**DEFENSE HEALTH AGENCY**
**TRIPLER ARMY MEDICAL CENTER**
**1 JARRETT WHITE ROAD**
**TRIPLER, AMC, HAWAII 96859-5000**

Office Symbol Date

MEMORANDUM FOR RECORD

SUBJECT: Statement of Medical Condition and Treatment Plan

1. Soldier's Name and DOD ID:

2. 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:

3. Current Treatment Plan: A detailed plan per diagnosis is required. Please include non-invasive care, surgical options and physical therapy with frequency and length of sessions, estimated duration and end dates. For conditions without a firm diagnosis, please provide recommended diagnostic studies and time frame to complete.

4. Treatment /Recovery time: Days or months anticipated for recovery

5. Prognosis for recovery: Provide for each diagnosis; must identify or articulate period of time to convalesce, recover, or recuperate due to incapacitation from military or civilian duties.

a. Attending Physician's Full Name:
b. Grade, Rank, or Title (if applicable):
c. Address:
d. Phone:
e. Email:

FULL NAME
RANK, ORGANIZATION
Duty Position