Texas Military Department Case Management Services

Civilian Medical Provider's Functional Assessment

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 104-191; E.O 9397 (SSAN); DoD 6025.18R.
PRINCIPAL PURPOSE(S): TXMF 3349-R is utilized to provide the Texas Army National Guard (TXARNG), G1 Health Services Medical Case Management personnel with pertinent medical diagnoses, treatment, and prognoses information for a TXARNG Service Member's past or present medical condition(s).
ROUTINE USE(S): Information provided on this form by a civilian medical provider for a TXARNG service member's past or present medical condition(s) is exclusively utilized to formulate the military medical treatment plan of care in order to determine the service member's medical condition trajectory and their availability for continued military service IAW AR 40-501, Standards of Medical Fitness and any other applicable TMD established policies.
DISCLOSURE: Voluntary; however, failure to provide this information may result in the significant delay of the Service Member's concurrent military medical plan of care and/or the processing of current or future Physical Disability Evaluation System (PDES) procedures or determinations.

Thank You for taking the time to provide this important medical treatment information for your patient serving in the Texas Army National Guard. Please be as specific as possible with your diagnosis (using ICD-10 coding), the treatment(s), prognosis, and applicable temporary or permanent limitation listed on this form.

The information you provide for your patient will help in the collaboration of your patient's military medical care with the appropriate TXARNG medical services providers and will additionally assist the Texas Military Department Case Management staff to facilitate, support, and disposition your patient's medical plan of care.

SECTION I – PATIENT DATA *(This section completed by Medical Readiness NCO)*

1. NAME (*Last, First, Middle Initial*)	2. DATE OF BIRTH (*YYYYMMDD*)	3. EDIPN (*CAC ID Number*)

4. UNIT (*UIC*)	5. DATE(s) OF MILITARY ASSESSMENT/PROFILE(*Completed by Military Provider*)	6. DATE OF REQUEST
	☐ N/A ☐ Permanent ☐ Temporary Dated:_____	

Please provide detailed information related to your patient's medical conditions in order to assist the TXANRG in determining the service member's availability for worldwide military deployment or thier capacity for continued military service in the United States Armed Forces. Please detail the medical condition(s) you are currently treating, or have provided care for, in the last 90-days. ***IMPORANT NOTICE:*** **Supporting medical treatment records are required to validate the statements on this form.**

SECTION II – MEDICAL CONDITIONS

7a. CONDITION # 1	**ICD-10 Dx Code**	**CONDITION #1 NARRATIVE** (*If ICD-10 code not provided or applicable*)
7b. CONDITION # 2 (*if any*)	**ICD-10 Dx Code**	**CONDITION #2 NARRATIVE** (*If ICD-10 code not provided or applicable*)
7c. CONDITION # 3 (*if any*)	**ICD-10 Dx Code**	**CONDITION #3 NARRATIVE** (*If ICD-10 code not provided or applicable*)

SECTION III – CIVILIAN PROVIDER TREATMENT PLAN

8. Please provide some details of your medical treatment plan for the service member's condition(s) listed above and the likely improvements or deteriorations that you expect. Please include any pertinent laboratory tests performed, results of imaging studies, or physical finding that you have encountered that are not adequately described or clarified by the service member's medical treatment record.

Condition #	Treatment Plan:
Condition #	**Treatment Plan:**
Condition #	**Treatment Plan:**

SECTION IV – CIVILIAN PROVIDER PROGNOSIS

9. Please provide your medical prognosis and limitations, if any, of the service member's condition(s) as they pertain to the questions below:

9a. Do you expect the service member's recovery period to be greater than one (1) year from onset? →	Yes ☐	No ☐
9b. If less than one year, how many weeks or months of recovery are anticipated?	No. of weeks _____	No. of months _____

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SECTION IV – CIVILIAN PROVIDER PROGNOSIS (CONT.)

9c. Provide the date you feel is optimal for the service member to return to limited, or light duty, work:			MONTH / DAY / YEAR
9d. Can the service member safely operate a motor vehicle?	Yes ☐	No ☐	Please detail below any necessary lifting, carying, standing or marching specific restrictions for your patient.
9d. Do you recommend lifting or carrying weight restrictions?	*Yes ☐	No ☐	*No weight greater than: _____ lbs.
9e. Do you recommend standing or marching time restrictions?	*Yes ☐	No ☐	*No time greater than: _____ mins.
9f. Do you recommend marching/walking distance restrictions?	*Yes ☐	No ☐	*No distance greater than: _____ miles.

SECTION V – SERVICE MEMBER'S PHYSICAL FITNESS TRAINING ASSESSMENT

10. Please provide your medical opinion of the service member's ability to participate in Physical Fitness Testing, i.e. sit-ups, push-ups and timed run; **Can the service member?**

10a. Participate in Physical Readiness Testing?	Yes ☐	No ☐	10b. If no, when can they participate? MONTH / DAY / YEAR
10c. Participate in the 2-mile timed run event?	Yes ☐	*No ☐	* **If question 10b. is "No" please indicate below the alternate aerobic event(s) you feel the service member can participate in as it's replacement (*if any*):**
10d. Participate in the push-ups event?	Yes ☐	No ☐	*Select* "None" *or any/all of the alternate event options below:* ☐ None
10e. Participate in the sit-ups event?	Yes ☐	No ☐	☐ 2.5-mile timed walk ☐ 800-meter swim ☐ 6.2-mile bicycle

SECTION VI – SERVICE MEMBER'S MILITARY COMMON TASKS ASSESSMENT

11. All TXARNG service members are required to perform the military common tasks listed below. Considering the service member's medical condition(s) you are treating, or have treated in the past, please tell us: **In your medical opinion, is it safe, i.e. medically prudent, for your patient to:**

11a. Physically and/or mentally able to carry and fire their assigned weapon (*i.e. firearm, rifle, pistol*)?	Yes ☐ No ☐
11b. Ride in a military vehicle while wearing all usual protective gear without worsening their condition(s)?	Yes ☐ No ☐
11c. Wear their helmet, body armor*, and load bearing equipment (LBE) without worsening their condition(s)?	Yes ☐ No ☐
*Body armor, known as the Improved Outer Tactical Vest (IOTV), when fully equipped and complete with all its components; soft armor panel inserts, four ballistic plate inserts with front/back/side bullet proof plates, collor and groin protectors). The total IOTV will weigh 30-35 pounds (13.6 - 15.9 kgs). Total loads for a service member can be in excess of 50 pounds (22.7 kgs).	
11d. Wear protective mask and MOPP* for at least 2 continuous hours per day without worsening their condition(s)?	Yes ☐ No ☐
*Mission Oriented Protective Posture (MOPP) is a flexible system of protection against chemical, biological, and radiation contamination where the service member is required to wear a protective mask and overclothing that imposes work-rate limitations depending upon the environmental conditions employed in, e.g. ambient temperatures, humidity, ect.	
11e. Move greater than 40 lbs. while wearing protective gear (helmet, weapon, body armor, and LBE) up to 100 yards without worsening their condition(s)?	Yes ☐ No ☐
11f. Live and function, without restriction, in any geographic or climatic area* without worsening their condition(s)?	Yes ☐ No ☐
*An austere environment for service members can involve; temperature extremes in excess of 120° F and below 0° F, operational elevations of 400 feet above ground level, and extended periods of time without the availability to perform personal hygiene needs. Austere environments must be tolerated while isolated from medical care and for no less than 72-hours without worsening the service member's medical condition(s).	
12. Are any of the restrictions or limitations on this form permanent, i.e. chronic, static, or reached end of treatment?	Yes ☐ No ☐

Thank you again for taking the time and effort to provide this important medical information for your patient.

If you have any questions about this form, please have the service member contact their Medical Readiness NCO.

SECTION VI – CIVLIAN PROVIDER DEMOGRAPHICS

13. PROVIDER'S NAME	**14. PRIMARY MEDICAL SPECIALTY**
15. OFFICE ADDRESS	**16. CITY, STATE, & ZIP CODE**
17. OFFICE PHONE	**18. OFFICE FAX**
19. PROVIDER'S SIGNATURE	**20. DATE SIGNED** MONTH / DAY / YEAR

SECTION VII – TXARNG CASE MANAGEMENT USE ONLY

21. MEDCHART CASE #	22. EMMPS CASE # (*if applicable*)	23. eProfile Initiated	24. eProfile Date	25. eProfile Routed To:
	NA	☐ Yes ☐ No		NA