

# NAVAL MEDICAL CENTER SAN DIEGO (NMCS D) SUBSTANCE ABUSE REHABILITATION PROGRAM (SARP) HEALTH AND PHYSICAL EVALUATION SCREENING (SHAPES)

## PART 1 – TO BE FILLED OUT BY SERVICE MEMBER

1. WHAT SUBSTANCE(S) ARE YOU BEING SCREENED FOR? \_\_\_\_\_  
HAS YOUR SUBSTANCE USE INCREASED OR DECREASED? \_\_\_\_\_
2. DATE OF YOUR LAST ALCOHOL OR DRUG USE? \_\_\_\_\_  
LIST THE AMOUNT OF ALCOHOL OR DRUGS USED ON LAST OCCASION: \_\_\_\_\_
3. HAVE YOU EVER EXPERIENCED ANY SYMPTOMS AFTER YOU STOPPED USING DRUGS OR ALCOHOL?
 

BODY ACHE	YES	NO	NAUSEA, VOMITING, OR DIARRHEA	YES	NO
FLU LIKE SYMPTOMS	YES	NO	ANXIETY	YES	NO
AGITATION	YES	NO	DEPRESSION	YES	NO
TREMORS OR "THE SHAKES"	YES	NO	SLEEP DISTURBANCES	YES	NO
INCREASED SWEATING	YES	NO	HALLUCINATIONS	YES	NO
INCREASED HEART RATE	YES	NO	SEIZURES	YES	NO
4. ANY PRIOR TREATMENT FOR DRUGS OR ALCOHOL? YES NO  
IF YES, CIRCLE TREATMENT: Prime for Life, Outpatient, Intensive Outpatient, Residential.  
LIST PROGRAM DATES: \_\_\_\_\_
5. IN THE PAST YEAR, HAVE YOU BEEN EVALUATED OR TREATED FOR:
 

HIGH BLOOD PRESSURE	YES	NO	CANCER	YES	NO
CHEST PAIN	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 PROBLEMS	YES	NO	BONE OR JOINT PAIN	YES	NO
INFECTIONS	YES	NO	BACK PAIN	YES	NO
DIABETES	YES	NO	DENTAL PROBLEMS	YES	NO
6. DO YOU HAVE ANY CURRENT MEDICAL PROBLEMS OR CONCERNS NOT LISTED YES NO  
ABOVE? IF YES, LIST HERE: \_\_\_\_\_
7. HAVE YOU IN THE PAST OR ARE YOU CURRENTLY BEING TREATED FOR ANY MENTAL YES NO  
HEALTH PROBLEMS OR CONCERNS (Including psychiatric hospitalizations)?  
IF YES, DESCRIBE HERE: \_\_\_\_\_
8. HAVE YOU EVER BEEN TREATED OR HOSPITALIZED FOR WITHDRAWAL SYMPTOMS YES NO  
OR "DETOX?" IF YES, DESCRIBE HERE: \_\_\_\_\_
9. ARE YOU CURRENTLY TAKING ANY MEDICATIONS INCLUDING OTC MEDICATIONS? YES NO  
(Note that SARP does not permit use of controlled substances during treatment)  
IF YES, LIST HERE: \_\_\_\_\_
10. DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR OTHER SUBSTANCES? YES NO  
IF YES, LIST HERE: \_\_\_\_\_

