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.

There is a Certification Section on page 3 that should be signed AFTER the entire form is completed by medical provider(s) and the form has been reviewed for completeness and accuracy.

The Parent/Guardian or Person of Majority Age signs block 11b, and the MTF coordinator/authorized reviewer signs block 12b.

A **Qualified Medical Provider** is responsible for assessing whether the services they are eligible to prescribe are within the scope of their practice and their state licensing requirements.

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 unless they are court-appointed guardians. 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).

Item 1. Self-explanatory.

Item 2.a. Family Member (FM). Name of family member described in subsequent pages.
Item 2.b. Sponsor Name. Name of the military member responsible for the family member identified in Item 2.a.
Items 2.c. - e. Self-explanatory.
Item 2.f. Family Member Prefix (FMP). Applies to Miliitary medical beneficiary only. The Family Member Prefix is assigned when the family member is enrolled in DEERS.
Item 2.g. DoD Benefits Number (DBN). This 11-digit number has two components. The first nine digits are assigned to the sponsor; the last two digits identify the specific person covered under that sponsor. The first nine digits do not reflect the sponsor's nine-digit SSN. The DBN can be found above the bar code on the back of the beneficiary's ID card. If the child has not been issued an ID card, enter the first 9 digits of the parent's DBN.
Items 2.h. - j. Self-explanatory.

Items 3.a. - h. All items refer to the sponsor. Self-explanatory.
Item 3.i. Annotate with an "X" whether the family member resides with the sponsor. If the family member does not, then provide an explanation.

Item 4.a. Answer Yes if both spouses are on active duty or if the enrolling spouse was a former member of the U.S. military. If Yes, complete Items 4.b. - e.

Item 5.a. - d. If Yes, enter SSN, name of sponsor and branch of Service. Military only.

Item 6.a. If Yes, complete b. - c. Self-explanatory.

Item 7. Identify current medically necessary adaptive equipment or special medical equipment used by the family member. Include make and model of the equipment.

Item 8. Required Actions. Self-explanatory.

Item 9. Required Addenda. To be completed by the EFMP/Screening Coordinator completing the administrative review/certification. Please note: Each addenda is completed, and submitted for EFMP review, only if applicable to the patient described. **SIGNATURE of a Qualified Medical Provider is REQUIRED.**

Items 10.a. - c. To be completed by the administrator in consultation with the family. Mark (X) all services being provided to the family member.

Items 11.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 applicable forms are completed and attached before signing.**

Items 12.a. - f. The MTF authorized case coordinator/administrator name, signature, date, location of military treatment facility or certifying EFMP program, telephone number, and official stamp. Self-explanatory. **Administrator must ensure that all forms are complete and attached before signing.**

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 1 before this summary is completed. Please complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM. If the patient has an asthma, mental health or autism spectrum disorder/developmental delay diagnosis, enter ONLY the diagnostic description/code on Page 4 and the remainder of the information on the appropriate attached addendum form.

Items 1.a. - c. Place an "X" in the appropriate box if the information is included in an addendum.

Items 2.a. - b. Primary Diagnosis. Enter the primary diagnosis and corresponding diagnostic code for the family member.

Items 3.a. - c. Medication History. Enter all current medications associated with the primary diagnosis, the dosage and frequency medication should be taken.

Items 4.a. - d. Hospital Support for the Last 12 Months. Enter the number of emergency room visits/urgent care visits, hospitalizations, ICU admissions, and number of outpatient visits.

Item 5. Prognosis. Self-explanatory.

Item 6. Treatment Plan for Primary Diagnosis. Include medical and/or surgical procedures, special therapies planned or recommended over the next three years. Also include the expected length of treatment, required participation of family members, and if treatment is ongoing.

Items 7. - 21. Secondary Diagnoses. Follow procedures for Items 2. - 6. above.

