

**FAMILY MEMBER MEDICAL SUMMARY**

*(To be completed by service member, adult family member, or civilian employee.)*

*(Read Instructions before completing this form.)*

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**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19; DoDI 1342.12; and E.O. 9397 (SSN) as amended.

**PRINCIPAL PURPOSE(S):** Information will be used by DoD personnel to evaluate and document the special medical needs of family members. This information will enable: (1) military assignment personnel to match the special medical needs of family members against the availability of medical services, and (2) civilian personnel officers to advise civilian employees about the availability of medical services to meet the special medical needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files. The SORNs may be found at <http://privacy.defense.gov/notices>.

**ROUTINE USE(S):** The DoD "Blanket Routine Uses" found at [http://privacy.defense.gov/blanket\\_uses.shtml](http://privacy.defense.gov/blanket_uses.shtml) apply.

**DISCLOSURE:** Voluntary for civilian employees and applicants for civilian employment. 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. The Social Security Number of the sponsor (and sponsor's spouse if dual military) allows the Military Healthcare System and Service personnel offices to work together to ensure any special medical needs of your dependent can be met at your next duty assignment. Dependent special needs are noted in the official military personnel files which are retrieved by name and Social Security Number.

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

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

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

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

<b>2.a. FAMILY MEMBER/PATIENT NAME (Last, First, Middle Initial)</b>	<b>b. SPONSOR NAME (Last, First, Middle Initial)</b>	<b>c. FAMILY MEMBER PREFIX (FMP)</b>	<b>d. SPONSOR SSN</b>
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<b>e. FAMILY MEMBER GENDER (X)</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<b>f. FAMILY MEMBER DATE OF BIRTH (YYYYMMDD)</b>	<b>g. CURRENT FAMILY MEMBER MAILING ADDRESS (Street, Apartment Number, City, State, ZIP Code, APO/FPO)</b>
<b>h. HOME TELEPHONE NUMBER (Include Area Code/Country Code)</b>	<b>i. FAMILY HOME E-MAIL ADDRESS</b>	

<b>3.a. SPONSOR RANK OR GRADE</b>	<b>b. DESIGNATION/NEC/MOS/AFSC (Military only)</b>	<b>c. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT</b>
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<b>d. BRANCH OF SERVICE (Military only)</b> <input type="checkbox"/> ARMY <input type="checkbox"/> AIR FORCE <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS	<b>e. STATUS (X one)</b> <input type="checkbox"/> REGULAR ACTIVE SERVICE MEMBER <input type="checkbox"/> ACTIVE GUARD RESERVE PROGRAM (AGR)	<input type="checkbox"/> RESERVIST <input type="checkbox"/> NATIONAL GUARD	<input type="checkbox"/> CIVILIAN
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**f. SPONSOR'S CURRENT UNIT MAILING ADDRESS**

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

<input type="checkbox"/> YES	<b>b. ACTIVE DUTY SPOUSE'S NAME (Last, First, Middle Initial)</b>	<b>c. BRANCH OF SERVICE</b>	<b>d. RANK/RATE</b>	<b>e. SPOUSE SSN</b>
<input type="checkbox"/> NO				

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

<input type="checkbox"/> YES	<b>b. IF YES, UNDER WHAT SSN</b>	<b>c. NAME OF SPONSOR (Last, First, Middle Initial)</b>	<b>d. BRANCH OF SERVICE</b>
<input type="checkbox"/> NO			

**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:**

<b>a. PRINTED NAME</b>	<b>b. SIGNATURE</b>	<b>c. DATE (YYYYMMDD)</b>
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FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN
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**FOR ADMINISTRATIVE USE ONLY**

**7. REQUIRED ACTIONS** (X one)

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

**8. SUMMARY** (X one)

<input type="checkbox"/>	ONGOING MEDICAL CONDITIONS	<input type="checkbox"/>	TEMPORARY MEDICAL CONDITIONS	<input type="checkbox"/>	BOTH
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**9.a. DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES?** (X one)

<input type="checkbox"/>	YES	<input type="checkbox"/>	NO (If Yes, complete 9.b. and c.)
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**b. LOCATION OF CASE MANAGER** (X)

<input type="checkbox"/>	MTF	<input type="checkbox"/>	TRICARE	<input type="checkbox"/>	CIVILIAN
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**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)
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**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:

<input type="checkbox"/>	ASTHMA ADDENDUM 1 IS REQUIRED AND	<input type="checkbox"/>	ATTACHED
<input type="checkbox"/>	MENTAL HEALTH SUMMARY ADDENDUM 2 IS REQUIRED AND	<input type="checkbox"/>	ATTACHED
<input type="checkbox"/>	AUTISM SPECTRUM DISORDER/DEVELOPMENTAL DELAY ADDENDUM 3 IS REQUIRED AND	<input type="checkbox"/>	ATTACHED

