This form must be completed electronically. Handwritten forms will not be accepted.

POST DEPLOYMENT HEALTH ASSESSMENT (PDHA)

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting the personal information required by the DD Form 2796, Post Deployment Health Assessment (PDHA), and how it will be used.

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. 1074f, Medical Tracking System for Members Deployed Overseas; DoDD 1404.10, DoD Civilian Expeditionary Workforce; DoDD 6490.02E, Comprehensive Health Surveillance; and E.O. 9397 (SSN), as amended.

PURPOSE: To collect information on your physical and mental health status after a deployment in a combat, contingency, or other operation outside of the United States, and to assist health care providers in administering present or future care.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx, and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. However, if you choose not to provide the requested information comprehensive health care services may not be possible or administrative delays may occur. Care will not be denied.

INSTRUCTIONS: You are encouraged to answer all questions. You must at least complete the first portion on who you are and when and where you deployed. If you do not understand a question, please discuss the question with a health care provider.

DEMOGRAPHICS

Last Name _____ **First Name** _____ **Middle Initial** ____

Social Security Number _____ **Today's Date** (*dd/mmm/yyyy*) _____

Date of Birth (*dd/mmm/yyyy*) _____ **Gender** ○ Male ○ Female

Service Branch
- ○ Air Force
- ○ Army
- ○ Navy
- ○ Marine Corps
- ○ Coast Guard
- ○ Civilian Expeditionary Workforce (CEW)
- ○ USPHS
- ○ Other Defense Agency List: _____

Component
- ○ Active Duty
- ○ National Guard
- ○ Reserves
- ○ Civilian Government Employee

Pay Grade

○ E1	○ O1	○ W1
○ E2	○ O2	○ W2
○ E3	○ O3	○ W3
○ E4	○ O4	○ W4
○ E5	○ O5	○ W5
○ E6	○ O6	
○ E7	○ O7	○ Other
○ E8	○ O8	
○ E9	○ O9	
	○ O10	

Home station/unit: _____

Current contact information:

Phone: _____
Cell: _____
DSN: _____
Email: _____
Address: _____
_____
_____

Point of contact who can always reach you:

Name: _____
Phone: _____
Email: _____
Address: _____
_____
_____

PLEASE ANSWER ALL QUESTIONS BASED ON YOUR MOST RECENT DEPLOYMENT

Date arrived theater (*dd/mmm/yyyy*) _____ **Date departed theater** (*dd/mmm/yyyy*) _____

Location of operation
To what areas were you mainly deployed?
(Please list all that apply, including the number of months spent at each location.)

- ○ Country 1 _____ Time at location (*months*) _____
- ○ Country 2 _____ Time at location (*months*) _____
- ○ Country 3 _____ Time at location (*months*) _____
- ○ Country 4 _____ Time at location (months) _____
- ○ Country 5 _____ Time at location (months) _____

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Deployer's SSN (Last 4 digits): _____

1. Overall, how would you rate your health during the PAST MONTH?
○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

2. Compared to before this deployment, how would you rate your health in general now?
○ Much better now than before I deployed
○ Somewhat better now than before I deployed
○ About the same as before I deployed
○ Somewhat worse now than before I deployed Please explain: _____
○ Much worse now than before I deployed Please explain: _____

3. How often did you smoke tobacco (for example cigarettes, cigars, pipe, or hookah) during your deployment?
○ Just about every day ○ Some days ○ Not at all

4. Were you wounded, injured, assaulted or otherwise hurt during your deployment? ○ Yes ○ No

If yes, are you still having any problems or concerns related to this event? ○ Yes ○ No

If yes, please explain: _____

5. During your deployment:
a. Did you ever feel like you were in great danger of being killed? ○ Yes ○ No
b. Did you encounter dead bodies or see people killed or wounded during this deployment? ○ Yes ○ No
c. Did you engage in direct combat where you discharged a weapon? ○ Yes ○ No

6. How many times during your deployment did you visit a health care provider for a medical or dental health problem/concern?
○ No visits ○ 1 visit ○ 2-3 visits ○ 4-5 visits ○ 6 or more

7. During this deployment did you receive care for combat stress or a mental health problem/concern? ○ Yes ○ No

If yes, please explain: _____

8. During this deployment, did you have to spend one or more nights in a hospital as a patient? ○ Yes ○ No

Reason/dates: _____

9. During the PAST MONTH, how difficult have physical health problems *(illness or injury)* made it for you to do your work or other regular daily activities?
○ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

10.a. During this deployment, did any of the following events happen to you? (Mark all that apply)
(1) Blast or explosion (e.g., IED, RPG, EFP, land mine, grenade, etc.)? ○ Yes ○ No
If yes, please estimate your distance from the closest blast or explosion:
○ Less than 25 meters (82 feet)
○ 25-50 meters (82-164 feet)
○ 50-100 meters (164-328 feet)
○ More than 100 meters (328 feet)
(2) Vehicular accident/crash (any vehicle including aircraft)? ○ Yes ○ No
(3) Fragment wound or bullet wound?
a. Head or neck ○ Yes ○ No
b. Rest of body ○ Yes ○ No
(4) Other injury (e.g., sports injury, accidental fall, etc.)? ○ Yes ○ No

If yes to any of the above, please explain: _____

10.b. As a result of any of the events in 10.a., did you receive a jolt or blow to your head that IMMEDIATELY resulted in:
(1) Losing consciousness ("knocked out")? ○ Yes ○ No
If yes, for about how long were you knocked out?
○ Less than 5 min ○ 5-30 min ○ more than 30 min
(2) Losing memory of events before or after the injury? ○ Yes ○ No
(3) Seeing stars, becoming disoriented, functioning differently, or nearly blacking out? ○ Yes ○ No

10.c. How many total times during this deployment did you receive a blow or jolt to your head?
(only answer if you had a yes to any of the questions on 10a.)
○ 0 ○ 1 ○ 2 ○ 3 ○ more than 3 (list number of times) _____

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Deployer's SSN (Last 4 digits): _____

11. During the PAST MONTH, how much have you been bothered by any of the following problems?

Symptom	Not bothered at all	Bothered a little	Bothered a lot
a. Stomach pain	○	○	○
b. Back pain	○	○	○
c. Pain in the arms, legs, or joints (knees, hips, etc.)	○	○	○
d. Menstrual cramps or other problems with your periods (Women only)	○	○	○
e. Headaches	○	○	○
f. Chest pain	○	○	○
g. Dizziness	○	○	○
h. Fainting spells	○	○	○
i. Feeling your heart pound or race	○	○	○
j. Wheezing, shortness of breath, or difficulty breathing (other than asthma)	○	○	○
k. Pain or problems during sexual intercourse	○	○	○
l. Constipation, loose bowels, or diarrhea	○	○	○
m. Nausea, gas, or indigestion	○	○	○
n. Feeling tired or having low energy	○	○	○
o. Trouble sleeping	○	○	○
p. Trouble concentrating on things (such as reading a newspaper or watching television)	○	○	○
q. Memory problems	○	○	○
r. Balance problems	○	○	○
s. Noises in your head or ears (such as ringing, buzzing, crickets, humming, tone, etc.)	○	○	○
t. Trouble hearing	○	○	○
u. Sensitivity to bright light	○	○	○
v. Becoming easily annoyed or irritable	○	○	○
w. Fever	○	○	○
x. Cough lasting more than 3 weeks	○	○	○
y. Numbness or tingling in the hands or feet	○	○	○
z. Hard to make up your mind or make decisions	○	○	○
aa. Watery, red eyes	○	○	○
bb. Dimming of vision, like the lights were going out	○	○	○
cc. Skin rash and/or lesion	○	○	○
dd. Pain with urination, frequency of urination, or strong urge to urinate	○	○	○
ee. Bleeding gums, tooth pain, or broken tooth	○	○	○

12. a. Over the PAST MONTH, what major life stressors have you experienced that are a cause of significant concern or make it difficult for you to do your work, take care of things at home, or get along with other people (for example, serious conflicts with others, relationship problems, or a legal, disciplinary or financial problem)?

○ None or
○ Please list and explain: _____

_____

_____

b. Are you currently in treatment or getting professional help for this concern?

○ Yes ○ No

13. What prescription or over-the-counter medications (including herbals/supplements) for sleep, pain, combat stress, or a mental health problem are you CURRENTLY taking?

○ Please list: _____

_____

○ None

14. a. How often do you have a drink containing alcohol?

○ Never ○ Monthly or less ○ 2-4 times a month ○ 2-3 times per week ○ 4 or more times a week

b. How many drinks containing alcohol do you have on a typical day when you are drinking?

