

Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT) Screening

Required Screen

S2BI

Screening Tool (English)

Screening Tool (Spanish)

Interpretation

Supplemental Screen

CRAFFT

Screening Tool (English)

Screening Tool (Spanish)

Interpretation

S2BI:

In the PAST YEAR , how many times have you used:	Never	Once or twice	Monthly	Weekly
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered “Never” to all questions above, please stop. Otherwise, continue answering all questions below.

Prescription drugs that were not prescribed for you: (such as pain medication or Adderall)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illegal drugs: (such as cocaine or ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants: (such as nitrous oxide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herbs or synthetic drugs: (such as salvia, “K2”, or bath salts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S2BI:

En el AÑO PASADO, cuántas veces consumió:	Nunca	Una vez o dos veces	Mensualmente	Semanalmente
Tabaco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marihuana:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Si respondió "Nunca" a todas las preguntas anteriores, deténgase. De lo contrario, continúe respondiendo a todas las preguntas a continuación.

Medicamentos con receta que no le fueron prescritos a usted: (como medicamentos para el dolor o Adderall)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drogas ilegales: (como la cocaína o el éxtasis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalantes: (como el óxido nitroso)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hierbas o drogas sintéticas: (como la salvia, "K2" o sales de baño)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S2BI Interpretation:

Highest frequency of Substance Use	Risk category	Recommended action
Never	Abstinence	Positive reinforcement
Once or twice	No substance use disorder (SUD)	Brief education
Monthly	Possible mild SUD	Brief intervention
Weekly	Possible moderate or severe SUD	Brief intervention and referral to treatment

More resources: www.sbirtoregon.org

Citation: Levy SJ, Williams JF, AAP COMMITTEE ON SUBSTANCE USE AND PREVENTION. Substance Use Screening, Brief Intervention, and Referral to Treatment. *Pediatrics*. 2016;138(1).

CRAFFT

	Yes	No
1. Have you ever ridden in a car driven by someone (including yourself) who was “high” or had been using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you ever use alcohol or drugs while you are by yourself, or alone?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you ever forget things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever gotten into trouble while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

CRAFFT

	No	Si
1. ¿Ha viajado, alguna vez, en un carro o vehículo conducido por una persona (incluyéndolo a usted) que haya consumido alcohol, drogas o sustancias psicoactivas?	<input type="checkbox"/>	<input type="checkbox"/>
2. ¿Ha usado, alguna vez, bebidas alcohólicas, drogas o sustancias psicoactivas para relajarse, para sentirse mejor consigo mismo o para integrarse a un grupo?	<input type="checkbox"/>	<input type="checkbox"/>
3. ¿Ha consumido, alguna vez, alcohol, drogas o alguna sustancia psicoactiva, encontrándose solo y sin compañía?	<input type="checkbox"/>	<input type="checkbox"/>
4. ¿Ha olvidado, alguna vez, lo que hizo al tomar alcohol, drogas o sustancias psicoactivas?	<input type="checkbox"/>	<input type="checkbox"/>
5. ¿Le han sugerido, alguna vez, sus amigos o su familia que disminuya el consumo de alcohol, drogas o sustancias psicoactivas?	<input type="checkbox"/>	<input type="checkbox"/>
6. ¿Se ha metido, alguna vez, en líos o problemas al tomar alcohol, drogas o sustancias psicoactivas?	<input type="checkbox"/>	<input type="checkbox"/>

CRAFFT Interpretation:

Any “Yes” responses should be explored with the patient to reveal the extent of substance use–related problems and inform the brief intervention.

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