

RISK ASSESSMENT TOOL FOR OTC CODEINE DEPENDENCE

Patient Ref No:						Date:					
Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Other <input type="checkbox"/>	Prefer Not to Say <input type="checkbox"/>							
Age:	18-24 <input type="checkbox"/>	25-34 <input type="checkbox"/>	35-49 <input type="checkbox"/>	50-64 <input type="checkbox"/>	65 or older <input type="checkbox"/>						
Pharmacist Completing Form:						Intervention Refused:	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

PATIENT INTERVENTION OFFERED BUT REFUSED, SKIP TO "OUTCOMES" BELOW

1a	How often do you take over-the-counter (OTC) Codeine? (Choose one of the following)									
Every Day <input type="checkbox"/> Most Days <input type="checkbox"/>										Proceed to question 1b
Once a Week or more <input type="checkbox"/> About once a Month <input type="checkbox"/> Every few Months <input type="checkbox"/> Once or Twice a Year <input type="checkbox"/>										Proceed to question 2
1b	How long have you been taking OTC Codeine with this frequency?									
Last Week <input type="checkbox"/> Last Four Weeks <input type="checkbox"/>										1 Point <input type="checkbox"/>
Last Year <input type="checkbox"/> Longer than One Year <input type="checkbox"/> Longer than Three Years <input type="checkbox"/>										2 Points <input type="checkbox"/>
2	What was the main reason OTC Codeine was taken on the last occasion it was used? (Choose one of the following)									
Headache <input type="checkbox"/> Back Pain <input type="checkbox"/> Dental Pain <input type="checkbox"/> Migraine <input type="checkbox"/> Period Pain <input type="checkbox"/> Any other Physical Pain <input type="checkbox"/>										0 Points <input type="checkbox"/>
To relax <input type="checkbox"/> To feel better <input type="checkbox"/> To sleep <input type="checkbox"/> Other (please specify)										1 Point <input type="checkbox"/>
3	In the last 12 months, how difficult did you find it to stop or go without OTC Codeine? (Choose one of the following)									
Not difficult <input type="checkbox"/> Quite Difficult <input type="checkbox"/> Very Difficult <input type="checkbox"/> Impossible <input type="checkbox"/>										
0 Points	1 Point	1 Point	1 Point							

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Codeine Dependency Scale (CDS)

<https://www.sciencedirect.com/science/article/pii/S1551741123004692>

Total Points:

≥ 2 indicates patient may be at risk

Additional Risk Questions

What product are you taking and how many tablets do you take each day?

Information (maximum OTC doses):

Ibuprofen: 1200 mg/day = 6 Nurofen Plus® (76.8 mg codeine) // Paracetamol: 4 mg/day = 8 Co-codamol 8/500 (64 mg codeine)

Have you had any unpleasant effects from taking the tablets? e.g.

(tick all that apply)

Nausea and vomiting

Stomach pain

Tired/sleepy

Tinnitus

Difficulty breathing or changes in heart rate

Headaches

Other (please specify)

OUTCOMES

Please tick or give more detail

Brief intervention

Yes

No

Product taken and daily dose

Leaflets provided

Yes

No

Signposted to

Emergency Dept

GP

Referral to

Community Addiction Service

Any other comments e.g., why intervention was refused