

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 |
| - | <input type="checkbox"/> YES | <input type="checkbox"/> NO | - | <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 |
| - | <input type="checkbox"/> YES | <input type="checkbox"/> NO | TRAUMATIC BRAIN INJURY-- | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HEART DISEASE----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | MEMORY PROBLEMS----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| - | <input type="checkbox"/> YES | <input type="checkbox"/> NO | - | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| RESPIRATORY PROBLEMS----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | HEADACHES----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| - | <input type="checkbox"/> YES | <input type="checkbox"/> NO | - | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| LIVER PROBLEMS----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | SEIZURES----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| - | <input type="checkbox"/> YES | <input type="checkbox"/> NO | - | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| KIDNEY PROBLEMS----- | | | BONE AND/OR JOINT PAIN---- | | |
| - | | | DENTAL PROBLEMS----- | | |
| GASTROINTESTINAL ISSUES-- | | | CHRONIC PAIN----- | | |
| INFECTIONS----- | | | - | | |
| DIABETES----- | | | PTSD----- | | |
| CANCER----- | | | - | | |
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: _____

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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 | |

Page 1 of 4

SARP FORM (REV. 01-2009)

15. HAVE YOU EVER BEEN TREATED FOR A MENTAL HEALTH ISSUE, PAST OR PRESENT?-- YES NO
 - 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. RETIREEE/ELIGIBLE SPOUSE <AGE 65, ELIGIBLE CHILD >AGE 18? ----- YES NO
 c. LAST TRICARE REHAB PROGRAM >365 DAYS AGO? ----- YES NO N/A
 -- YES NO N/A
 d. ATTENDED 2 OR LESS TRICARE REHAB PROGRAMS IN PAST? ----- YES NO
 -
 e. WILLING TO BE IN TREATMENT? ----- AGREE DISAGREE
 --
 f. YOU HAVE NO PHYSICAL, MENTAL, OR LEGAL PROBLEMS THAT WOULD INTERFERE WITH THE COURSE OF TREATMENT -----
 g. IF YOUR PRIMARY PYSICIAN DID NOT REFER YOU TO SARP, PROVIDE

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 NAME, ADDRESS, AND PHONE NUMBER OF THE PERSON WHO DID:

PATIENT SIGNATURE: _____ DATE: _____

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 |
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MEDICAL PROVIDER INSTRUCTIONS (PAGES 3-4):

- This evaluation must be completed within 30 DAYS prior to SARP admission date. Patient must be physically and mentally stable prior to SARP Admission.** Please assess patients medical / psychiatric history and any other pertinent history as provided by your Command DAPA and recommend further treatment options i.e. detoxification, psychiatric referral etc. **Please order the following labs prior to SARP treatment: GGT, Comprehensive Metabolic Panel with GFR, PPD (within 6 months or CXR if known converter, Hepatitis A, B & C, RPR, Urine GC & CHL, HIV-1 (within last 6 months), and Urine Drug Screen.**
- Ensure patient comes with a 30 day supply of medication(s).

| VITAL SIGNS | |
|---|---------------|
| BLOOD PRESSURE: | RESPERATIONS: |
| PULSE: | TEMPATURE: |
| IS THE PATIENT CURRENTLY IN ANY PAIN?----- <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| IF YES, RATE PAIN ON SCALE OF 1 TO 10 AND EXPLAIN: | |

| PHYSICAL EXAMINATION: | | |
|-----------------------|--------|-------------------|
| EXAM | NORMAL | ABNORMAL FINDINGS |
| HEENT | | |
| HEART | | |
| LUNGS | | |
| ABDOMEN | | |
| EXTREMITIES | | |
| MUSCULO-SKELETAL | | |
| SKIN | | |
| NEUROLOGICAL | | |

| |
|--|
| MEDICAL / PSYCHIATRIC HISTORY: (ADDRESS "YES" ANSWERS ON FIRST TWO PAGES) |
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SUBSTANCE ABUSE REHABILITATION PROGRAM (SARP) SARP HEALTH AND PHYSICAL EVALUATION SCREENING (SHAPES)

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 PRESCRIBED 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:

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|------------------------------|--------------------|-------|
| 13. PRINTED NAME OF PROVIDER | PROVIDER SIGNATURE | DATE: |
|------------------------------|--------------------|-------|

14. PROVIDER LOCATION AND CONTACT INFORMATION

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

| | |
|------------------------|--|
| RECORDS MAINTAINED AT: | |
|------------------------|--|

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