INSTRUCTIONS FOR COMPLETING DD FORM 2792, FAMILY MEMBER MEDICAL SUMMARY

GENERAL.

The DD Form 2792 and attached addenda are completed to identify a family member with special medical needs.

The addenda to the medical summary are completed only if noted in Item 10 of the Demographics/Certification section (p.3).

The Exceptional Family Member Program (EFMP)/ Special Needs Identification and Clearance (SNIAC) Screening Coordinator and the Parent/Guardian or Person of Majority Age sign Items 6.b and 13.b only after all addenda have been completed and the form reviewed for completeness and accuracy.

AUTHORIZATION FOR DISCLOSURE (Page 1)**.**

Health Insurance Portability and Accountability Act (HIPAA) Requirement.

Each adult family member must sign for the release of his/her own medical information. The sponsor or spouse cannot authorize the release of information for those dependent family members who have reached the age of majority. Please consult with your military treatment facility (MTF) or dental treatment facility (DTF) privacy/HIPAA coordinator about questions regarding authorizations for disclosure.

DEMOGRAPHICS/CERTIFICATION (Page 2)**.**

Items 1. Self-explanatory.

Item 2.a. Family Member (FM) Name of family member described in subsequent pages.

Item 2.b. Self-explanatory.

Item 2.c. Applies to Military medical beneficiary only. The Family Member Prefix is assigned when the family member is enrolled in DEERS.

Items 2.d. - i. Self-explanatory.

Items 3.a. - j. All items refer to the sponsor. Self- explanatory.

Item 4.a. Answer Yes if both spouses are on active duty; otherwise answer No.
If Yes, complete Items 4.b. - e. All items refer to the active duty spouse. Self-explanatory.

IItem 5.a. - d. If Yes, enter Social Security Number, name of sponsor and branch of Service. Military only.

Item 6.a. - c. Parent/Guardian or Person of Majority Age. Parent/guardian or person of majority age certifies that the information contained in the DD 2792 is correct. **Individual must ensure that all forms are completed and attached before signing.**

Item 7. Purpose for Completing the Form (X one). Initial Screening Enrollment - Review of medical history for the family member noted for the purpose of determining eligibility for EFMP. Request for government sponsored travel and/or command sponsorship review of projected location(s). Update to previous evaluation for the family member. Qualifies for a change in EFMP status. Used to disenroll an EFMP when he/she no longer has the medical condition that requires enrollment, or when the EFM no longer qualifies as a dependent.

Item 8. Indicate status of medical condition.

Item 9.a. If yes, complete b. - c.

Item 10. Required Addenda. This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum. **Signature of Qualified Medical Provider is required.** Each Military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Items 11.a. - h. Mark (X) all services being provided to the family member.

Item 12.a. Additional Family Member. Answer Yes if there is any member of the family, not including this patient, who has been identified as having special needs.

Item 12.b. Indicate the number of other family members who have been identified as an EFM. **Do not include the individual named in this summary in the count of family members.**

Items 13.a. - e. EFMP/SNIAC/Screening Coordinator or Advisor name, signature, date, facility address, telephone number. Self-explanatory. **Coordinator must ensure that all forms are complete and attached before signing.**

Item 13.f. This area is reserved for Service-specific guidance to validate the form.

MEDICAL SUMMARY beginning on page 4 must be completed by a qualified medical professional.

Sponsor, spouse, or family member of majority age must sign release authorization on page 4 before this summary is completed.

Item 1.a. - c. Pertains to children under 6 years of age. Self-explanatory.

Items 2.a. - d. Temporary Conditions. Self-explanatory.

Item 3.a. Diagnosis. Enter the diagnosis(es), one per line. With the exception of asthma, cancer or mental health, identify all diagnoses that have been active within the last year. For asthma, cancer or mental health, identify all diagnoses active within the last 5 years.

Item 3.b. ICD or DSM. Enter ICD-9-CM or DSM IV designations. **REQUIRED.**

Item 3.c. Medications and Therapies. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 3.d. Enter per diagnosis the number of outpatient visits, ER visits, hospitalizations and ICU admissions for the last 12 months.

Item 4. Prognosis. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 5. Treatment Plan. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 6. Cancer. Self-explanatory.

Item 7. Minimum Health Care Specialty. Codes in the first column are used by Army coding teams only. In column 1, indicate with an X those specialists essential (required) to meet the needs of the patient. For example, if a developmental pediatrician is a child's primary care provided, but a pediatrician can meet the needs, do not mark developmental pediatrician. In column 2, indicate frequency of care. Enter A - Annually; B - Biannually; Q - Quarterly; M - Monthly; Bi - Bimonthly; W - Weekly.

Item 8 - Artificial Openings. Self-explanatory.

Item 9 - Environmental/Architectural Considerations. Self-explanatory.

Item 10. Adaptive Equipment/Special Medical Equipment. Self-explanatory.

Item 11. Comments. Enter any additional information that would assist in determining necessary treatment.

Item 12.a. - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and the date the summary was signed. Self-explanatory.

