

St Mary's Hospital In-Patient Alcohol Guidelines

May 2007

For Review June 2009

Principal Author: Adrian Brown, Alcohol Nurse Specialist

Contributing authors:

Scott Savage (Deputy Chief Pharmacist),
Dr Chris Ford (RCGP London Regional Clinical Lead for substance misuse),
Dr Janice Main (Consultant, Medicine)
Anna Fletcher (Pharmacist DAAU),
Simone Brackenborough (Medicines Directorate Lead Pharmacist),
Dr Ashley Brown (Consultant Hepatology),
Dr Rupert Negus (Consultant Medicine),
Mr Robin Touquet (Consultant A&E),
Dr Julian Redhead (Consultant A&E),
Dr Steven Reid (Consultant, Liaison psychiatry, CNWL Mental Health),
Teresa Wirz (Manager, CNWL SMS),
Dr Kostas Agath (Consultant CNWL SMS),
Victoria Baster (Nurse Practitioner, A&E),
Claire Connor (Sister, DAAU),
Rebecca Maud (Sister, DAAU),
Susan Milligan (Sister, DAAU).

- A Detection of alcohol misuse & dependence (1 page)**
- B Alcohol Health Work referral process (1 page)**
- C Alcohol withdrawal syndrome (1 page)**
- D Ward-based prescribing (3 pages)**

Appendix 1: Treatment and prevention of Wernicke's Encephalopathy

Appendix 2: Modified CIWA for monitoring withdrawal symptoms

Appendix 3: Paddington Alcohol Test form for ward referrals

Further references

A Detection of alcohol misuse

Alcohol problems can be a sensitive subject to discuss with a patient, however not only is early detection very important, but there are physical complications that will need medical intervention if not dealt with promptly.

The Government recommended **daily** limits for drinking alcohol are 2-3 units for a woman and 3-4 units for a man (appendix 3 for guide to units). In some documents this is extrapolated to weekly limits of 14 for a woman and 21 for a man, but the healthy drinking message advises two to three days per week of abstinence.

Patients who misuse alcohol can be divided into two broad categories, dependent drinkers and harmful or hazardous drinkers.

Dependent drinkers are those who are drinking to excess most days, having developed a craving for alcohol including physical withdrawals. They are likely to experience shakes, sweats and anxiety or irritability if they do not drink alcohol (see section 3, withdrawals). Models of Care for Alcohol Misuse (MOCAM) defines "harmful drinkers" as anyone drinking at levels above those recommended for sensible drinking, typically at higher levels than most hazardous drinkers, which would include dependent drinkers. The World Health Organisation (WHO) defines dependence in someone having experienced three or more of the following:

- A strong desire or compulsion to drink.
- Difficulty in controlling onset or termination of drinking or levels of alcohol use.
- A physiological withdrawal state upon cessation of alcohol or the use of alcohol to avoid withdrawal symptoms.
- An increased tolerance to alcohol.
- Progressive neglect of other interests.
- Persisting use of alcohol despite clear evidence and an awareness of the nature and extent of the harm it is causing.

Complications for dependent drinkers

Physical withdrawal symptoms – severe cases include fits & Delirium Tremens.

Withdrawal management is quite straightforward to manage with benzodiazepines, usually chlordiazepoxide. Because of the psychological impact of alcohol, detoxification regimes often require planning and coordination with alcohol counselling services.

Wernicke-Korsakoff syndrome (WKS). The primary signs of WKS are confusion, ataxia and ophthalmoplegia, which may be difficult to distinguish from general drunkenness. Therefore any patient with signs of chronic alcohol misuse and signs of ataxia, confusion and ophthalmoplegia should be given IV Pabrinex (*Pabrinex B vitamins iv over 30 minutes IN 100ML saline as an infusion*), as a prophylactic measure (see page 7).

A definitive diagnosis of Wernicke's can only be made in the sober patient.

Hazardous drinkers including binge drinkers and those early in their "career" of alcohol misuse. They do not usually drink every day, but several days of excess per week can escalate to dependent levels. "Binge drinking" as defined by the Alcohol Harm Reduction Strategy is above twice the recommended daily limits (ie above 8 units for men, above 6 units for women).

Complications for hazardous drinkers

Hazardous drinkers drink more than the recommended limits on a regular basis, but usually have a normal lifestyle, and are therefore more difficult to detect in A&E. They may well attend when they are sober and deny alcohol excess. However the earlier alcohol misuse is detected and counselling offered, the more likely will be its success. The 'Paddington Alcohol Test' (PAT) has been developed to detect hazardous drinking as well as more chronic alcohol misuse and identifies patients suitable for referral to the Alcohol Nurse Specialist (ANS).

B Alcohol Health Work referral process.

The PAT is a selective screening tool – carried out in A&E for nine presenting complaints which may arise as a result of dependent or hazardous drinking.

These are:- fall, collapse, head injury, assault, accident, “unwell”, non-specific gastro-intestinal, psychiatric and cardiac. Additionally, repeat attendees for whom alcohol is implicated can be referred. There is a modified PAT for ward referrals, without these criteria (Appendix 3)

The five PAT questions should take one minute to complete for patients who are “PAT positive”, but the majority of people will be “PAT negative” (ie not drinking at all or within recommended daily limits) and so require less time.

1 Do you drink alcohol?

(Government estimates say that over half of the population drink less than the recommended weekly limits, including about 8% who do not drink at all.)

2 What is the most you will drink in any one day?

(A scale is included to assist calculation of standard alcohol units)

3 How often do you drink more than twice the recommended amount?

(Guidance is given to the patient about the recommended limits.)

Anyone drinking every day is likely to be a dependent drinker, and PAT positive.

If drinking heavily once a week or more, they are a hazardous drinker, and may be PAT positive, and will benefit from advice and information about “sensible drinking”.

4 Do you feel your attendance here is related to alcohol?

If “yes” they are PAT+ve, although people who drink hazardous amounts may deny the connection. Some people who say they rarely drink above recommended limits may admit that on this occasion their attendance is related to alcohol - ie a good opportunity to offer advice.

If PAT +ve, patients are given feedback “We advise you that this drinking is harming your health”. If they are drinking daily, but not excessively, they are advised about drink-free days.

5 We would like to offer you advice about your alcohol consumption; would you be willing to see our alcohol nurse specialist?

If a patient is PAT +ve but does not wish to see the ANS, they can be given an appointment card, which is also an alcohol advice card, as they may change their mind later and return. A referral can still be made to the ANS even if the patient reports being PAT –ve, as denial of the problem is often found in early stages of alcohol problems.

Out-patient Alcohol Health Work sessions occur in the A&E department on Monday to Friday at 10am. Ward assessments will be carried out daily after those sessions, usually by 12 noon. Referrals can be made by any member of staff and at any time, and an assessment will usually be carried out within twenty four hours. Anyone seen in A&E and then admitted to the wards will be followed up, but if in doubt please refer for a review.

In A&E, complete the yellow PAT form and if positive (or you suspect denial of problem), leave in the box in A&E Majors or fax to extension 6366. The ANS can be contacted via extension 7663, where there is an answer-phone. For ward referrals, fax the modified PAT or call direct during working hours.

If the patient is being sent home, they should be given an alcohol advice leaflet and an appointment card (available at A&E: blue writing on a white background) with an appointment for the next day's 10am clinic. Any ward staff or out-patient clinics can contact ANS to discuss a referral of an out-patient.

C Alcohol Withdrawal Syndrome (AWS)

Some patients are not troubled by alcohol withdrawal whilst 40% will develop an acute withdrawal syndrome upon stopping or significantly reducing alcohol intake.

A modified version of the PAT is being developed for ward-based screening, to assist with establishing chlordiazepoxide regimes when patients likely to experience withdrawal symptoms are admitted. However, the risk of withdrawal is not necessarily directly related to intake.

The alcohol withdrawal syndrome can be a continuum from simple tremulousness (the most common symptom) with relatively mild symptoms of autonomic overactivity (agitation, irritability) to hallucinosis, seizures and, most severely, life-threatening delirium tremens. The AWS can therefore be grouped into four sets of symptoms:

Uncomplicated alcohol withdrawal

This results from autonomic hyperactivity. Symptoms are typically seen within 6 to 8 hours of the last drink and may develop before the blood alcohol level has fallen to zero.

Symptoms outlined below may vary in severity, commonly peaking at 10 to 30 hours and usually subsiding by 40 to 50 hours.

- Tremulousness (note: hands, tongue or eyelids)
- Sweating
- Fever, with or without infection
- Nausea, vomiting, retching
- Anxiety
- Agitation
- Irritability
- Anorexia
- Insomnia
- Tachycardia
- Mild systolic hypertension.
- Hallucinosis

Onset in the majority of cases is within 24 hours of the last drink or reduction in alcohol consumption. Stopping within another 24 to 48 hours.

Usually auditory (frequently accusatory or derogatory voices) and sometimes visual hallucinations occur in an otherwise clear sensorium. This is unlike the case for delirium tremens where sensorium is diffusely impaired.

Delirium tremens

DTs occurs in only about 5% of patients undergoing alcohol withdrawal but accounts for the highest morbidity and mortality. Onset of DTs is 2 to 5 days (most commonly at 2 to 3 days) following cessation and represents a medical emergency.

Characteristic symptoms.

- Auditory and visual illusions and hallucinations.
- Severe tremor in hands and body.
- Confusion and disorientation. Delusions (may become withdrawn).
- Clouding of consciousness.
- Agitation.
- Profound symptoms of autonomic overactivity
- Tachycardia, > 100/min
- Fever, with or without infection, temperature > 101°F/38.3°C

Admission for 24 hours minimum to treat withdrawal and monitor, may need observation for up to 72 hours after cessation of drinking (consider accuracy of self-reporting).

Alcohol related seizures

This includes epileptiform seizures (normally grand mal) that usually occur within 12 to 48 hours of alcohol cessation and may develop before the blood level has fallen to zero. Fits are rare beyond 48 hours following cessation. Consider admission if first ever incidence, otherwise base on severity of seizure and observation of recovery.

D Ward-based prescribing

Treatment of Alcohol Withdrawal Syndrome (AWS)

It is important to avoid either under-treatment, which may lead to DTs or seizures or over treatment, associated with sedation and interaction with additional alcohol consumption.

If untreated, death may result from respiratory and cardiovascular collapse or cardiac arrhythmias. Patients most at risk are those with a high fever (>104°F/39.9°C), tachycardia, dehydration and an associated illness (e.g. pneumonia or pancreatitis), general debility or where the diagnosis is delayed.

Untreated, delirium tremens is fatal in 15-20% of patients whilst early detection and prompt initiation of treatment usually prevents onset. Appropriate management reduces mortality to around 1%. A well lit, cool environment with good ventilation and sympathetic nursing reduces the impact of sensory deprivation on the confused patient.

Benzodiazepines, particularly chlordiazepoxide, are central to the management of alcohol withdrawal (*RCP 2001*) and have the following important properties: Sedative, anxiolytic, anticonvulsant, cross-tolerant with alcohol, and do not induce liver enzymes.

Chlordiazepoxide regime should be prescribed on “variable dose” section.

20mg qds should be considered the norm for patients showing signs of withdrawal, with 30mg for heavy drinkers. Doses may need tailoring to individual care – eg increase frequency of regular 30mg doses or increase to 40mg qds (PRN can be given in between regular doses up to 400mg per 24 hours in severe cases). If symptoms persist consider Lorazepam or Haloperidol rather than Chlordiazepoxide and refer to Alcohol Nurse Specialist (9 to 5) or Psychiatric Liaison (out of hours). First line option for night time sedation should be increased nocte dose of Chlordiazepoxide, otherwise Temazepam 10mg nocte.

Do not reduce dosage within the first 24 hours, unless oversedation is indicated. Stabilization may need to be prolonged for the first three days, but usually doses can be reduced within 48 hours.

Once “detox” starts, reduce by 10-40mg daily, subject to planned duration of admission and nursing staff monitoring of patient response (nocte dose ends last).

