INSTRUCTIONS FOR COMPLETING DD FORM 2792,
EXCEPTIONAL 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 9 of the Demographics/Certification section. The EFM Screening Coordinator and sponsor sign Items 10a and 10b 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.

The spouse 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 - 8 (Completed by Sponsor or Spouse).
Item 1.a. Application Status (X one).
Initial Screening/Enrollment - First Exceptional Family Member (EFM) application for the family member noted.
Updated Information - Update to a previous EFM evaluation for the family member noted.
Request Disenrollment - Used to disenroll an EFM when he/she no longer has the medical condition that required enrollment, or when the EFM no longer qualifies as a dependent.

Item 1.b. Family Status. Additional Family Member - X if there is another family member who has been identified as an EFM.

Items 2.a. - k. All items refer to sponsor. Self-explanatory.

Item 3. Answer Yes if the sponsor was assigned to current duty station for humanitarian or compassionate reasons, e.g., to ensure that a family member receives health care at a major medical treatment facility.
Enter No if the sponsor is not currently assigned for humanitarian or compassionate reasons.

Item 4. Answer Yes if both spouses are on active duty; otherwise answer No.
If Yes, complete Items 4.a. - c. (Self-explanatory.)

Item 5.a. Exceptional family member name. Enter name for the family member for whom this form will be completed.

Item 5.b. Relationship to sponsor. (Son, daughter, spouse, etc.)

Item 5.c. Date of birth. Self-explanatory.

Item 6. Primary health care system.
Military treatment facility - services provided by a uniformed or civilian provider at the military treatment facility.
TRICARE/Non-MTF - if the provider is a civilian contract provider who provides services under one of the TRICARE options.
State - if the services are provided under Medicaid or another state program.
Other - if the sponsor is civilian.

Item 7. DEERS enrollment. Military only. Self-explanatory.

Item 8. Self-explanatory.

Item 9. Required addenda. (Completed by provider and/or EFMP Screening Coordinator.) Mark (X) those addenda that require completion based on a review of medical records and/or screening of a family member. If the addenda are not required, place an X in the box at the upper right hand corner on each addendum indicating that the form is not applicable.

Item 10.a. Sponsor name, signature, date. **Sponsor must ensure that all forms are complete and attached before signing.** In the event that the sponsor is deployed or otherwise unavailable, the spouse may sign the certification.

Item 10.b. EFM Screening Coordinator name, signature, date. **Coordinator must ensure that all forms are complete and attached before signing.**

MEDICAL SUMMARY.

Sponsor must sign release authorization before Summary is completed.

Items 1.a. - b. Provider name, address, telephone numbers, and fax number. Self-explanatory.

Items 2.a. - b. Provider address and e-mail address. Self-explanatory.

Item 3.a. Diagnoses. Enter the diagnosis(es), one per line.

Item 3.b. Severity. Enter severity of the diagnosis(es).

Item 3.c. ICD or DSM. Enter ICD-9-CM or DSM IV designations.

Item 3.d. Medications and therapies. Self-explanatory.

Item 3.e. Enter the number of visits, hospitalizations, etc., for the last 12 months.

Items 4 - 9. Self-explanatory. Codes in Items 6 and 9 are used by the Army coding teams and should be ignored by persons completing the form.

Item 10. Comments. Enter any additional information to describe this individual's medical needs.

Item 11. (1) Minimum health care specialty. Ignore the codes in the first column under Item 11.a. (used by Army coding teams only). Indicate with an X those specialists required by the patient.

(2) Frequency of care. Enter A - Annually; B - Biannually; Q - Quarterly; M - Monthly; or W - Weekly for each specialist indicated.

Item 12. Name and signature of the provider completing this summary, and date the summary was signed.

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY.

This addendum is completed only if indicated in Item 9, Demographics/Certification.

Items 1.a. - c. Self-explanatory.

Items 2.a.- c. Self-explanatory.

Items 3.a.- e. Self-explanatory.

Items 4 - 6. Self-explanatory.

ADDENDUM 2 - MENTAL HEALTH SUMMARY.

This addendum is completed only if indicated in Item 9, Demographics/Certification.

Items 1.a.-c. Self-explanatory.

Items 2.a.-c. - 5.a.-b. Self-explanatory.

Item 6. Cooperation. Describe patient (guardian if a minor) cooperation with treatment.

Items 7 - 8. Self-explanatory.

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

EXCEPTIONAL FAMILY MEMBER MEDICAL SUMMARY

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

Form Approved
OMB No. 0704-0411
Expires Sep 30, 2006

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.

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 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 (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.

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 family 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

Authority - Public Law 104-191, "Health Insurance Portability and Accountability Act (HIPAA)", August 21, 1996.
This form will not be used for authorization to disclose psychotherapy notes, alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program.

I authorize _____ (MTF/DTF) to release my patient information to the Exceptional Family Member/Special Needs Program to be used in the assignment coordination process. The information on this form and addenda will be used to determine whether there are adequate medical, housing and community resources to meet your special 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.

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 coordination process. Only representatives from the medical department and the offices responsible for EFMP assignment coordination will have access to the information.

Start Date: The authorization start date is the date that you sign this form authorizing the 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 Service specific criteria, or you no longer meet 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.

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 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 my protected information on the basis of this authorization.

b. If I authorize my 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 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 to the named individual/ organization indicated.

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.

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

DEMOGRAPHICS/CERTIFICATION

1.a. APPLICATION STATUS *(X one)*

☐ INITIAL SCREENING/ ENROLLMENT ☐ UPDATED INFORMATION ☐ REQUEST DISENROLLMENT

b. FAMILY STATUS

☐ ADDITIONAL FAMILY MEMBER HAS BEEN IDENTIFIED

2.a. SPONSOR NAME *(Last, First, Middle Initial)*	**b. SSN**	**c. RANK OR GRADE**

d. BRANCH OF SERVICE *(Military only)*	**e. DESIG/NEC/MOS/AFSC** *(Military only)*

f. HOME ADDRESS *(Street, Apartment Number, City, State, ZIP Code)*	**g. DUTY STATION ADDRESS**
	h. E-MAIL ADDRESS

i. HOME TELEPHONE NUMBER *(Include Area Code)*	**j. FAX NUMBER** *(Include Area Code)*	**k. DUTY TELEPHONE NUMBER** *(Include Area Code)* **(1) COMMERCIAL**	**(2) DSN**

3. ARE YOU CURRENTLY ON COMPASSIONATE OR HUMANITARIAN ASSIGNMENT? *(Military only) (X one)* ☐ YES ☐ NO

4. ARE BOTH SPOUSES ON ACTIVE DUTY? *(X one. If Yes, answer a., b., and c. below)* ☐ YES ☐ NO ☐ N/A

a. SPOUSE'S NAME *(Last, First, Middle Initial)*	**b. RANK/RATE**	**c. SSN**

5.a. EXCEPTIONAL FAMILY MEMBER NAME *(Last, First, Middle Initial)*	**b. RELATIONSHIP TO SPONSOR**	**c. DATE OF BIRTH** *(YYYYMMDD)*

6. PRIMARY HEALTH CARE SYSTEM USED BY FM *(X one)*

☐ MILITARY TREATMENT FACILITY ☐ STATE

☐ TRICARE/NON-MTF ☐ OTHER

7. IS FAMILY MEMBER ENROLLED IN DEERS *(Military only) (X one)*

☐ YES **IF YES, UNDER WHAT SSN:** _____

☐ NO **FAMILY MEMBER PREFIX** _____

8. DOES FAMILY MEMBER RESIDE WITH SPONSOR *(X one)*

☐ YES

☐ NO. **IF NO, PROVIDE ADDRESS OF FAMILY MEMBER** *(Include ZIP Code)* **AND EXPLAIN WHY.**

9. REQUIRED ADDENDA *(X as necessary)*

☐ ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY

☐ ADDENDUM 2 - MENTAL HEALTH SUMMARY

10. CERTIFICATION

We certify that the information submitted on this DD Form 2792 (Medical Summary and the addenda checked above) are complete and accurate.

a. SPONSOR *(See Instructions)*

(1) PRINTED NAME	**(2) SIGNATURE**	**(3) DATE** *(YYYYMMDD)*

b. EFMP SCREENING COORDINATOR

(1) PRINTED NAME	**(2) SIGNATURE**	**(3) DATE** *(YYYYMMDD)*

(4) MILITARY TREATMENT FACILITY ADDRESS *(Include ZIP Code)*	**(5) TELEPHONE NUMBER** *(Include area code)*

