# FAMILY MEMBER MEDICAL SUMMARY
## INSTRUCTIONS FOR COMPLETING DD FORM 2792 FAMILY MEMBER MEDICAL SUMMARY

OMB No. 0704-0411
OMB APPROVAL EXPIRES 20230930

**GENERAL**

The DD Form 2792 is 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 9b, and the MTF case coordinator / authorized reviewer signs block 10b.

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 2)

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 3)

**Item 1.** Select the appropriate purpose for filling out the form and provide documentation.

**Item 2.a.** Family Member / Patient Name. 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.
**Item 2.c. - e.** Self-explanatory.
**Item 2.f.** Family Member Prefix (FMP). Only applies to Military medical beneficiary. The FMP is assigned when the family member is enrolled in the Defense Enrollment Eligibility Reporting System (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.
**Item 2.h. - j.** Self-explanatory.

**Item 3.a. - h.** All items refer to the sponsor. Self-explanatory.
**Item 3.i.** Annotate 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 DoD ID #, name of sponsor and branch of Service. Military only.

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

**Item 7.** To be completed by the administrator in consultation with the family. Required Actions. Self-explanatory.

**Item 8.a. - c.** To be completed by the administrator in consultation with the family. Mark all services being provided to the family member.

**Item 9.a. - c.** Parent / Guardian or Person of Majority Age. Parent / Guardian or Person of Majority Age certifies that the information contained in the DD Form 2792 is correct. **Individual must ensure that all applicable forms are completed and attached before signing.**

**Item 10.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 Provider. Sponsor, spouse, or family member of majority age must sign release authorization on page 2 before this summary is completed.** Please complete as accurately as possible using the current International Classification of Diseases (ICD) Code(s).

**Item 1.a. - b.** Diagnosis 1. Enter the diagnosis and corresponding diagnostic code for the family member.
**Item 1.c.** Prognosis. Self-explanatory.
**Item 1.d(1) - 1.d(4)** Medical History for the Last 12 Months. Enter the number of outpatient visits, emergency room visits / urgent care visits, hospitalizations, and ICU admissions.
**Item 1.e(1) - 1.e(3)** Medications. Enter all current medications associated with Diagnosis 1, the dosage and frequency medication should be taken.
**Item 1.f.** Treatment Plan for Diagnosis 1. Include medical and / or surgical procedures and 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.

**Item 2.a.- f.** Diagnosis 2. Follow procedures for Items 1.a. - 1.f. above.

**Item 3.a. - f.** Provider Information. Official stamp or printed name and signature of the provider completing this page, date the page was signed, telephone numbers for the provider, email, and medical specialty.

**Item 4.a. - 5.f.** Diagnoses 3 and 4. Follow procedures for Items 1.a. - 1.f. above.

**Item 6.a. - f.** Provider Information. Official stamp or printed name and signature of the provider completing this page, date the page was signed, telephone numbers for the provider, email, and medical specialty.

**Item 7.** History Associated with Asthma (if applicable). Answer “Yes” or “No”, and include additional details as directed on the patient's asthma history for the last 5 years, as directed.

**Item 8.** History Associated with Behavioral Health (if applicable). Answer "Yes" or "No", and include additional details as directed on the patient's mental health history for the last five years, as directed.

**Item 9.** Current Intervention Therapies for Autism Spectrum Disorders and / or Significant Developmental Delays (if applicable).

**Item 10.** Communication. Indicate if the patient is verbal or non-verbal. If non-verbal, indicate the appropriate communication methods used.

**Item 11.** Other Interventions / Therapies Used by the Family. Self-explanatory.

**Item 12.** Behavior. Answer "Yes" if the child exhibits high risk or dangerous behaviors.

**Item 13.a. - c.** Provider Information. Official stamp or printed name and signature of provider completing the page and date the page was signed.

**Item 14.** Health Care Required. In column 1, mark 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 should reflect the providers that are necessary to meet the needs of the patient.

**Item 15. - 20.** Self-explanatory.

# 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 20230930



## PRIVACY ACT STATEMENT

**AUTHORITY:** 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19: DoDI 1342.12.

**PRINCIPAL PURPOSE(S):** Information will be used by DoD personnel to evaluate and document the special medical needs of family members. This information will enable: (1) sponsors to enroll into the Exceptional Family Member Program (EFMP), (2) military assignment personnel to match the special medical needs of family members against the availability of medical services through the Family Member Travel Screening (FMTS) process, (3) EFMP Family Support staff to offer information on community support services, and (4) civilian personnel offices 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 applicable SORNs and routine uses that apply can be found at: Air Force: F036 AF PC C: Military Personnel Records System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569821/f036-af-pc-c/; F044 AF SG U: Special Needs and Educational and Developmental Intervention Services at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569875/f044-af-sg-u/; Army: A0600-8-104b AHRC - Official Military Personnel Record at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570054/a0600-8-104-ahrc/; A0608b CFSC, Personnel Affairs: Army Community Service Assistance Files at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570084/a0608b-cfsc/
DHA: EDHA 07: Military Health Information System at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570672/edha-07/
OSD/JS: DMDC 02 DoD: Defense Enrollment Eligibility Reporting Systems (DEERS) at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/627618/dmdc-02-dod/
DPR 34 DoD: Defense Civilian Personnel Data System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570697/dpr-34-dod/
EDHA 16 DoD: Special Needs Program Management Information System (SNPMIS) Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570679/edha-16-dod/
DoDEA 29: DoDEA Non-DoD Schools Program at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570576/dodea-29/
DoDEA 26: Department of Defense Education Activity Educational Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570573/dodea-26/
Navy and Marine Corps: M01070-6: Marine Corps Official Military Personnel Files at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570626/m01070-6/
M01754-6: Exceptional Family Member Program Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570631/m01754-6/
N01070-3: Navy Military Personnel Records System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570310/n01070-3/
N01301-2: On-Line Distribution Information System (ODIS) at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570320/n01301-2/

**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 DoD Identification (DoD ID) 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 DoD ID number.

## AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Per DoD Instruction, Service members are required to enroll in the EFMP if they have a family member with a qualifying medical condition. Accordingly, the Sponsor will have access to the health information contained herein during the accomplishment and submission of this application. By signing the below authorization for disclosure of medical information you acknowledge your sponsor may have access to the health information contained herein. The authorization for sponsor access is terminated once the application is received by EFMP. The sponsor may be held accountable for the accuracy and completeness of the DD Form 2792 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 Program (EFMP) medical / the Family Member Travel Screening (FMTS) Office and EFMP Family Support Office. This information may be used for enrollment into the EFMP, the family travel review process, and / or community support services to determine whether there are adequate medical, housing, and community resources to meet your needs at the sponsor's proposed duty location, and / or to assist family members with community support at the current and/or projected duty location.

a. The military medical department or appropriate headquarters family support office will use the information to determine whether you meet the criteria for enrollment into the EFMP and the military medical departments will provide recommendations on the availability of care in communities where the sponsor may be assigned or employed.
b. Information that you have a special medical need (not the nature or scope of the need) may be included in the sponsor's personnel record, if EFMP enrollment criteria are met.
c. Information may be shared with EFMP Family Support staff who assist the family and / or sponsor with appropriate community resources.
d. The authorization applies to the summary data included on the medical summary form, and subsequent updates to information on this form. If additional clarification or information is needed, I authorize review of my health record, which may be maintained in an electronic format. This information may be stored in electronic databases used for medical management or dedicated to the assignment process. Access to the information is limited to representatives of the medical departments, the offices responsible for enrollment into the Exceptional Family Member Program, the offices responsible for assignment coordination, the offices responsible for EFMP Family Support services, and, at your request, other agents responsible for care or services. Summary data may be transmitted (e.g. encrypted electronic mail or faxing) 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 in the 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. Failure to release this information or any subsequent revocation may result in ineligibility for accompanied family travel at government expense.
b. 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.
c. 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.
d. 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.
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)* |
|---|---|---|---|
| | | | |

