Office of the State Surgeon
New York Army National Guard Medical Command

1 Buffington Street, Building 25, Suite 336
Watervliet, NY 12189
FAX: (518) 270-1523

RE: MUTUAL PATIENT

***Note: Assessment by Licensed Clinical Social Workers or Licensed Clinical Psychologists required.**

****If completing provider is a LMFT, LMHC, or LMSW, a second signature is required from a LCSW or Licensed Clinical Psychologist/Psychiatrist.**

Dear Sir / Ma'am:

Your patient is a service member of the New York Army National Guard. We at Medical Command for the New York Army National Guard, are tasked with tracking every service member's medical and behavioral health care – to ensure ultimate safety among our ranks.

This packet is an effort to outline the information we need to track, and develop a collaborative relationship with you. Please call with any questions, any time. We are happy to answer any questions either specifically about your patient's case, or about the process in general without specific acknowledgment of your patient.

Your patient's Case Manager at MEDCOM is:

☐ **27th BCT/Recruiting &Retention**
Patricia Hopson, LMSW
patricia.a.hopson10.ctr@army.mil
(518) 270-1521

☐ **53rd Troop Command**
Jackie Preville
jaquanna.d.preville.ctr@army.mil
(518) 270-1514

☐ **JFHQ / 42nd** Ab-Daya Johnson
ab-daya.m.johnson.ctr@army.mil
(518) 270-1517

☐ **Deployments**
Jackie Preville
jaquanna.d.preville.ctr@army.mil
l (518) 270-1514

Respectfully,

Patricia Hopson
Ab-Daya Johnson
Jaquanna Preville

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Our role / process:
When a service member: (1) has a behavioral health diagnosis, (2) possibly needs behavioral health treatment, and/or (3) is prescribed any psychotropic medication(s), medical documentation is required to be file in his or her medical record, to support readiness for future deployments, and stability to remain in the military as a career.

When a service member has a medical or behavioral health condition, with active symptoms, we issue the service member a "temporary profile" to outline any military duties that should temporarily be avoided while the service member recovers. When a service member is on a temporary profile, updates on the condition's status are required at a minimum of every 90 days.

OUTLINE OF DOCUMENTATION NEEDED
At the beginning of care (all/any that apply)
___ Psychosocial Evaluation ___ Treatment Plan ___ Initial Evaluation ___ Clinical Summary** ___ Signed Release of Information form
Throughout treatment, at a minimum of every 90 days
___ Session notes ___ Clinical Summary**
At conclusion of treatment / when stability is observed
___ Clinical Summary** ___ Completion of attached assessment (3 pages)

****CLINICAL SUMMARY**:
(a) Known history of condition: When symptoms began, inciting events if applicable, progression of symptoms, any prior treatment (levels of care / outcome from that treatment), observed patterns of symptoms/behavior
(b) Description of treatment: When treatment began, frequency, assessments completed, interventions utilized, service member's response to interventions, plan for treatment moving forward, medications prescribed (if you do not prescribe the medication, please note if the service member is prescribed medication by any provider for this condition)
(c) Current DSM-V diagnosis/diagnoses or impressions/working theories
(d) Triggers/symptoms the service member experienced before treatment / how it has progressed (or not) through present time. How is life affected with this behavioral health condition?
(e) Risk to self or others?
(f) Anticipated prognosis - in general and/or if the service member remains in the military. (If, as a provider, you do not feel comfortable stating a prognosis in the context of the military, please address some of the following objective questions: Does the service member discuss specific triggers from the military? Are there any patterns of symptomology that correspond with military duties? Any concerns about the military, expressed from the service member?

