Health Domain

JOHNS HOPKINS
MEDICINE
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HEALTHCARE

CAGE Substance Abuse Screening Tool

Directions: Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

The normal cutoff for the CAGE is two positive answers, however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders. A number of other screening tools are available.

CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

CAGE Source: Ewing 1984

Case Management Comprehensive Assessment

Consumer Name:

Medical Information

Diagnoses:

Medical:

Diagnosis	
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Mental Health (DSM-IV-TR)

Axis 1:	
Axis 2:	
Axis 3:	
Axis 4:	
Axis 5:	
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Current Prescribed Medications:

Current Symptoms:

Health Care Provider Information:

Who is your regular doctor? ☐ None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Who is your regular dentist? ☐ None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Are you seeing any other doctors, such as a psychiatrist, or specialists of any kind?

☐ Yes (list below) ☐ No ☐ Don't know

Name	Specialty	Address	Phone

Case Management Comprehensive Assessment

Section B: Medical and Physical Health

Health Conditions

B1. Overall, how would you rate your physical health?

☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ No Response
Comments:				

B2. Do you have any health problems that require assistance to manage?

☐ Cardiac ☐ Skin Related ☐ G.I. Disorders ☐ Urinary Tract ☐ Weight problems ☐ Evidence of communicable disease ☐ Other – Specify ☐ None
How do they affect you and how long have you had them?
Comments:

B3. Any respiratory problems that require assistance to manage?

☐ Ventilator ☐ Oxygen ☐ Suctioning ☐ Tracheotomy ☐ Cardiorespiratory monitor ☐ Chest physiotherapy ☐ Nebulizer treatment ☐ Other – Specify ☐ None
How do they affect you and how long have you had them?
Comments:

B4. Do you regularly receive any of the following medical treatments?

			Days per week	Hours per day
Nursing	☐ no	☐ yes		
Physical Therapy	☐ no	☐ yes		
Occupational Therapy	☐ no	☐ yes		
Speech Therapy	☐ no	☐ yes		
Supervision for Safety	☐ no	☐ yes		
Diabetes Education	☐ no	☐ yes		
Dialysis	☐ no	☐ yes		
Respiratory Treatment	☐ no	☐ yes		
Catheter Care	☐ no	☐ yes		
Colostomy Care	☐ no	☐ yes		
Nasogastric Tube Care	☐ no	☐ yes		
Other	☐ no	☐ yes		

Consumer Name:

B5. Hearing

- ☐ No hearing impairment.
- ☐ Hearing impairment, but managed through assistive devices
- ☐ Hearing difficulty at level of conversation.
- ☐ Hears only very loud sounds.
- ☐ No useful hearing.
- ☐ Not determined.

Comments:

B6. Vision

- ☐ Has no impairment of vision.
- ☐ Vision impairment, but managed through assistive devices
- ☐ Has difficulty seeing at level of print (far-sighted).
- ☐ Has difficulty seeing obstacles in environment (near-sighted).
- ☐ Has no useful vision.
- ☐ Not determined.

Comments:

B7. Speech/Communication

- ☐ Communicates independently or impairment has been compensated to function independently.
- ☐ Communicates with difficulty but can be understood.
- ☐ Communicates with sign language, symbol board, written messages, gestures or an interpreter.
- ☐ Communicates inappropriate content, makes garbled sounds, or displays echolalia.
- ☐ Does not communicate.

Comments:

B8. Sensory Perception (e.g. – taste, smell, tactile, spatial)

- ☐ No impairment
- ☐ Impaired – Specify

Comments:

B9. Cognitive Status

- ☐ Alert and fully oriented
- ☐ Alert and oriented with significant alteration on self-concept/mood
- ☐ Generally oriented through use of assistive techniques
- ☐ Cognitive deficits (e.g. orientation, attention/concentration, perception, memory, reasoning)
- ☐ Exhibits mental status changes consistent with psychiatric disorder
- ☐ Comatose, but responsive
- ☐ Comatose, but unresponsive
- ☐ Other – Specify

Comments:

B10. Musculoskelatal/Fine or Gross Motor Skills

- ☐ No Impairment of Musculoskelatal/Fine or Gross Motor Skills
- ☐ Impaired muscle tone
- ☐ Contractures
- ☐ Scoliosis

Paralysis: ☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia ☐ Other (Specify)

Comments:

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

B11. Do you have someone who could stay with you for a while if you were sick or needed help?
☐ Yes (Complete below) ☐ No
Name: Relationship:
Address:
City, State, Zip code:
Phone:

B12. Is there anybody you would **not** want to be involved with your care if you were sick or needed help?
☐ Yes (Complete below) ☐ No
Name: Relationship:

HEALTH CONDITIONS RISK FACTORS	YES	NO
R1. Has the consumer had a seizure in the past year?	☐	☐
R2. Does the consumer have a diagnosis of any other serious medical conditions or other serious health concerns (i.e., diabetes, cerebral palsy, heart condition, etc.)? If yes, list all conditions/concerns:	☐	☐
R3. Does the consumer have any life threatening allergies (such as peanuts, bee stings, or shellfish)?	☐	☐
R4. Is the consumer in need of a primary health care provider (or the provider's contact information is unknown)?	☐	☐
R5. Is the consumer in need of a dentist (or dentist's contact information is unknown)?	☐	☐
R6. Is the consumer in need of a specialist (or the specialist's contact information is unknown)?	☐	☐
R7. Has the consumer had difficulty making, keeping, or following through with appointments in the last year?	☐	☐
R8. In the past year, has the consumer gone to a hospital emergency room? If yes, how many times? Why?	☐	☐
R9. In the past year, has the consumer stayed overnight or longer in a hospital? If yes, how many times? Why?	☐	☐
R10. Is the consumer in need of someone to help if he or she was sick or injured?	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:	