Guidelines for Post-Deployment Health Screening Utilizing the DD Form 2796

1. References:

a. DOD Instruction 6490.3 “Implementation and Application of Joint Medical Surveillance for Deployments,” 7 August 1997.

b. 10 USC 1074f, “Medical tracking system for members deployed overseas,” 18 November 1997.

c. ASD(HA) Memorandum, “Policy for Pre- and Post-Deployment Health Assessments and Blood Samples,” 6 October 1998 (HA Policy 99-002).

d. ASD(HA) Memorandum, “Updated Policy for Pre- and Post-Deployment Health Assessments and Blood Samples,” 25 October 2001 (HA Policy 10-017).

e. JCS Memorandum, “Updated Procedures for Deployment Health Surveillance and Readiness,” 1 February 2002 (MCM-0006-02).

f. USD(P&R) Memorandum, “Enhanced Post-Deployment Health Assessments,” 22 April 2003.

2. Background:

a. In accordance with public law, military regulation, and policy, all service members returning from a deployment will complete a DD Form 2796 and receive a face-to-face health assessment by a trained health care provider (HCP). The purpose of this screening is to review each service member’s current health, possible exposures, and to discuss deployment-related health concerns..

b. The Post-Deployment Health Assessment (DD Form 2796) is primarily used to document post-deployment health and any deployment-related occupational/environmental (O/E) exposures. The form provides a preliminary clinical template for the assessment of O/E exposures potentially associated with both physical and psychological ailments. It is not necessarily a sensitive screening tool for detecting or predicting specific post-deployment medical conditions such as latent malaria, tuberculosis, or even post-traumatic stress disorder; but it will serve as a useful adjunct to future clinical encounters related to the deployment, and permits early-as-possible referral to appropriate care for high-risk individuals.

3. General Guidance:

a. Provider sensitivity is the key to the success of this screening program. Given battlefield conditions and the fog of war, isolating the reality of exposure to trauma or to O/E significant elements (toxins, vectors, etc.) is very difficult. Providers need to listen to and be empathetic to the service member's clinical complaints. Based on the screening HCP’s clinical judgment, service members who may need further assessment or definitive specialty care should be given an opportunity to obtain it. Experience from the last Gulf War and the subsequent “Gulf War Syndrome” indicates the importance of communicating honestly, openly, and forthrightly with service members and their exposure concerns.

b. When dealing with exposure or trauma-linked symptoms, a quick diagnosis may be obtained, but in some cases multiple clinic visits and evaluations are needed to arrive at a final diagnosis. Specialty assessment or consultation with the Deployment Health Clinical Center (DHCC) may be needed. Further, some symptoms may not present for months, so it is imperative that all service members be provided a fact sheet listing available resources and points of contact should they have symptoms or concerns that arise in the future.

c. A systematic approach in evaluating patients with symptoms associated with deployment has been developed by the DHCC in conjunction with the Veteran's Administration (http://www.pdhealth.mil/clinicians/PDHEM/Guideline/content/algorithms/algo1.htm). The DHCC website (http://www.pdhealth.mil/main.asp) also provides several screening tools to aid providers in better evaluation of service members.

4. **Screening Algorithm or Pathway** (see Enclosure 1)

a. The screening algorithm or pathway depicts the normal flow of screening and may be modified as circumstances warrant. Further, this algorithm is not meant to restrict a HCP's clinical judgment, only to aid in the screening and decision-making processes.

b. Service members should be thoroughly screened by the screening HCP prior to referral to specialty care. Sometimes service members endorse items by mistake. Based on the HCP's clinical interview and judgment, many of these mistaken endorsements can be resolved prior to a specialty care referral.

c. In sum, there are three likely types of situations screeners will face:

(1) The service member without symptom or complaint. This individual will have selected few if any positive exposure answers, will deny any complaints, and will not have any concerns. During the interview, probe a little to ensure the person is not merely "pencil-whipping" the form or is "in denial" while actually being at risk. Once cleared, this individual should be given a standard fact sheet discussing available resources and points of contact should concerns or symptoms arise in the future.