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BEHAVIORAL HEALTH ASSESSMENT

***note: assessment by licensed clinical social workers or licensed clinical psychologists required**

PATIENT INFORMATION		
Patient / Service Member Name:		DOB:
Today's date:	Approximate session number:	Next session date:
BEHAVIORAL HEALTH PROVIDER INFORMATION		
Full Name (printed):		Credentials:
Signature:		License #:
Email address, if used:		Phone/fax:
Address of facility:		
LMFT, LMHC, LMSW - must have your supervising Clinician co-sign your assessment		
Supervisor Name (if applicable):		Supervisor Credentials:
Supervisor Signature:		

MENTAL STATUS EXAM			
COGNITION: ☐ Not impaired ☐ Impaired		BEHAVIOR: ☐ Normal ☐ Abnormal	
PERCEPTION: ☐ Not impaired ☐ Impaired		IMPULSIVITY: ☐ Normal ☐ Abnormal	
RISK TO SAFETY			
BH RISK FOR HARM TO SELF: ☐ Not Elevated ☐ Low ☐ Intermediate ☐ High			
BH RISK FOR HARM TO OTHERS: ☐ Not Elevated ☐ Low ☐ Intermediate ☐ High			
SCREENING COMPLETED			
☐ PCL ☐ GAD-7 ☐ CAGE ☐ PHQ-9 ☐ C--SSRS ☐ Other _____			
Notable results:			
_____			
_____			

DIAGNOSES		Initial date given
Primary DSM-V Diagnosis:		
Secondary DSM-5 Diagnoses:		
Co-morbidities:		

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MEDICATIONS				
Name	Dosage	If PRN, frequency	Date started	Date ended

☐ Patient on additional medications, listed on separate page

Do any medications require monitoring (labs, EKG, etc.)? ☐ Yes ☐ No Medication: _____

Any concerns if patient is separated from medication for several doses? ☐ Yes ☐ No _____
_____

For any sedative medication prescribed – any observed/reports effects on daytime performance or arousal from sleep in case of emergency? ☐ Yes ☐ No _____

Patient is currently: ☐ Compliant with Medication ☐ Non-compliant with Medication ☐ N/A

ACTIVE SYMPTOMS / IMPAIRMENT

(Consider functional areas of sleep, social, work, school, physical health, eating, ADL's, hobbies/interests):

_____
_____
_____
_____
_____
_____

Symptoms are currently:

☐ Active, with evidence of effects on areas noted above

☐ Remitting, patient still benefits from regular support

☐ In full remission, therapy is not clinically indicated at this time/for maintenance purposes

On the current treatment trajectory, do you anticipate the Patient / Service Member will be able to demonstrate clinical stability within 6 months (12 session minimum)? ☐ Yes ☐ No

Provider's Initials: _____

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HISTORY OF CONDITION (*Relapses / periods of stability / observed patterns of behavior / history of suicidal or homicidal concerns or actions / Hospital admissions / Compliancy with treatment*)
_____ _____ _____ _____ _____ _____
PROGNOSIS REMAINING IN MILITARY (Include statement on prognosis based on total medical picture. How might the service member respond to an austere environment, considering: sleep deprivation, heat, exposure to trauma, separation from support systems.)
_____ _____ _____ _____

(1) Has the Patient / Service Member noted that his/her involvement with the New York Army National Guard exacerbates any current symptoms (having to report to drills, training, potential of upcoming deployment)?
☐ Yes ☐ No If yes, please provide more detail: _____
_____
_____

(2) THE FOLLOWING QUESTION RELATES TO FIREARM USE ONLY WHILE ON MILITARY DUTY AND IS USED AS INPUT, NOT FINAL AUTHORITY. Does the Service Member appear currently ready to safely handle the responsibilities associated with the use of weapons (semi-automatic / fully automatic weapons / explosive devices) in a military environment? ☐ Yes ☐ No ☐ Unwilling to answer

I, patient / Service Member's Behavioral Health Provider, attest to the information on this three-page assessment.

BEHAVIORAL HEALTH PROVIDER ATTESTATION	
Full Name (printed)	Signature:
LMFT, LMHC, LMSW - must have your supervising Clinician co-sign your assessment	
Supervisor Name (if applicable):	Supervisor Signature: