WOUNDED WARRIOR REGIMENT
PATIENT REFERRAL MEDICAL QUESTIONNAIRE

Return to SNM parent command to be forwarded to WWBN-E or WWBnW
All of the following fields must be completed

Date of Request: _____

***Patient information**

Rank: _____

Name: _____

Phone: _____

Date of Injury: _____

Combat related (circle one): Yes / No

Unit Information

Unit: _____

Unit POC: _____

Phone: _____

Email: _____

*This document may contain information covered under the Privacy Act, 5 USC 552(a), and/or Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. If this correspondence contains healthcare information, it is being provided to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. Redisclosure without additional patient consent or as permitted by law is prohibited.

Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of an appropriate sanction. If you have received this correspondence in error, please notify the sender at once and destroy any copies you have made." A covered entity may use AND DISCLOSE the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission...

Unit Medical Officer/Primary Care Provider

Providers Information:

Name/Rank: _____

Phone: _____

E-Mail: _____

Marine Information:

Name/Rank: _____

Marital Status: Single:_____ Married: _____ Other:_____

Billeting Required: Yes or No

Does this member require any adaptive equipment or housing? Yes or No
Please explain if yes

1. Describe the primary diagnosis or mechanism of injury causing this referral to the Wounded Warrior Battalion:

2. Can a local Military Treatment Facility (Hospital) provide appropriate care for this member? Yes or no

3. Estimated recovery period: _____

4. List Medical Specialties are assigned to this members care?

5. Period of Limited Duty assigned: _____ Date: _____
MEB: Yes or No: Date: _____ PEB: Yes or No Date Mailed_____
(Attach a copy of current LIMDU, expired LIMDU's will not be accepted)

6. Do you feel the member will be capable of returning to full duty?
Yes or No

7. Is the member medically cleared to drive? Yes or No Please list limitations if indicated.

8. Number of missed appointments in the past 90 day: Yes or No Please list reason if yes.

9. Does the member have any alcohol abuse or substance abuse? Yes or No Please explain if yes.

10. Has the member ever received treatment for substance abuse? Yes or No If yes please provide the following.

Date: _____
Reason:
_____

_____

Facility: _____

11. Has the member been screened for TBI or PTSD? Yes or No. List results of screening.

Positive for TBI? Yes or No Date: _____
Positive for PTSD? Yes or No Date: _____

12. Does the member have a history of suicidal or homicidal ideations or attempts? Yes or No Please explain if yes.

13. Are there any specific medical needs for this member? Yes or No Please explain if yes

14. Is the member on any controlled medications? Yes or No Please list.

15. Why is Wounded Warrior Battalion the best place for the member?

16. What is the medical plan of care for the member?

17. Will the member require any surgeries in the near future? Yes or No Please explain if yes

18. Please provide any additional information relevant to the recommendation to transfer this member to the Wounded Warrior Battalion.

_____
Signature Date
(Medical Officer Stamp Required)

Information Verified by
Wounded Warrior Battalion Medical Staff _____
Signature Date