

**SUBSTANCE ABUSE REHABILITATION PROGRAM (SARP)
NAVAL MEDICAL CENTER SAN DIEGO
PATIENT ADMIN REQUEST FORM**

----- THIS SECTION TO BE COMPLETED BY THE COMMAND REPRESENTATIVE (PLEASE TYPE) -----

Services Requested: Screening PRIME for Life **Treatment:** OP IOP Residential

Rate/Rank (if applicable)		Last Name		First		MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
DODID		LAST 4 SSN	Date of Birth (DD/MMM/YYYY)		Status: <input type="checkbox"/> USN <input type="checkbox"/> USMC <input type="checkbox"/> USA <input type="checkbox"/> USAF <input type="checkbox"/> USCG <input type="checkbox"/> Reservist/TAR <input type="checkbox"/> Civilian		
Service Member Personal Address:				Service Member Government E-Mail address:			
				Service Member Personal E-Mail address:		Service Member Cell Phone Number:	
Command's Complete Name and Mailing Address:				Command Phone Quarterdeck/Duty Phone:			
				Commercial:		DSN:	
NAME/RANK COMMAND DAPA/SACO/ADAPT/CDAR				Phone:		Cell:	
				Email:			
NAME/RANK COMMAND SENIOR ENLISTED LEADER (CMC, SgtMaj, etc.)				Phone:		Cell:	
				Email:			
NAME/RANK COMMANDING OFFICER (CO, OIC, etc.)				Phone:		Cell:	
				Email:			
1. Has the member had prior Treatment(s)? <input type="checkbox"/> Yes (Date(s)) <input type="checkbox"/> No Types of treatment/care received: <input type="checkbox"/> PRIME for Life <input type="checkbox"/> OP <input type="checkbox"/> IOP <input type="checkbox"/> Residential <input type="checkbox"/> DETOX							
2. Has the member been Screened for a Substance Use Disorder? <input type="checkbox"/> Yes (when/where/recommended care) <input type="checkbox"/> No <input type="checkbox"/> SARP Point Loma (Date:) <input type="checkbox"/> NMCS (Date:) <input type="checkbox"/> Other: (Location and Date:) <input type="checkbox"/> PRIME for Life <input type="checkbox"/> OP <input type="checkbox"/> IOP <input type="checkbox"/> Residential <input type="checkbox"/> Continuing Care <input type="checkbox"/> DETOX							
All Legal Issues need to resolved prior to commencement of Treatment							
3. Is the member pending any legal issues? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, below, describe legal issue and expected resolution date.							
4. Is there a Military Protective Order in place? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, below, describe duration of MPO and restrictions in place.							
5. Is the member pending any of the following: <input type="checkbox"/> Admin Sep <input type="checkbox"/> Medical Appts/Procedures <input type="checkbox"/> Med Board <input type="checkbox"/> LIMDU							
6. Please provide non-availability dates to prevent delays due to rescheduling and or cancellation: Dates not available:							

----- FOR SARP USE ONLY -----

SCREENING – Scheduling Information			
Date Requested (DD/MMM/YYYY)	Date Assigned (DD/MMM/YYYY)	Location Assigned: <input type="checkbox"/> Point Loma	
TREATMENT – Scheduling Information			
Disengaged: <input type="checkbox"/> IOP <input type="checkbox"/> Residential Date:			
Date Requested (DD/MMM/YYYY)	Date Assigned (DD/MMM/YYYY)	Service: <input type="checkbox"/> PRIME for Life <input type="checkbox"/> OP <input type="checkbox"/> IOP <input type="checkbox"/> Residential	
First Contact Date (DD/MMM/YYYY) E/T:	Second Contact Date (DD/MMM/YYYY) E/T:	Third Contact Date (DD/MMM/YYYY) E/T:	Fourth Contact Date (DD/MMM/YYYY) E/T:

CHCS: _____ DEERS/MRG: _____ DBASE: _____ PACKAGE: E-Mailed/SAFE _____ HAIMS: _____

FOR QA: _____

DAPA/SACO Packet SF-513 Other SPEC Documents SF-600 SHAPES PE TAD LES Flight Info NEG COVID TEST