Routine Opioid Outcomes Monitoring (ROOM) Tool

(Healthcare professional version for scoring)

1 **What number best describes your pain on <u>average</u> over the past 7 days?**

	Mild or well managed pain					Moderate pain		Severe or unmanaged pain				
No pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as you can imagine

2 **What number best describes how, during the past week, pain has interfered with your enjoyment of life?**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

3 **What number best describes how, during the past week, pain has interfered with your general activity?**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

Please indicate how often you have been bothered by the following problems over the past three months. There are no right or wrong answers. Do not spend too much time on any one statement.

	Not at all	A little	Quite a lot	A great deal
4 **In the past three months, did you use your opioid medicines for other purposes, for example, to help you sleep or to help with stress or worry?**	0	1	1	1
5 **In the past three months did opioid medicines cause you to feel slowed down, sluggish or sedated?**	0	1	1	1
6 **In the past three months did opioid medicines cause you to lose interest in your usual activities?**	0	1	1	1
7 **In the past three months did you worry about your use of opioid medicines?**	0	1	1	1

A total score of 3 or more over the four items indicates the patient is likely to meet criteria for opioid use disorder. Further assessment is warranted.

Please indicate how often you have been bothered by the following problems over the last two weeks. There are no right or wrong answers. Do not spend too much time on any one statement.

	Not at all	Several days	More than half days	Nearly everyday
8 **Little interest in doing things**	0	1	2	3
9 **Feeling down, depressed or hopeless**	0	1	2	3

A total score of 3 or more indicates that the patient could be experiencing depression and/or anxiety. Further assessment is warranted.

10 **How many times in the past year have you had 4 (for women) or (5 for men) or more drinks in a day?** _____
(a response of 1 or greater is considered positive for risky drinking)

11a **Are you experiencing constipation?**
If symptoms are current, speak to healthcare professional.

Yes / No

11b **If yes: Are you taking any of the following medication or supplements for constipation? (prescribed or OTC)**

- ☐ Lactulose / Lacdol
- ☐ Movicol
- ☐ Microlax
- ☐ Coloxyl
- ☐ Coloxyl and Senna
- ☐ Bisalax
- ☐ Normacol
- ☐ Nulax
- ☐ Fibre supplement (e.g. Metamucil, fybogel)
- ☐ Unsure
- ☐ Other _____