|  |
| --- |
| Fort Meade Behavioral Health Inprocessing    SM Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DoD ID: |
|  |

**Age:  
Rank:  
MOS:  
Unit:  
Military Branch:  
Patient Contact Number:  
Unit Contact Number:**

**Arrival Date to Fort Meade**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been seen by Behavioral Health, FAP, SUDCC, or other BH services in the past 180 days?** Yes No

**If yes, list where:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any current Behavioral Health or safety concerns?** Yes No

**Current Medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Over the last month, have you had thoughts of harm to self or others?** Yes No