RI MomsPRN

Maternal Psychiatry Resource Network

Recommended Screening Tools

RI MomsPRN
Maternal Psychiatry Resource Network

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Scoring and Interpreting the EPDS

Instructions for Use:

1. The mother is asked to check the response that comes closest to how she has been feeling **in the previous 7 days**.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers should come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

Scoring:

Questions 1, 2, & 4 (without an *) are scored 0, 1, 2 or 3 with the top box scored as 0 and the bottom box scored as 3.
Questions 3, 5-10 (marked with an *) are reverse scored, with the top box scored as 3 and the bottom box scored as 0.

Maximum score: 30

Possibly depressed: 13 or greater

Always look at item 10 ***(thoughts of self-harm/suicide)***

Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- □ Yes, all the time
- ☒ Yes, most of the time
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have coped quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale
Translation – Spanish
Escala de Edimburgo para la depresión postparto

Name: _____ Date: _____

Si está embarazada: número de semanas de embarazo: _____

Si se encuentra en la etapa de postparto: número de semanas de postparto: _____

Como va a tener un bebé (o acaba de tener un bebé) nos gustaría saber cómo se ha estado sintiendo. Marque la respuesta que más se acerca a cómo se ha sentido en los últimos 7 días, no solamente cómo se siente hoy. En el ejemplo que se encuentra a continuación, la "X" significa "Me he sentido contenta casi siempre durante la última semana".

EJEMPLO: Me he sentido contenta:
____Sí, siempre
_X_ Sí, casi siempre
____No muy a menudo
____No, nunca

Complete las siguientes preguntas de la misma manera.

En los últimos 7 días:

1. He podido reír y ver el lado bueno de las cosas:
____ Tanto como siempre
____ No tanto ahora
____ Mucho menos
____ No, no he podido

2. He mirado al futuro con placer:
____ Tanto como siempre
____ Algo menos de lo que solía hacer
____ Definitivamente menos
____ No, nada

3. Me he culpado sin necesidad cuando las cosas marchaban mal:
____ Si, casi siempre
____ Sí, algunas veces
____ No muy a menudo
____ No, nunca

4. He estado ansiosa y preocupada sin motivo:
____ No, nada
____ Casi nada
____ Sí, a veces
____ Sí, a menudo

5. He sentido miedo o pánico sin motivo alguno:
____ Sí, bastante
____ Sí, a veces
____ No, no mucho
____ No, nada

6. Las cosas me oprimen o agobian:
____ Sí, casi siempre
____ Sí, a veces
____ No, casi nunca
____ No, nada

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:
____ Sí, casi siempre
____ Sí, a menudo
____ No muy a menudo
____ No, nada

8. Me he sentido triste o desgraciada:
____ Sí, casi siempre
____ Sí, bastante a menudo
____ No muy a menudo
____ No, nada

9. He estado tan infeliz que he estado llorando:
____ Sí, casi siempre
____ Sí, bastante a menudo
____ Solo ocasionalmente
____ No, nunca

10. He pensado en hacerme daño a mi misma:
____ Sí, bastante a menudo
____ Sí, a menudo
____ Casi nunca
____ No, nunca

© The Royal College of Psychiatrists 1987. Translated from Cox,JL, Holden JM & Sagovsky R. (1987). Detection ofpostnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*.150, 782-786.

Edinburgh Postnatal Depression Scale
Translation – Portuguese
Escala de Depressão Pós-Natal de Edimburgo

Name: _____ Date: _____

Se estiver grávida: De quantas semanas está grávida? _____

Se estiver em período pós-parto: Há quantas semanas se encontra em período pós-parto? _____

Se estiver para ter bebé (ou se teve um bebé recentemente), gostaríamos de saber como se sente. Agradecemos que assinale a resposta que melhor indique o modo como se tem sentido nestes últimos 7 dias e não apenas como se sente hoje. No exemplo abaixo, o "X" significa, "Senti-me feliz quase sempre durante a semana passada."

EXEMPLO: Senti-me feliz
___ Sim, sempre
_X_ Sim, quase sempre
___ Não, poucas vezes
___ Nunca

Queira responder às perguntas abaixo do mesmo modo.

