

EXCEPTIONAL FAMILY MEMBER MEDICAL SUMMARY*(To be completed by service member or civilian employee.)**(Read Instructions before completing this form.)*Form Approved
OMB No. 0704-0411
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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, Executive Services and Communications Directorate (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 USC 3013, 5013, and 8013; 20 USC 921 - 932; and EO 9397.

PRINCIPAL PURPOSE(S): Information will only be used by personnel of the Military Departments to evaluate and document the medical needs of family members. This information will enable: (1) Military assignment personnel to match the needs of family members against the availability of medical services; and (2) Civilian personnel offices to determine the availability of medical services to meet the medical needs of family members of DoD and Military Department civilian employees.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; failure to respond will preclude the successful processing of an application for family travel/command sponsorship. Mandatory for military personnel; failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Authority - Public Law 104-191, "Health Insurance Portability and Accountability Act (HIPAA)", August 21, 1996.

This form will not be used for authorization to disclose psychotherapy notes, alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program.

I authorize _____ (MTF/DTF) to release my patient information to the Exceptional Family Member/Special Needs Program to be used in the assignment coordination process. The information on this form and addenda will be used to determine whether there are adequate medical, housing and community resources to meet your special medical needs at the sponsor's proposed duty locations.

- The military medical department will use the information to make recommendations on the availability of care in communities where the sponsor may be assigned or employed.
- 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.
- 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 coordination process. Only representatives from the medical department and the offices responsible for EFMP assignment coordination will have access to the information.

Start Date: The authorization start date is the date that you sign this form authorizing the release of information.**Expiration Date:** The authorization shall continue until enrollment in the Exceptional Family Member Program/Special Needs Program is no longer necessary according to Service specific criteria, or you no longer meet the criteria to qualify as a dependent, or the sponsor is no longer in active military service or employment of the U.S. Government overseas.

I understand that:

- I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my 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 my protected information on the basis of this authorization.
- If I authorize my 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.
- I have a right to inspect and receive a copy of my own 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 to the named individual/organization indicated.
- 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.

SIGNATURE OF PATIENT/PARENT/GUARDIAN

RELATIONSHIP TO PATIENT *(If applicable)*

DATE (YYYYMMDD)

DEMOGRAPHICS/CERTIFICATION

1.a. APPLICATION STATUS <i>(X one)</i>			b. FAMILY STATUS		
<input type="checkbox"/> INITIAL SCREENING/ ENROLLMENT	<input type="checkbox"/> UPDATED INFORMATION	<input type="checkbox"/> REQUEST DISENROLLMENT	<input type="checkbox"/> ADDITIONAL FAMILY MEMBER HAS BEEN IDENTIFIED		
2.a. SPONSOR NAME <i>(Last, First, Middle Initial)</i>		b. SSN		c. RANK OR GRADE	
d. BRANCH OF SERVICE <i>(Military only)</i>		e. DESIG/NEC/MOS/AFSC <i>(Military only)</i>			
f. HOME ADDRESS <i>(Street, Apartment Number, City, State, ZIP Code)</i>		g. DUTY STATION ADDRESS			
		h. E-MAIL ADDRESS			
i. HOME TELEPHONE NUMBER <i>(Include Area Code)</i>		j. FAX NUMBER <i>(Include Area Code)</i>		k. DUTY TELEPHONE NUMBER <i>(Include Area Code)</i>	
				(1) COMMERCIAL	
				(2) DSN	
3. ARE YOU CURRENTLY ON COMPASSIONATE OR HUMANITARIAN ASSIGNMENT? <i>(Military only) (X one)</i>			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
4. ARE BOTH SPOUSES ON ACTIVE DUTY? <i>(X one. If Yes, answer a., b., and c. below)</i>			<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
a. SPOUSE'S NAME <i>(Last, First, Middle Initial)</i>		b. RANK/RATE		c. SSN	
5.a. EXCEPTIONAL FAMILY MEMBER NAME <i>(Last, First, Middle Initial)</i>		b. RELATIONSHIP TO SPONSOR		c. DATE OF BIRTH <i>(YYYYMMDD)</i>	
6. PRIMARY HEALTH CARE SYSTEM USED BY FM <i>(X one)</i>			7. IS FAMILY MEMBER ENROLLED IN DEERS <i>(Military only) (X one)</i>		
<input type="checkbox"/> MILITARY TREATMENT FACILITY	<input type="checkbox"/> STATE	<input type="checkbox"/> YES IF YES, UNDER WHAT SSN: _____			
<input type="checkbox"/> TRICARE/NON-MTF	<input type="checkbox"/> OTHER	<input type="checkbox"/> NO FAMILY MEMBER PREFIX _____			
8. DOES FAMILY MEMBER RESIDE WITH SPONSOR <i>(X one)</i>					
<input type="checkbox"/> YES					
<input type="checkbox"/> NO. IF NO, PROVIDE ADDRESS OF FAMILY MEMBER <i>(Include ZIP Code)</i> AND EXPLAIN WHY.					
9. REQUIRED ADDENDA <i>(X as necessary)</i>					
<input type="checkbox"/> ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY					
<input type="checkbox"/> ADDENDUM 2 - MENTAL HEALTH SUMMARY					
10. CERTIFICATION					
We certify that the information submitted on this DD Form 2792 (Medical Summary and the addenda checked above) are complete and accurate.					
a. SPONSOR <i>(See Instructions)</i>					
(1) PRINTED NAME		(2) SIGNATURE		(3) DATE <i>(YYYYMMDD)</i>	
b. EFMP SCREENING COORDINATOR					
(1) PRINTED NAME		(2) SIGNATURE		(3) DATE <i>(YYYYMMDD)</i>	
(4) MILITARY TREATMENT FACILITY ADDRESS <i>(Include ZIP Code)</i>				(5) TELEPHONE NUMBER <i>(Include area code)</i>	

MEDICAL SUMMARY

PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX
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PART A - PROVIDER INFORMATION *(Authorization by patient included on Page 1 of this form.)*

1.a. PROVIDER NAME	2.a. ADDRESS <i>(Include ZIP Code)</i>
b. TELEPHONE NUMBERS <i>(Include Area Code)</i>	b. E-MAIL ADDRESS
(1) COMMERCIAL (2) DSN (3) FAX NUMBER	

PART B - PATIENT STATUS *(To be completed by provider)*

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

a. CURRENT ACTIVE DIAGNOSIS	b. SEVERITY: A - MILD B - MODERATE C - SEVERE	c. ICD OR DSM	d. MEDICATIONS AND SPECIAL THERAPIES	e. COMPLETE FOR THE LAST 12 MONTHS:
				<input type="checkbox"/> (1) NUMBER OF OUTPATIENT VISITS <input type="checkbox"/> (2) NUMBER OF ER VISITS <input type="checkbox"/> (3) NUMBER OF HOSPITALIZATIONS <input type="checkbox"/> (4) NUMBER OF ICU ADMISSIONS
				<input type="checkbox"/> (1) NUMBER OF OUTPATIENT VISITS <input type="checkbox"/> (2) NUMBER OF ER VISITS <input type="checkbox"/> (3) NUMBER OF HOSPITALIZATIONS <input type="checkbox"/> (4) NUMBER OF ICU ADMISSIONS
				<input type="checkbox"/> (1) NUMBER OF OUTPATIENT VISITS <input type="checkbox"/> (2) NUMBER OF ER VISITS <input type="checkbox"/> (3) NUMBER OF HOSPITALIZATIONS <input type="checkbox"/> (4) NUMBER OF ICU ADMISSIONS
				<input type="checkbox"/> (1) NUMBER OF OUTPATIENT VISITS <input type="checkbox"/> (2) NUMBER OF ER VISITS <input type="checkbox"/> (3) NUMBER OF HOSPITALIZATIONS <input type="checkbox"/> (4) NUMBER OF ICU ADMISSIONS

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

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

6. ARTIFICIAL OPENINGS/PROSTHETICS *(e.g., gastrostomy, tracheostomy, VP shunts, artificial limbs)*

YES IF YES, SPECIFY:
 NO

CODING USE ONLY

F01 - GASTROSTOMY	F07 - OTHER, UNSPECIFIED PROSTHETICS
F02 - TRACHEOSTOMY	F99 - OTHER UNSPECIFIED OPENING
F03 - CSF SHUNT	
F04 - CYSTOSTOMY	
F05 - COLOSTOMY	
F06 - ILEOSTOMY	

MEDICAL SUMMARY (Continued)

PATIENT NAME

SPONSOR SSN

FAMILY MEMBER PREFIX

7. HISTORY OF CANCER OR LEUKEMIA

YES IF YES, SPECIFY PROJECTED TREATMENT NEEDS:
 NO

8. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS (e.g., limited steps, complete wheelchair accessibility, air conditioning)

YES IF YES, SPECIFY:
 NO

9. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT (X as applicable)

<input type="checkbox"/> L03 - APNEA HOME MONITOR	<input type="checkbox"/> L99 - OTHER (Specify)
<input type="checkbox"/> L13 - HOME NEBULIZER	
<input type="checkbox"/> L08 - WHEELCHAIR	
<input type="checkbox"/> L07 - SPLINTS, BRACES, ORTHOTICS	
<input type="checkbox"/> L04 - HEARING AIDS	
<input type="checkbox"/> L12 - HOME OXYGEN THERAPY	
<input type="checkbox"/> L14 - HOME VENTILATOR	

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

MEDICAL SUMMARY (Continued)

PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX
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PART C - REQUIRED CARE (To be completed by provider)

11. MINIMUM HEALTH CARE SPECIALTY REQUIRED FOR CARE

INDICATE THE FREQUENCY OF CARE: **A - ANNUALLY** **B - BIANNUALLY** **Q - QUARTERLY** **M - MONTHLY** **W - WEEKLY**

(1) CARE PROVIDER <i>(X as appropriate)</i>		(2) FREQUENCY	(1) CARE PROVIDER <i>(X as appropriate)</i>		(2) FREQUENCY
C01	a. ALLERGIST		C57	ee. PAIN CLINIC	
C52	b. AUDIOLOGIST		C30	ff. PEDIATRICIAN	
C02	c. CARDIOLOGIST		C31	gg. PEDODONTIST	
C03	d. CARDIOLOGIST - PEDIATRIC		C32	hh. PHYSIATRIST	
C05	e. DERMATOLOGIST		C58	ii. PHYSICAL THERAPIST	
C06	f. DEVELOPMENTAL PEDIATRICIAN		C59	jj. PHYSICAL THERAPIST - PEDIATRIC	
C53	g. DIALYSIS TEAM		C34	kk. PODIATRIST	
C07	h. DIETARY/NUTRITION SPECIALIST		C35	ll. PSYCHIATRIST	
C08	i. ENDOCRINOLOGIST - ADULT		C36	mm. PSYCHIATRIST - CHILD	
C09	j. ENDOCRINOLOGIST - PEDIATRIC		C37	nn. PSYCHOLOGIST	
C10	k. FAMILY PRACTITIONER		C38	oo. PSYCHOLOGIST - CHILD	
C11	l. GASTROENTEROLOGIST - ADULT		C33	pp. PULMONOLOGIST	
C12	m. GASTROENTEROLOGIST - PEDIATRIC		C60	qq. RESPIRATORY THERAPIST	
C13	n. GENERAL MEDICAL OFFICER		C39	rr. RHEUMATOLOGIST	
C15	o. GYNECOLOGIST		C40	ss. RHEUMATOLOGIST - PEDIATRIC	
C17	p. HEMATOLOGIST/ONCOLOGIST		C61	tt. SOCIAL WORKER	
C18	q. HEMATOLOGIST/ONCOLOGIST - PEDIATRIC		C62	uu. SPEECH AND LANGUAGE PATHOLOGIST	
C19	r. IMMUNOLOGIST		C42	vv. SURGEON - CARDIAC/THORACIC	
C20	s. INTERNIST		C43	ww. SURGEON - GENERAL	
C21	t. NEPHROLOGIST - ADULT		C44	xx. SURGEON - NEURO	
C22	u. NEPHROLOGIST - PEDIATRIC		C45	yy. SURGEON - ORAL	
C23	v. NEUROLOGIST - ADULT		C47	zz. SURGEON - ORTHOPEDIC - ADULT	
C24	w. NEUROLOGIST - PEDIATRIC		C48	aaa. SURGEON - ORTHOPEDIC - CHILD	
C25	x. NUCLEAR MEDICAL PHYSICIAN		C46	bbb. SURGEON - OTORHINOLARYNGOLOGIST	
C54	y. OCCUPATIONAL THERAPIST		C49	ccc. SURGEON - PEDIATRIC	
C55	z. OCCUPATIONAL THERAPIST - PEDIATRIC		C50	ddd. SURGEON - PLASTIC	
C26	aa. OPHTHALMOLOGIST		C41	eee. TRANSPLANT TEAM	
C27	bb. OPHTHALMOLOGIST - PEDIATRIC		C51	fff. UROLOGIST	
C29	cc. ORTHODONTIST		C99	ggg. OTHER <i>(Describe)</i>	
C56	dd. OTORHINOLARYNGOLOGIST				

12.a. PROVIDER NAME	b. SIGNATURE	c. DATE (YYYYMMDD)
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ADDENDUM 2 - MENTAL HEALTH SUMMARY *(To be completed by provider)*

X IF NOT APPLICABLE

1.a. PATIENT NAME	b. SPONSOR SSN	c. FAMILY MEMBER PREFIX
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2.a. PROVIDER NAME <i>(PCM or specialty provider)</i>	b. SIGNATURE	c. DATE <i>(YYYYMMDD)</i>
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3.a. DIAGNOSIS(ES)	b. AGE AT DIAGNOSIS

4. MEDICATION HISTORY			
a. MEDICATION	b. DOSAGE	c. LENGTH OF TIME ON MEDICATION	d. RESPONSE

5. HISTORY OF MENTAL HEALTH HOSPITALIZATIONS		
(1) TYPE OF STAY	(2) DATES	(3) DISCHARGE DIAGNOSES
a. HOSPITAL STAYS		
b. PARTIAL-DAY HOSPITALIZATIONS		

6. HOW COOPERATIVE IS/WAS PATIENT WITH TREATMENT? *(Parent/legal guardian cooperation, if a minor.)*

7. TREATMENT NEEDS WITHIN THE NEXT YEAR *(Consider increased stressors of residing in new environment (e.g., stressors of family relocation, isolated posts, deployments, foreign cultures, restricted travel, separation from nuclear family, cost of living.)*

<input type="checkbox"/> NO ASSISTANCE REQUIRED	<input type="checkbox"/> FEWER THAN 4 CONTACTS	<input type="checkbox"/> 4 OR MORE CONTACTS	<input type="checkbox"/> INPATIENT SERVICES
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8. HISTORY	
YES	NO
a. HISTORY OF SUICIDAL GESTURES/ATTEMPTS?	
b. HISTORY OF SUBSTANCE ABUSE/ADDICTIVE BEHAVIORS/EATING DISORDERS?	
c. HISTORY OF PROBLEMS WITH AUTHORITY FIGURES?	
d. HISTORY OF PSYCHOTIC EPISODES?	
e. HISTORY OF FAMILY ADVOCACY PROGRAM INVOLVEMENT? <i>(If Yes and case occurred in last 18 months, include case determination, treatment and follow-up.)</i>	

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

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

NOTE TO PERSONNEL COMPLETING THIS FORM:

It is important to the military and to the family that the family be assigned to a location that can meet the child's educational needs. Please take care in completing the requested information. (Attach a copy of the child's most recent active Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) to this page.)

1 RELEASE OF INFORMATION (To be completed by sponsor, spouse, or student who has reached the age of majority)

I hereby authorize the release of information on the DD Form 2792-1 and in the attached reports to personnel of the Military Departments. This information will be used only to evaluate and document my family member's need for early intervention or special education services for the purpose of assignment/coordination of my next assignment.

a NAME OF SPONSOR	b RANK	c SSN	d SIGNATURE OF SPONSOR, SPOUSE, OR STUDENT WHO HAS REACHED THE AGE OF MAJORITY	e DATE (YYYYMMDD)
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2 DEPENDENT CHILD INFORMATION (To be completed by sponsor or spouse)

a NAME OF CHILD (Last, First, Middle Initial)	b CURRENT GRADE LEVEL (If school age)	c DATE OF BIRTH (YYYYMMDD)	d AGE (Years/months)	e SEX (X one) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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3 EARLY INTERVENTION PROGRAM (EIP)/SCHOOL INFORMATION (To be completed by representative of EIP or school)

YES	NO	a IS THE CHILD CURRENTLY BEING EVALUATED FOR SPECIAL EDUCATION OR EARLY INTERVENTION SERVICES?
		b DOES THIS CHILD RECEIVE EARLY INTERVENTION SERVICES UNDER A CURRENT INDIVIDUALIZED FAMILY SERVICES PLAN (IFSP)? IF YES, DATE OF NEXT ANNUAL REVIEW: ATTACH CURRENT IFSP
		c DOES THIS CHILD RECEIVE SPECIAL EDUCATION SERVICES UNDER A CURRENT INDIVIDUALIZED EDUCATION PROGRAM (IEP)? IF YES, DATE OF NEXT ANNUAL REVIEW: ATTACH CURRENT IEP
		d IS THE CHILD RECEIVING SERVICES UNDER A SECTION 504 PLAN?
		e IS THE CHILD BEING "HOME-SCHOOLED"? IF YES, SPECIFY PROGRAM, IF KNOWN:

IF YOU ANSWERED "YES" to questions 3 b or 3 c, complete Items 4, 5, and 6. Sign and return to sponsor.

IF YOU ANSWERED "NO" to questions 3 a through d, DO NOT complete Items 4 and 5, but complete Section 6. Sign and return to sponsor.

4 ELIGIBILITY CRITERIA (Indicate the eligibility criteria under which the child is eligible for Early Intervention or Special Education.)

a IF THE CHILD IS FROM 3 TO 21 YEARS OF AGE:

<input type="checkbox"/> N07 AUTISTIC	<input type="checkbox"/> N09 COMMUNICATION IMPAIRED	<input type="checkbox"/> N04 MENTAL RETARDATION
<input type="checkbox"/> N01 DEAF	<input type="checkbox"/> ARTICULATION	<input type="checkbox"/> MILD/MODERATE
<input type="checkbox"/> N02 BLIND	<input type="checkbox"/> DYSFLUENCY	<input type="checkbox"/> MODERATE/SEVERE
<input type="checkbox"/> N13 DEAF/BLIND	<input type="checkbox"/> VOICE	<input type="checkbox"/> SEVERE/PROFOUND
<input type="checkbox"/> N11 VISUALLY IMPAIRED	<input type="checkbox"/> LANGUAGE/PHONOLOGY	<input type="checkbox"/> N12 SPECIFIC LEARNING DISABILITY
<input type="checkbox"/> N03 HEARING IMPAIRED	<input type="checkbox"/> N05 TRAUMATIC BRAIN INJURY	<input type="checkbox"/> N10 EMOTIONALLY IMPAIRED
<input type="checkbox"/> N14 PERVASIVE DEVELOPMENTAL DISORDER	<input type="checkbox"/> N06 ORTHOPEDICALLY IMPAIRED	<input type="checkbox"/> N16 BEHAVIORAL/CONDUCT DISORDER
<input type="checkbox"/> N15 DEVELOPMENTAL DELAY		
<input type="checkbox"/> N08 OTHER HEALTH IMPAIRED (Specify)		

b IF THE CHILD IS FROM BIRTH TO 3 YEARS OLD:

<input type="checkbox"/> DEVELOPMENTAL DELAY	<input type="checkbox"/> HIGH PROBABILITY FOR DEVELOPMENTAL DELAY	c DISABILITY (Identify if known, e.g., blindness)
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5 SEVERITY OF THE DISABILITY

<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE	<input type="checkbox"/> PROFOUND
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6 PROVIDER/SCHOOL OFFICIAL INFORMATION

a NAME OF INDIVIDUAL COMPLETING THIS SECTION (Last Name, First Name)	b TITLE	c TELEPHONE NUMBER (Include area code)	d FAX NUMBER (Include area code)
e NAME OF SCHOOL/EARLY INTERVENTION PROGRAM	f ADDRESS (Include ZIP Code)		
g SCHOOL DISTRICT			
h E-MAIL ADDRESS	i SIGNATURE	j DATE SIGNED (YYYYMMDD)	