

# CLINICAL TOOLS: COWS SCALE

## OPIOID WITHDRAWAL RECORD (INDUCTION FORM)

(Adapted from Clinical Opioid Withdrawal Scale)

Patient Name: \_\_\_\_\_

Treatment Start Date: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Date: \_\_\_\_\_

Select the number/description that best corresponds to your patient's present symptoms.

Parameter	Baseline Observation Administer 1st Dose _____ mg Time given _____	1st Dose Observation _____ min. After 1st dose	1st Dose, 2nd Observation (if needed) _____ min. After 1st dose	2nd dose (if needed) _____ mg Time given _____	2nd Dose Observation _____ min. After 2nd dose
<b>Resting pulse rate</b> _____ beats/min <i>Measure after patient is sitting/lying for 1 minute</i> 0 pulse rate 80 or below 1 pulse rate 81–100 2 pulse rate 101–120 4 pulse rate greater than 120	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4
<b>Sweating</b> <i>Over past 30 minutes; not accounted for by room temperature or patient activity</i> 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
<b>Restlessness</b> <i>Observation during assessment</i> 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 5
<b>Tremors</b> <i>Observation of outstretched hands</i> 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4
<b>Pupil size</b> 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 5
<b>GI upset</b> <i>Over past 30 minutes</i> 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 5
<b>Anxiety or irritability</b> 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable/anxious 4 patient so irritable/anxious that participation in assessment is difficult	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4

Parameter	Baseline Observation Administer 1st Dose _____ mg Time given _____	1st Dose Observation _____ min. After 1st dose	1st Dose, 2nd Observation (if needed) _____ min. After 1st dose	2nd dose (if needed) _____ mg Time given _____	2nd Dose Observation _____ min. After 2nd dose
<b>Bone or joint aches</b> <i>If patient was having pain previously, gauge the additional component attributed to opioid withdrawal only</i> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4
<b>Yawning</b> <i>Observation during assessment</i> 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4
<b>Runny nose or tearing</b> <i>Not accounted for by cold symptoms or allergies</i> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4
<b>Gooseflesh skin</b> 0 skin is smooth 3 skin piloerection can be felt or hairs standing up on arms 5 prominent piloerection	<input type="checkbox"/> 0 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 3 <input type="checkbox"/> 5	<input type="checkbox"/> 0 <input type="checkbox"/> 3 <input type="checkbox"/> 5
<b>Total Score</b> _____ Total score is the sum of all 11 items • 5–12 = mild • 13–24 = moderate • 25–35 = moderately severe • >36 = severe withdrawal					

Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *Journal of Psychoactive Drugs*, 32(2), 253–259.

**After completion, scan form into patient record and provide a copy to the patient.**