Army Regulation 40–66

Medical Services

Medical Record Administration and Health Care Documentation

Headquarters
Department of the Army
Washington, DC
3 May 1999

UNCLASSIFIED

SUMMARY of CHANGE

AR 40–66
Medical Record Administration and Health Care Documentation

This revision--

- Changes the title of AR 40-66 to "Medical Record Administration and Health Care Documentation."

- Addresses automation and abbreviation list inconsistencies (para 1-3b).

- Revises the procedures for the release of medical information (paras 2-2, 2-3, 2-4, and 2-5).

- Adds forms guidance regarding automated forms and optional forms (paras 3-2 and 3-3).

- Converts SF 520 (Clinical Record--Electrocardiographic Record), SF 522 (Medical Record--Request for Administration of Anesthesia and for Performance of Operations and Other Procedures), and SF 523-B (Medical Record--Authorization for Tissue Donation) to OF 520, OF 522, and OF 523-B respectively (paras 3-2a, 3-3e, and 3-3q and figs 5-1, 5-2, 6-1, 6-2, 6-3, 7-1, and 9-1).

- Converts both SF 517 (Clinical Record--Anesthesia) and OF 517 (Clinical Record--Anesthesia) to DA Form 7389 (Medical Record--Anesthesia) (paras 3-2a, 9-9a, and 9-11b(1)(c) and figs 5-1, 5-2, 6-1, 6-2, and 9-1).

- Includes special instructions for medical records of Human Immunodeficiency Virus patients (para 3-10).

- Deletes the requirement to have the chief of obstetrics and gynecology, the deputy commander for clinical services, or the hospital commander countersign the physician’s statement documenting a therapeutic abortion (para 3-16).

- Includes guidelines for recording the use of restraints/seclusion (para 3-17).

- Incorporates guidance on record folder bar code technology (para 4-4a(4)).

- Prescribes DD Form 2005 (Privacy Act Statement--Health Care Records) formerly prescribed by AR 40-2 (paras 4-4a(9) and 7-4a).

- Prescribes DD Form 877 (Request for Medical/Dental Records or Information) formerly prescribed by AR 40-3 (para 4-7).

- Prescribes new DD Form 877-1 (Request for Medical/Dental Records from the National Personnel Records Center (NPRC), St. Louis, MO) for ordering medical records from the National Personnel Records Center (para 4-7).

- Updates tables to show medical record and x-ray retirement colors for the next 10 years (tables 4-2 and 4-3).

- Adds instructions on filing DD Form 2569 (Third Party Collection Program--Insurance Information) to the health record, outpatient treatment record, and inpatient treatment record (paras 5-19a(6), 6-2i, and 9-19).

- Revises DA Form 8007 (Individual Medical History), and converts it into a reproducible form, DA Form 8007-R (para 5-30).

- Adds instructions to group SF 600, SF 558, DA Form 5181-R (as applicable), SF 513, and DD Form 2161 in reverse chronological order in the health record, outpatient treatment record, and civilian employee medical record (figs 5-1, 5-2, 6-1, 6-2, and 7-1).

- Adds directions for filing forms completed in civilian facilities to the health record, outpatient treatment record, civilian employee medical record, and Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record (figs 5-1, 5-2, 6-1, 6-2, 7-1, and 8-1).

- Defines advance directives (living wills and durable powers of attorney for health care) (paras 6-2j and 9-2c(2)).

- Prescribes DA Form 3705 (Receipt for Outpatient Treatment/Dental Records), formerly prescribed by AR 40-400 (para 6-4b(1)).

- Converts DA Form 8006 (Pediatric Dentistry Diagnostic Form) into a reproducible form, DA 8006-R (para 6-7e).

- Adds a new chapter on the Occupational Health Program Civilian Employee Medical Record (chap 7).

- Explains guidelines on release of information from Alcohol and Drug Abuse Prevention and Control Program records (para 8-3).

- Supersedes chapter 2, paragraphs 3-3, 3-4, 3-8, 3-9, and chapter 5 of AR 40-407 (Nursing Records and Reports) (chap 9).

- Rescinds the use of SF 537 (Medical Record--Pediatric Graphic Chart) (chap 9).

- Adds documentation requirements for Ambulatory Procedure Visit cases (para 9-5).

- Changes guidance to no longer allow the forwarding of original inpatient treatment records with patients to other military medical treatment facilities; directs that copies of these records must be forwarded instead (para 9-10a).

- Permits integrated progress notes when approved by Executive Committee (para 9-12b).

- Includes the Joint Commission on Accreditation of Healthcare Organizations guidelines on discharge from postoperative care units (para 9-12b(1)(d)).

- Adds guidance for psychologists in adding documentation to the medical record (para 9-12b(7)).

- Reduces the hospitalization time requirement for a narrative summary from 72 to 48 hours (paras 9-12e(2)(a), 9-21a, 9-21c(2), and 9-21e).

- Prescribes the following forms formerly prescribed by AR 40-407: DA Form 3888 (Medical Record--Nursing History and Assessment) (para 9-13b); DA Form 3888-2 (Medical Record--Nursing Care Plan) (para 9-13c); SF 510 (Clinical Record--Nursing Notes) (para 9-13d); DA Form 3888-3 (Medical Record--Nursing Discharge Summary) (para 9-13e); DD Form 792 (Twenty-Four Hour Patient Input and Output Worksheet) (para 9-23); DA Form 3950 (Flowsheet for Vital Signs and Other Parameters) (para 9-24); DA Form 4677 (Therapeutic Documentation Care Plan (Non-Medication) (para 9-27); DA Form 4678 (Therapeutic Documentation Care Plan (Medication) (para 9-28); DA Form 4028 (Prescribed Medication) (para 9-28g); DA Form 4107 (Operation Request and Worksheet) (para 9-29); DA Form 7001 (Operating Room Schedule) (para 9-30); DD Form 1924 (Surgical Checklist) (para 9-31); DA Form 4108 (Register of Operations) (para 9-32); DA Form 5179 (Medical Record--Preoperative/Postoperative Nursing Document) (para 9-33); and DA Form 5179-1 (Medical Record--Intraoperative Document) (para 9-34).

- Converts SF 539 (Medical Record--Abbreviated Medical Record) to DD Form 2770 (Abbreviated Medical Record) (para 9-21).

- Prescribes DA Form 4359-R (Authorization for Psychiatric Service Treatment) formerly prescribed by AR 40-3 (para 9-22).

- Adds an updated listing of addresses of the national military medical authorities of NATO countries (table 9-1), formerly contained in AR 40-400.

- Reorders the filing of forms in inpatient treatment records (figs 9-1 and 9-2).

- Supersedes AR 600-6 (Individual Sick Slip) (chap 12).

- Prescribes DD Form 689 (Individual Sick Slip), formerly prescribed by AR 600-6 (paras 12-1 and 12-3).

- Supersedes AR 40-15 (Medical Warning Tag and Emergency Medical Identification Symbol) (chap 13).

- Prescribes the following forms formerly prescribed by AR 40-15: DA Form 3365 (Authorization for Medical Warning Tag) (paras 15-3 and 15-5); and DA Label 162 (Emergency Medical Identification Symbol) (paras 13-1, 13-3, 13-4, and 13-5).

- Adds an appendix C, Management Control Evaluation Checklist.

Headquarters
Department of the Army
Washington, DC
3 May 1999

*Army Regulation 40–66

Effective 3 June 1999

Medical Services

Medical Record Administration and Health Care Documentation

Louis Caldera
Secretary of the Army

History. This printing publishes a revision of this publication. Because the publication has been extensively revised, the changed portions have not been highlighted.

Summary. This regulation prescribes policies for preparing and using medical reports and records in accordance with North Atlantic Treaty Organization standardization agreements (NATO STANAGs) 2348 and 2132 and quadripartite standardization agreement (QSTAG) 470.

Applicability. This regulation applies to all Active Army medical treatment facilities. It also applies to the Army National Guard of the United States, the U.S. Army Reserve, and other members of the uniformed services of the United States and Allied Nations who receive medical treatment or evaluation in an Army medical treatment facility. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is the Office of the Surgeon General. The proponent has the authority to approve exceptions to this regulation that are consistent with controlling law and regulation. The proponent may delegate the approval authority, in writing, to a division chief within the proponent agency in the grade of colonel or the civilian equivalent.

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated.

Supplementation. Supplementation of this regulation is prohibited without prior approval from the Office of the Surgeon General, ATTN: DASG-HS-AP, 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Suggested Improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the Office of the Surgeon General, ATTN: DASG-HS-AP, 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Distribution. Distribution of this publication is made in accordance with initial distribution number (IDN) 092063, intended for command levels A, B, C, D, and E for the Active Army, the Army National Guard of the United States, and the U.S. Army Reserve.

Contents (Listed by paragraph and page number)

Chapter 1
Introduction, *page 1*
Purpose • 1–1, *page 1*
References • 1–2, *page 1*
Explanation of abbreviations and terms • 1–3, *page 1*
Responsibilities • 1–4, *page 1*
Record ownership • 1–5, *page 2*
International standardization agreements • 1–6, *page 2*

Chapter 2
Confidentiality of Medical Information, *page 2*
General • 2–1, *page 2*
Policies governing the protection of confidentiality • 2–2, *page 2*
Release of information when the patient consents to disclosure • 2–3, *page 2*
Disclosure without consent of the patient • 2–4, *page 3*
Processing requests for patient medical information and medical records • 2–5, *page 3*
Medical records of teenage family members • 2–6, *page 4*
Disclosure of medical records containing classified defense information • 2–7, *page 4*
Research using military medical records • 2–8, *page 4*

Chapter 3
Preparation of Medical Records, *page 6*

Section I
Forms and Documents, page 6
Authorized forms and documents • 3–1, *page 6*
Filing automated and computerized forms • 3–2, *page 6*
Guidelines for local forms and overprints • 3–3, *page 6*

Section II
Medical Record Entries, page 7
General • 3–4, *page 7*
Patient identification • 3–5, *page 7*
Facility identification • 3–6, *page 8*
Destruction of unidentifiable medical documents • 3–7, *page 8*

Section III
Recording Diagnoses and Procedures, page 8
Nomenclature used in recording diagnoses • 3–8, *page 8*
Special instructions for certain diseases • 3–9, *page 8*
Special instructions for certain diagnoses • 3–10, *page 8*
Recording psychiatric conditions • 3–11, *page 9*
Recording injuries • 3–12, *page 9*
Recording deaths • 3–13, *page 9*
Recording cases observed without treatment, undiagnosed cases, and causes of separation • 3–14, *page 10*

*This regulation supersedes AR 40-66, 20 July 1992; AR 40-15, 24 March 1975; parts of AR 40-407 (chapter 2, paragraphs 3-3, 3-4, 3-8, 3-9, and chapter 5), 15 August 1991; and AR 600-6, 30 April 1985. It also rescinds SF 537, June 1975.

UNCLASSIFIED

Recording surgical, diagnostic, and therapeutic procedures • 3–15, *page 10*
Recording therapeutic abortions • 3–16, *page 10*
Recording use of restraints/seclusion • 3–17, *page 10*

Section IV
Records for Carded-for-Record-Only Cases and Absent-Sick Status, page 10
Carded-for-record-only cases • 3–18, *page 10*
Absent-sick status • 3–19, *page 10*

Chapter 4
Filing and Requesting Medical Records, *page 11*
Filing by social security number and family member prefix • 4–1, *page 11*
Terminal digit filing system • 4–2, *page 11*
Use of DA Form 3443-series, DA Form 3444-series, and DA Form 8005-series folders • 4–3, *page 11*
Preparation of DA Form 3444-series and DA Form 8005-series folders • 4–4, *page 12*
Preparation of DA Form 3443-series folders • 4–5, *page 13*
Record chargeout system • 4–6, *page 14*
Record requests • 4–7, *page 14*

Chapter 5
Health Records, *page 16*

Section I
General, page 16
Purpose of the health record • 5–1, *page 16*
Use of the health record • 5–2, *page 16*
For whom prepared and maintained • 5–3, *page 17*
Forms and documents of health records • 5–4, *page 17*
DA Form 5007A-R and DA Form 5007B-R • 5–5, *page 17*
DA Form 5008 • 5–6, *page 17*
DA Form 5181-R • 5–7, *page 17*
DA Form 5569-R • 5–8, *page 17*
DA Form 5570 • 5–9, *page 17*
DA Form 5571 • 5–10, *page 17*
DD Form 1380 • 5–11, *page 17*
DD Form 2482 • 5–12, *page 17*
SF 512 • 5–13, *page 17*
SF 558 • 5–14, *page 17*
SF 559 • 5–15, *page 17*
SF 600 • 5–16, *page 18*
SF 601 and PHS Form 731 • 5–17, *page 19*
SF 603 and SF 603A • 5–18, *page 19*
Other forms filed in the health record • 5–19, *page 20*
Military consultation service case files (mental health) • 5–20, *page 21*
Access to health records • 5–21, *page 21*
Cross-servicing of health records • 5–22, *page 21*

Section II
Initiating, Keeping, and Disposing of Health Records, page 22
Initiating health records • 5–23, *page 22*
Transferring health records • 5–24, *page 22*
Establishing "temporary" and "new" health records • 5–25, *page 23*
Filing health records • 5–26, *page 23*
Disposing of health records • 5–27, *page 24*

Section III
Special Considerations for Personnel Reliability Program Health Records and Civilian Employee Medical Records, page 24
Screening Personnel Reliability Program records • 5–28, *page 24*
Maintaining Personnel Reliability Program records • 5–29, *page 24*

Section IV
Maintenance of Health Records Upon Mobilization, page 24
Health records of deployed military members • 5–30, *page 24*
Preparation of health record forms • 5–31, *page 25*
Use of field files • 5–32, *page 25*
Operation after hostilities cease • 5–33, *page 25*

Chapter 6
Outpatient Treatment Records, *page 39*

Section I
General, page 39
For whom prepared • 6–1, *page 39*
Outpatient treatment record forms and documents • 6–2, *page 39*

Section II
Initiating, Keeping, and Disposing of Outpatient Treatment Records, page 39
Initiating and keeping outpatient treatment records • 6–3, *page 39*
Transferring outpatient treatment records • 6–4, *page 39*
Requests other than DD Form 2138 • 6–5, *page 40*
Disposition • 6–6, *page 40*

Section III
Preparation and Use of Outpatient Treatment Records, page 40
Preparation • 6–7, *page 40*
Use • 6–8, *page 41*

Chapter 7
Occupational Health Program Civilian Employee Medical Record, *page 51*

Section I
General, page 51
Compliance • 7–1, *page 51*
Definition and purpose of the civilian employee medical record • 7–2, *page 51*
For whom prepared • 7–3, *page 51*
Civilian employee medical records folder and forms • 7–4, *page 51*

Section II
Maintaining, Transferring and Disposing of Civilian Employee Medical Records and Retention of Job-Related X-Ray Films, page 51
Custody and maintenance of civilian employee medical records • 7–5, *page 51*
Medical record entries • 7–6, *page 51*
Recording occupational injuries and illnesses • 7–7, *page 51*
Cross-coding of medical records • 7–8, *page 52*
Transferring and retiring civilian employee medical records • 7–9, *page 52*
Retention of job-related x-ray films • 7–10, *page 52*

Section III
Confidentiality of Medical Information, Access to Civilian Employee Medical Records, and Performance Improvement, page 52
Protection of confidentiality and disclosure procedures • 7–11, *page 52*
Civilian employee medical record review • 7–12, *page 52*

Chapter 8
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record, *page 55*

Section I
General, page 55
For whom prepared • 8–1, *page 55*
Access • 8–2, *page 55*
Disclosure of information • 8–3, *page 55*
Forms and documents • 8–4, *page 56*

Section II
Initiating, Maintaining, and Disposing of Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Records, page 56
Initiating and maintaining • 8–5, *page 56*
Transferring • 8–6, *page 56*
Requests other than DD Form 2138 • 8–7, *page 56*
Disposition • 8–8, *page 56*

Section III
Preparation and Use of Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Records, page 56
Preparation • 8–9, *page 56*
Use • 8–10, *page 57*

Chapter 9
Inpatient Treatment Records, *page 59*

Section I
General, page 59
For whom prepared • 9–1, *page 59*
Inpatient forms and documents • 9–2, *page 59*
Fetal monitoring strips • 9–3, *page 60*

Section II
Initiating, Keeping, and Disposing of Inpatient Treatment Records, page 60
General • 9–4, *page 60*
Records for Ambulatory Procedure Visit patients • 9–5, *page 60*
North Atlantic Treaty Organization Standardization Agreement 2348 requirements • 9–6, *page 60*
Inpatient treatment records of absent-without-leave patients • 9–7, *page 61*
Five-year inpatient treatment record maintenance • 9–8, *page 61*
Access and audit trail • 9–9, *page 61*
Disposition of inpatient treatment records • 9–10, *page 61*

Section III
Preparation and Use of Inpatient Treatment Records, page 61
Inpatient treatment records content • 9–11, *page 61*
Medical reports • 9–12, *page 62*
Nursing process documentation • 9–13, *page 63*
Countersignatures • 9–14, *page 65*

Section IV
DA Form 3647, page 65
General purpose • 9–15, *page 65*
Use • 9–16, *page 65*
Initiation and disposition • 9–17, *page 65*
Preparation • 9–18, *page 65*
Corrections and corrected copies • 9–19, *page 65*

Section V
Preparation and Use of Other Inpatient Treatment Record Forms, page 65
DD Form 2569 • 9–20, *page 65*
DD Form 2770 • 9–21, *page 66*
DA Form 4359-R • 9–22, *page 66*
DD Form 792 • 9–23, *page 66*
DA Form 3950 • 9–24, *page 66*
Laboratory test requisition and reporting forms • 9–25, *page 66*
DA Form 4256 • 9–26, *page 67*
DA Form 4677 • 9–27, *page 67*
DA Form 4678 • 9–28, *page 68*
DA Form 4107 • 9–29, *page 69*
DA Form 7001 • 9–30, *page 69*
DD Form 1924 • 9–31, *page 70*
DA Form 4108 • 9–32, *page 70*
DA Form 5179 • 9–33, *page 70*
DA Form 5179-1 • 9–34, *page 70*
SF 511 • 9–35, *page 71*
SF 536 • 9–36, *page 71*
SF 519-B • 9–37, *page 71*
DA Form 5009-R • 9–38, *page 71*

Chapter 10
DD Form 1380, *page 79*
Use • 10–1, *page 79*
Preparation • 10–2, *page 79*
Supplemental DD Form 1380 • 10–3, *page 80*
Disposition • 10–4, *page 80*
DA Form 4006 • 10–5, *page 80*

Chapter 11
Role of the Medical Department Activity or U.S. Army Medical Center Patient Administration Division in the Improving Organizational Performance Process, *page 81*
General • 11–1, *page 81*
Internal performance improvement process for medical record services • 11–2, *page 81*
Patient care assessment • 11–3, *page 81*
Patient Administration Division role in handling medical records in the Risk Management Program • 11–4, *page 82*

Chapter 12
DD Form 689, *page 82*
Purpose and use • 12–1, *page 82*
Issuing authority • 12–2, *page 82*
Procedures • 12–3, *page 82*
Health record entry (treatment record) • 12–4, *page 83*
Disposition of DD Forms 689 • 12–5, *page 83*

Chapter 13
Medical Warning Tag and DA Label 162, *page 84*
Description and use • 13–1, *page 84*
Applicability • 13–2, *page 84*
Responsibilities • 13–3, *page 84*
Criteria for issue of Medical Warning Tags and DA Labels 162 • 13–4, *page 84*
Procedures • 13–5, *page 85*
Supply of tag blanks and forms • 13–6, *page 85*

Appendixes

A. References, *page 88*

B. Authorized Medical Records Abbreviations and Symbols, *page 95*

C. Management Control Evaluation Checklist, *page 109*

Table List

Table 3–1: File numbers, recordkeeping requirements, *page 11*
Table 4–1: Assignment of family member prefix, *page 14*
Table 4–2: Key to color folder assignment by terminal digits, *page 15*
Table 4–3: Key to tape colors for year in which records are to be retired, *page 15*
Table 4–4: Key for tape denoting patient status, *page 15*

Contents—Continued

Table 4–5: Last four digits—sponsor's social security number, *page 16*
Table 4–6: Retirement of radiology images and reports, DA Form 3443-series, *page 16*
Table 9–1: NATO national military medical authorities, *page 72*
Table 9–2: General instructions for preparing laboratory forms, *page 73*
Table 9–3: Specific instructions for preparing laboratory forms, *page 74*
Table 10–1: Instructions for preparing DD Form 1380, *page 80*

Figure List

Figure 2–1: Sample confidentiality notice accompanying facsimile transmissions, *page 5*
Figure 2–2: Opinion from the DOD Privacy Board Legal Committee, 24 November 1980, *page 6*
Figure 5–1: Forms and documents of the HREC (treatment) using DA Form 3444-series jackets, *page 26*
Figure 5–2: Forms and documents of the HREC using DA Form 8005-series jackets, *page 30*
Figure 5–3: Forms and documents of the HREC dental record, *page 35*
Figure 5–4: Sample message format for stray medical records, *page 37*
Figure 5–5: Sample entries on SF 600, *page 38*
Figure 6–1: Forms and documents of the OTR using DA Form 3444-series jackets, *page 42*
Figure 6–2: Forms and documents of the OTR using DA Form 8005-series jackets, *page 46*
Figure 6–3: Forms and documents of the nonmilitary dental record, *page 50*
Figure 7–1: Forms and documents of the CEMR using DA Form 3444-series jackets or SF 66D folders, *page 53*
Figure 8–1: Forms and documents of the ADAPCP-OMR, *page 58*
Figure 9–1: Forms and documents of the ITR, *page 75*
Figure 9–2: Examples for calculation of episodes of OR nursing and episodes of anesthesia, *page 79*
Figure 12–1: Sample of a completed DD Form 689, *page 84*
Figure 13–1: DA Label 162 (Emergency Medical Identification Symbol), shown actual size, *page 86*
Figure 13–2: Sample letter to be presented to patients upon issuance of Medical Warning, *page 86*
Figure 13–3: Example of completed "Tag Content" section, DA Form 3365 (Authorization for Medical Warning Tag), *page 87*
Figure B–1: Medical symbols, *page 108*

Glossary

Index

Chapter 1
Introduction

1–1. Purpose

a. This regulation sets policies and procedures for the preparation and use of Army medical records and other health care documentation discussed in the following chapters.

b. The purpose of a medical record is to provide a complete medical and dental history for patient care, medicolegal support (for example, reimbursement and tort claims), research, and education. A medical record also provides a means of communication where necessary to fulfill other Army functions (for example, identification of remains).

c. The following types of health-care records will be used to document medical and dental care. All care provided to beneficiaries as hospital inpatients will be recorded in an inpatient treatment record (ITR). Outpatient care on a military member will be recorded in either the member's treatment record or dental record. Combined, the treatment record and dental record are considered a health record (HREC). Care provided to nonmilitary beneficiaries will be documented in an outpatient treatment record (OTR) that includes a separate dental record. Both military and nonmilitary personnel enrolled in an Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) will have an ADAPCP outpatient medical record (ADAPCP-OMR). Occupational and nonoccupational outpatient care provided to a civilian employee will be recorded in a civilian employee medical record (CEMR).

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

a. Abbreviations and special terms used in this regulation are explained in the glossary.

b. Abbreviations and symbols authorized for use in medical records are explained in appendix B. Dental terminology, abbreviations, and symbols are provided in TB MED 250. The use of locally approved abbreviations and symbols is authorized if the conditions in paragraph 3-8 are met. When automated systems are utilized, users must resolve any inconsistencies concerning local abbreviations and capitalization.

1–4. Responsibilities

a. Medical treatment facility (MTF) and dental treatment facility (DTF) commanders. The MTF or DTF commanders will—

(1) Be the official custodians of the medical or dental records at their facilities.

(2) Ensure that policies and procedures of this regulation are followed.

(3) Issue local rules to enforce the policies and procedures stated in this regulation.

(4) Ensure that an adequate and timely ITR is prepared for each patient who must have one.

(5) Ensure that a blood sample for deoxyribonucleic acid (DNA) identification is on file with the DNA Repository for all military members and deploying civilians.

b. Unit Commanders. Unit commanders will ensure that HRECs are always available to Army Medical Department (AMEDD) personnel who require such records in the performance of their duties. Unit commanders will also ensure that information in HRECs is kept private and confidential in accordance with law and regulation. If a commander acquires HRECs or documents belonging in HRECs, the commander will ensure that the documents are properly secured and sent to the proper HREC custodian without delay. As an exception to e(1) below, if no AMEDD or military MTF personnel are available to act as the custodian of unit HRECs, a unit commander may act as the custodian of his or her unit's HRECs, or, as the alternative, appoint a competent person of the unit as the custodian. Examples of situations in which unit HRECs may be maintained centrally at a unit in the custody of the unit commander or competent designee include those units located away from a military MTF, to include recruiting stations, Reserve Officers' Training Corps detachments, professors of military science, and Reserve Component (RC) units receiving medical or dental care from civilian facilities. HRECs maintained at such units must be managed in accordance with this regulation. Such units must place special emphasis on compliance with chapter 2 of this regulation. Questions about centralized HREC maintenance in isolated units will be referred to the Army MTF with administrative responsibility for that health service support area. OTRs for family members accompanying those active duty military members assigned to isolated units will not be maintained at the unit. Per paragraph 6-4 of this regulation, a copy of an OTR may be furnished to a pertinent family member. However, the original record will be returned, along with an explanatory letter, to the military MTF that last provided medical care to that family member.

c. RC specific commanders.

(1) State adjutants general will initiate, maintain, and dispose of Army National Guard of the United States (ARNGUS) HRECs.

(2) U.S. Army Reserve (USAR) unit commanders will initiate and dispose of HRECs of troop program unit (TPU) members.

(3) The Commanding General, Army Reserve Personnel Center (ARPERCEN), will initiate and dispose of HRECs for Individual Ready Reserve (IRR) members.

d. Military personnel officers. Military personnel officers will—

(1) Initiate HRECs and send them to the proper HREC custodian.

(2) Ensure that personnel who are changing stations hand-carry their HRECs. When an HREC custodian thinks a person should not hand-carry his or her record, the custodian will send it to the person's next station. (See para 5-24a(3).)

(3) Tell the HREC custodian of impending unit or personnel movements.

(4) Provide, on a quarterly basis, rosters that identify personnel for whom MTF and DTF commanders are medical record custodians.

(5) Keep secure any defense information in HRECs (para 2-7). When military personnel officers acquire HRECs or documents belonging in HRECs, they will ensure that the records are maintained confidentially (chap 2) and sent to the proper HREC custodian without delay.

e. AMEDD officers. AMEDD officers will—

(1) Serve as custodians of HRECs except in those instances where exception is granted as outlined in *b* and *c* above and in paragraph 5-24*b*(1) of this regulation. AMEDD officers are in charge of the HRECs for members of the units to which they supply primary medical and dental care. They are also in charge of the HRECs of other individuals they are currently treating.

(2) Use HRECs for diagnoses and treatment. HRECs are important for the conservation and improvement of patient health. Therefore, AMEDD officers will ensure that all pertinent information is promptly entered in the HRECs in their custody. If any such pertinent information has been omitted, AMEDD officers will take immediate action to obtain such information from the proper authority and include it in the HREC.

(3) Send the appropriate records to the military member's HREC custodian when an AMEDD officer examines or treats a person whose HREC is not in his or her custody. These records will be sent sealed in an envelope that is stamped or plainly marked "Health (or Dental) Records." In addition to the address, the envelope will also be plainly marked "Health (or Dental) Record of (person's name, grade, and social security number (SSN))." The person's unit of assignment will also be shown. If the HREC custodian is not known, the document will be sent to the medical department activity (MEDDAC), U.S. Medical Center (MEDCEN), or dental activity (DENTAC) commander of the person's assigned installation.

f. Chief, Patient Administration Division. The Chief, Patient Administration Division of an MTF, will act for the commander in matters pertaining to medical records management and information. The office of patient administration will keep the professional staff

informed of the requirements for medical records and related health care documentation.

g. Medical and dental officers. Medical and dental officers will ensure that—

(1) Information is promptly and accurately recorded on medical and dental forms.

(2) Records prepared and received from other MTFs and DTFs are promptly reviewed and filed in the medical record.

h. Health-care providers. Health-care providers will promptly and correctly record all patient observations, treatment, and care.

i. Chaplains. Hospital chaplains are allowed access to medical records subject to standards contained in the American Hospital Association Guidelines for Recording Chaplains' Notes in Medical Records. Visiting clergy will not have access to ITRs. Chaplains enrolled as students in clinical pastoral education courses will be afforded the same privileges as hospital chaplains. Chaplains assigned to a residential treatment facility (RTF) will be allowed, but not required, to document information in medical records. The RTF chaplain will document the factual and observational information called for in the American Hospital Association Guidelines. As a team member in an RTF, the chaplain is encouraged to include additional information that would be helpful for the total care and treatment of the patient. Such information is considered observational.

j. Persons within Department of the Army (DA) agencies. Persons within DA agencies who use medical information for official purposes must protect the privacy and confidentiality of that information in accordance with law and regulation.

k. Research personnel. Research personnel will ensure that data collected from medical records are within guidelines of human use committees and maintain the confidentiality of patients. See AR 40-38 and paragraph 2-8 of this regulation.

1–5. Record ownership

a. Army medical records are the property of the Government. Thus, the same controls that apply to other Government documents apply to Army medical records. (See AR 25-55, AR 25-400-2, and AR 340-21 for policies and procedures governing the maintenance and release of Government documents.)

b. Army medical records, other than those of RCs, will remain in the custody of the military MTFs at all times. RC records will remain in the custody of the appointed HREC custodian. This medical record is the Government's record of the medical care that it has rendered and must be protected. Upon request, the patient may be provided with a copy of his or her record, but not the original record. Only one free copy may be provided to the patient. Procedures should ensure conscientious Government control over medical records for good medical care, performance improvement, and risk management.

1–6. International standardization agreements

Some provisions of this regulation are covered by North Atlantic Treaty Organization standardization agreements (NATO STANAGs) 2348 and 2132 and quadripartite standardization agreement (QSTAG) 470. These parts are annotated to show the related agreement. Any proposed changes or cancellations of these provisions must be approved through international standardization channels.

Chapter 2
Confidentiality of Medical Information

2–1. General

This chapter explains DA policies and procedures governing the release of medical information or medical records pertaining to individual patients. The policies expressed in this chapter are to be used in coordination with those expressed in AR 25-55 and AR 340-21. Note that no information pertaining to the identity, treatment, prognosis, diagnosis, or participation in the ADAPCP will be released, except in accordance with AR 600-85, chapter 6, and chapter 8 of this regulation. Refer to AR 40-68, paragraph 1-7, for information pertaining to the confidentiality of medical quality assurance records.

2–2. Policies governing the protection of confidentiality

DA policy mandates that the confidentiality of patient medical information and medical records will be protected to the fullest extent possible. Patient medical information and medical records will be released only if authorized by law and regulation.

a. Within DA, patient medical information and medical records may be used for diagnosis, treatment, and preventive care of patients. Patient medical information may also be used within DA to monitor the delivery of health care services, to conduct medical research, for medical education, to facilitate hospital accreditation, and for other official purposes.

b. Unless otherwise authorized by law or regulation, no other person or organization will be granted access to patient medical information or medical records.

c. Any person who, without proper authorization, discloses a patient's medical information or medical record may be subject to adverse administrative action or disciplinary proceedings.

d. Private medical information and medical records are often viewed by clerical and administrative personnel, such as secretaries, transcriptionists, and medical specialists. This access is authorized and necessary in order for an MTF to properly process and maintain information and records. However, the MTF commander will ensure that all persons with access to medical information or medical records are trained in their obligation to maintain the confidentiality and privacy of medical information and medical records.

e. When medical information is officially requested for a use other than patient care, only enough information will be provided to satisfy the request.

2–3. Release of information when the patient consents to disclosure

a. Requests from patients. If a patient requests information from his or her medical record or copies of documents in the record, the information or record will be provided to the patient.

(1) Any request from a patient for disclosure of information or documents from his or her own medical record must be in writing. The patient may complete a DA Form 5006-R (Medical Record—Authorization for Disclosure of Information) or submit a letter detailing the request for information or documents. DA Form 5006-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy of this form is located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site. If the patient is requesting information from his or her own record or a document from that record, the patient is not required to disclose the reason for the request or the manner in which the information or document will be used. Accordingly, that part of DA Form 5006-R titled "Use of Medical Information" need not be completed by a patient who is requesting information or documents from his or her own record.

(2) A patient may be denied direct access to information or documents from his or her own medical record only if a physician or dentist determines that access to such information could adversely affect the patient's physical, mental, or emotional health. Such a determination, together with the rationale for such, should be documented by the determining physician or dentist in a memorandum for record to be forwarded with the record to a physician or dentist chosen by the patient. The receiving physician or dentist will disclose the records in a manner so as to limit the potential harm to the patient. All such medical records will be identified with a conspicuous strip of tape. (See para 4-4a(10).) Direct access of an identified patient to his or her original record will be allowed only in the presence of the patient administrator or his or her designee.

(3) Medical information obtained from nonmilitary sources will be filed with the patient's medical record. Such information is available for further diagnosis and treatment of the patient and for other

official DA uses. The MTF will release a copy of the information to the individual if requested to do so, but will caution him or her that that copy is not certified as a correct and true copy. The patient or other requester will be told that the original medical information is the property of the nonmilitary facility and may be requested from the originating facility. This does not apply to medical information on patients treated under supplemental or cooperative care. Such information may be released as a part of the patient's medical record.

b. Requests from third parties when patient consents to disclosure.

(1) Medical information or medical records pertaining to a particular patient may be disclosed to a third party provided that the third party has obtained the prior written consent of the patient concerned. Whenever possible, DA Form 5006-R will be completed by a patient to document that patient's consent to release medical information or medical records. The original DA Form 5006-R must be submitted by the third party with that party's request for a patient's medical information or medical records. In all cases, the DA Form 5006-R must—

(a) Be submitted in writing.

(b) Contain the patient's original signature and must be dated by the patient.

1. If the patient is a minor child, a parent or legal guardian must sign the consent form on behalf of the child. According to AR 40-3, paragraph 19-2, a minor child is any person who has not attained the age of 18 years and is not emancipated as determined by the law of the State in which the MTF is located.

2. If the patient has been determined to be mentally incompetent by a court of competent jurisdiction, the person who has been appointed as the legal guardian of that patient may sign the consent form on behalf of the incompetent patient. A copy of the court order appointing the legal guardian must accompany the signed consent form.

(c) Be submitted to the MTF for processing within 1 year from the date on which the form was signed by the patient. Consent forms older than 1 year are not valid.

(d) State the specific medical information or medical record for which the patient has consented to release. Only the specific information or medical record for which the patient has consented to release will be released.

(e) Name the individual or organization to whom the patient has authorized release of medical information or medical records. Medical information or medical records will be released only to those persons or organizations named.

(f) State the purpose(s) for which the patient has consented for his or her medical information or medical record to be used upon disclosure to a third party.

(2) Consult with the local judge advocate to determine the validity of a DA Form 5006-R.

(3) DA Form 4876-R (Request and Release of Medical Information to Communications Media) will be used for release of medical information to communications media. DA Form 4876-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy of this form is located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site. See AR 25-55, paragraph 3-200.

2–4. Disclosure without consent of the patient

a. Requests from personnel within the Department of Defense (DOD).

(1) Patient medical information of medical records may be disclosed to officers and employees of DOD who have an official need for access to the record in the performance of their duties. Consent of the patient is not required.

(2) DOD personnel will submit requests for private medical information or medical records on DA Form 4254-R (Request for Private Medical Information). DA Form 4254-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy of this form is located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site. When requesting disclosure of private medical information or medical records of a patient, DA personnel will present their official credentials and document their official need to know the requested information.

(3) The receiving MTF will file all DA Forms 4254-R received according to AR 25-400-2.

b. Requests from the Defense Investigative Service (DIS). DIS agents are required to provide the following appropriate release form(s) before they are provided the requested information.

(1) A completed DIS Form 40 (Alcohol and Drug Abuse Information Release and Consent to Redisclosure) is required for release of ADAPCP records to DIS agents.

(2) A completed "Authorization for Release of Medical Information" included in SF 86 (Questionnaire for National Security Positions) is required for release of information from HRECs.

(3) A completed DIS Form 16 (Doctor/Patient Release Statement) is required before releasing general records maintained by doctors, hospitals, and other institutions pertaining to medical or psychiatric examinations or treatment. This form should also be used if the DIS agent desires to interview a physician for evaluation or opinion of the individual's case.

c. Other requests. All other requests for disclosure of medical information or medical records will be analyzed and processed according to AR 25-55 and AR 340-21.

2–5. Processing requests for patient medical information and medical records

a. The MTF commander is responsible for the management and oversight of this program. The patient administrator, as the representative of the MTF commander, is responsible for the processing of requests for patient medical information and medical records. In the absence of the patient administrator, the acting patient administrator will assume this responsibility.

b. All requests for patient medical information or medical records must be submitted in writing. However, in urgent situations, facsimile requests for disclosure may be accepted. In some situations, for example, cases of emergency, rape, assault, child abuse, or death, the need for information may be extremely urgent. In such cases, a verbal request for disclosure of medical information or medical records may be submitted and acted on. The requester will be informed that the verbal request must be supplemented by the submission of a written request in accordance with law and regulation, at the first available opportunity.

c. Authorization for the release of medical information or medical records will normally be documented in writing. However, in certain emergency situations, the MTF commander or patient administrator may verbally authorize the release of medical information or medical records, provided that such release is otherwise authorized by law and regulation. Immediately after granting verbal authorization for disclosure, the authorizing official will prepare a memorandum for record, documenting the release and the reasons for the use of emergency procedures.

d. Usually, copies of medical information or medical records authorized for release must be picked up, in person, by the requester or other person to whom disclosure has been authorized. In emergency situations, facsimile transmission of released medical information is authorized, provided that appropriate measures are taken to ensure that the information is delivered to the correct party. A cover letter, including a confidentiality notice, will accompany each such facsimile transmission. The confidentiality notice will include instructions on redisclosure and destruction of the disclosed information. A sample is shown in figure 2-1.

e. MTF commanders or patient administrators will determine the legitimacy of the request for patient medical information or medical records. MTF commanders or patient administrators are encouraged to seek the advice and assistance of their servicing judge advocate in determining the legitimacy of a request for disclosure and in authorizing release of medical information or medical records.

f. Only that specific medical information or medical record required to satisfy the terms of a request will be authorized for disclosure.

g. If disclosure of all or part of the request for patient medical information or medical record is approved, certified copies of that information or record will be released. If the requester seeks disclosure of the original records, the requester must justify, in writing, why certified copies are not adequate to fulfill the purpose for which the records are being sought. Advice of the local judge advocate should be sought in determining the legitimacy of a request for disclosure of an original record.

h. A copy of the request for release of medical information or medical records, a copy of any consent form, together with copies of the release authorization and the records released, will be filed in the patient's medical record. If these copies cannot be made, the request will be annotated to reflect the specific information released. When requests are made for information from both inpatient and outpatient records at the same time, the request and all copies will be filed in the inpatient record. The other record will be properly cross-referenced.

i. Fees and charges for copying, certifying, and searching records will be calculated and imposed according to AR 25-55, chapter 6.

j. Continued coordination with a judge advocate is encouraged on all matters pertaining to the request for and release of patient medical information or medical records.

2–6. Medical records of teenage family members

a. Disclosure of information.

(1) Minors have rights to access under the Privacy Act, section 552a, title 5, United States Code (5 USC 552a). Parents or guardians have a right to access to the medical records of their minor children under the Privacy Act, 5 USC 552a(h). The law of the State in which the minor is located determines whether, for the purposes of the Privacy Act, the child is a minor. If not a minor, the teenager can act on his or her own behalf and the parent or guardian does not have a right to access. If, however, the teenager is a minor under the State law where he or she resides, then the law of the State in which the medical record is maintained governs the disclosure of information from that record. Patient administrators must be especially sensitive to restrictions contained in statutory or regulatory programs for—

(a) Drug and alcohol abuse.

(b) Venereal disease control.

(c) Birth control.

(d) Abortion.

(2) For overseas installations, the opinion from the DOD Privacy Board Legal Committee (24 November 1980) will be used. See figure 2-2.

b. Medical confidentiality. So that medical confidentiality will not be compromised, medical records of minors in *a* above will be maintained as "Civilian Consultation Service Case Files." Because medical information in these records may be an important part of continued and followup care, SF 600 will note "Patient seen, refer to file number 40-216b" and will be filed in the patient's OTR. Disposition of these records will be per AR 25-400-2, file number 40-216b, civilian consultation service cases. See table 3-1 and paragraph 6-7h.

2–7. Disclosure of medical records containing classified defense information

a. Medical records will not usually contain classified defense information. The entry of such information should be avoided unless doing so jeopardizes the interests of the patient or of the Government. If entered, the documents containing classified defense information will be safeguarded and transferred per AR 380-5. The custodian of the record will state on SF 600 (Health Record—Chronological Record of Medical Care) that the record has a classified portion. Such documents will be screened often to see whether declassification is possible. When declassified, a note will be made on SF 600, and the documents will be returned to the custodian of the record.

b. Before records are sent to the Department of Veterans Affairs (VA), any separate file of documents bearing defense information will be reviewed for possible declassification. Documents that cannot be declassified will not be sent to the VA. Those documents in records of officers and warrant officers will be sent to the Commander, U.S. Total Army Personnel Command (PERSCOM), ATTN: TAPC-MSR, Alexandria, VA 22332-0002. Those documents in records of enlisted personnel will be sent to the Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE-RP, 8899 56th Street, Indianapolis, IN 46249-5301.

2–8. Research using military medical records

Qualified people may have access to Army medical records and biostatistical information for research and study. Access may be granted to records in MTFs and DTFs, Army record centers, and facilities of the General Services Administration. Medical records used for research will not be removed from the MTF or DTF or the center; space and facilities will be furnished by the custodian. Further, commanders of MTFs and DTFs will not borrow retired records for researchers. The Surgeon General will approve any exception.

a. Approval of requests.

(1) The Surgeon General will approve all requests for research. An exception to this is given in (2) below.

(2) The MTF or DENTAC commanders will approve requests from personnel under their command whose research projects involve medical records at that facility. Researchers will abide by applicable portions of AR 40-38 and section 219, title 32, Code of Federal Regulations (32 CFR 219).

b. Submission of requests. With the exception of those requests falling under a(2) above, all requests from outside and within DA will be made through channels to U.S. Army Medical Command (USAMEDCOM), ATTN: MCHO-CL-P/Patient Administration, 2050 Worth Road, Fort Sam Houston, TX 78234-6000. Such requests will—

(1) Provide the name and address of the researcher and of any assistants.

(2) List the professional qualifications of the researcher and of any assistants.

(3) Describe the researcher's project or field of study.

(4) Provide the reason for requesting the use of Army records.

(5) Name the particular records needed (for example, the historical range for which records are desired) and their location.

(6) Give inclusive dates when access is wanted.

(7) Attach evidence of institutional approval (training director) for residency training projects.

(8) Have each person named in the request sign an agreement that lists the following conditions:

(a) Information taken from Army medical records will be treated according to the ethics of the medical and dental profession.

(b) The identities of people mentioned in the records will not be divulged without their permission, and photographs of a person or of any exterior portion of his or her body will not be released without his or her consent.

(c) The researcher understands that permission to study the records does not imply approval of the project or field of study by The Surgeon General.

(d) All identifying entries about a person will be deleted from abstracts or reproduced copies of the records.

(e) Any published material or lectures on the particular project or study will contain the following statement: "The use of Army medical records in the preparation of this material is acknowledged, but it is not to be construed as implying official Department of the Army approval of the conclusions presented."

c. Access authorization proof. Any approval letter from The Surgeon General allowing access to records will be shown to the proper authority (Chief, Patient Administration Division; medical records administrator) when requesting access to records at the MTF level.

CONFIDENTIALITY NOTICE

The documents accompanying this telecopy transmission contain confidential information, belonging to the sender, that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.

Figure 2-1. Sample confidentiality notice accompanying facsimile transmissions

"For the purpose of parental access to the medical records and medical determinations regarding a minor, the age of majority is 18 years except where—

a. The minor at the time he or she sought or consented to the treatment was between 15 and 17 years of age;

b. The treatment was sought in a program that promised to keep treatment records confidential;

c. The minor specifically requested or indicated that he or she wished the treatment record to be kept confidential and not released to a parent or guardian; and

d. The parent or guardian seeking access does not have the written authorization of the minor or a valid court order for access.

If all four conditions are met, the parent or guardian will not have access to the medical records of the minor. Nothing in this opinion would in any way deny the minor the access to his or her own records which he or she has under the Privacy Act or other statutes."

Figure 2-2. Opinion from the DOD Privacy Board Legal Committee, 24 November 1980

Chapter 3
Preparation of Medical Records

Section I
Forms and Documents

3–1. Authorized forms and documents

a. The forms authorized for use in medical and dental records are listed in the figures in chapters 5, 6, 7, 8, and 9. Unless authorized by this regulation, only documents prepared by authorized AMEDD personnel will be filed in Army medical records. (This restriction does not prohibit the use of other documents created by attending physicians and dentists outside the AMEDD (Navy, Air Force, civilian, etc.), or the filing of other documents as summaries or brief extracts. If such documents are filed, their source, and the physician or dentist under whom they were prepared, must be identified.)

b. Recordkeeping requirements (file numbers) required by this regulation are listed in table 3-1.

3–2. Filing automated and computerized forms

a. Automated and computerized medical reports may be filed in Army medical records. Examples of such reports are electrocardiograms, coronary care unit or intensive care unit vital-sign-monitoring records, scans, anesthesia monitoring records, and laboratory test results. Such reports will be filed with the SFs, DD forms, or DA forms to which they most closely relate (for example, electrocardiogram and cardiac monitoring with OF 520 (Clinical Record—Electrocardiographic Record) (formerly SF 520), anesthesia monitoring with DA Form 7389 (Medical Record—Anesthesia) (formerly SF 517 and OF 517), and laboratory test results with SF 545 (Laboratory Report Display). Undersized reports, such as monitoring strips, will be mounted on DA Form 4700 (Medical Record—Supplemental Medical Data) overprints identified as display sheets, except for cardiac rhythm strips, which may be mounted on the corresponding SF 510 (Clinical Record—Nursing Notes). When DA Form 4700 is used, it should be referenced on SF 600. (Also see paras 3-3, 9-2, and 11-4 for information on DA Form 4700.)

b. When a computerized or automated summary of all previous laboratory (lab) tests is provided, only the cumulative final report will be filed. All other results will be discarded. For this reason, it is vital that health care providers not document medical information or opinions on the daily lab reports as they will not be retained.

c. Computerized or automated versions of recognized forms will include reference to "Automated version of (form number)" in lower left corner and must be mirror images of DD or DA forms.

3–3. Guidelines for local forms and overprints

The approval of overprinted medical forms and proposed forms using the DA Form 4700 overprint not listed in figures in chapters 5, 6, 7, 8, and 9 is delegated to MEDCEN and MEDDAC or DENTAC commanders, using the guidelines described in *a* through *r* below.

a. Local forms and proposed overprints will be well thought out in content and design; be well identified with a title, heading, and or subject; and present data in a neat and organized format. The MTF or DENTAC overprint number will appear under the form number and edition date on each form or overprint. On SF overprints, the entry "approved by U.S. Army Publishing Agency" must be printed under the overprint number.

b. All overprinting of SFs, OFs, DD forms, and DA forms must be processed and approved before implementation. Overprinting of these forms is limited to items that specifically pertain to the form on which they are printed (for example, admission note overprint on SF 509 (Medical Record—Progress Notes) and nursing history and assessment overprint on DA Form 3888-2 (Medical Record—Nursing Care Plan)). Other overprints should be printed on DA Form 4700.

c. The MTF or DENTAC group that reviews medical records is directly responsible for review and approval of local forms and overprints.

d. Local forms and overprints submitted to the MTF or DENTAC for review and approval as in *c* above will be accompanied by written justification.

e. Creation of a form for which a higher echelon form exists (for example, creation of a local form as a substitute for an SF) is prohibited. When optional forms exist, such as OF 522 (Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures) (formerly SF 522), the MTF or DENTAC may elect to utilize a State mandated form instead of the optional form.

f. Titles of overprints should be printed inside the border of the form because titles printed at the top of the page between hole perforations are obscured when the forms are fastened in the records. OF 275 (Medical Record Report), a continuous report form, may be used in ITRs, HRECs, and OTRs. OF 275 may be used for the transcription of dictated reports or it may replace approved overprints on DA Form 4700. When OF 275 is used, the title and

number of the form that it replaces are noted in the lower left corner. All standard information needed on the report form replaced by OF 275 will be entered on OF 275, including subtitles and name and address of MTF. OF 275 will be filed in the ITR, HREC, or OTR, according to the number of the form that it replaces. (Also see para 9-12 for information to be included on OF 275.)

g. Overprints on SFs, OFs, DD forms, and DA forms (other than DA Form 4700) must facilitate completion of subject forms, not provide "substitute" information.

h. Overprints that contain fill-in lines and or lined charts or graphs must be printed on DA Form 4700, rather than on lined SFs, OFs, DD forms, or DA forms. Lined overprints superimposed on lined SFs, OFs, DD forms, and DA forms create serious printing and user problems.

i. Overprinting on nonstandard-size DA Forms 4700 (for example, 8-inch by 13-inch overprints) will not be approved.

j. Multipage forms and overprints should be printed on both sides of the paper (head to foot) and indicate "page 1 of 3," "page 2 of 3," and so on if they consist of more than two pages.

k. Overprints on SF 509 and SF 600 should not extend over into the "Date" column, except for data pertaining specifically to the date and or time entry.

l. Ward policies and procedures should not be included in forms and overprints because they do not belong in the patient's medical record.

m. Worksheets should not be overprinted on SFs, DD forms, and DA forms (including DA Form 4700) because these documents will not be permanently filed in medical records.

n. When preprinted instructions are given to the patient and family, the patient's record will so indicate, and a sample of the instruction sheet will be retained in the ITR, HREC, or OTR on a DA Form 4700 overprint. Local policy will dictate how classes, videos, and other types of learning activities are documented.

o. Preprinted instructions to the health-care provider do not belong in the patient's record and therefore should not be included in local forms and overprints.

p. Approval for entering doctors' orders on DA Form 4256 (Doctor's Orders) and DA Form 4700 is not required, including orders that are handwritten, taken over the phone by authorized personnel, or overprinted as standing orders. See paragraph 9-26.

q. OF 522 or a State mandated consent form will be used to meet the requirements of counseling and authorization required for consent to inpatient or outpatient medical or dental care. No approval is necessary for local consent forms designed specifically for these procedures.

r. Use of abbreviations on forms and overprints should be in strict compliance with those included in appendix B or locally approved per paragraph 3-3c. Otherwise the abbreviations must be spelled out.

