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

GENERAL
The DD Form 2792 is completed to identify a family member with special medical needs.

There is a Certification Section on page 3 that should be signed AFTER the entire form is completed by medical provider(s) and the form has been reviewed for completeness and accuracy.

The Parent / Guardian or Person of Majority Age signs block 9b, and the MTF case coordinator / authorized reviewer signs block 10b.

A Qualified Medical Provider is responsible for assessing whether the services they are eligible to prescribe are within the scope of their practice and their state licensing requirements.

AUTHORIZATION FOR DISCLOSURE (Page 2)
Health Insurance Portability and Accountability Act (HIPAA) Requirement.
Each adult family member must sign for the release of his / her own medical information. The sponsor or spouse cannot authorize the release of information for those dependent family members who have reached the age of majority unless they are court-appointed guardians. Please consult with your military treatment facility (MTF) or dental treatment facility (DTF) privacy / HIPAA coordinator about questions regarding authorizations for disclosure.

DEMOGRAPHICS / CERTIFICATION (Page 3)
Item 1. Select the appropriate purpose for filling out the form and provide documentation.
Item 2.a. Family Member / Patient Name. Name of family member described in subsequent pages.
Item 2.b. Sponsor Name. Name of the military member responsible for the family member identified in Item 2.a.
Item 2.c. - e. Self-explanatory.
Item 2.f. Family Member Prefix (FMP). Only applies to Military medical beneficiary. The FMP is assigned when the family member is enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).
Item 2.g. DoD Benefits Number (DBN). This 11-digit number has two components. The first nine digits are assigned to the sponsor; the last two digits identify the specific person covered under that sponsor. The first nine digits do not reflect the sponsor's nine-digit SSN. The DBN can be found above the bar code on the back of the beneficiary's ID card. If the child has not been issued an ID card, enter the first 9 digits of the parent's DBN.
Item 2.h. - j. Self-explanatory.
Item 3.a. - h. All items refer to the sponsor. Self-explanatory.
Item 3.i. Annotate whether the family member resides with the sponsor. If the family member does not, then provide an explanation.
Item 4.a. Answer "Yes" if both spouses are on active duty or if the enrolling spouse was a former member of the U.S. military. If "Yes," complete Items 4.b. - e.
Item 5.a. - d. If "Yes," enter DoD ID #, name of sponsor and branch of Service. Military only.
Item 7. To be completed by the administrator in consultation with the family. Required Actions. Self-explanatory.
Item 8.a. - c. To be completed by the administrator in consultation with the family. Mark all services being provided to the family member.
Item 9.a. - c. Parent / Guardian or Person of Majority Age. Parent / Guardian or Person of Majority Age certifies that the information contained in the DD Form 2792 is correct. Individual must ensure that all applicable forms are completed and attached before signing.

Item 10.a. - f. The MTF authorized case coordinator / administrator name, signature, date, location of military treatment facility or certifying EFMP program, telephone number, and official stamp. Self-explanatory. Administrator must ensure that all forms are complete and attached before signing.

