

## Fast Alcohol Screening Test (FAST)

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

1 drink = ½ 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

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 drinking?

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

## Construction of the FAST Questionnaire

The development and validation of the FAST questionnaire involved over 3000 patients in a range of busy medical settings and almost 100 nurses administering a number of measures (Hodgson et al., 2002a, 2002b). Since most users of this manual will mainly be interested in administering and scoring the FAST questionnaire, the details of the development work are described in a later section.

## Test Procedures

### Administration

A copy of the FAST questionnaire is shown opposite. It consists of just 4 items. Administration of the FAST questionnaire is a very straightforward procedure and can either be self completed or administered by a health professional.

For the purpose of routine screening, it is advisable to administer the questionnaire in conditions where distractions are kept to a minimum.

The purpose of the questionnaire is to assess alcohol misuse through routine screening in a variety of clinical contexts, although this will not be possible with individuals who are in pain, distressed or have other obvious cognitive limitations or with individuals who are intoxicated.

Average administration time is less than 20 seconds.

In the case of self-completion a staff member should be available to address any problems and should check that all questions have been answered. Patients should be asked to circle the most appropriate response for each question. If more than one response has been made for an individual question, staff should clarify the correct response with the patient.

## Scoring the FAST Questionnaire

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

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

### Stage 1

The first stage only involves question 1.

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

If the response to question 1 is **weekly or 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 and 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 4 questions is scored 0 to 4. These are then added together resulting in a total score between 0 and 16. The person is misusing alcohol if the total score for all 4 questions is 3 or more.

### In summary:

**Score questions 1 to 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**