

Rapid Opioid Dependence Screen (RODS)

Instructions: [Interviewer reads] The following questions are about your prior use of drugs. For each question, please indicate “yes” or “no” as it applies to your drug use during the last 12 months.

1. Have you ever taken any of the following drugs?

- | | | |
|---|---------------------------|--------------------------|
| a. Heroin | <input type="radio"/> Yes | <input type="radio"/> No |
| b. Methadone | <input type="radio"/> Yes | <input type="radio"/> No |
| c. Buprenorphine | <input type="radio"/> Yes | <input type="radio"/> No |
| d. Morphine | <input type="radio"/> Yes | <input type="radio"/> No |
| e. MS CONTIN | <input type="radio"/> Yes | <input type="radio"/> No |
| f. Oxycotin | <input type="radio"/> Yes | <input type="radio"/> No |
| g. Oxycodone | <input type="radio"/> Yes | <input type="radio"/> No |
| e. Other opioid analgesics
(e.g., Vicodin, Darvocet, etc.) | <input type="radio"/> Yes | <input type="radio"/> No |

If any drug in question 1 is coded “yes”, proceed to questions 2-8.

If all drugs in question 1 are “no”, skip to end and code “no” for opioid dependent.

- | | | |
|---|---------------------------|--------------------------|
| 2. Did you ever need to use more opioids to get the same high as when you first started using opioids? | <input type="radio"/> Yes | <input type="radio"/> No |
| 3. Did the idea of missing a fix (or dose) ever make you anxious or worried? | <input type="radio"/> Yes | <input type="radio"/> No |
| 4. In the morning, did you ever use opioids to keep from feeling “dope sick” or did you ever feel “dope sick”? | <input type="radio"/> Yes | <input type="radio"/> No |
| 5. Did you worry about your use of opioids? | <input type="radio"/> Yes | <input type="radio"/> No |
| 6. Did you find it difficult to stop or not use opioids? | <input type="radio"/> Yes | <input type="radio"/> No |
| 7. Did you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high? | <input type="radio"/> Yes | <input type="radio"/> No |
| 8. Did you ever miss important things like doctor’s appointments, family/friend activities, or other things because of opioids? | <input type="radio"/> Yes | <input type="radio"/> No |

Scoring Instructions: Add number of “yes” responses for questions 2-8. If total is ≥ 3 , code “yes” for opioid dependent. If total is ≤ 2 , code “no” for opioid dependent.

Opioid Dependent: Yes No