PATIENT'S NAME (LAST, FIRST, Middle Initial)		SEX
DATE OF BIRTH	ORGANIZATION	RANK/GRADE
DOD ID		

# NMCS D SARP HEALTH AND PHYSICAL EVALUATION SCREENING (SHAPES)

## PART 1 – TO BE FILLED OUT BY SERVICE MEMBER

11. HAVE YOU EXPERIENCED ANY RECENT WEIGHT GAIN OR LOSS? YES NO  
 IF YES, DESCRIBE HERE: \_\_\_\_\_
12. HAVE YOU OR PEOPLE YOU LIVE WITH BEEN EXPOSED TO BED BUGS, LICE, OR SCABIES WITHIN THE PAST MONTH? YES NO
13. DO YOU HAVE ANY CONDITIONS THAT WOULD PREVENT YOU FROM EXERCISING? YES NO  
 IF YES, DESCRIBE HERE: \_\_\_\_\_
14. DO YOU HAVE ANY CONDITIONS THAT REQUIRE ASSISTANCE USING THE STAIRS? YES NO  
 IF YES, DESCRIBE HERE: \_\_\_\_\_
15. ARE YOU CURRENTLY USING A CAST, BRACE, SLING, CRUTCHES, OR CANE? YES NO  
 IF YES, DESCRIBE HERE: \_\_\_\_\_
16. DO YOU HAVE ANY UPCOMING APPOINTMENTS (Medical, Dental, Physical Therapy, etc.)? YES NO  
 IF YES, LIST HERE: \_\_\_\_\_  
 \_\_\_\_\_
17. DO YOU HAVE ANY MEDICALLY ORDERED DIETARY OR NUTRITIONAL NEEDS? YES NO  
 IF YES, DESCRIBE HERE: \_\_\_\_\_
18. DO YOU HAVE ANY CURRENT MEDICAL RESTRICTIONS (i.e. No Shave Chit, No PT, etc.)? YES NO  
 IF YES, LIST HERE: \_\_\_\_\_
19. DO YOU HAVE ANY CURRENT PENDING LEGAL OR DISCIPLINARY ISSUES? YES NO  
 IF YES, DESCRIBE HERE: \_\_\_\_\_  
 ARE YOU CURRENTLY PENDING AN ADMINSTRATIVE SEPARATION BOAD? YES NO
20. ARE YOU CURRENTLY PENDING A MEDICAL EVALUATION BOARD? YES NO
21. ARE YOU CURRENTLY ON LIMITED DUTY (LIMDU)? YES NO  
 IF YES, DESCRIBE HERE: \_\_\_\_\_  
 \_\_\_\_\_
22. *FEMALES ONLY*: ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? YES NO

**BY SIGNING BELOW I CERTIFY THE INFORMATION I HAVE PROVIDED IS TRUE AND ACCURATE. I ALSO ACKNOWLEDGE THAT SARP IS A TOBACCO-FREE FACILITY AND I WILL BE PROHIBITED FROM USING TOBACCO OR VAPING PRODUCTS IN ANY FORM UPON ARRIVAL.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

PATIENT'S NAME (LAST, FIRST, Middle Initial)		SEX
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**NMCS D SARP HEALTH AND PHYSICAL EVALUATION SCREENING (SHAPES)**

**PART 2 – TO BE FILLED OUT BY MEDICAL PROVIDER**

<b>Vital Signs:</b>	
Blood Pressure:	Respirations:
Pulse:	Temperature:
Current pain rating (0 to 10):	CIWA/COWS:
Location and explanation of pain:	

**Physical Examination:**

<b>Exam</b>	<b>Normal</b>	<b>Abnormal Findings</b>
HEENT		
HEART		
LUNGS		
ABDOMEN		
EXTREMITIES		
MSK		
SKIN		
NEURO		

**SARP requires the following labs to be ordered within the time indicated to the right of each item.**  
Please enter the most recent date for the labs listed below, ordering anew if necessary.

<b>Immunizations:</b>	<b>Date: (DDMMYYYY)</b>
<b>****Please attach Force IMR Report if available ****</b>	
PPD with read (within the last year) or Chest X-ray if known PPD converter	
Influenza (within the last year)	
<b>Labs:</b>	<b>Date: (DDMMYYYY)</b>
CHEM 18 (within the last 30 days)	
CBC (within the last 30 days)	
UDS (within the last 30 days)	
HIV-1/2 Ag/Ab Screen 4 <sup>th</sup> Gen (within the last year)	
HCG (females only) (within the last 30 days)	

**Please list patient's current medication(s) in the table below:**


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**NMCS D SARP HEALTH AND PHYSICAL EVALUATION SCREENING (SHAPES)**

**PART 2 – TO BE FILLED OUT BY MEDICAL PROVIDER**

**SARP is a tobacco-free program and nicotine must be prescribed for tobacco users.** If patient uses tobacco, please ensure outpatient prescriptions have been ordered as clinically indicated:

Nicotine transdermal patch	<input type="checkbox"/> 7mg patch	or	<input type="checkbox"/> 14mg patch	or	<input type="checkbox"/> 21mg patch
Nicotine replacement gum/lozenge	<input type="checkbox"/> 2mg gum/lozenge	or	<input type="checkbox"/> 4mg gum/lozenge		

**SARP requires its participants to be able to ambulate and use stairs without assistance of any kind.**

Is patient able to ambulate and climb stairs without assistance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**SARP requires participants to be medically and mentally stable and appropriate for 5-week residential substance abuse treatment.**

Is patient medically and mentally stable and appropriate for 5-week residential substance abuse treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**SARP requires participants to be clear of all appointments (medical, dental, legal, etc.) during attendance.**

Is patient clear of all appointments (medical, dental, legal, etc.) for the next two months? If "No," please explain here:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Additional Provider Comments:**

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**Printed Provider Name and Credentials:**

**Location and Contact Information:**

**Signature:**

**Date:**

PATIENT'S NAME (LAST, FIRST, Middle Initial)		SEX
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