MEDICAL SUMMARY beginning on page 4 must be completed by a Qualified Medical Provider. Sponsor, spouse, or family member of majority age must sign release authorization on page 2 before this summary is completed. Please complete as accurately as possible using the current International Classification of Diseases (ICD) Code(s).
Item 1.a. - b. Diagnosis 1. Enter the diagnosis and corresponding diagnostic code for the family member.
Item 1.d(1) - 1.d(4) Medical History for the Last 12 Months. Enter the number of outpatient visits, emergency room visits / urgent care visits, hospitalizations, and ICU admissions.
Item 1.e(1) - 1.e(3) Medications. Enter all current medications associated with Diagnosis 1, the dosage and frequency medication should be taken.
Item 1.f. Treatment Plan for Diagnosis 1. Include medical and/or surgical procedures and special therapies planned or recommended over the next three years. Also include the expected length of treatment, required participation of family members, and if treatment is ongoing.
Item 2.a. - f. Diagnosis 2. Follow procedures for Items 1.a. - 1.f. above.
Item 3.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this page, date the page was signed, telephone numbers for the provider, email, and medical specialty.
Item 6.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this page, date the page was signed, telephone numbers for the provider, email, and medical specialty.
Item 7. History Associated with Asthma (if applicable). Answer "Yes" or “No”, and include additional details as directed on the patient's asthma history for the last 5 years, as directed.
Item 8. History Associated with Behavioral Health (if applicable). Answer "Yes" or "No", and include additional details as directed on the patient's mental health history for the last five years, as directed.
Item 9. Current Intervention Therapies for Autism Spectrum Disorders and / or Significant Developmental Delays (if applicable).
Item 10. Communication. Indicate if the patient is verbal or non-verbal. If non-verbal, indicate the appropriate communication methods used.
Item 11. Other Interventions / Therapies Used by the Family. Self-explanatory.
Item 12. Behavior. Answer "Yes" if the child exhibits high risk or dangerous behaviors.
Item 13.a. - c. Provider Information. Official stamp or printed name and signature of the provider completing the page and date the page was signed.
Item 14. Health Care Required. In column 1, mark any specialists REQUIRED to meet the patient's needs. If a specialist was used to determine a diagnosis and is not necessary for ongoing care, DO NOT place an X next to that specialist. If a developmental pediatrician is a child's primary care manager, but a pediatrician meets the needs, DO NOT mark developmental pediatrician. This section should reflect the providers that are necessary to meet the needs of the patient.
**PRIVACY ACT STATEMENT**


**PRINCIPAL PURPOSE(S):** Information will be used by DoD personnel to evaluate and document the special medical needs of family members. This information will enable: (1) sponsors to enroll into the Exceptional Family Member Program (EFMP), (2) military assignment personnel to match the special medical needs of family members against the availability of medical services through the Family Member Travel Screening (FMTS) process, (3) EFMP Family Support staff to offer information on community support services, and (4) civilian personnel offices to advise civilian employees about the availability of medical services to meet the special medical needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files.


**DISCLOSURE:** Voluntary for civilian employees and applicants for civilian employment. Mandatory for military personnel: failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice. The DoD Identification (DoID) number of the sponsor (and sponsor's spouse if dual military) allows the Military Healthcare System and Service personnel offices to work together to ensure any special medical needs of your dependent can be met at your next duty assignment. Dependent special needs are annotated in the official military personnel files which are retrieved by name and DoD ID number.

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION**

Per DoD Instruction, Service members are required to enroll in the EFMP if they have a family member with a qualifying medical condition. Accordingly, the Sponsor will have access to the health information contained herein during the accomplishment and submission of this application. By signing the below authorization for disclosure of medical information you acknowledge your sponsor may have access to the health information contained herein. The authorization for sponsor access is terminated once the application is received by EFMP. The sponsor may be held accountable for the accuracy and completeness of the DD Form 2792 and should review all pages prior to signing on page 2.

I authorize

(Provide Name of MTF/DTF/Civilian Provider)

To release my patient information to the Exceptional Family Member Program (EFMP) medical / the Family Member Travel Screening (FMTS) Office and EFMP Family Support Office. This information may be used for enrollment into the EFMP, the family travel review process, and / or community support services to determine whether there are adequate medical, housing, and community resources to meet your needs at the sponsor's proposed duty location, and / or to assist family members with community support at the current and/or projected duty location.

a. The military medical department or appropriate headquarters family support office will use the information to determine whether you meet the criteria for enrollment into the EFMP and the military medical departments will provide recommendations on the availability of care in communities where the sponsor may be assigned or employed.

b. Information that you have a special medical need (not the nature or scope of the need) may be included in the sponsor's personnel record, if EFMP enrollment criteria are met.

c. Information may be shared with EFMP Family Support staff who assist the family, and / or sponsor with appropriate community resources.

d. The authorization applies to the summary data included on the medical summary form, and subsequent updates to information on this form. If additional clarification or information is needed, I authorize review of my record, which may be maintained in an electronic format. This information may be stored in electronic databases used for medical management or dedicated to the assignment process. Access to the information is limited to representatives of the medical departments, the officers responsible for enrollment into the Exceptional Family Member Program, the offices responsible for assignment coordination, the offices responsible for EFMP Family Support services, and, at your request, other agents responsible for care or services. Summary data may be transmitted (e.g. encrypted electronic mail or faxing) using authorized secure media transfer.

**Start Date:** The authorization start date is the date that you sign this form authorizing release of information.

**Expiration Date:** The authorization shall continue until enrollment in the Exceptional Family Member Program is no longer necessary according to criteria specified in DoD Instruction 1315.19, or if family member no longer meets the criteria to qualify as a dependent, or the sponsor is no longer in active military service or in the employment of the U.S. Government overseas, or completion of assignment coordination, or eligibility determination for specialized services if that is the sole purpose for the completion of the form.

I understand that:

a. Failure to reissue this information or any subsequent revocation may result in ineligibility for accompanying family travel at government expense.

b. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my or my child's medical records are kept. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and / or disclosed protected information on the basis of this authorization. My revocation will have no impact on disclosures made prior to the revocation.

c. If I authorize my or my child's protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

d. I have a right to inspect and receive a copy of my own or my child's protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524. I request and authorize the named provider / treatment facility to release the information described above for the stated purposes.

e. Refusal to sign does not preclude the provision of medical and dental information authorized by other regulations and those noted in this document.

**NAME OF PATIENT**

**SIGNATURE OF PATIENT / PARENT / GUARDIAN**

**RELATIONSHIP TO PATIENT (if applicable)**

**DATE (YYYYMMDD)**

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**FAMILY MEMBER MEDICAL SUMMARY**

*(To be completed by Service member, adult family member, or civilian employee.)*

*Read Instructions before completing this form.*

The public reporting burden for this collection of information, 0704-0411, 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 the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at ws. mc-alex. esd. mbx. dd-dod-information-collections@mail.mil. 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 currently display a valid OMB control number.
**FAMILY MEMBER / PATIENT NAME** (Last, First, Middle Initial)  
**SPONSOR NAME** (Last, First, Middle Initial)  
**SPONSOR DoD ID #**

<table>
<thead>
<tr>
<th>DEMOGRAPHICS / CERTIFICATION: To be completed by the Sponsor, Parent or Guardian, or Patient</th>
</tr>
</thead>
</table>

1. **PURPOSE OF THIS FORM** (Select One)  
- EFMP Enrollment or Update  
- Request for Government Sponsored Travel  
- Request Change in EFMP Status:  
  - No Longer Have Previously Identified Condition  
  - No Longer Qualifies as Dependent  
  - Family Member Deceased  
  - Divorce / Change in Custody  

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

2d. **FAMILY MEMBER GENDER** (Select One)  
- Male  
- Female

2e. **FAMILY MEMBER DATE OF BIRTH** (YYYYMMDD)

2f. **FAMILY MEMBER PREFIX (FMP)**

2g. **DoD BENEFITS NUMBER (DBN)** (On Back of ID Card)

2h. **CURRENT FAMILY MEMBER MAILING ADDRESS** (Street, Apartment Number, City, State, ZIP Code, APO / FPO)

2i. **HOME TELEPHONE NUMBER** (Include Country Code / Area Code)

2j. **FAMILY HOME E-MAIL ADDRESS**

3a. **SPONSOR RANK OR GRADE**

3b. **DESIGNATION / NEC / MOS / AFSC** (Military Only)

3c. **INSTALLATION OF SPONSOR’S CURRENT ASSIGNMENT**

3d. **BRANCH OF SERVICE**  
- Army  
- Marine Corps  
- Air Force  
- Navy  
- National Guard  
- Coast Guard  
- Active Reserve  
- Active Guard  
- Civilian

3e. **STATUS** (Select One)  
- Regular Active Service Member  
- Reserves  
- National Guard  
- Active Reserve  
- Active Guard  
- Civilian

3f. **SPONSOR’S OFFICIAL E-MAIL ADDRESS**

3g. **DUTY TELEPHONE NUMBER** (Include Country Code / Area Code)

3h. **MOBILE NUMBER** (Include Country Code / Area Code)

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

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

4b. **SPOUSE’S NAME** (Last, First, Middle Initial)

4c. **BRANCH OF SERVICE**

4d. **RANK / RATE**

4e. **SPOUSE DoD ID #**

5a. **HAS THE FAMILY MEMBER EVER BEEN ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR’S NAME OR DoD ID #?** (Select One.)  
- Yes  
- No  

5b. IF "YES," UNDER WHAT DoD ID #?

5c. **UNDER WHAT SPONSOR’S NAME ?** (Last, First, Middle Initial)

5d. **BRANCH OF SERVICE**

6a. **DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES?** (Select One)  
- Yes  
- No  

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

6c. **CASE MANAGER CONTACT INFORMATION**

6c(1). **NAME** (Last, First, Middle Initial)

6c(2). **E-MAIL ADDRESS** (If Available)

6c(3). **TELEPHONE NUMBER** (Include Country Code / Area Code)

**FOR ADMINISTRATIVE USE ONLY**

7. **REQUIRED ACTIONS** (Select One)  
- First Review of Medical History for the Family Member  
- Qualifies for Change in EFMP Status:  
- Family Member No Longer Has Previously Identified Condition  
- Family Member Deceased*  
- Family Member No Longer Qualifies as a Dependent*  
- Divorce / Change in Custody*  

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

**CERTIFICATION**

9. **CERTIFICATION. DO NOT CERTIFY BEFORE THE MEDICAL PROVIDER COMPLETES THE ENTIRE FORM.**  
By signing below, we certify that the information submitted on this DD Form 2792 is complete and accurate.

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

10. **ADMINISTRATIVE CERTIFICATION**

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

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

10e. **TELEPHONE NUMBER** (Include Country Code / Area Code)
FAMILY MEMBER / PATIENT NAME (Last, First, Middle Initial)  SPONSOR NAME (Last, First, Middle Initial)  SPONSOR DoD ID #

MEDICAL SUMMARY: To be completed by a Qualified Medical Provider

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

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

DIAGNOSIS INFORMATION

1a. DIAGNOSIS 1

1b. ICD CODE

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

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

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

1e. MEDICATIONS

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

1f. TREATMENT PLAN FOR DIAGNOSIS 1 (Medical, mental health, surgical procedures or therapies provided in the last 12 months, or planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)

2a. DIAGNOSIS 2

2b. ICD CODE

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

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


2e. MEDICATIONS

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

2f. TREATMENT PLAN FOR DIAGNOSIS 2 (Medical, mental health, surgical procedures or therapies provided in the last 12 months, or planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)

PROVIDER INFORMATION

3a. PROVIDER PRINTED NAME OR STAMP

3b. SIGNATURE

3c. DATE (YYYYMMDD)

3d. TELEPHONE NUMBERS (Include Country Code / Area Code)

3d(1). COMMERCIAL  3d(2). DSN (Military Only)

3e. OFFICIAL EMAIL ADDRESS

3f. MEDICAL SPECIALTY
FAMILY MEMBER / PATIENT NAME (Last, First, Middle Initial)  SPONSOR NAME (Last, First, Middle Initial)  SPONSOR DoD ID #

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

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

PART A - PATIENT STATUS (Continued)

DIAGNOSIS INFORMATION

4a. DIAGNOSIS 3

4b. ICD CODE

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

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

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

4e. MEDICATIONS

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

4f. TREATMENT PLAN FOR DIAGNOSIS 3 (Medical, mental health, surgical procedures or therapies provided in the last 12 months, or planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)

5a. DIAGNOSIS 4

5b. ICD CODE

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

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

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

5e. MEDICATIONS

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

5f. TREATMENT PLAN FOR DIAGNOSIS 4 (Medical, mental health, surgical procedures or therapies provided in the last 12 months, or planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)

PROVIDER INFORMATION

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

6d. TELEPHONE NUMBERS (Include Country Code / Area Code)  6e. OFFICIAL EMAIL ADDRESS  6f. MEDICAL SPECIALTY

6d(1). COMMERCIAL  6d(2). DSN (Military Only)
### Medical Summary (Continued)

#### Part A - Patient Status (Continued)

**Additional Information for Asthma, Behavioral Health, and Autism Spectrum Disorders and / or Significant Developmental Delays**

(Complete if patient has been evaluated or treated for asthma (within the past five years), a behavioral health condition (within the past five years) and / or autism spectrum disorders and / or significant developmental delays.)

<table>
<thead>
<tr>
<th>Asthma Information</th>
<th>N/A</th>
</tr>
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</table>

7. History Associated with Asthma

(See note above for additional information) (Select as applicable)

- **YES**
- **NO**

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7a.</td>
<td>Are there any triggers for the patient's asthma exacerbations? (If &quot;Yes,&quot; specify exact trigger(s))</td>
</tr>
<tr>
<td>7b.</td>
<td>Has the patient ever taken oral steroids during the past year for exacerbations? (Prednisone, prednisolone)</td>
</tr>
<tr>
<td>7c.</td>
<td>Has the patient required an urgent visit to the ER or clinic for acute asthma during the past year?</td>
</tr>
<tr>
<td>7d.</td>
<td>Does the patient have a history of one or more hospitalizations for asthma related conditions within the past five years?</td>
</tr>
<tr>
<td>7e.</td>
<td>Does the patient have a history of intensive care admissions?</td>
</tr>
</tbody>
</table>

**Behavioral Health Information**

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>History</td>
</tr>
</tbody>
</table>

(Select and provide details for each "Yes" answer)

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8a.</td>
<td>History of suicidal behaviors / attempts?</td>
</tr>
<tr>
<td>8b.</td>
<td>History of substance misuse / abuse?</td>
</tr>
<tr>
<td>8c.</td>
<td>History of addictive behaviors?</td>
</tr>
<tr>
<td>8d.</td>
<td>History of eating disorders?</td>
</tr>
<tr>
<td>8e.</td>
<td>History of other compulsive behaviors?</td>
</tr>
<tr>
<td>8f.</td>
<td>History of problems with legal authority or authority figures? (If &quot;Yes,&quot; specify)</td>
</tr>
<tr>
<td>8g.</td>
<td>History of psychotic episodes?</td>
</tr>
<tr>
<td>8h.</td>
<td>History of services received for allegations of family maltreatment? (If &quot;Yes,&quot; and services are delivered by Family Advocacy, note case determination)</td>
</tr>
</tbody>
</table>

**Current Intervention Therapies for Autism Spectrum Disorder and / or Significant Developmental Delays**

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9a.1.</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>9a.2.</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>9a.3.</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>9a.4.</td>
<td>Psychological Counseling</td>
</tr>
<tr>
<td>9a.5.</td>
<td>Intensive Behavioral Intervention (Includes ABA)</td>
</tr>
<tr>
<td>9a.6.</td>
<td>Other (Specify)</td>
</tr>
</tbody>
</table>

**Communication**

(Select one)

- **Verbal**
- **Non-verbal** (Uses:)
  - Signing
  - Picture Exchange Communication System (PECS)
  - Communication Device
  - Combination

**Other Interventions / Therapies Used by the Family**

(Identify)

**Behavior: Child Exhibits High Risk or Dangerous Behavior**

(If "Yes," provide details)

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>Other interventions / therapies used by the family</td>
</tr>
<tr>
<td>12.</td>
<td>Behavior: child exhibits high risk or dangerous behavior</td>
</tr>
</tbody>
</table>