Item 22. Minimum Health Care Required. Codes in the first column are used by Army coding teams only. In column 1, mark with an X any specialists **REQUIRED** to meet the patient's needs. If a specialist was used to determine a diagnosis, and is not necessary for ongoing care, **DO NOT** place an X next to that specialist. If a developmental pediatrician is a child's primary care manager, but a pediatrician meets the needs, **DO NOT** mark developmental pediatrician. This section is not a wish list, but should reflect the providers that are necessary to meet the needs of the patient.

Items 23. - 26. Self-explanatory.

Items 27.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this summary, date the summary was signed, telephone number(s) for the provider, email and medical specialty.

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.

Item 1. Diagnostic Description Code. Enter the diagnostic description code (ICD-9-CM or, when approved, ICD-10-CM) for patients evaluated or treated for asthma within the past 5 years and continue the completion of the addendum and sign. **Signature of Qualified Medical Provider is REQUIRED in Item 5.b.**

Items 2. - 4. Self-explanatory.

Item 5.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this addendum, the date the summary was signed, the telephone number(s) for the provider, email, and medical specialty.

ADDENDUM 2 - MENTAL HEALTH SUMMARY (pp. 9 - 10). **To be completed and signed by a qualified medical professional.** This addendum is completed only if applicable to the patient described.

Items 1.a. - c. Diagnosis(es). Complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM if the patient has current or past (within the last 5 years) history of mental health diagnosis (to include attention deficit disorders).

Items 2.a. - c. Medication History. Provide current medications, dosage, and frequency for diagnoses listed in Item 1.a.

Items 2.d. - e. Include any discontinued medication(s) related to the diagnosis(es), with reasons for discontinuing, and the frequency taken.

Items 3.a. - b. Therapy Received or Recommended. Include past compliance with treatment programs, frequency and expected length of treatment, required participation of family members, and if treatment is ongoing.

Items 4.a. - c. Treatment. Insert the number of outpatient visits in the **LAST YEAR**, the number of hospitalizations in the **LAST FIVE YEARS**, and the number of residential treatment admissions in the **LAST FIVE YEARS** (include the date of last admission).

Items 5.a. - h. History. Answer Yes or No, and include additional details as directed on the patient's mental health history for the last five years.

Items 6. - 9. Self-explanatory.

Items 10.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this addendum, the date the summary was signed, the telephone number(s) for the provider, email and medical specialty.

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.

Item 1.a. - c. Indicate the diagnosis(es) using an X. Insert the date when diagnosed and select the appropriate specialty provider(s) or school-based team that diagnosed the patient.

Items 2. - 3. Self-explanatory.

Items 4.a. - d. Current Medications. List all current medications used to treat the diagnosis(es) listed in Items 1 and 3, the dosage, the frequency taken, and the reason prescribed.

Items 5.a. - e. Current Interventions/Therapies. Providing a list of current interventions and therapies is important information for the family travel determination for this patient. The information should be completed by a qualified medical professional in consultation with the family. Self-explanatory.

Item 6. Communication. Using an X, indicate if the patient is verbal or non-verbal. If non-verbal, indicate the appropriate communication methods used.

Item 7. Self-explanatory.

Item 8. Behavior. Answer yes if the child exhibits high risk or dangerous behaviors. Additional information may be included in item 13 if more space is required.

Item 9. Cognitive Ability. Indicate appropriate intelligence quotient (IQ), if known.

Items 10. - 11. Self-explanatory.

Item 12. Respite Care Received. Provide the number of hours per month, and the source, e.g., EFMP Respite Care Program, ECHO or Medicaid.

Item 13. General Comments. Self-explanatory.

Item 14. Provider Information. Official Stamp or printed name, signature, date signed, telephone number(s), official email and medical specialty. Self-explanatory.

Yellow = Member Red = EFMP Coordinator Blue = Doctor

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 Jul 31, 2017

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. **T**his information will enable: (1) military assignment personnel to match the special medical needs of family members against the availability of medical **s**ervices, 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://dpclo.defense.gov/Privacy/SORNSIndex/DODComponentNotices.aspx.

