FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 2 - MENTAL HEALTH SUMMARY *(Continued)*: To be Completed by a Qualified Clinical Provider

5. PROGNOSIS *(Include past compliance with treatment programs, expected length of treatment, required participation of family members, and if treatment is ongoing.)*

6. TREATMENT PLAN *(Medical, mental health, surgical procedures or therapies related to the patient's mental health condition planned over the next three years)*

7. TREATMENT NEEDS WITHIN THE NEXT YEAR *(Consider increased stressors of residing in new environment (e.g., stressors of family relocation, isolated posts, deployments, foreign cultures, restricted travel, separation from nuclear family, cost of living.)*

8. PROVIDERS REQUIRED TO IMPLEMENT TREATMENT PLAN AND FREQUENCY OF VISITS

☐ PSYCHIATRIST	☐ PSYCHOLOGIST	☐ SOCIAL WORKER	☐ OTHER *(Specify)*
☐ WEEKLY	☐ WEEKLY	☐ WEEKLY	☐ WEEKLY
☐ BI-MONTHLY	☐ BI-MONTHLY	☐ BI-MONTHLY	☐ BI-MONTHLY
☐ MONTHLY	☐ MONTHLY	☐ MONTHLY	☐ MONTHLY
☐ QUARTERLY	☐ QUARTERLY	☐ QUARTERLY	☐ QUARTERLY
☐ ANNUALLY	☐ ANNUALLY	☐ ANNUALLY	☐ ANNUALLY

9. OTHER COMMENTS *(Include additional information that would assist in determining necessary treatments.)*

10. PROVIDER INFORMATION *(Authorization by patient included on Page 1 of this form.)*

a. PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			