Nos últimos 7 dias:

1. Tenho sido capaz de me rir e de ver o lado divertido das coisas
____ Tanto como antes
____ Não tanto como antes
____ Definitivamente muito menos do que antes
____ Nunca

2. Tenho vindo a aguardar pelo futuro com optimismo
____ Tanto como sempre
____ Bastante menos do que costumava
____ Definitivamente muito menos do que costumava
____ Quase nunca

3. Tenho-me culpado sem necessidade quando as coisas correm mal
____ Sim, a maioria das vezes
____ Sim, algumas vezes
____ Raramente
____ Nunca

4. Tenho estado ansiosa ou preocupada sem motivo
____ Não, nunca
____ Quase nunca
____ Sim, por vezes
____ Sim, muitas vezes

5. Tenho-me sentido com medo ou apavorada sem grande motivo
____ Sim, muitas vezes
____ Sim, por vezes
____ Raramente
____ Nunca

6. Tenho-me sentido oprimida sem poder resolver as coisas do dia-a-dia
____ Sim, a maioria das vezes não tenho conseguido resolvê-las
____ Sim, por vezes não tenho conseguido resolvê-las como normalmente
____ Não, a maioria das vezes resolvo-as facilmente
____ Não, resolvo-as tão bem como antes

7. Tenho-me sentido tão infeliz que tenho dificuldade em dormir
____ Sim, a maioria das vezes
____ Sim, por vezes
____ Raramente
____ Nunca

8. Tenho-me sentido triste ou muito infeliz
____ Sim, a maioria das vezes
____ Sim, frequentemente
____ Raramente
____ Nunca

9. Tenho-me sentido tão infeliz que choro
____ Sim, a maioria das vezes
____ Sim, frequentemente
____ Apenas ocasionalmente
____ Nunca

10. Tive ideias de fazer mal a mim mesma
____ Sim, muitas vezes
____ Por vezes
____ Muito raramente
____ Nunca

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Scoring and Interpreting the PHQ-9

The patient is asked to respond to each of the 9 items based on how they've been feeling **over the last 2 weeks.** The total score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. PHQ-9 total score for the nine items ranges from 0 to 27. In the perinatal period, a score of $\geq$ 10 indicates possible depression.

The final question asks the patients to report – *"how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?"* This single patient-rated difficulty item is not used in calculating any PHQ-9 score or diagnosis but rather represents the patient's global impression of symptom-related impairment. It may be useful in decisions regarding initiation of or adjustments to treatment since it is strongly associated with both psychiatric symptom severity as well as multiple measures of impairment and health-related quality of life.

Maximum score: 27

Possibly depressed: 10 or greater

Always look at item 9 ***(thoughts of self-harm/suicide)***

Kroenke K, Spitzer RL. The PHQ-9: a new depression diagnostic and severity measure. Psychiatric Annals 2002;32:509-521. *[also includes validation data on PHQ-8*].

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9 (PHQ-9)

Durante las <u>últimas 2 semanas</u>, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? *(Marque con un "□" para indicar su respuesta)*	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Poco interés o placer en hacer cosas	0	1	2	3
2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	0	1	2	3
3. Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado	0	1	2	3
4. Se ha sentido cansado(a) o con poca energía	0	1	2	3
5. Sin apetito o ha comido en exceso	0	1	2	3
6. Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	0	1	2	3
7. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión	0	1	2	3
8. ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal	0	1	2	3
9. Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera	0	1	2	3

FOR OFFICE CODING 0 **+** _____ **+** _____ **+** _____

=Total Score: _____

Si marcó <u>cualquiera</u> de los problemas, ¿qué tanta <u>dificultad</u> le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar, o llevarse bien con otras personas?

