

# Modified single alcohol screening questionnaire (M SASQ)

M SASQ is an alcohol harm assessment tool consists of one question from the full alcohol use disorders identification test (AUDIT). This single question test was developed for use in emergency departments.

Questions	Scoring system					Your score
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

<b>M SASQ score</b>	
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## Scoring:

- A total of 0 to 1 indicates lower risk drinkers
- A total of 2 to 4 indicates increasing or higher risk drinkers
- An overall total score of 2 or above is M SASQ positive

## What to do next

If you have a score of 2 or more on the single question and if time permits, complete the remaining alcohol harm questions below to obtain a full score.

# Remaining alcohol harm assessment questions from AUDIT

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 8	10 or more	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

<b>Total AUDIT score</b>	
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## Scoring:

- 0 to 7 indicates low risk
- 8 to 15 indicates increasing risk
- 16 to 19 indicates higher risk
- 20 or more indicates possible dependence

## Alcohol unit reference

One unit of alcohol



Half pint of "regular" beer, lager or cider



Half a small glass of wine



1 single measure of spirits



1 small glass of sherry



1 single measure of aperitifs

Drinks more than a single unit



Pint of "regular" beer, lager or cider



Pint of "strong" or "premium" beer, lager or cider



Alcopop or a 275ml bottle of regular lager



440ml can of "regular" lager or cider



440ml can of "super strength" lager



250ml glass of wine (12%)



75cl Bottle of wine (12%)