SOUTH CAROLINA Healthy Connections MEDICAID

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT) INTEGRATED SCREENING TOOL

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

*** 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

☐ Advicare
Fax: 888-781-4316

☐ BlueChoice HealthPlan Medicaid
Fax: 855-580-2810

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

☐ Molina
Fax: 866-423-3889

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

☐ Wellcare
Fax: 866-455-6562

☐ 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 **S**tate your medical concern?			
Did you **A**dvise to abstain or reduce use?			
Did you **C**heck patient's reaction?			
Did you **R**efer 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)	☐ **Department of Mental Health**	☐ **Department of Alcohol and Other Drug Abuse Services**	☐ **Department of Health and Environmental Control Quitline Fax: 800-483-3114**	☐ **Private Provider (Name & NPI)**	☐ **Domestic Violence** **803-256-2900**
Date of Referral Appointment (DD/MM/YY):		**Date Screened:**	☐ **Patient Refused Referral**	☐ **Referral Not Warranted**	☐ **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)*