

APPENDIX R: PTO SERVICE MEMBER INTAKE QUESTIONNAIRE PTO REFERRAL QUESTIONNAIRE & TRACKING

SECTION I – DEMOGRAPHICAL INFORMATION	
1. DATE OF INTAKE (YYYY/MM/DD)	13. DATE OF INITIAL REFERRAL (YYYY/MM/DD)
2. NAME (LAST, FIRST, MI)	14. ADDRESS, STATE, ZIP
3. RANK	15. YEARS OF SERVICES: ACTIVE DUTY: _____ M-DAY/TRADITIONAL: _____
4. DOB	16. DEPLOYED <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, # OF YEARS _____ IF YES, WHERE & WHEN: _____
5. AGE	17. UNIT IDENTIFICATION CODE/WING IDENTIFICATION
6. TELEPHONE	
7. EMAIL ADDRESS	18. CURRENT STATUS <input type="checkbox"/> M-DAY/TRAD <input type="checkbox"/> ADOS <input type="checkbox"/> AGR <input type="checkbox"/> VETERAN <input type="checkbox"/> TECH
8. MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED	19. HOW DID YOU LEARN ABOUT PTO? <input type="checkbox"/> PAMPHLET <input type="checkbox"/> STATIC DISPLAY <input type="checkbox"/> PREVENTION TRAINING <input type="checkbox"/> BRIEFING <input type="checkbox"/> SEPARATED <input type="checkbox"/> OTHER: _____
9. EMPLOYMENT STATUS <input type="checkbox"/> FULLTIME <input type="checkbox"/> PARTTIME <input type="checkbox"/> UNEMPLOYED	20. REFERRAL IDENTIFICATION TYPE: <input type="checkbox"/> SELF <input type="checkbox"/> COMMAND <input type="checkbox"/> DRUG TESTING <input type="checkbox"/> MEDICAL <input type="checkbox"/> ALCOHOL <input type="checkbox"/> INVESTIGATION/APPREHENSION
10. BRANCH OF SERVICE <input type="checkbox"/> ARNG <input type="checkbox"/> ANG <input type="checkbox"/> OTHER, SPECIFY _____	21. DO YOU HAVE HEALTH INSURANCE? <input type="checkbox"/> NO <input type="checkbox"/> YES
11. MOS/AFSC	22. NAME & TELEPHONE OF COMMANDER:
12. ARE YOU IN A MANDATORY DRUG TESTING GROUP? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, WHICH _____	23. DATE OF COMMANDER'S COUNSELING: (YYYY/MM/DD) *INITIAL ASSESSMENT MUST BE COMPLETED WITHING 30 DAYS OF THE COUNSELING.
SECTION II – AREAS OF NEEDS & REFERRAL INFORMATION	
24. INDICATE PRIMARY, SECONDARY & TERTIARY USE <input type="checkbox"/> THC _____ <input type="checkbox"/> ALCOHOL _____ <input type="checkbox"/> COC _____ <input type="checkbox"/> COC _____ <input type="checkbox"/> PCP _____ <input type="checkbox"/> PCP _____ <input type="checkbox"/> COD/MOR _____ <input type="checkbox"/> COD/MOR _____ <input type="checkbox"/> LSD _____ <input type="checkbox"/> LSD _____ <input type="checkbox"/> AMPH _____ <input type="checkbox"/> OTHER _____ IF OTHER, LIST:	25. OTHER PRESENTING CONCERNS: <input type="checkbox"/> CHILD CARE <input type="checkbox"/> EDUCATION <input type="checkbox"/> EMERGENCY ASSIST. <input type="checkbox"/> EMPLOYMENT <input type="checkbox"/> FINANCIAL <input type="checkbox"/> FAMILY <input type="checkbox"/> HEALTH CARE <input type="checkbox"/> HOUSING <input type="checkbox"/> LEGAL <input type="checkbox"/> MENTAL HEALTH <input type="checkbox"/> RECOVERY SUPPORT <input type="checkbox"/> SPECIAL NEEDS <input type="checkbox"/> TRANSPORTATION <input type="checkbox"/> VETERAN SERVICES <input type="checkbox"/> OTHER: IF OTHER, LIST:
26. DID YOU TEST POSITIVE ON A UA? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, WHICH DRUG? _____	29. AGENCY REFERRED & PHONE :
27. HOURS AVAILABLE FOR REHABILITATION?	30. AGENCY CONTACT:
28. HAVE YOU SIGNED A RELEASE OF CONFIDENTIAL INFORMATION WITH YOUR COMMENDAR? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, DATE: _____	31. DATE OF INITIAL APPOINTMENT (YYYY/MM/DD) & WITH WHOM: