



## Wounded Warrior Regiment Recovering Service Member Referral 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

Date of Request: \_\_\_\_\_

### \*Service Members Information

Rank: \_\_\_\_\_

Name: \_\_\_\_\_ EDIPI: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Combat related: Yes  No

### Unit Information

Unit: \_\_\_\_\_

Unit POC (Rank and Name): \_\_\_\_\_

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**

Rank: \_\_\_\_\_ National Identification Number (NIP #): \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Service Member Information**

Rank: \_\_\_\_\_ Name: \_\_\_\_\_

Marital Status: Single  Married  Other

Billeting Required: Yes  No

1. Does this member require any adaptive equipment or housing? Yes  No

Please explain if yes: \_\_\_\_\_  
\_\_\_\_\_

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

3. Can a local Military Treatment Facility (hospital) provide appropriate care for this service member? Yes  No  If **Yes**, MTF or WWBn Detachment Name/Location: \_\_\_\_\_

If **No**, What Medical facility can provide appropriate treatment/care and has any medical referrals been submitted or approved for an accepting provider? \_\_\_\_\_

4. Estimate recovery period: \_\_\_\_\_

5. List any medical specialties assigned to this service member's care? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Period of limited duty assigned: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

IDES Referral: YES  No  Date: \_\_\_\_\_ PEB Mailed: Yes  No  Date: \_\_\_\_\_

**(Attach a copy of current limited duty/IDES Referral Forms, expired limited duty forms will not be accepted)**

7. Do you feel the service member will be capable of returning to full duty?

Yes  No

8. Is the service member medically cleared to drive? Yes  No  Please list limitation if indicated: \_\_\_\_\_  
\_\_\_\_\_

9. Number of missed appointments in the past 90 days: \_\_\_\_\_ Please list reasons for missed appointments. \_\_\_\_\_  
\_\_\_\_\_

10. Does the service member have any alcohol abuse or substance abuse? Yes  No  If Yes, explain: \_\_\_\_\_  
\_\_\_\_\_

11. Has the service member ever received any treatment for substance abuse? Yes  No  If Yes Date(s): \_\_\_\_\_ Facility: \_\_\_\_\_ Reason: \_\_\_\_\_  
\_\_\_\_\_

12. Has the service member been screened for TBI or PTSD? Yes  No   
Positive for TBI? Yes  No  Date: \_\_\_\_\_  
Positive for PTSD? Yes  No  Date: \_\_\_\_\_

13. Does the service member have a history of suicidal or homicidal ideations or attempts? Yes  No  If Yes, please explain  
\_\_\_\_\_  
\_\_\_\_\_

14. Are there any specific medical needs for this service member? Yes  No  If Yes, please explain  
\_\_\_\_\_  
\_\_\_\_\_

15. Is the service member on any controlled medications? Yes  No  Please List  
\_\_\_\_\_  
\_\_\_\_\_

16. Why is Wounded Warrior Battalion the best place for this service member?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. What is the medical plan of care for this service member?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Will this service member require any surgeries in the near future? Yes  No

Please explain if Yes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. Please provide any additional information relevant to the recommendation to assign this service member to Wounded Warrior Battalion.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Medical Officer

\_\_\_\_\_  
Date