

**INSTITUTE FOR HEALTH AND RECOVERY  
SBIRT INTEGRATED SCREENING TOOL**

**\* Fax the COMPLETED form to the patient's plan and referral site and keep a copy in patient file**

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|--|--|--|---|
| <input type="checkbox"/> Absolute Total Care<br>Fax: 877-285-3226            | <input type="checkbox"/> Blue Choice Health Plan Medicaid<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: 888-454-9152                     | <input type="checkbox"/> United Healthcare Community Plan<br>Fax: 866-456-6722 | <input type="checkbox"/> SCDHHS (Fee-For-Service)<br>Fax: 803-255-8342      |

**PATIENT INFORMATION**

Patient's last name:	First:	Middle:	Language:	Race:	Ethnicity:
Phone no:	Street address:		Medicaid Recipient no.:		

**PROVIDER INFORMATION**

Practice Name:	Group NPI:	Individual NPI:	Screening Provider's Name:	Phone no:
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**PATIENT SCREENING INFORMATION**

<b>Parents</b> Did any of your parents have a problem with alcohol or drug use?	YES				NO
<b>Peers</b> Do any of your friends have a problem with alcohol or other drug use?	YES				NO
<b>Partner</b> Does your partner have a problem with alcohol or other drug use?			YES		NO
<b>Violence</b> Are you feeling at all unsafe in any way in your relationship with your current partner?		YES			NO
<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?				YES	NO
<b>Past</b> In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?			YES		NO
<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? _____ 4. In the past month have you taken any prescription drugs?			YES		NO
<b>Smoking</b> Have you smoked any cigarettes in the past three months?			YES		NO
<b>Comments:</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>State</b> your medical concern?			
Did you <b>Advice</b> to abstain or reduce use?			
Did you <b>Check</b> patient's reaction?			
Did you <b>Refer</b> for future assessment?			

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

CONFIDENTIAL SBIRT REFERRAL INFORMATION					
Patient referred to: Check all that apply	<input type="checkbox"/> DMH	<input type="checkbox"/> DAODAS	<input type="checkbox"/> DHEC QUIT LINE Fax#: 1-800-483-3114	<input type="checkbox"/> Private provider (Name & NPI)	<input type="checkbox"/> Domestic Violence 803-256-2900
Date of Referral Appointment (DD/MM/YY):	Date Screened:	<input type="checkbox"/> Patient Refused Referral	<input type="checkbox"/> Referral Not Warranted	<input type="checkbox"/> Patient requested assistance	

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 presented in people close to us. By "alcohol," we mean beer, wine, wine coolers, or liquor.