

CAGEAID
Substance Use Screening

Consumer's Name: _____ CR#: _____ Date: _____

Instructions: Administer at intake or to consumers who were not previously screened with the CAGEAID. Ask the consumer the following four questions:

1. Have you ever felt you should CUT down on your drinking or drug using (excluding prescribed medication, drugs given to you by your doctor)? Yes No
2. Have you ever felt ANNOYED (i.e. irritated/aggravated) by a friend, significant other, or an individual in your family criticizing your drinking or drug use (e.g. anyone telling you to cut down or stop drinking and/or using drugs, or anyone telling you that you might have-a-problem with drinking and/or drug use)? Yes No .
3. Have you ever felt bad or GUILTY about how much you drink and/or use drugs? Yes No
4. Have you ever had to drink or use drugs first thing in the morning (EYE-OPENER) to get rid of a hangover or to get the day started? Yes . No

Clinician Over-ride: The interviewer should answer (not ask) the following question:

5. There is compelling evidence (e.g., history of DUI's, presence of paraphernalia, observed intoxication, etc.) that the consumer has a history of substance-related problems or issues:
Yes No

To report the findings of the screening:

- AMHD CMHCs should enter this information directly into AVATAR
 - POSs should enter this information into the Access Database which also includes the QOLI and demographic information OR
- Send the form to: MHSRET at 3465 Wai'ala'e Ave Suite 200 Honolulu, HI 96816 Attention: Kim Pang

Completed by (Please print name)

_____ Date _____

Input to Access by (Please print name)

_____ Date _____