Suggested standard alcohol withdrawal management regime

	Stabilisation 1-3 days	Reduction DAY 1	Reduction DAY 2	Reduction DAY 3	Reduction DAY 4	Reduction DAY 5	Reduction DAY 6	
8.00am	20-30 mg	20 mg	20 mg	10 mg	10 mg	10 mg		E N D
12.00noon	20-30 mg	20 mg	10 mg	10 mg				
6.00pm	20-30 mg	20 mg	10 mg	10 mg	10 mg			
10.00pm	20-30 mg	20 mg	20 mg	10 mg	10 mg	10 mg	10 mg	

For patients requiring parenteral treatment, IV diazepam 10mg every 30 to 60 minutes should be given until symptoms subside or the patient is markedly sedated.

If used IV diazepam should be infused into a large vein at a rate not greater than 5mg/minute.

Constant observation is mandatory, NB respiratory function.

Vitamin supplement should always be considered alongside this regime

(see appendix 1, pt 5) *For patients with hepatic impairment, IV lorazepam 1mg to 2mg every 5 minutes should be used until the patient is awake but calm.*

Anyone with an altered level of consciousness, including those who are drunk must have a glucoStix blood glucose measurement carried out as alcohol can precipitate hypoglycaemia, especially in the inexperienced drinker.

Management of alcohol withdrawal related seizures

Prophylactic treatment of seizures in patients with a prior history of withdrawal seizures, or seizures occurring during sedative treatment for other withdrawal symptoms, should be managed with diazepam 20mg or chlordiazepoxide 40mg administered orally upon presentation, followed by a further 2 doses at 1-hour intervals.

If status epilepticus occurs this should be treated with:
 IV diazepam 2mg/min to a maximum of 10mg to 20mg.
 IV lorazepam 2mg/min to a maximum of 4mg to 8mg.

For patients requiring parenteral treatment, IV diazepam 10mg every 30 to 60 minutes should be given until symptoms subside or the patient is markedly sedated. If used IV diazepam should be infused into a large vein at a rate not greater than 5mg/minute. Constant observation is mandatory.

Breakthrough symptoms

Obviously a hazardous drinker may have been drinking more prior to admission, requiring withdrawal management some time after admission, so PRN should be available in all cases.

The CIWA-Ar (Sullivan et al, 1989) and the modified scale (Foy et al, 2006 - see appendix 2) afford some guidance in dosage level, but are aimed at ongoing monitoring of withdrawals rather than establishing initial doses. Monitoring of withdrawal symptoms by nursing staff may indicate increasing the regular dose – if more than three PRN doses of chlordiazepoxide given in a twenty four hour period, consider increasing regular dose.

NB. Sometimes people are receiving PRN doses long after physical withdrawals have ended – serving as an anxiolytic rather than withdrawal management. This should be avoided.

Severe withdrawal symptoms

Increased frequency or dose of chlordiazepoxide may be needed initially up to 40mg every 2 hours and a maximum of 400mg in 24 hours. When increasing chlordiazepoxide dosage or giving PRN doses, use caution as over-intoxication may not reduce agitated behaviour – hence haloperidol or lorazepam preferred.

Also note that more frequent lower doses will avoid over-sedation, but may serve to reassure the anxious patient.

Alternative regime example for management of severe alcohol withdrawal symptoms

	<i>Chlordiazepoxide regime</i>	<i>Total daily</i>	
Stabilisation (may be 1-3 days)			
Day 1	40mg qds <i>plus 30mg - 40mg PRN</i>	120mg - 200mg <i>(max 400mg)</i>	<i>It may be more desirable to give 30mg five times rather than increased single doses.</i>
Day 2	40mg qds	120mg - 160mg	
Day 3	30mg qds <i>(or 30mg tds & 40mg nocte)</i>	120mg- 130mg	
Reduction regime to start on stabilised dose			
Day 4	20mg qds	80mg	<i>PRN usually discontinued after day 5 (subject to absence of withdrawal signs)</i>
Day 5	20mg bd & 10mg bd	60mg	
Day 6 >	10mg qds	40mg	<i>Reducing by 10mg per day as per standard regime above</i>

Hepatic impairment

Shorter acting benzodiazepines such as lorazepam or oxazepam may be preferred in patients with hepatic impairment or the elderly.

Start with 8mg in the first 24 hours in regular divided doses.

