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POST-DEPLOYMENT HEALTH RE-ASSESSMENT (PDHRA)

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting the personal information required by the DD Form 2900, Post Deployment Health Re-Assessment (PDHRA), 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 Pafts 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 highly encouraged to answer all questions. You must meet with a health care provider who will review the form with you to address any questions or concerns.

DEMOGRAPHICS

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

Provide your 10-digit DoD ID number located on the back of your CAC _____ **Today's Date** *(dd/mmm/yyyy)* _____

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

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

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

Pay Grade
- ○ E1
- ○ E2
- ○ E3
- ○ E4
- ○ E5
- ○ E6
- ○ E7
- ○ E8
- ○ E9
- ○ O1
- ○ O2
- ○ O3
- ○ O4
- ○ O5
- ○ O6
- ○ O7
- ○ O8
- ○ O9
- ○ O10
- ○ W1
- ○ W2
- ○ W3
- ○ W4
- ○ W5
- ○ Other *(List):* _____

Unit Name: _____ **Duty Station/Location:** _____

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 country of last deployment: _____ **Date departed theater/theater location** *(dd/mmm/yyyy)* _____

Total deployments in the PAST 5 YEARS: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 or more

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Deployer's DoD ID (10 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 Please explain: _____
   ○ Much worse now than before I deployed 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	○	○	○
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. Shortness of breath	○	○	○
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	○	○	○

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Deployer's DoD ID (10 digits): _____

9. a. Over the PAST MONTH, what major life stressors, if any, 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? *(Mark all that apply.)*

- ❍ None
- ❍ Legal
- ❍ Financial
- ❍ Spiritual
- ❍ Substance abuse *(including alcohol)*
- ❍ Family/relationship
- ❍ Employment
- ❍ Sleep
- ❍ Behavioral health
- ❍ Other *(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 *(please explain)* _____

❍ No

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

❍ Please list: _____

❍ None

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

❍ Never *(skip to 13)* ❍ Monthly ❍ 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

e. Felt guilt or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? ❍ Yes ❍ No

NOTE: If 3 or more items on 13a. through 13e. are marked yes, continue to answer items 13f. through 13w.

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**
13f. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	❍	❍	❍	❍	❍
13g. Repeated, disturbing dreams of a stressful experience from the past?	❍	❍	❍	❍	❍
13h. Suddenly acting or feeling as if a stressful experience were happening again *(as if you were reliving it)*?	❍	❍	❍	❍	❍
13i. Feeling very upset when something reminded you of a stressful experience from the past?	❍	❍	❍	❍	❍
13j. Having physical reactions *(e.g., heart pounding, trouble breathing, or sweating)* when something reminded you of a stressful experience from the past?	❍	❍	❍	❍	❍
13k. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	❍	❍	❍	❍	❍
13l. Avoid activities or situations because they remind you of a stressful experience from the past?	❍	❍	❍	❍	❍
13m. Trouble remembering important parts of a stressful experience from the past?	❍	❍	❍	❍	❍
13n. Loss of interest in things that you used to enjoy?	❍	❍	❍	❍	❍
13o. Feeling distant or cut off from other people?	❍	❍	❍	❍	❍
13p. Feeling emotionally numb or being unable to have loving feelings for those close to you?	❍	❍	❍	❍	❍

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Deployer's DoD ID (10 digits): _____

13q. Feeling as if your future will somehow be cut short?	❍	❍	❍	❍	❍
13r. Trouble falling or staying asleep?	❍	❍	❍	❍	❍
13s. Feeling irritable or having angry outbursts?	❍	❍	❍	❍	❍
13t. Having difficulty concentrating?	❍	❍	❍	❍	❍
13u. Being "super alert" or watchful, on guard?	❍	❍	❍	❍	❍
13v. Feeling jumpy or easily startled?	❍	❍	❍	❍	❍

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
13w. How difficult have these problems *(13f. through 13v.)* made it for you to do your work, take care of things at home, or get along with other	❍	❍	❍	❍

14. 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	❍	❍	❍	❍

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.	❍	❍	❍	❍
14d. Feeling tired or having little energy.	❍	❍	❍	❍
14e. Poor appetite or overeating.	❍	❍	❍	❍
14f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	❍	❍	❍	❍
14g. Trouble concentrating on things, such as reading the newspaper or watching television.	❍	❍	❍	❍
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.	❍	❍	❍	❍
	Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
14i. How difficult have these problems *(14a.through14h.)* made it for you to do your work, take care of things at home, or get along with other people?	❍	❍	❍	❍

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: _____

16. a. During this deployment were you based or stationed at a location where an open burn pit was used? ❍ Yes ❍ No ❍ Not Sure

b. During this deployment were you exposed to toxic airborne chemicals or other airborne contaminants? ❍ Yes ❍ No ❍ Not Sure

c. *(If 16a or 16b is "Yes" or "Not Sure")* For Service members, are you enrolled in the Airborne Hazards and Open Burn Pit Registry?

❍ Yes

❍ No

d. *(If 16c is "No")* For Service members, federal law requires eligible members to enroll in the Airborne Hazards and Open Burn Pit Registry or opt-out. If eligible, choose one:

❍ Wish to enroll

❍ Opt-out

17. 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:

_____

_____

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

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

20 Are you interested in receiving assistance for a family or relationship concern? ❍ Yes ❍ No

21. Would you like to schedule a visit with a chaplain, mental health care provider, or a community support counselor? ❍ Yes ❍ No

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Deployer's DoD ID (10 digits): _____

HEALTH CARE PROVIDER ONLY

HEALTH CARE PROVIDER INFORMATION

1. Last Name: _____ **2. First Name :** _____ **3. Middle Initial :** _____

4. Service Branch
- ○ Air Force
- ○ Army
- ○ Navy
- ○ Marine Corps
- ○ Space Force
- ○ Coast Guard
- ○ U.S. Public Health Service
- ○ Other *(e.g., RHRP contractor)*

5. Component
- ○ Active Duty
- ○ Traditional Guardsman
- ○ Reservist
- ○ Active Guard Reserve or Full-time Support
- ○ Civilian Government Employee
- ○ Civilian Contractor
- ○ Other *(List):* _____

6. Select the appropriate title.
- ○ Physician *(MD, DO)*
- ○ Nurse Practitioner *(NP)*
- ○ Physician Assistant *(PA)*
- ○ Advance Practice Nurse *(Clinical Nurse Specialist)*
- ○ Independent Duty Corpsman
- ○ Independent Duty Health Services Technician
- ○ Independent Duty Medical Technician
- ○ Special Forces Medical Sergeant

7. Email: _____ **8. Facility:** _____ **9. Unit:** _____

10. Address: _____ **11. State:** _____ **12. ZIP Code:** _____ **13. Phone** *(Commercial)*: _____

HEALTH CARE 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	○	○		
Change in health post-deployment	○	○		

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	○	○	
Encountered bodies or saw people killed or wounded	○	○	
In direct combat and discharged weapon	○	○	

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Deployer's DoD ID (10 digits): _____

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	❍	❍		
Hospitalized since return	❍	❍		
Physical limitations/problems	❍	❍		

5. Post-deployment general symptoms/health concerns.

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

Physical symptom *(PHQ-15)* severity score for Deployer Questions 8a. through 8ee.				
	Minimal < 5	Low 5 - 9	Medium 10 - 14	High ≥ 15
Deployer's total				

a. Does deployer have evidence of high general post-deployment physical symptoms *(a score of ≥ 15 on the PHQ-15 physical symptom scale deployer questions 8a. through 8ee.)* or is "bothered a lot" by specific symptoms listed in 8a. through 8ee.?
❍ Yes
❍ No
❍ Not answered by deployer

b. Based on deployer's responses to deployer questions 8a. through 8ee. is a referral indicated?
❍ Yes *(complete blocks 16 and 17)*
❍ No ❍ Already under care
❍ Already has referral
❍ No significant impairment
❍ Other reason *(explain)*: _____

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 described on deployer questions 10 and 11.

