Call Date: ____________ **Time:** ____________ **Military Admission Checklist**

Case Manager		Name: ______ Title: ______ E-mail: ______ Phone: ______ Fax: ______
Service Member		Name: ______ SSN: ______ DOB: ______ E-mail: ______ Phone: ______ Address: ______ Branch: ______ Rank: ______ MOS: ______ Permanent Duty Station: ______
Clinical Details		Treatment Track: ☐PTSD ☐ SA ☐ Dual ☐ Crisis Axis I: ______ Axis II/III/IV: ______ ☐SI ☐ HI ☐ Hypervigilance ☐ Nightmares ☐ Trauma ______ ☐ Drug Abuse ☐ Alcohol Abuse ☐ Isolative ☐ Deployments ______
BH Clinician	Contact? ☐ Y ☐ N ☐ Done!	Name: ______ Title: ______ E-mail: ______ Phone: ______ Fax: ______
SA Clinician	Contact? ☐ Y ☐ N ☐ Done!	Name: ______ Title: ______ E-mail: ______ Phone: ______ Fax: ______
Psychiatrist	Contact? ☐ Y ☐ N ☐ Done!	Name: ______ Title: ______ E-mail: ______ Phone: ______ Fax: ______
Other (clinic admin, PEBLO, etc.)	Contact? ☐ Y ☐ N ☐ Done!	Name: ______ Title: ______ E-mail: ______ Phone: ______ Fax: ______
Command (CO, OIC)	Contact? ☐ Y ☐ N ☐ Done!	Name: ______ Title: ______ E-mail: ______ Phone: ______ Fax: ______
Command (SNCO, 1stSgt)	Contact? ☐ Y ☐ N ☐ Done!	Name: ______ Title: ______ E-mail: ______ Phone: ______ Fax: ______
Command (NCO, Leader)	Contact? ☐ Y ☐ N ☐ Done!	Name: ______ Title: ______ E-mail: ______ Phone: ______ Fax: ______
Aftercare Provider (if returning to different clinic)		Name: ______ Title: ______ E-mail: ______ Phone: ______ Fax: ______
Transportation		Provided by: ☐ Patient/Family ☐ Command ☐ PSH Pick-up Date/Time: ______ Pick-up Location: ______
Admission		Projected date: ______