Date:

Clinic/Hospital Name:

Address:

Phone:

Attending/Treating Provider Name:

Soldier’s Name (Last, First, MI) and Soldiers DoD ID:

1. Current Diagnosis and International Classification of Diseases, Tenth Edition (ICD-10 codes) for each diagnosis:
    a. Diagnosis/Code:
    b. Diagnosis/Code:
    c. Diagnosis/Code:
    d. Diagnosis/Code:

2. Current Treatment Plan (A detailed plan per diagnosis is required):

3. Treatment/Recovery Time (Days or Months anticipated for recovery):

Soldier’s Name (Last, First, MI) and Soldiers DoD ID:

4. Prognosis for recovery (Provide for each diagnosis):

Provider’s Full Name:

Signature: