

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

Absolute Total Care
Fax: 877-285-3226

BlueChoice HealthPlan Medicaid
Fax: 855-580-2810

Molina
Fax: 866-423-3889

Wellcare
Fax: 866-455-6562

Advicare
Fax: 888-781-4316

First Choice by Select Health
Fax: 866-533-5493

South Carolina Department of Health and Human Services (Fee-For-Service)
Fax: 803-255-8247

BlueCross BlueShield of South Carolina & BlueChoice HealthPlan
Fax: 803-870-9884

PATIENT INFORMATION						
Patient's Last Name:	First:	Middle:	Language:	Race:	Ethnicity:	Expected Due Date:
Phone No: ()	Street Address:		Member ID No:			

PROVIDER INFORMATION				
Practice Name:	Group National Provider Identifier (NPI):	Individual NPI:	Screening Provider's Name:	Phone No: ()

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 four 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
Seven+ drinks/week Three+ drinks/day	Any Use is Risky Drinking

CONFIDENTIAL SBIRT REFERRAL INFORMATION					
Patient Referred To: (Check all that apply)	<input type="checkbox"/> Department of Mental Health	<input type="checkbox"/> Department of Alcohol and Other Drug Abuse Services	<input type="checkbox"/> Department of Health and Environmental Control Quitline Fax: 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 them. By "alcohol," we mean beer, wine, wine coolers or liquor.

Physician's Signature: _____

*Adapted from Institute for Health & Recovery, (2015)