SUMMARY OF CARE BY NON-MILITARY MEDICAL PROVIDER

For use of this form, see PAM 40-502; the proponent agency is OTSG.

PURPOSE: The Summary of Care by Non-Military Medical Provider form provides the Army Healthcare team with essential current and relevant medical information for Soldiers seen by civilian network partners, to ensure that any functional limitation(s) is/are documented in a physical profile (DA Form 3349) when warranted. Appropriate and consistent Soldier profiles promote transparency and contribute to overall readiness of the Army. This form is applicable for Soldiers in the United States Army National Guard (ARNG), United States Army Reserves (USAR), and those on Active Duty receiving care covered by the Military Health System but at non-Military Treatment Facilities.

The following steps need to be taken to satisfy the requirement of completing the Summary of Care by Non-Military Medical Provider Form:

1. The Soldier will communicate with his/her Chain of Command within 7 business days any medical concerns being treated by a non-military healthcare provider that could negatively impact their physical capacity, deployability, or ability to perform satisfactorily. The Unit CDR or designee will provide a blank Summary of Care by Non-Military Provider Form to the Soldier, who will ensure completion by each civilian provider who performs any medical examination, evaluation, treatment, or consultation.
2. The civilian provider will complete the form based on the healthcare service(s) rendered.
3. The completed Summary of Care by Non-Military Medical Provider form and any additional available substantiating and supporting medical documents must be delivered by the Soldier to his/her Primary Care Manager (PCM) and the Regional Care Coordinator (RCC) within 7 business days of the civilian care encounter. Soldiers must also provide the form to his/her unit chain of command.
4. After review by the Soldier's PCM or RCC, appropriate processing will be made to ensure the form becomes part of the Soldier's Service Treatment Record (STR).

NOTE TO MEDICAL PROVIDER: ANY CONDITION(S) RESULTING IN FUNCTIONAL LIMITATIONS MAY LEAD TO THE ISSUANCE OF A TEMPORARY OR PERMANENT PROFILE AND MAY DIRECTLY IMPACT THE SOLDIER'S MEDICAL READINESS CLASSIFICATION AND ABILITY TO DEPLOY.

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 552e(3)(A); AR 40-501 Standards of Medical Fitness.

PRINCIPAL PURPOSE(S): This form is used to assess a Soldier's physical and functional capacity and limitations on both a temporary and permanent basis. Following this assessment, this form will be provided to the Soldier's physician and unit chain of command for the potential development of a temporary or permanent profile.

ROUTINE USE(S): Information in your records may be disclosed to:

- Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and
- Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;
  Government agencies to determine your eligibility for benefits and entitlements;
- Government and nongovernment third parties to recover the cost of MHS provided care;
- Public health authorities to document and review occupational and environmental exposure data; and
- Government and nongovernment organizations to perform DoD-approved research.

Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/Privacy/SORNsIndex/Blanket-Routine-Uses/

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:
Failure to provide information or sign may delay development of a Soldier's profile.

SUMMARY OF CARE BY NON-MILITARY MEDICAL PROVIDER

For use of this form, see PAM 40-502; the proponent agency is OTSG.

I. PATIENT DATA *(TO BE COMPLETED BY SOLDIER. PLEASE PRINT LEGIBLY)*

1. NAME *(Last, First, Middle Initial)*		2. PATIENT HOME ADDRESS *(Street, Apt Number, City, State, and ZIP Code)*	
3. DOD ID NUMBER	4. RANK/GRADE /	5. DOB *(YYYYMMDD)*	6. PHONE NUMBER *(Include Area Code)*
7. COMPONENT: ☐ AC	☐ ARNG (☐ AGR ☐ IDT/M-Day ☐ ING)	☐ USAR (☐ AGR ☐ TPU ☐ IMA ☐ IRR)	

8. Are you receiving any VA disability benefits? ☐ YES ☐ NO, IF YES, please list medical condition(s) with overall rating %:

II. EXAM *(TO BE COMPLETED BY MEDICAL PROVIDER. PLEASE PRINT LEGIBLY)*

9. What did you see the Soldier for today? For acute injuries, please describe how the injury occurred, including where and when:

☐ Soldier is here For Periodic Health Assessment (PHA)

