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

MEDICAL SUMMARY *(Continued)*: To be completed by a Qualified Medical Professional

8. ARTIFICIAL OPENINGS/PROSTHETICS *(X all that apply)*

☐ YES IF YES:
☐ NO

☐ F01 - GASTROSTOMY
☐ F02 - TRACHEOSTOMY
☐ F03 - CSF SHUNT
☐ F04 - CYSTOSTOMY
☐ F05 - COLOSTOMY
☐ F06 - ILEOSTOMY
☐ F07 - OTHER UNSPECIFIED PROSTHETICS *(Specify)*
☐ F99 - OTHER UNSPECIFIED OPENING *(Specify)*

9. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS

☐ R01 - LIMITED STEPS *(If Yes, please explain)*
☐ R02 - COMPLETE WHEELCHAIR ACCESSIBILITY
☐ R04 - SINGLE STORY/LEVEL HOUSE
☐ R05 - CARPET PROHIBITED
☐ R99 - OTHER *(Specify)*
☐ R03 - AIR CONDITIONING
☐ R03a - TEMPERATURE CONTROL
☐ R03b - HEPA FILTER
☐ R03c - POLLEN CONTROL
☐ R03d - AIR FILTERING

EXPLANATION OF SPECIAL CONSIDERATIONS:

10. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT *(If marked, describe type of equipment in Item 11 (Comments) below.)*

☐ L03 - APNEA HOME MONITOR
☐ L21 - CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY
☐ L20 - HOME DIALYSIS MACHINE
☐ L13 - HOME NEBULIZER
☐ L04 - HEARING AIDS: MAKE: MODEL:
☐ L22 - INSULIN PUMP: MAKE: MODEL:
☐ L23 - PACEMAKER: MAKE: MODEL:
☐ L99 - OTHER *(Specify)*
☐ L07 - SPLINTS, BRACES, ORTHOTICS
☐ L08 - WHEELCHAIR
☐ L12 - HOME OXYGEN THERAPY
☐ L14 - HOME VENTILATOR

EXPLANATION OF SPECIAL CONSIDERATIONS:

11. COMMENTS *(Enter additional information to describe this individual's medical needs.)*

PART C - PROVIDER INFORMATION

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

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