INSTRUCTIONS
DD FORM X678-1 TEST, MEDICAL AND EDUCATIONAL INFORMATION
(This User Guide provides clarifying descriptions and notes on the DD Form X678-1 TEST, Medical and Educational Information.)

GENERAL

The DD Form X678-1 TEST, Medical and Educational Information, informs Sponsors and FMTS staff about possible special medical and/or educational needs of each dependent. Additionally, it guides the losing Appointed FMTS Medical Screener during the review of medical records and the face-to-face interview.

One (1) form is completed for each dependent. This form is completed by the dependent at the age of majority or parent/guardian and the losing Appointed FMTS Medical Screener. It helps identify special needs prior to the face-to-face interview.

NOTE: Identified special needs may require completion of the DD Form 2792, Family Member Medical Summary, and/or DD Form 2792-1, Early Intervention/Special Education Summary, prior to the face-to-face interview.

NOTE: The screening process requires that the DD Form 2792, Family Member Medical Summary, and/or DD Form 2792-1, Early Intervention/Special Education Summary, be completed/updated within twelve (12) months of the projected report date at the new assignment location.

BLOCKS 1a-g: Provides information about the dependent to determine what FMTS Forms are required.

NOTE: The DD Form X678-2 TEST, Dental Health Information, is required for all Services. Reference BLOCKS 1c-d to determine the age of the dependent.

For Airmen, if the dependent is two (2) years of age and older, a DD Form X678-2 TEST, Dental Health Information, is required.

For Soldiers, Sailors, and Marines, if the dependent is six (6) months of age and older, a DD Form X678-2 TEST, Dental Health Information, is required.

NOTE: The DD Form 2792-1, Early Intervention/Special Education Summary, is required if the dependent is under 22 and does not have high school diploma or equivalent certification (unless the dependent is a spouse of the Sponsor). Reference BLOCKS 1d-e to determine the age of the dependent and if the dependent has a high school diploma or equivalent certification.

NOTE: If BLOCK 1f is checked "YES", a DD Form X678-3 TEST, Patient Care Review, is required.

NOTE: If BLOCK 1g is checked "YES", the family must provide the most recent copy of the DD Form 2792, Family Member Medical Summary, and/or DD Form 2792-1, Early Intervention/Special Education Summary (or the automated summary for the Army).

BLOCKS 2-4: Provides Sponsor information.

***NOTE:** The complete Social Security Number is required in order to retrieve the correct Military Healthcare System files and may be needed for Personnel.*

BLOCK 5: For Airmen ONLY, identifies the Servicing PAS CODE for the current assignment location.

BLOCKS 6-7: Provides preferred contact information for the Sponsor.

PART B: MEDICATIONS
Completed by the dependent at the age of majority or parent/guardian and the losing Appointed FMTS Medical Screener. **Do not include Sponsor information for the remainder of this form.**

BLOCK 8: Lists all prescribed medications within the last twelve (12) months, even if they are not currently being used, one (1) medication per line.

NOTE: Birth control prescriptions or over-the-counter drugs should not be included.

NOTE: The losing Appointed FMTS Medical Screener reviews the medication list to determine if any medications are a travel concern.

BLOCK 9: Records if the losing Appointed FMTS Medical Screener advised the dependent to take a 60-90 day supply of prescription medications to the projected physical duty location.

PART C: MEDICAL NEEDS
Completed by the dependent at the age of majority or parent/guardian and the losing Appointed FMTS Medical Screener.

BLOCKS 10-22: Identifies potential medical needs that require a DD Form 2792, Family Member Medical Summary.

NOTE: A checked circle indicates a special medical need that requires a DD Form 2792, Family Member Medical Summary, to be completed/updated before the face-to-face interview and within twelve (12) months of the projected report date to the new assignment location.

BLOCK 23: Records if the Appointed FMTS Medical Screener advised the dependent to see any specialists before moving if the next scheduled visit is within 45 days after arrival to the new duty location.

PART D: EARLY INTERVENTION/EDUCATION
Completed by the dependent at the age of majority or parent/guardian and the losing Appointed FMTS Medical Screener.

NOTE: This section does not apply to spouses, dependents over 22 or children who have a high school diploma or equivalent certification. The "N/A" box must be checked if this section does not apply to the dependent.

BLOCKS 24-27: Identifies potential educational needs that require an Individualized Family Service Plan (IFSP)/Individualized Education Plan (IEP).

NOTE: A checked circle indicates that an IFSP/IEP must be attached to the DD Form 2792-1, Early Intervention/Special

Education Summary, completed/updated before the face-to-face interview and within twelve (12) months of the projected report date to the new assignment location. Do not include Sponsor information.

BLOCK 28: For dependent children ONLY. Records if the losing Appointed FMTS Medical Screener determined that the dependent child required a DD Form 2792, Family Member Medical Summary, based on information on the DD Form 2792-1, Early Intervention/Special Education Summary.

NOTE: The Appointed FMTS Medical Screener reviews all questions and responses in PARTS C and D prior to or during the face-to-face interview.

BLOCK 29: Provides any additional dependent information for this entire form.

BLOCKS 30a-c: Certifies the information provided. This is completed by the dependent at the age of majority or parent/guardian.

PART E: APPOINTED FMTS MEDICAL SCREENER SUMMARY
Completed by the losing Appointed FMTS Medical Screener.

BLOCKS 31a-h: Tracks the travel concerns, medical records, DD Forms, IFSPs/IEPs, and immunization records reviewed during the screening process.

BLOCK 32: Records if there is any additional information required to complete the screening.

BLOCK 33: Provides any additional comments from the Appointed FMTS Medical Screener.

BLOCKS 34a-b: Records the outcome of the screening for the dependent. If there are special medical, educational, and/or dental needs, BLOCK 34a will be checked. Otherwise, BLOCK 34b will be checked. This information must be indicated in the applicable box(es) on DD Form X678 TEST, Screening Verification, PART C BLOCKS 18a-e.

BLOCK 35: Indicates the date the DD Form X678 TEST, Screening Verification, PART C BLOCKS 18a-e were completed for the dependent.

BLOCKS 36a-c: Provides losing Appointed FMTS Medical Screener information.

BLOCK 37: Indicates the screening Military Treatment Facility (MTF).

BLOCK 38: Certifies the information provided by the losing Appointed FMTS Medical Screener.

BLOCK 39: Indicates the date the form is signed.

NOTE: UPON COMPLETION, THIS FORM IS UPLOADED TO THE DEPENDENT'S MEDICAL RECORD.

MEDICAL AND EDUCATIONAL INFORMATION
FAMILY MEMBER TRAVEL SCREENING

(All white BLOCKS completed by dependent at the age of majority or parent/guardian. Any reference to "you" in the white BLOCKS refers to the dependent. All gray BLOCKS completed by losing Appointed FMTS Medical Screener. One (1) form per dependent.)

OMB No.

OMB approval expires

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 20 U.S.C. 927, Allotment Formula; DoDI 1315.19, Authorizing Special Needs Families Travel Overseas at Government Expense; DoDI 1342.12, Provision of Early Intervention and Special Education Services to Eligible DoD Dependents; and E.O. 9397 (SSN) as amended.
PRINCIPAL PURPOSE(S): Information will be used by the Military Services to identify dependents with special medical and/or educational needs and to determine if additional screenings and evaluations are required to determine the extent of the dependents' needs. This information will enable Military Assignment Personnel to match the needs of dependents against the availability of services.
ROUTINE USE(S): Disclosure of records are generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended. Applicable Blanket Routine Use(s) are: Law Enforcement Routine Use, Congressional Inquiries, Disclosure to the Department of Justice for Litigation Routine Use, Disclosure of Information to the National Archives and Records Administration Routine Use, and Data Breach Remediation Purposes Routine Use. The DoD Blanket Routine Uses set forth at the beginning of the Office of the Secretary of Defense (OSD) compilation of systems of records notices may apply to this system. The complete list of DoD Blanket Routine Uses can be found online at: http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx. The applicable system of records notices are: DMDC 02 DoD; Defense Enrollment Eligibility Reporting Systems (DEERS), EDHA 07: Military Health Information System. EDHA 16: Special Needs Program Management Information System (SNPMIS), DoDEA 26: DoDEA Educational Records, DoDEA 29: DoDEA Non-DoD Schools Program. The SORNs may be found at http://dpclo.defense.gov/Privacy/SORNsIndex
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 the 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.

