

POST-DEPLOYMENT HEALTH RE-ASSESSMENT (PDHRA)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, 1074f, 3013, 5013, 8013 and E.O. 9397.

PRINCIPAL PURPOSE(S): To assess your state of health after deployment in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care you may need. The information you provide may result in a referral for additional healthcare that may include medical, dental or behavioral healthcare or diverse community support services.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, to other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

DISCLOSURE: Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before entering your response or marking your selection. **YOU ARE ENCOURAGED TO ANSWER EACH QUESTION.** Withholding or providing inaccurate information may impair a healthcare provider's ability to identify health problems and refer you to appropriate sources for additional evaluation or treatment. If you do not understand a question, please ask for help. Please respond based on your **MOST RECENT DEPLOYMENT.**

DEMOGRAPHICS

Last Name

First Name

Middle Initial

Social Security Number

Date of Birth (dd/mmm/yyyy)

Today's Date (dd/mmm/yyyy)

S A M P L E

Date arrived theater (dd/mmm/yyyy)

Date departed theater (dd/mmm/yyyy)

Gender

- Male
- Female

Service Branch

- Air Force
- Army
- Navy
- Marine Corps
- Coast Guard
- Civilian Employee
- Other

Status Prior to Deployment

- Active Duty
- Selected Reserves - Reserve - Unit
- Selected Reserves - Reserve - AGR
- Selected Reserves - Reserve - IMA
- Selected Reserves - National Guard - Unit
- Selected Reserves - National Guard - AGR
- Ready Reserves - IRR
- Ready Reserves - ING
- Civilian Government Employee
- Other

Pay Grade

- E1 O1 W1
- E2 O2 W2
- E3 O3 W3
- E4 O4 W4
- E5 O5 W5
- E6 O6
- E7 O7 Other
- E8 O8
- E9 O9
- O10

Marital Status

- Never Married
- Married
- Separated
- Divorced
- Widowed

Location of Operation

To what areas were you mainly deployed (*land-based operations more than 30 days*)? Please mark all that apply, including the number of months spent at each location.

- Country 1 _____ Months _____
- Country 2 _____ Months _____
- Country 3 _____ Months _____
- Country 4 _____ Months _____
- Country 5 _____ Months _____

Since return from deployment I have:

- Maintained/returned to previous status
- Transitioned to Selected Reserves
- Transitioned to IRR
- Transitioned to ING
- Retired from Military Service
- Separated from Military Service

Current Contact Information:

Phone: _____
 Cell: _____
 DSN: _____
 Email: _____
 Address: _____

Total Deployments in Past 5 Years:

- | | | |
|---------------------------------|---------------------------------|---------------------------------|
| OIF | OEF | Other |
| <input type="radio"/> 1 | <input type="radio"/> 1 | <input type="radio"/> 1 |
| <input type="radio"/> 2 | <input type="radio"/> 2 | <input type="radio"/> 2 |
| <input type="radio"/> 3 | <input type="radio"/> 3 | <input type="radio"/> 3 |
| <input type="radio"/> 4 | <input type="radio"/> 4 | <input type="radio"/> 4 |
| <input type="radio"/> 5 or more | <input type="radio"/> 5 or more | <input type="radio"/> 5 or more |

Current Unit of Assignment

Current Assignment Location

Point of Contact who can always reach you:

Name: _____
 Phone: _____
 Email: _____
 Mailing Address: _____

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: _____

1. Overall, how would you rate your health during the PAST MONTH?

- Excellent
- Very Good
- Good
- Fair
- Poor

2. Compared to before your most recent deployment, how would you rate your health in general now?

- Much better now than before I deployed
- Somewhat better now than before I deployed
- About the same as before I deployed
- Somewhat worse now than before I deployed
- Much worse now than before I deployed

3. During the past 4 weeks, how difficult have physical health problems (illness or injury) made it for you to do your work or other regular daily activities?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

4. During the past 4 weeks, how difficult have emotional problems (such as feeling depressed or anxious) made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

5. Since you returned from deployment, about how many times have you seen a healthcare provider for any reason, such as in sick call, emergency room, primary care, family doctor, or mental health provider?

- No visits
- 1 visit
- 2-3 visits
- 4-5 visits
- 6 or more

6. Since you returned from deployment, have you been hospitalized?

- Yes
- No

7. During your deployment, were you wounded, injured, assaulted or otherwise physically hurt?

- Yes
- No

If **NO**, skip to Question 8.

7a. If **YES**, are you still having problems related to this wound, assault, or injury?

- Yes
- No
- Unsure

8. In addition to wounds or injuries you listed in question 7., do you currently have a health concern or condition that you feel is related to your deployment?

- Yes
- No
- Unsure

If **NO**, skip to Question 9.

8a. If **YES**, please mark the item(s) that best describe your deployment-related condition or concern:

<input type="radio"/> Fever	<input type="radio"/> Dimming of vision, like the lights were going out
<input type="radio"/> Cough lasting more than 3 weeks	<input type="radio"/> Chest pain or pressure
<input type="radio"/> Trouble breathing	<input type="radio"/> Dizzy, light headed, passed out
<input type="radio"/> Bad headaches	<input type="radio"/> Diarrhea, vomiting, or frequent indigestion/heartburn
<input type="radio"/> Generally feeling weak	<input type="radio"/> Problems sleeping or still feeling tired after sleeping
<input type="radio"/> Muscle aches	<input type="radio"/> Trouble concentrating, easily distracted
<input type="radio"/> Swollen, stiff or painful joints	<input type="radio"/> Forgetful or trouble remembering things
<input type="radio"/> Back pain	<input type="radio"/> Hard to make up your mind or make decisions
<input type="radio"/> Numbness or tingling in hands or feet	<input type="radio"/> Increased irritability
<input type="radio"/> Trouble hearing	<input type="radio"/> Taking more risks such as driving faster
<input type="radio"/> Ringing in the ears	<input type="radio"/> Skin diseases or rashes
<input type="radio"/> Watery, red eyes	<input type="radio"/> Other (please list): _____

S A M P L E

9a. During this deployment, did you experience any of the following events? (Mark all that apply)

- | | Yes | No |
|--|-----------------------|-----------------------|
| (1) Blast or explosion (IED, RPG, land mine, grenade, etc.) | <input type="radio"/> | <input type="radio"/> |
| (2) Vehicular accident/crash (any vehicle, including aircraft) | <input type="radio"/> | <input type="radio"/> |
| (3) Fragment wound or bullet wound above your shoulders | <input type="radio"/> | <input type="radio"/> |
| (4) Fall | <input type="radio"/> | <input type="radio"/> |
| (5) Other event (for example, a sports injury to your head). Describe: _____ | <input type="radio"/> | <input type="radio"/> |

9b. Did any of the following happen to you, or were you told happened to you, IMMEDIATELY after any of the event(s) you just noted in question 9a.? (Mark all that apply)

- | | Yes | No |
|---|-----------------------|-----------------------|
| (1) Lost consciousness or got "knocked out" | <input type="radio"/> | <input type="radio"/> |
| (2) Felt dazed, confused, or "saw stars" | <input type="radio"/> | <input type="radio"/> |
| (3) Didn't remember the event | <input type="radio"/> | <input type="radio"/> |
| (4) Had a concussion | <input type="radio"/> | <input type="radio"/> |
| (5) Had a head injury | <input type="radio"/> | <input type="radio"/> |

c. Did any of the following problems begin or get worse after the event(s) you noted in question 9a.? (Mark all that apply)

- | | Yes | No |
|-----------------------------------|-----------------------|-----------------------|
| (1) Memory problems or lapses | <input type="radio"/> | <input type="radio"/> |
| (2) Balance problems or dizziness | <input type="radio"/> | <input type="radio"/> |
| (3) Ringing in the ears | <input type="radio"/> | <input type="radio"/> |
| (4) Sensitivity to bright light | <input type="radio"/> | <input type="radio"/> |
| (5) Irritability | <input type="radio"/> | <input type="radio"/> |
| (6) Headaches | <input type="radio"/> | <input type="radio"/> |
| (7) Sleep problems | <input type="radio"/> | <input type="radio"/> |

d. In the past week, have you had any of the symptoms you indicated in 9c.? (Mark all that apply)

- | | Yes | No |
|-----------------------------------|-----------------------|-----------------------|
| (1) Memory problems or lapses | <input type="radio"/> | <input type="radio"/> |
| (2) Balance problems or dizziness | <input type="radio"/> | <input type="radio"/> |
| (3) Ringing in the ears | <input type="radio"/> | <input type="radio"/> |
| (4) Sensitivity to bright light | <input type="radio"/> | <input type="radio"/> |
| (5) Irritability | <input type="radio"/> | <input type="radio"/> |
| (6) Headaches | <input type="radio"/> | <input type="radio"/> |
| (7) Sleep problems | <input type="radio"/> | <input type="radio"/> |

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10. Do you have any persistent major concerns regarding the health effects of something you believe you may have been exposed to or encountered while deployed? Yes No
If **NO**, skip to question 11.

10a. If **YES**, please mark the item(s) that best describe your concern:

<input type="radio"/> Animal bites	<input type="radio"/> Loud noises
<input type="radio"/> Animal bodies (<i>dead</i>)	<input type="radio"/> Paints
<input type="radio"/> Chlorine gas	<input type="radio"/> Pesticides
<input type="radio"/> Depleted uranium (<i>If yes, explain</i>) _____	<input type="radio"/> Radar/Microwaves
<input type="radio"/> Excessive vibration	<input type="radio"/> Sand/dust
<input type="radio"/> Fog oils (smoke screen)	<input type="radio"/> Smoke from burning trash or feces
<input type="radio"/> Garbage	<input type="radio"/> Smoke from oil fire
<input type="radio"/> Human blood, body fluids, body parts, or dead bodies	<input type="radio"/> Solvents
<input type="radio"/> Industrial pollution	<input type="radio"/> Tent heater smoke
<input type="radio"/> Insect bites	<input type="radio"/> Vehicle or truck exhaust fumes
<input type="radio"/> Ionizing radiation	<input type="radio"/> Other exposures to toxic chemicals or materials, such as ammonia, nitric acid, etc.: (<i>If yes, explain</i>) _____
<input type="radio"/> JP8 or other fuels	
<input type="radio"/> Lasers	

