SUBSTANCE ABUSE REHABILITATION PROGRAM
CLINICAL PACKAGE

PATIENT INFORMATION

Sponsor SSN:_____

Last Name: _____ First Name: _____ MI: _____

Screening Date: ____/____/_____ Facility Code: _____ Staff Number: _____

Previous TX: Yes No If Yes, Where? _____ When? ____/____/_____

Marital Status: Single Married Divorced Widowed Separated

SEX: Male Female Age:_____ Birth Date: ____/____/_____ Education level: _____

RACE: Black White Asian/Pacific Islander Hispanic Native American Other

REFERRAL CONTACT

Name:_____

Command: _____

Telephone: Commercial ( )_____ DSN _____

Patient Telephone: Home ( )_____ Work ( )_____

MILITARY INFORMATION

BRANCH OF SERVICE: Navy Air Force Army Marines Coast Guard National Guard Civilian

Status: Active Duty Reserve Retired TAR Dependent Other

ADSD: ____/____/_____ EAOS: ____/____/_____ PRD: ____/____/_____

Command _____ UIC: _____

City _____ State _____ Zip _____

Telephone: Commercial ( )_____ DSN _____

PRIMARY NEXT OF KIN/EMERGENCY CONTACTS

Name_____

Relation to Patient_____

Street_____ City _____ State _____ Zip _____

Telephone: Work ( )_____ Home ( )_____

Patient Name	Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth
Branch of Service	Organization	
Sponsor's Name	Relationship to Sponsor	