

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

POST DEPLOYMENT HEALTH RE-ASSESSMENT (PDHRA)

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personally identifiable information through the DD Form 2900, Post-Deployment Health Re-Assessment (PDHRA).

- 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; DoDI 1404.10, DoD Civilian Expeditionary Workforce; DoDI 6490.02E, Comprehensive Health Surveillance, and E.O. 9397 (SSN), as amended.
PURPOSE: To obtain information from an individual in order to assess the state of the individual's health after deployment outside the United States, its territories and possessions as part of a contingency, combat, or other operation and to assist health care providers in identifying and providing present and future medical care to the individual.
ROUTINE USES: Your records may be disclosed to other Federal and State agencies and civilian health care providers, as necessary, in order to provide medical care and treatment.
DISCLOSURE: Voluntary. If you chose not to provide information, comprehensive healthcare services may not be possible or administrative delays may occur. HOWEVER, 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 Component Pay Grade
Air Force Active Duty E1 O1 W1
Army National Guard E2 O2 W2
Navy Reserves E3 O3 W3
Marine Corps Civilian Government Employee E4 O4 W4
Coast Guard E5 O5 W5
Civilian Expeditionary Workforce (CEW) E6 O6
USPHS E7 O7 Other
Other Defense Agency List: 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

Primary location of last deployment: Date departed theater (dd/mmm/yyyy)

Total deployments in past 5 years: 1 2 3 4 5 or more

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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 your most recent 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
 Much worse now than before I deployed
 Please explain: _____
 Please explain: _____

3. **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 the event(s)? Yes No
 If yes, please explain: _____

4. **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

5. **Since you returned from deployment, how many times have you gone to a health care provider for a medical, dental, or mental health problem/concern?**
 No visits 1 visit 2-3 visits 4-5 visits 6 or more

6. **Since you returned from deployment, have you been hospitalized?** Yes No
 If yes, please list date and brief details: _____

7. **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

8. **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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Pain in the arms, legs, or joints (knees, hips, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Menstrual cramps or other problems with your periods (Women only)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Fainting spells	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Feeling your heart pound or race	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Pain or problems during sexual intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Constipation, loose bowels, or diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Nausea, gas, or indigestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Feeling tired or having low energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Trouble sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. Trouble concentrating on things (such as reading a newspaper or watching television)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
q. Memory problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
r. Balance problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
s. Noises in your head or ears (such as ringing, buzzing, crickets, humming, tone, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
t. Trouble hearing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
u. Sensitivity to bright light	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
v. Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
w. Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
x. Cough lasting more than 3 weeks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
y. Numbness or tingling in the hands or feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
z. Hard to make up your mind or make decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
aa. Watery, red eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
bb. Dimming of vision, like the lights were going out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
cc. Skin rash and/or lesion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
dd. Bleeding gums, tooth pain, or broken tooth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Deployer's SSN (Last 4 digits): _____

9. 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
10. In the PAST YEAR did you receive care for any mental health condition or concern such as, but not limited to post traumatic stress disorder (PTSD), depression, anxiety disorder, alcohol abuse or substance abuse? Yes No
- If yes, please explain: _____
11. 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
12. 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
13. 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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NOTE: If two or more items on 13a. through 13d. are marked yes, continue to answer items 13e through 13v.

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each question carefully and check the box for how much you have been bothered by that problem in the LAST MONTH. Please answer all items.					
	Not at all	A little bit	Moderately	Quite a bit	Extremely
13e. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	<input type="radio"/>				
13f. Repeated, disturbing dreams of a stressful experience from the past?	<input type="radio"/>				
13g. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	<input type="radio"/>				
13h. Feeling very upset when something reminded you of a stressful experience from the past?	<input type="radio"/>				
13i. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	<input type="radio"/>				
13j. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	<input type="radio"/>				
13k. Avoid activities or situations because they remind you of a stressful experience from the past?	<input type="radio"/>				
13l. Trouble remembering important parts of a stressful experience from the past?	<input type="radio"/>				
13m. Loss of interest in things that you used to enjoy?	<input type="radio"/>				
13n. Feeling distant or cut off from other people?	<input type="radio"/>				
13o. Feeling emotionally numb or being unable to have loving feelings for those close to you?	<input type="radio"/>				
13p. Feeling as if your future will somehow be cut short?	<input type="radio"/>				
13q. Trouble falling or staying asleep?	<input type="radio"/>				
13r. Feeling irritable or having angry outbursts?	<input type="radio"/>				
13s. Having difficulty concentrating?	<input type="radio"/>				
13t. Being "super alert" or watchful, on guard?	<input type="radio"/>				
13u. Feeling jumpy or easily startled?	<input type="radio"/>				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult	
13v. How difficult have these problems (13e through 13u.) made it for you to do your work, take care of things at home, or get along with other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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

- | | <u>Not at all</u> | <u>Few or several days</u> | <u>More than half the days</u> | <u>Nearly every day</u> |
|--|-----------------------|----------------------------|--------------------------------|-------------------------|
| a. Little interest or pleasure in doing things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Feeling down, depressed, or hopeless | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

NOTE: If 14a. or 14b. are marked "More than half the days" or "Nearly every day," continue to answer items 14c. through 14i.

Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?	Not at all	Few or several days	More than half the days	Nearly every day
14c. Trouble falling/staying asleep, sleep too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14d. Feeling tired or having little energy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14e. Poor appetite or overeating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14g. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety that you have been moving around a lot more than usual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
14i. How difficult have these problems (14a.-14h.) made it for you to do your work, take care of things at home, or get along with other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. 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: _____

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16. 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:

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

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

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

20. 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 most recent deployment was to _____ and has deployed _____ times before in the past five years.

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

Deployer question	Not answered	Deployer indicated concern	Deployer's response or concern	Provider comments (if indicated)
Self health rating	<input type="radio"/>	<input type="radio"/>		
Change in health post-deployment	<input type="radio"/>	<input type="radio"/>		

2. Address wounds, injuries, assaults, etc., occurring during deployment as reported on deployer question 3.

- 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 16 and 17)
 No Already under care
 Already has referral
 No significant impairment
 Other reason (explain): _____

3. Deployment experiences as reported in deployer question 4. Consider in overall assessment; ask follow-up questions as indicated.

Deployer question	Not answered	Yes response	Provider comments (if indicated)
Danger of being killed	<input type="radio"/>	<input type="radio"/>	
Encountered bodies or saw people killed or wounded	<input type="radio"/>	<input type="radio"/>	
In direct combat and discharged weapon	<input type="radio"/>	<input type="radio"/>	

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4. Address concerns identified on deployer questions 5 through 7.

Deployer question	Not answered	Deployer indicated concern	Deployer's response or concern	Provider comments (if indicated)
Health care visits since return	<input type="radio"/>	<input type="radio"/>		
Hospitalized since return	<input type="radio"/>	<input type="radio"/>		
Physical limitations/problems	<input type="radio"/>	<input type="radio"/>		

5. Post-deployment general symptoms/health concerns.

List of symptoms reported as "Bothered a Lot" on Deployer Questions 8a. through 8dd.
List of symptoms reported as "Bothered a Little" on Deployer Questions 8a. through 8dd.

Physical symptom (PHQ-15) severity score for Deployer Questions 8a. through 8o.				
	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 symptom scale – deployer questions 8a. through 8o.) or is "bothered a lot" by specific symptoms listed in 8a. through 8dd.? Yes
 No
 Not answered by deployer
- b. Based on deployer's responses to deployer questions 8a. through 8dd. is a referral indicated? Yes (complete blocks 16 and 17)
 No Already under care
 Already has referral
 No significant impairment
 Other reason (explain): _____

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6. Major life stressor as reported on deployer question 9.

- a. Did deployer mark they have a concern or a difficulty with a major life stressor? Yes Deployer's concern: _____
 No (go to block 7)
 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 16 and 17)
 No Already under care
 Already has referral
 No significant impairment
 Other reason (explain) _____

7. Address concerns as reported in deployer questions 10 and 11.

Deployer question	Not answered	Yes response	Deployer's response	Provider comments (if indicated)
History of mental health care	<input type="radio"/>	<input type="radio"/>		
Medications	<input type="radio"/>	<input type="radio"/>		

8. Alcohol use as reported in deployer question 12.

- a. Deployer's AUDIT-C screening score was _____. (If score between 0-4 (men) or 0-3 (women) nothing required, go to block 9). Not answered by deployer
- 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 Matrix		
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 <u>OR</u> ≤ 4 drinks on any occasion Women: ≤ 7 drinks per week <u>OR</u> ≤ 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	Refer if indicated for further evaluation AND conduct BRIEF counseling*

* **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 16 and 17)
 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): _____

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9. PTSD screening as reported in deployer question 13.

- a. Did deployer mark yes on two or more of questions 13a. through 13d.? Yes
 No (go to block 10)
 Not answered by deployer
- b. If yes, deployer's responses to questions 13e. through 13u. resulted in a PCL-C score of _____ and the deployer's response to level of impairment with life events (13v.) is indicated in the table below.
- 13e. through 13v. were not answered or are incomplete.

Based on the PCL-C score, the deployer's level of functioning, and your exploration of responses, follow the guidance below:

Post-Traumatic Stress Disorder Intervention Matrix				
Self-Reported Level of Functioning	PCL-C Score <30 (Sub-threshold or no Symptoms)	PCL-C Score 30-39 (Mild Symptoms)	PCL-C Score 40-49 (Moderate Symptoms)	PCL-C Score ≥ 50 (Severe Symptoms)
<input type="radio"/> Not Difficult at All or Somewhat Difficult	No intervention	Provide PTSD education*		Consider referral for further evaluation AND provide PTSD education*
<input type="radio"/> Very Difficult to Extremely Difficult	Assess need for further evaluation AND provide PTSD education*	Consider referral for further evaluation AND provide PTSD education*		Refer for further evaluation AND provide PTSD education*

* PTSD Education = Reassurance/supportive counseling, provide literature on PTSD, encourage self-management activities, and counsel deployer to seek help for worsening symptoms.

