

OPIOID RISK TOOL

Patient Name	Today's Date
--------------	--------------

		Mark each box that applies	Item score IF FEMALE	Item score IF MALE
1. Family History of Substance Abuse	Alcohol	<input type="checkbox"/>	1	3
	Illegal Drugs	<input type="checkbox"/>	2	3
	Prescription Drugs	<input type="checkbox"/>	4	4
2. Personal History of Substance Abuse	Alcohol	<input type="checkbox"/>	3	3
	Illegal Drugs	<input type="checkbox"/>	4	4
	Prescription Drugs	<input type="checkbox"/>	5	5
3. Age (Mark box if 16 – 45)		<input type="checkbox"/>	1	1
4. History of Preadolescent Sexual Abuse		<input type="checkbox"/>	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	<input type="checkbox"/>	2	3
	Depression	<input type="checkbox"/>	1	1
TOTAL				

Low Risk: 0 – 3
 Moderate Risk: 4 – 7
 High Risk: ≥ 8

Patient Name _____