ROUTINE USE(S): DoD Blanket Routine Uses 1, 4, 6, 8, 9, 12, and 15 found at http://dpclo.defense.gov/Privacy/SORNSIndex/BlanketRoutineUses.aspx may 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 annotated 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 determine 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. Summary data may be transmitted (e.g., faxing or emailing) using authorized secure media transfer.
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 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 *(does not pertain to civilian employees)*.

e. Failure to release this information or any subsequent revocation may result in ineligibility for 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)*

Page must be signed by parent/guardian or person of majority of age.

The family is responsible for completing all fields on pages 1-2 and SIGN BLOCK # 11 on Page 3

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 for Government Sponsored Travel
- ☐ Request Change in EFMP Status:
  - ☐ No Longer Have Previously Identified Condition
  - ☐ No Longer Qualifies as a Dependent*
  - ☐ Family Member Deceased*
  - ☐ Divorce/Change in Custody*

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

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

d. FAMILY MEMBER GENDER *(X)*	e. FAMILY MEMBER DATE OF BIRTH *(YYYYMMDD)*	f. FAMILY MEMBER PREFIX (FMP)	g. DOD BENEFITS NUMBER (DBN) *(on back of ID Card)*
☐ Male ☐ Female			

h. CURRENT FAMILY MEMBER MAILING ADDRESS *(Street, Apartment Number, City, State, ZIP Code, APO/FPO)*	i. HOME TELEPHONE NUMBER *(Include Area Code/Country Code)*
	j. 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 ☐ Navy ☐ Air Force ☐ Marine Corps ☐ Coast Guard

e. STATUS *(X one)*

☐ Regular Active Service Member ☐ Active Reserve ☐ Active Guard ☐ Reserves ☐ National Guard ☐ Civilian

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

i. DOES CHILD RESIDE WITH SPONSOR? *(X one. If No, explain.)*

☐ YES ☐ NO

4.a. ARE YOU DUAL MILITARY OR IS YOUR SPOUSE FORMER MILITARY? *(Military only) (X one. If Yes, complete 4.b. - e. below)*

☐ YES ☐ NO	b. 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 OR EVER BEEN ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR'S NAME OR SSN? *(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.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) EMAIL ADDRESS *(If available)*	(3) TELEPHONE NUMBER *(Include Area Code/Country Code)*

7. MEDICALLY NECESSARY EQUIPMENT *(X and complete as applicable)*

	If applicable: (1) MAKE	(2) MODEL
☐ a. COCHLEAR IMPLANT		
☐ b. HEARING AIDS		
☐ c. INSULIN PUMP		
☐ d. PACEMAKER		

☐ e. OTHER EQUIPMENT *(Specify and include make and model as appropriate.)*

FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	SPONSOR NAME	SPONSOR SSN *(Last four)*

FOR ADMINISTRATIVE USE ONLY

8. REQUIRED ACTIONS *(X one)*

- ☐ **First Review of Medical History for the Family Member**
- ☐ **Request for Government Sponsorship/Family Travel**
- ☐ **Update to a Previous Evaluation for the Family Member**
- ☐ **Other** *(e.g., Extended Care Health Option Eligibility)*:
- ☐ **Qualifies for Change in EFMP Status:**
  - ☐ Family Member No Longer Has Previously Identified Condition
  - ☐ Family Member No Longer Qualifies as a Dependent*
  - ☐ Family Member Deceased*
  - ☐ Divorce/Change in Custody*

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

9. REQUIRED ADDENDA.

Verify required addendum is attached and has been signed *(X each that applies)*. Do not submit a blank addendum for EFMP review.

