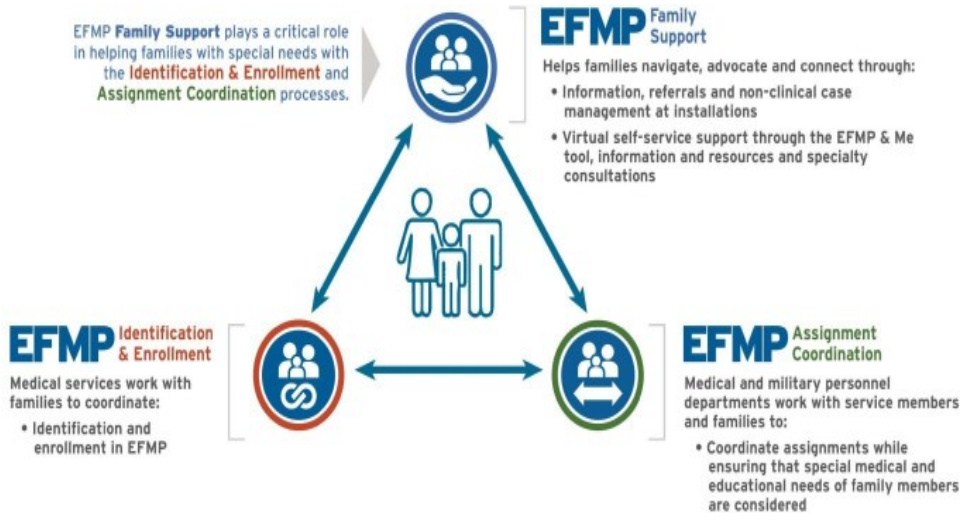
EXCEPTIONAL FAMILY MEMBER PROGRAM—FORT BLISS

Army Medicine

Dear Healthcare Provider,

The purpose of this letter is to guide you in completing the DD Form 2792 (Exceptional Family Member Medical Summary) to ensure accurate and thorough documentation of a patient's medical needs. This form is essential for identifying military dependents with special medical needs and ensuring appropriate care and support are available at future duty stations.



All steps to accurately fill out this form are listed in the following pages. Please remember, the goal of EFMP is to ensure that your patient has access to appropriate care at their Service Member's next duty station. If you have any questions regarding this form, please contact us.

Thank you for all you do!

ADDRESS AND CONTACT INFORMATION:

18511 Highlander Medics St
3rd Floor, West Clinic

Fort Bliss, Texas 79918

Hours: Mon-Thurs 0730-1615
Closed on Fridays and 2nd and 4th Thursday of every month

Phone: 915-742-3715

Fax: 915-742-9333
Email:USARMY.BLISS.MEDCOM-WBAMC.MBX.EFMP@HEALTH.

EFMP Exceptional Family Member Program

Below is a step-by-step guide to assist you in completing the form:

STEP 1:

Pages 2 & 3 are completed by the Service member or their family. Ensure page 2 is completed and signed before you proceed filling out the rest of the form.

NAME OF PATIENT	SIGNATURE OF PATIENT / PARENT / GUARDIAN	RELATIONSHIP TO PATIENT *(if applicable)*	DATE *(YYYYMMDD)*
Jane A. Doe	Jane A. Doe	Self/Parent	20241213

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STEP 2:

Pages 4 & 5 is where you will explain the diagnosis (section 1,2,4 & 5). Each page has space for 2 diagnoses, please only include one diagnosis per section, if you need to add more than 4 diagnoses, feel free to make copies of pages 4 or 5 and add them to the form. The sub-sections a, b & c boxes are self-explanatory, diagnosis, ICD code, and prognosis.

DIAGNOSIS INFORMATION

1a. DIAGNOSIS 1	1b. ICD CODE
Generalized Anxiety Disorder	F41.1

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

2a. DIAGNOSIS 2	2b. ICD CODE
Mild Intermittent Asthma with (acute exacerbation	J45.21

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

STEP 3:

Sub-section d (1-4) covers utilization of care over the last 12 months. Outpatient requires to be at least 1 visit (even if patient has yet to follow-up as an outpatient). All other sections require an entry, even if it is 0.

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
1	0	0	0

STEP 4:

Current medications for the diagnosis are listed in box e; please include medications that are given in your clinic or infusion clinic.

1e. MEDICATIONS

1e(1). CURRENT MEDICATION(S)	1e(2). DOSAGE	1e(3). FREQUENCY
Sertraline (Zoloft)	50 MG	Once a day

2e. MEDICATIONS

2e(1). CURRENT MEDICATION(S)	2e(2). DOSAGE	2e(3). FREQUENCY
Albuterol Inhaler	90 mcg/2puffs	As needed/PRN every 4 hours
Flovent	120 mcg/1puff	Twice a day

STEP 5:

The treatment plan is outlined in box f and should include specific treatments provided over the last 12 months and anticipated or recommended treatments over the next three years. In this section, please indicate if you feel that patient's care can be transitioned back to a primary care provider and still meet the standard of care. If you are waiting labs results or follow-up by the specialist, please wait to fill out the form until you have a clear and concise picture of the treatment plan for the patient. Treatment plans saying "pending referral, awaiting labs results or blank" will be rejected by our office.

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.)*

Condition well Controlled by PCM with Zoloft. Follow-up in 90 days for medication evaluation. Counseling quaterly. If conditions worsen, please return ASAP or to the nearest ER.

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.)*

Condition well managed by PCM. Take albuterol s needed every 4 hours. Flovent is taken twice a day. Take albuterol 30 minutes before exercise. If Conditions worsen, please return ASAP or go to the neasret ER.

STEP 6:

Sections 3 and 6 (a-f) at the bottom of pages 4 & 5 must be fully completed, even if a page is blank.

PROVIDER INFORMATION			
3a. PROVIDER PRINTED NAME OR STAMP	3b. SIGNATURE		3c. DATE *(YYYYMMDD)*
Mark P. Sonatro, MD	Mark P. Sonatro		20241213
3d. TELEPHONE NUMBERS *(Include Country Code / Area Code)*		3e. OFFICIAL EMAIL ADDRESS	3f. MEDICAL SPECIALTY
3d(1). COMMERCIAL: (123) 456-7890	3d(2). DSN *(Military Only)*	mark.p.sonatro@gmail.com	Primary Care

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STEP 7:

Page 6, there are some specific questions regarding Asthma, Behavioral Health, and autism spectrum disorders and/or significant developmental delays that require you to document care that your patient has received over the last 5 years. If there is a diagnosis associated with Asthma, Behavioral Health or autism spectrum disorders on pages 4 or 5, section 7, 8 or 9 must be completed as applicable, N/A should only be selected if there is not a diagnosis associated with the respective boxes, even if everything is no.

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.)

ASTHMA INFORMATION ☐ N/A

7. HISTORY ASSOCIATED WITH ASTHMA *(See note above for additional information) (Select as applicable)*

YES	NO		
☒	☐	7a. ARE THERE ANY TRIGGERS FOR THE PATIENT'S ASTHMA EXACERBATIONS? *(If "Yes," specify exact trigger(s))*	Exercise, pollen, air quality
☐	☒	7b. HAS THE PATIENT EVER TAKEN ORAL STEROIDS DURING THE PAST YEAR FOR EXACERBATIONS? *(prednisone, prednisolone)* If "YES", NUMBER OF COURSES IN THE PAST YEAR:	
☐	☒	7c. HAS THE PATIENT 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:	
☐	☒	7d. DOES THE PATIENT HAVE A HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA RELATED CONDITIONS WITHIN THE PAST FIVE YEARS? IF "YES," HOW MANY? INDICATE DATE OF LAST ADMISSION: *(YYYYMMDD)*:	
☐	☒	7e. DOES THE PATIENT HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?	