**Provider Information**

- **Provider Printed Name or Stamp**
- **Signature**
- **Date (YYYYMMDD)**
FAMILY MEMBER / PATIENT NAME  (Last, First, Middle Initial) SPONSOR NAME  (Last, First, Middle Initial) SPONSOR DoD ID 

Prescribed by: DoDI 1315.19

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

PART B - REQUIRED MEDICAL SPECIALTIES

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

(1) CARE PROVIDER (Select as Appropriate)

(2) FREQUENCY (See Above)

(1) CARE PROVIDER (Select as Appropriate)

(2) FREQUENCY (See Above)

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

PROVIDER INFORMATION

15a. PROVIDER PRINTED NAME OR STAMP
15b. SIGNATURE
15c. DATE (YYYYMMDD)
<table>
<thead>
<tr>
<th>FAMILY MEMBER / PATIENT NAME (Last, First, Middle Initial)</th>
<th>SPONSOR NAME (Last, First, Middle Initial)</th>
<th>SPONSOR DoD ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL SUMMARY (Continued): To be completed by a Qualified Medical Provider</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

| YES | GASTROSTOMY | COLOSTOMY | OTHER UNSPECIFIED OPENING (Specify) |
| NO  | TRACHEOSTOMY | ILEOSTOMY  | OTHER UNSPECIFIED PROSTHETICS (Specify) |

#### 17. MEDICALLY INDICATED
(As indicated in diagnostic information)

<table>
<thead>
<tr>
<th>ENVIRONMENTAL / ARCHITECTURAL CONSIDERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIMITED STEPS (If selected, please explain below)</td>
</tr>
<tr>
<td>COMPLETE WHEELCHAIR ACCESSIBILITY</td>
</tr>
<tr>
<td>SINGLE STORY / LEVEL HOUSE</td>
</tr>
<tr>
<td>CARPET PROHIBITED</td>
</tr>
<tr>
<td>(Specify below)</td>
</tr>
</tbody>
</table>

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

**18a. TYPE OF EQUIPMENT** (Select as applicable)

<table>
<thead>
<tr>
<th>APNEA HOME MONITOR</th>
<th>COCHLEAR IMPLANT (Include make and model under &quot;Description&quot;)</th>
<th>CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY</th>
<th>FEEDING PUMP (Include make and model under &quot;Description&quot;)</th>
<th>HEARING AIDS (Include make and model under &quot;Description&quot;)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOME VENTILATOR (Include make and model under &quot;Description&quot;)</td>
<td>INSULIN PUMP (Include make and model under &quot;Description&quot;)</td>
<td>INTERNAL DEFIBRILLATOR (Include make and model under &quot;Description&quot;)</td>
<td>PACEMAKER (Include make and model under &quot;Description&quot;)</td>
<td>SPLINTS, BRACES, ORTHOTICS</td>
</tr>
<tr>
<td>HOME DIALYSIS MACHINE</td>
<td>SUCTION MACHINE</td>
<td>HOME NEBULIZER</td>
<td>WHEELCHAIR</td>
<td>HOME OXYGEN THERAPY</td>
</tr>
<tr>
<td>HOME VENTILATOR</td>
<td>HOME VENTILATOR</td>
<td>WHEELCHAIR</td>
<td>WHEELCHAIR</td>
<td>WHEELCHAIR</td>
</tr>
</tbody>
</table>

**19. IDENTIFY ANY LIMITATIONS FOR ACTIVITIES OF DAILY LIVING AND ANY TRAVEL LIMITATIONS**

(Please explain)

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### PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>PROVIDER PRINTED NAME OR STAMP</th>
<th>SIGNATURE</th>
<th>DATE (YYYY-MM-DD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20a</td>
<td>20b</td>
<td>20c</td>
</tr>
</tbody>
</table>

PREVIOUS EDITION IS OBSOLETE.