

SUBSTANCE ABUSE REHABILITATION PROGRAM (SARP)

SARP HEALTH AND PHYSICAL EVALUATION SCREENING (SHAPES)

PATIENT INSTRUCTIONS (PAGES 1-2):

Please enter your identifying information at the bottom of all four pages. Then complete questions 1 through 26 on pages 1 and 2 prior to seeing your Primary Care Manager (PCM). A medical officer is required to review your health status prior to any treatment at SARP Norfolk, VA. Ensure you bring a 30 day supply of all medication(s).

1. WHAT SUBSTANCE(S) ARE YOU BEING SCREENED FOR? _____
HAS YOUR SUBSTANCE USE INCREASED OR DECREASED? _____
2. WHAT DAY DID YOU LAST USE ALCOHOL OR DRUGS? _____
LIST THE AMOUNT OF ALCOHOL OR DRUGS USED: _____
3. HAVE YOU EVER EXPERIENCED THESE SYMPTOMS AFTER YOU STOPPED USING DRUGS OR ALCOHOL?

BODY ACHES-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	TREMORS OR "THE SHAKES" -	<input type="checkbox"/> YES <input type="checkbox"/> NO
FLU LIKE SYMPTOMS-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	INCREASED SWEATING-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
AGITATION-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	INCREASED HEART RATE-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
ANXIETY-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	HALLUCINATIONS-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
SLEEP DISTURBANCES-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	SEIZURE-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
DEPRESSION-----	<input type="checkbox"/> YES <input type="checkbox"/> NO		
4. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY OF THE SYMPTOMS ABOVE? ----- YES NO
IF YES, LIST DATES AND HOSPITAL LOCATION: _____
5. ANY PRIOR TREATMENT FOR DRUGS OR ALCOHOL? ----- YES NO
IF YES, **CIRCLE** THE TYPE OF TREATMENT: Outpatient, Intensive Outpatient, Residential, DUI Program, Other.
IF YES, LIST PROGRAM LOCATION AND DATES: _____
6. IN THE PAST YEAR, HAVE YOU BEEN TREATED FOR:

HIGH BLOOD PRESSURE-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	GUNSHOT WOUNDS-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
CHEST PAIN-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	IED/ BLAST INJURIES-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART DISEASE-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	TRAUMATIC BRAIN INJURY--	<input type="checkbox"/> YES <input type="checkbox"/> NO
RESPIRATORY PROBLEMS-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	MEMORY PROBLEMS-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
LIVER PROBLEMS-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEADACHES-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
KIDNEY PROBLEMS-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	SEIZURES-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
GASTROINTESTINAL ISSUES-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	BONE AND/OR JOINT PAIN---	<input type="checkbox"/> YES <input type="checkbox"/> NO
INFECTIONS-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	DENTAL PROBLEMS-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
DIABETES-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	CHRONIC PAIN-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
CANCER-----	<input type="checkbox"/> YES <input type="checkbox"/> NO	PTSD-----	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. HAVE YOU EVER HAD A SEIZURE? ----- YES NO
8. DO YOU HAVE ANY UPCOMING MEDICAL APPOINTMENTS? ----- YES NO
9. ARE YOU CURRENTLY ATTENDING OR SCHEDULED FOR PHYSICAL THERAPY? ----- YES NO
10. ARE YOU USING A CAST, BRACE, SLING, CRUTCHES, OR A WALKING CANE? ----- YES NO
11. DO YOU HAVE ANY WOUNDS THAT REQUIRE DRESSINGS? ----- YES NO
12. ARE YOU CURRENTLY OR HAVE YOU EVER BEEN ON AN OPIATE CONTRACT? ----- YES NO
13. DO YOU EXERCISE? ----- YES NO
IF YES, WHAT TYPE OF EXERCISE AND HOW OFTEN: _____
14. DO YOU HAVE ANY PENDING LEGAL ISSUES?----- YES NO
IF YES, EXPLAIN: _____

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT: ➔			
PATIENT'S NAME (LAST, FIRST, Middle Initial)			SEX
RELATIONSHIP TO SPONSOR		STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION	
DEPART/SERVICE	SSN/IDENTIFICATION	DATE OF BIRTH	

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YES NO

15. HAVE YOU EVER BEEN TREATED FOR A MENTAL HEALTH ISSUE, PAST OR PRESENT?
IF YES, LIST YOUR DIAGNOSIS: _____

16. ARE YOU CURRENTLY SEEING A MENTAL HEALTH PROVIDER? ----- YES NO
IF YES, LIST THE NAME, ADDRESS, AND PHONE NUMBER OF YOUR PROVIDER:

17. HAVE YOU EVER BEEN HOSPITALIZED FOR A PSYCHIATRIC REASON? ----- YES NO
IF YES, LIST REASON, LOCATION, AND DATES: _____

18. DO YOU HAVE ANY OTHER CURRENT MEDICAL PROBLEMS OR CONCERNS?----- YES NO
IF YES, EXPLAIN: _____

19. ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ----- YES NO
IF YES, LIST ALL MEDICATIONS: _____

20. ARE YOU ALLERGIC TO ANYTHING? ----- YES NO
IF YES, LIST: _____

21. RECENT WEIGHT GAIN OR LOSS? ----- YES NO
IF YES, EXPLAIN: _____

22. ARE YOU PREGNANT OR THINK YOU MIGHT BE PREGNANT? ----- YES NO / N/A

23. IF NOT ALL READY LISTED, GIVE NAMES, ADDRESSES, AND PHONE NUMBERS OF ANY PHYSICIANS CURRENTLY TREATING YOU: _____

24. ACTIVE DUTY ANSWER THE FOLLOWING QUESTIONS:

- a. LIST YOUR COMMAND, COMMAND LOCATION, AND DUTY PHONE# _____
- b. LIST YOUR SUPERVISORS NAME AND THEIR WORK PHONE# _____
- c. LIST YOUR HOME/CELL PHONE# _____ WORK PHONE# _____

25. IF YOU ARE NOT ACTIVE DUTY, PLEASE ANSWER THE FOLLOWING QUESTIONS:

- a. HOME ADDRESS Hampton Roads Area of Virginia? ----- YES NO
- b. RETIREE/ELIGIBLE SPOUSE <AGE 65, ELIGIBLE CHILD >AGE 18? ----- YES NO
- c. LAST TRICARE REHAB PROGRAM >365 DAYS AGO? ----- YES NO N/A
- d. ATTENDED 2 OR LESS TRICARE REHAB PROGRAMS IN PAST? ----- YES NO N/A
- e. WILLING TO BE IN TREATMENT? ----- YES NO
- f. YOU HAVE NO PHYSICAL, MENTAL, OR LEGAL PROBLEMS THAT WOULD INTERFERE WITH THE COURSE OF TREATMENT ----- AGREE DISAGREE
- g. IF YOUR PRIMARY PYSICIAN DID NOT REFER YOU TO SARP, PROVIDE NAME, ADDRESS, AND PHONE NUMBER OF THE PERSON WHO DID:

PATIENT SIGNATURE: _____ DATE: _____

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PROVIDER ASSESSMENT

1. RATE THE PATIENTS RISK FOR DRUG OR ALCOHOL WITHDRAWALS? - LOW HIGH- REFER TO MTF
2. ANY MENTAL HEALTH ISSUES THAT COULD INTERFERE WITH SARP TREATMENT GOALS? ----- YES NO
3. SHOULD THE PATIENT BE REFERED TO MENTAL HEALTH? ----- YES NO
4. ANY MEDICAL ISSUES THAT COULD INTERFERE WITH SARP TREATMENT GOALS? --- YES NO
5. DOES THE PATIENT HAVE AN EXCESSIVE AMOUNT OF PENDING MEDICAL APPOINTMENTS THAT COULD INTERFERE WITH SARP TREATMENT GOALS? ----- YES NO
6. DOES THE PATIENT HAVE ANY PENDING CONSULTS? ----- YES NO
7. IS THE PATIENT CURRENTLY TAKING ANY MEDICATION? ----- YES NO
IF YES, PLEASE LIST ALL MEDICATIONS: _____
8. IS THE PATIENT CURRENTLY ON ANY MEDICATIONS THAT MIGHT BE CONTRARY TO THEIR SARP TREATMENT GOALS? ----- YES NO
9. SARP IS A TOBACCO FREE PROGRAM. HAS THE PATIENT BEEN PRESCIBED MEDICATION FOR TOBACCO REPLACEMENT/CESSATION? ----- YES N/A
10. ANY ABNORMAL LAB RESULTS THAT REQUIRE ACTION OR FOLLOW UP? ----- YES NO
11. SHOULD THE PATIENT BE ON FALLS PRECAUTIONS WHILE IN TREATMENT? ----- YES NO

PROVIDER RECOMMENDATION:

12. IS THE PATIENT MEDICALLY AND MENTALLY APPROPRIATE FOR RESIDENTIAL SUBSTANCE ABUSE TREATMENT?----- YES NO- REFER TO MTF

PROVIDER COMMENTS AND PLAN:

13. PRINTED NAME OF PROVIDER	PROVIDER SIGNATURE	DATE:
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14. PROVIDER LOCATION AND CONTACT INFORMATION

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