MEDICAL SUMMARY

PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

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

1.a. PROVIDER NAME

b. TELEPHONE NUMBERS *(Include Area Code)*

(1) COMMERCIAL	(2) DSN	(3) FAX NUMBER

2.a. ADDRESS *(Include ZIP Code)*

b. E-MAIL ADDRESS

PART B - PATIENT STATUS *(To be completed by provider)*

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

a. CURRENT ACTIVE DIAGNOSIS	b. SEVERITY: A - MILD B - MODERATE C - SEVERE	c. ICD OR DSM	d. MEDICATIONS AND SPECIAL THERAPIES		e. COMPLETE FOR THE LAST 12 MONTHS:
					(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

4. PROGNOSIS *(Include expected length of treatment, required participation of family members, and if treatment is ongoing)*

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

6. ARTIFICIAL OPENINGS/PROSTHETICS *(e.g., gastrostomy, tracheostomy, VP shunts, artificial limbs)*

☐ YES IF YES, SPECIFY:

☐ NO

CODING USE ONLY

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

MEDICAL SUMMARY *(Continued)*

PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

7. HISTORY OF CANCER OR LEUKEMIA

☐ **YES** **IF YES, SPECIFY PROJECTED TREATMENT NEEDS:**

☐ **NO**

8. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS *(e.g., limited steps, complete wheelchair accessibility, air conditioning)*

☐ **YES** **IF YES, SPECIFY:**

☐ **NO**

9. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT *(X as applicable)*

☐ **L03** - APNEA HOME MONITOR

☐ **L13** - HOME NEBULIZER

☐ **L08** - WHEELCHAIR

☐ **L07** - SPLINTS, BRACES, ORTHOTICS

☐ **L04** - HEARING AIDS

☐ **L12** - HOME OXYGEN THERAPY

☐ **L14** - HOME VENTILATOR

☐ **L99** - OTHER *(Specify)*

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

MEDICAL SUMMARY *(Continued)*

PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

PART C - REQUIRED CARE *(To be completed by provider)*

11. MINIMUM HEALTH CARE SPECIALTY REQUIRED FOR CARE

INDICATE THE FREQUENCY OF CARE: A - ANNUALLY B - BIANNUALLY Q - QUARTERLY M - MONTHLY W - WEEKLY

(1) CARE PROVIDER *(X as appropriate)*			(2) FREQUENCY	(1) CARE PROVIDER *(X as appropriate)*			(2) FREQUENCY
C01		a. ALLERGIST		C57		ee. PAIN CLINIC	
C52		b. AUDIOLOGIST		C30		ff. PEDIATRICIAN	
C02		c. CARDIOLOGIST		C31		gg. PEDODONTIST	
C03		d. CARDIOLOGIST - PEDIATRIC		C32		hh. PHYSIATRIST	
C05		e. DERMATOLOGIST		C58		ii. PHYSICAL THERAPIST	
C06		f. DEVELOPMENTAL PEDIATRICIAN		C59		jj. PHYSICAL THERAPIST - PEDIATRIC	
C53		g. DIALYSIS TEAM		C34		kk. PODIATRIST	
C07		h. DIETARY/NUTRITION SPECIALIST		C35		ll. PSYCHIATRIST	
C08		i. ENDOCRINOLOGIST - ADULT		C36		mm. PSYCHIATRIST - CHILD	
C09		j. ENDOCRINOLOGIST - PEDIATRIC		C37		nn. PSYCHOLOGIST	
C10		k. FAMILY PRACTITIONER		C38		oo. PSYCHOLOGIST - CHILD	
C11		l. GASTROENTEROLOGIST - ADULT		C33		pp. PULMONOLOGIST	
C12		m. GASTROENTEROLOGIST - PEDIATRIC		C60		qq. RESPIRATORY THERAPIST	
C13		n. GENERAL MEDICAL OFFICER		C39		rr. RHEUMATOLOGIST	
C15		o. GYNECOLOGIST		C40		ss. RHEUMATOLOGIST - PEDIATRIC	
C17		p. HEMATOLOGIST/ONCOLOGIST		C61		tt. SOCIAL WORKER	
C18		q. HEMATOLOGIST/ONCOLOGIST - PEDIATRIC		C62		uu. SPEECH AND LANGUAGE PATHOLOGIST	
C19		r. IMMUNOLOGIST		C42		vv. SURGEON - CARDIAC/THORACIC	
C20		s. INTERNIST		C43		ww. SURGEON - GENERAL	
C21		t. NEPHROLOGIST - ADULT		C44		xx. SURGEON - NEURO	
C22		u. NEPHROLOGIST - PEDIATRIC		C45		yy. SURGEON - ORAL	
C23		v. NEUROLOGIST - ADULT		C47		zz. SURGEON - ORTHOPEDIC - ADULT	
C24		w. NEUROLOGIST - PEDIATRIC		C48		aaa. SURGEON - ORTHOPEDIC - CHILD	
C25		x. NUCLEAR MEDICAL PHYSICIAN		C46		bbb. SURGEON - OTORHINOLARYNGOLOGIST	
C54		y. OCCUPATIONAL THERAPIST		C49		ccc. SURGEON - PEDIATRIC	
C55		z. OCCUPATIONAL THERAPIST - PEDIATRIC		C50		ddd. SURGEON - PLASTIC	
C26		aa. OPHTHALMOLOGIST		C41		eee. TRANSPLANT TEAM	
C27		bb. OPHTHALMOLOGIST - PEDIATRIC		C51		fff. UROLOGIST	
C29		cc. ORTHODONTIST		C99		ggg. OTHER *(Describe)*	
C56		dd. OTORHINOLARYNGOLOGIST					

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

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY *(To be completed by provider)*

☐ X IF NOT APPLICABLE

1.a. PATIENT NAME	b. SPONSOR SSN	c. FAMILY MEMBER PREFIX

2.a. PROVIDER NAME *(PCM or specialty provider)*	b. SIGNATURE	c. DATE *(YYYYMMDD)*

3. MEDICATION HISTORY

a. PAST	b. PRESENT	c. MEDICATION	d. DOSAGE	e. FREQUENCY

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

YES	NO	
		a. ARE THERE ANY TRIGGERS FOR THE FAMILY MEMBER'S ASTHMA ATTACKS *(stress, environmental, 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?

5. 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. SOCIALIZATION WITH FRIENDS							
d. SCHOOL OR WORK ATTENDANCE							
e. OUTDOOR ACTIVITIES							
f. VIGOROUS/PLAY ACTIVITIES							

6. 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 $\leq$ 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%.

☐ 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%.

☐ 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%.

☐ 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%.

ADDENDUM 2 - MENTAL HEALTH SUMMARY *(To be completed by provider)*

☐ X IF NOT APPLICABLE

1.a. PATIENT NAME	b. SPONSOR SSN	c. FAMILY MEMBER PREFIX

2.a. PROVIDER NAME *(PCM or specialty provider)*	b. SIGNATURE	c. DATE *(YYYYMMDD)*

3.a. DIAGNOSIS(ES)	b. AGE AT DIAGNOSIS

4. MEDICATION HISTORY

a. MEDICATION	b. DOSAGE	c. LENGTH OF TIME ON MEDICATION	d. RESPONSE

5. HISTORY OF MENTAL HEALTH HOSPITALIZATIONS

(1) TYPE OF STAY	(2) DATES	(3) DISCHARGE DIAGNOSES
a. HOSPITAL STAYS		
b. PARTIAL-DAY HOSPITALIZATIONS		

6. HOW COOPERATIVE IS/WAS PATIENT WITH TREATMENT? *(Parent/legal guardian cooperation, if a minor.)*

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.)*

☐	NO ASSISTANCE REQUIRED	☐	FEWER THAN 4 CONTACTS	☐	4 OR MORE CONTACTS	☐	INPATIENT SERVICES

8. HISTORY

YES	NO	
☐	☐	a. HISTORY OF SUICIDAL GESTURES/ATTEMPTS?
☐	☐	b. HISTORY OF SUBSTANCE ABUSE/ADDICTIVE BEHAVIORS/EATING DISORDERS?
☐	☐	c. HISTORY OF PROBLEMS WITH AUTHORITY FIGURES?
☐	☐	d. HISTORY OF PSYCHOTIC EPISODES?
☐	☐	e. HISTORY OF FAMILY ADVOCACY PROGRAM INVOLVEMENT? *(If Yes and case occurred in last 18 months, include case determination, treatment and follow-up.)*

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