IndianaSBIRT.org

INDIANASBIRT

We Ask Everyone!

Screening, Brief Intervention, and Referral to Treatment

Step 1- ESTABLISH RAPPORT
Assure confidentiality and administer assessments

Step 2– ELICIT THOUGHTS– PROVIDE FEEDBACK
Explore pros and cons of changing, provide education

Step 3– ENHANCE MOTIVATION
Assess readiness to change and enhance motivation

Step 4– NEGOTIATE A PLAN
Summarize session, invite them back

INDIANASBIRT

Alcohol Screening Questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take.
Please help us provide you with the best medical care by answering the questions below.

One drink equals:

12 fl. oz. of regular beer

8-9 fl. oz. of malt liquor
(shown in a 12 oz. glass)

5 fl. oz. of table wine

1.5 fl. oz. of 80-proof spirits (liquor)

Guidelines for Interpretation of DAST-10

Interpretation (each "yes" response = 1 point). Add points together for score.

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level (Risky behavior)	Brief intervention; feedback and advice
3-5	Moderate level (Harmful behavior)	Brief treatment; feedback and counseling; Possible referral for specialized assessment
6-10	Substantial level	Referral for treatment

Drug Abuse Screening Test—DAST-10

These questions refer to the past 12 months

1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you abuse more than one drug at a time?	Yes	No
3. Are you unable to stop using drugs when you want to?	Yes	No
4. Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5. Do you ever feel bad or guilty about drug use?	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your drug use?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Alcohol Screening Questionnaire (AUDIT)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	Zero to two	Three or four	Five or six	Seven to nine	Ten or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	0	1	2	3	4

6. How often during the last year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you have a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not within the last year		Yes, within the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not within the last year		Yes, within the last year
	0	1	2	3	4

Guidelines for scoring the AUDIT

Add points for each question together to determine the final score.

Interventions for all scores are noted below.

I	II	III	IV
0-7	**8-15**	**16-19**	**20+**
Education	**Brief Intervention**	**Brief Treatment**	**Referral to Treatment**