- c. Referral indicated? Yes (complete blocks 16 and 17)
 No Already under care
 Already has referral
 No significant impairment
 Other reason (explain): _____

10. Depression screening as reported in deployer question 14.

- a. Did Deployer mark "More than half the days" or "Nearly every day" on question 14a. or 14b.? Yes
 No (go to block 11)
 Not answered by deployer
- b. If yes, deployer's responses to questions 14c. - 14h. resulted in a total PHQ-8 score of _____ and the deployer's response to level of impairment with life events (14i.) is indicated in the table below.
- 14c. through 14i. were not answered or incomplete.

Based on the PHQ-8 score, deployer's level of functioning, and exploration of responses, follow the guidance below:

Depression Intervention Matrix					
Self-Reported Level of Functioning	PHQ-8 Score 1-4 (No Symptoms)	PHQ-8 Score 5-9 (Sub-Threshold Symptoms)	PHQ-8 Score 10-14 (Mild Symptoms)	PHQ-8 Score 15-18 (Moderate Symptoms)	PHQ-8 Score 19-24 (Severe Symptoms)
<input type="radio"/> Not Difficult at All or Somewhat Difficult	No intervention	Depression education*		Consider referral for further evaluation AND provide depression education*	Consider referral for further evaluation AND provide depression education*
<input type="radio"/> Very Difficult to Extremely Difficult	Assess need for further evaluation AND provide depression education*		Consider referral for further evaluation AND provide depression education*	Consider referral for further evaluation AND provide depression education*	Refer for further evaluation AND provide depression education*

* Depression Education = Reassurance/supportive counseling, provide literature on depression, encourage self-management activities, and counsel deployer to seek help for worsening symptoms.

- c. Referral indicated? Yes (complete blocks 16 and 17)
 No Already under care
 Already has referral
 No significant impairment
 Other reason (explain): _____

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11. Environmental and exposure concern/assessment as reported in deployer question 15.

- a. Did deployer indicate a worry or possible exposure? Yes No (go to block 12)

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

- b. If yes, referral indicated? Yes (complete blocks 16 and 17)
 No (provide risk education)
 Already under care
 Already has referral
 No significant impairment
 Other reason (explain): _____

12. Animal bite (rabies risk) as reported on deployer question 16.

- a. Did deployer mark "yes" on animal bite/scratch? Yes
 No (go to block 13)
- 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 16 and 17)
 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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13. 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 14)
- b. If 13.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 13.a. was yes, **ask**: "Have you had thoughts of actually hurting yourself?"
 Yes (**If yes, ask questions 13d. through 13g.**)
 No (If no thoughts of self-harm, go to block 14)
- 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, or serious physical illness).
 Comments: _____

- i. Does deployer pose a current risk for harm to self?
 Yes (complete blocks 16 and 17)
 No

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14. 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 15)

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 16 and 17)
 No (briefly state reason): _____

15. 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 16 through 19.

16. Summary of provider's identified concerns needing referral < Mark all that apply >	Yes	No
a. None Identified <input type="radio"/>		
b. Physical health <input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Dental health <input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Mental health symptoms <input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Alcohol use <input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. PTSD symptoms <input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Depression symptoms <input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Environment/work exposure <input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Risk of self-harm <input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Risk of violence <input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Other, list: <input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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17. Recommended referral(s) < Mark all that apply even if deployer does not desire >	Within 24 hours	Within 7 days	Within 30 days
a. Primary Care, Family Practice, Internal Medicine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Behavioral Health in Primary Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Mental Health Specialty Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Dental	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Other specialty care:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Audiology	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dermatology	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OB/GYN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical Therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TBI/Rehab Med	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Podiatry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, list	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Case Manager / Care Manager	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Substance Abuse Program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Other, list:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. Comments:

19. Address requests as reported on deployer questions 17 through 20.

Deployer question	Not answered	Yes response	Comments (if indicated)
Request medical appointment	<input type="radio"/>	<input type="radio"/>	
Request info on stress/emotional/alcohol	<input type="radio"/>	<input type="radio"/>	
Family/relationship concern assistance	<input type="radio"/>	<input type="radio"/>	
Chaplain/counselor visit request	<input type="radio"/>	<input type="radio"/>	

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

Deployer's SSN (Last 4 digits): _____

20. Supplemental services recommended / information provided	
<input type="radio"/> Appointment Assistance	<input type="radio"/> Family Support
<input type="radio"/> Contract Support: _____	<input type="radio"/> Military One Source
<input type="radio"/> Community Service: _____	<input type="radio"/> TRICARE Provider
<input type="radio"/> Chaplain	<input type="radio"/> VA Medical Center or Community Clinic
<input type="radio"/> Health Education and Information	<input type="radio"/> Vet Center
<input type="radio"/> Health Care Benefits and Resources Information	<input type="radio"/> Other, list:
<input type="radio"/> In Transition	

Provider's Name: _____

Date (dd/mmm/yyyy) _____

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

I certify this assessment process has been completed.

This visit is coded by V70.5 _ F

S A M P L E