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| --- |
| 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