Wounded Warrior Regiment

Recovering Service Member Medical Questionnaire

Return to Service Members parent command for submission to Wounded Warrior Battalion-East or West All below fields must be completed; any blank fields could delay processing time

*__Service Members Information__

Rank: ______________________________

Name: ______________________________

EDIPI: ______________________________

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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.

Providers Information

Rank: _______
National Provider Identification Number (NPI #):______________________________

Name: ___________________________

Phone Number: ____________________

Email: __________________________

Global Teleconsultation Number: ___________________________

1. Provide a medical summary and justification for assignment to Wounded Warrior Battalion.

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 ____
 ____

2. Was this injury sustained due to combat? ≙ Yes ≙ No

 Has the member been evaluated for TBI or PTSD? ≙ Yes ≙ No

 Positive for TBI ≙ Yes ≙ No Date __________

 Positive for PTSD ≙ Yes ≙ No Date __________

3. Do you feel that the service member will be capable of returning to a fleet unit?

 ____
 ____
 ____
 ____
 ____

4. Is the local military treatment facility and Tricare network capable of providing the required services for the treatment of the service members conditions? ≙ Yes ≙ No

 If no, have referrals to another MTF or network facility been submitted? And if so, provide a list of the pending referrals (to where, their status, accepting physician, transfer date, etc.).

 ____
 ____
 ____
 ____

5. Period of Limited duty Assigned:________Start date:________End date:______

   IDES Referral: ≙ Yes ≙ No Date:________PEB Mailed: ≙ Yes ≙ No

   Date:______

6. What is the current medical plan of care for the service member, specialties assigned, and frequency of appointments or will the service member require any surgeries in the near future? ≙ Yes ≙ No

   If so, please explain.

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   ____

7. What medical assistive devices, adaptive equipment, or housing modifications are required for the service member’s recovery?

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   ____
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8. Has the service member attended any behavioral health intensive inpatient or outpatient treatments? ≙ Yes ≙ No

   If yes, where and when?

   ____
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   ____
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9. Does the service member have a history of substance abuse? ≙ Yes ≙ No

   If yes, where and when?

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10. Is the service member medically cleared to drive? Yes No
    If not, provide a list of limitations. If not, what is the date of revocation?

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11. Please provide any additional information relevant to the request for support from Wounded Warrior Battalion.

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Medical Officer Signature

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Date