Prescribed by: DoDI 1315.19

| FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME *(Last, First, Middle Initial)* | SPONSOR DoD ID # |
|---|---|---|
| | | |

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

**1. PURPOSE OF THIS FORM** *(Select One)*

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

*(Provide documentation to verify change in status.)*

| 2a. FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | 2b. SPONSOR NAME *(Last, First, Middle Initial)* | 2c. SPONSOR DoD ID # |
|---|---|---|
| | | |

| 2d. FAMILY MEMBER GENDER *(Select One)* | 2e. FAMILY MEMBER DATE OF BIRTH *(YYYYMMDD)* | 2f. FAMILY MEMBER PREFIX (FMP) | 2g. DoD BENEFITS NUMBER (DBN) *(On Back of ID Card)* |
|---|---|---|---|
| ☐ Male ☐ Female | | | |

| 2h. CURRENT FAMILY MEMBER MAILING ADDRESS *(Street, Apartment Number, City, State, ZIP Code, APO / FPO)* | 2i. HOME TELEPHONE NUMBER *(Include Country Code / Area Code)* |
|---|---|
| | 2j. FAMILY HOME E-MAIL ADDRESS |

| 3a. SPONSOR RANK OR GRADE | 3b. DESIGNATION / NEC / MOS / AFSC *(Military Only)* | 3c. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT |
|---|---|---|
| | | |

**3d. BRANCH OF SERVICE** *(Military Only)*

- ☐ Army ☐ Navy ☐ Air Force
- ☐ Marine Corps ☐ Coast Guard

**3e. STATUS** *(Select One)*

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

| 3f. SPONSOR'S OFFICIAL E-MAIL ADDRESS | 3g. DUTY TELEPHONE NUMBER | 3h. MOBILE NUMBER *(Include Country Code / Area Code)* |
|---|---|---|
| | | |

**3i. DOES FAMILY MEMBER RESIDE WITH SPONSOR?** *(Select One. If "No," Explain.)*

☐ Yes ☐ No

**4a. ARE YOU DUAL MILITARY** ☐ **OR IS YOUR SPOUSE FORMER MILITARY?** ☐ *(Military Only. If either is selected, complete 4b. - 4e. below.)*

| 4b. SPOUSE'S NAME *(Last, First, Middle Initial)* | 4c. BRANCH OF SERVICE | 4d. RANK / RATE | 4e. SPOUSE DoD ID # |
|---|---|---|---|
| | | | |

**5a. HAS THE FAMILY MEMBER EVER BEEN ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR'S NAME OR DoD ID #?** *(Select One.)*

☐ Yes
☐ No

| 5b. IF "YES," UNDER WHAT DoD ID #? | 5c. UNDER WHAT SPONSOR'S NAME ? *(Last, First, Middle Initial)* | 5d. BRANCH OF SERVICE |
|---|---|---|
| | | |

**6a. DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES?** *(Select One)*

☐ Yes ☐ No *(If "Yes," Complete 6b. and 6c.)*

**6b. LOCATION OF CASE MANAGER** *(Select One)* ☐ MTF ☐ TRICARE ☐ Civilian

**6c. CASE MANAGER CONTACT INFORMATION**

| 6c(1). NAME *(Last, First, Middle Initial)* | 6c(2). E-MAIL ADDRESS *(If Available)* | 6c(3). TELEPHONE NUMBER *(Include Country Code / Area Code)* |
|---|---|---|
| | | |

