately in the window for induction with minimal precipitated-withdrawal risk. Given fentanyl's prolonged tissue distribution, use a cautious approach: 4 mg sublingual observed in clinic with reassessment at 60 and 120 minutes, additional 4 mg increments as tolerated to a day-one total of up to 12 mg, then titrate to her previously effective maintenance dose of 16 mg/4 mg over 2–3 days. **Consider a dose increase above 16 mg** at follow-up if cravings persist — 24 mg is appropriate for fentanyl-exposed patients and higher doses provide greater blockade. Daily dispensing for the first week, then a 7-day supply, transitioning back to monthly once stable. **Structural safeguards, which are the actual intervention:** a 5-day emergency bridging supply protocol documented in her chart so no future prior-authorization gap causes withdrawal; a 90-day prescription with automatic refill once stable; and the clinic pharmacist assigned to resolve prior authorization proactively. She was told explicitly to call the clinic rather than go without.

Withdrawal management plan:

Mild withdrawal (COWS 7) managed outpatient through buprenorphine induction itself. Adjunctive comfort medications: clonidine 0.1 mg as needed for autonomic symptoms with blood pressure precautions, loperamide as needed, ondansetron as needed, and hydroxyzine for anxiety and sleep. No detox referral indicated — and importantly, detox alone is contraindicated in opioid use disorder as it reduces tolerance and increases overdose mortality; this was explained to her, as she had asked whether she "should just detox again." No seizure precautions required.

Relapse prevention plan:

Trigger analysis completed collaboratively, identifying pain as the primary trigger with shift-end and sleepless nights as high-risk windows. Concrete plan for pain flares that does not involve using: heat, prescribed non-opioid analgesia, a call to her sister, and clinic contact. She blocked her supplier's contact during the visit. Craving-management strategies rehearsed. Contingency planning for the custody hearing outcome in six weeks — both directions — given that this is her most likely destabilizing event. Recovery supports to be re-engaged as below. Discussed the specific risk of the immediate post-relapse period given reduced tolerance.

Harm reduction plan:

Two naloxone kits dispensed in clinic today with an additional kit prescribed for her sister; expired kit collected. Refresher training delivered to the patient and, by phone, to her sister — whose prior use of naloxone saved her life and who was told so explicitly. **Fentanyl test strips provided** with demonstration and instruction. Never-use-alone counseling including the national overdose prevention hotline number. Counseling on reduced tolerance after abstinence, delivered directly: if she does use, use less, use with someone present, and have naloxone within reach. Safer-use education provided without moralizing. Infection prevention reviewed, though she is not currently injecting.

Psychotherapy plan:

Re-engage Ms. Cole (LCSW) urgently — contacted during the visit with consent and an appointment secured for this week; the three-month lapse was a significant loss of support. **Trauma-focused therapy is the priority addition** — referral placed for EMDR or trauma-focused CBT with a clinician experienced in co-occurring substance use, since untreated PTSD is likely the deeper driver of her relapse pattern and repeated abstinence-only approaches have failed while it went untreated. Timing discussed: begin stabilization-phase work now with skills and grounding, moving to processing once medication is stable. Motivational interviewing conducted today. NA re-engagement discussed with specific attention to the anti-medication attitudes she encountered — referred instead to a medication-friendly group and to SMART Recovery, which does not hold those views.

Psychiatric medication plan for co-occurring conditions:

Defer antidepressant initiation at this visit — not because depression is absent but because PHQ-9 of 18 and GAD-7 of 15 are substantially inflated by an acute situational crisis and by withdrawal, and initiating during withdrawal risks misattributing side effects. Reassess in 2 weeks; if depressive symptoms persist once stabilized, initiate sertraline, which is appropriate for both depression and PTSD and is safe with buprenorphine. **Prazosin 1 mg at bedtime started today** for PTSD nightmares occurring 3–4 nights weekly, titrating as tolerated — this is a targeted, immediately available intervention and improving her sleep will reduce both pain and craving. **Explicitly avoid benzodiazepines** given the combined respiratory-depression risk with opioids; documented prominently and communicated to all treating clinicians. Hydroxyzine used instead for anxiety.

Substance monitoring plan:

Urine drug screening at every visit initially, with a clearly stated therapeutic rather than punitive purpose — explained to her directly, since fear of a positive screen contributes to patients concealing relapse, as happened here. Confirmatory testing when results are unexpected. Buprenorphine and norbuprenorphine metabolite monitoring to confirm adherence and exclude diversion. PDMP review at each visit. Treatment agreement reviewed and re-signed, with the punitive discharge language removed — discharge from treatment for a positive screen is not appropriate in opioid use disorder care and she was reassured on this point, as fear of being dismissed was part of why she did not disclose sooner.

Medical monitoring plan:

Hepatitis C treatment referral placed today — priority. The prior "six months clean" requirement is contrary to current standard of care; direct-acting antivirals are indicated regardless of ongoing substance use and are curative, and the referral letter states this explicitly to prevent another deferral. Repeat LFTs in 4 weeks and fibrosis staging via elastography ordered. Vitamin D supplementation started for a level of 19. Repeat HIV and STI screening at 3 months. Coordination with Dr. Petrosyan for primary care. **Pain management is a core part of the treatment plan, not an aside:** referral to a pain clinic that treats patients on buprenorphine, with a letter explaining that buprenorphine is not a contraindication to pain care; initiate duloxetine for chronic musculoskeletal pain, which also treats depression and anxiety, offering useful overlap; physical therapy referral; and topical and non-opioid analgesia. Note that buprenorphine at higher divided doses itself provides analgesia, supporting the planned increase.