Deployer question	Not answered	Yes response	Deployer's response	Provider comments *(if indicated)*
History of mental health care	❍	❍		
Medications	❍	❍		

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Deployer's DoD ID (10 digits): _____

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

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 **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 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)*: _____

9. PTSD screening as reported in deployer question 13.

a. Did deployer mark yes on three or more of questions 13a. through 13e?

❍ Yes

❍ No *(go to block 10)*

❍ Not answered by deployer

b. If yes, deployer's responses to questions 13f. through 13v. resulted in a PCL-C score of _____ and the deployer's response to level of impairment with life events (13w.) is indicated in the table below.

❍ 13f. through 13w. 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)*
❍ **Not Difficult at All or Somewhat Difficult**	No intervention	Provide PTSD education*		Consider referral for further evaluation AND provide PTSD education*
❍ **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)*: _____

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Deployer's DoD ID (10 digits): _____

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 14a. through 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)*
❍ **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*
❍ **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)*: _____

11. Environmental and exposure concern/assessment as reported in deployer questions 15 through 17.

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

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 burn pit, 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 16 and 17)*
❍ No
❍ 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://phc.amedd.army.mil/topics/envirohealth/hrasm/Pages/POEMS.aspx.

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Deployer's DoD ID (10 digits): _____

12. Animal bite *(rabies risk)* **as reported on deployer question 17.**

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? Rabies incubation period can be months to years. Rabies prophylaxis can begin at any time.
- ❍ Yes *(complete blocks 16 and 17)*
- ❍ No *(provide risk education)* Note:
  - ❍ Was appropriately treated
  - ❍ Already under care
  - ❍ Already has referral
  - ❍ Situation was not a risk for rabies
  - ❍ Other reason *(explain)*: _____

13. Suicide risk evaluation.

a. **Ask** "Over the PAST MONTH, have you wished you were dead or wished you could go to sleep and not wake up?"
- ❍ Yes
- ❍ No

b. **Ask** "Have you actually had any thoughts of killing yourself?"
- ❍ Yes
- ❍ No *(skip to 13.f1.)*

c. **Ask** "Over the PAST MONTH, have you been thinking about how you might do this?"
- ❍ Yes
- ❍ No

d. **Ask** "Over the past month, have you had these thoughts and had some intention of acting on them?"
- ❍ Yes
- ❍ No

e1. **Ask** "Over the past month, have you started to work out or worked out the details of how to kill yourself?"
- ❍ Yes
- ❍ No *(skip to 13.f1.)*

e2. **Ask** At any time in the past month, did you intend to carry out this plan?"
- ❍ Yes
- ❍ No

f1. **Ask** "In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life?"
- ❍ Yes
- ❍ No *(skip to 13.g.)*

f2. **Ask** "Was this within the past three months?"
- ❍ Yes
- ❍ No

g. **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).*

_____

_____

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

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):* _____

This form must be completed electronically in system designated by DoD Component or Agency. Handwritten forms will not be accepted.

Deployer's DoD ID (10 digits): _____

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 ❍		
b. Physical health	❍	❍
c. Dental health	❍	❍
d. Mental health symptoms	❍	❍
e. Alcohol use	❍	❍
f. PTSD symptoms	❍	❍
g. Depression symptoms	❍	❍
h. Environment/work exposure	❍	❍
i. Risk of self-harm	❍	❍
j. Risk of violence	❍	❍
k. Other *(list):* _____	❍	❍

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	❍	❍	❍
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. Other *(list):* _____	❍	❍	❍

18. Comments: _____

19. Address requests as reported on deployer questions 18 through 21.

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

20. Supplemental services recommended / information provided	
❍ Appointment Assistance: _____	❍ Family Support
❍ Contract Support: _____	❍ Military One Source
❍ Community Service: _____	❍ TRICARE Provider
❍ Chaplain	❍ VA Medical Center or Community Clinic
❍ Health Education and Information	❍ Veterans Center
❍ Health Care Benefits and Resources Information	❍ Other *(list):* _____
❍ In Transition	❍ No Supplemental Services Required

❍ **I hereby certify that this review process has been completed.**	
Health Care Provider Digital Signature:	**Date Completed** *(dd/mmm/yyyy)*:

This visit is coded by DOD0213.