MRC- Pacific Exceptional Family member Program
Physical Exam

Purpose:
The Exceptional Family Member Program (EFMP) is a mandatory enrollment program that works with other military and civilian agencies to provide comprehensive and coordinated medical, educational, community, housing, and personnel supports and services to families with special needs. This Physical Exam Form is the first step in determining type of EFMP enrollment, if any, and assist in appropriate Service Member placement at next duty station.

EFMP Medical Enrollment Criteria:

- Potentially life-threatening conditions or chronic (duration of 6 months or longer) medical or physical conditions requiring follow-up care from any specialty or from a primary care manager more than once per year (e.g. prescription for Epi-pen).
- Current and chronic mental health conditions (e.g. Bipolar, Depression, Anxiety, Thought or Personality disorders) requiring inpatient mental health service or intensive outpatient (greater than one visit monthly for more than 6 months) mental health services currently or within the last 5 years. This includes medical care from any provider, including primary care manager.
- Asthma – One or more of the below circumstances.
    - Scheduled use of inhaled or oral anti-inflammatory agents or bronchodilators.
    - History of ER visits/clinic visits for exacerbations within the last year.
    - Hospitalization for asthma/respiratory related diagnoses within last 5 years.
- ADHD – One or more of the below circumstances.
    - A comorbid psychological diagnosis.
    - Requires multiple medications, requires psycho-pharmaceutical (other than stimulants) or does not respond to normal doses of medication as determined by a medical provider.
    - Requires management and treatment by a mental health provider (e.g. psychiatrist, psychologist, social worker, or psychiatric nurse practitioner).
    - Requires the involvement of a specialty consultant, other than a primary care manager more than twice per year on a chronic basis.
    - Requires modifications of educational curriculum or the use of behavioral management staff.
- A condition that requires one or more of the below:
    - Adaptive equipment (e.g. an apnea home monitor, home nebulizer, wheelchair, custom-fit splints/braces/orthotics [not over the counter], hearing aids, home oxygen therapy, home ventilator, etc.)
    - Assistive technology devices (e.g. communication devices) or services
    - Environmental or architectural considerations (e.g. medically required limited number of steps, fenced yard, wheelchair accessibility, or housing modifications such as air conditioning or carpet removal)

*Note: If the Family Member meets any of the above criteria, a DD Form 2792 will need to be filled out by their provider (i.e. MD, DO, NP, APN).

☐ I acknowledge the above statements and understand that one or more of my dependents could be enrolled if they meet the above criteria.

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Sponsor's Name:_____ Sponsor's DOD ID:_____

Patient's Name:_____ DOB:_____ Sex: ☐ M ☐ F

Best Contact Phone: _____ Best Contact Email: _____

Patient Current Address:_____

Part A: Medical History (Completed by patient)

	Yes	No		Yes	No
Any hospitalizations or operations?	☐	☐	Broken bones or sprains?	☐	☐
Speech or developmental delays	☐	☐	Joint injuries (ankle/knee/wrist/shoulder)	☐	☐
Vision problems (including glasses or contacts)	☐	☐	Required restricted physical activity	☐	☐
Ear or hearing problems	☐	☐	Diabetes	☐	☐
Seizures or convulsions	☐	☐	Cancer	☐	☐
Dizziness or fainting with exercise	☐	☐	Dental or Orthodontic braces	☐	☐
Headaches	☐	☐	Learning problems (IEP, IFSP, 504)	☐	☐
Head injury or losses of consciousness	☐	☐	Sleep problems	☐	☐
Neck or back injury	☐	☐	Behavioral problems	☐	☐
Asthma or difficulty breathing	☐	☐	ADD/ADHD	☐	☐
Heart or blood pressure problems	☐	☐	Autism Spectrum Disorder	☐	☐
Chest pain with exercise	☐	☐	Mental Health conditions	☐	☐
Recieve medical care through the VA	☐	☐	Other (please specify below)	☐	☐
If yes to any of the above, please explain:					

Allergies – All Types (Food, Medicines, Insect Bites, etc.)

☐ I confirm that the information throughout this form is accurate to the best of my ability.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Provider Physical Form

PATIENT INFORMATION

Name of Patient:	Birth Date:	DOD ID:

PART B: Physical Exam

Medical Staff Assessment (Completed by licensed independent practitioner: Doctor – Dr., Nurse Practitioner – NP, Physician's Assistant – PA)

Age: YRS MOS	Height:	Weight:

BP: **P:**

	NORMAL	ABNORMAL	COMMENTS
1. Eyes	☐	☐	
2. Ear, Nose & Throat	☐	☐	
3. Hearing	☐	☐	
4. Heart	☐	☐	
5. Neck	☐	☐	
6. Chest & Lungs	☐	☐	
7. Abdomen	☐	☐	
8. Genitalia	☐	☐	
9. Skin & Lymphatics	☐	☐	
10. Spine	☐	☐	
11. Extremities	☐	☐	
12. Neurological	☐	☐	
13. Wears Braces	☐	☐	

Based on this HX and PX exam, the following abnormalities were found and may need treatment:

Children 6yo and under – Has child reached Development Milestones? ☐ YES ☐ NO

Medication List

Name	Dosage	Frequency

Immunizations are Current and Up To Date: ☐ YES ☐ NO

TRAVEL CONCERNS:

YES ☐ **NO** ☐

Additional Comments and/or Restrictions:

Date	Licensed Health Care Professional Stamp	Licensed Health Care Professional : Dr., NP, or PA Signature