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:_____

Unit Administrative Contact (Rank/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 provider any additional information relevant to the recommendation to assign this service member to Wounded Warrior Battalion.

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Medical Officer (stamp required) Date