**FOR ADMINISTRATIVE USE ONLY**

**7. REQUIRED ACTIONS** *(Select 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 (ECHO) Eligibility*):
- ☐ Qualifies for Change in EFMP Status:
  - ☐ Family Member No Longer Has Previously Identified Condition
  - ☐ Family Member Deceased*
  - ☐ Family Member No Longer Qualifies as a Dependent*
  - ☐ Divorce / Change in Custody*

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

**8. SPECIAL ASSIGNMENT CONSIDERATIONS** *(Mark all that apply)*

- ☐ 8a. Possible Special Education / Early Intervention *(If checked, DD Form 2792-1 must be completed.)*
- ☐ 8b. Receiving TRICARE Extended Care Health Option (ECHO) Benefits
- ☐ 8c. Receiving State Medicaid / Medicare Waiver Services

**CERTIFICATION**

**9. CERTIFICATION. DO NOT CERTIFY BEFORE THE MEDICAL PROVIDER COMPLETES THE ENTIRE FORM.**
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**

| 9a. PRINTED NAME *(Last, First, Middle Initial)* | 9b. SIGNATURE | 9c. DATE *(YYYYMMDD)* | 10f. OFFICIAL STAMP |
|---|---|---|---|
| | | | |

**10. ADMINISTRATIVE CERTIFICATION**

| 10a. PRINTED NAME *(Last, First, Middle Initial)* | 10b. SIGNATURE | 10c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |

| 10d. LOCATION OF MILITARY TREATMENT FACILITY OR CERTIFYING EFMP OFFICE | 10e. TELEPHONE NUMBER *(Include Country Code / Area Code)* |
|---|---|
| | |

| FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME *(Last, First, Middle Initial)* | SPONSOR DoD ID # |
|---|---|---|
| | | |

**MEDICAL SUMMARY: To be completed by a Qualified Medical Provider**

**PART A - PATIENT STATUS** *(Authorization by patient or parent / guardian included on Page 2 of this form.)*

Please complete as accurately as possible using the current ICD Code(s).

**DIAGNOSIS INFORMATION**

| 1a. DIAGNOSIS 1 | 1b. ICD CODE |
|---|---|
| | |

**1c. PROGNOSIS** *(Select One)* ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

**1d. MEDICAL HISTORY FOR THE LAST 12 MONTHS** *(Associated with Diagnosis 1)*

| 1d(1). NUMBER OF OUTPATIENT VISITS | 1d(2). NUMBER OF ER VISITS / URGENT CARE VISITS | 1d(3). NUMBER OF HOSPITALIZATIONS | 1d(4). NUMBER OF ICU ADMISSIONS |
|---|---|---|---|
| | | | |

**1e. MEDICATIONS**

| 1e(1). CURRENT MEDICATION(S) | 1e(2). DOSAGE | 1e(3). FREQUENCY |
|---|---|---|
| | | |
| | | |

**1f. TREATMENT PLAN FOR DIAGNOSIS 1** *(Medical, mental health, surgical procedures or therapies provided in the last 12 months, or 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.)*

| 2a. DIAGNOSIS 2 | 2b. ICD CODE |
|---|---|
| | |

**2c. PROGNOSIS** *(Select One)* ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

**2d. MEDICAL HISTORY FOR THE LAST 12 MONTHS** *(Associated with Diagnosis 2)*

| 2d(1). NUMBER OF OUTPATIENT VISITS | 2d(2). NUMBER OF ER VISITS / URGENT CARE VISITS | 2d(3). NUMBER OF HOSPITALIZATIONS | 2d(4). NUMBER OF ICU ADMISSIONS |
|---|---|---|---|
| | | | |

**2e. MEDICATIONS**

| 2e(1). CURRENT MEDICATION(S) | 2e(2). DOSAGE | 2e(3). FREQUENCY |
|---|---|---|
| | | |
| | | |

**2f. TREATMENT PLAN FOR DIAGNOSIS 2** *(Medical, mental health, surgical procedures or therapies provided in the last 12 months, or 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.)*

