

**PATIENT INTAKE/SCREENING RECORD (PIR)**

For use of this form, see DA PAM 600-85; the proponent agency is ODCSPER

**REQUIREMENTS CONTROL  
SYMBOL CSGPA-1400**

SEE FOLLOWING PAGE FOR PRIVACY ACT STATEMENT

**SECTION I - IDENTIFICATION**

1. DATE ENROLLED/SCREENED (YYYYMMDD)		2. PATIENT IDENTIFICATION		3. DATE OF BIRTH (YYYYMMDD)	
4. SERVICE AREA CODE		5. NAME OF COMMUNITY COUNSELING CENTER			
6. DEPARTMENT (Check one)		7. ELIGIBILITY CATEGORY (Check one)		8. CASE FINDING METHOD (Check one)	
<input type="checkbox"/> A. Army <input type="checkbox"/> F. Air Force <input type="checkbox"/> N. Navy <input type="checkbox"/> M. Marine <input type="checkbox"/> P. Coast Guard <input type="checkbox"/> W. Public Health Svc. <input type="checkbox"/> D. DOD Agency <input type="checkbox"/> X. Other		<input type="checkbox"/> A. Active Duty <input type="checkbox"/> B. Active Duty for Training <input type="checkbox"/> C. Cadet/Midshipman <input type="checkbox"/> D. Inactive Duty Training <input type="checkbox"/> E. Retired Military <input type="checkbox"/> F. Family Member of Military <input type="checkbox"/> G. US Civilian Employee <input type="checkbox"/> H. Local National <input type="checkbox"/> I. Family Member of Civilian Employee <input type="checkbox"/> J. Family Member of Retired Military <input type="checkbox"/> K. Minor Family Member (All Categories) <input type="checkbox"/> X. Other		a. BIO-CHEMICAL <input type="checkbox"/> CI. Cdr. Dir. Individual <input type="checkbox"/> CU. Cdr. Dir. Unit <input type="checkbox"/> CB. Cdr. Dir. Breathalyzer <input type="checkbox"/> AT. Applicant/ Accession Test <input type="checkbox"/> PD. Physician Directed <input type="checkbox"/> MA. Mishap/Accident (Civ only) <input type="checkbox"/> VT. Voluntary Test (Civ only) b. NON BIO-CHEMICAL <input type="checkbox"/> CD. Cdr/UPV Referral <input type="checkbox"/> DW. DWI/DUI <input type="checkbox"/> FM. Family Member Referral <input type="checkbox"/> IA. Investigation/ Apprehension <input type="checkbox"/> MD. Medical Referral <input type="checkbox"/> SR. Self Referral <input type="checkbox"/> SC. Security Clearance Check <input type="checkbox"/> XX. Other Source (School, Chaplain, etc.)	

**SECTION II - MILITARY PERSONNEL AND CIVILIAN EMPLOYEE DATA**

9. CIVILIAN EMPLOYEE CONSENT TO RELEASE INFORMATION TO SUPERVISOR		10. COMPONENT (Check one)		11. GRADE		12. SEX		13. PATIENT MACOM	
<input type="checkbox"/> A. AGREES <input type="checkbox"/> D. DISAGREES <input type="checkbox"/> Y. NOT APPLICABLE		<input type="checkbox"/> A. Active/Regular <input type="checkbox"/> G. National Guard <input type="checkbox"/> R. Reserve <input type="checkbox"/> C. Civilian				<input type="checkbox"/> F. FEMALE <input type="checkbox"/> M. MALE			
14. MANDATORY TESTING POSITION (Civilian only) (Check one)									
<input type="checkbox"/> A. Aviation <input type="checkbox"/> B. Guard/Police		<input type="checkbox"/> C. PRP <input type="checkbox"/> D. ASAP		<input type="checkbox"/> X. Other Designated Position <input type="checkbox"/> Y. Not Applicable					

**SECTION III - DRUG/ALCOHOL DIAGNOSIS (Physician Use Only)**

15a. PHYSICIAN DIAGNOSIS (List primary diagnosis first)						15b. DIAGNOSIS CODE					
16. TYPED NAME AND GRADE OF PHYSICIAN						17. SIGNATURE OF PHYSICIAN					

**SECTION IV - ENROLLMENT DECISION**

18. ENROLLMENT DECISION (Check one)			19. BASIS FOR ENROLLMENT/ SCREENING			20. ENROLLMENT FACILITY (Check one)		
<input type="checkbox"/> A. Enroll (Complete items 19-20) <input type="checkbox"/> B. Do Not Enroll (Complete Items 19-21)			PRIMARY    SECONDARY    TERTIARY			<input type="checkbox"/> A. Community Counseling Center <input type="checkbox"/> B. Adolescence Counseling Service (ASACS) <input type="checkbox"/> C. Civilian Facility		
21. REASON FOR NOT ENROLLING (Check one)								
<input type="checkbox"/> A. Refer for A/D Prevention Training (ADAPT) <input type="checkbox"/> B. Commander Decided Not to Enroll <input type="checkbox"/> C. Prescribed Medication Authorized Use			<input type="checkbox"/> D. Patient Refused Services <input type="checkbox"/> E. Refer to Other than A/D Resources <input type="checkbox"/> F. No Alcohol or Other Drug Problem					
22. SIGNATURE OF COUNSELOR			23. NAME AND GRADE OF CLINICAL DIRECTOR			24. SIGNATURE OF CLINICAL DIRECTOR		

## PRIVACY ACT STATEMENT

**AUTHORITY:** 5 USC Section 301, Department Regulations; 10 USC Section 3013, Secretary of the Army; 42 USC Section 290dd; Army Regulation 600-85, Army Substance Abuse Program (ASAP); and E.O. 9397.

**PRINCIPAL PURPOSE:** Information is used to treat, counsel, and rehabilitate individuals who participate in the ASAP.

**ROUTINE USES:** The Patient Administration Division at the medical treatment facility with jurisdiction is responsible for the release of medical information to malpractice insurers in event of malpractice litigation or prospect thereof. Information is disclosed only to the following persons/agencies: to health care components of the Department of Veterans Affairs furnishing health care to veterans; to medical personnel to the extent necessary to meet a bonafide medical emergency; to qualified personnel conducting scientific research, audits or program evaluations, provided that a patient may not be identified in such reports, or his or her identity further disclosed by such personnel; upon the order of a court of competent jurisdiction.

**DISCLOSURE:** Mandatory for active duty service members. Failure to provide required information may be subject to appropriate disciplinary action under the UCMJ. Voluntary for civilian employees. However, failure to provide all the requested information will prohibit processing comprehensive treatment.