- ☐ **Asthma Addendum 1 is required and** ☐ **Attached.**
- ☐ **Mental Health Summary Addendum 2 is required and** ☐ **Attached.**
- ☐ **Autism Spectrum Disorder/Developmental Delay (AS/DD) Addendum 3 is required and** ☐ **Attached.**

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

- ☐ **a. Possible Special Education/Early Intervention** *(If checked, DD Form 2792-1 must be completed)*
- ☐ **b. Receiving TRICARE Extended Care Health Option (ECHO) Benefits**
- ☐ **c. Receiving State Medicaid/Medicare Waiver Services**

CERTIFICATION

11. CERTIFICATION. DO NOT CERTIFY BEFORE THE MEDICAL PROVIDER COMPLETES THE ENTIRE FORM AND ADDENDA.

By signing below, we certify that the information submitted on this DD Form 2792 is complete and accurate.

PARENT/GUARDIAN OR PERSON OF MAJORITY AGE: MUST be signed - packet cannot be submitted without a signature!

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

12. ADMINISTRATIVE CERTIFICATION

a. PRINTED NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE *(YYYYMMDD)*	f. OFFICIAL STAMP

d. LOCATION OF MILITARY TREATMENT FACILITY OR CERTIFYING EFMP OFFICE	e. TELEPHONE NUMBER *(Include area code/Country Code)*

Pages 4-11 should be completed by an MD, DO, NP or PA that is familiar with the patient's minimum care.

FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	SPONSOR NAME	SPONSOR SSN *(Last four)*

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)*

Please complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM. If the patient has an asthma, mental health, or autism spectrum disorder/developmental delay diagnosis, enter ONLY the diagnostic description/code on this page and the remainder of the information on the appropriate attached addendum form.

1. INFORMATION INCLUDED IN ADDENDUM *(X all that apply)*

☐ **a. Asthma** *(Addendum 1)* ☐ **b. Mental Health/ADHD** *(Addendum 2)* ☐ **c. Autism/Developmental Delay (AS/DD)** *(Addendum 3)*

2. PRIMARY DIAGNOSIS

a. DIAGNOSIS	b. CODE ☐☐☐.☐☐☐☐

3. MEDICATION HISTORY *(Associated with primary diagnosis)*

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

4. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS *(Associated with primary diagnosis)*

a. NUMBER OF ER VISITS/URGENT CARE VISITS	b. NUMBER OF HOSPITALIZATIONS	c. NUMBER OF ICU ADMISSIONS	d. NUMBER OF OUTPATIENT VISITS

5. PROGNOSIS *(X one)*

☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE ☐ NON-COMPLIANT

6. TREATMENT PLAN FOR PRIMARY DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

7. SECONDARY DIAGNOSIS 1

a. DIAGNOSIS	b. CODE ☐☐☐.☐☐☐☐

8. MEDICATION HISTORY *(Associated with secondary diagnosis)*

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

9. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS *(Associated with secondary diagnosis)*

a. NUMBER OF ER VISITS/URGENT CARE VISITS	b. NUMBER OF HOSPITALIZATIONS	c. NUMBER OF ICU ADMISSIONS	d. NUMBER OF OUTPATIENT VISITS

10. PROGNOSIS *(X one)*

☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE ☐ NON-COMPLIANT

11. TREATMENT PLAN FOR SECONDARY DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

Pages 4-11 should be completed by an MD, DO, NP or PA that is familiar with the patient's required minimum care.

FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	SPONSOR NAME	SPONSOR SSN *(Last four)*

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

PART A - PATIENT STATUS *(Continued)*

12. SECONDARY DIAGNOSIS 2

a. DIAGNOSIS	b. CODE
	☐☐☐.☐☐☐☐

13. MEDICATION HISTORY *(Associated with secondary diagnosis)*

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

14. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS *(Associated with secondary diagnosis)*

a. NUMBER OF ER VISITS/URGENT CARE VISITS	b. NUMBER OF HOSPITALIZATIONS	c. NUMBER OF ICU ADMISSIONS	d. NUMBER OF OUTPATIENT VISITS