10. Please attach lab and x-ray results and provide brief summary of physical, radiological, and lab exam findings when available:

☐ See PHA for Pertinent Documentation

11. Does the Soldier have any allergies to medications, food, insects (bees, wasps, fire ants), grass, plants, or other? If YES, please list:

12. Does the Soldier take any medications, including prescription, over the counter, vitamins/minerals, and supplements? If YES, please list:

III. HAS THE SOLDIER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS? *(TO BE COMPLETED BY MEDICAL PROVIDER)*

13.	YES		YES		YES		YES
a. ADD/ADHD	☐	b. Anxiety	☐	c. Arthritis/Joint Pain	☐	d. Asthma/Shortness of Breath	☐
e. Concussion/TBI/Head Trauma	☐	f. Depression	☐	g. Diabetes/High blood sugar	☐	h. Dizziness	☐
i. Fainting	☐	j. Headaches/Migraines	☐	k. High blood pressure	☐	l. High cholesterol	☐
m. Insomnia	☐	n. PTSD	☐	o. Seizures	☐	p. Sleep apnea	☐

q. Other *(e.g. additional pertinent medical history, past surgeries)*: _____

IV. IS SOLDIER ABLE TO PERFORM THE FOLLOWING FUNCTIONAL ACTIVITIES?

	YES	NO
14. Physically and mentally able to carry and fire an individual assigned weapon (~8 lbs) that requires crouching, kneeling on one or both knees, lying prone or standing all while wearing a helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs)?	☐	☐
15. Ride in a military vehicle wearing helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs) without worsening condition?	☐	☐
16. Wear helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs) without worsening condition?	☐	☐
17. Able to wear a protective mask & full protection outfit (HAZMAT) against chemical or biologic agents for at least 2 continuous hours per day?	☐	☐
18. Move greater than 40 lbs (backpack/duffel bag) while wearing a helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs) up to 100 yards?	☐	☐
19. Live and function, without restrictions, in ANY geographical or climatic area (Desert, Jungle, Arctic, or Urban) without worsening condition?	☐	☐
20. Lifting/Carrying Restriction: Maximum weight restriction in lbs: _____	☐	☐
21. Standing Limitation in minutes: _____	☐	☐
22. Walking Limitations/Restriction in all terrains with Standard Field Gear (40 lbs) for _____ minutes or _____ miles.	☐	☐
Questions 23-25 are the events in the Army Physical Fitness Test (APFT)		
23. Able to perform two minute timed **sit-ups**?	☐	☐
24. Able to perform two minute timed **push-ups**?	☐	☐
25. Able to perform timed **2-mile run**? If unable to perform the timed **2-mile run**, can Soldier participate in a timed alternate aerobic event? *(check all that apply)* ☐ 2.5 Mile Timed Walk ☐ 6.2 Mile Timed Stationary Bike ☐ 800 Yard Timed Swim	☐	☐

V. DIAGNOSIS *(TO BE COMPLETED BY MEDICAL PROVIDER. PLEASE PRINT LEGIBLY)*:

THE FOLLOWING SECTION MUST BE COMPLETED AND SIGNED BY THE EXAMINING MEDICAL PROVIDER.
Your evaluation of this Soldier's Functional Limitations in section IV is important. Please complete all items below.

26. Diagnosis:

27. Treatment Plan *(example: X Rays, Physical Therapy, Medication)*:

28. Follow Up:

29. Functional Limitations are:

☐ Permanent or ☐ Temporary: the expected duration of the limitation(s) is for _____ Days (Max 90)

Can Soldier take record Army Physical Fitness Test **now** (Refer to 23-25 above)?

☐ Yes ☐ No If No, anticipation date to take the APFT? _____

MEDICAL PROVIDER'S FULL NAME *(PRINT OR TYPE)*	MEDICAL PROVIDER'S MEDICAL DEGREE *(MD, DO, NP, PA)*	
MEDICAL PROVIDER'S SPECIALTY	DATE OF EVALUATION	EMAIL ADDRESS

OFFICE PHONE NUMBER *(Include Area Code)*	FAX NUMBER *(Include Area Code)*	SIGNATURE	DATE SIGNED

CONTINUATION
(Please use this area to complete any response from the previous pages.)