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY (p.8)**. To be completed by a qualified medical professional.**

This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **Signature of Qualified Medical Provider is required.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a.- d. Self-explanatory.

Items 3.a.- k. Self-explanatory.

Items 4.a. - f. Self-explanatory.

Items 5.a. - d. Self-explanatory.

Items 6.a. - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and date the summary was signed. Self-explanatory.

ADDENDUM 2 - MENTAL HEALTH SUMMARY
(pp. 9 - 10). **To be completed by a qualified clinical provider.**

This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **Signature of Qualified Medical Provider is required.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a. - d. Self-explanatory. Item 2.b. ICD or DSM is **REQUIRED**.

Item 3. Self-explanatory.

Item 4.a. - i. History. Self-explanatory.

Item 5. Prognosis. Self-explanatory. Additional information may be included in Item 9 if more space is required.

Item 6. Treatment Plan. Self-explanatory. Additional information may be included in Item 9 if more space is required.

Item 7. Expected treatment needs within the next year. Mark only one box considering all diagnoses. Self-explanatory.

Item 8. Required Providers and Frequency of Visits. Mark all providers who are required to implement the treatment plan..

Item 9. Comments. Enter any additional information that would assist in determining necessary treatment.

Items 10.a - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and date the summary was signed. Self-explanatory.

ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS (p.11)**. To be completed by a qualified medical professional.**

This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **Signature of Qualified Medical Provider is required.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a.- b. Diagnosis(es). Self-explanatory.

Items 3. Self-explanatory.

Item 4. Coexisting Diagnoses. Indicate coexisting diagnosis.

Item 5. Current Medications. Self-explanatory.

Item 6. Current Interventions/Therapies. Indicate current interventions/therapies, if known.

Item 7. Communication. Self-explanatory.

Item 8. Other Interventions/Therapies Used by the Family. Specify any alternate or complementary therapies used.

Item 9. Behavior. Answer yes if the child exhibits high risk or dangerous behaviors. Additional information may be included in item 14 if more space is required.

Item 10. Cognitive Ability. Indicate appropriate intelligence quotient (IQ), if known.

Item 11. Education. Self-explanatory.

Item 12. Required Medical Services. Self-explanatory.

Item 13. Respite Care Received. Provide the number of hours per month, and the source, e.g., EFMP Respite Care Program, ECHO or Medicaid.

Item 14. General Comments. Self-explanatory.

Item 15. Provider Information. Official Stamp or printed name and signature of the provider completing this summary and date the summary was signed. Self-explanatory.

FAMILY MEMBER MEDICAL SUMMARY

(To be completed by service member, adult family member, or civilian employee.)
(Read Instructions before completing this form.)

OMB No. 0704-0411
OMB approval expires

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 3013, 5013, and 8013; 20 USC 921 - 932; and EO 9397.

PRINCIPAL PURPOSE(S): Information will only be used by personnel of the Department of Defense and Military Departments to evaluate and document the medical needs of family members. This information will enable: (1) Military assignment personnel to match the needs of family members against the availability of medical services and to engage in case management after assessment is made; (2) Civilian personnel offices to determine the availability of medical services to meet the medical needs of family members of DoD and Military Department civilian employees; and (3) Managed Care Support Contractor to support your application for further entitlement, i.e., the Extended Care Health Option (ECHO); and other Service-specific programs that require registration in the Exceptional Family Member Program (EFMP).

ROUTINE USE(S): None.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; failure to respond will preclude the successful processing of an application for travel/command sponsorship.
Mandatory for military personnel; failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

By signing this authorization, you confirm you understand your sponsor will have access to the health information contained herein and in addenda. The sponsor may be held accountable for the accuracy and completeness of the DD 2792 and addenda and should review all pages prior to signing on page 2.

I authorize _____ (MTF/DTF/Civilian Provider) (Name of Provider)
to release my patient information to the Relocation or Suitability Screening Office and/or the Exceptional Family Member/Special Needs Program to be used in the family travel review process and/or registration in the Exceptional Family Member Program. The information on this form and addenda may be used for DoD and Service-specific programs to determine whether there are adequate medical, housing and community resources to meet your medical needs at the sponsor's proposed duty locations.

a. The military medical department will use the information to make recommendations on the availability of care in communities where the sponsor may be assigned or employed.

b. Information that you have a special need (not the nature or scope of the need) may be included in the sponsor's personnel record or be maintained in the community office responsible for supporting families with special needs, if EFMP enrollment criteria are met.

c. The authorization applies to the summary data included on the medical summary form, its addenda and subsequent updates to information on this form. These data may be stored in electronic databases used for medical management or dedicated to the assignment process. Access to the information is limited to representatives from the medical departments, the offices responsible for assignment coordination, and at your request other military agents responsible for care or services.
Start Date: The authorization start date is the date that you sign this form authorizing release of information.
Expiration Date: The authorization shall continue until enrollment in the Exceptional Family Member Program/Special Needs Program is no longer necessary according to criteria specified in DoD Instruction 1315.19, or if family member no longer meets the criteria to qualify as a dependent, or the sponsor is no longer in active military service or employment of the U.S. Government overseas, or completion of assignment coordination, or eligibility determination for specialized services if that is the sole purpose for the completion of the form.

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my or my child's medical records are kept. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed protected information on the basis of this authorization. My revocation will have no impact on disclosures made prior to the revocation.

b. If I authorize my or my child's protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own or my child's protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524. I request and authorize the named provider/treatment facility to release the information described above for the stated purposes.

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization. However, failure to coordinate accompanied assignments prior to OCONUS travel may result in ineligibility for TRICARE Prime status.

e. Failure to release this information or any subsequent revocation may result in ineligibility for community based services, and/or accompanied family travel at government expense.

f. Refusal to sign does not preclude the provision of medical and dental information authorized by other regulations and those noted in this document.

NAME OF PATIENT	SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP TO PATIENT *(If applicable)*	DATE *(YYYYMMDD)*

DEMOGRAPHICS/CERTIFICATION: To be completed by the Sponsor, Parent or Guardian, or Patient

1. PURPOSE OF THIS FORM *(X one)*

- ☐ EFMP REGISTRATION/ENROLLMENT UPDATE
- ☐ REQUEST CHANGE IN EFMP STATUS
- ☐ SUMMARIZE MEDICAL INFORMATION FOR OFFICIAL USES
- ☐ NO LONGER HAVE PREVIOUSLY IDENTIFIED CONDITION
- ☐ FAMILY MEMBER DECEASED*
- ☐ REQUEST FOR GOVERNMENT SPONSORED TRAVEL AND/OR COMMAND SPONSORSHIP
- ☐ NO LONGER QUALIFIES AS A DEPENDENT*
- ☐ DIVORCE/CHANGE IN CUSTODY*
- ☐ OTHER *(Explain)*:

*(*Maintain documentation to verify change in status - do not update medical information.)*

D R A F T

2.a. FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	b. SPONSOR NAME *(Last, First, Middle Initial)*	c. FAMILY MEMBER PREFIX (FMP)	d. SPONSOR SSN

e. FAMILY MEMBER GENDER *(X)*	f. FAMILY MEMBER DATE OF BIRTH *(YYYYMMDD)*	g. CURRENT FAMILY MEMBER MAILING ADDRESS *(Street, Apartment Number, City, State, ZIP Code, APO/FPO)*
☐ MALE ☐ FEMALE		
h. HOME TELEPHONE NUMBER *(Include Area Code/Country Code)*	i. FAMILY HOME E-MAIL ADDRESS	

3.a. SPONSOR RANK OR GRADE	b. DESIGNATION/NEC/MOS/AFSC *(Military only)*	c. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT

d. BRANCH OF SERVICE *(Military only)*

- ☐ ARMY
- ☐ AIR FORCE
- ☐ NAVY
- ☐ MARINE CORPS

e. STATUS *(X one)*

- ☐ REGULAR ACTIVE SERVICE MEMBER
- ☐ RESERVIST
- ☐ CIVILIAN
- ☐ ACTIVE GUARD RESERVE PROGRAM (AGR)
- ☐ NATIONAL GUARD

f. SPONSOR'S CURRENT UNIT MAILING ADDRESS

g. SPONSOR'S OFFICIAL E-MAIL ADDRESS	h. DUTY TELEPHONE NUMBER *(Include Area Code/CountryCode)*	i. MOBILE NUMBER *(Include Area Code/Country Code)*

j. DOES FAMILY MEMBER RESIDE WITH SPONSOR *(X one. If No, explain.)*

- ☐ YES
- ☐ NO

4.a. ARE BOTH SPOUSES ON ACTIVE DUTY? *(Military only) (X one. If Yes, complete 4.b. - e. below)*

- ☐ YES
- ☐ NO

b. ACTIVE DUTY SPOUSE'S NAME *(Last, First, Middle Initial)*	c. BRANCH OF SERVICE	d. RANK/RATE	e. SPOUSE SSN

5.a. IS FAMILY MEMBER ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR'S NAME? *(Military only) (X one)*

- ☐ YES
- ☐ NO

b. IF YES, UNDER WHAT SSN	c. NAME OF SPONSOR *(Last, First, Middle Initial)*	d. BRANCH OF SERVICE

6. CERTIFICATION. **DO NOT CERTIFY BEFORE COMPLETING ENTIRE FORM AND ADDENDA.**

By signing below, we certify that the information submitted on this DD Form 2792 (Medical Summary and the addenda checked below) is complete and accurate.