Higher level of care plan:

Inpatient and residential care considered and discussed openly. Declined by the patient, and outpatient management judged appropriate given mild withdrawal, intact cognition, strong engagement, a supportive sister, no polysubstance use, and the practical reality that residential placement could complicate the custody proceedings. **Intensive outpatient program referral placed** as a middle course, offering structure without separation from her children's proceedings. Explicit escalation criteria documented and reviewed with her: continued use despite optimized buprenorphine, another overdose, active suicidal ideation with plan or intent, severe withdrawal, or loss of housing would prompt reconsideration of residential or inpatient care.

Care coordination plan:

Therapist re-engaged with an appointment this week. Case manager Devon Ames contacted regarding housing instability, transportation support (bus passes arranged), and benefits during unpaid leave. **Letter provided for child protective services and the court**, with her written consent, documenting her voluntary re-engagement, buprenorphine re-induction, treatment plan, and prognosis — factual and supportive without overstating, since accurate clinical documentation carries real weight in these proceedings and she had no advocate. Primary care updated. Hepatitis C and pain clinic referrals placed with explanatory letters. Sister included with consent as the identified overdose responder and support person. Employer not contacted — no disclosure authorized.

Patient education:

Explained buprenorphine re-induction, why the fentanyl exposure requires a cautious approach, and what precipitated withdrawal would feel like. Explained clearly and directly that her relapse followed a medication gap and untreated pain, not a failure of character — she became tearful and said no one had framed it that way before, and this reframing is likely to matter for her engagement. Reviewed reduced tolerance and why the coming weeks carry the highest overdose risk. Naloxone and fentanyl test strip training completed with return demonstration. Explained that hepatitis C is curable and that she should not have been made to wait. Reviewed why benzodiazepines must be avoided. Warning signs provided in writing to her and her sister. Reinforced that 20 months of stability is evidence this treatment works for her, not evidence that it failed.

F FOLLOW-UP

Return in 3 days for buprenorphine dose assessment and titration toward maintenance, with a COWS reassessment and review of craving control — the short interval reflects high overdose risk and active re-induction. Then twice weekly for two weeks, weekly for one month, and biweekly once stable. Therapy appointment with Ms. Cole this week; trauma-focused therapy intake within 2–3 weeks. Intensive outpatient intake within 1 week. Hepatitis C clinic within 2–3 weeks. Pain clinic within 4 weeks, expedited if possible given that pain is the primary relapse trigger. Repeat PHQ-9, GAD-7, and PCL-5 at 2 weeks to reassess once withdrawal resolves and to determine whether an antidepressant is needed. LFTs at 4 weeks. Urine screening at every visit. Contact the clinic immediately for cravings she cannot manage, any return to use, or worsening mood; present to the emergency department or call 988 for active suicidal ideation or overdose. Court review in 6 weeks — a follow-up is scheduled deliberately in the week before and the week after, as both outcomes carry relapse risk.

TD TIME DOCUMENTATION, IF APPLICABLE

TOTAL TIME SPENT
110 minutes (including observed induction and monitoring)

SAFETY PLANNING TIME
20 minutes

MEDICATION MANAGEMENT TIME
35 minutes (induction, observation, titration planning)

RECOVERY SUPPORT COORDINATION TIME, IF APPLICABLE
15 minutes (case manager, IOP referral, sister)

PSYCHOTHERAPY / COUNSELING TIME
25 minutes (motivational interviewing and harm-reduction counseling)

RECORDS REVIEW TIME, IF APPLICABLE
20 minutes (ED record, PDMP, pharmacy history, pain clinic letter, imaging)

CARE COORDINATION TIME
25 minutes (therapist, CPS letter, hepatitis C and pain referrals, primary care)

TB BILLING CONSIDERATIONS

E/M LEVEL
99215 — Established patient, high complexity

PSYCHOTHERAPY CODE(S), IF APPLICABLE
90833 — Psychotherapy, 30 minutes, with E/M service (add-on)

PSYCHIATRIC DIAGNOSTIC EVALUATION CODE, IF APPLICABLE
Not applicable — established patient

SUBSTANCE USE / MEDICATION-ASSISTED TREATMENT CODE(S), IF APPLICABLE
G2067 / H0020 as applicable for office-based opioid treatment; 99417 prolonged service given total time

BASIS FOR BILLING
Medical Decision Making (high), with add-on psychotherapy and prolonged service; total time 110 minutes

PRIMARY SUBSTANCE USE DISORDER DIAGNOSIS CODE + DESCRIPTION
F11.20 — Opioid dependence, uncomplicated (severe opioid use disorder, relapse)

SECONDARY PSYCHIATRIC OR MEDICAL DIAGNOSIS CODE(S)
T40.4X1A (poisoning by synthetic narcotics, accidental, initial encounter); F43.10 (PTSD); F32.1 (major depressive disorder, moderate); B18.2 (chronic viral hepatitis C); M54.51 (vertebrogenic low back pain); Z98.1 (arthrodesis status); F17.200 (nicotine dependence); R45.851 (suicidal ideation); Z63.5 (disruption of family)

SO SIGNATURE

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Theodore Nwachukwu, MD	MD, FASAM	Addiction Psychiatry	10/08/2026	13:25