15. PROGNOSIS *(X one)*

☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE ☐ NON-COMPLIANT

16. TREATMENT PLAN FOR THIS DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

17. SECONDARY DIAGNOSIS 3

a. DIAGNOSIS	b. CODE
	☐☐☐.☐☐☐☐

18. MEDICATION HISTORY *(Associated with secondary diagnosis)*

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

19. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS *(Associated with secondary diagnosis)*

a. NUMBER OF ER VISITS/URGENT CARE VISITS	b. NUMBER OF HOSPITALIZATIONS	c. NUMBER OF ICU ADMISSIONS	d. NUMBER OF OUTPATIENT VISITS

20. PROGNOSIS *(X one)*

☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE ☐ NON-COMPLIANT

21. TREATMENT PLAN FOR THIS DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

Include frequency of care.

FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	SPONSOR NAME	SPONSOR SSN *(Last four)*

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

PART B - REQUIRED MEDICAL SPECIALTIES

22. MINIMUM HEALTH CARE REQUIRED

INDICATE 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		C57	☐	hh. ORAL SURGEON	
C99	☐	b. AUDIOLOGIST		C47	☐	ii. ORTHOPEDIC SURGEON - ADULT	
C52	☐	c. BEHAVIOR ANALYST		C48	☐	jj. ORTHOPEDIC SURGEON - PEDIATRIC	
C42	☐	d. CARDIAC/THORACIC SURGEON		C56	☐	kk. OTORHINOLARYNGOLOGIST	
C02	☐	e. CARDIOLOGIST - ADULT		C77	☐	ll. PAIN CLINIC	
C03	☐	f. CARDIOLOGIST - PEDIATRIC		C72	☐	mm. PEDIATRIC NURSE PRACTITIONER	
C70	☐	g. CLEFT PALATE TEAM - PEDIATRIC		C30	☐	nn. PEDIATRICIAN	
C05	☐	h. DERMATOLOGIST		C49	☐	oo. PEDIATRIC SURGEON	
C06	☐	i. DEVELOPMENTAL PEDIATRICIAN		C32	☐	pp. PHYSIATRIST *(Physical Rehabilitation)*	
C53	☐	j. DIALYSIS TEAM		C58	☐	qq. PHYSICAL THERAPIST	
C07	☐	k. DIETARY/NUTRITION SPECIALIST		C50	☐	rr. PLASTIC SURGEON - ADULT	
C08	☐	l. ENDOCRINOLOGIST - ADULT		C71	☐	ss. PLASTIC SURGEON - PEDIATRIC	
C09	☐	m. ENDOCRINOLOGIST - PEDIATRIC		C99	☐	tt. PODIATRIST	
C10	☐	n. FAMILY PRACTITIONER		C35	☐	uu. PSYCHIATRIST - ADULT	
C11	☐	o. GASTROENTEROLOGIST - ADULT		C36	☐	vv. PSYCHIATRIST - PEDIATRIC	
C12	☐	p. GASTROENTEROLOGIST - PEDIATRIC		C72	☐	ww. PSYCHIATRIST NURSE PRACTITIONER	
C43	☐	q. GENERAL SURGEON		C37	☐	xx. PSYCHOLOGIST - ADULT	
C14	☐	r. GENETICS		C38	☐	yy. PSYCHOLOGIST - PEDIATRIC	
C15	☐	s. GYNECOLOGIST		C33	☐	zz. PULMONOLOGIST - ADULT	
C99	☐	t. GYNECOLOGIST/ONCOLOGIST		C76	☐	aaa. PULMONOLOGIST - PEDIATRIC	
C17	☐	u. HEMATOLOGIST/ONCOLOGIST - ADULT		C99	☐	bbb. RADIATION ONCOLOGIST	
C18	☐	v. HEMATOLOGIST/ONCOLOGIST - PEDIATRIC		C60	☐	ccc. RESPIRATORY THERAPIST	
C75	☐	w. INFECTIOUS DISEASE		C39	☐	ddd. RHEUMATOLOGIST - ADULT	
C20	☐	x. INTERNIST		C40	☐	eee. RHEUMATOLOGIST - PEDIATRIC	
C21	☐	y. NEPHROLOGIST - ADULT		C61	☐	fff. SOCIAL WORKER	
C22	☐	z. NEPHROLOGIST - PEDIATRIC		C62	☐	ggg. SPEECH AND LANGUAGE PATHOLOGIST	
C23	☐	aa. NEUROLOGIST - ADULT		C41	☐	hhh. TRANSPLANT TEAM	
C24	☐	bb. NEUROLOGIST - PEDIATRIC		C51	☐	iii. UROLOGIST - ADULT	
C44	☐	cc. NEUROSURGEON		C78	☐	jjj. UROLOGIST - PEDIATRIC	
C54	☐	dd. OCCUPATIONAL THERAPIST - ADULT		C99	☐	kkk. VASCULAR SURGEON	
C55	☐	ee. OCCUPATIONAL THERAPIST - PEDIATRIC		C99	☐	lll. OTHER *(Describe)*	
C26	☐	ff. OPHTHALMOLOGIST - ADULT					
C27	☐	gg. OPHTHALMOLOGIST - PEDIATRIC					

FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	SPONSOR NAME	SPONSOR SSN *(Last four)*

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

23. 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)*

24. MEDICALLY INDICATED *(as indicated in diagnostic information)* **ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS**

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

(Specify and provide justifications for environmental/architectural considerations):

25. MEDICALLY NECESSARY ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT *(Identified in diagnostic information). (If marked, describe.)*

a. TYPE OF EQUIPMENT *(X)*	b. DESCRIPTION	a. TYPE OF EQUIPMENT *(X)*	b. DESCRIPTION
☐ L03 - APNEA HOME MONITOR		☐ L14 - HOME VENTILATOR	
☐ L31 - COCHLEAR IMPLANT		☐ L22 - INSULIN PUMP	
☐ L21 - CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY		☐ L32 - INTERNAL DEFIBRILLATOR	
☐ L33 - FEEDING PUMP		☐ L23 - PACEMAKER	
☐ L04 - HEARING AIDS		☐ L07 - SPLINTS, BRACES, ORTHOTICS	
☐ L20 - HOME DIALYSIS MACHINE		☐ L08 - WHEELCHAIR	
☐ L13 - HOME NEBULIZER		☐ L99 - OTHER *(Specify)*	
☐ L12 - HOME OXYGEN THERAPY			

26. IDENTIFY ANY LIMITATIONS FOR ACTIVITIES OF DAILY LIVING AND ANY TRAVEL LIMITATIONS *(Please explain.)*

PART C - PROVIDER INFORMATION

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

d. TELEPHONE NUMBERS *(Include Area Code/Country Code)*		e. OFFICIAL E-MAIL ADDRESS	f. MEDICAL SPECIALTY
(1) COMMERCIAL	(2) DSN *(Military only)*		

This page MUST be signed, indicate credentials (MD, DO, NP, PA)

Complete if applicable to patient. If not applicable, leave blank but include addendum in packet. Packet must contain 11 of 11 pages.

FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	SPONSOR NAME	SPONSOR SSN *(Last four)*

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

Complete addendum if patient has been evaluated or treated for asthma within the past five years.

