



POST-DEPLOYMENT HEALTH REASSESSMENT (PDHRA)



33348

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health after deployment in support of military operations and to assist military healthcare providers, including behavioral health providers, in identifying present and future medical care needs you may have. The information you provide may result in a referral for additional healthcare that may include behavioral healthcare.

Routine Use: To other Federal and State agencies and civilian healthcare providers as necessary in order to provide necessary medical care and treatment. Responses may be used to guide possible referrals.

Disclosure: Disclosure is voluntary.

INSTRUCTIONS: Please read each question completely and carefully before making your selections. Provide a response for each question. If you do not understand a question, ask the administrator. Please respond based on your MOST RECENT DEPLOYMENT.

Demographics

Last Name

Today's Date (dd/mm/yyyy)

First Name

MI

DOB (dd/mm/yyyy)

Date arrived theater (mm/yyyy)

Date departed theater (mm/yyyy)

Social Security Number

Gender

- Male
- Female

Service Branch

- Air Force
- Army
- Navy
- Marine Corps
- Coast Guard
- 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 O01 W1
- E2 O02 W2
- E3 O03 W3
- E4 O04 W4
- E5 O05 W5
- E6 O06
- E7 O07 Other
- E8 O08
- E9 O09
- O10

Marital Status

- Never Married
- Married
- Separated
- Divorced
- Widowed

Location of Operation

- Iraq
- Afghanistan
- Kuwait
- Qatar
- Bosnia/Kosovo
- SW Asia - other
- Africa
- South America
- North America
- Australia
- Europe
- On a ship
- Other:

Since return from deployment I have:

- Maintained/returned to previous status
- Transitioned to Selected Reserves: _____
- Transitioned to Ready Reserves: _____
- 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: _____

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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. 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 Over 6 visits

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

- Yes No

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

- Yes No

IF NO, skip to Question 6.

5a. **IF YES**, are you still having problems related to this wound, assault, or injury?

- Yes No Unsure

6. Other than wounds or injuries, 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 7.

6a. **IF YES**, please mark the item(s) that best describe your deployment-related condition or concern:

- | | |
|---|---|
| <input type="radio"/> Chronic cough | <input type="radio"/> Redness of eyes with tearing |
| <input type="radio"/> Runny nose | <input type="radio"/> Dimming of vision, like the lights were going out |
| <input type="radio"/> Fever | <input type="radio"/> Chest pain or pressure |
| <input type="radio"/> Weakness | <input type="radio"/> Dizziness, fainting, light headedness |
| <input type="radio"/> Headaches | <input type="radio"/> Difficulty breathing |
| <input type="radio"/> Swollen, stiff or painful joints | <input type="radio"/> Diarrhea, vomiting, or frequent indigestion |
| <input type="radio"/> Back pain | <input type="radio"/> Problems sleeping or still feeling tired after sleeping |
| <input type="radio"/> Muscle aches | <input type="radio"/> Difficulty remembering |
| <input type="radio"/> Numbness or tingling in hands or feet | <input type="radio"/> Increased irritability |
| <input type="radio"/> Skin diseases or rashes | <input type="radio"/> Taking more risks such as driving faster |
| <input type="radio"/> Ringing of the ears | <input type="radio"/> Other: _____ |

7. 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 8.

7a. **IF YES**, please mark the item(s) that best describe your concern:

- | | |
|--|--|
| <input type="radio"/> DEET insect repellent applied to skin | <input type="radio"/> Paints |
| <input type="radio"/> Pesticide-treated uniforms | <input type="radio"/> Radiation |
| <input type="radio"/> Environmental pesticides (like area fogging) | <input type="radio"/> Radar/microwaves |
| <input type="radio"/> Flea or tick collars | <input type="radio"/> Lasers |
| <input type="radio"/> Pesticide strips | <input type="radio"/> Loud noises |
| <input type="radio"/> Smoke from oil fire | <input type="radio"/> Excessive vibration |
| <input type="radio"/> Smoke from burning trash or feces | <input type="radio"/> Industrial pollution |
| <input type="radio"/> Vehicle or truck exhaust fumes | <input type="radio"/> Sand/dust |
| <input type="radio"/> Tent heater smoke | <input type="radio"/> Blast or motor vehicle accident |
| <input type="radio"/> JP8 or other fuels | <input type="radio"/> Depleted Uranium (if yes, explain) |
| <input type="radio"/> Fog oils (smoke screen) | |
| <input type="radio"/> Solvents | <input type="radio"/> Other: _____ |

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8. 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
9. Have you had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you
- a. Have had any 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
10. a. 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
11. 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"/> |
12. If you checked off any problems or concerns on this questionnaire, how difficult have these problems 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
13. Would you like to schedule a visit with a healthcare provider to further discuss your health concern(s)? Yes No
14. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? Yes No
15. Are you currently interested in receiving assistance for a family or relationship concern? Yes No
16. Would you like to schedule a visit with a chaplain or a community support counselor? Yes No

Health Care Provider Only

SERVICE MEMBER'S SOCIAL SECURITY #

□□□□ - □□□□ - □□□□□□

DATE (dd/mm/yyyy)

□□ / □□ / □□□□

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.

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 YES OR UNSURE to behavioral risk questions, 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, referred

b. Outcome of assessment Immediate referral Routine follow-up referral Referral not indicated

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

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.)

5. Identified Concerns	Minor Concern	Major Concern	Already Under Care	
			Yes	No
<input type="radio"/> Physical Symptom	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Exposure Concern	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Depression Symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> PTSD Symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Anger/Aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Suicidal Ideation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Social/Family Conflict	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Alcohol Use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> None	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Referral Information

- a. No referral made
- b. Immediate/emergent care
- c. Primary Care, Family Practice
- d. Specialty Care: _____
- e. Behavioral Health in Primary Care
- f. Mental Health Specialty Care
- g. Case Manager, Care Manager
- h. Substance Abuse Program
- i. Health Promotion, Health Education
- j. Other Healthcare Service
- k. Chaplain
- l. Family Support, Community Service
- m. Military OneSource
- n. Other: _____

7. Comments:

8. Provider

a. Name (Last, First) _____

b. Signature and stamp: _____

ICD-9 Code for this visit: V70.5_6

Ancillary Staff/Administrative Section

9. Member was provided the following:

- Health Education and Information
- Health Care Benefits and Resources Information
- Appointment Assistance
- Service member declined to complete form
- Service member declined to complete interview/assessment
- Service member declined referral for services
- Other: _____

10. Referral made to the following healthcare or support system:

- Military Treatment Facility
- Division/Line-Based Medical Resource
- VA Medical Center or Community Clinic
- Vet Center
- TRICARE Provider
- Contract Support: _____
- Community Service: _____
- Other: _____
- None