PARENT/GUARDIAN OR PERSON OF MAJORITY AGE:

a. PRINTED NAME	b. SIGNATURE	c. DATE *(YYYYMMDD)*

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

FOR ADMINISTRATIVE USE ONLY

7. REQUIRED ACTIONS *(X one)*

- ☐ FIRST REVIEW OF MEDICAL HISTORY FOR THE FAMILY MEMBER
- ☐ QUALIFIES FOR CHANGE IN EFMP STATUS:
- ☐ REQUEST FOR GOVERNMENT SPONSORED TRAVEL AND/OR COMMAND SPONSORSHIP - REVIEW PROJECTED LOCATION(S)
- ☐ FAMILY MEMBER NO LONGER HAS PREVIOUSLY IDENTIFIED CONDITION
- ☐ FAMILY MEMBER DECEASED*
- ☐ UPDATE TO A PREVIOUS EVALUATION FOR THE FAMILY MEMBER
- ☐ FAMILY MEMBER NO LONGER QUALIFIES AS A DEPENDENT*
- ☐ DIVORCE/CHANGE IN CUSTODY*
- ☐ OTHER *(e.g., Extended Care Health Option Eligibility)*: *(*Maintain documentation to verify change in status - do not update medical information.)*

D R A F T

8. SUMMARY *(X one)*

☐ ONGOING MEDICAL CONDITIONS ☐ TEMPORARY MEDICAL CONDITIONS ☐ BOTH

9.a. DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES? *(X one)*

☐ YES ☐ NO *(If Yes, complete 9.b. and c.)*

b. LOCATION OF CASE MANAGER *(X)* ☐ MTF ☐ TRICARE ☐ CIVILIAN

c. CASE MANAGER CONTACT INFORMATION

(1) NAME *(Last, First, Middle Initial)*	(2) TELEPHONE NUMBER *(Include Area Code/Country Code)*	(3) ADDRESS *(Include ZIP Code or APO/FPO)*

10. REQUIRED ADDENDA. Complete Item 1 on Addendum 1 (page 8) and item 1 on Addendum 2 (page 9) and item 1 on Addendum 3 (page 11) AND X box below if:

- ☐ ASTHMA ADDENDUM 1 IS REQUIRED AND ☐ ATTACHED
- ☐ MENTAL HEALTH SUMMARY ADDENDUM 2 IS REQUIRED AND ☐ ATTACHED
- ☐ AUTISM SPECTRUM DISORDER/DEVELOPMENTAL DELAY ADDENDUM 3 IS REQUIRED AND ☐ ATTACHED

11. SPECIAL ASSIGNMENT CONSIDERATIONS *(X all that apply)*

- ☐ a. POSSIBLE SPECIAL EDUCATION/EARLY INTERVENTION *(If marked, DD Form 2792-1 must be completed)*
- ☐ b. RECEIVING TRICARE EXTENDED CARE HEALTH OPTION (ECHO) BENEFITS
- ☐ c. RECEIVING SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) FROM THE SOCIAL SECURITY ADMINISTRATION
- ☐ d. RECEIVING SOCIAL SECURITY DISABILITY INSURANCE (SSDI) FROM THE SOCIAL SECURITY ADMINISTRATION
- ☐ e. RECEIVING STATE MEDICAID/MEDICARE WAIVER SERVICES
- ☐ f. RECEIVING VOCATIONAL REHABILITATION SERVICES
- ☐ g. RECEIVING SPECIAL CHILD CARE ACCOMMODATIONS
- ☐ h. OTHER *(Specify)*

12.a. ARE THERE OTHER EFMP MEMBERS IN THE FAMILY *(Not including this family member)***?**

☐ YES ☐ NO **b. IF YES, HOW MANY?** _____

13. ADMINISTRATIVE CERTIFICATION

a. PRINTED NAME *(Last, First, Middle Initial)*	b. TITLE	c. SIGNATURE	d. DATE *(YYYYMMDD)*

e. FACILITY ADDRESS *(Include ZIP Code or APO/FPO)*	f. TELEPHONE NUMBER *(Include area code/Country Code)*	g. OFFICIAL STAMP

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY: To be completed by a Qualified Medical Professional

PART A - PATIENT STATUS *(Authorization by patient or parent/guardian included on Page 1 of this form)*

1. FOR CHILDREN UNDER AGE 6 ONLY

a. IF PATIENT IS LESS THAN 12 MONTHS OLD, WAS IT A PREMATURE BIRTH? *(X one)*

☐ YES ☐ NO

b. DATE OF LAST WELL-CHILD EXAMINATION *(YYYYMMDD)*

c. WERE ALL DEVELOPMENTAL MILESTONES WITHIN NORMAL LIMITS? *(X one. If No, please explain.)*

☐ YES ☐ NO

2. TEMPORARY CONDITIONS THAT MAY IMPACT TRAVEL CONSIDERATIONS IN THE NEXT YEAR

a. DIAGNOSIS	b. ICD OR DSM: REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES

d. TIME FRAME *(Explain anticipated duration of temporary condition and identify any limitations for activities of daily living and travel considerations.)*

D R A F T

3. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV Use item 11 (Comments) if more space is needed.

a. ACTIVE DIAGNOSIS WITHIN LAST YEAR *(If Asthma, Cancer or Mental Health within last 5 years)*	b. ICD OR DSM REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES	d. COMPLETE FOR THE LAST 12 MONTHS:	
If Asthma or RAD is noted, also complete Asthma Addendum 1. If Mental Health is noted, also complete Mental Health Addendum 2. If Autism Spectrum Disorder(ASD)/Developmental Delay (DD) is noted, also complete Addendum 3.				
				(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF ER VISITS (3) NUMBER OF HOSPITALIZATIONS (4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF ER VISITS (3) NUMBER OF HOSPITALIZATIONS (4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF ER VISITS (3) NUMBER OF HOSPITALIZATIONS (4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF ER VISITS (3) NUMBER OF HOSPITALIZATIONS (4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF ER VISITS (3) NUMBER OF HOSPITALIZATIONS (4) NUMBER OF ICU ADMISSIONS