PART A: DEPENDENT AND SPONSOR INFORMATION

(Completed by dependent at the age of majority or the parent/guardian.)

1a. NAME OF DEPENDENT TO BE SCREENED *(LAST, FIRST, MI)*	1b. RELATIONSHIP *(Spouse, son, daughter, etc.)*	1c. BIRTHDATE *(YYYY/MM/DD)*	1d. AGE	1e. H.S. DIPLOMA OR EQUIV. CERT.		1f. PRIMARY CARE MANAGER OUTSIDE MTF		1g. ENROLLED IN EFMP	
				YES	NO	YES	NO	YES	NO
				☐	☐	☐	☐	☐	☐

2. SPONSOR NAME *(LAST, FIRST, MI)*	3. RANK/GRADE	4. SPONSOR SSN	5. SERVICING PAS CODE *(Air Force Only)*

6. PREFERRED PHONE *(Include area/country codes)*	7. PREFERRED E-MAIL ADDRESS *(Personal or Official)*

PART B: MEDICATIONS

(Attach additional document, if necessary.)

8. PRESCRIBED MEDICATIONS *(List all medications prescribed within the last twelve (12) months. List one (1) medication per line.)*	**Appointed FMTS Medical Screener USE ONLY** Travel concern?	
	YES	**NO**
D R A F T	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

9. The dependent was advised to take a 60-90 day supply of prescription medications to the projected physical duty location. *(If no, provide comments. Attach an additional sheet if necessary.)*
☐ YES ☐ NO

PART C: MEDICAL NEEDS

(Answer the following questions as they apply to you. You will have the opportunity to discuss all "YES" answers with the losing Appointed FMTS Medical Screener. ***A checked circle indicates a special medical need that requires a DD Form 2792 Family Member Medical Summary. Complete a DD Form 2792 before the face-to-face interview and within twelve (12) months of the projected report date to the duty location.*** *Provide additional information in BLOCK 29.)*	**Completed by dependent or parent/guardian**		**Appointed FMTS Medical Screener USE ONLY**
	YES	**NO**	**CONFIRM REVIEW**
10. Is there a temporary condition, e.g., pregnancy, injury, recent illness, etc.? If pregnant, indicate the due date *(YYYY/MM/DD)* _____	☐	☐	☐
11. Do you have a condition that may require surgery in the next twelve (12) months?	☐	☐	☐
12. Do you have any outstanding specialist referrals?	☐	☐	☐
13. In the last five (5) years, have you had a vision impairment not corrected by glasses?	○	☐	☐
14. In the last five (5) years, have you had a hearing impairment?	○	☐	☐
15. In the last twelve (12) months, have you had any examinations with abnormal results, e.g., prostate, mammogram, pap smear, etc.?	☐	☐	☐
16. In the last five (5) years, have you had any other chronic conditions, e.g., cancer, diabetes, TBI, seizure disorders, cerebral palsy, sickle cell, chronic pain, etc.? If "YES", specify the condition: _____	○	☐	☐

MEDICAL AND EDUCATIONAL INFORMATION

FAMILY MEMBER TRAVEL SCREENING

DEPENDENT NAME *(LAST, FIRST, MI)*	SPONSOR NAME *(LAST, FIRST, MI)*	SPONSOR SSN	SERVICING PAS CODE *(Air Force Only)*

***(Part C (Continued):** Answer the following questions as they apply to you. You will have the opportunity to discuss all "YES" answers with the losing Appointed FMTS Medical Screener. **A checked circle indicates a special medical need that requires a DD Form 2792, Family Member Medical Summary. Complete a DD Form 2792 before the face-to-face interview and within twelve (12) months of the duty location to the new assignment location.** Provide additional information in BLOCK 29.)*	**Completed by dependent or parent/guardian**		**Appointed FMTS Medical Screener USE ONLY**
	YES	**NO**	**CONFIRM REVIEW**
17. In the last twelve (12) months, have you received or required: a. A visit to the emergency room?	☐	☐	☐
b. Hospitalization (excluding hospitalization for uncomplicated childbirth)?	☐	☐	☐
c. Medical services from any specialists (not general pediatrics, family practice, and general internal medicine)?	☐	☐	☐
d. Specialized equipment, e.g., a wheelchair, walker, home nebulizer, apnea monitor, insulin pump, etc.?	○	☐	☐
e. Special environmental considerations, e.g., limited steps, temperature control, air filtering, etc.?	○	☐	☐
f. Speech, physical, or occupational therapy, or Applied Behavior Analysis (ABA) through TRICARE or private health insurance?	○	☐	☐
18. Have you had: a. Any cardiovascular conditions, e.g., chest pain/angina, arrhythmia, valve disease, infarction, etc., requiring ongoing care?	○	☐	☐
b. Any neurologic conditions, e.g., seizure, migraine, neuropathy, etc. requiring ongoing care?	○	☐	☐
c. Any respiratory conditions, e.g., asthma, Reactive Airway Disease (RAD), allergies requiring immunotherapy, etc.?	○	☐	☐
19. Have you: a. Used oral steroids for more than seven (7) days in the past year to treat asthma or RAD?	○	☐	☐
b. Been hospitalized in the last five (5) years for an acute respiratory condition?	○	☐	☐
c. Had more than one (1) emergency room visit for an acute asthma episode in the past year?	○	☐	☐
d. Had an environmental asthma trigger that could limit relocation to specific geographic areas?	☐	☐	☐
20. In the last five (5) years, have you: a. Been diagnosed by, or received treatment from, any provider for a behavioral health problem, e.g., depression, eating disorders, self-harming behaviors, acting out behaviors, etc.?	○	☐	☐
b. Been referred to or received treatment in any of the following: inpatient psychiatric facility, residential treatment program, group home, day treatment center, or drug or alcohol treatment rehabilitation center?	○	☐	☐
c. Been referred or received treatment for suicidal thoughts, gestures, or attempts?	○	☐	☐
d. Been referred or received treatment for alcohol/drug use or abuse?	○	☐	☐
21. Are you in primary or secondary school and receiving psychological or counseling services not included on an IEP?	○	☐	☐
22. In the last five (5) years, have you been referred to Family Advocacy for reports of maltreatment?	☐	☐	☐

23. Was the dependent advised to see any specialists before moving if the next scheduled visit is within 45 days after arrival to the new duty location? *(If no, provide comments. Attach an additional sheet if necessary.)*
☐ YES ☐ NO

PART D: EARLY INTERVENTION/EDUCATION

(If you checked "YES" in PART A BLOCK 1e or are 22 years of age and older, check N/A and skip to BLOCK 29.) ☐ **N/A**

*(Answer the following questions as they apply to you. You will have the opportunity to discuss all "YES" answers with the losing Appointed FMTS Medical Screener. **A checked circle indicates that an Individualized Family Service Plan (IFSP)/ Individualized Education Program (IEP) should be attached to the DD Form 2792-1 Special Education/Early Intervention Summary.** Provide additional information in BLOCK 29.)*	**Completed by dependent or parent/guardian**		**Appointed FMTS Medical Screener USE ONLY**
	YES	**NO**	**CONFIRM REVIEW**
24. Are you receiving: a. Early intervention services?	○	☐	☐
b. Special education services to include physical, occupational, or speech therapy services from the school system?	○	☐	☐
25. Have you withdrawn from early intervention or special education services within the last twelve (12) months?	○	☐	☐
26. Are you currently being evaluated to determine eligibility for early intervention or special education services?	☐	☐	☐
27. Are you homeschooled or attending a private/charter school?	☐	☐	☐
a. Did you ever receive special education services prior to or while homeschooling?	☐	☐	☐
b. Did you receive physical, occupational, or speech therapy services from the local school district prior to or while homeschooling?	☐	☐	☐

28. **Dependent children only:** After the review of the DD Form 2792-1, does the eligibility category suggest a medical condition, which requires completion of the DD Form 2792?	**N/A**	**YES**	**NO**
	☐	☐	☐

29. OVERALL COMMENTS *(Provide any additional information pertaining to any of the above sections in this BLOCK. Attach an additional sheet if necessary.)*

DEPENDENT CERTIFICATION

I verify that the information I have provided on this form is accurate and complete.

30a. CERTIFIER NAME *(Dependent at the age of majority or parent/guardian)*	30b. SIGNATURE	30c. DATE *(YYYY/MM/DD)*

MEDICAL AND EDUCATIONAL INFORMATION
FAMILY MEMBER TRAVEL SCREENING

DEPENDENT NAME *(LAST, FIRST, MI)*	SPONSOR NAME *(LAST, FIRST, MI)*	SPONSOR SSN	SERVICING PAS CODE *(Air Force Only)*

PART E: APPOINTED FMTS MEDICAL SCREENER SUMMARY
(Completed by the losing Appointed FMTS Medical Screener.)

31. I, as the Appointed FMTS Medical Screener, reviewed:	N/A	YES	NO
a. Potential travel concerns. *(If there are potential travel concerns, a DD Form 2792 must be completed and forwarded to the gaining FMTS Office.)*		☐	☐
b. Medical records.		☐	☐
c. DD Form X678-3 TEST.	☐	☐	☐
d. DD Form 2792. *(If there is a DD Form 2792, it must be forwarded to the gaining FMTS Office.)*	☐	☐	☐
e. DD Form X678-2 TEST. *(If (3) and/or (4) on the DD Form X678-2 TEST are checked "YES", it must be forwarded to the gaining FMTS Office.)*	☐	☐	☐
f. DD Form 2792-1 (dependent children only).	☐	☐	☐
g. IFSP/IEP (dependent children receiving early intervention/special education services). *(If there is an IFSP/IEP, it must be forwarded to the gaining FMTS Office.)*	☐	☐	☐
h. Immunization records *(Navy and Marine Corps dependents only. For Air Force and Army dependents, check "N/A" and proceed to BLOCK 32.)*	☐	☐	☐
(1) Are ACIP recommended immunizations up-to-date?		☐	☐
(2) Do the immunication records meet destination country entry requirements? *(Contact the Regional Navy Environmental Preventive Medicine Unit for country specific vaccines.)*		☐	☐
(3) Is the dependent declining any vaccinations? *(If the dependent declines any vaccine, counsel on risks of not vaccinating and the potential to impact travel, document counseling in BLOCK 33, and check BLOCK 34a below.)*		☐	☐

32. Is additional information required to complete the screening? *(If "YES", specify below. Attach an additional sheet if necessary.)*
☐ YES ☐ NO

33. COMMENTS *(Provide additional information captured during the face-to-face interview. Attach an additional sheet if necessary.)*

34. **LOSING FMTS SCREENING OUTCOME**
(Check one of the following boxes and indicate in the applicable box(es) on DD Form X678 TEST Screening Verification PART C BLOCKS 18a-e.)

☐ a. There are special medical, educational, and/or dental needs as identified by a DD Form 2792, DD Form X678-2 TEST, and/or IFSP/IEP. This requires formal coordination with the gaining FMTS Office.

☐ b. There are no identified special medical, educational, and/or dental needs.

35. Indicate the date the DD Form X678 TEST Screening Verification PART C BLOCKS 18a-e were completed for this dependent *(YYYY/MM/DD)* _____

36a. APPOINTED FMTS MEDICAL SCREENER NAME *(LAST, FIRST, MI)*	36b. RANK/GRADE	36c. TITLE/DISCIPLINE

37. MTF	38. SIGNATURE	39. DATE *(YYYY/MM/DD)*