

**INSTITUTE FOR HEALTH & 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
Fax: 877-285-3226 | <input type="checkbox"/> BlueChoice HealthPlan Medicaid
Fax: 855-580-2810 | <input type="checkbox"/> Molina
Fax: 866-423-3889 | <input type="checkbox"/> Wellcare
Fax: 866-455-6562 |
| <input type="checkbox"/> Advicare
Fax: 888-781-4316 | <input type="checkbox"/> First Choice by Select Health
Fax: 866-533-5493 | <input type="checkbox"/> SCDHHS (Fee-For-Service)
Fax: 803-255-8247 | <input type="checkbox"/> BlueCross BlueShield of South Carolina
& BlueChoice HealthPlan
Fax: 803-870-9884 |

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Language:	Race:	Ethnicity:
Phone no: ()	Street address:		Member ID no.:		

PROVIDER INFORMATION

Practice name:	Group NPI:	Individual NPI:	Screening provider's name:	Phone no: ()
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PATIENT SCREENING INFORMATION

Parents Did any of your parents have a problem with alcohol or drug use?	YES				NO	
Peers Do any of your friends have a problem with alcohol or other drug use?	YES				NO	
Partner Does your partner have a problem with alcohol or other drug use?			YES		NO	
Violence Are you feeling at all unsafe in any way in your relationship with your current partner?		YES			NO	
Emotional Health 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	
Past In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?			YES		NO	
Present In the past month, have you drunk any alcohol or used other drugs? 1. How many days per month do you drink? _____ 2. How many drinks on any given day ? _____ 3. How often did you have 4 or more drinks per day in the last month? _____ 4. In the past month have you taken any prescription drugs?			YES		NO	
Smoking Have you smoked any cigarettes in the past three months?			YES		NO	
Please provide additional details for any "yes" responses:						
			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 State your medical concern?			
Did you Advise to abstain or reduce use?			
Did you Check patient's reaction?			
Did you Refer for future assessment?			

At Risk Drinking

Non-Pregnant	Pregnant/Planning Pregnancy
7+ drinks/week 3+ drinks/day	Any Use is Risky Drinking

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.