



Family Members Clearance Process SPECIAL
NEEDS and/or Off-Base PCM



Off Base Provider Checklist to assess for need to complete DD Form 2792

Patient Name: _____ Date of birth: _____

Please check all that apply to patient:

- Yes / No Potentially Life Threatening conditions?
- Yes / No Chronic medical or physical condition?
- Yes / No Diagnosis of Cancer within last 5 years?
- Yes / No Sickle Cell Disease?
- Yes / No Diabetes?
- Yes / No Any condition requiring specialty care more than once a year?
- Yes / No Current Mental Health diagnosis?
- Yes / No Current Mental Health Meds?
- Yes / No Psychiatric/Psychologist Counseling Services ACTIVE or in past 5 years
- Yes / No Any inpatient or intensive outpatient mental health service within last 5 years?
- Yes / No Asthma
- Yes / No ADD/ADHD requiring multiple medications, psycho-pharmaceuticals (other than stimulants, or higher than normal doses of medications
- Yes / No Requires adaptive equipment (home apnea monitor, CPAP, home nebulizer, splints, hearing aids, home ventilator, home oxygen therapy)
- Yes / No Requires assistive technology devices
- Yes / No Requires environmental/architectural modifications
- Yes / No IEP/IFSP/504 plan
- Yes / No Speech/occupational therapy/physical therapy

*If the answer is **NO** to all the above questions, please sign/date below:

Provider's Stamp/Printed Signature

Provider's Signature/Date

If you answered **YES** to **ANY** of above questions, please have patient schedule an appointment and complete **DD Form 2792** (provided to you by the patient) in order to provide us with information regarding the patients current medical conditions.