○ 1 or 2 ○ 3 or 4 ○ 5 or 6 ○ 7 to 9 ○ 10 or more

c. How often do you have six or more drinks on one occasion?

○ Never ○ Less than monthly ○ Monthly ○ Weekly ○ Daily or almost daily

15. Have you ever had any experience that was so frightening, horrible, or upsetting that, in the PAST MONTH, you:

a. Have had nightmares about it or thought about it when you did not want to? ○ Yes ○ No
b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? ○ Yes ○ No
c. Were constantly on guard, watchful or easily startled? ○ Yes ○ No
d. Felt numb or detached from others, activities, or your surroundings? ○ Yes ○ No

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16. Over the LAST 2 WEEKS, how often have you been bothered by the following problems?

	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○

17. Are you worried about your health because you believe you were exposed to something in the environment while deployed? ○ Yes ○ No

If yes, please explain: _____

18. Do you think you were exposed to any chemical, biological, or radiological warfare agents during this deployment? ○ Yes ○ No

If yes, please explain: _____

19. Were you in a vehicle hit by a depleted uranium (DU) round; inside a destroyed vehicle that contained DU; or closely inspect such a vehicle? ○ Yes ○ No ○ Don't know

If yes, please explain: _____

20. Were you told to take medicines to prevent malaria? ○ Yes ○ No

If yes, please indicate which medicines you took and whether you took all pills as directed. (Mark all that apply)

Anti-malarial medications received	Took all pills?
○ Chloroquine (Aralen®)	○ Yes ○ No
○ Doxycycline (Vibramycin®)	○ Yes ○ No
○ Malarone®	○ Yes ○ No
○ Mefloquine (Lariam®)	○ Yes ○ No
○ Primaquine	○ Yes ○ No
○ Other: _____	○ Yes ○ No
○ Given pills but do not know drug name	○ Yes ○ No

21. Were you bitten or scratched by an animal during your deployment? ○ Yes ○ No

If yes, please explain what kind of animal was involved, your injury, and what happened:

_____

_____

22. Would you like to schedule an appointment with a health care provider to discuss any health concern(s)? ○ Yes ○ No

23. Are you interested in receiving information or assistance for a stress, emotional or alcohol concern? ○ Yes ○ No

24. Are you interested in receiving assistance for a family or relationship concern? ○ Yes ○ No

25. Would you like to schedule a visit with a chaplain or a community support counselor? ○ Yes ○ No

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Deployer's SSN (Last 4 digits): _____

Health Care Provider Only – Provider Review, Interview, Assessment, and Recommendations:

Deployer reports arriving in theater on: _____ Deployer reports departing theater on: _____

1. Address concerns identified on deployer questions 1 and 2.

Deployer question	Not answered	Deployer indicated concern	Deployer's or concern	Provider (if indicated)
Self health rating	○	○		
Change in health post-deployment	○	○		

2. Address wounds, injuries, assaults, etc., occurring during deployment as reported on deployer question 4.

a. Did deployer mark that he/she is still having a problem or concern related to a wound, injury, or assault that occurred during their deployment?
- ○ Yes
- ○ No (*go to block 3)*
- ○ Not answered by deployer

b. Refer for evaluation?
- ○ Yes (complete blocks 19 and 20)
- ○ No
  - ○ *Already under care*
  - ○ *Already has referral*
  - ○ *No significant impairment*
  - ○ *Other reason (explain):* _____

3. Deployment experiences as reported in deployer question 5. Consider in overall assessment; ask follow-up questions as indicated.

Deployer question	Not answered	Yes response	Provider comments (if indicated)
Danger of being killed	○	○	
Encountered bodies or saw people killed or wounded	○	○	
In direct combat and discharged weapon	○	○	

4. Address concerns identified on deployer questions 6 through 9.

Deployer question	Not answered	Deployer indicated concern	Deployer's or concern	Provider comments (if indicated)
Health care visits during deployment	○	○		
Care for combat stress/mental health	○	○		
Hospitalized during deployment	○	○		
Physical limitations/problems	○	○		

5. Deployment injury and concussion risk assessment.

a. Did deployer have an injury based on their responses to question 10.a.?
- ○ Yes
- ○ No (*go to block 6)*

b. Did deployer have a possible concussion based on their responses to questions 10.a. through 10.c.?
- ○ Yes
- ○ No (*go to block 6)*

c. Evaluate injury history and concussion-related experiences and symptoms.

Refer for evaluation?
- ○ Yes (complete blocks 19 and 20)
- ○ No
  - ○ *Already under care*
  - ○ *Already has referral*
  - ○ *No significant impairment*
  - ○ *Other reason (explain):* _____

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Deployer's SSN (Last 4 digits): _____

6. Post-deployment general symptoms/health concerns.

List of symptoms reported as "Bothered a Lot" on Deployer Questions 11a. through 11ee.
List of symptoms reported as "Bothered a Little" on Deployer Questions 11a. through 11ee.

Physical symptom (PHQ-15) severity score for Deployer Questions 11a. through 11o.				
	Minimal < 4	Low 5 - 9	Medium 10 - 14	High ≥ 15
Deployer's total	_____	_____	_____	_____

a. Does deployer have evidence of high generalized post-deployment physical symptoms (a score of ≥ 15 on the PHQ-15 physical symptoms scale - deployer questions 11a. - 11o.) or is "bothered a lot" by specific symptoms listed in 11a. – 11ee.?
- ○ Yes
- ○ No
- ○ Not answered by deployer

b. Based on deployer's responses to deployer questions 11a. through 11ee. is a referral indicated?
- ○ Yes (complete blocks 19 and 20)
- ○ No
  - ○ *Already under care*
  - ○ *Already has referral*
  - ○ *No significant impairment*
  - ○ *Other reason (explain):* _____

7. Major life stressor as reported on deployer question 12.

a. Did deployer mark they have a concern or a difficulty with a major life stressor?
- ○ Yes Deployer's concern: _____
- ○ No (*go to block 8)*
- ○ Not answered by deployer

b. If yes, **ask** additional questions to determine level of problem: _____

c. Consider need for referral. Referral indicated?
- ○ Yes (complete blocks 19 and 20)
- ○ No
  - ○ *Already under care*
  - ○ *Already has referral*
  - ○ *No significant impairment*
  - ○ Other *reason (explain):* _____

8. Self-reported history of prescription or over-the-counter medications as described on deployer question 13.

Deployer question	Not answered	Yes response	Deployer's response	Provider comments (if indicated)
Medications	○	○		

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9. Alcohol use as reported in deployer question 14.

a. Deployer's AUDIT-C screening score was _____. *(If score between 0-4 (men) or 0-3 (women) nothing required, go to block 10).* ○ Not answered

Number of drinks per week: _____ Maximum number of drinks per occasion: _____

Based on the AUDIT-C score and assessment of alcohol use, follow the guidance below:

Alcohol Use Intervention		
Assess Alcohol Use	**AUDIT-C Score Men 5 - 7 Women 4 - 7**	**AUDIT-C Score Men and Women ≥ 8**
Alcohol use WITHIN recommended limits: Men: ≤ 14 drinks per week **OR** ≤ 4 drinks on any occasion Women: ≤ 7 drinks per week **OR** ≤ 3 drinks on any occasion	Advise patient to stay below recommended limits	Refer if indicated for further evaluation AND conduct BRIEF counseling*
Alcohol use EXCEEDS recommended limits: Men: > 14 drinks per week or > 4 drinks on any occasion Women: > 7 drinks per week or > 3 drinks on any occasion	Conduct BRIEF counseling* AND consider referral for further evaluation	

* **BRIEF** counseling**:** **B**ring attention to elevated level of drinking; **R**ecommend limiting use or abstaining; **I**nform about the effects of alcohol on health; **E**xplore and help/support in choosing a drinking goal; **F**ollow-up referral for specialty treatment, if indicated.

b. Referral indicated for evaluation?

○ Yes (complete blocks 19 and 20)
○ No Provide education/awareness as needed.
State reason if AUDIT-C score was 8+:
○ *Already under care*
○ *Already has referral*
○ *No significant impairment*
○ *Other reason (explain):* _____

10. PTSD screening as reported in deployer question 15.

a. Are two or more of the deployer's responses to questions 15a. through 15d. "yes?"

○ Yes
○ No *(go to block 11)*
○ Not answered by deployer

b. If yes, ask additional questions to determine extent of problem: _____

c. Consider need for referral. Referral indicated?

○ Yes (complete blocks 19 and 20)
○ No
○ *Already under care*
○ *Already has referral*
○ *No significant impairment*
○ **Other** *reason (explain):* _____

11. Depression screening as reported in deployer question 16.

a. Did deployer mark "more than half the days" or "nearly every day" on question 16a. or 16b.?

○ Yes
○ No *(go to block 12)*
○ Not answered by deployer

b. If yes, ask additional questions to determine extent of problem; briefly describe results: _____

c. Consider need for referral. Referral indicated?

○ Yes (complete blocks 19 and 20)
○ No
○ *Already under care*
○ *Already has referral*
○ *No significant impairment*
○ **Other** *reason (explain):* _____

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12. Environmental and exposure concern/assessment as reported in deployer questions 17 and 18.

a. Did deployer indicate a worry or possible exposure? ○ Yes ○ No (go to block 13)

If yes, mark deployer's exposure concern(s)	
○ Animal bites	○ Paints
○ Animal bodies (dead)	○ Pesticides
○ Chlorine gas	○ Radar/Microwaves
○ Depleted uranium	○ Sand/dust
○ Excessive vibration	○ Smoke from burning trash or feces
○ Fog oils (smoke screen)	○ Smoke from oil fire
○ Garbage	○ Solvents
○ Human blood, body fluids, body parts, or dead bodies	○ Tent heater smoke
○ Industrial pollution	○ Vehicle or truck exhaust fumes
○ Insect bites	○ Chemical, biological, radiological warfare agent
○ Ionizing radiation	○ Other exposures to toxic chemicals or materials, such as ammonia, nitric acid, etc. Please list:
○ JP8 or other fuels	
○ Lasers	
○ Loud noises	

b. If yes, referral indicated? ○ Yes (complete blocks 19 and 20)
○ No (provide risk education)
○ *Already under care*
○ *Already has referral*
○ *No significant impairment*
○ *Other reason (explain):*_____

When an individual's medical condition(s) or concern may be associated with possible occupational or environmental exposures during a deployment, a Periodic Occupational and Environmental Monitoring Summary (POEMS) document may be available for review online at https://mesl.apgea.army.mil/mesl/ .

13. Depleted uranium (DU) as reported in deployer question 19.

a. Did deployer mark either "yes" or "don't know to question 19? ○ Yes ○ No *(go to block 14)*

b. If yes, based on details of event and extent of exposure is referral to PCM for completion of DD Form 2872 (DU Questionnaire) and possible 24-hour urinalysis indicated? ○ Yes (complete blocks 19 and 20)
○ No (provide risk education)
○ *Already under care*
○ *Already has referral*
○ *No significant impairment*
○ Other *reason (explain):* _____

14. Malaria prophylaxis review as reported in deployer question 20.

Deployer reports having deployed to: _____

a. Deployment location required malaria prophylaxis? ○ Yes ○ No *(go to block 15)*

b. Did deployer receive anti-malarial prophylaxis AND report compliance? ○ Yes *(go to block 15)* ○ No

c. If no, determine need for prophylaxis. Prescription indicated? ○ Yes (complete blocks 19 and 20)
○ No (briefly state reason): _____

15. Animal bite (rabies risk) as reported on deployer question 21.

a. Did deployer mark "yes" on animal bite/scratch? ○ Yes
○ No *(go to block 16)*

b. If yes, based on details of event and care received is a referral and/or follow-up indicated?
Note: Rabies incubation period can be months to years. Rabies prophylaxis can begin at anytime. ○ Yes (complete blocks 19 and 20)
○ No (provide risk education)
○ *Was appropriately treated*
○ *Already under care*
○ *Already has referral*
○ *Situation was not a risk for rabies*
○ Other *reason (explain):* _____

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Deployer's SSN (Last 4 digits): _____

