Queensland Government

Metro North Mental Health - Alcohol and Drug Service

Biala Acute Care Service

SUBJECTIVE OPIOID WITHDRAWAL SCALE

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

LAST OPIATE USE - Date: ..... / ..... / ..... **Time:** ..... : ..... AM / PM

Ratings:
0 None
1 Mild
2 Moderate
3 Severe

DATE											
TIME											
BAL											
Do you have nausea or are you vomiting?											
Do you have stomach cramps?											
Do you have leg cramps and/or restless legs?											
Are you having hot or cold flushes or shivering?											
Is your heart pounding?											
Do you have muscle tension?											
Do you have aches and pains?											
Are you yawning often?											
Do you have a runny nose and/or weepy eyes?											
Did you have sleeping problems last night?											
TOTAL											
BLOOD PRESSURE SUPINE											
BLOOD PRESSURE ERECT											
PULSE											
TEMPERATURE											
RESPIRATIONS											
PERSPIRATION	**0.** Nil **1.** Moist skin **2.** Beads on face and body **3.** Profuse, whole body wet										
PUPILS – LEFT	Size										
	Reaction										
PUPILS – RIGHT	Size										
	Reaction										
	+ Reactive **B** Brisk **–** No Reaction **S** Sluggish	Scale (mm) 1 2 3 4 5 6 7 8									
MEDICATION GIVEN?											
NURSE INITIALS											

DO NOT WRITE IN THIS BINDING MARGIN

v1.00 - 05/2015
Source: RBWH

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