A Northside Network Provider

English - Spanish

Patient's name: _____ **Date of Birth:** _____

Medicare B enrollment date: _____ *

Today's date: _____

Health Risk Assessment has been reviewed by physicians, signed and dated: Initial _____

MEDICAL/SOCIAL HISTORY

Past personal illnesses or injuries:

Injury/Illness/Surgery	Date	Hospitalized? (Indicate Yes or No)

Medications, supplements and vitamins:

Drug allergies/other allergies:

Social history notes (including diet, physical activities, alcohol use, drug use and tobacco use):

Family history notes:

	Mother	Father	Brother	Sister	Son	Daughter
Deceased						
Hypertension						
Stroke						
Diabetes						
Kidney disease						
Heart disease						
Cancer						
Other						

Other physicians and providers/suppliers of care (include provide name, specialty & type of care)

WELCOME TO MEDICARE
IPPE/ANNUAL WELLNESS VISIT

DEPRESSION SCREEN**

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

ALCOHOL/DRUG SCREEN**

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

MEN: How many times in the past year have you had 5 or more drinks in a day? None _____ 1 or more _____

WOMEN: How many times in the past year have you had 4 or more drinks in a day? None _____ 1 or more _____

Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?

None _____ 1 or more _____

TO BE COMPLETED WITH THE PROVIDER

PHYSICAL EXAMINATION

Height: _____ Weight: _____

Blood Pressure: _____ BMI:_____

Visual Acuity **(IPPE only)**:

	With Correction	Without correction
L		
R		
Both		

FUNCTIONAL ABILITY/SAFETY SCREEN**

1. Was the patient's timed Up & Go test unsteady or long than 30 seconds? ☐ Yes ☐ No
2. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? ☐ Yes ☐ No
3. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? ☐ Yes ☐ No
4. Have you noticed any hearing difficulties? ☐ Yes ☐ No

****If further evaluation is needed, please use additional forms: Alcohol Screening AUDIT (PP1083), Drug Screening DAST (PP1082), Depression Screening PHQ-9 (PP0012), Fall Prevention Checklist (PP0011).**

EVALUATION OF COGNITIVE FUNCTION

Mood/Affect: _____

Appearance: _____

Family member/Caregiver input: _____

ELECTROCARDIOGRAM (G0403-EKG) – Only at the time of the IPPE

Referral or result:_____

EVALUATIONS/REFERRALS BASED ON HISTORY, EXAM AND SCREENING:

DISCUSSION OF ADVANCE DIRECTIVE (PATIENT PREFERENCE, PHYSICIAN AGREEMENT/DISAGREEMENT-if patient consents):

☐ **Reviewed medical and family history for opioid use and if applicable, patient was assessed for non-opioid pain therapy replacement.**

Physicians signature:_____ **Date:**_____ **Time:**_____

A Northside Network Provider

(must be viewed by physician, signed and dated)

Patient's name: _____ **Date of Birth:** _____

Medicare B eligibility date: _____ **Today's date:** _____

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

   ☐ Not at all
   ☐ Slightly
   ☐ Moderately
   ☐ Quite a bit
   ☐ Extremely

2. During the past four weeks, how much bodily pain have you generally had?

   ☐ No pain
   ☐ Very mild pain
   ☐ Mild pain
   ☐ Moderate pain
   ☐ Severe pain

3. During the past four weeks, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

   ☐ Yes, as much as I wanted
   ☐ Yes, quite a bit
   ☐ Yes, some
   ☐ Yes, a little
   ☐ No, not at all

4. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?

   ☐ Very heavy
   ☐ Heavy
   ☐ Moderate
   ☐ Light
   ☐ Very light

5. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?) ☐ Yes ☐ No

6. Can you go shopping for groceries or clothes without someone's help? ☐ Yes ☐ No

7. Can you prepare your own meals? ☐ Yes ☐ No

8. Can you do your housework without help? ☐ Yes ☐ No

9. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around in the house? ☐ Yes ☐ No

10. During the past four weeks, how would you rate your health in general?

    ☐ Excellent
    ☐ Very good
    ☐ Good
    ☐ Fair
    ☐ Poor

HEALTH RISK ASSESSMENT

11. How have things been going for you during the past four weeks?

☐ Very well, could hardly be better
☐ Pretty well
☐ Good and bad parts, about equal
☐ Pretty bad
☐ Very bad; could hardly be worse

12. Are you having difficulties driving your car?

☐ Yes, often
☐ Sometimes
☐ No
☐ Not applicable, I do not use a car

13. Do you always fasten your seat belt when you are in a car?

☐ Yes, usually
☐ Yes, sometimes
☐ No

14. How often during the past four weeks have you been *bothered* by any of the following problems?

Please indicate with: Never, Seldom, Sometimes, Often or Always

Sexual problems _____
Trouble eating well _____
Teeth or denture problems _____
Problems using the telephone _____
Tiredness or fatigue _____

15. Have you fallen two or more times in the past year? ☐ Yes ☐ No

16. Are you afraid of falling? ☐ Yes ☐ No

17. Do you exercise for about 20 minutes three or more days a week?

☐ Yes, most of the time
☐ Yes, some of the time
☐ No, I usually do not exercise this much

18. Have you been given any information to help you with the following:

Hazards in your house that might hurt you? ☐ Yes ☐ No
Keeping track of your medications? ☐ Yes ☐ No

19. How often do you have trouble taking medicines the way you have been told to take them?

☐ I do not have to take medicine
☐ I always take them as prescribed
☐ Sometimes I take them as prescribed
☐ I seldom take them as prescribed

20. How confident are you that you can control and manage most of your health problems?

☐ Very confident
☐ Somewhat confident
☐ Not very confident
☐ I do not have any health problems

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Provider signature: _____ Date: _____

A Northside Network Provider

English - Spanish

Patient's name: _____ **Date of Birth:** _____

Things that may be affecting your health:

- ☐ Alcohol
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty with daily activities
- ☐ Drug or Tobacco use
- ☐ Falls or Fall Risk
- ☐ Food Choices
- ☐ Hearing Loss
- ☐ Home Safety
- ☐ Lack of Physical Exercise
- ☐ Medicines
- ☐ Motor Vehicle Safety
- ☐ Pain
- ☐ Weight

Patient signature: _____ Date: _____

Your doctor has referred you for:

Service	Name/Location	Date or N/A
☐ Counseling		
☐ Hearing Specialist		
☐ Nutrition Therapy		
☐ Diabetes Self-Management		
☐ Other		

Please see attached list of Community Resources

Provider signature: _____ Date: _____

A Northside Network Provider

English - Spanish

Patient's name: _____ **Date of Birth:** _____

Things that may be affecting your health:

- ☐ Alcohol
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty with daily activities
- ☐ Drug or Tobacco use
- ☐ Falls or Fall Risk
- ☐ Food Choices
- ☐ Hearing Loss
- ☐ Home Safety
- ☐ Lack of Physical Exercise
- ☐ Medicines
- ☐ Motor Vehicle Safety
- ☐ Pain
- ☐ Weight

Patient signature: _____ Date: _____

Your doctor has referred you for:

Service	Name/Location	Date or N/A
☐ Counseling		
☐ Hearing Specialist		
☐ Nutrition Therapy		
☐ Diabetes Self-Management		
☐ Other		

Please see attached list of Community Resources

Provider signature: _____ Date: _____

A Northside Network Provider

English - Spanish

Patient's name: _____ **Date of Birth:** _____

Today's date: _____

Service

Vaccinations	**Date Last Occurred or N/A**
Influenza (once per flu season)	
Pneumococcal	
Hepatitis B	

Labs	**Date Last Occurred or N/A**
PSA-males (every 12 months)	
Cardiovascular screening - Lipid panel (every 5 years)	
Diabetes screening-FBS or GTT*	
* One screening every 6 months if diagnosed with pre-diabetes; One screening every 12 months if previously tested but not diagnosed with pre-diabetes or if never tested	

Women's Services	**Date Last Occurred or N/A**
Mammography screening (Ages 35-39: One baseline; Aged 40+: Annually)	
Pap smear (every 24 months or yearly if high risk)	
Pelvic exam (every 24 months or yearly if high risk)	

Diagnostic Services	**Date Last Occurred or N/A**
Pulmonary Screening (annually) – MUST BE:	
* Aged 55 through 77 and no signs or symptoms of lung cancer	
* Tobacco smoking history of at least 30 pack-years	
* Current smoker or one who has quit smoking within the last 15 years **AND** Have a written order for lung cancer screening with Low Dose CT (with counseling only before the first screening)	
Bone mass measurement - DEXA (every 24 months; more frequently if medically necessary)	
Glaucoma screening by an Optometrist (annually)	
PSA/Digital Rectal Exam - males (annually)	
Colorectal cancer screening (ages 50+)	
* FOBT (every 12 months)	
* MT-sDNA (ages 50-85) (every 3 years)	
* Flex Sig (every 4 years if high risk **or** 120 months after screening colonoscopy for non-high risk)	
* Colonoscopy screening (every 10 years or 24 months for high risk)	
* Barium enema - as an alternative to Flex Sig (every 48 months or 24 months for high risk)	

Additional Recommendations
Diabetes self-management training
Medical nutrition therapy services
Abdominal aortic aneurysm screening - (once in a lifetime)

For an all-inclusive list, please review the *Medicare Preventive Services Quick Reference Chart* on www.CMS.gov.

Physician's signature: _____ **Date:** _____

Reorder #350004 PP0429 MEDICARE PACKET

Reorder #26513 PP0008
Piedmont Graphics Rev. 01/25/2022

COUNSELING AND/OR REFERRAL OF PREVENTATIVE SERVICES

Original – Chart
Yellow – Patient

A Northside Network Provider

English - Spanish

Patient's name: _____ **Date of Birth:** _____

Today's date: _____

Service

Vaccinations	**Date Last Occurred or N/A**
Influenza (once per flu season)	
Pneumococcal	
Hepatitis B	

Labs	**Date Last Occurred or N/A**
PSA-males (every 12 months)	
Cardiovascular screening - Lipid panel (every 5 years)	
Diabetes screening-FBS or GTT*	
* One screening every 6 months if diagnosed with pre-diabetes; One screening every 12 months if previously tested but not diagnosed with pre-diabetes or if never tested	

Women's Services	**Date Last Occurred or N/A**
Mammography screening (Ages 35-39: One baseline; Aged 40+: Annually)	
Pap smear (every 24 months or yearly if high risk)	
Pelvic exam (every 24 months or yearly if high risk)	

Diagnostic Services	**Date Last Occurred or N/A**
Pulmonary Screening (annually) – MUST BE:	
* Aged 55 through 77 and no signs or symptoms of lung cancer	
* Tobacco smoking history of at least 30 pack-years	
* Current smoker or one who has quit smoking within the last 15 years **AND** Have a written order for lung cancer screening with Low Dose CT (with counseling only before the first screening)	
Bone mass measurement - DEXA (every 24 months; more frequently if medically necessary)	
Glaucoma screening by an Optometrist (annually)	
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* MT-sDNA (ages 50-85) (every 3 years)	
* Flex Sig (every 4 years if high risk **or** 120 months after screening colonoscopy for non-high risk)	
* Colonoscopy screening (every 10 years or 24 months for high risk)	
* Barium enema - as an alternative to Flex Sig (every 48 months or 24 months for high risk)	

Additional Recommendations
Diabetes self-management training
Medical nutrition therapy services
Abdominal aortic aneurysm screening - (once in a lifetime)

For an all-inclusive list, please review the *Medicare Preventive Services Quick Reference Chart* on www.CMS.gov.

Physician's signature: _____ **Date:** _____

Reorder #350004 PP0429 MEDICARE PACKET

Reorder #26513 PP0008
Piedmont Graphics Rev. 01/25/2022

COUNSELING AND/OR REFERRAL OF PREVENTATIVE SERVICES

Original – Chart
Yellow – Patient

A Northside Network Provider

English - Spanish

Northside Hospital offers a full range of outpatient services.