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

4. PROGNOSIS FOR EACH ACTIVE DIAGNOSIS IDENTIFIED IN PART A, ITEM 3 *(Include expected length of treatment, required participation of family members, and if treatment is ongoing)*

5. TREATMENT PLAN FOR EACH ACTIVE DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned over the next three years)*

6. CANCER, ADDITIONAL INFORMATION *(If not addressed in Items 3, 4, and 5) (Indicate date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment completed.)*

IF TREATMENT COMPLETED, DATE *(YYYYMMDD)* _____

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY *(Continued)*: **To be completed by a Qualified Medical Professional**

PART B - REQUIRED CARE

7. MINIMUM HEALTH CARE SPECIALTY REQUIRED FOR CARE

INDICATE THE FREQUENCY OF CARE: **A - ANNUALLY** **B - BIANNUALLY** *(Twice a year)* **Q - QUARTERLY** **M - MONTHLY** **W - WEEKLY**

(1) CARE PROVIDER *(X as appropriate)*			(2) FREQUENCY *(See above)*	(1) CARE PROVIDER *(X as appropriate)*			(2) FREQUENCY *(See above)*
C01		a. ALLERGIST/IMMUNOLOGIST		C56		gg. OTORHINOLARYNGOLOGIST	
C52		b. AUDIOLOGIST		C47		hh. ORTHOPEDIC SURGEON - ADULT	
C42		c. CARDIAC/THORACIC SURGEON		C48		ii. ORTHOPEDIC SURGEON - PEDIATRIC	
C02		d. CARDIOLOGIST - ADULT		C57		jj. PAIN CLINIC	
C03		e. CARDIOLOGIST - PEDIATRIC		C72		kk. PEDIATRIC NURSE PRACTITIONER	
C70		f. CLEFT PALATE TEAM - PEDIATRIC		C30		ll. PEDIATRICIAN	
C05		g. DERMATOLOGIST		C49		mm. PEDIATRIC SURGEON	
C06		h. DEVELOPMENTAL PEDIATRICIAN		C32		nn. PHYSIATRIST *(Physical Rehabilitation)*	
C53		i. DIALYSIS TEAM		C58		oo. PHYSICAL THERAPIST	
C07		j. DIETARY/NUTRITION SPECIALIST		C50		pp. PLASTIC SURGEON - ADULT	
C08		k. ENDOCRINOLOGIST - ADULT		C71		qq. PLASTIC SURGEON - PEDIATRIC	
C09		l. ENDOCRINOLOGIST - PEDIATRIC		C35		rr. PSYCHIATRIST - ADULT	
C10		m. FAMILY PRACTITIONER		C36		ss. PSYCHIATRIST - PEDIATRIC	
C11		n. GASTROENTEROLOGIST - ADULT		C72		tt. PSYCHIATRIST NURSE PRACTITIONER	
C12		o. GASTROENTEROLOGIST - PEDIATRIC		C37		uu. PSYCHOLOGIST - ADULT	
C43		p. GENERAL SURGEON		C38		vv. PSYCHOLOGIST - PEDIATRIC	
C14		q. GENETICS		C33		ww. PULMONOLOGIST - ADULT	
C15		r. GYNECOLOGIST		C76		xx. PULMONOLOGIST - PEDIATRIC	
C17		s. HEMATOLOGIST/ONCOLOGIST - ADULT		C60		yy. RESPIRATORY THERAPIST	
C18		t. HEMATOLOGIST/ONCOLOGIST - PEDIATRIC		C39		zz. RHEUMATOLOGIST - ADULT	
C75		u. INFECTIOUS DISEASE		C40		aaa. RHEUMATOLOGIST - PEDIATRIC	
C20		v. INTERNIST		C61		bbb. SOCIAL WORKER	
C21		w. NEPHROLOGIST - ADULT		C62		ccc. SPEECH AND LANGUAGE PATHOLOGIST	
C22		x. NEPHROLOGIST - PEDIATRIC		C41		ddd. TRANSPLANT TEAM	
C23		y. NEUROLOGIST - ADULT		C51		eee. UROLOGIST - ADULT	
C24		z. NEUROLOGIST - PEDIATRIC		C78		fff. UROLOGIST - PEDIATRIC	
C44		aa. NEUROSURGEON		C99		ggg. OTHER *(Describe)*	
C54		bb. OCCUPATIONAL THERAPIST - ADULT					
C55		cc. OCCUPATIONAL THERAPIST - PEDIATRIC					
C26		dd. OPHTHALMOLOGIST - ADULT					
C27		ee. OPHTHALMOLOGIST - PEDIATRIC					
C57		ff. ORAL SURGEON					

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY *(Continued)*: **To be completed by a Qualified Medical Professional**

8. ARTIFICIAL OPENINGS/PROSTHETICS *(X all that apply)*

- ☐ YES — IF YES:
- ☐ NO

- ☐ F01 - GASTROSTOMY
- ☐ F02 - TRACHEOSTOMY
- ☐ F03 - CSF SHUNT
- ☐ F04 - CYSTOSTOMY
- ☐ F05 - COLOSTOMY
- ☐ F06 - ILEOSTOMY
- ☐ F07 - OTHER UNSPECIFIED PROSTHETICS *(Specify)*
- ☐ F99 - OTHER UNSPECIFIED OPENING *(Specify)*

9. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS

- ☐ R01 - LIMITED STEPS *(If Yes, please explain)*
- ☐ R02 - COMPLETE WHEELCHAIR ACCESSIBILITY
- ☐ R04 - SINGLE STORY/LEVEL HOUSE
- ☐ R05 - CARPET PROHIBITED
- ☐ R99 - OTHER *(Specify)*
- ☐ R03 - AIR CONDITIONING
  - ☐ R03a - TEMPERATURE CONTROL
  - ☐ R03b - HEPA FILTER
  - ☐ R03c - POLLEN CONTROL
  - ☐ R03d - AIR FILTERING

EXPLANATION OF SPECIAL CONSIDERATIONS:

10. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT

- ☐ L03 - APNEA HOME MONITOR
- ☐ L21 - CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY
- ☐ L20 - HOME DIALYSIS MACHINE
- ☐ L13 - HOME NEBULIZER
- ☐ L04 - HEARING AIDS: MAKE: MODEL:
- ☐ L22 - INSULIN PUMP: MAKE: MODEL:
- ☐ L23 - PACEMAKER: MAKE: MODEL:
- ☐ L99 - OTHER *(Specify)*
- ☐ L07 - SPLINTS, BRACES, ORTHOTICS
- ☐ L08 - WHEELCHAIR
- ☐ L12 - HOME OXYGEN THERAPY
- ☐ L14 - HOME VENTILATOR

EXPLANATION OF SPECIAL CONSIDERATIONS:

11. COMMENTS *(Enter additional information to describe this individual's medical needs.)*

PART C - PROVIDER INFORMATION

12.a. PROVIDER PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code/Country Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY: To be completed by a Qualified Medical Professional

1. PATIENT HAS BEEN EVALUATED OR TREATED FOR ASTHMA WITHIN THE PAST 5 YEARS.

☐ NO ☐ YES **IF YES, CONTINUE COMPLETION OF ASTHMA ADDENDUM ITEMS 2 - 6.**

2. MEDICATION HISTORY

a. MEDICATION	b. DOSAGE	c. FREQUENCY	d. APPROXIMATE DATE MEDICATION LAST USED

3. HISTORY ASSOCIATED WITH ASTHMA ATTACKS *(X as applicable)*

YES	NO	
		a. ARE THERE ANY TRIGGERS FOR THE FAMILY MEMBER'S ASTHMA ATTACKS *(stress, environment, exercise)***?**
		b. DOES THE FAMILY MEMBER ROUTINELY *(greater than 10 days per month/four months per year)* **USE INHALED ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS?**
		c. HAS THE FAMILY MEMBER TAKEN ORAL STEROIDS DURING THE PAST YEAR *(prednisone, prednisolone)***? IF YES, NUMBER OF DAYS IN PAST YEAR:**
		d. HAS THE FAMILY MEMBER EVER EXPERIENCED UNCONSCIOUSNESS OR SEIZURES ASSOCIATED WITH ASTHMA ATTACKS?
		e. HAS THE FAMILY MEMBER REQUIRED AN URGENT VISIT TO THE ER OR CLINIC FOR ACUTE ASTHMA DURING THE PAST YEAR? IF "YES', INDICATE THE NUMBER OF VISITS IN THE PAST YEAR:
		f. HAS THE FAMILY MEMBER BEEN HOSPITALIZED FOR PULMONARY DISEASE *(pneumonia, bronchitis, bronchiolitis, croup, RSV)* **DURING THE PAST YEAR? IF "YES', INDICATE THE DATE(S) OF HOSPITALIZATION** *(YYYYMMDD)***:**
		g. DOES THE FAMILY MEMBER HAVE A HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA RELATED CONDITIONS WITHIN THE PAST 5 YEARS? IF "YES', HOW MANY? INDICATE DATE OF LAST ADMISSION *(YYYYMMDD)***:**
		h. HAS THE FAMILY MEMBER REQUIRED MECHANICAL VENTILATION *(Intubation/use of respirator)* **DURING THE PAST 3 YEARS?**
		i. DOES THE FAMILY MEMBER HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?

j. HOW MANY DAYS HAS THE FAMILY MEMBER MISSED SCHOOL/WORK/PLAY DUE TO ASTHMA-RELATED PROBLEMS *(including visits to physicians)* **DURING THE PAST YEAR?**

k. HOW OFTEN DOES THE FAMILLY MEMBER USE HIS/HER RESCUE INHALER OR NEBULIZER MEDICATION *(such as Albuterol or Levalbuterol)* **FOR INCREASED OR ACUTE SYMPTOMS?**

4. DISRUPTION OF ACTIVITY. How often does asthma disrupt the following activities? *(X as applicable)*

(1) ACTIVITY	(2) NEVER A PROBLEM	(3) 2 TIMES A YEAR OR LESS	(4) 3 - 7 TIMES A YEAR	(5) 8 - 10 TIMES A YEAR	(6) AT LEAST MONTHLY	(7) AT LEAST WEEKLY	(8) ALMOST DAILY
a. SLEEP							
b. QUIET ACTIVITY							
c. SOCIALIZING WITH FRIENDS							
d. SCHOOL OR WORK ATTENDANCE							
e. OUTDOOR ACTIVITIES							
f. VIGOROUS/PLAY ACTIVITIES							

5. SEVERITY LEVEL. What is the family member's severity level based on the clinical picture? *(Select one level of severity. Definitions are examples of severity. Pulmonary function tests are required only if clinically indicated.)*

☐	**a. INTERMITTENT ASTHMA**. Intermittent symptoms ≤ 1 time per week. Brief exacerbations (from a few hours to a few days). Nighttime asthma symptoms < 2 times a month. Asymptomatic and normal lung function between exacerbations. PEF or FEV1 ≥ 80% predicted; variability <20%.
☐	**b. MILD PERSISTENT ASTHMA.** Symptoms ≥ 2 times a week but < 1 time per day. Exacerbations may affect sleep and activity. Nighttime asthma symptoms > 2 times a month. PEF or FEV1 ≥ 80% predicted; variability 20 - 30%.
☐	**c. MODERATE PERSISTENT.** Symptoms daily. Exacerbations affect sleep and activity. Nighttime asthma > 1 time a week. Daily use of inhaled short-acting B2 agonist. PEF or FEV1 ≥ 60% and 80% predicted; variability > 30%.
☐	**d. SEVERE PERSISTENT.** Continuous symptoms. Frequent exacerbations. Frequent nighttime asthma symptoms. Physical activities limited by asthma symptoms. PEF or FEV1 ≤ 60% predicted; variability > 30%.

6.a. PROVIDER PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code/Country Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
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FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 2 - MENTAL HEALTH SUMMARY: To be Completed by a Qualified Clinical Provider

1. PATIENT HAS CURRENT OR PAST *(within the last 5 years)* **HISTORY OF MENTAL HEALTH DIAGNOSIS** *(To include attention deficit disorders)*

☐ **NO** ☐ **YES** **IF YES, CONTINUE WITH COMPLETION OF MENTAL HEALTH ADDENDUM.**

2. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV.

a. DIAGNOSIS	b. ICD OR DSM REQUIRED	c. AGE AT DIAGNOSIS	d. COMPLETE FOR THE LAST 5 YEARS
			(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF HOSPITALIZATIONS (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF HOSPITALIZATIONS (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF HOSPITALIZATIONS (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF HOSPITALIZATIONS (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:

3. MEDICATION HISTORY RELATED TO THE DIAGNOSIS LISTED ABOVE; THERAPIES RECEIVED OR RECOMMENDED
(Including frequency of medication and therapy, and their effectiveness)

4. HISTORY

YES	NO	WITHIN THE LAST 5 YEARS, HAS THE PATIENT HAD:
		a. HISTORY OF SUICIDAL GESTURES/ATTEMPTS?
		b. HISTORY OF SUBSTANCE ABUSE?
		c. HISTORY OF ADDICTIVE BEHAVIORS?
		d. HISTORY OF EATING DISORDERS?
		e. HISTORY OF OTHER COMPULSIVE BEHAVIORS?
		f. HISTORY OF PROBLEMS WITH LEGAL AUTHORITY? *(If Yes, specify)*
		g. HISTORY OF PSYCHOTIC EPISODES?
		h. HISTORY OF SERVICES RECEIVED FOR ALLEGATIONS OF FAMILY MALTREATMENT? *(If Yes, and services are delivered by Family Advocacy, note case determination.)*

i. COMMENTS

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 2 - MENTAL HEALTH SUMMARY *(Continued)*: **To be Completed by a Qualified Clinical Provider**

5. PROGNOSIS *(Include past compliance with treatment programs, expected length of treatment, required participation of family members, and if treatment is ongoing.)*

6. TREATMENT PLAN *(Medical, mental health, surgical procedures or therapies related to the patient's mental health condition planned over the next three years)*

7. TREATMENT NEEDS WITHIN THE NEXT YEAR *(Consider increased stressors of residing in new environment (e.g.,stressors of family relocation, isolated posts, deployments, foreign cultures, restricted travel, separation from nuclear family, cost of living.)*

