SDOH Short Form Scorer

*Positive screens are indicated in **red**.*

*If a patient screens positive, follow-up with the additional screening questions and/or referrals outlined in the **red** boxes on pages 3-5.*

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1. Do you have a primary care provider? ☐ Yes ■ **No** **If yes**, who? _____

2. Are you employed? (check all that apply)

☐ Yes, full-time ☐ Yes, part-time ☐ Yes, contract ☐ Yes, seasonal ☐ I'm a student

■ **No because of a disability or illness** ■ **No because of child or elder care** ■ **No because of transportation challenges** ■ **No because of difficulty finding a job** ■ **No, other reason**

If employed, at work are you exposed to any chemicals, materials, or conditions that you worry may not be safe for your health (whether you are pregnant or not)? ■ **Yes** ☐ No

3. What is your highest level of education?

■ **Less than high school** ■ **Some high school** ☐ High school diploma/GED ☐ Some college

☐ Associates degree ☐ Bachelors degree ☐ Masters degree ☐ Doctoral degree

4. How comfortable are you understanding written health information?

■ **Not at all** ■ **A little bit** ■ **Somewhat** ☐ Quite a bit ☐ Extremely

5. How comfortable are you understanding what you are told about your health?

■ **Not at all** ■ **A little bit** ■ **Somewhat** ☐ Quite a bit ☐ Extremely

6. How comfortable are you completing medical forms on your own?

■ **Not at all** ■ **A little bit** ■ **Somewhat** ☐ Quite a bit ☐ Extremely

7. Do you use any of these products? (check all that apply)

■ **Cigarettes** ■ **Electronic cigarettes** ■ **Smokeless Tobacco** ■ **Hookah** ■ **Cigars** ☐ No, none of these products

If yes:
How old were you when you first started using this/these product(s)? _____

How much do you use each day? _____ Cigars/ Cigarettes _____ Packs _____ Pods Other: _____

Have you ever tried to quit? ☐ Yes ☐ No

Are you interested in attempting to quit? ■ **Yes** ☐ No

Continue →

8. How often do you drink alcohol?

☐ Never ☐ Less than monthly ■ **Monthly** ■ **Weekly** ■ **Daily**

9. How often do you have four or more alcoholic drinks on one occasion?

☐ Never ☐ Less than monthly ■ **Monthly** ■ **Weekly** ■ **Daily**

10. How many alcoholic drinks do you have on a typical day when you are drinking?

☐ 0-2 ☐ 3-4 ■ **5-6** ■ **7-9** ■ **10+**

11. Have you ever been in treatment for an alcohol problem? ■ **Yes, now** ■ **Yes, in the past** ☐ No, never

12. Are you currently in recovery for alcohol or substance use? ■ **Yes** ☐ No

13. In the past year, have you used a recreational drug or used a prescription medication for non-medical reasons (including marijuana)? ■ **Yes** ☐ No

In the past two weeks, how often have you felt the following ways?

14. Little interest or pleasure in doing things

☐ Not at all ■ **Several days** ■ **More than half the days** ■ **Nearly every day**

15. Feeling down, depressed, or hopeless

☐ Not at all ■ **Several days** ■ **More than half the days** ■ **Nearly every day**

16. In the next two months, are you worried that you may not have stable housing? ■ **Yes** ☐ No

17. *Think about the place you live*. Do you have any problems with the following? (check all that apply)

■ **Bug infestation** ■ **Inadequate heat** ■ **Lead paint or pipes** ■ **Mold**

■ **Oven or stove not working** ■ **No or not working smoke detectors** ■ **Water leaks** ☐ None of the above

18. In the past year, did you worry that your food would run out before you got money to buy more? ■ **Yes** ☐ No

In the past year, has someone:

19. Humiliated or emotionally abused you ■ **Yes** ☐ No

20. Made you afraid of them ■ **Yes** ☐ No

21. Kicked, hit, slapped, or otherwise physically hurt you ■ **Yes** ☐ No

22. Raped or forced you to have any kind of sexual activity you did not want to ■ **Yes** ☐ No

23. Told you not to use birth control (like the pill, shot, ring, etc.), taken away your birth control, or kept you from going to the clinic to get birth control ■ **Yes** ☐ No

24. Made you have sex without a condom when you wanted to use one, including taking off the condom during sex or damaging the condom on purpose ■ **Yes** ☐ No

25. Made or forced you to use birth control when you did not want to at all or did not want to use that specific method ■ **Yes** ☐ No

Follow-up and referral information

1. Do you have a primary care provider?

Staff response: Ask "Would you like a referral to a PCP?" If they answer **yes**, refer to PCP resources.
Referral: Refer patients to _____ [PCP referral].

2. Are you employed? (check all that apply)

Staff response to being unemployed:
- Ask "Have you applied for unemployment benefits?" If they answer **no**, refer to unemployment benefits.
- Ask "Are you interested in job training programs?" If they answer **yes**, refer to job training programs.
- If they checked ***No because of transportation challenges***, ask "What transportation challenges do you have?"

Referrals for unemployment:
- Refer to **The Massachusetts Department of Unemployment Assistance**.
- Refer to _____ [jobs trainings programs referral].
- Refer to _____ [transportation resources].

Staff response to workplace exposures: Ask "What are you exposed to at work that you are concerned about?" Flag answer for clinician to discuss during visit.
Referrals for workplace exposures: N/A

3. What is your highest level of education?

Staff response: *Pay attention to patient age. If a patient is less than 18 years old, they may not need referrals.* Ask "Are you interested in learning about opportunities to earn a GED or complete your education?" If they say **yes**, refer to GED/education resources.
Referral: Refer to _____ [GED/education resources].

4. How comfortable are you understanding written health information?
5. How comfortable are you understanding what you are told about your health?
6. How comfortable are you completing medical forms on your own?

Staff response: Keep the patient's literacy level in mind during the visit. They may require assistance reading and/or understanding written materials, understanding verbal instructions or information, or completing medical forms you give them. Flag for clinician to keep in mind during visit.
Referral: N/A

7. Do you use any of these products?

Staff response: Clarify which tobacco products the patient uses for the medical record. Flag answer for clinician to discuss during visit.
Referral: N/A

Are you interested in attempting to quit?

Staff response: Ask "Would you like a referral to a program to help you stop smoking?" If they answer **yes**, refer to smoking cessation program.
Referral: Refer patients to _____ [smoking cessation referral].

8. How often do you drink alcohol?
9. How often do you have four or more alcoholic drinks on one occasion?
10. How many alcoholic drinks do you have on a typical day when you are drinking?

Staff response: Flag the positive screen (**red** answers to any and/or all of questions 8, 9, and 10) for clinician to discuss during visit.
Clinician response: Ask "How do you feel about your alcohol consumption? Would you like any help to reduce your alcohol use?" If they answer **yes**, refer to alcohol treatment/recovery resources. If you engage a patient in a discussion about their alcohol consumption, you may choose to use these questions as a guide:

- How often during the last year have you found that you were not able to stop drinking once you had started?
- How often during the last year have you not been able to do what was normally expected of you because of drinking?
- How often during the last year have you been unable to remember what happened the night before because of your drinking?
- Has your drinking negatively impacted your relationships with the people close to you?

Referral: Refer patients to _____ [alcohol treatment/recovery resources].

11. Have you ever been in treatment for an alcohol problem?
12. Are you currently in recovery for alcohol or substance use?

Staff response: Flag answers for clinician to discuss during visit.
Referral: N/A

13. In the past year, have you used a recreational drug or used a prescription medication for non-medical reasons (including marijuana)?

Staff response: Flag the positive screen for the clinician to discuss during visit.
Clinician response: Ask "How do you feel about your substance use? Would you like any help to reduce your substance use?" If they answer **yes**, refer to substance use treatment/recovery resources. If you engage a patient in a discussion about their substance use, you may choose to use these questions as a guide:

- Have you used substances other than those required for medical reasons?
- Do you use more than one substance at a time?
- Are you unable to stop using substances when you want to?
- Have you ever had blackouts or flashbacks as a result of substance use?
- Has your substance use negatively impacted your relationships with the people close to you?
- Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking substances?
- Have you ever had medical problems due to your substance use (e.g., memory loss, hepatitis, convulsions)?

Referral: Refer patients to _____ [substance use treatment/recovery resources].

14. Little interest or pleasure in doing things
15. Feeling down, depressed, or hopeless

Staff response: Flag the positive screen (**red** answers to 14 and/or 15) for the clinician to discuss during visit.
Clinician response: Ask the patient about their mental health. Focus on asking about immediate safety (i.e. do they have any thoughts of harming themselves or others). Ask "Are you currently seeing a therapist/getting help from someone? Would you like a referral to a therapist?" If they answer **yes**, refer to mental health services. If you engage a patient in a discussion about their mental health, you may choose to use these questions as a guide:

- Over the last 2 weeks, how often have you:
  - Had trouble falling asleep, staying asleep, or sleeping too much
  - Felt tired or had little energy
  - Had poor appetite or overate
  - Felt bad about yourself or that you have let yourself or your family down
  - Had trouble concentrating on things, such as reading the newspaper or watching television
  - Moved or spoke so slowly that other people could have noticed. Or, the opposite - were so fidgety or restless that you moved around a lot more than usual
  - Had thoughts that you would be better dead or of hurting yourself in some way

Referral: Refer patients to _____ [mental health services].
For emergent safety concerns: _____ [emergency mental health resources].

16. In the next two months, are you worried that you may not have stable housing?
17. *Think about the place you live.* Do you have any problems with the following? (check all that apply)

Staff response: Ask "Tell me more about your housing situation" to learn more information. Flag answers for clinician to discuss during visit. Ask "Would you like a referral to housing resources?" If they answer **yes**, refer to housing resources and/or tenants rights organizations based on need.
Referral: Refer patients to _____ [housing/tenants rights resources].

18. In the past year, did you worry that your food would run out before you got money to buy more?

Staff response: Ask "Would you like help accessing free food?" If they answer **yes**, refer to food insecurity resources.
Referral: Refer patients to _____ [food insecurity resources].

19. Humiliated or emotionally abused you
20. Made you afraid of them
21. Kicked, hit, slapped, or otherwise physically hurt you
22. Raped or forced you to have any kind of sexual activity you did not want to
23. Told you not to use birth control (like the pill, shot, ring, etc.), taken away your birth control, or kept you from going to the clinic to get birth control
24. Made you have sex without a condom when you wanted to use one, including taking off the condom during sex or damaging the condom on purpose
25. Made or forced you to use birth control when you did not want to at all or did not want to use that specific method

Staff response: Flag positive screen (**red** answers to any and/or all of questions 19-25) for clinician to discuss during visit. If form was administered verbally, respond with "Thank you for telling me that. Keeping you safe is part of keeping you healthy. I will let the clinician know."
Clinician response: Discuss IPV with the patient to learn more about the situation. Verbally respond with "Thank you for telling me that. May I ask a colleague to come talk to you and offer some information you may find useful?" If they answer **yes**, page/summon clinical or case management champion with training in safety planning and knowledge of local resources. Allow adequate time for a colleague to prepare custom referrals. If they answer **no**, accept that the patient declines assistance. Let them know that this clinic is always a safe space to seek help.
Note: If a patient screens positive and is under 18 years old, this may be a moment of mandatory reporting. Consult with a colleague to determine appropriate next steps.
Referral: Refer patients to _____ [clinical/case management champion/IPV resources].

Once finished, remember to thank the patient for taking the time to complete the form and for providing this information. Remind them that, like the rest of their visit, this information will be kept in strict confidence and will be used to inform better care or referrals.