BEHAVIORAL HEALTH INFORMATION ☐ N/A

8. HISTORY *(Select and provide details for each "Yes" answer)*

YES	NO	WITHIN THE LAST 5 YEARS, HAS THE PATIENT HAD A:	
☐	☒	8a. HISTORY OF SUICIDAL BEHAVIORS / ATTEMPTS? *(If "Yes," include dates)*	
☐	☒	8b. HISTORY OF SUBSTANCE MISUSE / ABUSE?	
☐	☒	8c. HISTORY OF ADDICTIVE BEHAVIORS?	
☐	☒	8d. HISTORY OF EATING DISORDERS?	
☐	☒	8e. HISTORY OF OTHER COMPULSIVE BEHAVIORS?	
☐	☒	8f. HISTORY OF PROBLEMS WITH LEGAL AUTHORITY OR AUTHORITY FIGURES? *(If "Yes," specify)*	
☐	☒	8g. HISTORY OF PSYCHOTIC EPISODES?	
☐	☒	8h. HISTORY OF SERVICES RECEIVED FOR ALLEGATIONS OF FAMILY MALTREATMENT? *(If "Yes," and services are delivered by Family Advocacy, note case determination)*	

STEP 8:

Page 7 is used to indicate the types of medical providers a patient needs as well as frequency of visits. This information is utilized to determine how far your patient can travel to receive care; the more frequent the visits, the closer services will need to be. All specialists must be associated with a diagnosis, i.e., somebody with a diagnosis of acne and Dermatologist specialist is good, but if you select pulmonologist and only 1 diagnosis GERD on page 4 or 5, will cause this packet to be rejected. Please only use the acronyms on the top of the page to indicate the frequency of care. If you select Counselor (box i) or other (ppp), please specify. Do not use 'PRN or as needed' in these boxes.

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

i	☒ COUNSELOR *(Specify)* LCSW	Q	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	☐ ENDOCRINOLOGIST - ADULT		vv	☐ PLASTIC SURGEON - ADULT	
o	☐ ENDOCRINOLOGIST - PEDIATRIC		ww	☐ PLASTIC SURGEON - PEDIATRIC	
p	☒ FAMILY PRACTITIONER	Q	xx	☐ PODIATRIST	

STEP 9:

Page 8, The final page identifies any additional special needs such as ostomy care, prosthetics, or assistive devices. Service Members and their Families utilize housing supplied by the government and box 17 identifies environmental/architectural considerations for patients with mobility issues or environmental triggers of their diagnosis (asthma and allergies as an example).

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

☐ YES IF "YES": ☐ GASTROSTOMY ☐ COLOSTOMY ☐ OTHER UNSPECIFIED OPENING *(Specify)*
☒ NO ☐ TRACHEOSTOMY ☐ ILEOSTOMY
☐ CSF SHUNT ☐ OTHER UNSPECIFIED PROSTHETICS *(Specify)*

17. MEDICALLY INDICATED *(As indicated in diagnostic information)* **ENVIRONMENTAL / ARCHITECTURAL CONSIDERATIONS**

☐ LIMITED STEPS *(If selected, please explain below)* ☒ AIR CONDITIONING
☐ COMPLETE WHEELCHAIR ACCESSIBILITY ☐ TEMPERATURE CONTROL ☒ POLLEN CONTROL
☐ SINGLE STORY / LEVEL HOUSE ☐ HEPA FILTER ☐ AIR FILTERING
☒ CARPET PROHIBITED ☐ OTHER *(Specify below)*

(Specify and provide justifications for environmental / architectural considerations):

Carpert and pollen exacerbate the patient's Asthma symptoms.

If you have identified any limitations in activities of daily living or specific travel limitation/constraints, please make this notation with explanation in box 19. If you select any of the conditions above, please ensure there is also a diagnosis associated with this. This page must be signed and dated on the bottom, even if it is blank. Please ensure that the care plan you document on the 2792 reflects the care plan documented in the medical record. A part of the process is to review a patient's medical record to ensure that information provided on the 2792 is accurate.