

Recovery Pathways, LLC Fetal Alcohol Exposure Screening Tool

Patient Name: _____

Date of Birth: _____ Date of Screen: _____

- I am a male – this form is not applicable to me (if you checked this box, DO NOT continue)
- I am a female without children – this form is not applicable to me (if you checked this box, DO NOT continue)
- I am a female with children and I will complete the form below (continue filling out this form)

Directions: Choose the letter from the dropdown menu to describe your situation for each pregnancy you have experienced. If you have not consumed alcohol during any of your pregnancies, mark “No” under question #1 and do NOT continue filling out the form.

Pregnancy #:	1	2	3	4	5	6
1. Did you consume alcohol during any of your pregnancies?						
a. Yes – Continue to question 2.						
b. No – STOP. You do not need to complete this form						
2. During each pregnancy, how often did you drink?						
a. Never						
b. Monthly or less						
c. Two to four times a month						
d. Two to four times a week						
e. Four or more times a week						
3. During each pregnancy, when drinking, how many drinks did you typically have?						
a. 0 (none)						
b. 1 or 2						
c. 3 or 4						
d. 5 or 6						
e. 7 to 9						
f. 10 or more						
4. During each pregnancy, how often did you have 6 or more drinks?						
a. Never						
b. Less than monthly						
c. Monthly						
d. Weekly						
e. Daily or almost daily						
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Sum of points for each pregnancy:						

If any pregnancy scores greater than 3 points the physician must be notified for the full Fetal Alcohol Syndrome Pre-Screen.

TURN PAGE OVER
Recovery Pathways, LLC
Risk Assessment for Communicable Diseases

Patient Name: _____

Date of Birth: _____ **Date of Screen:** _____

Directions: Check “Yes” or “No” for each question as appropriate

Part I – HIV/AIDs, Hepatitis, STD

1. Have you engaged in unprotected sexual intercourse (oral, anal, or genital) with one or more partners whose HIV status is unknown? Yes No
2. Have you engaged in sexual activity with individuals who have been identified as HIV positive? Yes No
3. Have you shared needles or injecting “works” with other individuals? Yes No
4. Have you experienced other forms of blood contact where you have questions about your HIV status, i.e. blood transfusions, hemophilia treatments, etc.? Yes No
5. Have you been exposed to Hepatitis? Yes No
6. Have you been treated for Hepatitis? Yes No
7. Have you been exposed to a sexually transmitted disease? Yes No
8. Have you been treated for a sexually transmitted disease? Yes No

Part II – Tuberculosis

1. Have you been exposed to Tuberculosis? Yes No
2. Have you ever tested positive for Tuberculosis? Yes No
3. Have you received treatment for Tuberculosis? Yes No
 - a. If yes, was recommended treatment for Tuberculosis completed? Yes No
4. Are you a returning veteran from Afghanistan or have you been in close contact with someone who has been deployed to that country? Yes No

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Part I Total Positive Indicators: _____ **Part II Total Positive Indicators:** _____

Based on these scores, is referral for testing/treatment needed? Yes No

If yes, patient must be given referral information or a lab order slip.

Was the patient issued lab orders from a Recovery Pathways physician? Yes No

If referred for testing/treatment, where? _____