ARMY SUBSTANCE ABUSE PROGRAM (ASAP) ENROLLMENT

For use of this form, see AR 40-66; the proponent agency is the OTSG

The person named below is being referred to the ASAP for a comprehensive assessment to determine whether or not the individual meets the criteria for enrollment.

1. Name *(Last, First, MI).*	2. Rank/Grade.	3. SSN.	4. DOB *(YYYYMMDD)*	5. Yrs Act/Fed Svc.

6. Is Servicemember/Employee expected to depart installation within 90 days?	7. Is Servicemember/Employee on flying status?	8. Is Servicemember/Employee involved in Personnel Reliability Program?
☐ **YES** **NO** ☐	☐ **YES** **NO** ☐	☐ **YES** **NO** ☐

9. Type of Referral: Biochemical *(Type Drug)* _____ Self _____ Command _____ Supervisor _____
Investigation/Apprehension _____ Medical _____ Other _____

10. Record of Civilian Arrests/Convictions, Courts Martial, Company Punishments, and Disciplinary Problems, including those Pending: *(Specific dates and offenses)*

_____

_____

11. Performance: *(Give specifics of fair or unsatisfactory ratings)*
Performance/ Efficiency: Excellent _____ Good _____ Fair _____ Unsatisfactory _____
Behavioral/ Conduct: Excellent _____ Good _____ Fair _____ Unsatisfactory _____

12. Reasons for Referral: *(Check appropriate spaces)*

a. Physical Signs

_____Flushed Face

_____Nervousness

_____Red or Bleary Eyes

_____Hand Tremors

_____Hangovers on the Job

_____Minor Illnesses

_____Minor Injuries

_____Unexcused Absences

_____Other _____

_____

b. Personality Changes

_____Irritability

_____Increased Defensiveness

_____Increased Use of Excuses

_____Intolerant of Co-workers or Subordinates

c. Other Behavioral Indicators

_____Decreased Quality of Work

_____Sporadic Work

_____Mood Changes after Lunch

_____Drinking Before Lunch

_____Drinking During the Day

_____Drinking After Lunch

_____Drinking During Duty

_____Longer Lunch Hours

_____Absenteeism

_____Improper Use of Drugs

_____Unusual Excuses for Absences

_____Avoidance of Supervisor or associates

d. Behavioral changes needed for soldier/employee to become effective/functioning in until: _____

_____

_____

13. PATIENT IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility):*

14. Other Problems: Financial _____ Marriage/Family _____ Medical _____ Other _____ *(specify)*

15. Is soldier/employee seen by other helping agencies? Chaplain _____ Other _____
Community Mental Health Service _____

16. Commander's/Supervisor's Recommendation:

_____ No further action needed at this time.

_____ Soldier/employee needs alcohol and/or drug education.

_____ I suspect soldier/employee has an alcohol and/or other drug problem.

_____ Other *(specify).*

17. Immediate Supervisor's Name.	18. Date *(YYYYMMDD)*	19. Phone.
20. Commander's/Supervisor's Signature.	21. Date *(YYYYMMDD)*	22. Phone.

REHABILITATION TEAM MEETING RESULTS *(MANDATORY FOR MILITARY)*

Record of contact with commanders/supervisors concerning this referral - Record face-to-face rehabilitation team meeting results or telephone concurrences, to include dates of programmatic agreements.

Note: Results of rehabilitation team meetings must also be recorded on SF 600.

*TO: FROM: DATE: *(YYYYMMDD)*

1. Per your basic memorandum and agreements made during rehabilitation team meeting on _____ , the following actions have been taken by the Army Substance Abuse Program (ASAP) in an effort to assist referred soldier/employee with his/her problem(s):

_____ Returned to duty, no further action required.

_____ Placed on extended evaluation (30/60 days).

_____ Alcohol/drug education Date *(YYYYMMDD)* _____ Time: _____ Bldg#: _____

_____ Rehabilitation: Track: _____ Date *(YYYYMMDD)* _____ Time: _____ Bldg#: _____

2. If you have any questions, please call the following counselor: _____

at: _____

Clinical Director _____

** Note for Federal Employees: To be completed **ONLY** with written consent of employee.*