Benzodiazepine equivalences are as follows:

30mg chlordiazepoxide is considered equivalent to 1mg lorazepam, 25mg oxazepam, or 10mg diazepam (Ashton 2002). For lorazepam the maximum daily dose should be 8mg.

Screening for alcohol levels

Blood alcohol testing

Blood alcohol tests can now be done within the hour, where blood samples are sent to Chemical Pathology in grey-topped bottles (as with Cr, EI, sugar...) with standard A&E request forms; or with other Trust request forms if clinically indicated.

Number of requests per patient

We do not expect more than one request per patient (unless the patient is on ICU receiving alcohol infusions for methyl alcohol poisoning etc), and the lab staff may question any repeats.

All lab staff have been informed of the change in requesting, but it will take time for all on-call staff to become familiar with the change.

Patient consent

Patients must give verbal consent to these tests. Those patients not able to give consent, and where the doctor judges that he is acting in the patient's best interests by requesting such tests, the patient must be given feedback when conscious and in confidence. If the patient is found to be misusing alcohol (i.e. Blood alcohol >80mgs), they should be given 'Brief Advice' by the doctor or nurse, with the offer of a referral to the Alcohol Nurse Specialist.

Discharge Medication

Chlordiazepoxide as a TTA should NOT be considered unless the patient has been monitored for 72 hours in hospital with no incidence of withdrawals & daily dose is 10mg qds or less. It is not acceptable to prescribe other benzodiazepines for alcohol detox TTAs.

This should have been discussed with Alcohol Nurse Specialist, Consultant or Registrar. Alcohol Nurse Specialist should have made provision for out-patient follow-up, or a suitable supportive home environment will have been identified.

Patient can be given advice to contact GP regarding further prescription after discharge. If advising patients about continued drinking on discharge, give clear information on reducing consumption of alcohol rather than stopping abruptly – because of risk of withdrawals.

While in hospital, patients should receive an original pack of thiamine and vitamin B strong. On discharge, if they have less than 14 days' supply remaining, they will receive a further month's supply with advice to contact their GP for continuation.

Appendix 1: **Prevention and Treatment of Wernicke-Korsakoff Syndrome (WKS)**

1 The Problem

WKS is a relatively common potentially lethal condition, due to thiamine deficiency but reversible if treated early. WKS can also have major long-term consequences, with patients requiring permanent institutional care. It is commonest in heavy drinkers who have a poor diet.

Most alcohol dependent patients presenting to A&E will spontaneously leave on sobering up. The common signs of WKS – confusion, ataxia and varying levels of impaired consciousness – are difficult or impossible to differentiate from drunkenness. The eye signs (ophthalmoplegia/nystagmus) are present in only 29% of cases. Because of this, WKS may go unrecognised if not considered, e.g. for the affluent or elderly. Heavy drinkers presenting to hospital - often collapsed and/or with a head injury - require repeated neurological assessment. The intoxicated patient who does not recover fully and spontaneously may be suffering from WKS.

Only if such a patient is admitted will full assessment be possible and further treatment be practical. **There is no simple test to determine patients at risk of WKS.**

2 The Answer

To prevent the development of, and to treat symptoms of, WKS by administration of parenteral B complex vitamins.

3 Treatment

The only available intravenous (i.v.) treatment which includes thiamine (B1), riboflavin (B2), pyridoxine (B6), and nicotinamide is Pabrinex. Intramuscular Pabrinex preparation is available and includes benzyl alcohol as a local anaesthetic.

Two pairs of vials of Pabrinex 1 and 2 diluted in 100ml of crystalloid should be given i.v. over 30 minutes initially (anaphylaxis is rare) in A&E stat (see 4.). If a patient is admitted to the wards consider 2 pairs of vials tds. for 72 hours IV to be followed, if there is improvement, by 1 pair per day for 5 days (IV or IM) at the discretion of the admitting team (mandatory for any patient with evidence of WKS when sober). Oral thiamine treatment alone is ineffective even if such patients comply fully.

Measure serum magnesium initially as well (together with creatinine & electrolytes.) and correct if low.

4 Who to Treat

All patients with evidence of chronic alcohol misuse and any of the following: acute confusion, decreased conscious level, ataxia, ophthalmoplegia, memory disturbance, hypothermia with hypotension, when initially seen in hospital (may well be drunk but still treat, see 3). Patients with delirium tremens may often also have WKS. All of these patients should be presumed to have WKS and be considered for admission.

All hypoglycaemic patients (who are treated with i.v. glucose) with evidence of chronic alcohol ingestion must be given i.v. Pabrinex immediately because of the risk of acutely precipitating WKS.

5 Follow-up

All patients should receive 14 days supply of twice daily thiamine 100mg and twice daily vitamin B Compound Strong B on discharge, with advice to contact their GP for continuation. If the patient is admitted, eg to manage alcohol withdrawal or for delirium tremens, it will be possible to distinguish signs of WKS from those of drunkenness once they sober up.

All such patients should be offered support for reducing alcohol dependence, e.g. referral to an Alcohol Nurse Specialist.

References:

Touquet R, Fothergill J, Henry JA, Harris NH (2000): Accident and emergency medicine. Chap. 29. In: Clinical negligence. 3rd ed., Eds: Powers,MJ; Harris,NH, Butterworths, London, p989-1037. (see para 29.103).

Royal College of Physicians of London. Alcohol – can the NHS afford it? Recommendations for a coherent alcohol strategy for hospitals. February 2001; appendix 3, p49.

Thomson AD, Cook CCH, Touquet R, Henry JA. The Royal College of Physicians report on Alcohol: Guidelines for managing Wernicke's Encephalopathy in the A&E Department. Alcohol & Alcoholism 2002; 37, 513-521.

Paton A, Touquet R, Eds ABC of Alcohol, 4th Edition, March 2005, BMJ Books, Blackwell Publishing.

Appendix 2: Modified **CIWA**

NAME		OTHER NAMES					
DATE OF BIRTH	HOSPITAL NUMBER	WARD:					
REPORTED DAILY ALCOHOL CONSUMPTION:							
REFER TO ALCOHOL GUIDELINES WHERE AVAILABLE							
	TIME /DATE						
Temperature (per axilla)	0) 37.0-37.5°C 1) 37.6-38.0°C 2) Greater than 38.0°C						
Pulse (beats per minute)	0) 90-95 1) 96-100 2) 101-105 3) 106-110 4) 111-120 5) Greater than 120						
Respiration rate (inspirations per minute)	1) 20-24 2) Greater than 24						
Tremor (arms extended, fingers spread)	0) No tremor 2) Not visible—can be felt fingertip to fingertip 4) Moderate with arms extended 6) Severe even with arms not extended						
Sweating (observation)	0) No sweat visible 2) Barely perceptible, palms moist 4) Beads of sweat visible 6) Drenching sweats						
Clouding of sensorium (“What day is this? What is this place?”)	0) Orientated 2) Disorientated for date by no more than two days 3) Disorientated for date 4) Disorientated for place (re-orientate if necessary)						
Quality of contact	0) In contact with examiner 2) Seems in contact, but is oblivious to environment 4) Periodically becomes detached 6) Makes no contact with examiner						
Agitation (your observation)	0) Normal activity 2) Somewhat more than normal activity 4) Moderately fidgety and restless 6) Pacing, or thrashing about constantly						
Thought disturbances (flight of ideas, paranoid ideas)	0) No disturbance 2) Does not have much control over nature of own thoughts 4) Constantly troubled by unpleasant thoughts 6) Thoughts come too rapidly and in a disconnected fashion						
Visual disturbances (photophobia, seeing things)	0) Not present 2) Mild sensitivity (bothered by the lights) 4) Intermittent visual hallucinations (occasionally sees things you cannot) 6) Continuous visual hallucinations (seeing things constantly)						
	TOTAL						
Alcohol withdrawal scale regime—NOTE CHANGE IN SCORE 1 Score four-hourly routinely 2 If greater than 6 score two-hourly 3 If greater than 9 score hourly							

Figure 1 The shortened scale.

ORIGINAL ARTICLE

Clinical use of a shortened alcohol withdrawal scale in a general hospital*

A. Foy, S. McKay, S. Ling, M. Bertram and C. Sadler Internal Medicine Journal 36 (2006) 150–154

“With the modified scale, the reaction is significant at a score of 6, with benzodiazepines recommended after two scores of 9 or one of 12.”

PADDINGTON ALCOHOL TEST
PAT January 2007

PATIENT IDENTIFICATION STICKER:
NAME
D.O.B.

Consider PAT for ALL of the **TOP 10 reasons for attendance**.
Circle number(s) below for any specific trigger(s);

NAME
ADDRESS

D.O.B.

POSTCODE
DATE OF ADMISSION

WARD NAME
DIAGNOSIS/ REASON
FOR ADMISSION
DISCHARGE PLAN
(inc probable date if known)

We routinely ask all patients with (state reason for screening) **about their use of alcohol.**
Ask the patient the following questions, which may help to suggest chlordiazepoxide regime.

1	Do you drink alcohol?	YES (go to #2)	NO (end)
----------	------------------------------	-----------------------	-----------------

2	What is the most you will drink in any one day? (standard alcohol units)	
----------	---	--

If necessary, please use the following guide to estimate total daily units.
(Standard pub units in brackets; home measures often three times the amount!)

Beer /lager/cider	Pints (2)	<input type="text"/>	Cans (1.5)	<input type="text"/>	Litre bottles	<input type="text"/>
Strong beer /lager /cider	Pints (5)	<input type="text"/>	Cans (4)	<input type="text"/>	Litre bottles	<input type="text"/>
Wine	Glasses (1.5)	<input type="text"/>	75cl bottles	<input type="text"/>	Alcopop	
Fortified Wine (Sherry, Port, Martini)	Glasses (1)	<input type="text"/>	75cl bottles	<input type="text"/>	330ml bottles	<input type="text"/>
Spirits (Gin, Vodka, Whisky etc)	Singles (1)	<input type="text"/>	75cl bottles	<input type="text"/>		

The medically recommended daily limits of alcohol are
4 units per day for a man or 3 units per day for a woman.

3	How often do you drink more than twice the recommended amount?
----------	--

- Never or less than weekly **GO TO QUESTION 4**
- Everyday **Dependent Drinker** (PAT+ve) (? Pabrinex & chlordiazepoxide)
- _____ times per week **Hazardous Drinker** (may be PAT+ve)

4	Do you feel your attendance here is related to alcohol?	YES (PAT+ve) NO
----------	--	----------------------------------

If PAT +ve give feedback e.g. "We advise you that this drinking is harming your health".
If drinking daily, but not excessively, advise about drink free days.

5	We would like to offer you advice about your alcohol consumption; would you be willing to see our alcohol nurse specialist?	YES (PAT+ve) NO
----------	--	----------------------------------

If "PAT positive" or "possible" but you are concerned about their drinking FAX this form to **Adrian Brown on 6366, and call extension 7663**, or in the event of any problems, phone the Westminster SMS treatment centre on 6485.

Referrer's Signature

Name Stamp

Date:

Further references

St Mary's Handbook of Medical Emergencies, Eighth Edition 2007

Guideline: Alcohol Withdrawal Treatment in Patients over 18 years old,
Ranjita Dhal & Dr William Shanahan et al, CNWL MHT Substance Misuse Service, 2005

UK Alcohol Forum. Guidelines for the management of alcohol problems in primary care and general psychiatry. London: The Forum; 2001
(www.ukalcoholforum.org/pages/alcoholguidelineset.htm)

The Management of harmful drinking and alcohol dependence in primary Care. Scottish Intercollegiate Guideline Network (SIGN). Edinburgh: SIGN publication 74, 2003.
(www.sign.ac.uk/pdf/sign74.pdf)

Early management of adults with an uncomplicated first generalised seizure
M J G Dunn, D P Breen, R J Davenport and A J Gray *Emerg. Med. J.* 2005;22;237-242

Alcohol misuse: Positive response. Alcohol Health Work for every acute hospital saves money and reduces repeat attendances
Touquet R & Brown A *Emergency Medicine Australasia* (2006) **18**, 103–107

Benzodiazepines: How they Work & How to Withdraw (The Ashton Manual),
Ashton H. 2002 (revised 2004)