Cancer Screenings & Diagnostics: Northside hospital Northside Hospital understands the importance of education and screening in the early detection and successful treatment of cancer. We offer annual screenings and special community outreach programs designed to reach individuals who are at a higher risk for cancer and are most in need. Learn more at www.northside.com/Cancer-Screening-Diagnostics

Diabetes Education: Northside's outpatient diabetes education program is recommended for newly diagnosed patients as well as those whose diabetes control needs improvement. The program is available on an individual basis or in small group settings at each Northside campus. For more information, please visit www.northside.com/diabetes or call:

- **Atlanta**
  404-851-6023
- **Alpharetta**
  404-851-6023
- **Cumming**
  404-851-6023
- **Duluth**
  678-312-6040
- **Lawrenceville**
  678-312-6040
- **Woodstock**
  678-388-6400

Health Screenings: At Northside, our goal is to help you live healthier lives and prevent disease. Throughout the year, we offer health screenings at a variety of convenient locations throughout the communities we serve. Some screenings may be free or at low cost to those who qualify.
www.northside.com/healthscreenings
www.everydaywellness.org/community-health/community-health-home

Nutrition Services: Weight management and nutrition services designed to help you achieve optimal health and feel your best. For more information, please call 404-236-8036 or visit www.northside.com/nutrition

Smoking Cessation: As part of our comprehensive approach to prevention and early detection, Northside offers a Smoking Cessation Program to help individuals quit smoking. For more information,
404-780-7653 www.northside.com/smoking-and-tobacco-resources
678-312-5000 www.gwinnettmedicalcenter.org/services/respiratory-care/smoking-cessation

Reorder #35004 PP0429 MEDICARE PACKET

COMMUNITY RESOURCES

Community Resources

Agency on Aging: The Georgia area local Agency on Aging can help you find information about transportation services, Meals on Wheels, classes on healthy living and more.

- Region 2 Counties: Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union and White

  Phone: 770-538-2650 www.legacylink.org

- Region 3 Counties: Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry and Rockdale

  Phone: 404-463-3333 www.empowerline.org

Georgia Department of Public Health: The Georgia Department of Public Health (DPH) is the lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective.

Phone: 404-657-2700 dph.georgia.gov

Tobacco quit line of Georgia: 1-877-270-STOP dph.georgia.gov/ready-quit

United Way: Offers assistance in areas of health, education and many more.

- Greater Atlanta & Cherokee: 404-527-7200 www.unitedwayatlanta.org
- Forsyth: 770-781-4110 www.unitedwayforsyth.com
- Gwinnett: 404-527-5935 www.unitedwayatlanta.org/county/gwinnett-county

YMCA: Offers physical activities, self-management programs, and more at many YMCA locations.
www.ymcaatlanta.org/programs-for-adults Locations: www.ymcaatlanta.org/locations

Metro Atlanta:

- Cowart Family YMCA
  Phone: 770-451-9622
- Carl E. Sanders Family YMCA
  Phone: 404-350-9292

Cherokee County:

- G. Cecil Pruett Community Center Family YMCA
  Phone: 770-345-9622
- Cherokee Outdoor YMCA
  Phone: 770-345-9622

Forsyth County:

- Forsyth County Family YMCA
  Phone: 770-888-2788

Gwinnett County:

- JM Tull Gwinnett Family YMCA
  Phone: 770-963-1313
- Robert D. Fowler Family YMCA
  Phone: 770-246-9622

A Northside Network Provider

English - Spanish

Patient's name: _____ **DOB:** _____

Complete this form only if there is a positive response to the PHQ-2 depression screening.

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such, as. reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	**TOTAL:**			

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

Patient's signature: _____ **Date:** _____

___ Provider assessment: No further evaluation needed.

___ Referral: _____

Physician's signature: _____ **Date:** _____

SCREENING FOR DEPRESSION

PHQ-9 Scoring Instructions

(FOR OFFICE USE ONLY)

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A Northside Network Provider

English - Spanish

Patient's name: _____ **DOB:** _____

1. Have you fallen before or been injured because of a fall?	YES / NO
2. Do you feel weaker than you used to or have less strength in your arms and legs?	YES / NO
3. Have you stopped doing daily activities or avoided exercise because you're afraid of falling?	YES / NO
4. Do you experience incontinence?	YES / NO
5. Has your hand strength decreased?	YES / NO
6. Has your eyesight diminished or do you have trouble seeing depth or seeing at night?	YES / NO
7. Do you feel dizzy when you stand up?	YES / NO
8. Have you experienced hearing loss?	YES / NO
9. Do you have foot ulcers, bunions, hammertoes or callouses that hurt or cause you to adjust your steps?	YES / NO
10. Do you feel unsteady on your feet or shuffle when you walk?	YES / NO

Patient's signature: _____ **Date:** _____

___ Provider assessment: No further evaluation needed.

___ Referral: _____

Physician's signature: _____ **Date:** _____

Reorder #26515 PP0011
Piedmont Graphics Rev. 08/22/17

PERSONAL RISK FACTORS FALL PREVENTION CHECKLIST

A Northside Network Provider

Drug Screening Questionnaire (DAST)

Using drugs 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.