16. Suicide risk evaluation.

a. **Ask** "Over the **PAST MONTH**, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?"
- ○ Yes
- ○ No (go to block 17)

b. If 16.a. was yes, **ask:** "How often have you been bothered by these thoughts?"
- ○ Few or several days
- ○ More than half of the time
- ○ Nearly every day

c. If 16.a. was yes, **ask:** "Have you had thoughts of actually hurting yourself?"
- ○ Yes **(If yes, ask questions 16d. through 16g.)**
- ○ No (If no thoughts of self-harm, go to block 17)

d. **Ask** "Have you thought about how you might actually hurt yourself?"
- ○ Yes How? _____
- ○ No

e. **Ask** "There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life over the next month?"
- ○ Not at all likely
- ○ Somewhat likely
- ○ Very likely

f. **Ask** "Is there anything that would prevent or keep you from harming yourself?"
- ○ Yes What? _____
- ○ No

g. **Ask** "Have you ever attempted to harm yourself in the past?"
- ○ Yes How? _____
- ○ No

h. Conduct further risk assessment (e.g., interpersonal conflicts, social isolation, alcohol/substance abuse, hopelessness, severe agitation/anxiety, diagnosis of depression or other psychiatric disorder, recent loss, financial stress, legal disciplinary problems, serious physical illness)

Comments: _____

_____

i. Does deployer pose a current risk for harm to self?
- ○ Yes (complete blocks 19 and 20)
- ○ No

17. Violence/harm risk evaluation.

a. **Ask,** "Over the past month have you had thoughts or concerns that you might hurt or lose control with someone?"
- ○ Yes
- ○ No *(go to block 18)*

If yes, **ask** additional questions to determine extent of problem (target, plan, intent, past history) Comments: _____

b. Does member pose a current risk to others?
- ○ Yes (complete blocks 19 and 20)
- ○ No (briefly state reason): _____

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Deployer's SSN (Last 4 digits): _____

18. Deployer issues with this assessment (mark as appropriate):
☐ Deployer declined to complete form
☐ Deployer declined to complete interview/assessment

Assessment and Referral: After review of deployer's responses and interview with the deployer, the assessment and need for further evaluation is indicated in blocks 19 through 22.

19. Summary of provider's concerns needing < Mark all that apply>	Yes	No
a. None Identified	☐	
b. Physical health	☐	☐
c. Dental health	☐	☐
d. Concussion	☐	☐
e. Mental health symptoms	☐	☐
f. Alcohol use	☐	☐
g. PTSD symptoms	☐	☐
h. Depression symptoms	☐	☐
i. Environment/work exposure	☐	☐
j. Depleted uranium	☐	☐
k. Malaria prophylaxis	☐	☐
l. Risk of self-harm	☐	☐
m. Risk of violence	☐	☐
n. Other, list:	☐	☐

20. Recommended < Mark all that apply deployer does not desire>	Within 24 hours	Within 7 days	Within 30 days
a. Primary Care, Family Practice, Internal Medicine	☐	☐	☐
b. Behavioral Health in Primary Care	☐	☐	☐
c. Mental Health Specialty Care	☐	☐	☐
d. Dental	☐	☐	☐
e. Other specialty care:	☐	☐	☐
Audiology	☐	☐	☐
Dermatology	☐	☐	☐
OB/GYN	☐	☐	☐
Physical Therapy	☐	☐	☐
TBI/Rehab Med	☐	☐	☐
Podiatry	☐	☐	☐
Other, list	☐	☐	☐
f. Case Manager / Care Manager	☐	☐	☐
g. Substance Abuse Program	☐	☐	☐
h. Immunization clinic	☐	☐	☐
i. Laboratory	☐	☐	☐
j. Other, list:	☐	☐	☐

21. Comments

_____

_____

_____

_____

22. Address requests as reported on deployer questions 22 through 25.

Deployer question	Not answered	Yes response	Comments (if indicated)
Request medical appointment	☐	☐	
Request info on stress/emotional/alcohol	☐	☐	
Family/relationship concern assistance	☐	☐	
Chaplain/counselor visit request	☐	☐	

23. Supplemental services recommended / information provided	
☐ Appointment Assistance	☐ Family Support
☐ Information on post-deployment blood specimen requirement	☐ Military One Source
☐ Contract Support: _____	☐ TRICARE Provider
☐ Community Service: _____	☐ VA Medical Center or Community Clinic
☐ Chaplain	☐ Vet Center
☐ Health Education and Information	☐ Other, list:
☐ Health Care Benefits and Resources Information	
☐ In Transition	

Provider's Name: _____ Date (*dd/mmm/yyyy*) _____

Title: ☐ MD or DO ☐ PA ☐ Nurse Practitioner ☐ Adv Practice Nurse ☐ IDMT ☐ IDC ☐ IDHS

I certify that this review process has been completed. **This visit is coded by DOD0212.**