No ha sido difícil	**Un poco difícil**	**Muy difícil**	**Extremadamente difícil**
☐	☐	☐	☐

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QUESTIONÁRIO SOBRE A SAÚDE DO/A PACIENTE- (PHQ-9)

Durante as <u>últimas 2 semanas</u>, com que freqüência você foi incomodado/a por qualquer um dos problemas abaixo? *(Marque sua resposta com "✔")*	**Nenhuma vez**	**Vários dias**	**Mais da metade dos dias**	**Quase todos os dias**
1. Pouco interesse ou pouco prazer em fazer as coisas	0	1	2	3
2. Se sentir "para baixo", deprimido/a ou sem perspectiva	0	1	2	3
3. Dificuldade para pegar no sono ou permanecer dormindo, ou dormir mais do que de costume	0	1	2	3
4. Se sentir cansado/a ou com pouca energia	0	1	2	3
5. Falta de apetite ou comendo demais	0	1	2	3
6. Se sentir mal consigo mesmo/a — ou achar que você é um fracasso ou que decepcionou sua família ou você mesmo/a	0	1	2	3
7. Dificuldade para se concentrar nas coisas, como ler o jornal ou ver televisão	0	1	2	3
8. Lentidão para se movimentar ou falar, a ponto das outras pessoas perceberem? Ou o oposto – estar tão agitado/a ou irrequieto/a que você fica andando de um lado para o outro muito mais do que de costume	0	1	2	3
9. Pensar em se ferir de alguma maneira ou que seria melhor estar morto/a	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

Se você assinalou <u>qualquer</u> um dos problemas, indique o grau de <u>dificuldade</u> que os mesmos lhe causaram para realizar seu trabalho, tomar conta das coisas em casa ou para se relacionar com as pessoas?

Nenhuma dificuldade	**Alguma dificuldade**	**Muita dificuldade**	**Extrema dificuldade**
☐	☐	☐	☐

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Scoring and Interpreting the GAD-7

The patient is asked to respond to each of the 7 items based on how they've been feeling **over the last 2 weeks.** The total score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. GAD-7 total score for the seven items ranges from 0 to 21. Though designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder. In the perinatal period, a score of $\geq$ 7 indicates possible anxiety.

Maximum score: 21

Possible anxiety: 7 or greater

Spitzer RL, Kroenke K, Williams JBW, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med 2006;166:1092-1097.

Zhong Q-Y, Gelaye B, Zaslavsky AM, et al. Diagnostic Validity of the Generalized Anxiety Disorder - 7 (GAD-7) among Pregnant Women. *PLoS ONE*. 2015;10(4):1-17. doi:10.1371/journal.pone.0125096.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

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GAD-7

Durante las <u>últimas 2 semanas</u>, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? *(Marque con un " " para indicar su respuesta)*	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta	0	1	2	3
2. No ha sido capaz de parar o controlar su preocupación	0	1	2	3
3. Se ha preocupado demasiado por motivos diferentes	0	1	2	3
4. Ha tenido dificultad para relajarse	0	1	2	3
5. Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)	0	1	2	3
6. Se ha molestado o irritado fácilmente	0	1	2	3
7. Ha tenido miedo de que algo terrible fuera a pasar	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

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GAD-7

Durante as <u>últimas 2 semanas</u>, com que freqüência você foi incomodado/a pelos problemas abaixo? *(Marque sua resposta com "✔")*	**Nenhuma vez**	**Vários dias**	**Mais da metade dos dias**	**Quase todos os dias**
1. Sentir-se nervoso/a, ansioso/a ou muito tenso/a	0	1	2	3
2. Não ser capaz de impedir ou de controlar as preocupações	0	1	2	3
3. Preocupar-se muito com diversas coisas	0	1	2	3
4. Dificuldade para relaxar	0	1	2	3
5. Ficar tão agitado/a que se torna difícil permanecer sentado/a	0	1	2	3
6. Ficar facilmente aborrecido/a ou irritado/a	0	1	2	3
7. Sentir medo como se algo horrível fosse acontecer	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

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Scoring and Interpreting the AUDIT-C

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument. The 3 questions can be self-administered via pen and paper, or administered via clinician interview.

The AUDIT-C is scored on a scale of 0-12. Each AUDIT-C question has 5 answer choices. Points allotted are:

a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points

In perinatal women, a score of 3 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. ***However, when the points are all from Question #1 alone (#2 and #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the few months immediately prior to learning of pregnancy, to confirm accuracy.*** Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

Maximum score: 12

Possible alcohol misuse: 3 or greater

Bush K, Kivlahan DR, McDonell MB, et al. The AUDIT Alcohol Consumption Questions (AUDIT-C): An effective brief screening test for problem drinking. Arch Internal Med. 1998 (3): 1789-1795.

AUDIT-C Questionnaire (modified)

Name: _____ Date: _____

These questions refer to the last 12 months, *excluding the time during which you knew you were pregnant*.

1. How often do you have a drink containing alcohol?

- ☐ a. Never
- ☐ b. Monthly or less
- ☐ c. 2-4 times a month
- ☐ d. 2-3 times a week
- ☐ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- ☐ a. 1 or 2
- ☐ b. 3 or 4
- ☐ c. 5 or 6
- ☐ d. 7 to 9
- ☐ e. 10 or more

3. How often do you have six or more drinks on one occasion?

- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

Cuestionario AUDIT-C (modificado)

Nombre: _____ Fecha: _____

Estas preguntas se refieren a los últimos 12 meses, *excluyendo el tiempo durante el cual supo que estaba embarazada.*

1. ¿Con qué frecuencia consume alguna bebida alcohólica?

- ☐ a. Nunca
- ☐ b. Una o menos veces al mes
- ☐ c. De 2 a 4 veces al mes
- ☐ d. De 2 a 3 más veces a la semana
- ☐ e. 4 o más veces a la semana

2. ¿Cuántas consumiciones de bebidas alcohólicas suele realizar en un día de consumo normal?

- ☐ a. 1 o 2
- ☐ b. 3 o 4
- ☐ c. 5 o 6
- ☐ d. 7, 8 o 9
- ☐ e. 10 o más

3. ¿Con qué frecuencia toma 6 o más bebidas alcohólicas en un solo día?

- ☐ a. Nunca
- ☐ b. Menos de una vez al mes
- ☐ c. Mensualmente
- ☐ d. Semanalmente
- ☐ e. A diario o casi a diario

AUDIT-C is available for use in the public domain.

Scoring and Interpreting the DAST-10

The DAST-10 is a 10-item, yes/no, self-report instrument that has been shortened from the 28-item DAST and should take less than 5 minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. The answer options for each item are “YES” or “NO”.

When the term “drug abuse” is used, it refers to the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g. LSD) or narcotics (e.g., heroin. Remember that the questions *do not include alcohol or tobacco.*

For the DAST-10, total score is calculated by adding 1 point for each question answered “YES”, except for question (3) for which a “NO” answer receives 1 point and a “YES” answer receives 0. In perinatal women, a score of ≥1 or greater indicates risk of substance misuse and should be further assessed.

Maximum score: 10

Possible substance misuse: 1 or greater

Skinner, H.A. (1982) The Drug Abuse Screening Test. *Addictive Behavior, 7*(4), 363-371.

Lam LP, Leung WC, Ip P, et al. (2015) Validation of the Drug Abuse Screening Test (DAST-10): A study on illicit drug use among Chinese pregnant women. *Scientific Reports, 5*(1). doi:10.1038/srep11420.

DAST-10 Questionnaire (modified)

Name: _____ Date: _____

The following questions concern information about your potential involvement with drugs other than alcohol and tobacco ***during the past 12 months, excluding the time during which you knew you were pregnant.*** Carefully read each question and decide if your answer is "Yes" or "No." Then circle the number under the appropriate column.

When the term "drug abuse" is used, it means the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g. LSD) or narcotics (e.g., heroin. Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in the section.

These questions refer to the last 12 months, *excluding the time during which you knew you were pregnant.*	**No**	**Yes**
1. Have you ever used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes.")	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you feel bad or guilty about your drug use? (If never use drugs, choose "No.")		
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.?)	0	1

Skinner, H.A. (1982) The Drug Abuse Screening Test. *Addictive Behavior, 7*(4), 363-371.

Cuestionario DAST-10 (modificado)

Nombre: _____ Fecha: _____

Las siguientes preguntas se refieren a información acerca de su potencial envolvimiento con drogas excluyendo alcohol y tabaco durante los últimos 12 meses, ***excluyendo el tiempo durante el cual supo que estaba embarazada***. Lea con cuidado cada pregunta y decida si su respuesta es "No" o "Si". Después, marque el casillero apropiado junto a la pregunta.

Cuando la palabra "abuso de drogas" es usada, esta se refiere al uso de medicinas compradas con receta medica o sin ella y que son ingeridas en exceso de lo recomendado. Las varias clases de drogas pueden incluir: cannabis (mariguana, hashis), solventes, tranquilizantes (Valium), barbitúricos, cocaína, estimulantes (speed), alucinógenos (LSD) o narcóticos (heroína). Recuerde que las preguntas no incluyen alcohol o tabaco.

Por favor responda cada pregunta. Si tiene dificultades con alguna de las preguntas, escoja la que le parezca correcta.

Estas preguntas se refieren a los últimos 12 meses, ***excluyendo el tiempo durante el cual supo que estaba embarazada.***	**No**	**Sí**
1. ¿Ha usado drogas que no eran requeridas por razones médicas?	0	1
2. ¿Ud. abusa mas de una droga a la vez?	0	1
3. ¿Es Ud. capaz de parar de usar drogas siempre cuando se lo propone?	1	0
4. ¿Ha tenido "perdidas de conocimiento" o una "memoria repentina" como resultado del uso de drogas?	0	1
5. ¿Alguna vez se siente mal o culpable debido a su uso de drogas?	0	1
6. ¿Alguna vez su pareja (o familiares) se han quejado de su uso de drogas?	0	1
7. ¿Ha desatendido a su familia debido a su uso de drogas?	0	1
8. ¿Se ha implicado en actividades ilegales con el fin de obtener drogas?	0	1
9. ¿Alguna vez ha experimentado síntomas de abstinencia (sentirse enfermo) cuando dejo de usar drogas?	0	1
10. ¿Ha tenido problemas médicos como resultado de su uso de drogas (perdida de la memoria, hepatitis, convulsiones, hemorragia, etc.)?	0	1

Skinner, H.A. (1982) The Drug Abuse Screening Test. *Addictive Behavior, 7*(4), 363-371.

Instructions for Using the 4Ps

The 4Ps is a screening device often used as a way to begin a discussion about drug and alcohol use. The 4Ps is comprised of 4 “YES/NO” questions regarding the patient’s **P**ast, **P**resent, **P**arents, and **P**artner. The 4Ps can be administered via clinician interview or self-administered via pen and paper.

Any "YES" should be used to trigger further discussion about drug or alcohol use. Any woman who answers "YES" to 2 or more questions should be considered for referral for further assessment.

RECOMMENDATION: All pregnant women should be educated on the dangers of substance use during pregnancy and screened for substance use disorder and alcohol use, particularly during the first and third trimesters. The American College of Obstetricians and Gynecologists (ACOG) recommends universal screening with brief intervention and treatment referrals for cannabinoids, alcohol, dissociative drugs, hallucinogens, opioids, stimulants, tobacco and other compounds such as anabolic steroids and inhalants.

Adapted from Ewing H Medical Director, Born Free Project, Contra Costa County, 111 Allen Street, Martinez, CA. Phone: 510-646-1165.

The 4Ps Screening for Substance Use

Please answer the following questions by checking the box next to "Yes" or "No."

1. Have you ever used drugs or alcohol during this Pregnancy?
   - ☐ Yes
   - ☐ No

2 Have you had a problem with drugs or alcohol in the Past?
   - ☐ Yes
   - ☐ No

3 Does your Partner have a problem with drugs or alcohol?
   - ☐ Yes
   - ☐ No

4 Do you consider one of your Parents to be an addict or alcoholic?
   - ☐ Yes
   - ☐ No

Source: Adapted from Ewing H Medical Director, Born Free Project, Contra Costa County, 111 Allen Street, Martinez, CA. Phone: 510-646-1165.