Patient name: _____

Date of birth: _____

Which recreational drugs have you used in the past year? (Check all that apply)

- ☐ methamphetamines (speed, crystal)
- ☐ cocaine
- ☐ cannabis (marijuana, pot)
- ☐ narcotics (heroin, oxycodone, methadone, etc.)
- ☐ inhalants (paint thinner, aerosol, glue)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ tranquilizers (valium)
- ☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse (use) more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Do you inject drugs? No ☐ Yes ☐

Have you ever been in treatment for a drug problem? No ☐ Yes ☐

I	II	III	IV
0	1-2	3-5	6

DRUG SCREENING QUESTIONNAIRE DAST

(For the Provider)

Scoring and interpreting the DAST:

1. "Yes" responses are one point, "No" responses are zero points. All response scores are added for a total score.

2. The total score correlates with a zone of use, which can be circled on the bottom right corner.

Score*	Zone	Explanation	Action
0	I – Low Risk	"Someone at this level is not currently using drugs and is at low risk for health or social complications."	Reinforce positive choices and educate about risks of drug use
1 - 2	II – Risky	"Someone using drugs at this level may develop health problems or existing problems may worsen."	Brief Intervention to reduce or abstain from use
3 - 5	III – Harmful	"Someone using drugs at this level has experienced negative effects from drug use."	Brief Intervention to reduce use and specific follow-up appointment (Brief Treatment if available)
6-10	IV – Severe	"Someone using drugs at this level could benefit from more assessment and assistance."	Brief Intervention to accept referral to specialty treatment for a full assessment

Positive Health Message: Reinforce positive choices and educate about risks of drug use

Brief Intervention to Reduce Use or Abstain from Using: Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual's awareness of his/her drug use and enhance his/her motivation towards behavioral change. Brief interventions are 5-15 minutes, and should occur in the same session as the initial screening. The recommended behavior change is to decrease or abstain from use.

Brief intervention to Reduce or Abstain (Brief Treatment if available) & Follow-up: Patients with numerous or serious negative consequences from their drug use, or patients who likely have a substance use disorder who cannot or are not willing to obtain specialized treatment, should receive more numerous and intensive interventions with follow up. The recommended behavior change is to abstain from use. Brief treatment is 1 to 5 sessions, each 15-60 minutes. Refer for brief treatment if available. If brief treatment is not available, secure follow-up in 2-4 weeks.

Brief Intervention to Accept Referral: The focus of the brief intervention is to enhance motivation for the patient to accept a referral to specialty treatment. If accepted, the provider should use a proactive process to facilitate access to specialty substance use disorder treatment for diagnostic assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

More resources: www.sbirtoregon.org

***** Gavin, D. R., Ross, H. E., and Skinner, H. A. Diagnostic validity of the DAST in the assessment of DSM-III drug disorders. British Journal of Addiction, 84, 301-307. 1989.

A Northside Network Provider

Patient name: _____

Date of birth: _____

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 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 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
6. How often during the last year have you needed a first drink 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 had 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 in the last year		Yes, in 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 in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

I	II	III	IV
0-3	4-9	10-13	14+

(For the Provider)

Scoring and interpreting the AUDIT:

1. Each response has a score ranging from 0 to 4. All response scores are added for a total score.

2. The total score correlates with a risk zone, which can be circled on the bottom left corner.

Score	Zone	Explanation	Action
0-3	I – Low Risk	"Someone using alcohol at this level is at low risk for health or social complications."	Positive Health Message – describe low risk drinking guidelines
4-9	II – Risky	"Someone using alcohol at this level may develop health problems or existing problems may worsen."	Brief intervention to reduce use
10-13	III – Harmful	"Someone using alcohol at this level has experienced negative effects from alcohol use."	Brief Intervention to reduce or abstain and specific follow-up appointment (Brief Treatment if available)
14+	IV – Severe	"Someone using alcohol at this level could benefit from more assessment and assistance."	Brief Intervention to accept referral to specialty treatment for a full assessment

Positive Health Message: An opportunity to educate patients about the NIAAA low-risk drinking levels and the risks of excessive alcohol use.