8. PROVIDERS REQUIRED TO IMPLEMENT TREATMENT PLAN AND FREQUENCY OF VISITS

☐ PSYCHIATRIST	☐ PSYCHOLOGIST	☐ SOCIAL WORKER	☐ OTHER *(Specify)*
☐ WEEKLY	☐ WEEKLY	☐ WEEKLY	☐ WEEKLY
☐ BI-MONTHLY	☐ BI-MONTHLY	☐ BI-MONTHLY	☐ BI-MONTHLY
☐ MONTHLY	☐ MONTHLY	☐ MONTHLY	☐ MONTHLY
☐ QUARTERLY	☐ QUARTERLY	☐ QUARTERLY	☐ QUARTERLY
☐ ANNUALLY	☐ ANNUALLY	☐ ANNUALLY	☐ ANNUALLY

9. OTHER COMMENTS *(Include additional information that would assist in determining necessary treatments.)*

10. PROVIDER INFORMATION *(Authorization by patient included on Page 1 of this form.)*

a. PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
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FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS

To be Completed by a Qualified Medical Professional

1. PATIENT HAS BEEN EVALUATED OR RECEIVED TREATMENT(S) FOR AUTISM SPECTRUM DISORDERS AND/OR SIGNIFICANT DEVELOPMENTAL DELAYS *(X one)*

☐ NO ☐ YES IF YES, CONTINUE WITH COMPLETION OF AUTISM AND SIGNIFICANT DEVELOPMENTAL DELAYS ADDENDUM 3, ITEMS 2 - 15.

2.a. DIAGNOSIS(ES) *(X and complete as applicable)*

☐ AUTISTIC DISORDER
☐ ASPERGER'S SYNDROME
☐ PERVASIVE DEVELOPMENTAL DISORDER
☐ OTHER *(Specify)*

b. AGE WHEN DIAGNOSED

3. DATE OF BIRTH *(YYYYMMDD)*

c. DIAGNOSED BY:

☐ CHILD PSYCHOLOGIST ☐ DEVELOPMENTAL PEDIATRICIAN ☐ OTHER PHYSICIAN ☐ OTHER *(Specify)*
☐ CHILD PSYCHIATRIST ☐ MEDICAL MULTIDISCIPLINARY TEAM ☐ SCHOOL-BASED TEAM

4. COEXISTING DIAGNOSES *(X all that apply)*

☐ CHROMOSOMAL ABNORMALITIES
☐ OBSESSIVE COMPULSIVE DISORDER
☐ ATTENTION DEFICIT/HYPERACTIVITY DISORDER
☐ INTERMITTENT EXPLOSIVE DISORDER
☐ CIRCADIAN-RHYTHM SLEEP DISORDER
☐ GENERALIZED ANXIETY DISORDER, ANXIETY DISORDER, NOS
☐ MAJOR DEPRESSIVE DISORDER, DEPRESSIVE DISORDER, NOS
☐ SEIZURE DISORDER
☐ OTHER *(Specify)*

5. CURRENT MEDICATIONS *(Used to treat diagnoses on this page)*

D R A F T

6. CURRENT INTERVENTION THERAPIES

(1) TYPE	(2) SCHOOL HOURS/WEEK *(If known)*	(3) TRICARE HOURS/WEEK *(If known)*	(4) OTHER SOURCE HOURS/WEEK *(If known)*	(5) OTHER *(Identify)*
a. SPEECH THERAPY				
b. OCCUPATIONAL THERAPY				
c. PHYSICAL THERAPY				
d. PSYCHOLOGICAL COUNSELING				
e. INTENSIVE BEHAVIORAL INTERVENTION *(Includes ABA)*				
f. OTHER *(Specify)*				

7. COMMUNICATION *(X)*

☐ VERBAL ☐ NON-VERBAL *(Uses:)*
☐ SIGNING
☐ PICTURE EXCHANGE COMMUNICATION SYSTEM
☐ COMMUNICATION DEVICE
☐ COMBINATION

8. OTHER INTERVENTIONS/THERAPIES USED BY THE FAMILY *(Specify)*

9. BEHAVIOR: CHILD EXHIBITS HIGH RISK OR DANGEROUS BEHAVIOR

☐ YES ☐ NO *(If Yes, provide details in Item 14 below)*

10. COGNITIVE ABILITY *(X)*

☐ <50 ☐ UNKNOWN
☐ 50 - 70 ☐ INDETERMINATE
☐ >70

11. EDUCATION *(X)*

☐ RECEIVES EARLY INTERVENTION
☐ RECEIVES SPECIAL EDUCATION
☐ ATTENDS SPECIAL PRIVATE SCHOOL
☐ ATTENDS PUBLIC SCHOOL
☐ ATTENDS PRIVATE SCHOOL
☐ IS HOME SCHOOLED

12. REQUIRED MEDICAL SERVICES *(X)*

☐ CHILD PSYCHOLOGY ☐ CHILD NEUROLOGY
☐ CHILD PSYCHIATRY ☐ DEVELOPMENTAL PEDIATRICS
☐ OTHER *(Specify)*

13. RESPITE CARE RECEIVED

a. HOURS PER MONTH	b. SOURCE

14. GENERAL COMMENTS *(Include Functional Levels)*

15. PROVIDER INFORMATION

a. PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code)*

(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER

e. MAILING ADDRESS *(Include ZIP Code)*

f. OFFICIAL E-MAIL ADDRESS