



## 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: \_\_\_\_\_

\*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.

**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?  $\Delta$  Yes  $\Delta$  No

Has the member been evaluated for TBI or PTSD?  $\Delta$  Yes  $\Delta$  No

Positive for TBI  $\Delta$  Yes  $\Delta$  No Date \_\_\_\_\_

Positive for PTSD  $\Delta$  Yes  $\Delta$  No Date \_\_\_\_\_

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

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4. Is the local military treatment facility and Tricare network capable of providing the required services for the treatment of the service members conditions?  $\Delta$  Yes  $\Delta$  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.).

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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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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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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