CAGE

- Have you ever felt the need to Cut down on your drinking?
- Have you ever felt Annoyed by someone criticising your drinking?
- Have you ever felt Guilty about your drinking?
- Have you ever felt the need for an Eye opener? (i.e. a drink to steady yourself in the morning).

If two or more responses are yes, assess further.

The Fast Alcohol Screening Test (FAST) for the Detection of Probable Hazardous Drinking

For the following questions please circle the answer which best applies.

1 drink = 1 unit = 1/2 pint of beer or 1 glass of wine or 1 single spirits

---

1. MEN: How often do you have EIGHT or more drinks on one occasion?

   WOMEN: How often do you have SIX or more drinks on one occasion?

Never Less than Monthly Monthly Weekly Daily or almost daily

Only ask Questions 2, 3 & 4 if the response to Question 1 is Less than monthly or Monthly

---

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Less than Monthly Monthly Weekly Daily or almost daily

---

3. How often during the last year have you failed to do what was normally expected of you because of drink?

Never Less than Monthly Monthly Weekly Daily or almost daily

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes, on one occasion Yes, on more than one occasion

Scoring is quick and can be completed with just a glance at the pattern of responses as follows:

Stage 1

The first stage only involves question 1.

If the response to question 1 is Never then the patient is not misusing alcohol.

If the response to question 1 is Weekly/Daily or Almost Daily then the patient is a hazardous, harmful or dependent drinker.

Over 50% of people will be classified using just this one question. Only consider Questions 2, 3 & 4 if the response to Question 1 is Less than monthly or Monthly.

Stage 2

If the response to Question 1 is Less than monthly or Monthly then each of the four questions is scored 0 to 4.

These are then added resulting in a total score between 0 and 16. The person is misusing alcohol if the total score for all four questions is 3 or more.

Score Questions 1, 2 & 3 as follows:	Score Question 4 as follows:
• Never = 0 • Less than monthly = 1 • Monthly = 2 • Weekly = 3 • Daily or almost daily = 4	• No = 0 • Yes, on one occasion = 2 • Yes, on more than one occasion = 4

In summary:

- Score Questions 1, 2 & 3: 0,1,2,3,4.
- Score Question 4: 0,2,4
- The minimum score is 0
- The maximum score is 16

The score for hazardous drinking is 3 or more