Eventide Hospice Prescription Opioid Misuse Index

Patients to answer questions 1 through 6; circle YES or NO:

1.	Do you ever use MORE of your medication, that is, take a higher dosage, than is prescribed for you?	**YES**	**NO**
2.	Do you ever use your medication MORE OFTEN, that is, shorten the time between dosages?	**YES**	**NO**
3.	Do you ever feel high or get a buzz after using your pain medication?	**YES**	**NO**
4.	Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain?	**YES**	**NO**
5.	Have you ever gone to multiple physicians, including emergency room doctors, seeking more of your pain medication?	**YES**	**NO**
6.	Do you ever need early refills for your pain medication?	**YES**	**NO**

If Patient is unable to answer questions 1 through 6, the person responsible for managing medications/caregiver should answer the following:

A.	Do you have any history of substance abuse?	**YES**	**NO**

Patient Name (PRINT) _____

Patient Signature _____ **Date** _____

If patient is unable to sign, please document reason _____

Caregiver Signature _____ **Date** _____