1. DIAGNOSTIC DESCRIPTION CODE (ICD-9-CM or, when approved, ICD-10-CM)

☐☐☐.☐☐☐☐

2. MEDICATION HISTORY

a. MEDICATION(S)	b. DOSAGE	c. FREQUENCY

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

YES	NO	
		a. ARE THERE ANY TRIGGERS FOR THE PATIENT'S ASTHMA ATTACKS *(stress, environment, exercise)*?
		b. DOES THE PATIENT ROUTINELY *(greater than 10 days per month/four months per year)* USE INHALED ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS?
		c. HAS THE PATIENT TAKEN ORAL STEROIDS DURING THE PAST YEAR *(prednisone, prednisolone)*? IF "YES", NUMBER OF DAYS IN PAST YEAR: _____
		d. HAS THE PATIENT EVER EXPERIENCED UNCONSCIOUSNESS OR SEIZURES ASSOCIATED WITH ASTHMA ATTACKS?
		e. HAS THE PATIENT 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 PATIENT 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 PATIENT HAVE A HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA RELATED CONDITIONS WITHIN THE PAST FIVE YEARS? IF "YES", HOW MANY? _____ INDICATE DATE OF LAST ADMISSION *(YYYYMMDD)*: _____
		h. HAS THE PATIENT REQUIRED MECHANICAL VENTILATION *(Intubation/use of respirator)* DURING THE PAST 3 YEARS?
		i. DOES THE PATIENT HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?

j. APPROXIMATE NUMBER OF DAYS THAT THE PATIENT MISSED SCHOOL/WORK/PLAY DUE TO ASTHMA-RELATED PROBLEMS *(including visits to physicians)* DURING THE PAST YEAR?

_____

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

4. SEVERITY LEVEL. What is the patient'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.)*

☐	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%.

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

d. TELEPHONE NUMBERS *(Include Area Code/Country Code)*		e. OFFICIAL E-MAIL ADDRESS	f. MEDICAL SPECIALTY
(1) COMMERCIAL	(2) DSN *(Military only)*		

Be sure to include provider credentials (MD, DO, NP, PA)

FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	SPONSOR NAME	SPONSOR SSN *(Last four)*

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

Complete addendum if the patient has current or past *(duration of 6 months or longer)* history *(within the last 5 years)* of mental health diagnosis *(to include attention deficit disorders)*.

1. DIAGNOSIS(ES). Please complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM.

a. DIAGNOSIS	b. ICD OR DSM (Required)	c. AGE AT DIAGNOSIS

2. MEDICATION HISTORY RELATED TO THE DIAGNOSIS LISTED ABOVE.

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

d. DISCONTINUED MEDICATION(S) RELATED TO DIAGNOSIS(ES) *(Include reason for discontinuing)*	e. FREQUENCY

3.a. THERAPIES RECEIVED OR RECOMMENDED. *(Include past compliance with treatment programs, expected length of treatment, required participation of family members, and if treatment is ongoing.)*	b. FREQUENCY

4. COMPLETE FOR TREATMENT:

a. NUMBER OF OUTPATIENT VISITS IN THE LAST YEAR:	b. NUMBER OF HOSPITALIZATIONS IN THE LAST FIVE YEARS:	c. NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS IN THE LAST FIVE YEARS:	DATE OF LAST ADMISSION *(YYYYMMDD)*:

5. HISTORY *(X and provide details for each "Yes" answer)*

YES	NO	WITHIN THE LAST 5 YEARS, HAS THE PATIENT HAD A:
		a. HISTORY OF SUICIDAL GESTURES/ATTEMPTS? *(If Yes, include dates)*
		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.)*

FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	SPONSOR NAME	SPONSOR SSN *(Last four)*

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

6. TREATMENT PLAN *(Related to the patient's mental health condition planned over the next three years)*.

7. PROGNOSIS *(X one)*

	EXCELLENT		GOOD		FAIR		POOR		GUARDED		UNSTABLE		NON-COMPLIANT

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
	BIANNUALLY	BIANNUALLY	BIANNUALLY	BIANNUALLY
	ANNUALLY	ANNUALLY	ANNUALLY	ANNUALLY

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

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

d. TELEPHONE NUMBERS *(Include Area Code/Country Code)*		e. OFFICIAL E-MAIL ADDRESS	f. MEDICAL SPECIALTY
(1) COMMERCIAL	(2) DSN *(Military only)*		

Be sure to indicate provider credentials.

