AUDIT-C Documentation Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · September 2026 · Reproduces no questionnaire items or forms

The AUDIT-C is the three consumption items of the WHO's ten-item AUDIT, validated as a standalone screen by Bush and colleagues in 1998 and scored 0 to 12. It asks how often, how much, and how often heavily a person drinks over the past year; it never diagnoses, and its positive threshold, heavy-occasion wording, and standard drink vary by version and setting. Defensible charting names the version and drink definition, records the item pattern and total, states the threshold applied, adds the patient's own account, and documents the follow-up and intervention.

Version and standard drink original / USAUDIT-C / VA reminder / local build
Do: name the wording used, the heavy-occasion item if adapted, and the standard drink the patient counted (US, Canada, Australia, UK differ).
Pitfall: "AUDIT-C 5" with no version or drink definition, a number the next reader cannot decode.

Mode, language, completeness self-completed or asked; all three answered
Do: record paper, tablet, portal, or verbal; the language or translation; all three items answered; who computed the total.
Pitfall: a verbal score trended against a portal baseline; a translation charted as plain AUDIT-C.

Item pattern, then the total frequency, quantity, heavy occasions
Do: chart the three item scores in order with the total; when every point comes from the frequency item, review actual intake.
Pitfall: a bare total; a positive built entirely from the frequency item read as risky drinking without checking intake.

Threshold stated and applied conventions differ by setting and population
Do: write the convention and its source (practice, VA, national guideline, older-adult) and the result under it.
Pitfall: "positive" with no threshold; a US primary-care rule applied in a VA record or a service that reads another.

Patient's own account the screen bins intake; the note needs it
Do: drinks per typical week, heavy days, last drink, pour size and strength converted to standard drinks, pregnancy, medications, prior withdrawal.
Pitfall: "two beers nightly" charted as two standard drinks; a zero read as "no alcohol concerns" in pregnancy or recovery.

A screen, then the follow-up not a diagnosis; no severity bands exist
Do: write "positive screen; disorder not established" and name the next step: full AUDIT, DSM-5 criteria, withdrawal-risk assessment.
Pitfall: "AUDIT-C 8, severe alcohol use disorder" with no criteria assessed; a positive screen with nothing after it.

Intervention, minutes, and record what supports the claim and the measure
Do: feedback against the limits, the patient's goal, referral decision, face-to-face minutes, rescreen date, and where the result is stored.
Pitfall: "counseled on alcohol" with no content or minutes; a bare score claimed under a counseling code.

Before the note is signed

- [ ] Version and standard drink named
- [ ] Mode, language, and completeness recorded
- [ ] Three item scores charted with the total
- [ ] Threshold stated, source named, result given
- [ ] Patient's own account converted to standard drinks
- [ ] Result labeled a screen, follow-up named
- [ ] Intervention content, minutes, and rescreen date documented

Drafting with AI

Give it the facts: the wording used and the drink definition, mode and language, the three item scores, the threshold your setting applies, weekly intake and heavy days in the patient's words, any criteria or withdrawal assessment, the intervention and its minutes, and where the result is stored.

> *"Draft AUDIT-C documentation: original wording, US 14 g drink, portal self-completed 09/15; item scores 3, 1, 1, total 5; positive under the practice convention for women; 7 to 9 drinks a week, nightly zolpidem, two near-falls; no AUD criteria; counseling 16 minutes, goal set; claim G0442 and G0443."*

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

3 items, 12 points	Thresholds vary	Screen, not diagnosis	Name the drink
frequency, quantity, heavy occasions	by version, setting, population	criteria assessment comes next	US, Canada, Australia, UK differ

AUDIT-C Documentation Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements. Contains no questionnaire items.

Setting: | Patient (initials): | Date: | Clinician:

Version + standard drink used: | Mode (self-completed / verbal) + language:

Screen result
Item scores in order: frequency ___ · typical quantity ___ · heavy occasions ___ · total ___ of 12 · all three items answered · who computed the total

Threshold applied and result
Convention used and its source (practice protocol, VA, national guideline, older-adult validation) · positive or negative under it · prior score on the same version

Patient's own account
Drinks per typical week · heavy days · last drink · pour size and strength converted to standard drinks · pregnancy, medications, prior withdrawal

Interpretation
A consumption screen, not a diagnosis · pattern: steady use or heavy episodes · population caveat: older adult, pregnancy, adolescent, translation · read against national limits

Follow-up assessment triggered
Full AUDIT · DSM-5 criteria assessment · withdrawal-risk assessment (CIWA-Ar) if indicated · labs · result and date

Brief intervention or referral
Feedback against the limits · patient's goal · referral made, declined, or not indicated · face-to-face time in minutes

Plan, record, and billing
Rescreen instrument and date · next visit · code claimed (bare number) · where the result is stored · Part 2 status if created by a Part 2 program

Clinician (name and credentials): | Signature: | Date: