DEPARTMENT OF DEFENSE
DEPENDENTS SCHOOLS
OFFICE OF THE DIRECTOR, EUROPE
UNIT 29649 BOX 7000
APO AE 09096

September 12, 2006

MEMORANDUM FOR DISTRICT SUPERINTENDENTS, DoDDS-EUROPE

SUBJECT: DoDDS-Europe Compassionate Reassignment Standard Operating Procedures (SOP)

A. PURPOSE: This is to establish the DoDDS-Europe procedures regarding the reassignment of teachers based on documented compassionate need. This SOP also establishes submission requirements as well as approval criteria. Compassionate reassignments have been removed from the DoDEA Transfer Program.

B. APPLICABILITY: This policy applies to permanent Title 20 (TP) teachers employed by DoDDS-Europe, District Superintendent Offices, and DoDDS-Europe schools. Teachers in their first year of employment are not eligible for a compassionate reassignment.

C. POLICY: It is the DoDDS-Europe policy that compassionate reassignment requests will be considered for teachers whose applications provide sufficient information/documentation to justify such reassignment. The Human Resources Office (HRO), DoDDS-Europe, Director, DoDDS-Europe, and appropriate medical personnel will review each case. The bargaining units will receive a copy of the decision to the applicant for those teachers in the bargaining unit. Reassignments will be to school level positions within DoDDS-Europe, unless reassignment to DoDDS-Pacific is justified and agreed to by the Director, DoDDS-Pacific. Teachers whose request would result in a downgrade must indicate they volunteer for the downgrade. Teachers approved for compassionate reassignment will receive consideration without regard to their current travel eligibility.

1. Reassignment is not guaranteed and is a right maintained by Management. Matching against vacancies can only be made as vacancies occur at a location that meets the reasons for the reassignment. Approved candidates for reassignment will be considered in the following order: a) settlement agreements; b) approved compassionates; c) locally available candidates; and d) CONUS recruitment. Approved candidates for reassignment will not be placed during the Transfer Program period. The Transfer Program period is defined as the day that the staffing documents are released from DoDEA Headquarters to the Area Office until the end of the last day of the last round of the Transfer Program. Approved

candidates are not precluded from applying for transfers under the rules of the Transfer Program.

2. Compassionate reassignments for medical reasons will not require locally available backfill. These reassignments will be made as matches occur. All other compassionate reassignments will require locally available backfill, or other accommodation, without the requirement to replace the teachers by recruiting from CONUS or effecting an additional transfer for the remainder of the school year. Reassignments for "other reasons" will be processed to provide for moves at the beginning of semesters. The administrator/supervisor will be contacted to determine if a backfill is available and/or necessary.

3. Approved applicants for compassionate reassignment will be considered for vacancies as they occur. If more than one reassignment request matches a location/category, the priority for matching the vacancy will be as indicated below. If more than one applicant in the same priority category matches a vacancy, then placement will be done based on seniority utilizing the service computation date (SCD) in the DoDEA Personnel Data System. A teacher who received a compassionate transfer in the preceding year will not be considered for the current year except in cases where medical facilities have closed and the appropriate medical care is no longer available.

4. Applicants may apply for consideration in any category that appears on the teacher's current DoDEA teaching certificate. However, applicants who have not taught in their selected category within the last seven years must have their placement approved by the district superintendent.

5. The criterion for consideration is as follows.

   (a) **Priority 1 - Medical reason** - Clearly documented medical need for the teacher or a member of the immediate family who resides with the teacher. The medical need is such that the teacher cannot remain at the current location and, absent the compassionate reassignment, the teacher may have to leave DoDDS due to the severity of the medical problems. The completed DD 2792 (Army Exceptional Family Member Program Medical Summary) and DA Form 7246-R (Exceptional Family Member Program Screening Questionnaire) are to be submitted for individuals receiving treatment/evaluation by military medical facilities. If a medical practitioner on the economy provides a medical statement, a supporting physician's statement is required (must be in English, or translated to English). It must indicate the specific medical condition (diagnosis), prognosis, the medical basis for inability to remain in the current location/position, and the medical basis for the ability to work at a new location/position, the type of medical

care, climate or environment needed to relieve the medical condition. The statement must also include documentation that the medical condition cannot be treated on the economy. All available military medical facilities in each district will be contacted to determine if the required medical care can be accommodated. As soon as appropriate military medical accommodations have been found, the reassignment matching process may begin. Teachers are not permitted to choose the district in which they will be reassigned; the compassionate reassignment program is designed to reassign the teacher to a district where medical care can be provided, not district of choice.

If the request for a compassionate reassignment is to accommodate a school age child with special needs, the Education Division, DoDDS-Europe will review the request along with the Individual Education Program (IEP) to determine availability of appropriate services based on identified student needs. After a tentative job offer is made, the teacher must be screened by the Exceptional Family Member Program (EFMP) for formal processing, if applicable.

(b) **Priority 2 - Other reasons** - Requests for compassionate reassignment for other than Priority 1-medical reasons, will be considered. Since the circumstances will be unique to the applicant, applications should provide as much information and supporting documentation as possible. A possible basis would be if married couples, both of whom are DoDDS teachers, have been involuntarily separated as a result of one of the teachers being declared excess and reassigned, the other teacher may be approved for compassionate reassignment consideration. Requests to reunite separated married couples under any other circumstances will not be approved. A copy of the excess notification and reassignment letter must be submitted with the request for compassionate reassignment. Individuals are only eligible when the placement has been made since that is the basis for separation.

6. Prior to assigning a teacher to a school under the compassionate reassignment program, HRO, DoDDS-Europe will immediately notify the district superintendent and principal at the receiving school. If there is a mutual conflict surrounding the reassignment of the teacher, the Director, DoDDS-Europe will be the final decision making authority.

7. Requests for compassionate reassignment are to be submitted on the attached form, via the administrator, with the appropriate supporting documentation/DA Forms. Applicants are required to submit updates to their application as medical conditions or circumstances change. Applicants are also required to update their application on an annual basis. They will be sent a reminder to submit an update by the HRO, DoDDS-Europe. Failure to submit the annual update, after a

reminder is sent, will result in removal from consideration for compassionate assignment.

8. The HRO Staffing Section, DoDDS-Europe will review vacancies as they occur to determine if there is a match for an approved compassionate reassignment candidate. If more than one approved candidate matches the vacancy the offer will be made based on the priority of the reassignment and, if necessary, on SCD.

D. EFFECTIVE DATE: This policy is effective September 15, 2006.

Diana J. Ohman
Director, DoDDS-Europe

Attachments:
1. Compassionate Reassignment Application
2. DD Form 2792 (Army EFMP Medical Summary)
3. DA Form 7246-R (EFMP Screening Questionnaire)

cc:
Director, DoDEA
Chief, HRO, DoDDS-E
Europe Area Director, FEA
President, OFT

CONFIDENTIAL

COMPASSIONATE REASSIGNMENT APPLICATION

Submit to: DoDDS-Europe
ATTN: Personnel Division
Unit 29649 BOX 7100
APO AE 09096

Phone: (49)611-380-7373
DSN: 338-7373
Fax: (49)611-380-7122
DSN: 338-7122

1. Name _____ SSN _____

2. Current Duty Station (School/District/DoDDS-E Division name): _____

3. Current Teaching Category(ies): _____ 4. Position Start Date: _____

5. Number of continuous years at current location: _____ 6. Service Comp Date: _____

7. Previously requested Compassionate Reassignment: ___ Yes (if yes, see below) ___ No

Requested in SY ____ Reason _____ Transferred to _____ Not Transferred ___
Requested in SY ____ Reason _____ Transferred to _____ Not Transferred ___
Requested in SY ____ Reason _____ Transferred to _____ Not Transferred ___
Requested in SY ____ Reason _____ Transferred to _____ Not Transferred ___

8. Category(ies) preference: (Must be certified in the category(ies))

1)_____ 2)_____ 3)_____ 4)_____ 5)_____ 6)_____ 7)_____ 8)_____ 9)_____ 10)_____

11)_____ 12)_____ 13)_____ 14)_____ 15)_____ 16)_____ 17)_____ 18)_____ 19)_____

9. Basis for request (check appropriate reason):

___ **Medical** (describe situation):

Documentation included:
___ Doctor's statement (in English) including diagnosis, prognosis, the medical basis for inability to remain in current location/position, and the medical basis for the ability to work at

new location/position, the type of medical care, climate or environment needed to relieve the medical condition. The completed DA Form 5862-R (Army Exceptional Family Member Program Medical Summary) and DA Form 7246-R (Exceptional Family Member Program Screening Questionnaire) should be submitted for individuals receiving treatment/evaluation by military medical facilities(Forms may be downloaded from internet: www.usapa.army.mil/forms/forms1.html). Doctor should identify locations that can meet the medical needs. Include in documentation a statement from doctor regarding ability to treat medical condition on the economy, either at current duty location, or in another geographic location.

____ **Other (**explain):

Documentation included:

10. Other options I have considered and explanation why these are not viable (i.e., Leave without pay, disability retirement; resignation, etc):

By signing below I verify the above information is correct. I certify that I have experience teaching or have received training in all of the teaching categories listed above. I understand that failure to accept an assignment will result in removal from consideration for compassionate reassignment.

I understand that I am required to submit updates to my application as medical conditions or circumstances change, including an annual update, after a reminder is sent. Failure to do so may result in removal from consideration for compassionate reassignment.

Signature: _____ Date: _____

Forwarded: _____ Date: _____
Administrator (Supervisor) Signature

Notification of request sent to district superintendent: _____ _____
HRO Staffer Initials ***Date***

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) SCREENING QUESTIONNAIRE

For use of this form, see AR 608-75; the proponent agency is OACSIM

NAME OF MEDICAL TREATMENT FACILITY

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: PL 94-142 *(Education for all Handicapped Children Act of 1975)*, PL 95-561 *(Defense Dependents' Education Act of 1978);* DODI 1342.12 *(Education of Handicapped Children in DODDS),* 17 December 1981; DODI 1010.13 *(Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DOD Dependents Schools Outside the United States),* 28 August 1986, 10 USC 3013; 20 USC 921-932 and 1401 et seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of family members. This will permit consideration of special education and medical needs of family members in the personnel assignment process.

ROUTINE USES: Information will be used by personnel of the Military Departments to evaluate and document special education and medical needs of family members for consideration in personnel assignments.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude U.S. Total Personnel Command from enrolling soldiers in the EFMP. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. Refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.

SERVICE MEMBER'S NAME/RANK	SOCIAL SECURITY NUMBER	DATE *(YYYYMMDD)*

BRANCH	UNIT	DUTY PHONE
PROJECTED PCS ASSIGNMENT	DSN	HOME PHONE
PROJECTED PCS DATE	HOME ADDRESS	DUTY ADDRESS

LIST ALL FAMILY MEMBERS	FAMILY MEMBER PREFIX	SEX	DATE OF BIRTH *(YYYYMMDD)*	CHECK IF ENROLLED IN EFMP

PLEASE ANSWER ALL QUESTIONS - FOR FAMILY MEMBERS ONLY

MEDICAL

1. Do any family members, excluding service member, have any medical records *(civilian or military)* other than the records you have provided us to screen? If yes, please list conditions/services received and address of provider. YES ☐ NO ☐

FAMILY MEMBER	CONDITIONS/SERVICES	NAME/ADDRESS OF PROVIDER

2. In the past five *(5)* years, have any members of your family, excluding service member, been hospitalized, excluding hospitalization for normal uncomplicated childbirth? If yes, please explain. YES ☐ NO ☐

NAME	REASON

3. Are any members of your family, excluding service member, currently receiving medical *(includes mental health)* or educational services from any providers other than a general practitioner or family practice physician? YES ☐ NO ☐

4. Are any family members, excluding service member, taking any prescribed medication other than birth control pills on a regular basis? YES ☐ NO ☐

NAME	PRESCRIBED MEDICATION

5. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Problems with sight *(other than corrected by glasses)*			g.	Asthma, allergies or other respiratory problems		
b.	Problems with hearing			h.	Cerebral Palsy		
c.	Heart condition			i.	Delayed Speech		
d.	Seizure disorder			j.	Sickle Cell Trait/Disease		
e.	Loss of mobility *(requiring use of a wheelchair/walker or aid in mobility)*			k.	Cancer		
				l.	High blood pressure		
f.	Diabetes			m.	Other, if yes, explain		

MENTAL HEALTH:

6. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Referral to, diagnosed by, or therapy with a Psychiatrist, Psychologist, or Social Worker in reference to a mental health problem			d.	Alcohol and drug use or abuse		
				e.	Emotional problems		
b.	Depression			f.	Behavioral problems/acting out behavior		
c.	Suicidal thoughts/ideas, gestures, attempts			g.	Received therapy *(marital, family, individual or group counseling)*		

7. Have any members of your family, excluding service member, been in any of the following? Inpatient Psychiatric Facility, Residential Treatment Center, Group Homes, Day Treatment Centers, Drug and Alcohol Treatment Rehabilitation Center. If Yes, please explain: YES ☐ NO ☐

EDUCATION

8. Do any of your children now have, or have they ever had, any of the following?

		YES	NO			YES	NO
a.	Slow development *(infants and preschoolers)*			d.	Counseling services for school-related problems		
b.	Learning problems *(school)*						
c.	Special services *(i.e., OT, PT, Speech, etc.)* for special education			e.	Mental retardation		

9. Are any of your children receiving Special Education help in school *(not in regular class placement and on an Individual Education Plan (IEP))*? If yes, who? YES ☐ NO ☐

According to AR 608-75, Exceptional Family Member Program, soldiers will provide accurate information as required when requested to do so by Army officials. Knowingly providing false information in this regard may be the basis for disciplinary or administrative action. For soldiers, refusal to provide information may preclude successful processing of an application for family travel or command sponsorship.

Commanders will take appropriate action against soldiers who knowingly provide false information, or who knowingly fail or refuse to enroll family members that meet the criteria for enrollment. *(A false official statement is a violation of Article 107, Uniform Code of Military Justice (UCMJ).)* These actions will include, at a minimum, a general officer letter of reprimand.

All the above information is true and correct to the best of my knowledge. I understand that it is my responsibility to provide any information about changes in medical or educational status for all members of my family, after the date indicated below, and prior to PCS move.

PRINTED NAME OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM	SIGNATURE OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM	DATE *(YYYYMMDD)*
PRINTED NAME OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	SIGNATURE OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	DATE *(YYYYMMDD)*

MEDICAL SUMMARY.

Sponsor must sign release authorization before Summary is completed.

Items 1.a. - b. Provider name, address, telephone numbers, and fax number. Self-explanatory.

Items 2.a. - b. Provider address and e-mail address. Self-explanatory.

Item 3.a. Diagnoses. Enter the diagnosis(es), one per line.

Item 3.b. Severity. Enter severity of the diagnosis(es).

Item 3.c. ICD or DSM. Enter ICD-9-CM or DSM IV designations.

Item 3.d. Medications and therapies. Self-explanatory.

Item 3.e. Enter the number of visits, hospitalizations, etc., for the last 12 months.

Items 4 - 9. Self-explanatory. Codes in Items 6 and 9 are used by the Army coding teams and should be ignored by persons completing the form.

Item 10. Comments. Enter any additional information to describe this individual's medical needs.

Item 11. (1) Minimum health care specialty. Ignore the codes in the first column under Item 11.a. (used by Army coding teams only). Indicate with an X those specialists required by the patient.

(2) Frequency of care. Enter A - Annually; B - Biannually; Q - Quarterly; M - Monthly; or W - Weekly for each specialist indicated.

Item 12. Name and signature of the provider completing this summary, and date the summary was signed.

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY.

This addendum is completed only if indicated in Item 9, Demographics/Certification.

Items 1.a. - c. Self-explanatory.

Items 2.a.- c. Self-explanatory.

Items 3.a.- e. Self-explanatory.

Items 4 - 6. Self-explanatory.

ADDENDUM 2 - MENTAL HEALTH SUMMARY.

This addendum is completed only if indicated in Item 9, Demographics/Certification.

Items 1.a.-c. Self-explanatory.

Items 2.a.-c. - 5.a.-b. Self-explanatory.

Item 6. Cooperation. Describe patient (guardian if a minor) cooperation with treatment.

Items 7 - 8. Self-explanatory.

Item 9. Comments. Include any additional information that would assist in determining necessary treatment.

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
Expires Sep 30, 2006

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.

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.

a. 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.

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.

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 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:
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 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.

b. 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.

c. 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.

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.

SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP TO PATIENT *(If applicable)*	DATE *(YYYYMMDD)*

DEMOGRAPHICS/CERTIFICATION

1.a. APPLICATION STATUS *(X one)*

	INITIAL SCREENING/ ENROLLMENT		UPDATED INFORMATION		REQUEST DISENROLLMENT		ADDITIONAL FAMILY MEMBER HAS BEEN IDENTIFIED

b. FAMILY STATUS

2.a. SPONSOR NAME *(Last, First, Middle Initial)*	b. SSN	c. RANK OR GRADE

d. BRANCH OF SERVICE *(Military only)*	e. DESIG/NEC/MOS/AFSC *(Military only)*

f. HOME ADDRESS *(Street, Apartment Number, City, State, ZIP Code)*	g. DUTY STATION ADDRESS
	h. E-MAIL ADDRESS

i. HOME TELEPHONE NUMBER *(Include Area Code)*	j. FAX NUMBER *(Include Area Code)*	k. DUTY TELEPHONE NUMBER *(Include Area Code)* (1) COMMERCIAL	(2) DSN

3. ARE YOU CURRENTLY ON COMPASSIONATE OR HUMANITARIAN ASSIGNMENT? *(Military only) (X one)*		YES		NO

4. ARE BOTH SPOUSES ON ACTIVE DUTY? *(X one. If Yes, answer a., b., and c. below)*		YES		NO		N/A

a. SPOUSE'S NAME *(Last, First, Middle Initial)*	b. RANK/RATE	c. SSN

5.a. EXCEPTIONAL FAMILY MEMBER NAME *(Last, First, Middle Initial)*	b. RELATIONSHIP TO SPONSOR	c. DATE OF BIRTH *(YYYYMMDD)*

6. PRIMARY HEALTH CARE SYSTEM USED BY FM *(X one)*

	MILITARY TREATMENT FACILITY		STATE
	TRICARE/NON-MTF		OTHER

7. IS FAMILY MEMBER ENROLLED IN DEERS *(Military only) (X one)*

	YES	IF YES, UNDER WHAT SSN:
	NO	FAMILY MEMBER PREFIX

8. DOES FAMILY MEMBER RESIDE WITH SPONSOR *(X one)*

	YES
	NO. IF NO, PROVIDE ADDRESS OF FAMILY MEMBER *(Include ZIP Code)* AND EXPLAIN WHY.

9. REQUIRED ADDENDA *(X as necessary)*

	ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY
	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 *(See Instructions)*

(1) PRINTED NAME	(2) SIGNATURE	(3) DATE *(YYYYMMDD)*

b. EFMP SCREENING COORDINATOR

(1) PRINTED NAME	(2) SIGNATURE	(3) DATE *(YYYYMMDD)*

(4) MILITARY TREATMENT FACILITY ADDRESS *(Include ZIP Code)*	(5) TELEPHONE NUMBER *(Include area code)*

MEDICAL SUMMARY

PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

PART A - PROVIDER INFORMATION *(Authorization by patient included on Page 1 of this form.)*

1.a. PROVIDER NAME

2.a. ADDRESS *(Include ZIP Code)*

b. TELEPHONE NUMBERS *(Include Area Code)*

(1) COMMERCIAL	(2) DSN	(3) FAX NUMBER

b. E-MAIL ADDRESS

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:	
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(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
F02 - TRACHEOSTOMY
F03 - CSF SHUNT
F04 - CYSTOSTOMY
F05 - COLOSTOMY
F06 - ILEOSTOMY
F07 - OTHER, UNSPECIFIED PROSTHETICS
F99 - OTHER UNSPECIFIED OPENING

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)*

☐ L03 - APNEA HOME MONITOR

☐ L13 - HOME NEBULIZER

☐ L08 - WHEELCHAIR

☐ L07 - SPLINTS, BRACES, ORTHOTICS

☐ L04 - HEARING AIDS

☐ L12 - HOME OXYGEN THERAPY

☐ L14 - HOME VENTILATOR

☐ L99 - OTHER *(Specify)*

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

MEDICAL SUMMARY *(Continued)*

PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

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 *(X as appropriate)*			(2) FREQUENCY	(1) CARE PROVIDER *(X as appropriate)*			(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 *(Describe)*	
C56		dd. OTORHINOLARYNGOLOGIST					

12.a. PROVIDER NAME	b. SIGNATURE	c. DATE *(YYYYMMDD)*

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY *(To be completed by provider)*

☐ X IF NOT APPLICABLE

1.a. PATIENT NAME	b. SPONSOR SSN	c. FAMILY MEMBER PREFIX

2.a. PROVIDER NAME *(PCM or specialty provider)*	b. SIGNATURE	c. DATE *(YYYYMMDD)*

3. MEDICATION HISTORY

a. PAST	b. PRESENT	c. MEDICATION	d. DOSAGE	e. FREQUENCY

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

YES	NO	
		a. ARE THERE ANY TRIGGERS FOR THE FAMILY MEMBER'S ASTHMA ATTACKS *(stress, environmental, exercise)*?
		b. DOES THE FAMILY MEMBER ROUTINELY *(greater than 10 days per month/four months per year)* USE INHALED ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS?
		c. HAS THE FAMILY MEMBER TAKEN ORAL STEROIDS DURING THE PAST YEAR *(prednisone, prednisolone)*? IF YES, NUMBER OF DAYS IN PAST YEAR:
		d. HAS THE FAMILY MEMBER EVER EXPERIENCED UNCONSCIOUSNESS OR SEIZURES ASSOCIATED WITH ASTHMA ATTACKS?
		e. HAS THE FAMILY MEMBER 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:
		f. HAS THE FAMILY MEMBER BEEN HOSPITALIZED FOR PULMONARY DISEASE *(pneumonia, bronchitis, bronchiolitis, croup, RSV)* DURING THE PAST YEAR? IF "YES', INDICATE THE DATE(S) OF HOSPITALIZATION *(YYYYMMDD)*:
		g. DOES THE FAMILY MEMBER HAVE A HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA RELATED CONDITIONS WITHIN THE PAST 5 YEARS? IF "YES', HOW MANY? INDICATE DATE OF LAST ADMISSION *(YYYYMMDD)*:
		h. HAS THE FAMILY MEMBER REQUIRED MECHANICAL VENTILATION *(Intubation/use of respirator)* DURING THE PAST 3 YEARS?
		i. DOES THE FAMILY MEMBER HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?

j. HOW MANY DAYS HAS THE FAMILY MEMBER MISSED SCHOOL/WORK/PLAY DUE TO ASTHMA-RELATED PROBLEMS *(including visits to physicians)* DURING THE PAST YEAR?

5. DISRUPTION OF ACTIVITY. How often does asthma disrupt the following activities? *(X as applicable)*

(1) ACTIVITY	(2) NEVER A PROBLEM	(3) 2 TIMES A YEAR OR LESS	(4) 3 - 7 TIMES A YEAR	(5) 8 - 10 TIMES A YEAR	(6) AT LEAST MONTHLY	(7) AT LEAST WEEKLY	(8) ALMOST DAILY
a. SLEEP							
b. QUIET ACTIVITY							
c. SOCIALIZATION WITH FRIENDS							
d. SCHOOL OR WORK ATTENDANCE							
e. OUTDOOR ACTIVITIES							
f. VIGOROUS/PLAY ACTIVITIES							

6. SEVERITY LEVEL. What is the family member's severity level based on the clinical picture? *(Select one level of severity. Definitions are examples of severity. Pulmonary function tests are required only if clinically indicated.)*

	a. INTERMITTENT ASTHMA. Intermittent symptoms ≤ 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 ≥ 80% predicted; variability <20%.
	b. MILD PERSISTENT ASTHMA. Symptoms ≥ 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 ≥ 80% predicted; variability 20 - 30%.
	c. MODERATE PERSISTENT. Symptoms daily. Exacerbations affect sleep and activity. Nighttime asthma > 1 time a week. Daily use of inhaled short-acting B2 agonist. PEF or FEV1 ≥ 60% and 80% predicted; variability > 30%.
	d. SEVERE PERSISTENT. Continuous symptoms. Frequent exacerbations. Frequent nighttime asthma symptoms. Physical activities limited by asthma symptoms. PEF or FEV1 ≤ 60% predicted; variability > 30%.

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

2.a. PROVIDER NAME *(PCM or specialty provider)*	b. SIGNATURE	c. DATE *(YYYYMMDD)*

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.)*

	NO ASSISTANCE REQUIRED		FEWER THAN 4 CONTACTS		4 OR MORE CONTACTS		INPATIENT SERVICES

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? *(If Yes and case occurred in last 18 months, include case determination, treatment and follow-up.)*

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