

# Clinical Opiate Withdrawal Scale

## Introduction

The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time. The summed score for the complete scale can be used to help clinicians determine the severity of opiate withdrawal.

## Instructions

For each item, circle the number that best describes the patient's signs or symptoms. Rate based on your best judgment of an apparent relationship of a symptom 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.

Patient's Name: _____ Date and Time _____	
Reason for this assessment: _____	
<p><b>Resting Pulse Rate:</b> _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i></p> <p>0 pulse rate 80 or below 1 pulse rate 81–100 2 pulse rate 101–120 4 pulse rate greater than 120</p>	<p><b>GI Upset:</b> <i>over last 1/2 hour</i></p> <p>0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting</p>
<p><b>Sweating:</b> <i>over past 1/2 hour not accounted for by room temperature or patient activity</i></p> <p>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</p>	<p><b>Tremor:</b> <i>observation of outstretched hands</i></p> <p>0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching</p>
<p><b>Restlessness:</b> <i>observation during assessment</i></p> <p>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</p>	<p><b>Yawning:</b> <i>observation during assessment</i></p> <p>0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute</p>
<p><b>Pupil Size</b></p> <p>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</p>	<p><b>Anxiety or Irritability</b></p> <p>0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult</p>
<p><b>Bone or Joint Aches:</b> <i>if patient was having pain previously, only the additional component attributed to opiate withdrawal is scored</i></p> <p>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</p>	<p><b>Gooseflesh Skin</b></p> <p>0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection</p>
<p><b>Runny Nose or Tearing:</b> <i>not accounted for by cold symptoms or allergies</i></p> <p>0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks</p>	<p><b>Total Score</b> _____</p> <p>The total score is the sum of all 11 items Initials of person completing assessment: _____</p> <p>Score: 5–12 = mild; 13–24 = moderate; 25–36 = moderately severe; more than 36 = severe withdrawal. This version may be copied and used clinically.</p>

Source: Wesson DR and Ling W, *J Psychoactive Drugs* 2003;35(2):253–259.