11. Since return from your deployment, have you had serious conflicts with your spouse, family members, close friends, or at work that continue to cause you worry or concern? Yes No Unsure

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12. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you ...

a. Have had nightmares about it or thought about it when you did not want to? Yes No

b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? Yes No

c. Were constantly on guard, watchful, or easily startled? Yes No

d. Felt numb or detached from others, activities, or your surroundings? Yes No

13a. In the PAST MONTH, Did you use alcohol more than you meant to? Yes No

b. In the PAST MONTH, have you felt that you wanted to or needed to cut down on your drinking? Yes No

c. How often do you have a drink containing alcohol?
 Never Monthly or less 2 to 4 times a month 2 to 3 times a week 4 or more times a week

d. How many drinks containing alcohol do you have on a typical day when you are drinking?
 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

e. How often do you have six or more drinks on one occasion?
 Never Less than monthly Monthly Weekly Daily

14. Over the PAST MONTH, have you been bothered by the following problems?

	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. Would you like to schedule a visit with a healthcare provider to further discuss your health concern(s)? Yes No

16. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? Yes No

17. Are you currently interested in receiving assistance for a family or relationship concern? Yes No

18. Would you like to schedule a visit with a chaplain or a community support counselor? Yes No

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Service Member's Social Security Number:

Date (dd/mmm/yyyy):

Health Care Provider Only

Provider Review and Interview

1. Review symptoms and deployment concerns identified on form:

- Confirmed screening results as reported
- Screening results modified, amended, clarified during interview:

2. Ask behavioral risk questions. Conduct risk assessment.

- a. Over the PAST MONTH, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way? Yes No
- IF **YES**, about how often have you been bothered by these thoughts? Very few days More than half of the time Nearly every day
- b. Since return from your deployment, have you had thoughts or concerns that you might hurt or lose control with someone? Yes No Unsure

3. If member reports positive or unsure response to 2a. or 2b., conduct risk assessment.

- a. Does member pose a current risk for harm to self or others? No, not a current risk Yes, poses a current risk Unsure
- b. Outcome of assessment Immediate referral Routine follow-up referral Referral not indicated

4. Alcohol screening result

- No evidence of alcohol-related problems.
- Potential alcohol problem (positive response to either question 13a. or 13b. and/or AUDIT-C (questions 13c.-e.) score of 4 or more for men or 3 or more for women). Refer to PCM for evaluation. Yes No

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5. Traumatic Brain Injury (TBI) risk assessment

- No evidence of risk based on responses to questions 9.a. - d.
- Potential TBI with persistent symptoms, based on responses to question 9d. Refer for additional evaluation. Yes No

6. Record additional questions or concerns identified by patient during interview:

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Service Member's Social Security Number: _____

Date (dd/mmm/yyyy): _____

Assessment and Referral: After my interview with the service member and review of this form, there is a need for further evaluation and follow-up as indicated below. (More than one may be noted for patients with multiple concerns.)

7. Identified Concerns	Minor Concern	Major Concern	Already Under Care		8. Referral Information	Within 24 hours	Within 7 days	Within 30 days
			Yes	No				
<input type="checkbox"/> Physical Symptom(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Primary Care, Family Practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Exposure Symptom(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Behavioral Health in Primary Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Depression symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Mental Health Specialty Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PTSD symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Other specialty care:			
<input type="checkbox"/> Anger/Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Audiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Suicidal Ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Social/Family Conflict	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dentistry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dermatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Comments: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____					GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Internal Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Neurology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					OB/GYN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Ophthalmology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Optometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Orthopedics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Pulmonology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Urology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					e. Case Manager, Care Manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					f. Substance Abuse Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					g. Health Promotion, Health Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					h. Chaplain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					i. Family Support, Community Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					j. Military OneSource	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				k. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
				l. No referral made <input type="checkbox"/>				

I certify that this review process has been completed.

10. Provider's signature and stamp:

S A M P L E

ICD-9 Code for this visit: V70.5 _ F

Ancillary Staff/Administrative Section

11. Member was provided the following:	12. Referral was made to the following healthcare or support system:
<input type="checkbox"/> Health Education and Information	<input type="checkbox"/> Military Treatment Facility
<input type="checkbox"/> Health Care Benefits and Resources Information	<input type="checkbox"/> Division/Line-based medical resource
<input type="checkbox"/> Appointment Assistance	<input type="checkbox"/> VA Medical Center or Community Clinic
<input type="checkbox"/> Service member declined to complete form	<input type="checkbox"/> Vet Center
<input type="checkbox"/> Service member declined to complete interview/assessment	<input type="checkbox"/> TRICARE Provider
<input type="checkbox"/> Service member declined referral for services	<input type="checkbox"/> Contract Support: _____
<input type="checkbox"/> LOD	<input type="checkbox"/> Community Service: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> None