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

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

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

<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	b. IF YES, HOW MANY? _____
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**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
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**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)	b. DATE OF LAST WELL-CHILD EXAMINATION (YYYYMMDD)
<input type="checkbox"/> YES <input type="checkbox"/> NO	
c. WERE ALL DEVELOPMENTAL MILESTONES WITHIN NORMAL LIMITS? (X one. If No, please explain.)	
<input type="checkbox"/> YES <input type="checkbox"/> NO	

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

a. DIAGNOSIS	b. ICD OR DSM <u>REQUIRED</u>	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 limitations.)

**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 REQUIRING CARE WITHIN LAST YEAR (If Asthma, Cancer or Mental Health within last 5 years)	b. ICD OR DSM <u>REQUIRED</u>	c. MEDICATIONS AND SPECIAL THERAPIES (Also annotate rare or special consideration medications used within specified time period)	d. COMPLETE FOR THE LAST 12 MONTHS:
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If Asthma or RAD is noted, also complete Asthma Addendum 1.  
 If Mental Health is noted, to include Attention Deficit Disorders, also complete Mental Health Addendum 2.  
 If Autism Spectrum Disorder(ASD)/Developmental Delay (DD) is noted, also complete Addendum 3.

a.	b.	c.	d.
			(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
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			(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
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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
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**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 BI - BI-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		C77	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 ( <i>Physical Rehabilitation</i> )	
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 ( <i>Describe</i> )	
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
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**MEDICAL SUMMARY (Continued): To be completed by a Qualified Medical Professional**

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

<input type="checkbox"/> YES	IF YES:	<input type="checkbox"/> F01 - GASTROSTOMY	<input type="checkbox"/> F05 - COLOSTOMY
<input type="checkbox"/> NO		<input type="checkbox"/> F02 - TRACHEOSTOMY	<input type="checkbox"/> F06 - ILEOSTOMY
		<input type="checkbox"/> F03 - CSF SHUNT	<input type="checkbox"/> F07 - OTHER UNSPECIFIED PROSTHETICS (Specify)
		<input type="checkbox"/> F04 - CYSTOSTOMY	<input type="checkbox"/> F99 - OTHER UNSPECIFIED OPENING (Specify)

**9. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS**

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

EXPLANATION OF SPECIAL CONSIDERATIONS:

**10. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT (If marked, describe type of equipment in item 11 (Comments) below.)**

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

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
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**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 FAMILY 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 current treatment plan? (Select one level of severity.)

Definitions are examples of severity. Pulmonary function tests are required only if clinically indicated.)

<input type="checkbox"/>	a. INTERMITTENT ASTHMA. Intermittent symptoms $\leq$ 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 $\geq$ 80% predicted; variability $<$ 20%.
<input type="checkbox"/>	b. MILD PERSISTENT ASTHMA. Symptoms $\geq$ 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 $\geq$ 80% predicted; variability 20 - 30%.
<input type="checkbox"/>	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 $\geq$ 60% and 80% predicted; variability $>$ 30%.
<input type="checkbox"/>	d. SEVERE PERSISTENT. Continuous symptoms. Frequent exacerbations. Frequent nighttime asthma symptoms. Physical activities limited by asthma symptoms. PEF or FEV1 $\leq$ 60% predicted; variability $>$ 30%.

6.a. PROVIDER PRINTED NAME OR STAMP	6.b. SIGNATURE	6.c. DATE (YYYYMMDD)
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6.d. TELEPHONE NUMBERS (Include Area Code/Country Code)			6.e. MAILING ADDRESS (Include ZIP Code)	
(1) COMMERCIAL	(2) DSN (Military only)	(3) FAX NUMBER		
6.f. OFFICIAL E-MAIL ADDRESS				

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

**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? <i>(If Yes, specify)</i>
		g. HISTORY OF PSYCHOTIC EPISODES?
		h. HISTORY OF SERVICES RECEIVED FOR ALLEGATIONS OF FAMILY MALTREATMENT? <i>(If Yes, and services are delivered by Family Advocacy, note case determination.)</i>

**i. COMMENTS**

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN
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**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)	
<input type="checkbox"/>					
<input type="checkbox"/>	WEEKLY	<input type="checkbox"/>	WEEKLY	<input type="checkbox"/>	WEEKLY
<input type="checkbox"/>	BI-MONTHLY	<input type="checkbox"/>	BI-MONTHLY	<input type="checkbox"/>	BI-MONTHLY
<input type="checkbox"/>	MONTHLY	<input type="checkbox"/>	MONTHLY	<input type="checkbox"/>	MONTHLY
<input type="checkbox"/>	QUARTERLY	<input type="checkbox"/>	QUARTERLY	<input type="checkbox"/>	QUARTERLY
<input type="checkbox"/>	ANNUALLY	<input type="checkbox"/>	ANNUALLY	<input type="checkbox"/>	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			
f. OFFICIAL E-MAIL ADDRESS					

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN
<b>ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS</b>			
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)			
<input type="checkbox"/> NO <input type="checkbox"/> 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)		b. AGE WHEN DIAGNOSED	3. DATE OF BIRTH (YYYYMMDD)
<input type="checkbox"/> AUTISTIC DISORDER <input type="checkbox"/> PERVASIVE DEVELOPMENTAL DISORDER/NOS <input type="checkbox"/> ASPERGER'S SYNDROME <input type="checkbox"/> OTHER (Specify)			
c. DIAGNOSED BY:			
<input type="checkbox"/> CHILD PSYCHOLOGIST	<input type="checkbox"/> DEVELOPMENTAL PEDIATRICIAN	<input type="checkbox"/> OTHER PHYSICIAN	<input type="checkbox"/> OTHER (Specify)
<input type="checkbox"/> CHILD PSYCHIATRIST	<input type="checkbox"/> MEDICAL MULTIDISCIPLINARY TEAM	<input type="checkbox"/> SCHOOL-BASED TEAM	
4. COEXISTING DIAGNOSES (X all that apply)			
<input type="checkbox"/> CHROMOSOMAL ABNORMALITIES	<input type="checkbox"/> INTERMITTENT EXPLOSIVE DISORDER	<input type="checkbox"/> MAJOR DEPRESSIVE DISORDER, DEPRESSIVE DISORDER, NOS	
<input type="checkbox"/> OBSESSIVE COMPULSIVE DISORDER	<input type="checkbox"/> CIRCADIAN-RHYTHM SLEEP DISORDER	<input type="checkbox"/> SEIZURE DISORDER	
<input type="checkbox"/> ATTENTION DEFICIT/HYPERACTIVITY DISORDER	<input type="checkbox"/> GENERALIZED ANXIETY DISORDER, ANXIETY DISORDER, NOS	<input type="checkbox"/> OTHER (Specify)	
5. CURRENT MEDICATIONS (Used to treat diagnoses on this page)			
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)		8. OTHER INTERVENTIONS/THERAPIES USED BY THE FAMILY (Specify alternate or complementary therapies)	
<input type="checkbox"/> VERBAL <input type="checkbox"/> NON-VERBAL (Uses:)			
<input type="checkbox"/> SIGNING			
<input type="checkbox"/> PICTURE EXCHANGE COMMUNICATION SYSTEM (PECS)			
<input type="checkbox"/> COMMUNICATION DEVICE			
<input type="checkbox"/> COMBINATION			
		9. BEHAVIOR: CHILD EXHIBITS HIGH RISK OR DANGEROUS BEHAVIOR	
		<input type="checkbox"/> YES	<input type="checkbox"/> NO (If Yes, provide details in Item 14 below)
10. COGNITIVE ABILITY (X)	11. EDUCATION (X)		
<input type="checkbox"/> <50 <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> RECEIVES EARLY INTERVENTION	<input type="checkbox"/> ATTENDS PUBLIC SCHOOL	
<input type="checkbox"/> 50 - 70 <input type="checkbox"/> INDETERMINATE	<input type="checkbox"/> RECEIVES SPECIAL EDUCATION	<input type="checkbox"/> ATTENDS PRIVATE SCHOOL	
<input type="checkbox"/> >70	<input type="checkbox"/> ATTENDS SPECIAL PRIVATE SCHOOL	<input type="checkbox"/> IS HOME SCHOOLED	
12. REQUIRED MEDICAL SERVICES (X)		13. RESPITE CARE RECEIVED	
<input type="checkbox"/> CHILD PSYCHOLOGY <input type="checkbox"/> CHILD NEUROLOGY	<input type="checkbox"/> CHILD PSYCHIATRY <input type="checkbox"/> DEVELOPMENTAL PEDIATRICS	a. HOURS PER MONTH	b. SOURCE
<input type="checkbox"/> OTHER (Specify)			
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)	e. MAILING ADDRESS (Include ZIP Code)		
(1) COMMERCIAL	(2) DSN (Military only)	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			