

## INSTITUTE FOR HEALTH AND RECOVERY - INTEGRATED SCREENING TOOL

**\*Fax the COMPLETED form to the patient's plan with the requested information**

- |                                                                              |                                                                     |                                                                               |                                                                             |
|------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Absolute Total Care<br>Fax: 877-285-3226            | <input type="checkbox"/> BlueChoice HealthPlan<br>Fax: 877-798-1028 | <input type="checkbox"/> Carolina Medical Homes<br>Fax: 803-509-5366          | <input type="checkbox"/> First Choice by Select Health<br>Fax: 866-533-5493 |
| <input type="checkbox"/> Palmetto Physician Connections<br>Fax: 888-781-4316 | <input type="checkbox"/> SC Solutions<br>Fax: 866-907-4842          | <input type="checkbox"/> UnitedHealthcare Community Plan<br>Fax: 866-456-6722 | <input type="checkbox"/> SCDHHS (Fee-for-Service)<br>Fax: 803-255-8232      |

Women's health can be affected by emotional problems, alcohol, tobacco, other drug use, and domestic violence. Women's health is also affected when those same problems are present in people close to us. By "alcohol," we mean beer, wine, wine coolers, or liquor.

<b>Parents</b> Did any of your parents have a problem with alcohol or other drug use?	<b>YES</b>				<b>NO</b>
<b>Peers</b> Do any of your friends have a problem with alcohol or other drug use?	<b>YES</b>				<b>NO</b>
<b>Partner</b> Does your partner have a problem with alcohol or other drug use?			<b>YES</b>		<b>NO</b>
<b>Violence</b> Are you feeling at all unsafe in any way in your relationship with your current partner?		<b>YES</b>			<b>NO</b>
<b>Emotional Health</b> Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with people, or take care of things at home?				<b>YES</b>	<b>NO</b>
<b>Past</b> In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?			<b>YES</b>		<b>NO</b>
<b>Present</b> In the past month, have you drunk any alcohol or used other drugs? 1. How many <b>days per month</b> do you drink? _____ 2. How many <b>drinks on any given day</b> ? _____ 3. How often did you have <b>4 or more drinks per day</b> in the last month? _____			<b>YES</b>		<b>NO</b>
<b>Smoking</b> Have you smoked any cigarettes in the past three months?			<b>YES</b>		<b>NO</b>

Review Risk
Review Domestic Violence Resources
Review Substance Use, Set Healthy Goals
Consider Mental Evaluation

**Advice for Brief Intervention**

	Y	N	N/A
Did you <b>S</b> tate your medical concern?			
Did you <b>A</b> dvice to abstain or reduce use?			
Did you <b>C</b> heck patient's reaction?			
Did you <b>R</b> efer for further assessment?			

<b>At-Risk Drinking</b>	
Non-Pregnant	Pregnant/ Planning Pregnancy
➤ 7 drinks/week ➤ 3 drinks/day	<b>Any Use is Risky Drinking</b>

**Patient Referred to:**  
Check applicable box(es)

DHEC Quit Line	DMH	DAODAS	Private Provider (Name & NPI)

Date Screened: \_\_\_\_\_ Patient Refused Referral:  Referral Not Warranted:

Medicaid Recipient #: \_\_\_\_\_ Patient's Health Plan: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Practice NPI: \_\_\_\_\_

Screening Provider's Name: \_\_\_\_\_

**For the best health of mothers and babies, we strongly recommend that pregnant women, or those planning to become pregnant, do not use alcohol, illegal drugs or tobacco. Safe levels of usage have not been determined.**

Language: \_\_\_\_\_  
Race: \_\_\_\_\_  
Ethnicity: \_\_\_\_\_