**PROVIDER INFORMATION**

| 3a. PROVIDER PRINTED NAME OR STAMP | 3b. SIGNATURE | 3c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |

| 3d. TELEPHONE NUMBERS *(Include Country Code / Area Code)* | | 3e. OFFICIAL EMAIL ADDRESS | 3f. MEDICAL SPECIALTY |
|---|---|---|---|
| 3d(1). COMMERCIAL | 3d(2). DSN *(Military Only)* | | |
| | | | |

| FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME *(Last, First, Middle Initial)* | SPONSOR DoD ID # |
|---|---|---|
| | | |

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

**PART A - PATIENT STATUS** *(Continued)*

Please complete as accurately as possible using the current ICD Code(s).

**DIAGNOSIS INFORMATION**

| 4a. DIAGNOSIS 3 | 4b. ICD CODE |
|---|---|
| | |

**4c. PROGNOSIS** *(Select One)* ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

**4d. MEDICAL HISTORY FOR THE LAST 12 MONTHS** *(Associated with Diagnosis 3)*

| 4d(1). NUMBER OF OUTPATIENT VISITS | 4d(2). NUMBER OF ER VISITS / URGENT CARE VISITS | 4d(3). NUMBER OF HOSPITALIZATIONS | 4d(4). NUMBER OF ICU ADMISSIONS |
|---|---|---|---|
| | | | |

**4e. MEDICATIONS**

| 4e(1). CURRENT MEDICATION(S) | 4e(2). DOSAGE | 4e(3). FREQUENCY |
|---|---|---|
| | | |
| | | |

**4f. TREATMENT PLAN FOR DIAGNOSIS 3** *(Medical, mental health, surgical procedures or therapies provided in the last 12 months, or 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.)*

| 5a. DIAGNOSIS 4 | 5b. ICD CODE |
|---|---|
| | |

**5c. PROGNOSIS** *(Select One)* ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

**5d. MEDICAL HISTORY FOR THE LAST 12 MONTHS** *(Associated with Diagnosis 4.)*

| 5d(1). NUMBER OF OUTPATIENT VISITS | 5d(2). NUMBER OF ER VISITS / URGENT CARE VISITS | 5d(3). NUMBER OF HOSPITALIZATIONS | 5d(4). NUMBER OF ICU ADMISSIONS |
|---|---|---|---|
| | | | |

**5e. MEDICATIONS**

| 5e(1). CURRENT MEDICATION(S) | 5e(2). DOSAGE | 5e(3). FREQUENCY |
|---|---|---|
| | | |
| | | |

**5f. TREATMENT PLAN FOR DIAGNOSIS 4** *(Medical, mental health, surgical procedures or therapies provided in the last 12 months, or 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.)*

**PROVIDER INFORMATION**

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

| 6d. TELEPHONE NUMBERS *(Include Country Code / Area Code)* | | 6e. OFFICIAL EMAIL ADDRESS | 6f. MEDICAL SPECIALTY |
|---|---|---|---|
| 6d(1). COMMERCIAL | 6d(2). DSN *(Military Only)* | | |
| | | | |

| FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME *(Last, First, Middle Initial)* | SPONSOR DoD ID # |
|---|---|---|
| | | |

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

**PART A - PATIENT STATUS** *(Continued)*

**ADDITIONAL INFORMATION FOR ASTHMA, BEHAVIORAL HEALTH, AND AUTISM SPECTRUM DISORDERS AND / OR SIGNIFICANT DEVELOPMENTAL DELAYS**
*(Complete if patient has been evaluated or treated for asthma (within the past five years), a behavioral health condition (within the past five years) and / or autism spectrum disorders and / or significant developmental delays.)*