Complete if applicable to patient. If not applicable, leave blank but include addendum in packet. Packet must contain 11 of 11 pages.

FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	SPONSOR NAME	SPONSOR SSN *(Last four)*

ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS:

To be Completed by a Qualified Medical Professional

Complete addendum if the patient has been evaluated or received treatment(s) for autism spectrum disorders and/or significant developmental delays.

1.a. DIAGNOSIS(ES)

- ☐ Autism Spectrum Disorder
- ☐ Global Developmental Delay
- ☐ Other *(Specify)*

b. AGE WHEN DIAGNOSED

2. DATE OF BIRTH *(YYYYMMDD)*

c. DIAGNOSED BY:

- ☐ Child Psychologist
- ☐ Child Psychiatrist
- ☐ Developmental Pediatrician
- ☐ Other Physician
- ☐ Medical Multidisciplinary Team
- ☐ School-Based Team
- ☐ Other *(Specify)*

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

- ☐ Chromosomal Abnormalities
- ☐ Intermittent Explosive Disorder
- ☐ Major Depressive Disorder, Depressive Disorder, NOS
- ☐ Obsessive Compulsive Disorder
- ☐ Circadian-Rhythm Sleep Disorder
- ☐ Seizure Disorder
- ☐ Attention Deficit/Hyperactivity Disorder
- ☐ Generalized Anxiety Disorder, Anxiety Disorder, NOS
- ☐ Other *(Specify)*

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

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY	d. REASON PRESCRIBED

5. CURRENT INTERVENTION THERAPIES

a. TYPE *(To be completed by a qualified medical professional in consultation with the family)*	b. SCHOOL HOURS/WEEK *(If known)*	c. TRICARE HOURS/WEEK *(If known)*	d. OTHER SOURCE HOURS/WEEK *(If known)*	e. OTHER *(Identify)*
(1) Speech Therapy				
(2) Occupational Therapy				
(3) Physical Therapy				
(4) Psychological Counseling				
(5) Intensive Behavioral Intervention *(Includes ABA)*				
(6) OTHER *(Specify)*				

6. COMMUNICATION *(X)*

- ☐ VERBAL
- ☐ NON-VERBAL *(Uses:)*
  - ☐ Signing
  - ☐ Communication Device
  - ☐ Picture Exchange Communication System (PECS)
  - ☐ Combination

7. OTHER INTERVENTIONS/THERAPIES USED BY THE FAMILY *(Specify alternate or complementary therapies)*

8. BEHAVIOR: CHILD EXHIBITS HIGH RISK OR DANGEROUS BEHAVIOR

☐ YES ☐ NO *(If Yes, provide details in Item 13 below)*

9. COGNITIVE ABILITY *(X)*

- ☐ <50
- ☐ 50 - 70
- ☐ >70
- ☐ Unknown
- ☐ Indeterminate

10. EDUCATION *(X)*

- ☐ Receives Early Intervention
- ☐ Receives Special Education
- ☐ Attends Public School
- ☐ Attends Private School
- ☐ Attends Special Private School
- ☐ Is Home Schooled

11. REQUIRED MEDICAL SERVICES

(X)	a. TYPE	b. FREQUENCY	(X)	a. TYPE	b. FREQUENCY
☐	Child Psychology		☐	Child Neurology	
☐	Child Psychiatry		☐	Developmental Pediatrics	

12. RESPITE CARE RECEIVED

a. HOURS PER MONTH	b. SOURCE

13. GENERAL COMMENTS *(Include Functional Levels)*

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

d. TELEPHONE NUMBERS *(Include Area Code/Country Code)*		e. OFFICIAL E-MAIL ADDRESS	f. MEDICAL SPECIALTY
(1) COMMERCIAL	(2) DSN *(Military only)*		

Be sure to indicate provider credentials.