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 8 of the Demographics/Certification section (p.2).

The Exceptional Family Member Program (EFMP)/ Special Needs Identification and Clearance (SNIAC) Screening Coordinator and the Parent/Guardian or Person of Majority Age sign Items 6b and 9b only after all addenda have been completed and the form reviewed for completeness and accuracy.

AUTHORIZATION FOR DISCLOSURE (Page 1).

Health Insurance Portability and Accountability Act (HIPAA) Requirement.

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

DEMOGRAPHICS/CERTIFICATION (Page 2).

Items 1 - 5 (Completed by Parent/Guardian or family member who has reached the age of majority).

Item 1.a. Exceptional Family Member (EFM). Name of family member described in subsequent pages.

Item 1.b. Applies to Military medical beneficiary only. The Family Member Prefix is assigned when a family member is enrolled in DEERS (see Item 4 below).

Items 1.c. - d. Self-explanatory.

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

Item 3.a. Answer Yes if both spouses are on active duty; otherwise answer No.
If Yes, complete Items 3.b. - e. All items refer to active duty spouse. Self-explanatory.

Item 4. DEERS enrollment. If Yes, enter Social Security Number and family member prefix for the DEERS enrollment. Military only.

Item 5. Self-explanatory. If family member does not live with sponsor, then enter the address where the family member does live and explain why the family member does not live with sponsor.

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

Item 7. Application Status (X one).
Initial Screening Enrollment - First review of medical information 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 7.b. Additional Family Member. X if there is another family member who has been identified as an EFM.

Item 7.c. Indicate the number of other family members who have been identified as an EFM. **Do not include the individual named in this application in the count of family members**.

Item 8. Required Addenda. (Completed by provider and/or EFMP/SNIAC Screening Coordinator.) Place an X next to each addendum that requires completion based on a review of medical records and/or screening of a family member. At this time, also **mark the appropriate response (Yes or No) at the top of each addendum.**

Items 9.a. - e. EFMP/SNIAC Screening Coordinator name, signature, date, MTF address, telephone number. Self-explanatory. **Coordinator must ensure that all forms are complete and attached before signing.**

Item 9.f. This area is reserved for Service-specific guidance to validate the form.

MEDICAL SUMMARY beginning on page 3 must be completed by qualified medical professional.

Sponsor, spouse or family member of majority age must sign release authorization on page 1 before the Summary is completed.

Patient name, sponsor name, Family Member Prefix and Social Security Number. Self-explanatory.

Item 1.a. Diagnosis. Enter the diagnosis(es), one per line. With the exception of asthma, cancer or mental health, identify all diagnoses that have been active within the last year. For asthma, cancer or mental health, identify all diagnoses active within the past 5 years.
Item 1.b. Severity. Enter severity of the diagnosis(es) (A - mild, B - moderate or C - severe).
Item 1.c. ICD or DSM. Enter ICD-9-CM or DSM IV designations. **REQUIRED**.
Item 1.d. Medications and therapies. Self-explanatory. Additional information may be included in item 9 if more space is required.
Item 1.e. Enter per diagnosis the number of visits, hospitalizations, etc., for the last 12 months.

Item 2. Prognosis. Self-explanatory. Additional information may be included in item 9 if more space is required.

Item 3. Treatment Plan. Self-explanatory. Additional information may be included in item 9 if more space is required.

Item 4. History of Cancer or Leukemia. Self-explanatory.

Item 5. Artificial Openings. Self-explanatory.

Item 6.a. Minimum Health Care Specialty. Codes in the first column are used by Army coding teams only. Indicate with an X those specialists essential (required) to meet the needs of the patient. For example, if a developmental pediatrician is a child's primary care provider, but a pediatrician can meet the needs, do not mark developmental pediatrician.
Item 6.b. Frequency of care. Enter A - Annually; B - Biannually (twice a year); Q - Quarterly; M - Monthly; or W - Weekly for each specialist indicated.

Item 7. Environmental/Architectural Considerations. Self-explanatory.

Item 8. Adaptive Equipment/Special Medical Equipment. Self-explanatory.

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

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

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY (p.6). To be completed by qualified medical professional.

This addendum is completed only if indicated in Item 8, page 2, Demographics/Certification, and may be completed by a different provider than pages 3 - 5, if necessary.

Item 1. Self-explanatory.

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

Items 3.a.- j. Self-explanatory.

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

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

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

ADDENDUM 2 - MENTAL HEALTH SUMMARY (pp. 7 - 8). To be completed by qualified clinical provider.

This addendum is completed only if indicated in Item 8, page 2, Demographics/Certification, and may be completed by a different provider than pages 3 - 5, if necessary.