**ASTHMA INFORMATION** ☐ N/A

**7. HISTORY ASSOCIATED WITH ASTHMA** *(See note above for additional information) (Select as applicable)*

| YES | NO | |
|---|---|---|
| ☐ | ☐ | **7a. ARE THERE ANY TRIGGERS FOR THE PATIENT'S ASTHMA EXACERBATIONS?** *(If "Yes," specify exact trigger(s))* |
| ☐ | ☐ | **7b. HAS THE PATIENT EVER TAKEN ORAL STEROIDS DURING THE PAST YEAR FOR EXACERBATIONS?** *(prednisone, prednisolone)* **If "YES", NUMBER OF COURSES IN THE PAST YEAR:** |
| ☐ | ☐ | **7c. 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:** |
| ☐ | ☐ | **7d. 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)*: |
| ☐ | ☐ | **7e. DOES THE PATIENT HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?** |

**BEHAVIORAL HEALTH INFORMATION** ☐ N/A

**8. HISTORY** *(Select and provide details for each "Yes" answer)*

| YES | NO | WITHIN THE LAST 5 YEARS, HAS THE PATIENT HAD A: |
|---|---|---|
| ☐ | ☐ | **8a. HISTORY OF SUICIDAL BEHAVIORS / ATTEMPTS?** *(If "Yes," include dates)* |
| ☐ | ☐ | **8b. HISTORY OF SUBSTANCE MISUSE / ABUSE?** |
| ☐ | ☐ | **8c. HISTORY OF ADDICTIVE BEHAVIORS?** |
| ☐ | ☐ | **8d. HISTORY OF EATING DISORDERS?** |
| ☐ | ☐ | **8e. HISTORY OF OTHER COMPULSIVE BEHAVIORS?** |
| ☐ | ☐ | **8f. HISTORY OF PROBLEMS WITH LEGAL AUTHORITY OR AUTHORITY FIGURES?** *(If "Yes," specify)* |
| ☐ | ☐ | **8g. HISTORY OF PSYCHOTIC EPISODES?** |
| ☐ | ☐ | **8h. HISTORY OF SERVICES RECEIVED FOR ALLEGATIONS OF FAMILY MALTREATMENT?** *(If "Yes," and services are delivered by Family Advocacy, note case determination)* |

**CURRENT INTERVENTION THERAPIES FOR AUTISM SPECTRUM DISORDER AND / OR SIGNIFICANT DEVELOPMENTAL DELAYS** ☐ N / A

| 9a. TYPE *(To be completed by a Qualified Medical Professional in consultation with the family)* | 9b. SCHOOL OR EARLY INTERVENTION HOURS / WEEK *(If known)* | 9c. TRICARE HOURS / WEEK *(If known)* | 9d. OTHER SOURCE HOURS / WEEK *(If known)* | 9e. OTHER *(Identify)* |
|---|---|---|---|---|
| **9a(1). Speech Therapy** | | | | |
| **9a(2). Occupational Therapy** | | | | |
| **9a(3). Physical Therapy** | | | | |
| **9a(4). Psychological Counseling** | | | | |
| **9a(5). Intensive Behavioral Intervention** *(Includes ABA)* | | | | |
| **9a(6). Other** *(Specify)* | | | | |

**10. COMMUNICATION** *(Select one)*

☐ VERBAL

☐ NON-VERBAL *(Uses:)*

- ☐ Signing
- ☐ Communication Device
- ☐ Picture Exchange Communication System (PECS)
- ☐ Combination

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

**12. BEHAVIOR: CHILD EXHIBITS HIGH RISK OR DANGEROUS BEHAVIOR**
*(If "Yes," provide details)* ☐ YES ☐ NO

**PROVIDER INFORMATION**

| 13a. PROVIDER PRINTED NAME OR STAMP | 13b. SIGNATURE | 13c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |

| FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME *(Last, First, Middle Initial)* | SPONSOR DoD ID # |
|---|---|---|
| | | |

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

**PART B - REQUIRED MEDICAL SPECIALTIES**

**14. HEALTH CARE REQUIRED** *(Educational services should be noted on a DD Form 2792-1)*
INDICATE FREQUENCY OF CARE: A - ANNUALLY B - BIANNUALLY *(Twice per year)* Q - QUARTERLY M - MONTHLY BI - BIMONTHLY W - WEEKLY

| | (1) CARE PROVIDER *(Select as Appropriate)* | (2) FREQUENCY *(See Above)* | | (1) CARE PROVIDER *(Select as Appropriate)* | (2) FREQUENCY *(See Above)* |
|---|---|---|---|---|---|
| a | ☐ ALLERGIST / IMMUNOLOGIST | | ii | ☐ OCCUPATIONAL THERAPIST - PEDIATRIC | |
| b | ☐ APPLIED BEHAVIOR ANALYST | | jj | ☐ OPHTHALMOLOGIST - ADULT | |
| c | ☐ AUDIOLOGIST | | kk | ☐ OPHTHALMOLOGIST - PEDIATRIC | |
| d | ☐ BEHAVIOR ANALYST | | ll | ☐ ORAL SURGEON | |
| e | ☐ CARDIAC / THORACIC SURGEON | | mm | ☐ ORTHOPEDIC SURGEON - ADULT | |
| f | ☐ CARDIOLOGIST - ADULT | | nn | ☐ ORTHOPEDIC SURGEON - PEDIATRIC | |
| g | ☐ CARDIOLOGIST - PEDIATRIC | | oo | ☐ OTORHINOLARYNGOLOGIST | |
| h | ☐ CLEFT PALATE TEAM - PEDIATRIC | | pp | ☐ PAIN CLINIC | |
| i | ☐ COUNSELOR *(Specify)* | | qq | ☐ PEDIATRIC NURSE PRACTITIONER | |
| j | ☐ DERMATOLOGIST | | rr | ☐ PEDIATRICIAN | |
| k | ☐ DEVELOPMENTAL PEDIATRICIAN | | ss | ☐ PEDIATRIC SURGEON | |
| l | ☐ DIALYSIS TEAM | | tt | ☐ PHYSIATRIST *(Physical Rehabilitation)* | |
| m | ☐ DIETARY / NUTRITION SPECIALIST | | uu | ☐ PHYSICAL THERAPIST | |
| n | ☐ ENDOCRINOLOGIST - ADULT | | vv | ☐ PLASTIC SURGEON - ADULT | |
| o | ☐ ENDOCRINOLOGIST - PEDIATRIC | | ww | ☐ PLASTIC SURGEON - PEDIATRIC | |
| p | ☐ FAMILY PRACTITIONER | | xx | ☐ PODIATRIST | |
| q | ☐ GASTROENTEROLOGIST - ADULT | | yy | ☐ PSYCHIATRIST - ADULT | |
| r | ☐ GASTROENTEROLOGIST - PEDIATRIC | | zz | ☐ PSYCHIATRIST - PEDIATRIC | |
| s | ☐ GENERAL SURGEON | | aaa | ☐ PSYCHIATRIST NURSE PRACTITIONER | |
| t | ☐ GENETICS | | bbb | ☐ PSYCHOLOGIST - ADULT | |
| u | ☐ GYNECOLOGIST | | ccc | ☐ PSYCHOLOGIST - PEDIATRIC | |
| v | ☐ GYNECOLOGIST / ONCOLOGIST | | ddd | ☐ PULMONOLOGIST - ADULT | |
| w | ☐ HEMATOLOGIST / ONCOLOGIST - ADULT | | eee | ☐ PULMONOLOGIST - PEDIATRIC | |
| x | ☐ HEMATOLOGIST / ONCOLOGIST - PEDIATRIC | | fff | ☐ RADIATION ONCOLOGIST | |
| y | ☐ INFECTIOUS DISEASE | | ggg | ☐ RESPIRATORY THERAPIST | |
| z | ☐ INTERNIST | | hhh | ☐ RHEUMATOLOGIST - ADULT | |
| aa | ☐ NEPHROLOGIST - ADULT | | iii | ☐ RHEUMATOLOGIST - PEDIATRIC | |
| bb | ☐ NEPHROLOGIST - PEDIATRIC | | jjj | ☐ SOCIAL WORKER | |
| cc | ☐ NEUROLOGIST - ADULT | | kkk | ☐ SPEECH AND LANGUAGE PATHOLOGIST | |
| dd | ☐ NEUROLOGIST - PEDIATRIC | | lll | ☐ TRANSPLANT TEAM | |
| ee | ☐ NEUROPSYCHIATRIST | | mmm | ☐ UROLOGIST - ADULT | |
| ff | ☐ NEUROPSYCHOLOGIST | | nnn | ☐ UROLOGIST - PEDIATRIC | |
| gg | ☐ NEUROSURGEON | | ooo | ☐ VASCULAR SURGEON | |
| hh | ☐ OCCUPATIONAL THERAPIST - ADULT | | ppp | ☐ OTHER *(Specify)* | |

**PROVIDER INFORMATION**

| 15a. PROVIDER PRINTED NAME OR STAMP | 15b. SIGNATURE | 15c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |

| FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME *(Last, First, Middle Initial)* | SPONSOR DoD ID # |
|---|---|---|
| | | |

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

**PART B - REQUIRED MEDICAL SPECIALTIES** *(Continued)*

**16. ARTIFICIAL OPENINGS / PROSTHETICS** *(Select all that apply)*

☐ YES IF "YES": ☐ GASTROSTOMY ☐ COLOSTOMY ☐ OTHER UNSPECIFIED OPENING *(Specify)*

☐ NO ☐ TRACHEOSTOMY ☐ ILEOSTOMY

☐ CSF SHUNT ☐ OTHER UNSPECIFIED PROSTHETICS *(Specify)*

**17. MEDICALLY INDICATED** *(As indicated in diagnostic information)* **ENVIRONMENTAL / ARCHITECTURAL CONSIDERATIONS**

☐ LIMITED STEPS *(If selected, please explain below)*
☐ COMPLETE WHEELCHAIR ACCESSIBILITY
☐ SINGLE STORY / LEVEL HOUSE
☐ CARPET PROHIBITED
☐ AIR CONDITIONING
☐ TEMPERATURE CONTROL
☐ HEPA FILTER
☐ OTHER *(Specify below)*
☐ POLLEN CONTROL
☐ AIR FILTERING

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

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

| 18a. TYPE OF EQUIPMENT *(Select as applicable)* | 18b. DESCRIPTION | 18a. TYPE OF EQUIPMENT *(Select as applicable)* | 18b. DESCRIPTION |
|---|---|---|---|
| ☐ APNEA HOME MONITOR | | ☐ HOME VENTILATOR *(Include make and model under "Description")* | |
| ☐ COCHLEAR IMPLANT *(Include make and model under "Description")* | | ☐ INSULIN PUMP *(Include make and model under "Description")* | |
| ☐ CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY | | ☐ INTERNAL DEFIBRILLATOR *(Include make and model under "Description")* | |
| ☐ FEEDING PUMP *(Include make and model under "Description")* | | ☐ PACEMAKER *(Include make and model under "Description")* | |
| ☐ HEARING AIDS *(Include make and model under "Description")* | | ☐ SPLINTS, BRACES, ORTHOTICS | |
| ☐ HOME DIALYSIS MACHINE | | ☐ SUCTION MACHINE | |
| ☐ HOME NEBULIZER | | ☐ WHEELCHAIR | |
| ☐ HOME OXYGEN THERAPY | | ☐ OTHER *(Specify)* | |

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

**PROVIDER INFORMATION**

| 20a. PROVIDER PRINTED NAME OR STAMP | 20b. SIGNATURE | 20c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |