

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

### GENERAL.

The DD Form 2792 and attached addenda are 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 11b, and the MTF coordinator/authorized reviewer signs block 12b.

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 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 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 2).

Item 1. Self-explanatory.

Item 2.a. Family Member (FM). 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.

Items 2.c. - e. Self-explanatory.

Item 2.f. Family Member Prefix (FMP). Applies to Military medical beneficiary only. The Family Member Prefix is assigned when the family member is enrolled in 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.

Items 2.h. - j. Self-explanatory.

Items 3.a. - h. All items refer to the sponsor. Self-explanatory.

Item 3.i. Annotate with an "X" 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 SSN, name of sponsor and branch of Service. Military only.

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

Item 7. Identify current medically necessary adaptive equipment or special medical equipment used by the family member. Include make and model of the equipment.

Item 8. Required Actions. Self-explanatory.

Item 9. Required Addenda. To be completed by the EFMP/Screening Coordinator completing the administrative review/certification. Please note: Each addenda is completed, and submitted for EFMP review, only if applicable to the patient described. **SIGNATURE of a Qualified Medical Provider is REQUIRED.**

Items 10.a. - c. To be completed by the administrator in consultation with the family. Mark (X) all services being provided to the family member.

Items 11.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 applicable forms are completed and attached before signing.**

Items 12.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 professional. Sponsor, spouse, or family member of majority age must sign release authorization on page 1 before this summary is completed.** Please complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM. If the patient has an asthma, mental health or autism spectrum disorder/developmental delay diagnosis, enter ONLY the diagnostic description/code on Page 4 and the remainder of the information on the appropriate attached addendum form.

Items 1.a. - c. Place an "X" in the appropriate box if the information is included in an addendum.

Items 2.a. - b. Primary Diagnosis. Enter the primary diagnosis and corresponding diagnostic code for the family member.

Items 3.a. - c. Medication History. Enter all current medications associated with the primary diagnosis, the dosage and frequency medication should be taken.

Items 4.a. - d. Hospital Support for the Last 12 Months. Enter the number of emergency room visits/urgent care visits, hospitalizations, ICU admissions, and number of outpatient visits.

Item 5. Prognosis. Self-explanatory.

Item 6. Treatment Plan for Primary Diagnosis. Include medical and/or surgical procedures, 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.

Items 7. - 21. Secondary Diagnoses. Follow procedures for Items 2. - 6. above.

Item 22. Minimum Health Care Required. Codes in the first column are used by Army coding teams only. In column 1, mark with an X 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 is not a wish list, but should reflect the providers that are necessary to meet the needs of the patient.

Items 23. - 26. Self-explanatory.

Items 27.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this summary, date the summary was signed, telephone number(s) for the provider, email and medical specialty.

## INSTRUCTIONS FOR COMPLETING DD FORM 2792 (Continued)

### ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY

(p. 8). **To be completed by a qualified medical professional.** This addendum is completed only if applicable to the patient described.

Item 1. Diagnostic Description Code. Enter the diagnostic description code (ICD-9-CM or, when approved, ICD-10-CM) for patients evaluated or treated for asthma within the past 5 years and continue the completion of the addendum and sign. **Signature of Qualified Medical Provider is REQUIRED in Item 5.b.**

Items 2. - 4. Self-explanatory.

Item 5.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this addendum, the date the summary was signed, the telephone number(s) for the provider, email, and medical specialty.

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### ADDENDUM 2 - MENTAL HEALTH SUMMARY (pp. 9 - 10). **To be completed and signed by a qualified medical professional.** This addendum is completed only if applicable to the patient described.

Items 1.a. - c. Diagnosis(es). Complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM if the patient has current or past (within the last 5 years) history of mental health diagnosis (to include attention deficit disorders).

Items 2.a. - c. Medication History. Provide current medications, dosage, and frequency for diagnoses listed in Item 1.a.

Items 2.d. - e. Include any discontinued medication(s) related to the diagnosis(es), with reasons for discontinuing, and the frequency taken.

Items 3.a. - b. Therapy Received or Recommended. Include past compliance with treatment programs, frequency and expected length of treatment, required participation of family members, and if treatment is ongoing.

Items 4.a. - c. Treatment. Insert the number of outpatient visits in the **LAST YEAR**, the number of hospitalizations in the **LAST FIVE YEARS**, and the number of residential treatment admissions in the **LAST FIVE YEARS** (include the date of last admission).

Items 5.a. - h. History. Answer Yes or No, and include additional details as directed on the patient's mental health history for the last five years.

Items 6. - 9. Self-explanatory.

Items 10.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this addendum, the date the summary was signed, the telephone number(s) for the provider, email and medical specialty.

### ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS (p.11) . **To be completed by a qualified medical professional.** This addendum

is completed only if applicable to the patient described.

Item 1.a. - c. Indicate the diagnosis(es) using an X. Insert the date when diagnosed and select the appropriate specialty provider(s) or school-based team that diagnosed the patient.

Items 2. - 3. Self-explanatory.

Items 4.a. - d. Current Medications. List all current medications used to treat the diagnosis(es) listed in Items 1 and 3, the dosage, the frequency taken, and the reason prescribed.

Items 5.a. - e. Current Interventions/Therapies. Providing a list of current interventions and therapies is important information for the family travel determination for this patient. The information should be completed by a qualified medical professional in consultation with the family. Self-explanatory.

Item 6. Communication. Using an X, indicate if the patient is verbal or non-verbal. If non-verbal, indicate the appropriate communication methods used.

Item 7. Self-explanatory.

Item 8. Behavior. Answer yes if the child exhibits high risk or dangerous behaviors. Additional information may be included in item 13 if more space is required.

Item 9. Cognitive Ability. Indicate appropriate intelligence quotient (IQ), if known.

Items 10. - 11. Self-explanatory.

Item 12. Respite Care Received. Provide the number of hours per month, and the source, e.g., EFMP Respite Care Program, ECHO or Medicaid.

Item 13. General Comments. Self-explanatory.

Item 14. Provider Information. Official Stamp or printed name, signature, date signed, telephone number(s), official email and medical specialty. 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  
Jul 31, 2017

The public reporting burden for this collection of information is estimated to average 30 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, including 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 (0704-0411). 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 FORM TO THE ABOVE ORGANIZATION.**

### 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 DoD personnel to evaluate and document the special medical needs of family members. This information will enable: (1) military assignment personnel to match the special medical needs of family members against the availability of medical services, and (2) civilian personnel officers 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 SORNs may be found at <http://dpclo.defense.gov/Privacy/SORNSIndex/DODComponentNotices.aspx>.

**ROUTINE USE(S):** DoD Blanket Routine Uses 1, 4, 6, 8, 9, 12, and 15 found at <http://dpclo.defense.gov/Privacy/SORNSIndex/BlanketRoutineUses.aspx> may apply.

**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 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 Social Security Number.

### 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 Relocation or Suitability Screening Office and/or the Exceptional Family Member/Special Needs Program to be used in the family travel review process and/or registration in the Exceptional Family Member Program. The information on this form and addenda may be used for DoD and Service-specific programs to determine whether there are adequate medical, housing and community resources to meet your medical needs at the sponsor's proposed duty locations.

a. The military medical department will use the information to determine 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, if EFMP enrollment criteria are met.

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. Access to the information is limited to representatives from the medical departments, the offices responsible for assignment coordination, and at your request other military agents responsible for care or services. Summary data may be transmitted (e.g., faxing or emailing) 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 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. 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. However, failure to coordinate accompanied assignments prior to OCONUS travel may result in ineligibility for TRICARE Prime status (*does not pertain to civilian employees*).

e. Failure to release this information or any subsequent revocation may result in ineligibility for accompanied family travel at government expense.

f. 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

DATE (YYYYMMDD)

(If applicable)

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

**1. PURPOSE OF THIS FORM** (X one)

<input type="checkbox"/> EFMP Registration/Enrollment Update	<input type="checkbox"/> Request Change in EFMP Status:	<input type="checkbox"/> No Longer Have Previously Identified Condition	<input type="checkbox"/> Family Member Deceased*
<input type="checkbox"/> Request for Government Sponsored Travel	<input type="checkbox"/> No Longer Qualifies as a Dependent*	<input type="checkbox"/> Divorce/Change in Custody*	

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

<b>2.a. FAMILY MEMBER/PATIENT NAME</b> (Last, First, Middle Initial)	<b>b. SPONSOR NAME</b> (Last, First, Middle Initial)	<b>c. SPONSOR SSN</b>
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<b>d. FAMILY MEMBER GENDER</b> (X)	<b>e. FAMILY MEMBER DATE OF BIRTH</b> (YYYYMMDD)	<b>f. FAMILY MEMBER PREFIX (FMP)</b>	<b>g. DOD BENEFITS NUMBER (DBN)</b> (on back of ID Card)
<input type="checkbox"/> Male <input type="checkbox"/> Female			

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

<b>3.a. SPONSOR RANK OR GRADE</b>	<b>b. DESIGNATION/NEC/MOS/AFSC</b> (Military only)	<b>c. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT</b>
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<b>d. BRANCH OF SERVICE</b> (Military only)	<b>e. STATUS</b> (X one)
<input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps <input type="checkbox"/> Coast Guard	<input type="checkbox"/> Regular Active Service Member <input type="checkbox"/> Active Reserve <input type="checkbox"/> Active Guard <input type="checkbox"/> Reserves <input type="checkbox"/> National Guard <input type="checkbox"/> Civilian

<b>f. SPONSOR'S OFFICIAL E-MAIL ADDRESS</b>	<b>g. DUTY TELEPHONE NUMBER</b> (Include Area Code/Country Code)	<b>h. MOBILE NUMBER</b> (Include Area Code/Country Code)
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<b>i. DOES CHILD RESIDE WITH SPONSOR?</b> (X one. If No, explain.)
<input type="checkbox"/> YES <input type="checkbox"/> NO

<b>4.a. ARE YOU DUAL MILITARY OR IS YOUR SPOUSE FORMER MILITARY?</b> (Military only) (X one. If Yes, complete 4.b. - e. below)				
<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>b. SPOUSE'S NAME</b> (Last, First, Middle Initial)	<b>c. BRANCH OF SERVICE</b>	<b>d. RANK/RATE</b>	<b>e. SPOUSE SSN</b>

<b>5.a. IS FAMILY MEMBER ENROLLED IN DEERS OR EVER BEEN ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR'S NAME OR SSN?</b> (Military only) (X one)			
<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>b. IF YES, UNDER WHAT SSN?</b>	<b>c. NAME OF SPONSOR</b> (Last, First, Middle Initial)	<b>d. BRANCH OF SERVICE</b>

<b>6.a. DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES?</b> (X one)				
<input type="checkbox"/> YES <input type="checkbox"/> NO (If Yes, complete 9.b. and c.)	<b>b. LOCATION OF CASE MANAGER</b> (X)	<input type="checkbox"/> MTF	<input type="checkbox"/> TRICARE	<input type="checkbox"/> Civilian

<b>c. CASE MANAGER CONTACT INFORMATION</b>		
<b>(1) NAME</b> (Last, First, Middle Initial)	<b>(2) EMAIL ADDRESS</b> (If available)	<b>(3) TELEPHONE NUMBER</b> (Include Area Code/Country Code)

<b>7. MEDICALLY NECESSARY EQUIPMENT</b> (X and complete as applicable)		
<b>a. COCHLEAR IMPLANT</b>	If applicable: (1) MAKE	(2) MODEL
<b>b. HEARING AIDS</b>	If applicable: (1) MAKE	(2) MODEL
<b>c. INSULIN PUMP</b>	If applicable: (1) MAKE	(2) MODEL
<b>d. PACEMAKER</b>	If applicable: (1) MAKE	(2) MODEL
<b>e. OTHER EQUIPMENT</b> (Specify and include make and model as appropriate.)		

<b>FAMILY MEMBER/PATIENT NAME</b> (Last, First, Middle Initial)	<b>SPONSOR NAME</b>	<b>SPONSOR SSN</b> (Last four)
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**FOR ADMINISTRATIVE USE ONLY**

**8. REQUIRED ACTIONS** (X one)

<input type="checkbox"/> First Review of Medical History for the Family Member	<input type="checkbox"/> <b>Qualifies for Change in EFMP Status:</b>	<input type="checkbox"/> Family Member No Longer Has Previously Identified Condition	<input type="checkbox"/> Family Member Deceased*
<input type="checkbox"/> Request for Government Sponsorship/Family Travel		<input type="checkbox"/> Family Member No Longer Qualifies as a Dependent*	<input type="checkbox"/> Divorce/Change in Custody*
<input type="checkbox"/> Update to a Previous Evaluation for the Family Member			
<input type="checkbox"/> Other (e.g., Extended Care Health Option Eligibility):		(*Maintain documentation to verify change in status - do not update medical information.)	

**9. REQUIRED ADDENDA.**

Verify required addendum is attached and has been signed (X each that applies). Do not submit a blank addendum for EFMP review.

<input type="checkbox"/> Asthma Addendum 1 is required and <input type="checkbox"/> Attached.
<input type="checkbox"/> Mental Health Summary Addendum 2 is required and <input type="checkbox"/> Attached.
<input type="checkbox"/> Autism Spectrum Disorder/Developmental Delay (AS/DD) Addendum 3 is required and <input type="checkbox"/> Attached.

**10. SPECIAL ASSIGNMENT CONSIDERATIONS** (X all that apply)

<input type="checkbox"/> a. Possible Special Education/Early Intervention (If checked, DD Form 2792-1 must be completed)
<input type="checkbox"/> b. Receiving TRICARE Extended Care Health Option (ECHO) Benefits
<input type="checkbox"/> c. Receiving State Medicaid/Medicare Waiver Services

**CERTIFICATION**

**11. CERTIFICATION. DO NOT CERTIFY BEFORE THE MEDICAL PROVIDER COMPLETES THE ENTIRE FORM AND ADDENDA.**

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:**

a. <b>PRINTED NAME</b>	b. <b>SIGNATURE</b>	c. <b>DATE (YYYYMMDD)</b>
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**12. ADMINISTRATIVE CERTIFICATION**

a. <b>PRINTED NAME</b> (Last, First, Middle Initial)	b. <b>SIGNATURE</b>	c. <b>DATE (YYYYMMDD)</b>	f. <b>OFFICIAL STAMP</b>
d. <b>LOCATION OF MILITARY TREATMENT FACILITY OR CERTIFYING EFMP OFFICE</b>		e. <b>TELEPHONE NUMBER</b> (Include area code/Country Code)	

<b>FAMILY MEMBER/PATIENT NAME</b> (Last, First, Middle Initial)	<b>SPONSOR NAME</b>	<b>SPONSOR SSN</b> (Last four)
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**MEDICAL SUMMARY: To be completed by a Qualified Medical Professional**

**PART A - PATIENT STATUS** (Authorization by patient or parent/guardian included on Page 1 of this form)

Please complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM. If the patient has an asthma, mental health, or autism spectrum disorder/developmental delay diagnosis, enter ONLY the diagnostic description/code on this page and the remainder of the information on the appropriate attached addendum form.

**1. INFORMATION INCLUDED IN ADDENDUM** (X all that apply)

<input type="checkbox"/> a. Asthma (Addendum 1)	<input type="checkbox"/> b. Mental Health/ADHD (Addendum 2)	<input type="checkbox"/> c. Autism/Developmental Delay (AS/DD) (Addendum 3)
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**2. PRIMARY DIAGNOSIS**

a. DIAGNOSIS	b. CODE <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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**3. MEDICATION HISTORY** (Associated with primary diagnosis)

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

**4. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS** (Associated with primary diagnosis)

a. NUMBER OF ER VISITS/URGENT CARE VISITS	b. NUMBER OF HOSPITALIZATIONS	c. NUMBER OF ICU ADMISSIONS	d. NUMBER OF OUTPATIENT VISITS
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**5. PROGNOSIS** (X one)

<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR	<input type="checkbox"/> GUARDED	<input type="checkbox"/> UNSTABLE	<input type="checkbox"/> NON-COMPLIANT
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**6. TREATMENT PLAN FOR PRIMARY DIAGNOSIS** (Medical, mental health, surgical procedures or therapies 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.)

**7. SECONDARY DIAGNOSIS 1**

a. DIAGNOSIS	b. CODE <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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**8. MEDICATION HISTORY** (Associated with secondary diagnosis)

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

**9. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS** (Associated with secondary diagnosis)

a. NUMBER OF ER VISITS/URGENT CARE VISITS	b. NUMBER OF HOSPITALIZATIONS	c. NUMBER OF ICU ADMISSIONS	d. NUMBER OF OUTPATIENT VISITS
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**10. PROGNOSIS** (X one)

<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR	<input type="checkbox"/> GUARDED	<input type="checkbox"/> UNSTABLE	<input type="checkbox"/> NON-COMPLIANT
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**11. TREATMENT PLAN FOR SECONDARY DIAGNOSIS** (Medical, mental health, surgical procedures or therapies 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.)

<b>FAMILY MEMBER/PATIENT NAME</b> <i>(Last, First, Middle Initial)</i>	<b>SPONSOR NAME</b>	<b>SPONSOR SSN</b> <i>(Last four)</i>
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**MEDICAL SUMMARY** *(Continued): To be completed by a Qualified Medical Professional*

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

**12. SECONDARY DIAGNOSIS 2**

<b>a. DIAGNOSIS</b>	<b>b. CODE</b> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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**13. MEDICATION HISTORY** *(Associated with secondary diagnosis)*

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

**14. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS** *(Associated with secondary diagnosis)*

<b>a. NUMBER OF ER VISITS/URGENT CARE VISITS</b>	<b>b. NUMBER OF HOSPITALIZATIONS</b>	<b>c. NUMBER OF ICU ADMISSIONS</b>	<b>d. NUMBER OF OUTPATIENT VISITS</b>
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**15. PROGNOSIS** *(X one)*

<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR	<input type="checkbox"/> GUARDED	<input type="checkbox"/> UNSTABLE	<input type="checkbox"/> NON-COMPLIANT
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**16. TREATMENT PLAN FOR THIS DIAGNOSIS** *(Medical, mental health, surgical procedures or therapies 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.)*

**17. SECONDARY DIAGNOSIS 3**

<b>a. DIAGNOSIS</b>	<b>b. CODE</b> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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**18. MEDICATION HISTORY** *(Associated with secondary diagnosis)*

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

**19. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS** *(Associated with secondary diagnosis)*

<b>a. NUMBER OF ER VISITS/URGENT CARE VISITS</b>	<b>b. NUMBER OF HOSPITALIZATIONS</b>	<b>c. NUMBER OF ICU ADMISSIONS</b>	<b>d. NUMBER OF OUTPATIENT VISITS</b>
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**20. PROGNOSIS** *(X one)*

<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR	<input type="checkbox"/> GUARDED	<input type="checkbox"/> UNSTABLE	<input type="checkbox"/> NON-COMPLIANT
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**21. TREATMENT PLAN FOR THIS DIAGNOSIS** *(Medical, mental health, surgical procedures or therapies 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.)*

<b>FAMILY MEMBER/PATIENT NAME</b> (Last, First, Middle Initial)	<b>SPONSOR NAME</b>	<b>SPONSOR SSN</b> (Last four)
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**MEDICAL SUMMARY (Continued): To be completed by a Qualified Medical Professional**

**PART B - REQUIRED MEDICAL SPECIALTIES**

**22. MINIMUM HEALTH CARE REQUIRED**

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

		(1) CARE PROVIDER (X as appropriate)	(2) FREQUENCY (See above)			(1) CARE PROVIDER (X as appropriate)	(2) FREQUENCY (See above)
C01	a.	ALLERGIST/IMMUNOLOGIST		C57	hh.	ORAL SURGEON	
C99	b.	AUDIOLOGIST		C47	ii.	ORTHOPEDIC SURGEON - ADULT	
C52	c.	BEHAVIOR ANALYST		C48	jj.	ORTHOPEDIC SURGEON - PEDIATRIC	
C42	d.	CARDIAC/THORACIC SURGEON		C56	kk.	OTORHINOLARYNGOLOGIST	
C02	e.	CARDIOLOGIST - ADULT		C77	ll.	PAIN CLINIC	
C03	f.	CARDIOLOGIST - PEDIATRIC		C72	mm.	PEDIATRIC NURSE PRACTITIONER	
C70	g.	CLEFT PALATE TEAM - PEDIATRIC		C30	nn.	PEDIATRICIAN	
C05	h.	DERMATOLOGIST		C49	oo.	PEDIATRIC SURGEON	
C06	i.	DEVELOPMENTAL PEDIATRICIAN		C32	pp.	PHYSIATRIST (Physical Rehabilitation)	
C53	j.	DIALYSIS TEAM		C58	qq.	PHYSICAL THERAPIST	
C07	k.	DIETARY/NUTRITION SPECIALIST		C50	rr.	PLASTIC SURGEON - ADULT	
C08	l.	ENDOCRINOLOGIST - ADULT		C71	ss.	PLASTIC SURGEON - PEDIATRIC	
C09	m.	ENDOCRINOLOGIST - PEDIATRIC		C99	tt.	PODIATRIST	
C10	n.	FAMILY PRACTITIONER		C35	uu.	PSYCHIATRIST - ADULT	
C11	o.	GASTROENTEROLOGIST - ADULT		C36	vv.	PSYCHIATRIST - PEDIATRIC	
C12	p.	GASTROENTEROLOGIST - PEDIATRIC		C72	ww.	PSYCHIATRIST NURSE PRACTITIONER	
C43	q.	GENERAL SURGEON		C37	xx.	PSYCHOLOGIST - ADULT	
C14	r.	GENETICS		C38	yy.	PSYCHOLOGIST - PEDIATRIC	
C15	s.	GYNECOLOGIST		C33	zz.	PULMONOLOGIST - ADULT	
C99	t.	GYNECOLOGIST/ONCOLOGIST		C76	aaa.	PULMONOLOGIST - PEDIATRIC	
C17	u.	HEMATOLOGIST/ONCOLOGIST - ADULT		C99	bbb.	RADIATION ONCOLOGIST	
C18	v.	HEMATOLOGIST/ONCOLOGIST - PEDIATRIC		C60	ccc.	RESPIRATORY THERAPIST	
C75	w.	INFECTIOUS DISEASE		C39	ddd.	RHEUMATOLOGIST - ADULT	
C20	x.	INTERNIST		C40	eee.	RHEUMATOLOGIST - PEDIATRIC	
C21	y.	NEPHROLOGIST - ADULT		C61	fff.	SOCIAL WORKER	
C22	z.	NEPHROLOGIST - PEDIATRIC		C62	ggg.	SPEECH AND LANGUAGE PATHOLOGIST	
C23	aa.	NEUROLOGIST - ADULT		C41	hhh.	TRANSPLANT TEAM	
C24	bb.	NEUROLOGIST - PEDIATRIC		C51	iii.	UROLOGIST - ADULT	
C44	cc.	NEUROSURGEON		C78	jjj.	UROLOGIST - PEDIATRIC	
C54	dd.	OCCUPATIONAL THERAPIST - ADULT		C99	kkk.	VASCULAR SURGEON	
C55	ee.	OCCUPATIONAL THERAPIST - PEDIATRIC		C99	lll.	OTHER (Describe)	
C26	ff.	OPHTHALMOLOGIST - ADULT					
C27	gg.	OPHTHALMOLOGIST - PEDIATRIC					



<b>FAMILY MEMBER/PATIENT NAME</b> (Last, First, Middle Initial)	<b>SPONSOR NAME</b>	<b>SPONSOR SSN</b> (Last four)
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**MEDICAL SUMMARY - PART B (Continued): To be completed by a Qualified Medical Professional**

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

<input type="checkbox"/> YES	<input type="checkbox"/> IF YES:	<input type="checkbox"/> F01 - GASTROSTOMY	<input type="checkbox"/> F05 - COLOSTOMY	<input type="checkbox"/> F99 - OTHER UNSPECIFIED OPENING (Specify)
<input type="checkbox"/> NO		<input type="checkbox"/> F02 - TRACHEOSTOMY	<input type="checkbox"/> F06 - ILEOSTOMY	
		<input type="checkbox"/> F03 - CSF SHUNT	<input type="checkbox"/> F07 - OTHER UNSPECIFIED PROSTHETICS (Specify)	
		<input type="checkbox"/> F04 - CYSTOSTOMY		

**24. MEDICALLY INDICATED** (as indicated in diagnostic information) **ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS**

<input type="checkbox"/> R01 - LIMITED STEPS (If Yes, please explain)	<input type="checkbox"/> R03 - AIR CONDITIONING	<input type="checkbox"/> R03c - POLLEN CONTROL
<input type="checkbox"/> R02 - COMPLETE WHEELCHAIR ACCESSIBILITY	<input type="checkbox"/> R03a - TEMPERATURE CONTROL	<input type="checkbox"/> R03d - AIR FILTERING
<input type="checkbox"/> R04 - SINGLE STORY/LEVEL HOUSE	<input type="checkbox"/> R03b - HEPA FILTER	
<input type="checkbox"/> R05 - CARPET PROHIBITED	<input type="checkbox"/> R99 - OTHER (Specify below)	

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

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

a. TYPE OF EQUIPMENT (X)	b. DESCRIPTION	a. TYPE OF EQUIPMENT (X)	b. DESCRIPTION
L03 - APNEA HOME MONITOR		L14 - HOME VENTILATOR	
L31 - COCHLEAR IMPLANT		L22 - INSULIN PUMP	
L21 - CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY		L32 - INTERNAL DEFIBRILLATOR	
L33 - FEEDING PUMP		L23 - PACEMAKER	
L04 - HEARING AIDS		L07 - SPLINTS, BRACES, ORTHOTICS	
L20 - HOME DIALYSIS MACHINE		L08 - WHEELCHAIR	
L13 - HOME NEBULIZER		L99 - OTHER (Specify)	
L12 - HOME OXYGEN THERAPY			

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

**PART C - PROVIDER INFORMATION**

<b>27.a. PROVIDER PRINTED NAME OR STAMP</b>		<b>b. SIGNATURE</b>	<b>c. DATE</b> (YYYYMMDD)
<b>d. TELEPHONE NUMBERS</b> (Include Area Code/Country Code)		<b>e. OFFICIAL E-MAIL ADDRESS</b>	<b>f. MEDICAL SPECIALTY</b>
(1) <b>COMMERCIAL</b>	(2) <b>DSN</b> (Military only)		

<b>FAMILY MEMBER/PATIENT NAME</b> (Last, First, Middle Initial)	<b>SPONSOR NAME</b>	<b>SPONSOR SSN</b> (Last four)
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**ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY:  
To be completed by a Qualified Medical Professional**

Complete addendum if patient has been evaluated or treated for asthma within the past five years.

**1. DIAGNOSTIC DESCRIPTION CODE** (ICD-9-CM or, when approved, ICD-10-CM)

<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**2. MEDICATION HISTORY**

a. MEDICATION(S)	b. DOSAGE	c. FREQUENCY

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

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	a. ARE THERE ANY TRIGGERS FOR THE PATIENT'S ASTHMA ATTACKS (stress, environment, exercise)?
<input type="checkbox"/>	<input type="checkbox"/>	b. DOES THE PATIENT ROUTINELY (greater than 10 days per month/four months per year) USE INHALED ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS?
<input type="checkbox"/>	<input type="checkbox"/>	c. HAS THE PATIENT TAKEN ORAL STEROIDS DURING THE PAST YEAR (prednisone, prednisolone)? IF "YES", NUMBER OF DAYS IN PAST YEAR: _____
<input type="checkbox"/>	<input type="checkbox"/>	d. HAS THE PATIENT EVER EXPERIENCED UNCONSCIOUSNESS OR SEIZURES ASSOCIATED WITH ASTHMA ATTACKS?
<input type="checkbox"/>	<input type="checkbox"/>	e. 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: _____
<input type="checkbox"/>	<input type="checkbox"/>	f. HAS THE PATIENT BEEN HOSPITALIZED FOR PULMONARY DISEASE (pneumonia, bronchitis, bronchiolitis, croup, RSV) DURING THE PAST YEAR? IF "YES", INDICATE THE DATE(S) OF HOSPITALIZATION (YYYYMMDD): _____
<input type="checkbox"/>	<input type="checkbox"/>	g. 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): _____
<input type="checkbox"/>	<input type="checkbox"/>	h. HAS THE PATIENT REQUIRED MECHANICAL VENTILATION (Intubation/use of respirator) DURING THE PAST 3 YEARS?
<input type="checkbox"/>	<input type="checkbox"/>	i. DOES THE PATIENT HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?
j. APPROXIMATE NUMBER OF DAYS THAT THE PATIENT MISSED SCHOOL/WORK/PLAY DUE TO ASTHMA-RELATED PROBLEMS (including visits to physicians) DURING THE PAST YEAR? _____		
k. HOW OFTEN DOES THE PATIENT USE HIS/HER RESCUE INHALER OR NEBULIZER MEDICATION (such as Albuterol or Levalbuterol) FOR INCREASED OR ACUTE SYMPTOMS?		

**4. SEVERITY LEVEL.** What is the patient's severity level based on the current treatment plan? (Select one level of severity. Definitions are examples of severity. Pulmonary function tests are required only if clinically indicated.)

<input type="checkbox"/>	<b>a. INTERMITTENT ASTHMA.</b> 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 $< 20\%$ .
<input type="checkbox"/>	<b>b. MILD PERSISTENT ASTHMA.</b> 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%.
<input type="checkbox"/>	<b>c. MODERATE PERSISTENT.</b> 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 $> 30\%$ .
<input type="checkbox"/>	<b>d. SEVERE PERSISTENT.</b> Continuous symptoms. Frequent exacerbations. Frequent nighttime asthma symptoms. Physical activities limited by asthma symptoms. PEF or FEV1 $\leq 60\%$ predicted; variability $> 30\%$ .

<b>5.a. PROVIDER PRINTED NAME OR STAMP</b>	<b>b. SIGNATURE</b>	<b>c. DATE</b> (YYYYMMDD)
<b>d. TELEPHONE NUMBERS</b> (Include Area Code/Country Code) (1) <b>COMMERCIAL</b> (2) <b>DSN</b> (Military only)	<b>e. OFFICIAL E-MAIL ADDRESS</b>	<b>f. MEDICAL SPECIALTY</b>

<b>FAMILY MEMBER/PATIENT NAME</b> (Last, First, Middle Initial)	<b>SPONSOR NAME</b>	<b>SPONSOR SSN</b> (Last four)
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**ADDENDUM 2 - MENTAL HEALTH SUMMARY: To be completed by a Qualified Clinical Provider**

Complete addendum if the patient has current or past (duration of 6 months or longer) history (within the last 5 years) of mental health diagnosis (to include attention deficit disorders).

**1. DIAGNOSIS(ES).** Please complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM.

a. DIAGNOSIS	b. ICD OR DSM (Required)	c. AGE AT DIAGNOSIS

**2. MEDICATION HISTORY RELATED TO THE DIAGNOSIS LISTED ABOVE.**

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY
d. DISCONTINUED MEDICATION(S) RELATED TO DIAGNOSIS(ES) (Include reason for discontinuing)	e. FREQUENCY	

**3.a. THERAPIES RECEIVED OR RECOMMENDED.** (Include past compliance with treatment programs, expected length of treatment, required participation of family members, and if treatment is ongoing.)

b. FREQUENCY

**4. COMPLETE FOR TREATMENT:**

<b>a. NUMBER OF OUTPATIENT VISITS IN THE LAST YEAR:</b>	<b>b. NUMBER OF HOSPITALIZATIONS IN THE LAST FIVE YEARS:</b>	<b>c. NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS IN THE LAST FIVE YEARS:</b>	<b>DATE OF LAST ADMISSION (YYYYMMDD):</b>

**5. HISTORY** (X and provide details for each "Yes" answer)

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

<b>FAMILY MEMBER/PATIENT NAME</b> (Last, First, Middle Initial)	<b>SPONSOR NAME</b>	<b>SPONSOR SSN</b> (Last four)
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**ADDENDUM 2 - MENTAL HEALTH SUMMARY (Continued): To be completed by a Qualified Clinical Provider**

**6. TREATMENT PLAN** (Related to the patient's mental health condition planned over the next three years).

**7. PROGNOSIS** (X one)

<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR	<input type="checkbox"/> GUARDED	<input type="checkbox"/> UNSTABLE	<input type="checkbox"/> NON-COMPLIANT
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**8. PROVIDERS REQUIRED TO IMPLEMENT TREATMENT PLAN AND FREQUENCY OF VISITS**

<input type="checkbox"/> PSYCHIATRIST	<input type="checkbox"/> PSYCHOLOGIST	<input type="checkbox"/> SOCIAL WORKER	<input type="checkbox"/> OTHER (Specify)
<input type="checkbox"/> WEEKLY	<input type="checkbox"/> WEEKLY	<input type="checkbox"/> WEEKLY	<input type="checkbox"/> WEEKLY
<input type="checkbox"/> BI-MONTHLY	<input type="checkbox"/> BI-MONTHLY	<input type="checkbox"/> BI-MONTHLY	<input type="checkbox"/> BI-MONTHLY
<input type="checkbox"/> MONTHLY	<input type="checkbox"/> MONTHLY	<input type="checkbox"/> MONTHLY	<input type="checkbox"/> MONTHLY
<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> QUARTERLY
<input type="checkbox"/> BIANNUALLY	<input type="checkbox"/> BIANNUALLY	<input type="checkbox"/> BIANNUALLY	<input type="checkbox"/> BIANNUALLY
<input type="checkbox"/> ANNUALLY	<input type="checkbox"/> ANNUALLY	<input type="checkbox"/> ANNUALLY	<input type="checkbox"/> ANNUALLY

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

<b>10.a. PROVIDER PRINTED NAME OR STAMP</b>	<b>b. SIGNATURE</b>	<b>c. DATE</b> (YYYYMMDD)
<b>d. TELEPHONE NUMBERS</b> (Include Area Code/Country Code)	<b>e. OFFICIAL E-MAIL ADDRESS</b>	<b>f. MEDICAL SPECIALTY</b>
(1) <b>COMMERCIAL</b>	(2) <b>DSN</b> (Military only)	

<b>FAMILY MEMBER/PATIENT NAME</b> (Last, First, Middle Initial)	<b>SPONSOR NAME</b>	<b>SPONSOR SSN</b> (Last four)
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**ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS:**

**To be Completed by a Qualified Medical Professional**

Complete addendum if the patient has been evaluated or received treatment(s) for autism spectrum disorders and/or significant developmental delays.

<b>1.a. DIAGNOSIS(ES)</b> <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Global Developmental Delay <input type="checkbox"/> Other (Specify) _____	<b>b. AGE WHEN DIAGNOSED</b> _____	<b>2. DATE OF BIRTH</b> (YYYYMMDD)
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<b>c. DIAGNOSED BY:</b>			
<input type="checkbox"/> Child Psychologist	<input type="checkbox"/> Child Psychiatrist	<input type="checkbox"/> Developmental Pediatrician	<input type="checkbox"/> Other Physician
<input type="checkbox"/> Medical Multidisciplinary Team	<input type="checkbox"/> School-Based Team	<input type="checkbox"/> Other (Specify) _____	

<b>3. COEXISTING DIAGNOSES</b> (X all that apply)			
<input type="checkbox"/> Chromosomal Abnormalities	<input type="checkbox"/> Intermittent Explosive Disorder	<input type="checkbox"/> Major Depressive Disorder, Depressive Disorder, NOS	
<input type="checkbox"/> Obsessive Compulsive Disorder	<input type="checkbox"/> Circadian-Rhythm Sleep Disorder	<input type="checkbox"/> Seizure Disorder	
<input type="checkbox"/> Attention Deficit/Hyperactivity Disorder	<input type="checkbox"/> Generalized Anxiety Disorder, Anxiety Disorder, NOS	<input type="checkbox"/> Other (Specify) _____	

<b>4. CURRENT MEDICATIONS</b> (Used to treat diagnoses on this page)			
a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY	d. REASON PRESCRIBED

<b>5. CURRENT INTERVENTION THERAPIES</b>				
a. TYPE (To be completed by a qualified medical professional in consultation with the family)	b. SCHOOL HOURS/WEEK (If known)	c. TRICARE HOURS/WEEK (If known)	d. OTHER SOURCE HOURS/WEEK (If known)	e. OTHER (Identify)
(1) Speech Therapy				
(2) Occupational Therapy				
(3) Physical Therapy				
(4) Psychological Counseling				
(5) Intensive Behavioral Intervention (Includes ABA)				
(6) OTHER (Specify)				

<b>6. COMMUNICATION</b> (X)	<b>7. OTHER INTERVENTIONS/THERAPIES USED BY THE FAMILY</b> (Specify alternate or complementary therapies)
<input type="checkbox"/> VERBAL <input type="checkbox"/> NON-VERBAL (Uses:) <input type="checkbox"/> Signing <input type="checkbox"/> Communication Device <input type="checkbox"/> Picture Exchange Communication System (PECS) <input type="checkbox"/> Combination	<b>8. BEHAVIOR: CHILD EXHIBITS HIGH RISK OR DANGEROUS BEHAVIOR</b> <input type="checkbox"/> YES <input type="checkbox"/> NO (If Yes, provide details in Item 13 below)

<b>9. COGNITIVE ABILITY</b> (X)	<b>10. EDUCATION</b> (X)
<input type="checkbox"/> <50 <input type="checkbox"/> 50 - 70 <input type="checkbox"/> >70 <input type="checkbox"/> Unknown <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Receives Early Intervention <input type="checkbox"/> Receives Special Education <input type="checkbox"/> Attends Public School <input type="checkbox"/> Attends Private School <input type="checkbox"/> Attends Special Private School <input type="checkbox"/> Is Home Schooled

<b>11. REQUIRED MEDICAL SERVICES</b>				<b>12. RESPITE CARE RECEIVED</b>	
(X)	a. TYPE	b. FREQUENCY	(X)	a. TYPE	b. FREQUENCY
	Child Psychology			Child Neurology	
	Child Psychiatry			Developmental Pediatrics	

<b>13. GENERAL COMMENTS</b> (Include Functional Levels)		

<b>14.a. PROVIDER PRINTED NAME OR STAMP</b>	<b>b. SIGNATURE</b>	<b>c. DATE</b> (YYYYMMDD)
<b>d. TELEPHONE NUMBERS</b> (Include Area Code/Country Code)		<b>e. OFFICIAL E-MAIL ADDRESS</b>
(1) <b>COMMERCIAL</b>	(2) <b>DSN</b> (Military only)	<b>f. MEDICAL SPECIALTY</b>