Item 1. Self-explanatory.

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

Item 3. Self-explanatory.

Item 4. Prognosis. Self-explanatory. Additional information may be included in Item 8 if more space is required.

Item 5. Treatment Plan. Self-explanatory. Additional information may be included in Item 8 if more space is required.

Item 6. Treatment needs within the next year. Mark only one box considering all diagnoses. Self-explanatory.

Items 7.a. - c. History. Self-explanatory.

Item 8. Comments. Enter any additional information that would assist in determining necessary treatment.

Item 9. Required Providers. Mark all providers who are required to implement the treatment plan.

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

EXCEPTIONAL FAMILY MEMBER MEDICAL SUMMARY

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

OMB No. 0704-0411
OMB approval expires

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

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

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

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

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 Exceptional Family Member/Special Needs Program to be used in the enrollment and/or 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 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 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.

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.

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

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

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

1.a. EXCEPTIONAL FAMILY MEMBER NAME *(Last, First, Middle Initial)*	b. FAMILY MEMBER PREFIX (FMP)	c. GENDER *(X)* ☐ MALE ☐ FEMALE	d. DATE OF BIRTH *(YYYYMMDD)*

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

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

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

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

3.a. ARE BOTH SPOUSES ON ACTIVE DUTY? *(Military only) (X one. If Yes, complete 3.b. - e. below)* ☐ YES ☐ NO

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

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

☐ YES ☐ NO **IF YES, UNDER WHAT SSN:** _____ **FAMILY MEMBER PREFIX:** _____

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

☐ YES

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

STOP.

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

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

PARENT/GUARDIAN OR PERSON OF MAJORITY AGE:

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

FOR OFFICIAL USE ONLY

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

☐ INITIAL SCREENING ☐ UPDATED INFORMATION ☐ REQUEST DISENROLLMENT

b. ARE THERE OTHER EFMP MEMBERS IN THE FAMILY? ☐ YES ☐ NO **c. IF YES, HOW MANY?** _____

8. REQUIRED ADDENDA. Complete Item 1 on Addendum 1 (page 6) and item 1 on Addendum 2 (page 7) AND X box below if:

☐ ASTHMA ADDENDUM 1 IS REQUIRED

☐ MENTAL HEALTH SUMMARY ADDENDUM 2 IS REQUIRED

☐ DD FORM 2792-1, "EXCEPTIONAL FAMILY MEMBER SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY" IS REQUIRED

9. EFMP/SNIAC SCREENING COORDINATOR

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

d. MILITARY TREATMENT FACILITY ADDRESS *(Include ZIP Code)*	e. TELEPHONE NUMBER *(Include area code)*	f. OFFICIAL STAMP

PATIENT NAME	SPONSOR NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

MEDICAL SUMMARY: To be completed by a Qualified Medical Professional

PART A - PATIENT STATUS

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

a. ACTIVE DIAGNOSIS WITHIN LAST YEAR *(If Asthma, Cancer or Mental Health within last 5 years)*	b. SEVERITY: A - Mild B - Moderate C - Severe	c. ICD OR DSM REQUIRED	d. MEDICATIONS AND SPECIAL THERAPIES	e. COMPLETE FOR THE LAST 12 MONTHS:	
If Asthma or RAD is noted, also complete Asthma Addendum 1. If Mental Health is noted, also complete Mental Health Addendum 2.					
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(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

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

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

4. HISTORY OF CANCER OR LEUKEMIA

☐ YES *(If Yes, specify projected treatment needs)*
☐ NO

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

☐ YES IF YES: ☐ **F01** - GASTROSTOMY ☐ **F05** - COLOSTOMY
☐ NO ☐ **F02** - TRACHEOSTOMY ☐ **F06** - ILEOSTOMY
☐ **F03** - CSF SHUNT ☐ **F07** - OTHER UNSPECIFIED PROSTHETICS *(Specify)*
☐ **F04** - CYSTOSTOMY ☐ **F99** - OTHER UNSPECIFIED OPENING *(Specify)*

