SUBSTANCE ABUSE REHABILITATION/OASIS PROGRAM (**SARPO**)
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/OASIS San Diego, CA. Ensure you bring a 35 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----------	☐YES	☐NO	TREMORS OR "THE SHAKES" -	☐YES	☐NO
FLU LIKE SYMPTOMS--------	☐YES	☐NO	INCREASED SWEATING--------	☐YES	☐NO
AGITATION----------	☐YES	☐NO	INCREASED HEART RATE------	☐YES	☐NO
ANXIETY----------	☐YES	☐NO	HALLUCINATIONS----------	☐YES	☐NO
SLEEP DISTURBANCES------	☐YES	☐NO	SEIZURE----------	☐YES	☐NO
DEPRESSION----------	☐YES	☐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----------	☐YES	☐NO	GUNSHOT WOUNDS----------	☐YES	☐NO
CHEST PAIN----------	☐YES	☐NO	IED/ BLAST INJURIES----------	☐YES	☐NO
HEART DISEASE----------	☐YES	☐NO	TRAUMATIC BRAIN INJURY--	☐YES	☐NO
RESPIRATORY PROBLEMS----------	☐YES	☐NO	MEMORY PROBLEMS----------	☐YES	☐NO
LIVER PROBLEMS----------	☐YES	☐NO	HEADACHES----------	☐YES	☐NO
KIDNEY PROBLEMS----------	☐YES	☐NO	SEIZURES----------	☐YES	☐NO
GASTROINTESTINAL ISSUES---------	☐YES	☐NO	BONE AND/OR JOINT PAIN----	☐YES	☐NO
INFECTIONS----------	☐YES	☐NO	DENTAL PROBLEMS----------	☐YES	☐NO
DIABETES----------	☐YES	☐NO	CHRONIC PAIN----------	☐YES	☐NO
CANCER----------	☐YES	☐NO	PTSD----------	☐YES	☐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	
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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:
_____

26. BY SIGNING BELWO I ACKNOWLEDGE THAT SARP/OASIS IS A TOBACCO FREE FACILITY I'LL BE PROHIBITIED FROM USING TOBACCO IN ANY FORM UPON ARRIVAL. I ALSO CERTIFY THE INFORMAION I HAVE PROVIDED AS TRUE AND CORRECT.

PATIENT SIGNATURE: _____DATE:_____

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SARP HEALTH AND PHYSICAL EVALUATION SCREENING (SHAPES)

MEDICAL PROVIDER INSTRUCTIONS (PAGES 3-4):

1. **This evaluation must be completed within 30 DAYS prior to SARP/OASIS admission date**. **Patient must be physically and mentally stable prior to SARP/OASIS 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 LAST 6 months /Chest X-ray if known PPD converter), Urine HCG, HIV-1 (within last 6 months), and Urine Drug Screen and CHEM 18. Influenza within One year.**
2. Ensure patient comes with a 35 day supply of medication(s).

VITAL SIGNS
BLOOD PRESSURE: RESPERATIONS: PULSE: TEMPATURE:
IS THE PATIENT CURRENTLY IN ANY PAIN?---------- ☐YES ☐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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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:
14. PROVIDER LOCATION AND CONTACT INFORMATION	

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