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

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)* _____

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

Marital Status
- ○ Never Married
- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed

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	

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
○ 1	○ 1	○ 1
○ 2	○ 2	○ 2
○ 3	○ 3	○ 3
○ 4	○ 4	○ 4
○ 5 or more	○ 5 or more	○ 5 or more

Current Unit of Assignment _____

Current Assignment Location _____

Point of Contact who can always reach you:
Name: _____
Phone: _____
Email: _____
Mailing Address: _____

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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:

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

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.)*	○	○
(2) Vehicular accident/crash *(any vehicle, including aircraft)*	○	○
(3) Fragment wound or bullet wound above your shoulders	○	○
(4) Fall	○	○
(5) Other event *(for example, a sports injury to your head)*. Describe:	○	○

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"	○	○
(2) Felt dazed, confused, or "saw stars"	○	○
(3) Didn't remember the event	○	○
(4) Had a concussion	○	○
(5) Had a head injury	○	○

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	○	○
(2) Balance problems or dizziness	○	○
(3) Ringing in the ears	○	○
(4) Sensitivity to bright light	○	○
(5) Irritability	○	○
(6) Headaches	○	○
(7) Sleep problems	○	○

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	○	○
(2) Balance problems or dizziness	○	○
(3) Ringing in the ears	○	○
(4) Sensitivity to bright light	○	○
(5) Irritability	○	○
(6) Headaches	○	○
(7) Sleep problems	○	○

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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:

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

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	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○

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

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	
			Yes	No
○ Physical Symptom(s)	○	○	○	○
○ Exposure Symptom(s)	○	○	○	○
○ Depression symptoms	○	○	○	○
○ PTSD symptoms	○	○	○	○
○ Anger/Aggression	○	○	○	○
○ Suicidal Ideation	○	○	○	○
○ Social/Family Conflict	○	○	○	○
○ Alcohol Use	○	○	○	○
○ Other: _____	○	○	○	○

9. Comments:

8. Referral Information	Within 24 hours	Within 7 days	Within 30 days
a. Primary Care, Family Practice	○	○	○
b. Behavioral Health in Primary Care	○	○	○
c. Mental Health Specialty Care	○	○	○
d. Other specialty care:			
Audiology	○	○	○
Cardiology	○	○	○
Dentistry	○	○	○
Dermatology	○	○	○
ENT	○	○	○
GI	○	○	○
Internal Medicine	○	○	○
Neurology	○	○	○
OB/GYN	○	○	○
Ophthalmology	○	○	○
Optometry	○	○	○
Orthopedics	○	○	○
Pulmonology	○	○	○
Urology	○	○	○
e. Case Manager, Care Manager	○	○	○
f. Substance Abuse Program	○	○	○
g. Health Promotion, Health Education	○	○	○
h. Chaplain	○	○	○
i. Family Support, Community Service	○	○	○
j. Military OneSource	○	○	○
k. Other: _____	○	○	○
l. No referral made ○			

I certify that this review process has been completed.

10. Provider's signature and stamp:

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

S A M P L E

Ancillary Staff/Administrative Section

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