(2) The service member with some exposure and some symptomatology that cannot be explained and resolved during the screening visit or the service member that concerns you because of the amount of exposure, trauma, or other health issues. This individual should be given specific fact sheets regarding those exposures or symptoms involved and referred to his/her primary care provider (PCP) and/or specialty care as appropriate. In the case of demobilizing reservists, these PCP and/or specialty visits should be scheduled prior to their release from active duty if possible. This individual should also be given a standard fact sheet discussing available resources and points of contact should other concerns or symptoms arise in the future.

(3) The service member who has little exposure and no significant symptoms, but who is concerned – the asymptomatic concerned- should be given specific fact sheets targeted towards their concerns and a standard fact sheet discussing available resources and points of contact should additional concerns or symptoms arise in the future. If the individual remains concerned or requests a more thorough examination, refer the individual to his/her PCP for follow-up. In the case of demobilizing reservists, these clinic visits should be scheduled prior to their release from active duty if possible. Reserve component personnel may also request a physical

examination upon release from active duty (REFRAD). Follow-up care for deployment-related concerns that arise post REFRAD is available through the Veterans Health Administration. Additional information related to Reserve Component Health Benefits can be found on www.pdhealth.mil. .

d. The primary purpose of the DD Form 2796 is to provide HCPs a brief screening form to evaluate the post-deployment health of returning service members. Questions on the 2796 generally fall into four categories: demographic questions (primarily found on the first page), general health questions (items 1-3, 6 and interview questions 1-3, 6), occupational and environmental exposure questions (items 4, 5, 7-9, 14-18 and interview question 5), and mental health questions (items 10-13, and interview question 4).

e. For reserve component personnel, additional steps are required. All mobilized reserve component personnel must complete the DD2697 (Report of Medical Assessment) in addition to the DD Form 2796. At the time of demobilization, if the service member requests a physical examination, then a DD Form 2808 (Report of Medical Examination) should be completed to guide and document the exam.

5. General Health Questions

a. General health questions (items 1-3, 6 and interview questions 1-3, 6) should provide the screening HCP the basis for determining the current state of a service member's health. The questions listed on the 2796 should not be seen as all inclusive, but rather as a point of departure for any health issues, symptoms, or concerns the service member may have.

b. The screening HCP should develop a general sense of each service member's health by reviewing the service member's answers on the 2796, having a face-to-face discussion with the service member, and by reviewing, if available, the service member's deployment medical records – to include the service member's DD Form 2795, Pre-Deployment Health Assessment, and DD Form 2766, Deployable Health Record (Adult Preventive and Chronic Care Flow Sheet) if available. General health questions, health care utilization during deployment, vaccinations given, medications (current and taken during the deployment), and clinical symptoms should be components of the health assessment. A limited physical exam to evaluate positive symptoms may be indicated if time, privacy conditions, and circumstances allow.

c. General health issues or complaints that need additional assessment (beyond what time and circumstance will allow during the brief face-to-face screening) should be referred to the service member's PCP or to specialty care as appropriate. In the case of demobilizing reservists, these PCP visits should be scheduled prior to their release from active duty if possible.

6. Occupational and Environmental Exposure Questions

a. These exposures can come from the ambient environment (such as surrounding air, food, water, dirt/dust/sand, or insects), specifically from an occupational exposure (directly related to their military duties or job functions), or related to the wartime activities/military agent usage. These are referred to collectively as O/E exposures (occupational/environmental).

b. Redeploying service members may have concerns related to biological, chemical, and physical substance/agent exposures that they experienced, or believe they experienced, during this deployment. Their questions will likely center on potential health effects from these

exposures. They will wonder if their exposures caused health effects they had during the deployment or that they may currently have. Some may be concerned that they will suffer long-term health effects as a result of an exposure (such as cancer). They will also worry if any exposure may affect their spouses or children (born or unborn).

c. The screening HCP has a limited amount of time at the screening and may or may not be the service member's PCP. His/her primary purpose regarding disposition of the service member with O/E exposures or possible exposures is to: a) determine if the service member has concerns; b) if the concerns can be answered with information or risk communication tools at hand, by the screening HCP; or c) if the concerns are potentially significant, health-wise (see below) and the service member should be referred for more in-depth evaluation with either his/her PCP and/or specialist such as in Occupational and Environmental Medicine (OEM). [Note: any service member who has concerns on the questionnaire that cannot be addressed at health screening should have a follow-up visit with either their PCP or an appropriate specialist, in addition to being provided information on resources available].

d. Steps to follow (if resources and/or knowledge are readily available to the screening HCP(Otherwise, further evaluation and treatment may be needed through a follow-on appointment with either the screening HCP or the service member's PCP) to determine a potentially significant event or concern include:

(1) Determine if there was a plausible exposure

(2) Determine if there is/was/could be a health effect

(3) Determine if the exposure or amount of exposure could be related to the health effect, or if latent effects may be possible (which may require further medical surveillance)

(4) Determine if there were objective measurements taken to document the concerns. (If the screening HCP discovers that there were measurements taken, and the service member was unaware that they existed, determine if the exposure was sufficient to further evaluate the service member based on this)

(5) Determine if the service member's comrades were also affected

e. A potential plausible exposure is one in which the service member can give an account of what s/he was exposed to, from a trustworthy source, and/or if s/he can characterize the amount of exposure somehow (how often exposed, level of exposure). There may be objective evidence (e.g. measurements) or knowledge of such exposures from in-theater and these should be documented when available. Other DoD databases (e.g. DESP) may contain such information. In addition, use of protective clothing and equipment – availability and compliance - are important variables to consider.

f. Health effects related to deployment may have many possible causes. However, service members may perceive symptoms or health issues (as raised in the questionnaire) to be related to O/E exposures. These concerns should be addressed, either by the screening HCP, or in a follow-on visit with the service member's PCP or specialist. A review of (deployment) medical records may provide more objective insight into health issues. If there are or have been symptoms/health effects during or after the deployment, and a plausible exposure, follow-up with

a specialist may be indicated to determine an exposure-health association and to determine requirements for continued evaluation and treatment (e.g. medical surveillance).

g. Much information is available regarding the association between potential or plausible O/E exposures and their possible health effects. Some websites include: http://www.pdhealth.mil/ and the CHPPM website (http://chppm-www.apgea.army.mil/). In addition, consultation is available with OEM physicians/HCPs. The screening HCP may not have the time to look into these associations during the screening (so it may be up to the follow-on PCP or specialist to explore); however, the screening HCP could make a judgment regarding health effects as well as route and timing of exposure (e.g. an inhalation hazard and lung symptoms, a skin contact and subsequent rash).

h. Regarding the exposures listed in question 14 and other common exposures and/or concerns among redeploying service members, fact sheets for both the HCP and the service member are available on the above websites and may provide answers that address these concerns at the time of the screening.

i. The screening HCP may have limited time to address many of the issues that arise from positive answers to O/E exposure questions on DD2796 and possible related health effects during the interview. This section has provided a framework to understand and approach O/E issues as much as is possible, address what can be addressed in the interview, and make appropriate judgments as to when a service member should be referred to a follow-on appointment with their PCP or a specialist, e.g. in OEM. Here are some suggested minimum questions to ask about the exposures/agents that the service member lists as his/her top concerns:

(1) Agent/exposure _______________

(2) Date and location (Nearest city/troop camp) of exposure _________________

(3) How did you determine you were exposed?
( )Environmental testing ( ) NBC Alarm/Monitor
( ) Inhaled it ( )Got on Skin ( ) Read report/Heard from others
( ) Penetrating wound/imbedded fragment

(4) How much exposure did you have: ( ) High/frequent ( ) Med/Occasional
( ) Low/Rare ( ) Not sure

(5) Has the exposure caused any health problems for you and/or did you go on sick call for it/them? ( ) Yes ( ) No

(6) Did you use protective equipment? ( ) No ( ) Yes

7. Mental Health Questions

a. The 2796 is a screening tool and is intended to be a starting point towards a discussion of potential psychosocial issues with a HCP. It is not intended to be a definitive, diagnostic tool.

b. The 2796 provides brief screening for “interest in care” (item 10 and interview item 4), depression (item 11), suicidal ideation (item 11c), post-traumatic stress (item 12), and aggressive ideation (item 13).

c. Many mental health symptoms following traumatic events are normal reactions to the very unusual circumstances. In an effort to encourage follow-on care and to avoid any potential stigma sometimes perceived to be associated with seeking traditional mental health services, service members should be thoroughly screened by the HCP and offered options for treatment. All available options, such as treatment by the primary care provider, behavioral health in primary care assets, employee assistance or family services, if available, counseling by a chaplain, or traditional mental health care should be considered and explored with the service member. In some circumstances (such as those listed below), however, referral to a mental health provider may represent the standard of care and the most appropriate action to ensure the health and well being of the service member.

d. Particular attention must be paid to items 10-13. If a service member screens positive for one or more of the following items, gather additional information through the clinical interview and a medical records review:

- A desire for assistance (**item 10**),
- ANY concerns about self-harm (**item 11c**),
- "A LOT" to any of the other depression screening items (**item 11**),
- Three or more of the acute stress disorder/post-traumatic stress disorder screening items (**item 12**)
- ANY concerns over loss of control (**item 13b**)

e. Items 7-9 address combat exposure. Many service members cope very well with traumatic exposure and do not need any further medical support. If a service member endorses one of these items, the HCP may wish to inquire if the individual is interested in discussing the issue further with either a community or family counselor, primary care case manager or behavioral health asset, chaplain, or mental health/behavioral health specialist. Fact sheets about available resources should be provided to any individual who declines the invitation for follow-up of any kind.

f. At each screening location, behavioral health personnel should be available or on-call to handle any concerns screening HCPs may have and to follow-up on service members needed more in-depth specialty assessment. In addition, chaplain support should also be available or on-call.

8. Health Risk Communication and Handling Service member Concerns

a. General Guidelines

(1) Service members returning from a hostile environment may be highly concerned about environmental exposures they may have encountered during their deployment. Do not take their mistrust and apprehension personally and do not discount their concerns. Other underlying factors may be contributing to feelings of mistrust, confusion and frustration. HCPs must remain professional, actively listen to concerns, answer questions when possible, and document all concerns raised, taking extra care not to pass judgment on validity or non-validity of the concern.

(2) Screening HCPs should provide feedback on exceptionally difficult or exceptionally well-handled communication issues to pdhealth@na.amedd.army.mil to compile lessons learned and

to improve deployment risk communication efforts. Questions and comments can also be forwarded to the DHCC Helpline: 1-866-559-1627 or DSN: 642-0907.

b. Specific Guidelines

(1) HCPs should have as much information as possible about actual and potential environmental exposures at specific deployment locations. This allows HCPs to anticipate likely questions and prepare to answer them. Having information on specific exposure concerns ahead of time can help the HCP better answer service member questions directly and immediately, eliminating the need to rely solely on written products or send the service member to someone else for answers. By providing as much information as possible about known deployment location conditions pre-, during, and post-deployment, HCPs can reduce the effects of rumors, mistrust, and allegations of cover-up.

(2) HCPs should actively listen to returning service member concerns, answer questions immediately when possible, and let them know where to get additional information (DHCC, CHPPM website, etc.).

(3) Do not confront, contradict, or minimize individuals or their concerns; all concerns deserve an HCP's complete professionalism. HCPs should avoid taking it personally if service members express mistrust or anger at reassurances they might offer. Document concerns raised during the screening interview for further evaluation and analysis of underlying issues.

(4) HCPs need to show respect and appreciation for the service member's recent service and demonstrate care and respect for the service member at all times. When indicated, spend a few extra minutes to gain their perspective regarding possible exposures at their deployment locations.

9. Documentation

a. The HCP will document service member concerns and any referral needs on the DD Form 2796. The original completed 2796 must be filed in the service member's permanent medical records.

b. If the service member is screened in-theater, the original 2796 will be temporarily filed in the service member's deployment medical packet, pending final posting to his/her permanent medical records once the permanent record becomes available.

c. A copy of each individual's 2796 (along with any additional notations) must be forwarded to the Army Medical Surveillance Activity (AMSA). It can be mailed to AMSA Building T-20, Room 213, (Attn: MCHB-TS-EDM), 6900 Georgia Avenue, N.W., Washington, D.C. 20307-5001; phone (202) 782-0471 (DSN: 662). Or, you may submit the 2796 electronically by email to amsa@amsa.army.mil or through their website at http://amsa.army.mil.

c. Referrals to the PCP or to specialty care will be documented on both the DD Form 2796 and on an SF 513 (Consultation Request) form.

d. Local procedures will be developed for tracking requested and completed consultations in order to streamline the screening process and to ensure that service members receive the requested care.