Screening Brief Intervention Referral and Treatment (SBIRT)
Integrated Screening Tool

Provider Name: _____

Recipient: _____

Date Screened:_____

Start Time: _____ Stop Time: _____

Name of Staff performing screening: _____

Referred to: _____ Patient Refused Referral Referral Not Warranted

(A response of No indicates that the screening results are negative.)	**YES or NO**
Parents (If response is yes, review risk with client.) Did any of your parents have a problem with alcohol or other drug use?	
Peers (If response is yes, review risk with client.) Do any of your friends have a problem with alcohol or other drug use?	
Partner (If response is yes, review risk with client.) Does your partner have a problem with alcohol or other drug use?	
Emotional Health (If response is yes, refer for mental health evaluation.) 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?	
Past	
In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	
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?**	

Screener Checklist	**Yes**	**No**	**N/A**
Did you advise your client of the medical concerns for their health?			
Did you advise client to abstain or reduce use?			
Did you observe patient's reaction to questions?			
Did you refer for further assessment?			

NOTES:

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