OPIOID SERVICES:
ER SUBOXONE INITIATION

Place patient label sticker here

UNIT CLERK:
Please file all forms in Suboxone Folder in E.R. after completing

PHYSICIAN INSTRUCTIONS: Please confirm the following

Y | N	Patient ALT < 3X normal
Y | N	Patient is not pregnant
Y | N	Patient is not alcohol dependant
Y | N	Patient is aware of the *Umbrella Society* peer liaison service
Y | N	Patient has Naloxone Kit

If "YES" to all 5 questions above: complete COWS SCALE (see pg 2)

IF COWS >12: Patient start Suboxone in ER

Y | N	Patient consented & aware of precipitated withdrawal risk
Ensure patient has moist mouth	
Administer 2 to 4mg of Suboxone sublingually	
Repeat COWS Score in 45min – 1hr	
If feeling worse after Dose 1 / COWS Score increases: STOP! May be precipitated withdrawal	
If feeling better but still sick: Repeat dose of 2 to 4mg of Suboxone	
Repeat for 1hr until: • Patient feels well, or • Total of 16mg of Suboxone given	
Record total dose given (this is the dispensed once daily dose)	
Complete *Opioid Services: Referral Form*	
Give patient *Opioid Services: Treatment Resources* form	
Dispense Suboxone dose(s) to sustain until clinic visit if required	

IF COWS 12 or less:
Patient NOT ready to start Suboxone, but may be candidate for Suboxone Self Start

Confirm the follow given to patient:	
Y | N	*Opioid Services: Self Start Instructions w/ SOWS Scorecard* document
Y | N	*Opioid Services: Treatment Resources* form
Y | N	Eight (8) 2mg Suboxone tablets dispensed
Y | N	Confirm report from SAMI Team prior to discharge 778-676-1803

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OPIOID SERVICES:

Clinical Opiate Withdrawal Scale (COWS)

Instructions for Suboxone (buprenorphine) Induction

INSTRUCTIONS: Enter scores for Baseline (time zero), 1 hour after first dose, 2 hours after second dose.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example: If heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score		Baseline	1 hour	2 hour
	Date			
	Time			
	BP			
	Pulse			
	Temp			
	O2 Sat			
RESTING PULSE RATE: *Measured after patient is sitting or lying for one minute* 0= pulse rate 80 or below; 1 = pulse rate 81-100; 2= pulse rate 101-120 4 = pulse greater than 120				
SWEATING: *Over past ½ hour not accounted for by room temperature or patient activity* 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				
RESTLESSNESS: *Observation during assessment* 0 = able to sit still; 1 = reports difficulty sitting still, but is able to do so; 3 = frequent shifting or extraneous movement of legs/arms 5 = unable to sit still for more than a few seconds				
PUPIL SIZE: 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				
BONE OR JOINT ACHES: *If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored* 0 = not present; 1 = mild diffuse discomfort 2 = patient reports severe diffuse aching of joints/muscles; 4 = patient is rubbing joints/muscles and is unable to sit still because of discomfort				
RUNNY NOSE OR TEARING: *Not accounted for by cold symptoms or allergies* 0 = not present; 1 = nasal stuffiness or unusually moist eyes; 2 = nose running or tearing; 4 = nose constantly running or tears streaming down cheeks				
GI UPSET: *Over last ½ hour* 0 = not GI symptoms; 1 = stomach cramps; 2 = nausea or loose stool 3 = vomiting or diarrhea; 5 = multiple episodes of diarrhea or vomiting				
TREMOR: *Observation of outstretched hands* 0 = no tremor; 1 = tremor can be felt, but not observed 2 = slight tremor observable; 4 = gross tremor or muscle twitching				
YAWNING: *Observed during assessment* 0 = no yawning; 1 = yawning once or more during assessment 2 = yawning three or more times during assessment 4 = yawning several times/minute				
ANXIETY OR IRRITABILITY 0 = none; 1 = patient reports increasing irritability or anxiousness 2 = patient obviously irritable/anxious; 4 = patient so irritable or anxious that participation in the assessment is difficult				
GOOSEFLESH SKIN 0 = Skin is smooth; 3 = piloerection of skin can be felt or hairs standing up on arms 5 = prominent piloerection				
	Total Score:			
	Nurse's Initials			
Score: 5- 12 = mild; 13-24 = moderate; 25-36 = moderately severe; >36 = severe withdrawal				

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