INSTRUCTIONS
DD FORM X678-3 TEST, PATIENT CARE REVIEW

(This User Guide provides clarifying descriptions and notes on the DD Form X678-3 TEST, Patient Care Review.)

GENERAL

The DD Form X678-3 TEST, Patient Care Review, summarizes dependent ("patient") medical care received from a primary care manager (PCM) outside the Military Treatment Facility (MTF).

One (1) form is completed for each dependent that receives care outside of the MTF. This form is completed by the dependent at age of majority or parent / guardian and the non-MTF PCM, who is a TRICARE network or a non-network provider.

The patient's non-MTF PCM reviews medical records to determine if there are any medical needs that meet the criteria listed in PART B of this form. If the PCM does not have sufficient information to complete PART B, it may be necessary to conduct a physical evaluation.

PART A: PATIENT INFORMATION

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

BLOCKS 1-3: Provides patient information.

BLOCKS 4-5: Provides Sponsor information.

NOTE: The Sponsor is usually the active duty Service member.

PART B: MEDICAL SUMMARY

Completed by the patient's non-MTF PCM.

NOTE: This form should NOT be completed by providers in MTFs.

BLOCKS 6a-k: Provides medical information about the patient based on care provided and the historical information in the patient's medical records maintained in the practice.

NOTE: A checked "YES" box in PART B indicates that dependent has a special medical need that will require the PCM to complete a DD Form 2792, Family Member Medical Summary, for that family member.

NOTE: If the family indicates that they have completed a DD Form 2792, Family Member Medical Summary, for that dependent, the form has to be completed within twelve (12) months of the projected report date to the new assignment location. A DD Form 2792 that is older than twelve (12) months will need to be updated.

NOTE: If needed, the patient should provide the PCM with a copy of the DD Form 2792, Family Member Medical Summary, or the PCM may obtain a copy of the form at: dtic.mil/whs/directives/forms/eforms/dd2792.pdf.

BLOCKS 7-8: Provides preferred contact information for the PCM.

BLOCKS 9-12: Provides PCM information and the date the form is signed.

NOTE: The Appointed FMTS Medical Screener reviews the DD Form X678-3 TEST, Patient Care Review, during the screening to determine if there are medical needs that require coordination with the gaining FMTS Office. The Appointed FMTS Medical Screener annotates the DD Form X678-1 TEST, Medical and Educational Information, PART E BLOCK 31c and indicates any identified needs on the DD Form X678 TEST, Screening Verification, PART C BLOCK 18c. If any "YES" box is checked, the Appointed FMTS Medical Screener ensures that the family has provided a DD Form 2792, Family Member Medical Summary, completed within twelve (12) months of the projected report date.

PATIENT CARE REVIEW
FAMILY MEMBER TRAVEL SCREENING

(Completed by non-Military Treatment Facility (MTF) primary care manager. One (1) form per dependent.)

UT ÓÁP[ĚÁ
UT ÓÁæ] ¦[çæ¦Á¢]ã^•Á

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, iincluding suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (07XX-XXXX). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THIS ADDRESS. RETURN FORM AS DIRECTED BELOW.**

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 the Military Services to identify dependents with special medical needs and to determine if additional screening and evaluations are required to determine the extent of the dependents' medical needs. This information will enable Military Assignment Personnel to match the special medical needs of family members against the availability of services. The personally identifiable information collected on this form is covered by a number of system of records notices (SORNs) pertaining to Official Military Personnel Files, Exceptional Family Member Program. The SORNs may be found at http://dpclå.defense.gov/Privacy/SORNsIndex.

ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://dpclå.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply.

PART A: PATIENT INFORMATION

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

1. PATIENT NAME *(LAST, FIRST, MI)*	2. BIRTHDATE *(YYYY/MM/DD)*	3. AGE

4. SPONSOR NAME *(LAST, FIRST, MI)*	5. SPONSOR LAST 4 SSN

PART B: MEDICAL SUMMARY

(Completed by non-MTF primary care manager.)

(The patient you are examining is a dependent of a DoD employee or a member of the US Armed Forces who may be assigned to a location with limited medical services. Answer the following questions about your patient based on the care provided and the historical information in the medical records maintained in your practice. If you do not have sufficient information to complete PART B of this form, it may be necessary to conduct a physical evaluation. ***A checked "YES" box requires you to complete a DD Form 2792 Family Member Medical Summary with the family.****)*	CHECK	
	YES	NO
6. DOES THE PATIENT HAVE: a. A potentially life-threatening condition that may put the patient in danger of death without emergency room care, medication, treatment, or surgery?	☐	☐
b. A chronic medical/physical condition requiring follow-up support more than once a year or requiring ongoing support from a special care provider?	☐	☐
c. A current and chronic (duration of six (6) months or longer) behavioral health condition?	☐	☐
d. Intensive (greater than one (1) visit monthly for more than six (6) months) behavioral health services at the present time? This includes care from any provider, including a primary care manager (general pediatrics, family practice, and general internal medicine).	☐	☐
e. Inpatient or intensive outpatient behavioral health service within the last five (5) years?	☐	☐
f. A diagnosis of asthma or other respiratory-related diagnosis, which meets one (1) or more of the following criteria? -Scheduled use of inhaled anti-inflammatory agents and/or bronchodilators. -History of emergency room use or clinic visits for acute asthma exacerbations within the last year. -History of one (1) or more hospitalizations for asthma within the last five (5) years. -History of intensive care unit admissions for asthma within the last five (5) years.	☐	☐
g. A diagnosis of attention deficit disorder/attention deficit hyperactivity disorder that meets one (1) or more of the following criteria? -A co-morbid psychological diagnosis. -Requires multiple medications, psycho-pharmaceuticals (other than stimulants), or does not respond to normal doses of medication. -Requires management and treatment by behavioral health provider (e.g., Psychiatrist, Psychologist, Social Worker, etc.). -Requires a specialty consultant, other than a family practice physician, more than two (2) times a year on a chronic basis. -Requires modifications of the educational curriculum or the use of school behavioral management staff.	☐	☐
h. A requirement for adaptive equipment?	☐	☐
i. A requirement for assistive technology devices or services related to current diagnosis?	☐	☐
j. A requirement for considering environmental/architectural factors related to a current diagnosis?	☐	☐
k. Prescribed medications within the last twelve (12) months? If "YES", attach a listing.	☐	☐

D R A F T

7. PREFERRED PHONE	9. OFFICE ADDRESS
8. PREFERRED E-MAIL ADDRESS	

10. PROVIDER NAME (*LAST, FIRST, MI or stamped*)	11. SIGNATURE	12. DATE *(YYYY//MM//DD)*

APPOINTED FMTS MEDICAL SCREENER USE ONLY

The losing Appointed FMTS Medical Screener reviews this form for any medical needs that require coordination. Annotate DD Form X678-1 TEST Medical and Educational Information BLOCK 31c. If any "YES" is checked, ensure that the family has provided a DD Form 2792, completed within twelve (12) months of the projected report date.