PATIENT NAME	SPONSOR NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

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

PART B - REQUIRED CARE

6. MINIMUM HEALTH CARE SPECIALTY REQUIRED FOR CARE

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

	(1) CARE PROVIDER *(X as appropriate)*		(2) FREQUENCY *(See above)*
C01		a. ALLERGIST/IMMUNOLOGIST	
C52		b. AUDIOLOGIST	
C42		c. CARDIAC/THORACIC SURGEON	
C02		d. CARDIOLOGIST - ADULT	
C03		e. CARDIOLOGIST - PEDIATRIC	
C05		f. DERMATOLOGIST	
C06		g. DEVELOPMENTAL PEDIATRICIAN	
C53		h. DIALYSIS TEAM	
C07		i. DIETARY/NUTRITION SPECIALIST	
C08		j. ENDOCRINOLOGIST - ADULT	
C09		k. ENDOCRINOLOGIST - PEDIATRIC	
C10		l. FAMILY PRACTITIONER	
C11		m. GASTROENTEROLOGIST - ADULT	
C12		n. GASTROENTEROLOGIST - PEDIATRIC	
C43		o. GENERAL SURGEON	
C14		p. GENETICS	
C15		q. GYNECOLOGIST	
C17		r. HEMATOLOGIST/ONCOLOGIST - ADULT	
C18		s. HEMATOLOGIST/ONCOLOGIST - PEDIATRIC	
C99		t. INFECTIOUS DISEASE	
C20		u. INTERNIST	
C21		v. NEPHROLOGIST - ADULT	
C22		w. NEPHROLOGIST - PEDIATRIC	
C23		x. NEUROLOGIST - ADULT	
C24		y. NEUROLOGIST - PEDIATRIC	
C44		z. NEUROSURGEON	
C54		aa. OCCUPATIONAL THERAPIST - ADULT	
C55		bb. OCCUPATIONAL THERAPIST - PEDIATRIC	
C26		cc. OPHTHALMOLOGIST - ADULT	
C27		dd. OPHTHALMOLOGIST - PEDIATRIC	
C57		ee. ORAL SURGEON	
C56		ff. OTORHINOLARYNGOLOGIST	

	(1) CARE PROVIDER *(X as appropriate)*		(2) FREQUENCY *(See above)*
C47		gg. ORTHOPEDIC SURGEON - ADULT	
C48		hh. ORTHOPEDIC SURGEON - PEDIATRIC	
C57		ii. PAIN CLINIC	
C30		jj. PEDIATRICIAN	
C49		kk. PEDIATRIC SURGEON	
C32		ll. PHYSIATRIST *(Physical Rehabilitation)*	
C58		mm. PHYSICAL THERAPIST	
C50		nn. PLASTIC SURGEON	
C35		oo. PSYCHIATRIST - ADULT	
C36		pp. PSYCHIATRIST - PEDIATRIC	
C37		qq. PSYCHOLOGIST - ADULT	
C38		rr. PSYCHOLOGIST - PEDIATRIC	
C33		ss. PULMONOLOGIST - ADULT	
C99		tt. PULMONOLOGIST - PEDIATRIC	
C60		uu. RESPIRATORY THERAPIST	
C39		vv. RHEUMATOLOGIST - ADULT	
C40		ww. RHEUMATOLOGIST - PEDIATRIC	
C61		xx. SOCIAL WORKER	
C62		yy. SPEECH AND LANGUAGE PATHOLOGIST	
C41		zz. TRANSPLANT TEAM	
C51		aaa. UROLOGIST	
C99		bbb. OTHER *(Describe)*	

PATIENT NAME	SPONSOR NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

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

7. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS

- ☐ **LIMITED STEPS** *(If Yes, please explain)*
- ☐ **COMPLETE WHEELCHAIR ACCESSIBILITY**
- ☐ **AIR CONDITIONING** *(If Yes, please explain)*
- ☐ **OTHER** *(Specify)*

8. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT

- ☐ **L03** - APNEA HOME MONITOR
- ☐ **L13** - HOME NEBULIZER
- ☐ **L08** - WHEELCHAIR
- ☐ **L07** - SPLINTS, BRACES, ORTHOTICS
- ☐ **L04** - HEARING AIDS
- ☐ **L12** - HOME OXYGEN THERAPY
- ☐ **L14** - HOME VENTILATOR
- ☐ **L99** - HOME DIALYSIS MACHINE
- ☐ **L99** - OTHER *(Specify)*

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

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

10.a. PROVIDER 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			

PATIENT NAME	SPONSOR NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

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?**

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

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

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

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

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

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

PATIENT NAME	SPONSOR NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

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**

☐ **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 *(Currently or experienced within last 5 years)*	b. SEVERITY: A - Mild B - Moderate C - Severe	c. ICD OR DSM REQUIRED	d. AGE AT DIAGNOSIS

3. HISTORY OF MEDICATIONS AND THERAPIES RECEIVED OR RECOMMENDED AND FREQUENCY

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

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

6. 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

PATIENT NAME	SPONSOR NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

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

8. HISTORY

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

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

9. PROVIDERS REQUIRED TO IMPLEMENT TREATMENT PLAN

	PSYCHIATRIST		PSYCHOLOGIST		SOCIAL WORKER		OTHER *(Specify)*

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			