Brief Intervention to Reduce Use: Patient-centered discussion that uses Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhance his/her motivation to change behavior. Brief interventions are typically 5-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention. The recommended behavior change is to cut back to low-risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

Brief Intervention to Reduce or Abstain (Brief Treatment if available) & Follow-up: Patients with numerous or serious negative consequences from their alcohol use, or patients who likely have an alcohol use disorder who cannot or are not interested in obtaining specialized treatment, should receive more numerous and intensive BIs with follow up. The recommended behavior change is to cut back to low-risk drinking levels or abstain from use. Brief treatment is 1 to 5 sessions, each 15-60 minutes. Refer for brief treatment if available. If brief treatment is not available, secure follow-up in 2-4 weeks.

Brief Intervention to Accept Referral: The focus of the brief intervention is to enhance motivation for the patient to accept a referral to specialty treatment. If accepted, the provider should use a proactive process to facilitate access to specialty substance use disorder treatment for diagnostic assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

More resources: www.sbirtoregon.org

***** Johnson J, Lee A, Vinson D, Seale P. "Use of AUDIT-Based Measures to Identify Unhealthy Alcohol Use and Alcohol Dependence in Primary Care: A Validation Study." Alcohol Clin Exp Res, Vol 37, No S1, 2013: pp E253–E259

ALCOHOL SCREENING QUESTIONNAIRE AUDIT

Mini-Cog©

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

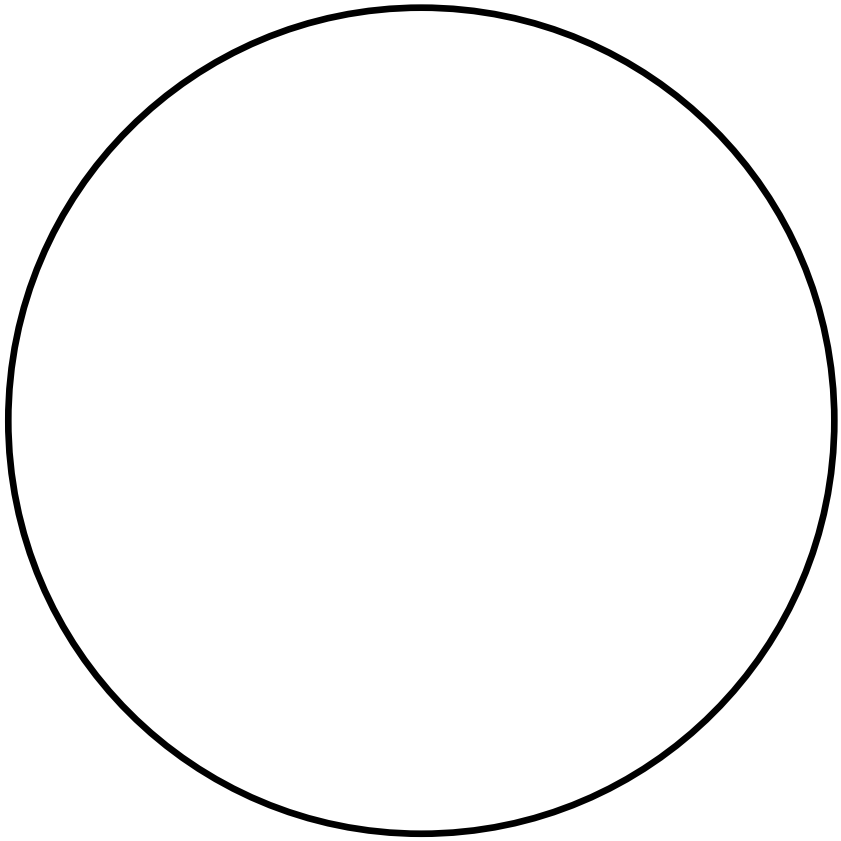
Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Clock Drawing

ID:_____ Date:_____



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2. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21: 349–355.

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