Section II
Medical Record Entries

3–4. General

a. Content. Entries will be made in a record by the health-care provider who observes, treats, or cares for the patient and in accordance with the locally defined patient assessment policy. No health-care practitioner is permitted to complete a medical record on a patient unfamiliar to him or her. In unusual extenuating circumstances (for example, death of a provider), local policy will ensure that all means have been exhausted to complete the record. If this action is impossible, the medical staff may vote to file the incomplete record as is. Documentation summarizing the reason for the action will be filed with the record.

b. Legibility. All entries must be legible. Entries should be typed, but may be handwritten. (However, radiology, pathology, and operative reports, as well as narrative summaries, will be typewritten.) Handwritten entries will be made in permanent black or blue-black ink, except when pencil entries are either directed or necessary under field conditions. Erasable ink and felt tip pens will not be used. Rubber stamps may be used only for standardized entries, such as routine orders.

c. Signatures. All entries must be signed or electronically authenticated. (Electronic signatures on a medical record are admissible and will not jeopardize the admissibility of the record in court. See the definition of an electronic signature in the glossary.) The first entry made by a person will be signed; later entries on the same page by that person will be signed or initialed. (A military member must add grade and corps; a civilian must add his or her title or certification.) Rubber-stamped signatures will not be used in place of written signatures, initialing, or electronic authentication. However, the use of (rubber) block stamps or handprinted or typed name under written signatures is recommended because it establishes a method to identify the authors of entries. Block stamps for military members will contain printed name, grade, and corps (officers), or military occupational specialty (enlisted); block stamps for civilians will contain printed name and title or certification or professional licensure (such as registered nurse (RN) or licensed practical nurse (LPN)).

d. Dating entries. All entries must be dated. Dates will be written in the day-month-year sequence; months will be stated by name, not by number. For example, a correct entry is "17 Jun 98."

e. Corrections to entries. To correct an entry, a single line is drawn through the incorrect information, and it is noted as "error," then dated and initialed. This information must remain readable. Deletion, obliteration, or destruction of medical record information is not authorized. The new information is then added, with the reason for the change (for example, "wrong patient's chart"), the date, and signature (with title) of the person making the change. Electronic corrections to entries must show a complete audit trail.

f. Amendment to medical records. Medical records will be amended per AR 340-21, paragraph 2-10.

g. Use of rubber stamps. Rubber stamp entries constitute overprints only when they are used to collect clinical data, not when used to document administrative data, such as the name of a specialty clinic, time and date of clinic visit, or signature block.

3–5. Patient identification

The patient identification section will be completed when each record document is begun. The patient's recording card will be used for the HREC and OTR; the inpatient identification plate will be used for the ITR. When mechanical imprinting is not available, patient identification will be typed, computer-generated, or handwritten in black or blue-black ink. Patient identification must include at least the patient's name; his or her rank, grade, or status; his or her family member prefix (FMP) and sponsor's SSN (para 4-1); the patient's SSN; date of birth; code for MTF that maintains records; and his or her register number (if any).

a. Patient's recording card. This card is used to enter identifying data on forms filed in the OTR and HREC; it is used with the ward or clinic identification plate. (See *b* below.) The card may also be used as an appointment card. An adhesive-backed paper appointment notice may be attached to the back. The clinic receptionist or appointment clerk fills in the date, time, and clinic name on the blank lines of the notice. (The notice also has space for the name, location, and telephone number of the MTF.) This information is then available to the patient and to clinical personnel during the patient's next visit.

(1) The patient's recording card should be prepared when the patient is first examined or treated in a troop medical clinic, health clinic, or MTF. The patient's DD Form 1173 (Uniformed Services Identification and Privilege Card) or DD Form 2(ACT) (Armed Forces of the United States Identification Card (Active)), DD Form 2(RES) (Armed Forces of the United States Identification Card (Reserve)), or DD Form 2(RET) (United States Uniformed Services Identification Card (Retired)) will be used to prepare the card; these forms contain all the information needed to prepare the patient's recording card.

(2) The information that may be embossed on the patient's recording card is given below. Format may vary at MTFs using the Composite Health-Care System (CHCS). The optical card reader

font will be used for the FMP and SSN to make the filing of records easier. The suggested format for this card is described in (a) through (e) below.

(a) Line 1. Spaces 1 through 14—FMP and SSN (para 4-1). Spaces 15 through 22—Blank.

(b) Line 2. All spaces—Blank.

(c) Line 3. Spaces 1 through 22—Patient's name (last, first, and middle initial).

(d) Line 4. Spaces 1 through 4—Year of birth. Space 5—Blank. Space 6—Sex (M—male, F—female). Spaces 13 through 16—Status of patient and of sponsor if patient is a family member (for example, AD equals active duty). Space 17—Blank. Spaces 18 through 22—Department of patient or of sponsor (Army, Navy, Air Force, etc.).

(e) Line 5. Spaces 1 through 3—Three-character abbreviation of grade or rank of patient or of sponsor if patient is a family member; otherwise, blank. Space 4—Blank. Spaces 5 through 22—Sponsor's name if patient is a family member; otherwise, blank.

(3) Because patients may be treated at several MTFs, information identifying the MTF that is the custodian of the patient's record may be imprinted on the card as well as any other locally required information.

(4) The patient's recording card is designed only to make the printing of identification data on records easy. It is not used to determine eligibility of care. Such determinations are made per AR 40-3.

b. Ward or clinic identification plate. This plate is used to identify the MTF and the nursing unit or clinic. It will also be used to identify the Uniformed Chart of Accounts code. This plate is used with the inpatient identification plate and the patient's recording card. Suggested format for this plate is as follows:

(1) Lines 1 and 2. Name and location of MTF and Uniformed Chart of Accounts code.

(2) Line 3. Name of the nursing unit or clinic.

c. Inpatient identification plate. This plate is used to imprint patient identification information on all forms in the ITR; it is used with the ward or clinic identification plate.

(1) Format may vary at CHCS facilities. Suggested format for this plate is as follows:

(a) Lines 1 and 2. All spaces—Blank.

(b) Line 3. Spaces 8 through 23—Patient's name (last, first, and middle initial). Space 24—Blank. Spaces 25 through 29—Rank, grade, or status.

(c) Line 4. Spaces 8 through 15—Register number. Space 16—Blank. Spaces 17 through 29—FMP and sponsor's SSN (para 4-1).

(d) Line 5. Space 8—Sex (M—male, F—female). Space 9—Blank. Spaces 10 through 12—Age. Spaces 13 through 29—Blank.

(2) The patient's identification plate will accompany the medical record. When the patient is ready for final disposition, local procedure will cover the use of the plate.

d. Patient bed card. This card will be prepared on a plain 3- by 5-inch card. The format for the information on the card is—

(1) Patient's first name, middle initial, and last name.

(2) Rank, grade, or status.

(3) Service affiliation (Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service, or National Oceanic and Atmospheric Administration).

(4) Date of admission.

3–6. Facility identification

The MTF or DTF providing care will be clearly named in all medical records and reports. (Such entries on SF 600 will be made by rubber stamp when possible.) Because patients are often treated at several MTFs, the MTF that is custodian of the patient's records will also be named. For OTRs and HRECs, this identification may be accomplished using the patient recording card.

3–7. Destruction of unidentifiable medical documents

An unidentifiable document is one that contains either no identifying data or such a small amount that it is impossible to identify the person to whom it belongs. Destruction of unidentifiable documents will follow instructions outlined in the MTF Information Management Plan (IMP).

Section III
Recording Diagnoses and Procedures

3–8. Nomenclature used in recording diagnoses

a. Acceptable diagnostic nomenclature will be used. Vague and general expressions will be avoided.

b. The affected body part will always be stated when relevant to the condition and when not given in the name of the condition. In addition, the body part will be described in as much detail as is needed (for example, "skin of," "tissue of," or "region of"). Terms such as "right," "left," "bilateral," "posterior," and "anterior" will also be added when applicable.

c. Few abbreviations should be used in medical records. Those abbreviations and symbols listed in appendix B, as well as locally approved abbreviations and symbols, are authorized if the following conditions are met:

(1) Local abbreviations and symbols will not delete or alter the meaning of those listed in appendix B.

(2) A copy of locally approved abbreviations and symbols will be readily available to those authorized to make entries in the medical record and to those who must interpret them.

(3) This exception to policy applies to all MTFs. However, each treatment facility will be responsible for altering its approved lists as new additions or deletions are made to appendix B. It is recommended that abbreviations not listed in appendix B or not locally approved be used in long narratives only if they are defined in the text. For example: "Nerve conduction time (NCT) is changed by many factors. NCT varies with electrolytes. NCT varies with temperature."

d. Instructions for recording dental diagnoses and procedures, to include abbreviations and symbols, are provided in TB MED 250.

3–9. Special instructions for certain diseases

See Triservice Disease and Procedure ICD-9-CM Coding Guidelines (app A) for details on coding specific diseases.

3–10. Special instructions for certain diagnoses

Information on, and results of, Human Immunodeficiency Virus (HIV) testing will be entered in individual medical records as follows (per AR 600-110, para 2-10):

a. For force surveillance testing, an entry will be made on SF 600, which will include the date and location of testing. Recording of test results in the medical record of Army, Active Guard Reserve, and RC members on tours for 30 days or more is required when the member is being processed for overseas permanent change of station (PCS). HIV test results for the ARNGUS and USAR will be annotated on SF 600, which will be posted in the medical record. The HIV test date and result will be annotated on SF 88 (Report of Medical Examination), item 19f, if the test was performed in conjunction with a physical exam.

b. Results of routine adjunct testing will always be recorded in the medical record using SF 557 (Miscellaneous). The slip will be clearly stamped either "HIV positive" or "HIV negative." Specimens which are enzyme-linked immunosuppressant assay (ELISA) positive by local testing only will not be reported as HIV positive. These specimens will be reported as "pending results" to the ordering physician, and finally reported as HIV positive or negative only after receipt of confirmatory test results (Western Blot or other supplementary tests).

c. The medical and dental record jacket for all HIV-infected military members will be marked only by affixing a DA Label 162 (Emergency Medical Identification Symbol) per chapter 13 of this regulation. The DA Form 5571 (Master Problem List) will be annotated "Donor Ineligible-V72.62."

d. The losing HIV program point of contact will ensure that copies of medical records pertaining to the patient's diagnosis and evaluation of the HIV infection are forwarded to the gaining HIV

program point of contact in advance of the patient's arrival. Care will be taken to protect the confidentiality of the records by sealing them in an envelope marked "Sensitive Medical Records—To Be Opened by Addressee Only," and then inserting the envelope into a carrier addressed directly to the attention of the receiving HIV program point of contact, by name when known.

3–11. Recording psychiatric conditions

Psychiatric conditions will be recorded using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised (or current edition), as nomenclature (app A).

3–12. Recording injuries

a. Details to be recorded.

(1) The same details will be given and the same terms used when both battle and nonbattle injuries are recorded. To be complete, the recording of an injury must include the details given in (a) through (g) below. (For information needed for proper coding, see Triservice Disease and Procedure ICD-9-CM Coding Guidelines (app A).) Record on DA Form 3647 (Inpatient Treatment Record Cover Sheet), item 33, or CHCS automated equivalent, the details listed in (c) through (g) below.

(a) The nature of the injury. Record the exact nature of the injury as well as the medical condition caused by it. Explain conditions, such as traumatic bursitis, traumatic neuritis, traumatic myositis, or traumatic synovitis, by describing the original injury. For example, record a contused wound resulting in bursitis as bursitis due to contusion.

(b) The part or parts of the body affected. In the case of fractures and wounds, state whether any nerves or arteries were involved; name major nerves or blood vessels.

(c) The external causative agent. In the case of acute poisoning, name the poison.

(d) How the injury occurred. State what the person was doing when injured (for example, in action against the enemy, work detail, marching, drilling, or motor vehicle accident, etc.). For motor vehicle accidents, state the kinds of vehicles involved and whether military owned or otherwise.

(e) Whether the injury was self-inflicted. If the injury was deliberately self-inflicted, state whether it was an act of misconduct (to avoid duty) or an act of the mentally unsound (a suicide or attempted suicide).

(f) The location where the person was injured. If on post, state the building or area (for example, barracks, mess, or motor pool); if off post, state the exact location where the accident occurred (such as name of business, city, State) or location of motor vehicle accident (city, State, etc.), and the person's status (for example, home or leave or in transit while absent without leave (AWOL)).

(g) The date of the injury.

(2) Examples of properly recorded diagnoses are provided in (a) and (b) below.

(a) "Fracture, open comminuted, upper third of shaft of femur, left, no nerve or artery involvement; bullet entering anterior upper portion of left thigh and lodging in femur. Caused by rifle bullet, accidently incurred when patient's rifle discharged while he was cleaning it in Barracks A, Fort Hood, TX, 8 Jul 98."

(b) "Bursitis, acute, knee, right, due to contusion, anterior aspect. Accidently incurred when patient tripped and fell, striking knee on floor while entering Barracks 26, Fort Lewis, WA, 2 Dec 98."

b. Wound or injury incurred in combat.

(1) In addition to the details described in *a* above, records on wounds or injuries incurred in combat must state—

(a) Whether the wound resulted from enemy action. (The definition of battle casualty (wounded in action (WIA)) is provided in the glossary of AR 40-400.) The abbreviation "WIA" will be used; however, "WIA" by itself is not acceptable as a diagnosis.

(b) The kind of missile or other agent that caused the wound.

(c) The time that the wound occurred.

(d) The general geographic location where the person was wounded. Entries such as "near Taegu, Korea" are sufficient; map coordinates alone are not.

(2) The following example is a correctly recorded WIA case: "WIA wound, penetrating, left arm; entrance, posterior lateral, proximal third, severing brachial artery without nerve involvement. Incurred during search and destroy mission when struck by enemy mortar shell fragments, 16 Dec 69 near Kon Found, Republic of Vietnam."

c. Injuries or diseases caused by chemical or bacteriological agents or by ionizing radiation.

(1) For these injuries, record the name of the agent or type of ionizing radiation (if known). If the agent or radiation is not recognized, record any known properties of it (for example, odor, color, or physical state).

(2) Record the date, time, and place where contamination took place.

(3) Estimate and record the time that lapsed between contamination and self-decontamination or first aid (if any). Describe the procedures used.

(4) For injury by ionizing radiation, estimate and record the distance from the source. If the exposure is to external gamma radiation, state the dosage (for example, "measured 200r"). If not known, the dosage should be estimated (for example, "est 150r").

(5) State, if known, whether exposure was through airburst, ground burst, water surface burst, or underwater burst.

d. Occupational injury and illness. This term includes all injury or illness incurred as the result of performance of duty for military and civilian personnel, including those identified in *c* above. In addition to the details in a above, identify the injury or illness as "occupational."

3–13. Recording deaths

a. Recording deaths of unknown cause. The following terms will be used to record deaths when the cause is unknown.

(1) *Sudden death.* Used in the case of sudden death known not to be violent.

(2) *Died without sign of disease.* Used in the case of death other than sudden death known not to be violent.

(3) *Found dead.* Used in cases not covered by (2) above when a body is found.

b. Recording underlying cause of death. The underlying cause of death is a disease, abnormality, injury, or poisoning that began the train of morbid events leading to death. For example, a fatal case with a diagnosis of cerebral hemorrhage, hypertension, and myocarditis would have hypertension as the underlying cause. The diagnosis that describes the underlying cause of death should be identified as the underlying cause on DA Form 3647 or CHCS automated equivalent.

(1) The train of events leading to death will be recorded in items 7a and b of DA Form 3894 (Hospital Report of Death). The immediate cause will be entered in item 7a, and the underlying cause will be entered in item 7b. Only one cause should be entered on each line of items 7a and b; no entry is needed in 7b if the immediate cause of death given in 7a describes completely the train of events. To record the example given in *b* above, cerebral hemorrhage would be entered in 7a as the condition directly leading to death; hypertension would be entered in 7b(1) as the antecedent cause or condition leading to the immediate cause; and myocarditis would be entered in 8a as the condition contributing to death but not related to the cause.

(2) The diagnosis given as the underlying cause of death on DA Form 3647 or CHCS automated equivalent should be the same as the diagnosis given on DA Form 3894 and on the Certificate of Death. On the Certificate of Death, the underlying cause of death is shown on line c. If line c has no entry, it is on line b; and if lines b and c are blank, it is on line a. (For more information, see the Physicians Handbook on Medical Certification: Death, Fetal Death, and Birth (app A).)

c. Recording neonatal deaths. When recording deaths of infants under 28 days of age, use the term "neonatal death," and state the infant's age at death. For deaths in the first 24 hours of life, state the age in number of hours lived; for deaths after the first day of

life, state the number of days lived. Examples of these entries are "Neonatal death less than 1 hour after birth," "Neonatal death, age 22 hours," and "Neonatal death, age 26 days."

3–14. Recording cases observed without treatment, undiagnosed cases, and causes of separation

a. Observation without need for further medical care. A record must be made when a patient shows a symptom of an abnormal condition but study reveals no need for medical care. That is, observation reveals no condition related to the symptom that would warrant recording and no need for any treatment. In such a case, the proper diagnosis entry is "Observation." After this entry, give the name of the suspected disease or injury; after this entry, enter either "No disease found" or "No need for further medical care."

(1) A diagnosis of "Observation" is used even when a condition unrelated to the one suspected is diagnosed and recorded. For example, a patient is admitted for possible cardiac disease, but a specific cardiac diagnosis is not made. While in the hospital, however, the patient is also treated for arthritis. In such a case, "Observation, suspected..." is entered as the cause of admission; arthritis is given as the second diagnosis.

(2) A diagnosis of "Observation" is not used for patients lost to observation before a final diagnosis is made, and it is not used for a medical examination of a well person who has no complaint and who shows no need for observation or medical care.

b. "Undiagnosed" or "undetermined diagnosis" (nonfatal cases). When a patient is admitted or transferred and an immediate diagnosis is not possible, give the symptoms or the name of the suspected condition. Replace these terms with a more definitive diagnosis as soon as possible. When a final or more definitive diagnosis cannot be made, use the condition or manifestation causing admission.

c. Recording cause of separation. For a noninjury patient separated or retired for physical disability, the cause must be recorded. If there is more than one diagnosis, select the one that is the principal cause of separation, and enter after it "principal cause." For an injury patient, the residual disability (the condition causing separation) must be recorded. If there is more than one residual disability, the one that is the principal cause of separation must be stated. The diagnosis that is the "underlying cause" must also be recorded, that is, the injury causing the residual disability. For example, if a leg injury leads to amputation, the leg injury is stated as the underlying cause.

3–15. Recording surgical, diagnostic, and therapeutic procedures

Principles for coding and sequencing surgical, diagnostic, and therapeutic procedures are found in the Triservice Disease and Procedure ICD-9-CM Coding Guidelines (app A).

3–16. Recording therapeutic abortions

10 USC 1093 states that funds available to DOD may not be used to perform abortions except when the mother's life would be endangered if the fetus were carried to term.

a. To ensure compliance with 10 USC 1093, before the procedure, physicians performing therapeutic abortions in Army hospitals will document in the clinical record that the abortion is being performed because the mother's life would be endangered if the fetus were carried to term.

b. The same documentation will be placed in the medical record of a patient referred out on supplemental care.

c. The legal advice of a judge advocate will be solicited if deemed necessary.

d. For guidance on all other categories of abortion, see AR 40-3, paragraph 2-34*c*.

3–17. Recording use of restraints/seclusion

Documentation of the use of restraints/seclusion will conform to local policy and the current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.

Section IV
Records for Carded-for-Record-Only Cases and Absent-Sick Status

3–18. Carded-for-record-only cases

a. Certain cases not admitted to an MTF will be carded-for-record-only (CRO) cases. (This does not include Ambulatory Procedure Visit (APV) cases.) For these cases, DA Form 3647 or CHCS automated equivalent, or DD Form 1380 (U.S. Field Medical Card) will be prepared. A register number will be assigned to each CRO case. When DA Form 3647 is used, items 7, 10, 14, 24, 27, and 30 and the name of the admitting officer do not need to be completed. When DD Form 1380 is used, block 17 does not need to be completed.

b. A CRO record will be prepared only for the following cases:

(1) *U.S. military personnel treated as outpatients for WIA.* These cases are CRO cases only if they were not previously recorded by another U.S. military MTF.

(2) *Deaths of U.S. military personnel who are not inpatients at the recording MTF.* (Killed in action cases are not CRO cases.)

(a) The death will be recorded by the first MTF to which the remains are brought.

(b) If the remains are not brought to an MTF, the MTF with geographical responsibility for the installation that disposes of the remains will record the death as CRO. In this case, the commander of the installation must notify the MTF of the death.

(c) When the remains are disposed of outside military supervision (for example, by the family of the deceased), the commander of the deceased's assigned station will report the death to the MTF serving the station. This MTF will record the death as CRO.

(3) *Deaths other than those of U.S. military personnel.* These deaths include—

(a) Deaths of internees and prisoners of war under U.S. military custody.

(b) Deaths of foreign military personnel attached to or serving with Army organizations.

(c) Death of any individual pronounced dead by physicians serving in an MTF involved in preparing a State or country death certificate. (This class does not include fetal death certificates.)

(4) *Retirement or separation due to disability.* This class includes—

(a) U.S. military personnel separated or retired for medical conditions under AR 600-8-24, AR 635-40, or AR 635-200. These personnel are CRO cases only if they were not in an inpatient status on the date of separation. The MTF serving the person's unit of assignment at the time of separation will prepare the CRO record. The commander of the unit effecting separation will notify the serving MTF and supply sufficient information.

(b) U.S. military personnel removed from the Temporary Disability Retired List and RTD or placed on the Permanent Disability Retired List. It also applies to those placed on Temporary Disability Retired List while in an outpatient status.

(5) *Other.*

(a) Any outpatient abortion procedures.

(b) Certain other cases considered to have medical, legal, or other significance. However, they are CRO cases only if an ITR has not already been prepared for them.

3–19. Absent-sick status

An Army patient admitted to a nonmilitary MTF is in an absent-sick status. (See AR 40-3, chap 16.)

a. Only Active Army members, RC members in the Active Guard/Reserve program, RC members on tours of duty for 30 days or more, and U.S. Military Academy cadets can be classified in an absent-sick status.

b. DA Form 3647 or CHCS automated equivalent and DA Form 2985 (Admission and Coding Information) for absent-sick status are prepared much the same as for a direct admission but with the exceptions noted in the Individual Patient Data System (IPDS) User's Manual (app A). Additional information on absent-sick patients

placed in quarters by civilian physicians is given in AR 40-3; DA Form 3647 and DA Form 2985 do not need to be completed for these cases.

Table 3–1
File numbers, recordkeeping requirements

File number	Title
40	General medical services correspondence files
40-5h	Civilian Employee Medical Files
40-14a	Personnel dosimetry files
40-66a	Health records
40-66b	Dental health records
40-66c	Register number files
40-66e	Foreign national inpatient treatment records
40-66f	Military inpatient treatment records
40-66g	Civilian inpatient treatment records
40-66i	NATO personnel inpatient treatment records
40-66j	Military outpatient records
40-66k	Civilian outpatient records
40-66m	Foreign national outpatient records
40-66p	Army Reserve and ROTC outpatient records
40-66q	NATO personnel outpatient records
40-66s	Field medical cards
40-66u	Medical care inquiries
40-66v	USMA applicant x rays
40-66w	Installation x-ray indices
40-66x	Troop and health clinic clinical record cover sheets
40-66y	Photograph and duplicate medical files
40-66z	Procurement and separation x rays
40-66aa	Applicant and registrant x-ray film
40-66bb	Patient treatment film
40-66cc	Occupational health surveillance x rays
40-66ee	Medical records access files
40-66ff	Medical information releases
40-66gg	Nominal indexes
40-66hh	Tubercular applicant and registrant x rays
40-66ii	Military dental files
40-66jj	Civilian dental files
40-66kk	Foreign national dental files
40-66mm	American Red Cross dental files
40-216a	Military consultation service cases
40-216b	Civilian consultation service cases
40-216c	Foreign national consultation service cases
40-216e	Clinical psychology individual cases
40-216f	Social work individual cases
40-216h	Electroencephalographic tracings
40-216i	NATO consultation service cases
40-407f	Register of operations
600-85d	Alcohol and drug abuse rehabilitation

Chapter 4
Filing and Requesting Medical Records

4–1. Filing by social security number and family member prefix

An 11-digit number is used to identify and file medical records under the terminal digit filing system. This number consists of the sponsor's SSN and an FMP.

a. The first two digits of the file number are the FMP. These digits identify the patient, as shown in table 4-1.

b. The other nine digits of the file number are the sponsor's SSN broken into three groups. The first group is the first five digits of the SSN; the second group is the next two digits of the SSN; and the third group is the last two digits of the SSN. For example, PFC Ernie Jones, SSN 390-22-3734, would be identified as 20 39022 37 34; his wife's number would be 30 39022 37 34; his third oldest child's number would be 03 39022 37 34. As shown in the example, the sponsor's SSN will be used for beneficiaries. When both parents are on active duty, the children's number will be the same SSN as that used on the mother's records. When a newborn infant has no entitlement to continued medical care (for example, a newborn infant of a daughter family member or of a civilian emergency patient), the FMP assigned to the infant will be 90-95, and the SSN will be the one that the mother uses.

c. Pseudo or artificial 11-digit numbers will be given to patients not described in *b* above and in table 4-1. These numbers will also be given to patients who do not have an SSN. In these numbers, the two-digit FMP will be either 98 or 99. The pseudo or artificial SSN will be constructed according to the patient's date of birth. The following format will be employed: (80 +(0-9) + YYMMDD), where 80 is constant in every case and the third digit is used for sequencing of multiple same birthdate admissions. For example, a birthdate of 21 Sep 46 is formed 800-46-0921; a second patient requiring a pseudo SSN with the same birthdate is distinguished by the third digit, 801-46-0921. (Civilian emergency patients who have an SSN are described in rule 13 of table 4-1 and will not be given an artificial number.)

4–2. Terminal digit filing system

The terminal digit filing system is used to file ITRs, OTRs (including dental), ADAPCP-OMRs, and CEMRs. It may also be used to file HRECs (including dental) when authorized by the local MTF commander. Terminal digit filing system files will not be maintained separately by year.

a. Under the terminal digit filing system, the sponsor's SSN is divided into three groups (para 4-1b). Records are filed by the last two groups; these groups are the last four digits of the SSN. The last two digits of the SSN are known as the primary group; the next-to-last two digits are the secondary group. For example, in SSN 790-22-3753, 53 is the primary group, and 37 is the secondary group.

b. In all files, records will be arranged first by their primary group numbers, ranging from 00 to 99. Within each primary group, the records will be arranged by their secondary group numbers, also ranging from 00 to 99. Within the secondary group, records will be ordered numerically by the first five digits of the SSN. For example, if record 390-22-3734 is needed, the clerk looks first for the primary group "34" files. Within this group, the clerk looks for the secondary group "37" files. Within this group, the clerk looks for the folder numbered 39022. Thus, when filing records, read the SSN backwards rather than the normal way. Read the last two digits first (34 in the example above), then the next two digits (37), then the remaining digits (39022).

c. To prevent misfiling, file folders have different colors and are blocked. (See para 4-4.) In addition, file guides may be used throughout the files.

4–3. Use of DA Form 3443-series, DA Form 3444-series, and DA Form 8005-series folders

a. The DA Form 3443-series are the only authorized preservers for filing non-dental x-ray films. Similarly, the DA Form 3444-series and DA Form 8005-series are the only folders authorized for filing ITRs, OTRs, HRECs, CEMRs, and nuclear medicine files. Only DA Form 3444-series folders will be used for dental records, ITRs, ADAPCP-OMRs, and CEMRs. DA Form 8005-series will be used only for HRECs and OTRs. DA Form 8005-series folders will replace DA Form 3444-series folders only when they have deteriorated or when beneficiaries are entering the system for the first time. Nuclear medicine departments will ensure that their folders are conspicuously stamped to eliminate the possibility of mixing them with ITRs, HRECs, OTRs, or CEMRs.

(1) The following forms are those contained in the DA Form 3443-series, the DA Form 3444-series, and the DA Form 8005-series. They can be requisitioned from the U.S. Army Publications Distribution Center, St. Louis, MO, through normal publications supply channels. Instructions for completing the forms are self-explanatory.

(a) DA Form 3443 (Terminal Digit—X-Ray Film Preserver).

(b) DA Form 3443X (Terminal Digit—X-Ray Film Negative Preserver (Loan)).

(c) DA Form 3443Y (Terminal Digit—X-Ray Film Negative Preserver (Insert)).

(d) DA Form 3443Z (Terminal Digit—X-Ray Film Negative Preserver (Report Insert)).

(e) DA Form 3444 (Alphabetical and Terminal Digit File for Treatment Record (Orange)).

(f) DA Form 3444-1 (Alphabetical and Terminal Digit File for Treatment Record (Light Green)).

(g) DA Form 3444-2 (Alphabetical and Terminal Digit File for Treatment Record (Yellow)).

(h) DA Form 3444-3 (Alphabetical and Terminal Digit File for Treatment Record (Grey)).

(i) DA Form 3444-4 (Alphabetical and Terminal Digit File for Treatment Record (Tan)).

(j) DA Form 3444-5 (Alphabetical and Terminal Digit File for Treatment Record (Light Blue)).

(k) DA Form 3444-6 (Alphabetical and Terminal Digit File for Treatment Record (White)).

(l) DA Form 3444-7 (Alphabetical and Terminal Digit File for Treatment Record (Brown)).

(m) DA Form 3444-8 (Alphabetical and Terminal Digit File for Treatment Record (Pink)).

(n) DA Form 3444-9 (Alphabetical and Terminal Digit File for Treatment Record (Red)).

(o) DA Form 8005 (Outpatient Medical Record (OMR) (Orange)).

(p) DA Form 8005-1 (Outpatient Medical Record (OMR) (Light Green)).

(q) DA Form 8005-2 (Outpatient Medical Record (OMR) (Yellow)).

(r) DA Form 8005-3 (Outpatient Medical Record (OMR) (Grey)).

(s) DA Form 8005-4 (Outpatient Medical Record (OMR) (Tan)).

(t) DA Form 8005-5 (Outpatient Medical Record (OMR) (Light Blue)).

(u) DA Form 8005-6 (Outpatient Medical Record (OMR) (White)).

(v) DA Form 8005-7 (Outpatient Medical Record (OMR) (Brown)).

(w) DA Form 8005-8 (Outpatient Medical Record (OMR) (Pink)).

(x) DA Form 8005-9 (Outpatient Medical Record (OMR) (Red)).

(2) The Chief, Patient Administration Division has priority to receive distribution of all folders in the DA Form 3444-series and DA Form 8005-series. Because these folders were designed primarily for primary care records, it is essential that the Chief, Patient Administration Division has priority during periods of supply shortages.

b. The DA Form 3444-series and DA Form 8005-series folders are designed to allow alphabetical or terminal digit filing of any folder. Because of this design, records can be transferred from an MTF using alphabetical filing to one using terminal digit filing without changing the folder. For alphabetical filing, the patient's name is entered along the upper left edge of the folder; for terminal digit filing the numerical blocks along the upper right edge are used. When first prepared, only one identification section of the folder should be completed, whichever is needed for the filing system used by the MTF. If a patient is transferred to an MTF using the other filing system, the other identification section is completed without changing the folder.

c. Whether medical records are filed in new folders or old folders, they will be transferred and retired in the folders holding them at the time, except for CEMRs, which must be transferred to SF 66D (Employee Medical Folder). (See chap 7.)

4–4. Preparation of DA Form 3444-series and DA Form 8005-series folders

a. The DA Form 3444-series or DA Form 8005-series are 10 different-colored folders. They are prepared as described in (1) through (10) below.

(1) Select the correctly colored folder as shown in table 4-2. The color of the folder represents the last two digits (the primary group) of the patient's SSN.

(2) Put an identification label in the "Patient Identification" block. (See b(1) below for instructions on preparing these labels.)

(3) Code the last digit of the patient's SSN on the folder by putting 1/2 inch of black tape over the number on the right edge that is the same as the last digit. The tape should be long enough to wrap around the edge of the folder and cover the number on the back also; a 1-inch length should be sufficient. (Instead of tape, the numbers of the front and back may be blocked out with black ink.) Then enter the last digit in the far right block on the upper edge of the folder. For the HREC, this coding will be done when the MTF uses the terminal data filing system.

(4) Enter the two digits of the secondary group in the two empty blocks in the upper right corner to the left of the primary group numbers. To make sure the numbers can be seen, enter them with a fiber-tipped pen or other marking device; do not use pencil or regular pen. The other numbers of the SSN and the FMP may also be entered on the folder. The other numbers of the SSN are put in the hyphenated blocks along the top of the folder; the FMP is put in the circles to the left of these blocks. (The rest of the SSN and the FMP may be entered if the local MTF wants these data or if they are not mechanically imprinted.) For those facilities using bar codes from an automated record system, place the bar code on the upper right corner of the folder.

(5) On ITRs and OTRs, show the retirement date by putting 1/2 inch of colored tape over the block marked "R" on the back also. If the retirement date changes (for example, a patient treated in 1994 is treated again in 1995), this block will be recoded. The colors of tape to be used are shown in table 4-3. HRECs are never retired using these procedures. For disposition of HRECs, see paragraph 5-27. On HRECs, the "R" block may be used at local discretion (for example, coded for semiannual inventory). (See b(2) and c(2) below for instructions on the retirement of ITRs and OTRs.)

(6) Show the status of the patient by putting 1/2 inch of colored tape over the block marked "S" on the right edge of the folder. Wrap the tape around the edge to cover the "S" on the back also. The colors of tape to be used are shown in table 4-4.

(7) Under "Type of Record," check the proper box to show how the folder will be used.

(8) When needed, check the proper "Note to Physician" block.

(9) Ensure that the patient completes the preprinted DD Form 2005 (Privacy Act Statement—Health Care Records) on the inside of the folder. If the patient's DD Form 2005 is already completed, he or she does not need to complete a new one. In cases where the individual refuses or is unable to sign the DD Form 2005, a notation to that effect will be entered on the form. It will be dated and signed by the individual attempting to obtain the signature.

(10) For special category patients, the empty block on the lower right edge of the front cover should be taped. (See AR 340-21, para 2-5 and para 2-3a(2) of this regulation.) The color of tape used will be determined locally.

b. Special instructions for ITRs are as follows:

(1) When mechanical imprinting is available, prepare the identification label using the patient's recording card (para 3-5a). When it is not available, prepare the label to show the data given in lines 1 and 3 of the patient's recording card; these data must be shown in the format prescribed for the card. Then put the label in the "Patient Identification" block. (Instead of this label, the patient's admitting plate (AR 40-400, table 2-2) may be used to stamp the folder.)

(2) To determine the retirement date, see AR 25-400-2, file numbers 40-66e (foreign national ITRs), 40-66f (military ITRs), 40-66g (civilian ITRs), and 40-66i (North Atlantic Treaty Organization (NATO) personnel ITRs). (See table 3-1.)

c. Special instructions for OTRs are as follows:

(1) Prepare and attach an identification label as described in b(1) above or affix the bar coded label from CHCS. Instead of this label, the data given in lines 1 and 3 of the patient's recording card may be printed legibly on an OTR folder.

(2) The retirement date for OTRs will be 3 years after the end of

the year in which last medical treatment was given. For example, if a record is initiated in 1992, it is color-coded for tentative retirement in January 1996 by placing a strip of blue tape over the block printed "R." If the record is used during 1995, the blue tape is covered with silver or white tape to show a new tentative retirement date of January 1999. Dental records (nonmilitary) are retired 2 years after the end of the year in which the last treatment was given; therefore, dental records begun in 1993 are color-coded blue for tentative retirement in January 1996.

(3) A nominal card index will be kept for OTRs filed by the terminal digit filing system. A nominal card index will not be maintained on HRECs when the facility receives and uses the active duty alpha roster. This index, consisting of 3- by 5-inch cards, will be used as a cross-reference between the patient's name and SSN. Only cards pertaining to treatment records on file will be held. AMEDD treatment facilities using the Medical and Dental Record Tracking System (MDRTS) may employ it in lieu of the manual system to maintain their outpatient nominal index file; however, a manual system must be in place to update MDRTS when that system is down.

d. To color code the DA Form 3444-series folder as a dental folder, place a piece of colored tape on the upper right margin of the rear flap just above the "O" block to indicate each dental fitness classification. The colors used for each class are blue for Class 1, white for Class 2, red for Class 3, and green for Class 4.

e. When the size of an individual medical record requires the creation of another DA Form 3444-series or DA Form 8005-series folder, the record jackets will be labeled "Vol 1 of 2, Vol 2 of 2," and so forth. To ensure that multiple record jackets are kept together at all times, each treatment facility will guarantee that when one volume is removed from the file, all other volumes are removed as well.

4–5. Preparation of DA Form 3443-series folders

The DA Form 3443-series are used to file all radiology images and reports unless the images and report are digitized and the information is stored as part of the hospital information system. The old DA forms, dated 1 March 1973, are prepared the same way as DA Form 3444-series folders. (See para 4-4.) The revised DA Form 3443-series consists of one master folder, one report folder, one subfolder, and one loan folder. These folders will begin to be used as existing supplies of old folders are exhausted; do not destroy any unused folders. In instances when old DA Form 3443-series are unevenly used, remaining folders will be used by substituting new folders only for the ones that are exhausted. (For example, if DA Forms 3443-1 through 3443-5 are exhausted and if DA Forms 3443-6 through 3443-9 are still on hand, only DA Forms 3443-1 through 3443-5 will be replaced by the new form until the entire series is depleted.) Existing patient folders will be converted to the revised series only as each patient returns for followup radiologic care. Duplication of master folders is not authorized except as needed to contain large volumes of images.

a. Preparation of the revised DA Form 3443-series folders.

(1) *Master folder patient identification.* Make bold entries with a felt-tip marker in the appropriate spaces.

(a) FMP. Enter the FMP in the circles, one digit per circle.

(b) Sponsor's SSN. Enter the entire SSN of the sponsor.

(c) Last name. Print the patient's last name.

(d) Name and middle initial. Print the patient's first name and middle initial.

(e) Date of birth. Use letters for the month, for example, 17 Jun 95.

(2) *Master folder terminal digit color-code identification.*

(a) Sponsor's SSN. The four adjoining box spaces at the right margin of the master folder are for color taping the last four digits of the SSN. The SSN code will be read from top to bottom in these spaces. Self-adhesive, numbered, and colored tape 1 7/8- by 1 7/8-inch will be used. Facilities maintaining 25,000 or fewer files will identify only the last two SSN digits by taping the lower two SSN boxes. Facilities maintaining more than 25,000 files will identify the last four SSN digits by taping all four SSN boxes. The colors used are shown in table 4-5.

(b) Master folder year code box. The terminal digit of the most recent examination will be identified by taping the lowest box on the right margin of the master folder according to the color scheme described in (a) above. Examples: 1990 would be "5" (blue); 1995 would be "0" (orange). Films would begin to be retired by the year code in 1990. Retirement of records will be according to the scheme shown in table 4-6. Old DA Form 3443-series continues per paragraph 4-4.

(3) *Subfolder identification.*

(a) FMP, SSN, last name, first name, and middle initial will be printed in the spaces provided.

(b) The subfolder code will be taped in the box provided in the center of the upper edge. The examination type (chest, bone, gastrointestinal, intravenous pyelogram, and so on) can be stamped on the face of the folder if desired by the local facility.

(c) Examinations will be entered as they are performed by date and type in the boxes provided.

(4) *Identification of subfolders contained in master folder.* All subfolders will be identified by code numbers in the boxes provided in the upper left of the master folders. Because a report folder will be in all master folders, it will not be identified on the face of the master folder.

(5) *Report folder identification.*

(a) FMP, SSN, last name, first name, and middle initial will be printed in the spaces provided.

(b) Report folder codes will be taped in the box provided in the center of the upper edge of the form only if small images are filed in this folder type.

(6) *Loan folder preparation.* The required information will be recorded in the boxes provided on the face of the folders.

b. Use of the revised series folder.

(1) *Master folder.* The master folder will not leave the radiology file until the entire record is retired. It will contain all radiology images and reports, as well as chargeout information for images that have been removed. All facilities will file these folders in terminal digit order. (See para 4-2b.)

(a) Chargeout. All chargeouts or transfers of film will be recorded on the master folder. Copies of the transmittal slips will be kept in the report folder until the film is returned.

(b) Alternate filing. When files are maintained in separate services (nuclear medicine, computerized tomography, or ultrasound) or when images are filed separately for teaching purposes, this alternate filing will be noted on the master folder.

(c) Final-type physical. Reports and film will be filed in a master folder without subfolders. The master folder will be marked with a black 1/2-inch tape below the year tape on the right edge.

(2) *Subfolder.*

(a) Subfolders will not be used in facilities without radiologists except where contrast examinations (intravenous pyelograms, barium enemas, and so forth) are performed.

(b) Subfolders will not be used if the average number of noncontrast examinations is fewer than 10 or the examination variety is less than 5.

(c) Angiography examinations will not be transferred or leave the radiology department. Specific written request for the angiographic examinations must be received, and only selected films will be copied and forwarded. Local arrangements will be made for patient care.

(3) *Report folder.* All master folders will contain a report folder. Report folders and their contents will not leave the radiology department.

(4) *Loan folders.* Any images leaving the radiology department will be sent in a loan folder. This folder or a plastic film caddy may be used within the radiology department. Loan folders with subfolders and the images they contain will be returned to the radiology file room the same day they are removed.

(5) *Automated systems.* Labels generated by automated systems may replace handwritten information. All information required by a(1), (3), and (5) above will be provided by such systems, whether

automated, handwritten, or a combination of the two. Tracking labels will be affixed to the appropriate box on the face of the insert and loan folders.

4–6. Record chargeout system

a. The current physical location or destination of each record must be known. A chargeout folder will be put in the file when a record is removed for use. The type of folder used may be determined locally; however, DA Form 3444-series or DA Form 8005-series may not be used.

(1) OF 23 (Charge-Out Record) or another chargeout record will be put in the folder; this record will show where the medical record is located. If a charged-out record is later moved to another location, a "change-of-charge" must be submitted to the record custodian.

(2) Any laboratory reports, x rays, or other reports that arrive while a record is charged out will be put in the folder until the record is returned.

(3) Records will be charged out no longer than necessary. Records sent to in-house clinics will be returned the same day as the clinic visit. However, if the record is transferred to another clinic for a consultation the following day, a change-of-charge will be sent to the record custodian instead of the record.

b. An automated record charge-out (CHCS) may be used to update a record tracking system (CHCS) using bar codes.

c. For health and outpatient records withdrawn from the files and transferred to another MTF, see paragraphs 5-25 and 6-4.

4–7. Record requests

The appropriate form must be used for requesting medical records. DD Form 877 (Request for Medical/Dental Records or Information) will be used for requesting medical records from treatment facilities and from the VA. DD Form 877-1 (Request for Medical Records from the National Personnel Records Center (NPRC), St. Louis, MO) will be used to request medical records which have been archived. These forms will be typewritten; they are designed for use with a window envelope. Procedures for handling the requests are given in *a* through *c* below.

a. The requesting MTF or DTF must—

(1) Complete the appropriate form as follows.

(a) DD Form 877. Complete items 1 through 10 (except 8b) and item 19. Check the appropriate boxes in item 8a to indicate whether military records, VA records, or both are needed.

(b) DD Form 877-1. Complete items 1 through 11 and item 14. Refer to the instructions on the back of the form for additional information. Incomplete forms will be returned.

(2) Send the original and duplicate copy of the form to the custodian of the records.

(a) Requests for records of commissioned and warrant officers on active duty will be addressed to Commander, PERSCOM, ATTN: TAPC-POR-R, 200 Stovall Street, Alexandria, VA 22332-0400.

(b) Requests for records of enlisted personnel on active duty will be addressed to Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE-RP, 8899 56th Street, Indianapolis, IN 46249-5301.

(c) Requests for records of USAR personnel not in the Active Army will be addressed to Commander, ARPERCEN, ATTN: ARPC-PRD-T, 9700 Page Avenue, St. Louis, MO 63132-5200.

(d) Requests for records of ARNGUS personnel not on active duty will be sent to the State adjutant general concerned.

(e) Requests for medical records from the VA will be sent to the VA Service Record Center, P.O. Box 15095, St. Louis, MO 63115-8950.

(3) Keep the triplicate copy.

b. The custodian of the records will treat requests as described in (1) through (3) below.

(1) If the requested records are available, the custodian will complete the response portion of the request form to transmit the records.

(a) For DD Form 877, complete items 8b and 11 through 14; check the appropriate boxes in item 8b to indicate whether military records, VA records, or both are sent. For DD Form 877-1, complete items 12 and 13, as appropriate.

(b) Send the original copy of the DD Form 877 or the DD Form 877-1 and the requested records to the addressee shown in the "Return To" block at the bottom of the form.

(c) File the duplicate copy of the DD Form 877 or the DD Form 877-1 where the records were to show that they were taken from the file. If records are taken from several files, place a charge card in each additional file. On this card will be the following statement: "(Type of records) pertaining to (name, SSN, or service number) were forwarded to (address) on (date) in compliance with (DD Form 877 or DD Form 877-1) received from (address). These records covered treatment during (inclusive dates)." When the records return, destroy the duplicate copy of the DD Form 877 or the DD Form 877-1 and remove the charge cards from the files.

(2) If the requested records are not on hand but their location is known (for example, if they are in the Adjutant General's office or another MTF), the custodian will send both copies of DD Form 877 to the office holding the records, first completing items 11 through 14. The custodian will inform the requesting activity of this referral. The office that has the records will answer the request using items 16 through 18. However, if the office has loaned the records to another office, they will send the request on to that office, first completing items 15 through 18.

(3) If the requested records are not on hand and their location is unknown, the custodian will complete items 11 through 14 on the DD Form 877, or items 12 and 13 on the DD Form 877-1, and return both copies of the form to the requesting activity.

c. After using the records, the requesting MTF or DTF will dispose of them as follows:

(1) If they were borrowed from an Army MTF or DTF or records center (other than the NPRC, St. Louis, MO), and the requesting MTF or DTF did not make additional records on the patient, they will be returned promptly, first completing items 15 through 18 of DD Form 877. If these items have been used, the records will be returned with a letter; the original copy of the DD Form 877 will be sent as an enclosure. Records will be returned to the NPRC, St. Louis, MO by attaching the original of the DD Form 877-1 to each related record.

(2) If the MTF or DTF made additional records on the patient, the borrowed records will be retained at that MTF or DTF along with the newly created records. The original DD Form 877 or DD Form 877-1 will be destroyed.

Table 4–1
Assignment of family member prefix

Rule	FMP	Rule
1	01	If the patient is—Sponsor's oldest child[1]
2	02	If the patient is—Sponsor's next oldest child
3	03	If the patient is—Sponsor's third oldest child
4	04, 05, and so on assigned through 19	If the patient is—Sponsor's fourth oldest child, fifth, and so on
5	20	If the patient is—The sponsor[2]
6	30 to 39	If the patient is—Sponsor's spouse or former spouse[3]
7	40	If the patient is—Sponsor's mother or stepmother
8	45	If the patient is—Sponsor's father or stepfather

Table 4–1
Assignment of family member prefix—Continued

Rule	FMP	Rule
9	50	If the patient is—Sponsor's mother-in-law
10	55	If the patient is—Sponsor's father-in-law
11	60, 61, 62, and so on through 69	If the patient is—Another relative[4]
12	90-95	If the patient is—A beneficiary assigned by statute[5]
13	98	If the patient is—A civilian brought to the MTF in an emergency
14	99	If the patient is—All others not elsewhere classified[6]

Notes:

[1] The sponsor's children include those adopted, legitimate, illegitimate, and stepchildren. Children are given an FMP in the order that they become eligible for medical care; that is, the order in which they become the sponsor's family members. If a sponsor remarries and adopts children older than his or her own, the FMP previously given to his or her natural children should not be changed. Following the FMP of natural children, adopted children are given FMPs by their ages. For example, a sponsor has two children and adopts three. The oldest natural child is 01 and the second oldest 02. The oldest adopted child then becomes 03, the next oldest adopted child 04, and the youngest adopted child 05.

[2] The prime beneficiary—a person who derives his or her eligibility based on individual status rather than dependency on another person.

[3] When a sponsor remarries, the new spouse takes the next higher number in the 30 series; that is, the first spouse is 30 and the second spouse is 31. Former female military members eligible to deliver in an MTF should be coded 20, and the child should be coded from the 90-95 category. Multiple births in this category would be assigned 90 for the first, 91 for the second, and so on. Women who qualify for care under the former spouse provisions and who enter the hospital for delivery are coded in the 30 series, and children are coded as beneficiary authorized by statute (90-95).

[4] Preadoptive children are eligible for medical care. (All family members eligible for medical care are listed in AR 40-3.)

[5] Children of unwed daughters of sponsors are assigned a number in the 90-95 category, unless the daughter's sponsor has adopted the child. If the child has been adopted by the sponsor, the FMP should be the next available number in the 01-19 category. Family members of former spouses are coded in the 90-95 series.

[6] For stillborn children who are CRO cases, use FMP 99.

Table 4–2
Key to color folder assignment by terminal digits

Primary group	Color	DA Form
00-09	Orange	3444 or 8005
10-19	Light green	3444-1 or 8005-1
20-29	Yellow	3444-2 or 8005-2
30-39	Grey	3444-3 or 8005-3
40-49	Tan	3444-4 or 8005-4
50-59	Light blue	3444-5 or 8005-5
60-69	White	3444-6 or 8005-6
70-79	Brown	3444-7 or 8005-7
80-89	Pink	3444-8 or 8005-8
90-99	Red	3444-9 or 8005-9

Table 4–3
Key to tape colors for year in which records are to be retired

Year records to be retired	Color
1995	Red

Table 4–3
Key to tape colors for year in which records are to be retired—Continued

Year records to be retired	Color
1996	Blue
1997	Green
1998	Yellow
1999	Silver or white
2000	Black
2001	Orange
2002	Red
2003	Blue
2004	Green
2005	Yellow
2006	Silver or white
2007	Black
2008	Orange
2009	Red
2010	Blue

Table 4–4
Key for tape denoting patient status

File number[1]	General group	Color
40-66a (HRECs), 40-66b (dental HRECs)	Active Army HREC (and dental) and RC personnel on active duty or active duty training for 30 days or more	Red
40-66f (military)	Military records (ITR)	Red
40-66j (military outpatient records), 40-66ii (military dental files)	Military other than active duty and RC personnel on active duty or active duty training for 29 days or less	Green
40-66m (foreign national outpatient records), 40-66e (foreign national ITRs), 40-66i (NATO personnel ITRs), 40-66q (NATO personnel outpatient records), 40-66kk (foreign national dental files)	Foreign nationals and North Atlantic Treaty Organization personnel	Silver or white
40-66g (civilian ITRs), 40-66mm (American Red Cross dental files), 40-66k (civilian outpatient records), 40-66jj (civilian dental files)	All others	Black

Notes:

[1] Records described in AR 25-400-2. Also see table 3-1 of this regulation.

Table 4–5
Last four digits—sponsor's social security number

0 = orange
1 = green
2 = yellow
3 = gray
4 = black
5 = blue
6 = white
7 = brown
8 = pink
9 = red

Table 4–6
Retirement of radiology images and reports, DA Form 3443-series

Year	Color
1995	Orange
1996	Green (1)
1997	Yellow (2)
1998	Gray (3)
1999	Black (4)
2000	Blue (5)
2001	White (6)
2002	Brown (7)
2003	Pink (8)
2004	Red (9)
2005	Orange
2006	Green (1)
2007	Yellow (2)
2008	Gray (3)
2009	Black (4)
2010	Blue (5) (repeat 10-year cycle)

Chapter 5
Health Records

Section I
General

5–1. Purpose of the health record

a. The HREC includes both the treatment record and the dental record. It is a permanent and continuous file that is initiated when a member enters the service. The HRECs are kept in separate folders and are prepared as the member receives medical and dental care or takes part in research.

b. The primary purpose of the HREC is to provide a complete, concise medical and dental history of everyone in the Active Army or in the RC. The HREC is used for patient care, medicolegal support, and research and education. The HREC helps medical officers advise commanders on retaining and using their personnel. It helps physical evaluation boards (PEBs) appraise the physical fitness of Army members and eligibility for benefits. In the case of USAR and ARNGUS, it assists in the mobilization process. The HREC also serves other purposes. For example, it simplifies the adjudication of claims and is an important source of medical research information. The dental portion (panogram) can be used to assist in identifying deceased persons.

5–2. Use of the health record

a. General. Throughout the person's military career, each contact with the AMEDD as a patient is recorded in the HREC. These contacts include periods of treatment as an inpatient and are described on copies of DA Form 3647 (or CHCS automated equivalent) and SF 502 (Clinical Record—Narrative Summary), possibly SF 515 (Medical Record—Tissue Examination) and SF 516 (Medical Record—Operation Report), or any other inpatient documents that the physician or dentist deems necessary for proper outpatient followup care. Duration and treatment quarters referrals, outpatient medical care, and dental care are all recorded. Medical care at military MTFs or DTFs that do not keep the HREC is recorded and sent to the HREC custodian.

b. Use in outpatient medical care.

(1) Each time the person seeks care or is treated, the HREC or dental record will be removed from the file and used by the healthcare provider. The findings and treatment will be recorded on the proper forms.

(2) When an MTF or DTF refers a patient elsewhere for outpatient care, the HREC may be sent also. The referring or the consulting practitioner makes this decision. If it is sent, the consulting practitioner will comment in the record on his or her findings and treatment. If it is not sent, the consulting practitioner will enter his or her findings on SF 513 (Medical Record—Consultation Sheet) or any other medical forms (including SF 600) that he or she deems proper. These consultation (SF 513) and treatment records will be filed in the HREC. Also see paragraph 9-12d.

(3) See paragraph 1-4e(3) for information on when a person reports for outpatient treatment to an MTF or DTF that does not keep his or her HREC.

c. Use in inpatient medical care.

(1) Normally, the HREC will be sent to the MTF when a person is admitted for treatment. (See paras 5-31 through 5-33 for information on patients from combat areas.) When an MTF receives an HREC, or a part of it, the patient administrator becomes the custodian and will ensure that it is accessible to AMEDD personnel. When received, the HREC will be sent to the patient's ward. It will be kept there during the patient's stay for use by the attending physician or dentist and other medical personnel involved in the case. The patient administrator will ensure that a copy of each of the forms required for the HREC prepared by the MTF are put in the HREC (para 5-3) and that the entries needed for inpatients on SF 600 are made. (See para 5-16.)

(2) When inpatient dental care is given, MTF dental personnel will try to obtain the patient's dental record. If it is not accessible, a temporary dental record will be prepared as described in paragraph 5-25b; the record will be sent to the proper custodian when the patient is released from the MTF. Any other necessary inpatient records will also be completed. Prolonged treatment for a dental condition (for example, fracture) will not be recorded in detail in the dental record; in most cases a brief summary of the diagnosis, general treatment, and results is sufficient. However, any extractions, restorations, or other oral or dental treatment rendered must be entered on SF 603 (Health Record—Dental) of the permanent or temporary dental record.

(3) When a patient is released from the MTF, the patient administrator will forward the HREC as described in (a) through (h) below.

(a) Attached patients RTD. Send the HREC to the record custodian of the MTF or DTF that provides the person with primary outpatient or dental care. If the MTF is not known, send the HREC to the MEDDAC or DENTAC or MEDCEN commander of the person's assigned installation.

(b) Assigned patients RTD. Send the HREC to the military personnel officer of the person's assigned unit. If the person is locally reassigned, send the HREC to the custodian as in (a) above.

(c) Patients transferred to another MTF. Send the HREC with a copy of the inpatient record to the other MTF.

(d) Deceased patients. Send the HREC to the officer holding the patient's personnel records.

(e) Patients transferred to VA Medical Centers. Send the HREC to the correct center. Also send a copy of the patient's inpatient records unless they have been sent to the PEB for examination (AR 635-40).

(f) Other patients separated from service. Send the HREC to the military personnel officer handling the separation at the transition point. He or she will dispose of them as stated in paragraph 5-27.

(g) Patients AWOL longer than 10 days. Send the HREC to the officer holding the person's Military Personnel Records Jacket, U.S. Army (MPRJ).

(h) RC patients in the Active Army or on Active Guard Reserve duty. Send the HREC to the unit health record custodian.

5–3. For whom prepared and maintained

HRECs will be prepared and maintained for all Army members. This includes Active Army and RC members, and cadets of the U.S. Military Academy. ARNGUS and USAR HRECs will be prepared and maintained by the custodian of personnel records. (These HRECs will be prepared per para 4-1 but will be filed in alphabetical sequence.) When transferred to Army custody, HRECs for members of the Navy and Air Force will also be maintained. HRECs for military prisoners will be kept as long as they are confined in U.S. military facilities.

5–4. Forms and documents of health records

a. The medical and dental forms authorized for use in the HREC are listed in figures 5-1, 5-2, and 5-3. To facilitate access to information in these folders, the forms will be filed from top to bottom in the order listed in the figures. Forms will be filed in reverse chronological order, that is, the latest on top. (For authorization of forms and overprinting, see paras 3-1 through 3-3.) The forms listed in figures 5-1 through 5-3 are available through normal publications supply channels.

b. The folders of USAR and ARNGUS members on active duty for training will be marked "ADT" on the front. The forms inside the folder will be given the same marking in the lower margin. Folders of Active Guard Reserve members will be maintained in the same manner as those in the Active Army.

5–5. DA Form 5007A-R and DA Form 5007B-R

DA Form 5007A-R (Medical Record—Allergy Immunotherapy Record—Single Extract) and DA Form 5007B-R (Medical Record—Allergy Immunotherapy Record—Double Extract) will be used to document hyposensitization injections as prescribed on SF 559 (Medical Record—Allergen Extract Prescription, New and Refill). DA Form 5007A-R is intended for patients on single injection immunotherapy, while DA Form 5007B-R is intended for patients on two separate immunotherapy prescriptions. (DA Form 5007A-R and DA Form 5007B-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy of these forms are located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site.)

5–6. DA Form 5008

DA Form 5008 (Telephone Medical Advice/Consultation Record) will be used to record medical advice or consultation given to a patient over the telephone. Self-explanatory instructions for completion are on the back of DA Form 5008. This form is attached to SF 600 when filed.

5–7. DA Form 5181-R

DA Form 5181-R (Screening Note of Acute Medical Care) will be used in conjunction with the Enlisted Screener Program in battalion aid stations and troop medical clinics. (DA Form 5181-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy of this form is located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site.)

5–8. DA Form 5569-R

DA Form 5569-R (Isoniazid (INH) Clinic Flow Sheet) will be used to document Isoniazid (INH) clinic visits. (DA Form 5569-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy of this form is located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site.)

5–9. DA Form 5570

DA Form 5570 (Health Questionnaire for Dental Treatment) will be used in the dental record as the medical history questionnaire. This questionnaire is printed on an envelope used to contain dental radiographs.

5–10. DA Form 5571

DA Form 5571 will be filed in each HREC, OTR, and CEMR to provide a summary of significant past surgical procedures, past and current diagnoses or problems, and currently or recently used medications. (Also see para 5-24b(2)(b).)

5–11. DD Form 1380

DD Form 1380 will be used as described in chapter 10 and paragraph 5-31 (as an HREC document under combat conditions). Instructions for the use and preparation of DD Form 1380 are provided in chapter 10.

5–12. DD Form 2482

DD Form 2482 (Venom Extract Prescription) will be used to order a venom extract prescription. One venom prescription (new or refill) will be ordered on each DD Form 2482. DD Form 2482 is not designed for multiple prescription orders.

5–13. SF 512

SF 512 (Clinical Record—Plotting Chart) will be filed in HRECs, OTRs, CEMRs, and ITRs to record cholinesterase levels and any single item deemed clinically significant. SF 512 will be filed immediately above SF 545.

5–14. SF 558

a. SF 558 (Medical Record—Emergency Care and Treatment) will be used instead of SF 600 to record all care provided to patients in the emergency center/emergency department (EC/ED). Self-explanatory instructions for completion are on the back of SF 558.

b. When the patient is admitted as an inpatient through the EC/ED, SF 558 will be the admission note filed in the patient's ITR. Whenever possible, a notation should be made on SF 600: "Patient admitted to (name of MTF), (date)." A copy of any State ambulance forms will be filed with the SF 558 in the ITR.

5–15. SF 559

SF 559 will be used when an allergen extract prescription is ordered. One treatment set or refill prescription will be ordered on each form. SF 559 is not designed for multiple prescription orders.

a. Use the patient's recording card to complete the patient's identification block in the lower left corner of SF 559 (para 3-5a). In all cases, give the patient's full name, sponsor's SSN, and appropriate FMP (table 4-1). Provide the patient's name, address, and phone number in the space provided on SF 559.

b. The address of the medical facility to which the prescription is to be sent must be given because it may differ from that of the prescribing MTF.

c. The front of SF 559 may be overprinted with the allergenic extracts most commonly prescribed for hyposensitization treatment (immunotherapy) in the geographic region. MTFs may overprint this information without submitting it to Office of The Surgeon General for approval. From top to bottom, left to right, overprint in the following order: trees, grasses, weeds, molds, environmentals, insects, and miscellaneous. List complete antigenic components, and state the volume in milliliters (mL) of those components in the final mixture. The volume must add up to a final volume of 10 mL including diluent. State the volume of diluent in mL in the space provided. The volume of refill vials will also be 10 mL. State the concentration of the allergenic components in protein nitrogen units/mL, weight/volume, or allergy units/mL. On the second line of the front page, state the strength of the described most concentrated vial. For example, 20,000 protein nitrogen units/mL, 1:100 weight/

volume, or 10,000 allergy units/mL. Immediately below the allergen contents section, annotate the vial numbers of the most dilute and most concentrated vials.

d. Complete the section on the lower front page for refill requests only. In addition, all subsequent portions of SF 559 must be completed as they would on the initial treatment set, including the recommended treatment instructions and responsible physician's signature.

e. Start the treatment instructions with the lowest numbered vial, listing one vial on each line. Give the strength of each vial from the line corresponding with that schedule.

f. In general, schedule A provides for the most rapid dosage progression, with each schedule through E being progressively more gradual.

g. SF 559 must be signed by the ordering physician. A signature card must be on file for the prescribing physician at the U.S. Army Centralized Allergen Extract Laboratory, Walter Reed Army Medical Center, Building 1, Washington, DC 20307.

5–16. SF 600

SF 600 will be used only in the HRECs, OTRs, CEMRs, and ADAPCP-OMRs. It is the chronological record of outpatient treatment and thus is the basic form of the HREC. The MTF initiating an SF 600 will complete the identification data at the bottom of the form. Entries on the form may be typed but will usually be written in ink; if written, entries must be legible. Each entry will show the date and time of visit and the MTF involved; these entries will be made by rubber stamp when possible. (As long as the patient is treated by the same MTF, the name of that MTF need not be repeated in every dated entry.) Each entry on the form will also be signed by the person making it (para 3-4c). (See fig 5-5 for examples of entries on SF 600.)

a. SF 600. One copy of SF 600 will be put in the HREC. The parts of the form to be completed are shown in (1) through (8) below. These entries will be either typed or printed. If printed, permanent black or blue-black ink will be used.

(1) Person's name.

(2) Sex.

(3) Year of birth.

(4) Component. (Do not include branch.)

(5) Department.

(6) Rank.

(7) Organization.

(8) SSN.

b. Entries for outpatient care.

(1) Entries must be concise but complete, that is, medically and adjudicatively adequate. Entries will—

(a) Describe the nature and history of the patient's chief complaint or condition.

(b) Record positive and pertinent examination or test results.

(c) Record diagnoses and impressions (if made).

(d) Record treatment, disposition, and any instructions given to the patient for later or followup care; record all prescribed drugs. These entries may be recorded in a "subjective, objective, assessment, plan" format.

(2) Record each visit and describe the complaint even if the patient is RTD without treatment. If a patient leaves before being seen, this fact will also be stated.

(3) When admission as an inpatient is imminent, the entries discussed in (1) above may be made on SF 509 instead of SF 600. SF 509 will be the inpatient admission note filed in the patient's inpatient record. For EC/ED admissions, see paragraph 5-14b. Record other referred or deferred inpatient admissions on SF 600.

(4) Record all requests for consultation, prescriptions, or other services on SF 600.

(5) For patients seen repeatedly for special procedures or therapy (for example, physical and occupational therapy, renal dialysis, or radiation), note the therapy on SF 600, and record interim progress statements. In addition, give a final summary when the special procedures or therapy are ended. This summary will include data shown in (a) through (h) below. Initial notes, interim progress notes, and any summaries may be recorded on any authorized form, but must be referenced on SF 600.

(a) Results of evaluative procedures.

(b) Treatment given.

(c) Number of visits.

(d) Reaction to treatment.

(e) Progress noted.

(f) Condition on discharge.

(g) Instructions to patient.

(h) Any other pertinent observations.

(6) If an injury is treated, the cause and circumstances ("how-when-where-leave status") will be entered.

(7) For persons taking part in research projects as test subjects, entries will include—

(a) Drugs given or appropriate identifying code.

(b) Investigative procedures performed.

(c) Significant observations, including effects.

(d) Physical and mental state of the subject.

(e) Tests and laboratory procedures performed.

(8) Outpatient care received at civilian facilities will also be recorded on SF 600. If available, copies of records of such care will be put in the HREC. Any forms completed at civilian facilities will be filed with SF 600. Personnel who prepare payment vouchers for civilian care (AR 40-3) will acquire a summary of diagnosis and treatment when processing the vouchers. They will send this information to the person's HREC custodian.

c. Entries for periods of medical excuse from duty. Except in combat, each admission to an MTF or referral to quarters will be recorded on SF 600.

(1) In addition to the information described in *a* above, entries for MTF admissions will include—

(a) Time and date of admission.

(b) Name and location of the MTF.

(c) Cause of admission.

(2) In the case of referral to quarters, detailed comments will include—

(a) Care given.

(b) Estimated duration.

(c) Extensions of quarters status.

(d) Instructions to patient.

(e) When the patient will be RTD.

(f) Laboratory, x-ray, consultation, and similar reports.

d. Entries for physical examinations. "Physical Examination" and the date will be entered on SF 600 for each complete physical examination made and recorded on SF 88. Entrance medical examinations will not be entered.

e. Entries for orthopedic footwear. When a person is authorized the issue of orthopedic footwear, the term "orthopedic footwear authorized" will be entered on SF 600, as well as the prescription and date.

f. Entries for board proceedings. When copies of PEB or medical board proceedings are put in the HREC, the insertion of the copies in the record, the date it was done, and the date of the board proceedings will be noted on SF 600.

g. Entries for syphilis treatment. The preparation of SF 602 (Health Record—Syphilis Record) and the date it was done will be noted on SF 600. Later information recorded on the SF 602 will not be noted on SF 600.

h. Entries for drug abuse treatment. When a person has been determined by clinical evaluation to be an alcohol or other drug abuser, entries will be made on the SF 600, which will be filed in the HREC.

i. Entries for a pregnancy diagnosis. After a pregnancy, all forms related to it will be filed in the ITR. When the records are filed, the following information will be entered on SF 600: "Prenatal care records filed in ITR of (patient's name, FMP, and SSN), (location of MTF), (date)." If the pregnancy is not concluded at an MTF, a notation will be made on the prenatal forms and they will be filed in the HREC.

5–17. SF 601 and PHS Form 731

An immunization record on SF 601 (Health Record—Immunization Record) will be prepared and kept for each person who needs an HREC. Public Health Service (PHS) Form 731 (International Certificates of Vaccination) is a personal record of immunizations received; it is normally needed for international travel. Usually, Active Army and USAR members have custody of their PHS Forms 731; they will ensure their safekeeping. PHS Forms 731 for RC personnel are usually issued to the person for custody upon mobilization or when traveling internationally. ARNGUS units may retain PHS Forms 731.

a. SF 601. One copy of SF 601 will be put in the HREC. The identification parts of this form will be completed as described for SF 600 in paragraph 5-16. At reception stations, procedures will be established to ensure that immunization information is entered on the copy of SF 601. For persons allergic to medication, the "Medical Condition" block on the front of the HREC folder will be checked. In addition, DA Label 162 will be placed on the front of the folder according to chapter 13. Instructions for completing the form are self-explanatory.

b. PHS Form 731. A copy of PHS Form 731 will be sent with the HREC for later entries of immunization data. If the military member prefers, the PHS Form 731 may be clipped or fastened to SF 601; it will not be punched like permanent documents in the record. The name and SSN of the person will be typed or written in ink on the front of the form. For officers and warrant officers, the form will be addressed to the Commander, PERSCOM, ATTN: TAPC-POR-R, Alexandria, VA 22332-0002. For enlisted personnel, the form will be addressed to the Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE-RP, 8899 East 56th Street, Indianapolis, IN 46249-5301. The name of the person's unit will be entered below the double line at the bottom of the form; it will not be entered until he or she reaches his or her first training or duty station.

c. Tasks.

(1) The unit commander will ensure that each assigned or attached member receives the immunizations required by AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E. The commander will periodically check the immunization status of each unit member and consult with the local medical officer to ensure that immunizations are given when due.

(2) The unit personnel officer, acting on behalf of the commander, will notify members that immunizations are needed according to the schedule in AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E.

(3) The medical officer will check the accuracy of the entries on SF 601 and PHS Form 731 as well as administer, record, and properly authenticate required immunizations.

d. Authentication of entries. Per international rules, entries on PHS Form 731 for immunizations against smallpox, yellow fever, and cholera will be authenticated. Each entry must show the DOD Immunization Stamp and the signature of the medical officer or his or her chosen representative (AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E). For other entries on PHS Form 731 and all entries on SF 601, the signature block may be stamped or typewritten and authenticated by initialing.

e. Entries.

(1) Immunizations and sensitivity tests will be recorded on SF 601. Rubella titre results must be recorded on SF 601. Rubella immunizations must be entered on both SF 601 and PHS Form 731.

(2) Remarks and recommendations for any entries on SF 601 may be added at the MTF. The reasons for waiving any immunization will be recorded in enough detail for later medical evaluation. Any attacks of diseases for which immunizing agents were used must be noted; the year and place of attack must also be given. Any untoward reactions to immunizations (including vaccines, sera, or other biologicals) will be recorded.

f. Loss of SF 601 or PHS Form 731. If PHS Form 731 is lost, a duplicate will be made by transcribing SF 601 kept in the HREC. If that SF 601 is lost, a duplicate will be made by transcribing PHS Form 731. If both forms are lost, new forms will be prepared.

g. Disposition on separation from service. When released from active duty or separated from the service, personnel will be encouraged to keep their PHS Form 731 for future use.

5–18. SF 603 and SF 603A

SF 603 is the basic form used in the HREC and dental record to document the oral status, oral health care, and oral or dental treatment provided in a DTF and MTF. SF 603A (Health Record—Dental Continuation) is the related form used as a continuation sheet when space on SF 603 is full.

a. One copy of SF 603 will be inserted in the dental record. The identification parts of this form will be completed as described for SF 600 in paragraph 5-16.

(1) *Personnel entering active service or active duty for training for more than 30 days.* All such personnel will have a panographic radiograph of the teeth and surrounding tissues taken. The radiograph will be taken during inprocessing. If a panographic x-ray capability is unavailable, the radiograph will be taken as soon as possible. This radiograph will be used for identification. In addition, these personnel will be inspected for disqualifying dental defects. (Determination of disqualifying dental defects will be made by a dental officer.) Except as indicated in (d) below, charts 4 and 5 in section I of SF 603 will no longer be used to record any dental defects that are found; chart 16 in section III of SF 603 will be used.

(2) *Personnel reentering military service.* A new SF 603 will be completed for personnel reentering active service.

(3) *Personnel discharged or released from full time duty in the military (active service).* When a military member has received a complete dental examination and all dental services within 90 days before discharge or release, the remarks section of the SF 603 will include the following statement: "The member was given a complete dental examination on (date) and all dental services and treatment indicated by the examination have been completed." (The statement may be stamped, and the date block filled in and initialed.) The officer in charge of the DTF will ensure that the dental records of all personnel being discharged or released from active service are reviewed.

(4) *Personnel entering active duty for training for 30 days or less.* USAR, ARNGUS, and members who enter initial active duty for training for 30 days or less and those who have no active duty training obligation (for example, direct appointment ARNGUS and USAR AMEDD officers) or those individuals without a panographic x-ray (initial entry service was prior to this policy) will have a dental record initiated. The dental records portion of the HREC will contain, at a minimum, an SF 603 with section I (items 1 through 4) and section II (items 6 through 14) completed. This information will be used for identification. This examination should be performed by dental officers of the RC who are not on active duty.

b. All dental treatment given to an individual after initiation of his or her dental record will be recorded in the correct section of SF 603 or SF 603A. Detailed instructions on completing SF 603 and SF 603A are provided in (1) through (5) below and in TB MED 250.

(1) *General information.* The front side of SF 603 is used to initiate a dental record. It contains complete patient identification information and a series of dental charts. The back side of SF 603 is the same as SF 603A. SF 603 and SF 603A are used to record dental treatment and simple treatment plans.

(2) *SF 603, section I.*

(a) Section I is used to record missing teeth, existing restorations, diseases, and abnormalities when a dental record is initiated. Part 5 of section I may be used to chart initial treatment needs.

(b) Part 4 of section I is charted in ink, using the symbols discussed in TB MED 250, when initial dental processing is performed and there is no panographic radiograph capability. A panograph must be added to the record at the earliest possible time. Any abnormalities that cannot be charted using the graphic chart and symbols discussed will be noted in the "Remarks" section.

(c) The entry will be dated, place of examination will be recorded, and the dental officer doing the examination will sign. Because this chart may have to be used for forensic identification purposes, restorations drawn in this section must accurately portray the restoration in the mouth.

(3) *SF 603, section II.*

(a) Permanent entries. The following entries are made by the military personnel officer or by the DTF. Entries will be typewritten or printed in permanent black ink. Sex (item 6); Enter M for male or F for female. Race (item 7); This entry is optional. If it is used, enter Cau for Caucasian, Bl for black, Oth for a member of any other race, and Unk for unknown. Component or Branch (item 10); Enter the applicable code according to TB MED 250. Service, Dept, or Agency (item 11); Enter Army, Navy, Air Force, etc., or whatever Service, department, or agency to which the sponsor belongs. Patient's Name and Date of Birth (items 12 and 13); Self-explanatory. Identification No. (item 14); Enter the SSN of military personnel (active and retired). For family members, enter the FMP followed by the sponsor's SSN.

(b) Temporary entries. The entries in section II will be made in number 1 or 2 pencil by the military personnel officer or by the DTF. The dental record custodian will make changes as they occur. See TB MED 250.

(4) *SF 603 and SF 603A, section III.*

(a) Block 15. This part of the SF 603 and SF 603A is used to record restorations and treatment of defects performed after the initial dental processing. Entries are made in black ink. The remarks block normally requires no entries. It should be annotated, however, if there is a significant item in the medical history and should detail that item.

(b) Block 16. This part of SF 603 and SF 603A is an examination chart. It is used to record those defects which are discovered at the time of initial and subsequent examinations. Entries are made in pencil and individual entries erased as each related treatment is completed and appropriate entries are made in block 15. Remarks block—Indicate in pencil the date of examination. If the patient is dental class 3, indicate the reason for this classification. This space may also be used by the dentist to sequence simple treatment plans.

(c) Entries in block 17—Services Rendered. All entries will be made legibly in black ink. Entries will include every treatment as well as major steps involved in multivisit treatments. Extensive narrative entries may be entered across the entire page when necessary. Date column—Enter the current year on the first line. Subsequent dates on the following lines will include only the day and month of each treatment visit. When the year changes, enter the new year on the next line. Diagnosis-Treatment column—Treatments should be entered in chronological order as performed during the appointment. Whenever possible, a tabular format for treatments performed should be used. This format greatly aids searching for data about a specific tooth, or area, and speeds record audits. See TB MED 250. Dental fitness classification (per AR 40-35) is performed at all examinations in which the dental record is present, to include screening examinations, preparation of replacements for oversea movement examinations, etc., and is recorded in the "Class" column of block 17 of SF 603 and SF 603A. Fitness classifications apply to active duty members only. Indicate the date of examination in pencil in the Remarks portion of block 16. For Class 3 patients, the reason(s) for placing the patient in Class 3 should be indicated in descending order of clinical importance. The dental fitness classification will be placed in the Class column of block 17. For active duty personnel the dental fitness classification will be indicated on the outside of the record jacket by colored tape codes. The appropriate tape code will be placed in the space to the left of the "O" block on the upper edge of the back of the record jacket and above the "O" block on the right edge. The name of the facility will be shown in block 17 for the first entry made at that facility. The operator's name, rank, and corps, occupation or degree will be shown for each treatment. Expanded duty assistants must also show the name of the supervising dentist on the last line of entry. Authentication of entries—The care provider will sign or initial all entries and be responsible for the accuracy and completeness of all entries. Entries transcribed from records received from civilian or foreign military facilities will carry the name and signature (or initials) of the person making the transcription.

(5) *SF 603A.*

(a) SF 603A is used as a continuation sheet for SF 603 and will be added to the dental record when there is not enough space for recording treatment or when accumulated entries in the charts of section III, SF 603, become confusing. Entries are made on SF 603A in the same manner as on SF 603. For convenience, any remaining entries in block 16 on the original SF 603 may be carried over to SF 603A. When a new SF 603A is initiated, the patient's last name, first name, middle initial, and identification number must be placed along the right-hand margin where indicated.

(b) Occasionally a new SF 603A with treatment entries will be added to a record before the previous SF 603 or SF 603A has been filled. In this instance, the empty portion of block 17 on the old form must be rendered unusable so that the proper chronology of the record will be maintained. This task is done by drawing a diagonal line from corner to corner through the unused portion of the two large columns in block 17.

c. For active duty personnel, any record of oral or dental care provided by personnel who did not have access to the permanent HRECs and dental records (for example, during field operations, from civilian or foreign sources, from other DTF or MTF, and so on) will be transferred to SF 603 or SF 603A in the permanent record, and the original document will be filed in the DA Form 3444-series folder. This task will be accomplished as soon as the temporary records are made available and will be performed by the record custodian or dental providers authorized such entries by the custodian.

5–19. Other forms filed in the health record

a. When the following forms are prepared, one legible copy will be filed in the HREC:

(1) DA Form 3647 or CHCS automated equivalent.

(2) SF 502.

(3) If the physician deems necessary for proper outpatient followup care, SF 515, SF 509, SF 516, and other physician-designated forms.

(4) DA Form 199 (Physical Evaluation Board (PEB) Proceedings) (AR 635-40).

(5) DA Form 3947 (Medical Evaluation Board Proceedings) (AR 40-3).

(6) DD Form 2569 (Third Party Collection Program Insurance Information.)

b. Copies of other HREC forms will be filed and prepared as described in (1) through (10) below.

(1) SF 88, SF 93 (Report of Medical History), DA Form 7349-R (Initial Medical Review Annual Medical Certificate), and DD Form 2697 (Report of Medical Assessment). The original of each of these forms will be filed (AR 40-501).

(2) DD Form 771 (Eyewear Prescription). Each time DD Form 771 is prepared, a copy will be filed permanently in the HREC.

(3) DA Form 3349 (Physical Profile). When a person's profile serial is revised per AR 40-501, a copy of DA Form 3349 will be put in the HREC.

(4) DA Form 4465-R (Patient Intake/Screening Record). DA Form 4465-R will be prepared, kept, and used per AR 600-85.

(5) DD Form 1141. DD Form 1141 (Record of Occupational Exposure to Ionizing Radiation) or Automated Dosimetry Records (ADRs) of personnel dosimetry must be kept in the HREC per AR 40-14/DLAR 1000.28. When a person changes station or leaves the service, these records will be moved with his or her HREC. The dosimetry records of personnel whose work exposes them to ionizing radiation may be removed from their HRECs and filed separately when the medical officer or other authority who keeps and uses the records does not have easy access to the HRECs of these personnel. In these cases, the separate file of dosimetry records will be kept as described in AR 40-14/DLAR 1000.28. (See

AR 25-400-2, file number 40-14a, personnel dosimetry files, and table 3-1 of this regulation.)

(a) When dosimetry records are temporarily withdrawn from the HREC, file OF 23 in their place. Under the Identification of Record column of OF 23, enter the numbers of the forms removed. In the Charge To column, enter the name of the medical officer (or other authority) borrowing the records and the name and address of the MTF (or activity) where these records will be kept. Enter the date the record is removed in the Date Charged Out column.

(b) OF 23 will not be removed from the HREC until the dosimetry records have been returned.

(6) DA Form 4186 (Medical Recommendation for Flying Duty). File the most recent DA Form 4186 according to figures 5-1 and 5-2. If the person is granted clearance to fly, file the most recent DA Form 4186 next, if any, that shows a medical restriction from flying. If a waiver has been granted for any cause of medical unfitness for flying, file the most recent DA Form(s) 4186 showing such waiver(s) next. File any additional DA Forms 4186 that the flight surgeon determines to be required as a permanent record next. (Enter "Permanent Record" in Remarks section.) Destroy other DA Forms 4186.

(7) State ambulance forms. By their design and content, State ambulance forms facilitate comprehensive documentation of prehospital treatment and therefore enhance the quality of the hospital medical records in which they are filed. Documentation of prehospital care is required by the JCAHO 1994 standards. If a patient is admitted to an MTF, a copy of this form must be placed in the ITR with the SF 558. MTFs that want to continue using local ambulance forms (DA Form 4700 overprints) may do so. The use of State ambulance forms in the OTR is also encouraged.

(8) DA Form 3180-R (Personnel Screening and Evaluation Record) and DA Form 4515 (Personnel Reliability Program Record Identifier). DA Form 3180-R and DA Form 4515 will be used to identify the medical records of individuals qualified for the Nuclear or Chemical Personnel Reliability Programs per AR 50-5 and AR 50-6. The records manager will insert DA Form 4515 as the top document on the right side of the folder and file DA Form 3180-R according to figures 5-1 and 5-2. See paragraph 5-29.

(9) DD Form 2493-1 and DD Form 2493-2. DD Form 2493-1 (Asbestos Exposure Part I—Initial Medical Questionnaire) and DD Form 2493-2 (Asbestos Exposure Part I—Periodic Medical Questionnaire) are required by AR 40-5. For workers initially entering asbestos surveillance programs, Part I is completed. Part II is filled out by individuals who have completed the initial questionnaire and are continuing in an asbestos surveillance program.

(10) SF 602.

(a) The medical officer who diagnoses syphilis will prepare SF 602 (original only) on the infected person. Examinations and laboratory procedures used to make the diagnosis will be noted on SF 600 when the case is given outpatient treatment; SF 602 will be completed after the diagnosis is made and antiluetic therapy is begun. When SF 602 is prepared, the medical officer will enter all identification data at the bottom of the form. A careful history and physical examination will be made; all pertinent findings will be recorded in sections I and II. A detailed account of all laboratory studies and all treatments will be entered in sections III and IV. In section II, the patient will sign and date his or her statement. Section VII of SF 602 will not be used.

(b) The medical officer treating or observing the case will record each periodic followup in section V of SF 602. The medical officer who treats and follows up syphilis cases will keep suspense files or appointment records needed to ensure that current cases are observed long enough.

(c) The medical officer treating the patient closes the record by signing section VI of SF 602. After closing, SF 602 will be kept as a permanent part of the HREC. The record will be closed if treatment and followup have been completed with satisfactory results, if the patient is separated from active service, if the patient deserts or is otherwise lost to military control, or if the patient dies.

(d) A syphilis record will be reopened for relapse (in which case, the record filed in the HREC will be used for needed information; entries about the case will be continued on SF 602) or reinfection. (If reinfection occurs before the record is closed, the current record will be continued. In addition, the followup will be extended for an additional period of observation. Interim progress notes will be entered on SF 602 and will give all pertinent information and state a new diagnosis. They will also cite the clinical and laboratory data that prove the new diagnosis. If reinfection occurs after the record is closed, a new syphilis record will be prepared.)

(e) If the patient and his or her HREC are transferred before the record is closed, the medical officer of the losing command will put a statement in the HREC that the person needs more followup studies. This statement will be fastened with SF 602 at the top of the inner right side of the HREC. Once noted by the physician providing the followup care, SF 602 will be put in its normal place in the record.

5–20. Military consultation service case files (mental health)

When outpatient mental health treatment is recorded in military consultation service case files, the following notation will be made on SF 600: "Patient seen, refer to file number 40-216a" (military consultation service case files). (See AR 25-400-2 and table 3-1 of this regulation.)

5–21. Access to health records

All personnel having access to HRECs will protect the privacy of medical information. (See chap 2.) The extent of access allowed to certain personnel is described in *a* through *e* below.

a. Medical personnel. AMEDD personnel are allowed direct access to HRECs for purposes of diagnosis, treatment, and the prevention of medical and dental conditions. They also have access to work for the health of a command and to do medical research.

b. Military members. If a military member requests information from his or her HREC or copies of the documents in it, it will be given to him or her. If the record is a special category record, see AR 340-21, paragraph 2-5.

c. Inspectors. Personnel inspecting MTF, DENTAC, or USAR records are allowed direct access to HRECs. These personnel include Inspector General personnel conducting Nuclear Surety Program and Chemical Surety Program inspections per AR 50-5 and AR 50-6 (AR 20-1); it also includes Defense Nuclear Agency inspectors conducting Defense Nuclear Surety Inspections per AR 50-5. Inspectors may have access to HRECs to evaluate the compliance of AMEDD personnel with regulations. All inspectors must respect the confidentiality of the HRECs they inspect. Inspectors do not have unlimited access to ADAPCP-OMRs per 42 CFR 290.

d. Mortuary affairs personnel. Mortuary affairs personnel are allowed direct access to the HRECs of personnel killed or missing in action. They may have access to extract medical and dental information needed by their service.

e. Other nonmedical Army personnel. Nonmedical personnel may need information from a person's HREC for official reasons. These personnel include unit commanders; inspectors general; officers, civilian attorneys, and military and civilian personnel of the Judge Advocate General's Corps; military personnel officers; and members of the U.S. Army Criminal Investigation Command or military police performing official investigations. Official requests for specific information from the HREC or copies of documents in it will be sent to the MTF Patient Administration Division, DENTAC commander, or RC record custodian, who will determine what information will be supplied by the MTF. (See para 2-3a.) Persons designated as certifying and reviewing officials in accordance with the terms of the Personnel Reliability Program, per AR 50-5 and AR 50-6, are authorized to review medical records of candidates and members of the Personnel Reliability Program in conjunction with proper medical authorities. Access to ADAPCP-OMRs is limited. See guidance in 42 CFR 290.

5–22. Cross-servicing of health records

This regulation and similar ones in the other Services allow and

direct cross-servicing of HRECs. Procedures for maintaining and transferring Navy and Air Force HRECs are similar to those described for Army HRECs.

a. When members of other services are attached to Army MTFs or DTFs for primary care, the MTF or DTF will assume custody for their HRECs. These HRECs will be maintained as discussed in this regulation.

b. HRECs not sent with Navy and Air Force patients will be requested when needed for treatment. Similarly, Army HRECs will be sent to Navy or Air Force HREC custodians when Army personnel are given care by MTFs or DTFs of those Services.

Section II
Initiating, Keeping, and Disposing of Health Records

5–23. Initiating health records

a. HRECs for personnel entering on active duty. These HRECs are prepared by the officer who prepares DA Form 2 (Personnel Qualification Record—Part I (For Army Reserve Use Only)) and DA Form 2-1 (Personnel Qualification Record—Part II). ARNGUS and USAR members not entering on initial active duty for training (for example, direct appointment ARNGUS or USAR AMEDD officers) will have HRECs prepared by the custodian of MPRJs.

b. HRECs for personnel reentering service. For personnel reentering service, HRECs will be prepared as described in *a* above and *d* and *e* below. Any past HREC will be acquired; the documents in the temporary HREC (para 5-25) will be put into the past one. Requests for past HRECs will be made by the military personnel officer of the first unit to which the person is assigned for training or other prolonged duty. Requests will not be made by reception station personnel. Requests for past HRECs should be sent to VA Record Center, P.O. Box 150950, St. Louis, MO 63115. For ARNGUS, the HREC for a person reentering ARNG should be requested from the State Adjutant General of the State from which he or she was separated.

c. HRECs for cadets of the U.S. Military Academy. HRECs will be initiated for cadets as described in *a* above and *d* and *e* below. These HRECs will continue in use when cadets enter active duty.

d. Custody of HRECs. The HREC prepared for a person entering military service will be kept in the MPRJ. It will not be sent to a health or dental record custodian until the person arrives at a station where he or she will remain 15 days or longer. Before his or her arrival at the station, the custodians of the MPRJ will retain custody of the HREC; however, they will send it immediately to a medical or dental officer who requests it or treats the person. (In the ARNGUS and USAR, a health record custodian is appointed.)

e. Forms prepared. The forms to be prepared when an HREC is initiated are listed in (1) through (6) below. No unit names will be entered on any of the forms until the person reports to his or her first training or duty station. Although some forms ask for the person's middle name, only the middle initial needs to be entered. Specialized occupational health forms may be contained in HRECs, but must be locally approved.

(1) DA Form 3444-series or DA Form 8005-series folders. For preparation of these folders, see paragraph 4-4. For HRECs, check the "Health" box under "Type of Record"; for dental records, using only DA Form 3444-series folders, check the "Health (Dental)" box. Handwritten entries will be made in dark ink and boldly printed. (The member's current organization (for example, "Co A, 163 Inf") will be handwritten in pencil.)

(2) SF 600. See paragraph 5-16.

(3) SF 601. See paragraph 5-17.

(4) SF 603 and SF 603A. See paragraph 5-18.

(5) SF 88 and SF 93. The original copies of SF 88 and SF 93 will be put in the HREC.

(6) HEW Form CDC 73-2936S (Field Report). If an HEW Form CDC 73-2936S has been received with a person's records, it will be stapled to a blank letter-sized sheet of paper and fastened in the HREC under SF 601. (See para 5-24b(2)(l).)

5–24. Transferring health records

a. Sending HRECs. Both parts (treatment and dental) of a military member's HREC are transferred (may be hand-carried) when his or her MPRJ is transferred (AR 600-8-104). When a member is to be transferred to another unit or station, the military personnel officer of the losing unit will receive both parts of the HREC from their custodians. The HREC will be sent with the MPRJ except when—

(1) The losing and gaining units receive primary (outpatient type) care from the same MTFs and DTFs. In this case, the military personnel officer will inform the HREC custodians about the unit change. The person's unit designation will be changed on the folders of both the treatment and dental records.

(2) An inpatient is assigned to a medical holding unit that already has the HREC. The MTF commander will inform the military personnel officer that the MTF has the HREC. When requesting the MPRJ, the MTF commander will also request the dental record.

(3) The HREC custodian sends the records directly to the gaining custodian. If the HREC custodian feels a person should not hand-carry his or her HREC, it will be sent directly to the commander of the person's next MTF. When this action is done, the servicing military personnel officer will be promptly informed that the HREC will be sent and not carried. If the custodian does not know the address of the person's next MTF or DTF, the HREC will be sent to the servicing military personnel officer, who will send it to the person's next HREC custodian.

b. Receiving HRECs.

(1) *Military personnel officers.* When a person transfers into the unit, the military personnel officer must acquire both parts of the person's HREC and must send them promptly to the officer in charge of the activity giving primary medical and dental care to the unit. However, post surgeons may grant an exception to this procedure. The HRECs of personnel staying at an installation only a short time (12 weeks or less) may be kept by the military personnel officer rather than the local HREC custodians. In this case, the two parts of the HREC will be kept as separate files in the military personnel offices (MILPO). Neither part will be sent to the local MEDDAC or DENTAC unless requested. Further, trainee units may maintain transient party trainee dental records. In the ARNGUS and the USAR, a health records custodian is appointed.

(2) *AMEDD personnel.*

(a) The officer in charge must ensure that any health problems of a newly arrived person are treated, and thus that the person's HREC is reviewed when received. Review of HRECs may be made by the medical officer, a physician assistant (PA) (area of concentration 65D), or other qualified individuals. Review of Personnel Reliability Program records is discussed in paragraphs 5-28 and 5-29. Each MTF will set the qualifications that people who are not physicians must possess to review HRECs. Each MTF will ensure that there is a verified ABO/Rh blood type in the medical history. Each MTF will also audit reviews to ensure that HRECs are referred to medical officers when needed. The responsible medical officer will develop written guidelines for the review of HRECs by nonmedical officers. These guidelines will ensure that reviews check for pending actions, health-care problems, and record inadequacies. When writing guidelines, the medical officer must ensure that reviews include the actions listed in (b) through (i) below. He or she may modify or expand these actions to fit the local situation.

(b) Consultation reports will be studied for incomplete or pending actions and profile recommendations.

(c) X-ray reports will be studied for unresolved pathological findings.

(d) Laboratory reports will be studied for unresolved abnormalities.

(e) Drug reactions and idiosyncratic responses will be noted.

(f) DA Form 5571, which includes known significant medical diagnoses and conditions, operative and invasive procedures, current medications, and adverse and allergic reactions to drugs, will be completed.

(g) DA Form 8007-R (Individual Medical History) will be updated to include verified ABO/Rh blood type. (See para 5-30a.)

(h) Significant deviations from normal weight, blood pressure, and hearing and visual acuity will be noted.

(i) The HREC will be checked to ensure that any allergic reaction to medication was entered (para 5-17a) and that DA Label 162 was affixed (chap 13).

(j) The medical officer will review all noted health problems to determine if treatment, examinations, or other medical attention is needed. All pertinent findings, the date of the HREC review, and the name of the reviewer will be recorded on SF 600.

(k) If the person's record shows that he or she has been diagnosed as an alcohol or drug abuser within the previous 360 days, the Alcohol and Drug Control Officer will be notified (AR 600-85).

(l) If HEW Form CDC 73-2936S is present in the person's record (para 5-23e(6)), the medical officer will immediately have the person examined and start an SF 602, if needed (para 5-19b(10)). If HEW Form CDC 73-2936S is not for syphilis, comments on the examination and treatment given will be made on SF 600. When no longer useful in the case, the HEW Form CDC 73-2936S will be removed from the HREC and destroyed.

c. HRECs not received. If an HREC is not received with a person's MPRJ and if there is no information that the HREC was sent separately, the military personnel officer will request information on the missing records from the person's last known unit and will also take the necessary action to find the records. If an officer's or warrant officer's HREC cannot be found, the military personnel officer will send a request for the missing HREC to Commander, PERSCOM, ATTN: TAPC-MSR, 200 Stovall Street, Alexandria, VA 22332-0002. If an enlisted member's HREC cannot be found, a request will be sent to Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE-RP, 8899 East 56th Street, Indianapolis, IN 46249-5301. A copy of this request will be kept in the person's MPRJ until a reply has been received. If the person is transferred before the reply arrives, the copy of the request will be endorsed to his or her next unit. When the request reaches the person's next unit, it will be put in his or her "temporary" HREC. (A notation of a reply to the request will be made on SF 600 or SF 603, and the reply will be inserted in the HREC per figs 5-1 or 5-2.)

d. Movements of units with MTFs or DENTACs. When a unit and its attached MTF or DENTAC move, the unit's HRECs will be kept and moved by the MTF or DENTAC only if the MTF or DENTAC continues to give primary medical and dental service to the unit during and after the move. If another MTF or DENTAC will give primary service to the unit during or after the move, the HRECs will be sent to the record custodian of the MTF that provides care during the move.

e. Transferring x rays. An attending physician may feel that certain x rays should go with a patient on PCS. If so, this transfer will be noted on SF 600, and the x rays will be identified. The x rays will then be sent in a mailer per paragraph 4-5.

5–25. Establishing "temporary" and "new" health records

a. "Temporary" medical record. When receipt of a record is delayed, a temporary one will be prepared by medical personnel. A manila folder rather than DA Form 3444-series or DA Form 8005-series folder will be used. DD Form 2005 will be initiated and filed in the temporary record. The date that the temporary record was begun will be printed on the folder. Documents on the person's medical care will be added to the temporary medical record as they are used. When a delayed HREC is received, the forms in the temporary record will be filed in it.

b. "Temporary" dental records. Temporary dental records will be prepared by dental personnel as described in *a* above. DA Form 5570 and SF 603A will be placed in the temporary record. A dental examination to complete section I of SF 603 will not be needed for a temporary dental record. This examination will be made only when the temporary record is replaced by a "new" dental record.

c. New HREC. If a delayed HREC is not received within 60 days after a temporary record is prepared, a new HREC will be prepared. This new HREC will also be prepared when information is received that a record has been destroyed.

(1) When a new HREC is prepared, SF 601 will be added if needed.

(2) New permanent dental records replacing lost records are prepared in accordance with guidance in TB MED 250. A new panographic x ray will be taken for the new record.

(3) If a lost health or dental record is found after a new record has been prepared, the forms of the new record will be filed in the original record. The custodian will note on SF 600 or SF 603 that the original health or dental record was received.

d. Personnel returned to military control. When personnel who have been missing, missing in action, interned, or captured are returned to military control, their original HREC will be acquired and continued in use.

5–26. Filing health records

a. HREC files. HRECs will be filed at the MTF or DTF (includes Primary Care for the Uniformed Services (PRIMUS) clinics authorized to provide primary care to active duty units and members) that provides military medical and dental care or with the RC health records custodian. If the member is assigned to an isolated unit without a servicing military MTF or AMEDD personnel, the HREC will be filed at the unit under the custodianship of the commander. (See para 1-4b.) The records may be filed alphabetically or in terminal digit sequence. (See chap 4.) A chargeout system will be used when the HREC is temporarily removed from the record room. (See para 4-6.)

b. Keeping HREC files current. The procedures described in (1) through (3) below will be followed to keep HREC files current.

(1) The MEDCEN, MEDDAC, or DENTAC commander and division surgeon will give the MILPO a list of MTFs and DTFs and the units that they serve.

(2) The MILPO will give to the MTFs and DTFs personnel rosters of the units that they serve. At a minimum, these rosters will be provided quarterly.

(3) HREC files for active duty personnel will be screened semiannually against current personnel rosters to ensure that the MTF file holds only the records of personnel served by that MTF. When an HREC or medical form is held by the wrong custodian, MTF records personnel will send the documents to the current custodian.

c. Handling identifiable HRECs and medical forms. A record or form is an identifiable form if it contains enough information to identify it as belonging to a specific person. To keep files current, identifiable HRECs and forms will be handled as follows:

(1) When a member out-processes at an MTF or DTF, the MTF or DTF will give the serving MILPO his or her HREC. The member may hand carry the HREC to the gaining MTF or DTF, or it can be sent with the MPRJ to the new custodian in accordance with paragraph 5-24a. When the HREC is sent to the MILPO, the MTF or DTF will record the new custodian so that any late-arriving medical records (laboratory slips, SF 600, and so on) can be sent to him or her. (The new custodian can be recorded in chargeout folders in the files, log books, and so forth.)

(2) When the MTF or DTF cannot find the member's HREC, it will prepare a suspense card with the member's name, rank, SSN, the complete address of his or her new unit, the MEDDAC or DENTAC that serves his or her new unit, and the date that the card is put in suspense. The suspense card will be kept in a chargeout folder; the folder is kept in the file where the member's records should have been. The card will be kept until the record is found and sent to the new custodian or until the files have received two semiannual reviews, whichever comes first. The suspense card will then be destroyed.

d. Handling stray records and forms. Stray records and forms found during the semiannual files review will be handled as described in (1) through (3) below.

(1) The records and forms will be screened against the MTF or DTF files, including the suspense cards. Those files that can be identified (that is, matched with a record or suspense card) will be sent to the proper custodian. The letter of transmittal will cite the member's assigned unit.

(2) When the proper custodians cannot be determined, the MTF

or DTF will, if possible, access its Defense Enrollment Eligibility Reporting System (DEERS) MDRTS to obtain the current record custodian. Otherwise, the MTF or DTF will make a list of the members to whom the records belong, giving each member's full name, SSN, and current unit of assignment if possible. (It is a requirement of the world-wide locator service that both the full name and SSN be included.) The list will be sent to the MILPO with a cover letter requesting that the names be checked. The local MILPO should determine the appropriate section within its organization to complete the required action on the list. (Some installations have In/Out Processing Sections where installations rosters and clearance files can be checked; at other installations, these functions are handled in the consolidation of military personnel activities.) After the MILPO has searched its files, the list should be forwarded to the post locator or to the installation activity that maintains the worldwide locator file. The MILPO or post locator response will be kept by the MTF or DTF in a file (file number 40 (general medical services correspondence files)) for 1 year. (See table 3-1.) (See AR 25-400-2 for information on nonaction paper files.)

(3) If the MILPO or post locator cannot find the address of the proper custodians, the MTF or DTF will follow the steps outlined in *(a)* through *(f)* below.

(a) Rule 1. If the records or forms have a complete name and SSN on them and are Army records or forms (officers, warrant officers, and enlisted personnel) (based on a check of outprocessing and separation files, the local Standard Installation/Division Personnel System alpha roster, DEERS, and the worldwide locator microfiche) and if the MILPO provides a forwarding active duty address, send them to the forwarding address. If the member retired or was discharged or separated to an inactive USAR status, send them to VA Record Center, P.O. Box 150950, St. Louis, MO 63115. If an address from orders or DD Form 214 (Certificate of Release or Discharge from Active Duty) assigns the members to a USAR troop program unit (TPU) or releases the USAR member from active duty for training or initial active duty for training, send them to the member's USAR unit. If an address from orders or DD Form 214 releases the ARNGUS member from active duty for training or initial active duty for training, send them to the appropriate State Adjutant General. If the member has departed on terminal leave but has not reached his or her actual separation date, send them to the servicing separation transfer point. If no information and no record are available, send a request for locator service, listing full name and sponsor's SSN, to the Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE-RP, 8899 East 56th Street, Indianapolis, IN 96249-5301, by mail, using the message format in figure 5-4, facsimile DSN 699-3685 or commercial (317) 542-3685, or Internet address daviss3 @hoffman-emh1.army.mil. The Locator Service Office can be contacted by telephone at DSN 699-3684 or commercial (317) 542-3684, but locator information will not be provided telephonically. Hold the records or forms for the message response containing a disposition address.

(b) Rule 2. If the records or forms have a complete name and SSN on them and are Navy records or forms, send them to Naval Military Personnel Command, ATTN: NMPC-036, Navy Worldwide Locator Service, WASH DC 20370-5000.

(c) Rule 3. If the records or forms have a complete name and SSN on them and are Marine Corps records or forms, send them to Commandant of the Marine Corps, HQ, U.S. Marine Corps, WASH DC 20380-0001.

(d) Rule 4. If the records or forms have a complete name and SSN on them and are Air Force records or forms, send them to HQ, U.S. Air Force, ATTN: AFMPC/RMIQL, 550 C Street West, Suite 50, Randolph Air Force Base, TX 78150-6001.

(e) Rule 5. If the records or forms have a complete name and SSN on them and are PHS or Coast Guard commissioned corps records or forms, send them to Medical Branch, 5600 Fishers Lane, Parklawn Building, Room 4-35, Rockville, MD 20857-0435.

(f) Rule 6. If the records or forms have a complete name and SSN on them and are National Oceanic and Atmospheric Administration records or forms, send them to Commissioned Personnel Center, NOAA (ATTN: CP01), 11400 Rockville Pike, Room 108, Rockville, MD 20852-3004.

e. Handling unidentifiable records and forms. An unidentifiable record or form is one that contains either no data or such a small amount of data that trying to identify the person to whom it belongs is impossible. See paragraph 3-7.

5–27. Disposing of health records

Upon discharge, release from active duty, retirement, death, or transfer from USAR to ARNGUS, the member's HREC will be disposed of per AR 600-8-104. ARNGUS HRECs will be disposed of as are MPRJs. (For officers and warrant officers, see NGR 640-100; for enlisted personnel, see NGR 600-200.)

Section III
Special Considerations for Personnel Reliability Program Health Records and Civilian Employee Medical Records

5–28. Screening Personnel Reliability Program records

a. Per AR 50-5 or AR 50-6, paragraph 3-15, each Personnel Reliability Program candidate must be medically evaluated as part of the screening process, including a review of the individual's medical records. HRECs or CEMRs of all personnel being screened and evaluated for the Personnel Reliability Program will be personally screened by a U.S. military physician, a PA, a U.S. civilian physician (or physician's assistant) under DOD contract or employed by the U.S. Government, or other qualified nonphysician medical personnel (officer or enlisted) specifically trained and designated by the supporting U.S. military MTF commander to screen medical records and complete part III, DA Form 3180-R.

b. Personnel Reliability Program HRECs or CEMRs will be screened per AR 50-5 or AR 50-6 by the losing organization's supporting medical activity before the individual departs on orders for reassignment to a nuclear or chemical surety duty position and by the gaining organization's supporting medical activity before being assigned to a nuclear or chemical duty position. The screening individual will annotate SF 600 with the following or similar statement: "Preceding entries screened under provisions of AR 50-5 (or AR 50-6)" followed by his or her printed name, grade, and signature. The entry on SF 600 will be made at the time the screening was accomplished and dated accordingly.

5–29. Maintaining Personnel Reliability Program records

a. Personnel Reliability Program HRECs or CEMRs will be maintained under continuing evaluation after screening has been accomplished. MTFs will segregate HRECs (treatment records and dental records), and CEMRs of personnel in the Personnel Reliability Program from other records. A cross-reference system must be established to account for the absence of these records from the central files.

b. Personnel Reliability Program HREC or CEMR custodians must ensure that the chain of custody in the handling of Personnel Reliability Program medical records is not broken. Personnel Reliability Program records signed out during the duty day must be returned to the section where the records are maintained before the close of the business day, except when a need exists for a record to be used for treatment lasting more than the normal duty day or when the location of the required consultation or medical treatment is away from the MTF where the Personnel Reliability Program records are maintained.

c. Personnel Reliability Program records will be labeled and identified by filing DA Form 3180-R and DA Form 4515 as described in paragraph 5-19b. The Personnel Reliability Program block on the record folder will be marked to indicate participation in the program.

Section IV
Maintenance of Health Records Upon Mobilization

5–30. Health records of deployed military members

a. HRECs of deployed military members. HRECs of deployed

military members will not accompany them to combat areas. When processing military members for deployment, the MTF and DTF will audit each member's HREC and record essential health- and dental-care information on DA Form 8007-R. DA Form 8007-R is a single-page document that will be prepared for every military member in the continental United States (CONUS) and outside the continental United States (OCONUS). DA Form 8007-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy of this form is located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site. DA Form 8007-R will be initiated and or updated during record screening (para 5-24b(2)(g)). DA Form 8007-R is intended for use until an electronic device that stores medical or dental, personnel, and finance data is fielded. The preparation and use of DA Form 8007-R is also applicable to civilian employees who may accompany deploying units. Units in CONUS and OCONUS are encouraged to use DA Form 8007-R during training exercises. (Also see para 5-24.)

(1) If an HREC is not available, DA Form 8007-R will be completed based on military member interviews and any other locally available data. An HREC may not be available for most IRR, Individual Mobilization Augmentee, and retired personnel because these HRECs may remain on file at the ARPERCEN or the VA.

(2) The completed DA Form 8007-R will be provided to the member's command, or to the member if he or she is an individual replacement, and then handed off to the MTF in the area of operation responsible for providing primary medical care to that member. That MTF will maintain DA Form 8007-R in an outpatient field file for reference as needed. The MTF will ensure that the ABO/Rh blood type is recorded in block 6 from a verified blood bank typing. The field file will consist of, in part, DA Form 8007-R and possibly SF 600, SF 558, SF 603, or DD Form 1380.

(3) The member's field file may be managed as a "drop" file (forms not attached).

(4) MTFs and DTFs at the mobilization site(s) will follow the procedure in AR 600-8-104 for incorporating the HREC into the MPRJ.

b. Forwarded deployed force. If time permits, follow guidance in a(1) and (2) above. If not, consolidate HREC in-country, and process when time permits.

c. Limited contingency operations. Retain the HREC at the MTF and DTF providing primary care. If the servicing primary care facility closes, forward the HREC to the MTF or DTF indicated by the servicing MEDDAC and DENTAC. If full mobilization occurs, follow guidance in a(1) and (2) above.

d. Units that do not process through a mobilization station before deployment or otherwise do not have access to an MTF or DTF. These units will follow the procedures in *b* above.

5–31. Preparation of health record forms

a. DD Form 1380. Instructions for preparing DD Form 1380 are provided in chapter 10. When DD Form 1380 is put into the HREC, it will be mounted on SF 600. To mount it, staple only along the top margin so that no entries on SF 600 are hidden and so that both sides of DD Form 1380 can be read.

b. SF 600. SF 600 is prepared the same during combat conditions as during peacetime. (See para 5-16.)

c. SF 603A. Each encounter for dental care in an operational setting will be recorded on SF 603A. To ensure legal documentation and quality-care continuity, provide complete, accurate, and clear information so that the forms can be returned to the record custodian and so that the information can be transposed to the permanent record. At a minimum, the name, SSN, service branch, unit (for example, division or separate brigade, company, and battalion), and homebase should be included in the identifying information. The provider's name and rank, and the field unit providing the care should be clear. The date, chief complaint, indication that medical history was reviewed, examination and test results, diagnosis, treatment, prescriptions, and disposition (including mode of transportation, if pertinent) will be included on the SF 603A, section 17.

5–32. Use of field files

a. If a member's primary MTF changes, the field file should be moved to the gaining MTF.

b. If a member requires admission to the hospital, every attempt will be made to forward the field file. The file will be returned to the member's primary MTF if disposition is "RTD."

5–33. Operation after hostilities cease

a. Field files will be integrated with the HREC after demobilization at home station or mobilization stations. Field files will be forwarded to ARPERCEN for those members whose HREC is maintained at ARPERCEN.

b. Each CONUS MTF must request records from ARPERCEN for those members who remain on active duty and are assigned for support upon demobilization.

Until the new four-part folder is fully assimilated into the system (fig 5-2), the following order will be used for forms of the HREC using DA Form 3444-series jackets (excluding dental).

All forms should be filed in an upright position on both sides of the folder. Order given below is from top to bottom of the record.

LEFT SIDE OF FOLDER

DA Form 5571[1,2]
Master Problem List. (See paras 3-10g(3), 5-10, 5-24b(2)(f), 7-4b(4), and 9-5e.)

DA Form 3180-R
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-28a, 5-29c, and 7-4b(7) of this regulation.)

DA Form 4186
Medical Recommendation for Flying Duty. (See AR 40-501 and para 5-19b(6) of this regulation.)

Documents and correspondence on flying status, that is, restrictions, removal of restrictions, suspensions, and termination of suspensions. (See AR 600-105.)

DA Form 8007-R
Individual Medical History. (See paras 5-24b(2)(g), 5-30a, and 11-3a(9).)

DD Form 2482[1]
Venom Extract Prescription. (See para 5-12.)

SF 601[1,2]
Health Record—Immunization Record. (See paras 5-17, 5-23e(3), 5-25c(1), and 6-7b.)

DD Form 1141; ADR
Record of Occupational Exposure to Ionizing Radiation; Automated Dosimetry Record. (See AR 40-14/DLAR 1000.28 and paras 5-19b(5) and 7-4b(5) of this regulation.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3-2, 5-13, and 9-25.)

SF 512[1]
Clinical Record—Plotting Chart. (See para 5-13.)

SF 545[1,2]
Laboratory Report Display. (See paras 3-2 and 9-25.) Instructions for completing this form are provided in tables 9-2 and 9-3.

SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 556; SF 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; Immunohematology; Miscellaneous. Attach to SF 545 in reverse chronological order. (See para 9-25.) Instructions for completing these forms are provided in tables 9-2 and 9-3.

SF 507[1]
Report on or Continuation of SF. File with the standard form being continued.

SF 519-B[1]
Radiologic Consultation Request/Report. (See para 9-37.)

SF 519; SF 519A
Medical Record—Radiographic Report. SF 519 and SF 519A are obsolete; use for file purposes only if already in existence.

OF 520[1]
Clinical Record—Electrocardiographic Record (formerly SF 520). Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of OF 520 or on another attached sheet of paper. Computerized assisted practice of cardiology (CAPOC) or other automated tracings may substitute for the OF 520.

SF 560
Medical Record—Electroencephalogram Request and History (formerly DA Form 4530). SF 560 is obsolete; use for file purposes only if already in existence.

Figure 5-1. Forms and documents of the HREC (treatment) using DA Form 3444-series jackets—Continued

DA Form 2631-R
Medical Care—Third Party Liability Notification. (See AR 40-16.)

DA Form 3647
Inpatient Treatment Record Cover Sheet or CHCS automated equivalent. File it with copies of SF 502 (if prepared), SF 515, SF 509, SF 516, and DD Form 2770 or SF 539. Also file AF Form 565 (Record of Inpatient Treatment), NAVMED 6300-5 (Admission/Disposition Record, Inpatient), DD Form 1380, DD Form 602 (Patient Evacuation Tag) or any other narrative summaries from the VA, PHS, or other Government MTF here. (See AR 40-400 and paras 3-12a(1), 3-13b, 3-17a, 3-18b, 5-2a, 5-19a, 6-7, 9-5d, 9-9b, 9-15, 9-16, 9-17, 9-18, 9-19, and 10-2 of this regulation.)

OF 275
Medical Record Report. File in order of the number of the form that it replaces. (See paras 3-3f, 9-12c, and 9-12e.)

DD Form 2770[1]
Abbreviated Medical Record (outpatient) (formerly SF 539). (See paras 9-5d(2) and 9-21.)

DA Form 4254-R[1]
Request for Private Medical Information. (See para 2-4a.)

DA Form 4876-R[1]
Request and Release of Medical Information to Communications Media. (See para 2-3b(3).)

DA Form 5006-R[1]
Medical Record—Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. (See paras 2-3a(1) and 2-3b(1).)

DA Form 5303-R
Volunteer Agreement Affidavit. (See AR 40-38 and para 6-2h of this regulation.)

DA Form 3365
Authorization for Medical Warning Tag. (See paras 6-7f, 13-1, 13-3c, and 13-5.)

DD Form 2569
Third Party Collection Program—Insurance Information. (See paras 5-19a, 6-2i, and 9-20.)

ABO/Rh blood type SF 600 overprint.

DA Form 4410-R[2]
Disclosure Accounting Record. DA Form 4410-R is printed on the folder. The separate form is obsolete; use for file purposes only if already in existence.

RIGHT SIDE OF FOLDER

DA Form 4515
Personnel Reliability Program Record Identifier. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-29c, and 7-4b(7) of this regulation.)

Interfile the following five forms in reverse chronological order with the most recent on top.

SF 600[1,2]; SF 558[1],; DA Form 5181-R[1],; SF 513[1]; DD Form 2161[1]
Health Record—Chronological Record of Medical Care; Medical Record—Emergency Care and Treatment; Screening Note of Acute Medical Care; Medical Record—Consultation Sheet; Referral for Civilian Medical Care. File any other basic chronological medical care records here, for example, Automated Military Outpatient System (AMOSIST) or other forms completed at civilian facilities. (See paras 5-7, 5-14, 5-16, 9-5d(3)(h), and 9-12.)

State ambulance forms. File behind corresponding SF 558. (See para 5-19b(7).)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5-6 and 9-5d(3)(h).)

DA Form 3824[1]
Urologic Examination.

DD Form 2493-1
Asbestos Exposure Part I—Initial Medical Questionnaire. (See AR 40-5 and para 5-19b(9) of this regulation.)

Figure 5-1. Forms and documents of the HREC (treatment) using DA Form 3444-series jackets—Continued

DD Form 2493-2
Asbestos Exposure Part II—Periodic Medical Questionnaire. (See AR 40-5 and para 5-19b(9) of this regulation.)

DA Form 3763
Community Health Nursing—Case Referral. (See paras 5-4 and 6-2.)

Home health care documentation.

DA Form 5569-R[1]
Isoniazid (INH) Clinic Flow Sheet. (See para 5-8.)

SF 602
Health Record—Syphilis Record. Also file any civilian or foreign military treatment records here. (See paras 5-16, 5-19b(10), and 5-24.)

DA Form 199
Physical Evaluation Board (PEB) Proceedings. (See AR 635-40 and para 5-19a(4) of this regulation.)

DA Form 2173
Statement of Medical Examination and Duty Status (if initiated prior to 1 July 1973). (See AR 600-8-1.)

DA Form 3349
Physical Profile (formerly DA Form 8-274). File any correspondence on a revision of physical profile serials here. (See AR 40-501 and para 5-19b(3) of this regulation.)

DA Form 3947
Medical Evaluation Board Proceedings. (See AR 40-3 and para 5-19a(5) of this regulation.)

DA Form 4060
Record of Optometric Examination. DA Form 4060 is obsolete; use for file purposes only if already in existence.

DA Form 4700[1]
Medical Record—Supplemental Medical Data. When DA Form 4700 is used, it should be referenced on SF 600. Undersized reports should be mounted on DA Form 4700 display sheets and filed with reports to which they most closely relate. (See paras 3-2a, 3-3, 5-19b(7), 9-2b, and 11-4b(4).)

DA Form 5551-R
Spirometry Flow Sheet. (See TB MED 509.)

DA Form 4970-E
Medical Screening Summary—Cardiovascular Risk Screening Program. (See AR 40-501.)

SF 88[2]; DA Form 7349-R; DD Form 2697; DA Form 4497-R[2]; FAA Form 8500-8[2]
Report of Medical Examination (statement in lieu of medical examination (NGR 40-501) for ARNGUS); Initial Medical Review—Annual Medical Certificate; Report of Medical Assessment; Interim (Abbreviated) Flying Duty Medical Examination (original); Medical Certificate—Class and Student Pilot Certificate (photocopy). (See AR 40-501 and paras 3-10g, 5-6, 5-16d, 5-19b(1), 5-23e(5), and 7-4b of this regulation.)

SF 93[2]
Report of Medical History. File any other medical history form here. (See AR 40-501 and paras 5-19b(1), 5-23e(5), and 7-4b(2) of this regulation.)

DA Form 7389[1]
Medical Record—Anesthesia (formerly SF 517 and OF 517). Outpatient surgery only. (See paras 9-5d(3)(f) and 9-12.)

OF 522[1] or State mandated forms
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures (formerly SF 522). File all other special consent forms here. (See paras 3-3 and 9-5d(3)(b).)

SF 559[1]
Medical Record—Allergen Extract Prescription, New and Refill. (See paras 5-5 and 5-15.)

DA Form 5007A-R[1]; DA Form 5007B-R[1]
Medical Record—Allergy Immunotherapy Record—Single Extract; Medical Record—Allergy Immunotherapy Record—Double Extract. (See para 5-5.)

Figure 5-1. Forms and documents of the HREC (treatment) using DA Form 3444-series jackets—Continued

Other SF 500-series forms. File here in numerical sequence with like form numbers together in reverse chronological order.

DD Form 741[1]
Eye Consultation.

DD Form 771
Eyewear Prescription. (See AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3 and para 5-19b(2) of this regulation.)

DD Form 2215[1,2]
Reference Audiogram. (See AR 40-5 and DA Pam 40-501.)

DD Form 2216
Hearing Conservation Data. Also file any correspondence on hearing aids here. (See AR 40-5 and DA Pam 40-501.)

Reports or certificates prepared by neuropsychiatric consultation services or psychiatrists.

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care, living wills, etc.). (See paras 6-2j and 9-2c(2).)

DA Form 4465-R
Patient Intake/Screening Record. Also file any other authorized alcohol and drug forms here. (See AR 600-85 and paras 5-19b(4) and 8-9k of this regulation.)

DD Form 2005[2]
Privacy Act Statement—Health Care Records. DD Form 2005 is always the bottom form or is printed on the folder. (See paras 4-4a(9), 5-25a, 7-4a, and 9-5d(1).)

Notes:

[1] Instructions for completing this form are self-explanatory.

[2] This form must be included in all HRECs.

Figure 5-1. Forms and documents of the HREC (treatment) using DA Form 3444-series jackets

All forms should be filed in an upright position on both sides of the folder. Order given below is from top to bottom of the record.

Part I

DA Form 5571[1,2]
Master Problem List. DA Form 5571 is always the top form. (See paras 3-10g(3), 5-10, 5-24b(2)(f), 7-4b(4), and 9-5e.)

DA Form 3180-R
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-28a, 5-29c, and 7-4b(7) of this regulation.)

DA Form 8007-R
Individual Medical History. (See paras 5-24b(2)(g), 5-30a, and 11-3a(9).)

DD Form 1141; ADR
Record of Occupational Exposure to Ionizing Radiation; Automated Dosimetry Record. (See AR 40-14/DLAR 1000.28 and paras 5-19b(5) and 7-4b(5) of this regulation.)

DD Form 2493-1
Asbestos Exposure Part I—Initial Medical Questionnaire. (See AR 40-5 and para 5-19b(9) of this regulation.)

DD Form 2493-2
Asbestos Exposure Part II—Periodic Medical Questionnaire. (See AR 40-5 and para 5-19b(9) of this regulation.)

SF 601[1,2]
Health Record—Immunization Record. (See paras 5-17, 5-23e(3), 5-25c(1), and 6-7b.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3-2, 5-13, and 9-25.)

SF 512[1]
Clinical Record—Plotting Chart. (See para 5-13.)

SF 545[1,2]
Laboratory Report Display. (See paras 3-2 and 9-25.) Instructions for completing this form are provided in tables 9-2 and 9-3.

SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 556; SF 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; Immunohematology; Miscellaneous. Attach to SF 545 in reverse chronological order. (See para 9-25.) Instructions for completing these forms are provided in tables 9-2 and 9-3.

SF 507[1]
Report on or Continuation of SF. File with the standard form being continued.

SF 519-B[1]
Radiographic Consultation Request/Report. (See para 9-37.)

SF 519; SF 519A
Medical Record—Radiographic Report. SF 519 and SF 519A are obsolete; use for file purposes only if already in existence.

OF 520[1]
Clinical Record—Electrocardiographic Record (formerly SF 520). Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of OF 520 or on another attached sheet of paper. CAPOC or other automated tracings may substitute for the OF 520.

SF 524[1]
Medical Record—Radiation Therapy.

SF 525[1]
Medical Record—Radiation Therapy Summary.

Figure 5-2. Forms and documents of the HREC using DA Form 8005-series jackets—Continued

SF 526[1]
Medical Record—Interstitial/Intercavitary Therapy.

SF 541[1]
Medical Record—Gynecologic Cytology.

SF 560
Medical Record—Electroencephalogram Request and History (formerly DA Form 4530). SF 560 is obsolete; use for file purposes only if already in existence.

DD Form 2482[1]
Venom Extract Prescription. (See para 5-12.)

SF 559[1]
Medical Record—Allergen Extract Prescription, New and Refill. (See paras 5-5 and 5-15.)

DA Form 5007A-R[1]; DA Form 5007B-R[1]
Medical Record—Allergy Immunotherapy Record—Single Extract; Medical Record—Allergy Immunotherapy Record—Single Extract. (See para 5-5.)

DA Form 5551-R
Spirometry Flow Sheet. (See TB MED 509.)

DA Form 4060
Record of Optometric Examination. DA Form 4060 is obsolete; use for file purposes only if already in existence.

DD Form 741[1]
Eye Consultation.

DD Form 771
Eyewear Prescription. (See AR 40-63/MAVMEDCOMINST 6810.1/AFR 167-3 and para 5-19b(2) of this regulation.)

DD Form 2215[1]
Reference Audiogram. (See AR 40-5 and DA Pam 40-501.)

DD Form 2216
Hearing Conservation Data. Also file any correspondence on hearing aids here. (See AR 40-5 and DA Pam 40-501.)

Reports or certificates prepared by neuropsychiatric consultation services or psychiatrists.

ABO/Rh blood type SF 600 overprint.

PART II

DA Form 4515
Personnel Reliability Program Record Identifier. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-29c, and 7-4b(7) of this regulation.)

DA Form 4186
Medical Recommendation for Flying Duty. (See AR 40-501 and para 5-19b(6) of this regulation.)

Documents and correspondence on flying status, that is, restrictions, removal of restrictions, suspensions, and termination of suspensions. (See AR 600-105.)

Interfile the following five forms in reverse chronological order with the most recent on top.

SF 600[1,2]; SF 558[1]; DA Form 5181-R[1]; SF 513[1]; DD Form 2161[1]
Health Record—Chronological Record of Medical Care; Medical Record—Emergency Care and Treatment; Screening Note of Acute Medical Care; Medical Record—Consultation Sheet; Referral for Civilian Medical Care. File any other basic chronological medical care records here, for example, AMOSIST or other forms completed at civilian facilities. (See paras 5-7, 5-14, 5-16, 9-5d(3)(h), and 9-12.)

State ambulance forms. File behind corresponding SF 558. (See para 5-19b(7).)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5-6 and 9-5d(3)(h).)

Figure 5-2. Forms and documents of the HREC using DA Form 8005-series jackets—Continued

DA Form 3824[1]
Urologic Examination.

SF 602
Health Record—Syphilis Record. Also file any civilian or foreign military treatment records here. (See paras 5-16, 5-19b(10), and 5-24.)

DA Form 3763
Community Health Nursing—Case Referral. (See paras 5-4 and 6-2.)

Home health care documentation.

DA Form 5569-R[1]
Isoniazid (INH) Clinic Flow Sheet. (See para 5-8.)

Other SF 500-series forms. File here in numerical sequence with like form numbers together in reverse chronological order.

SF 527[1]
Group Muscle Strength, Joint R.O.M. Girth and Length Measurements.

SF 528[1]
Clinical Record—Muscle and/or Nerve Evaluation—Manual and Electrical: Upper Extremity.

SF 529[1]
Medical Record—Muscle Function by Nerve Distribution: Trunk and Lower Extremity.

DA Form 4700[1]
Medical Record—Supplemental Medical Data. When DA Form 4700 is used, it should be referenced on SF 600. Undersized reports should be mounted on DA Form 4700 display sheets and filed with reports to which they most closely relate. (See paras 3-2a, 3-3, 5-19b(7), 9-2b, and 11-4b(4).)

DA Form 7389[1]
Medical Record—Anesthesia (formerly SF 517 and OF 517). Outpatient surgery only. (See paras 9-5d(3)(f) and 9-12.)

OF 522[1] or State mandated forms
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures (formerly SF 522). File all other special consent forms here. (See paras 3-3 and 9-5d(3)(b).)

SF 518[1]
Medical Record—Blood or Blood Component Transfusion.

SF 88[2]; DA Form 7349-R; DD Form 2697; DA Form 4497-R[2]; FAA Form 8500-8[2]
Report of Medical Examination; Initial Medical Review—Annual Medical Certificate; Report of Medical Assessment; Interim (Abbreviated) Flying Duty Medical Examination; Medical Certificate—Class and Student Pilot Certificate (photocopy). (See AR 40-501 and paras 3-10g, 5-6, 5-16d, 5-19b(1), 5-23e(5), and 7-4b of this regulation.)

SF 93[2]
Report of Medical History. File any other medical history form here. (See AR 40-501 and paras 5-19b(1), 5-23e(5), and 7-4b(2) of this regulation.)

DA Form 4970-E
Medical Screening Summary—Cardiovascular Risk Screening Program. (See AR 40-501.)

DA Form 4465-R
Patient Intake/Screening Record. Also file any other authorized alcohol and drug forms here. (See AR 600-85 and paras 5-19b(4) and 8-9k of this regulation.)

PART III

DA Form 199
Physical Evaluation Board (PEB) Proceedings. (See AR 635-40 and para 5-19a(4) of this regulation.)

DA Form 2173
Statement of Medical Examination and Duty Status. (See AR 600-8-1.)

DA Form 2631-R
Medical Care—Third Party Liability Notification. (See AR 40-16.)

Figure 5-2. Forms and documents of the HREC using DA Form 8005-series jackets—Continued

DA Form 3349
Physical Profile (formerly DA Form 8-274). File any correspondence on a revision of physical profile serials here. (See AR 40-501 and para 5-19b(3) of this regulation.)

DA Form 3365
Authorization for Medical Warning Tag. (See paras 6-7f, 13-1, 13-3c, and 13-5.)

DD Form 2569
Third Party Collection Program—Insurance Information. (See paras 5-19a, 6-2i, and 9-20.)

DA Form 3947
Medical Evaluation Board Proceedings. (See AR 40-3 and para 5-19a(5) of this regulation.)

DA Form 4254-R[1]
Request for Private Medical Information. (See para 2-4a.)

DA Form 4876-R[1]
Request and Release of Medical Information to Communications Media. (See para 2-3b(3).)

DA Form 5006-R[1]
Medical Record—Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. (See paras 2-3a(1) and 2-3b(1).)

DA Form 5303-R
Volunteer Agreement Affidavit. (See AR 40-38 and para 6-2h of this regulation.)

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care and living wills). (See paras 6-2j and 9-2c(2).)

DA Form 4410-R[2]
Disclosure Accounting Record. DA Form 4410-R is printed on the folder. The separate form is obsolete; use for file purposes only if already in existence.

PART IV

Group copies of the following forms by hospitalization episode with most recent on top[3].

DA Form 3647[2]
Inpatient Treatment Record Cover Sheet or CHCS automated equivalent. File it with copies of SF 502 (if prepared), SF 515, SF 509, SF 516, and DD Form 2770 or SF 539. Also file AF Form 565, NAVMED 6300-5, DD Form 1380, DD Form 602, or any other narrative summaries from the VA, PHS, or other Government MTF here. (See AR 40-400 and paras 3-12a(1), 3-13b, 3-17a, 3-18b, 5-2a, 5-19a, 6-7, 9-5d, 9-9b, 9-15, 9-16, 9-17, 9-18, 9-19, and 10-2 of this regulation.)

OF 275
Medical Record Report. File in order of the number of the form that it replaces. (See paras 3-3f, 9-12c, and 9-12e.)

SF 502[1,2]
Clinical Record—Narrative Summary (outpatient). (See para 9-12.)

DD Form 2770[1]
Abbreviated Medical Record (outpatient) (formerly SF 539). (See paras 9-5d(2) and 9-21.)

SF 509[1,2]
Medical Record—Progress Notes. SF 509 includes the final discharge note. (See paras 9-5d(3)(g) and 9-12.)

SF 515[1,2]
Medical Record—Tissue Examination (outpatient). (See paras 5-2, 5-19, and 9-5d(3)(e).)

SF 516[1,2]
Medical Record—Operation Report (outpatient). (See paras 9-5d(3)(d) and 9-12.)

SF 531[1]
Medical Record—Anatomical Figure.

SF 533[1]
Medical Record—Prenatal and Pregnancy. File any forms belonging to pregnancy episode not delivered in MTF here. (See para 6-7g.)

Figure 5-2. Forms and documents of the HREC using DA Form 8005-series jackets—Continued

DD Form 2005[2]
Privacy Act Statement—Health Care Records. DD Form 2005 is always the bottom form or is printed on the folder. (See paras 4-4a(9), 5-25a, 7-4a, and 9-5d(1).)

Notes:

[1] Instructions for completing this form are self-explanatory.

[2] This form must be included in all HRECs.

[3] These forms will usually be copies of inpatient forms, except for SF 533 when patient is not admitted to the MTF for delivery.

Figure 5-2. Forms and documents of the HREC using DA Form 8005-series jackets

All forms should be filed in an upright position on both sides of the folder. Order given below is from top to bottom of the record.

LEFT SIDE OF FOLDER

DA Form 3180-R
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-19*b*(8), 5-28*a*, 5-29*c*, and 7-4*b*(7) of this regulation.)

DA Form 5570[1,2]
Health Questionnaire for Dental Treatment. DA Form 5570 is printed on the radiograph storage envelope. Radiographs will be stored in the envelope. (See paras 5-9 and 5-25b.)

Panograph[1]. The panograph includes other radiographs too large to be included in the DA Form 5570 envelope.

DA Form 4410-R[1]
Disclosure Accounting Record. DA Form 4410-R is printed on the folder. The separate form is obsolete; use for file purposes only if already in existence.

RIGHT SIDE OF FOLDER

DA Form 4515
Personnel Reliability Program Record Identifier. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-29c, and 7-4b(7) of this regulation.)

SF 603[1]
Health Record—Dental. File in reverse chronological order with original SF 603 on the bottom. Also file SF 603A (Health Record—Dental Continuation) here when needed as a continuation of section III (Attendance Record) of SF 603. (See paras 5-2c, 5-18, 5-23e(4), 5-24c, 5-25b, 5-25c(3), 5-30a(2), 5-31c, and 6-7.)

DA Form 4700
Medical Record—Supplemental Medical Data. (See paras 3-2a, 3-3, 5-19b(7), 9-2b, and 11-4b(4).)

DA Form 3984
Dental Treatment Plan. (See TB MED 250.)

SF 513[2]
Medical Record—Consultation Sheet. (See para 9-12.)

SF 5071
Report on or Continuation of SF. File with the standard form being continued.

SF 519-B[2]
Radiologic Consultation Request/Report. (See para 9-37.)

SF 519; SF 519A
Medical Record—Radiographic Report. SF 519 and SF 519A are obsolete; use for file purposes only if already in existence.

SF 521
Clinical Record—Dental. SF 521 is obsolete; use for file purposes only if already in existence.

OF 522[2] or State mandated forms
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures (formerly SF 522). File all other special consent forms here. (See paras 3-3 and 9-5d(3)(b).)

DA Form 8-115
Register of Dental Patients. DA Form 8-115 is obsolete; use for file purposes only if already in existence.

Other medical or dental records important to the patient's care.

Figure 5-3. Forms and documents of the HREC dental record—Continued

DD Form 2005[1]
Privacy Act Statement—Health Care Records. DD Form 2005 is always the bottom form or is printed on the folder. (See paras 4-4a(9), 5-25a, 7-4a, and 9-5d(1).)

Notes:

[1] This form must be included in all military dental records.

[2] Instructions for completing this form are self-explanatory.

Figure 5-3. Forms and documents of the HREC dental record

JOINT MESSAGEFORM										SECURITY CLASSIFICATION
PAGE	DTG/RELEASER TIME			PRECEDENCE		CLASS	SPECAT	LMF	CIC	ORIG MSG IDENT
	DATE TIME	MONTH	YR	ACT	INFO					
OF						UNCLAS		CT	DDEB	
BOOK	MESSAGE HANDLING INSTRUCTIONS									

FROM

TO CHIEF RECORDS LOCATOR SVC//INDIANAPOLIS IN//PCRE-RP//

UNCLAS

SUBJECT: MEDICAL/DENTAL RECORD LOCATOR SERVICE

ADDED INSTRUCTIONS:

1. LMF - MUST BE CT.

2. CIC - MUST BE DDEB.

3. ORIG/MSG IDENT - MUST BE SENDER'S ROUTING INDICATOR CODE (RIC).

4. COMMUNICATIONS CENTER MUST ROUTE MSG TO RIC: RUFEHOS.

5. SUBJECT MUST BE AS SHOWN.

6. DATA FORMAT MUST BE:

LAST NAME (SPACE) FIRST NAME (SPACE) MIDDLE NAME/SSN. THE PARTS OF THE NAME MUST BE SEPARATED BY A SPACE. A SLASH (/) MUST SEPARATE THE NAME AND SSN. ALL NUMBERS OF THE SSN MUST RUN TOGETHER.

7. FORMAT EXAMPLE: DOE JOHN M./777889999

6
5
4
3
2
1
0

DISTR

DRAFTER TYPED NAME, TITLE, OFFICE SYMBOL, PHONE	SPECIAL INSTRUCTIONS	
RELEASER: TYPED NAME, TITLE, OFFICE SYMBOL AND PHONE		
SIGNATURE	SECURITY CLASSIFICATION	DATE TIME GROUP

DD FORM 1 MAR 79 173/2 (OCR) PREVIOUS EDITION IS OBSOLETE S/N 0102-LF-000 1775 ☆U.S. GOVERNMENT PRINTING OFFICE: 1985-468-249

Figure 5-4. Sample message format for stray medical records

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Physical Therapy	Clinic
Fort Splendid, TX	
3 Feb 97 1130	SOAP NOTE: SHOULDER PAIN
	SUBJECTIVE:
	33-year-old female section leader with acute onset of right shoulder pain doing pushups.
	Denies a fall. States she had swelling and small ecchymosis on shoulder for 2 days.
	Shoulder pain is much less now. Presently has pain with reaching behind (extension),
	reaching overhead and lifting objects. No pain when shoulder is at rest. Denies any neck
	pain and no numbness or tingling R UE. X rays--no focal abnormality identified per radiology
	report. Past history is noncontributory. Past surgical history--none.
	OBJECTIVE:
	Has full range of motion of cervical spine without pain. Has mild tightness R trapezius
	with left side bending. Has full range of motion of right shoulder in seated and supine
	positions; pain at A/C joint at end of range in abduction and internal rotation only.
	Tender right A/C joint with crepitace A/C joint with range of motion. No visible
	deformity. No swelling. No ecchymosis today. No deformity of biceps visible or
	palpable. Negative Speeds test and Crossover test. No sulcus sign, negative Jobe
	relocation test, negative load shift.
	ASSESSMENT:
	Apparent A/C joint sprain--grade 1; without any joint limitations.
	TREATMENT PLAN:
	Home program of ice to right shoulder followed by supine range of motion. Shown
	stretching for right upper trapezius. Discussed use of graded exercises. Profile--
	no pushups for 2 weeks.
	GOALS:
	Able to do pushups without pain in 3 weeks.
	Mary Thomas
	Mary Thomas, 1LT, SP

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	AD	Army	
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.
Walker, Paula C. 20 32932 99 93 F 1966 SSG		

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

Figure 5-5. Sample entries on SF 600

Chapter 6
Outpatient Treatment Records

Section I
General

6–1. For whom prepared

An outpatient treatment record (OTR) (including the dental record) will be prepared for each patient treated as an outpatient at a U.S. Army MTF and DTF for whom an HREC is not prepared. CEMRs will be maintained according to chapter 7. If a beneficiary has received medical care under two different SSNs as a result of remarriage to another military sponsor, record forms filed under the former SSN should be brought forward to the number currently in DEERS. For future inquiries, the previous folder should remain in its original place in the file, cross-referenced with the new number, and retired in accordance with AR 25-400-2 at the normal retirement date.

6–2. Outpatient treatment record forms and documents

a. DA Form 8005-series folders will replace DA Form 3444-series folders only when the latter have deteriorated or when beneficiaries are entering the system for the first time. On these folders, the "Outpatient Treatment" box will be checked if the folder will be used as a medical record, and the "Dental (Nonmilitary)" box will be checked if the folder will be used as a dental record. (For the preparation and filing of the DA Form 3444-series and DA Form 8005-series folders, see chap 4.)

b. The forms used in medical OTRs are listed in figures 6-1 and 6-2. These forms will be filed from top to bottom in the order that they are listed in the figures. Retrieved files will be converted to this order. Do not attempt to convert an existing file until it is retrieved and used. Forms will be grouped and filed in reverse chronological order by visit (that is, the latest visit on top). (For authorization of forms and overprinting, see chap 3, sec I.) The forms listed in figures 6-1 and 6-2 are available through normal publications supply channels.

c. The forms and documents used in the dental OTR are listed in figure 6-3. These forms will be filed from top to bottom in the order that they are listed in the figure. The forms listed in figure 6-3 are available through normal publications supply channels. Copies of the same form will be grouped and filed in reverse chronological order.

d. Because of the importance of plotting the height, weight, and head circumference of pediatric patients, usually through 2 years of age and periodically thereafter, and because no DA form, DD form, or SF records this information, civilian pediatric growth charts and developmental screening tests may be used and are authorized for filing in the OTR and the ITR. Figures 6-1, 6-2, and 9-1 indicate the location of these forms in the medical record. The source of supply is the responsibility of each MTF.

e. DA Form 5694 (Denver Developmental Screening Test) will be used to ensure adequate medical documentation of children enrolled in the Army Exceptional Family Member Program. A screening and developmental assessment on DA Form 5694 will be completed and filed on the left side of the OTR immediately below DA Form 5568-R (Chronological Record of Well-Baby Care). A copy of this form is authorized to be filed in the ITR if the form is completed during a hospital stay.

f. DA Form 5568-R will be used to document well-baby visits. (DA Form 5568-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy of this form is located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site.

g. DA Form 5862-R (Army Exceptional Family Member Program Medical Summary) and DA Form 5291-R (Army Exceptional Family Member Program Educational Summary) will be filed on the left side of the folder according to figures 6-1 and 6-2. DA Forms 5291-R and 5862-R will be destroyed and replaced by the automated Exceptional Family Member Program Summary when it is received (See AR 608-75).

h. DA Form 5303-R (Volunteer Agreement Affidavit) will be used to document voluntary participation in a clinical investigation or research protocol. DA Form 5303-R will be prepared by the clinical investigator or researcher, who is responsible for providing a copy to the records custodian. Use of DA Form 5303-R is required by AR 40-38. A copy is provided only as a source of information for the clinician treating a patient. The original form will be retained by the clinical investigator or researcher. DA Form 5303-R will only be sent to a records custodian if the patient agrees to it. This responsibility is left to the clinical investigator or researcher. This form is authorized for filing in the HREC.

i. Insurance information obtained on DD Form 2569 will be filed in the OTR and the ITR according to figures 6-1, 6-2, and 9-1. The original signed DD Form 2569 will be filed in the medical record applicable to the type of care, and a copy will be filed in the other type of medical record. For example, if the information is obtained during an outpatient visit, file the original in the OTR and a copy in the ITR. File one copy in the HREC and forward one copy to the billing office.

j. Advance directives (durable power of attorney for health care, living wills) will be recorded per paragraph 9-2c(2).

Section II
Initiating, Keeping, and Disposing of Outpatient Treatment Records

6–3. Initiating and keeping outpatient treatment records

An OTR will be prepared by the first MTF or DTF to which a person reports for outpatient treatment. After being initiated, the OTR will be kept at the MTF or DTF (including a separate record at PRIMUS clinics) that provides the person's primary care. For each person, only one medical OTR and one dental OTR will be kept at the MTF or DTF. Partial or multiple records are prohibited except in obstetrical cases (para 6-7g) or consultation service case files (para 6-7h). When receipt of an OTR is delayed, a temporary one will be prepared according to paragraph 5-25a.

6–4. Transferring outpatient treatment records

To ensure that a patient's outpatient records are complete, the MTF providing the care will include in the OTR all outpatient records prepared at other facilities. To this end, OTRs should be transferred to the next MTF when patients change residences. OTRs of patients who may be lost to the AMEDD system (that is, sponsor is being released from military service in conjunction with the move or is being assigned to a remote location not serviced by an Army MTF) will be retained by the losing MTF per AR 25-400-2. Upon request, the patient may be given a copy of pertinent parts of his or her OTR. As an alternative, the OTR may be transferred to the nearest military MTF where care will be sought.

a. Mailing OTRs.

(1) When a patient moves, his or her OTR may be hand-carried or mailed to the next MTF. However, special category records will be mailed. (See glossary.)

(2) When an OTR is mailed to the next MTF, the procedures described in (a) through (d) below will be followed.

(a) Before leaving the old station, the sponsor will report to the MTF that provides care to his or her family members as a part of outprocessing. He or she will give the MTF the information needed to identify the records to be mailed.

(b) The MTF or DTF will complete DD Form 2138 (Request for Transfer of Outpatient Records) and instruct the sponsor to present the card at the next MTF or DTF. (Also see paras 6-5 and 8-7 for information on DD Form 2138.)

(c) When the losing MTF or DTF receives DD Form 2138, it will mail the OTR to the requesting MTF or DTF. The losing MTF or DTF will file DD Form 2138 alphabetically and keep the form until

the retirement of that year's records, at which time it will be destroyed.

(d) Medical OTRs will be mailed to the commander of the next MTF and directed to the Patient Administration Division. Dental OTRs will be mailed to the commander of the next DENTAC. They will not be sent to installation, organization, or area commanders or to personnel officers.

(3) A person whose OTR must be mailed ((1) above) may be given a copy of certain parts of his or her OTR or an extract from his or her OTR if the person needs care en route to or upon arrival at another MTF or DTF. The extract or copies will be given to the person or any other authorized person as described in *b* below. Documentation of the treatment en route should be included in the original OTR; the patient should be told to give this documentation to the next MTF or DTF.

b. Hand-carrying OTRs. If the patient (other than those described in a(1) above) requests, he or she may hand-carry his or her OTR to the next MTF or DTF. In the case of minor children, the parent or legal guardian may deliver their OTRs to the next MTF or DTF. The procedures in (1) and (2) below will be followed when OTRs are hand-carried.

(1) The patient will sign for the OTR on DA Form 3705 (Receipt for Outpatient Treatment/Dental Records). The parent or legal guardian will sign for the OTR of minor children. (When preparing DA Form 3705, complete the "address" blocks.) Once signed, DA Form 3705 will be filed in the same manner as is DD Form 2138 (a(2)(c) above).

(2) An adult's OTR will not be released to anyone other than the patient unless a signed authorization and the identification card of the patient whose record is requested to be hand-carried are presented to the MTF or DTF. Any statement approving release to another person will be acceptable if signed and dated by the patient. This statement will be attached to DA Form 3705.

c. Troop-unit changes of station. When troop units change station, the losing and gaining MTFs or DTFs will coordinate to transfer the OTRs of family members accompanying their sponsors to the new station. For OTRs that are mailed, the losing MTF or DTF will securely package and seal all OTRs destined for the same MTF or DTF and send them by registered mail.

d. Transferring x rays.

(1) An attending physician may feel that certain x rays should go with a patient on PCS. If so, this transfer will be noted on SF 600. The x rays will be also be identified on SF 600. The x rays will then be sent in a sealed envelope or mailer to the gaining MTF or DTF.

(2) All x-ray films taken for medical surveillance purposes on military members exposed to toxic substances or harmful physical agents in their work environment will be transferred in their original state along with their health record to the new duty station MTF. Transfer of x rays will be handled according to instructions on transferring x rays in (1) above.

e. PRIMUS—OTRs. Medical care provided in PRIMUS clinics to other than HREC beneficiaries will be documented in an OTR maintained by PRIMUS. This OTR is the property of the U.S. Government and includes the same standard forms used in DOD MTFs. Release of information from PRIMUS records is the responsibility of the Patient Administration Division at the sponsoring MTF. Upon sponsor's PCS and presentation of orders, records of family members less than 18 years of age will be given to sponsor. (See para 2-6 for protection of medical records of teenage family members.) A patient over age 18 may pick up his or her medical record upon presentation of the sponsor's orders authorizing the concurrent travel of the family member and a valid identification card. The sponsor may be given records of family members over age 18 only by presenting a permission note from the family member and, if possible, the patient's identification card. Upon inprocessing at the next MTF, the PRIMUS medical record will be integrated into the OTR.

6–5. Requests other than DD Form 2138

Although DD Form 2138 is the only form authorized for use as a request for transferring OTRs in ordinary circumstances, this restriction does not preclude prompt response to other types of requests. Chargeout information for such requests will be filed and kept at the losing MTR or DTF as described in paragraph 6-4a(2)(c).

6–6. Disposition

a. OTRs will be disposed of per AR 25-400-2. (See para 3-7 of this regulation for information on destroying unidentifiable OTRs.)

b. If any member of a family receives health care in the MTF or DTF during the year, the OTR of eligible members who did not receive care may be retained if the family is still in the area and expects to receive care at the facility. In this case, retape the retirement date per paragraph 4-4a(5), but if the patient is not seen, retire the records by referencing the normal retirement date.

c. X-ray films that are 8 1/2- by 11 inches or smaller that were taken for medical surveillance purposes on military members exposed to toxic substances or harmful physical agents in their work environment will be retired to the NPRC with the individual's HREC. Oversized chest/torso x-ray films taken for exposure to work place hazards will not be sent to the NPRC when service is terminated. Instead, they will be retained in their original state by the MTF at the last duty station. Annotation will be placed on the SF 600 and will include the x ray findings, where the film is located, and how it can be obtained. These x rays must be retained for the duration of military service plus 30 years, or for 40 years, whichever is greater.

Section III
Preparation and Use of Outpatient Treatment Records

6–7. Preparation

Each contact with the AMEDD as an outpatient will be recorded in the OTR. Periods of treatment as an inpatient will be described on DA Form 3647 or CHCS automated equivalent and SF 502 and copies put into the OTR. Inpatient dental treatment will be recorded on SF 603 in the dental record. Participation in research as a human subject will also be fully recorded in the OTR (para 5-16). Occupational health related forms and documentation will be filed in the OTR.

a. Preparation and use of SF 600. SF 600 is the basic record form of the medical OTR. It is a chronological record of outpatient visits. For the preparation and use of SF 600, see paragraph 5-16.

b. Preparation and use of SF 601 and PHS Form 731.

(1) SF 601 will be prepared and permanently kept for each person who has an OTR. It will be placed in the OTR when—

(a) The OTR is initiated.

(b) The patient next reports for immunization or sensitivity tests.

(c) Reactions are noted.

(2) PHS Form 731 will be prepared or posted when a patient reports to an MTF for immunizations. Only the following identification information will be entered on PHS Form 731:

(a) The patient's name on the "Traveler's Name" line.

(b) The patient's address on the address line.

(c) The county of the individual's address on its appropriate line.

(3) Personnel preparing SF 601 and PHS Form 731 will ensure that all entries are recorded on both forms and that the forms both contain the same accurate and up-to-date information.

(4) Per international rules, entries on PHS Form 731 for immunization against smallpox, yellow fever, and cholera will be authenticated. Each entry must show the DOD Immunization Stamp and the signature of the medical officer or a designated representative. (See AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E.) For other entries on PHS Form 731 and all entries on SF 601, the signature block may be stamped or typewritten and initialed by the medical officer.

c. Preparation and use of SF 603. SF 603 is the basic dental treatment form. All dental treatments and all conditions noted on examination will be entered on SF 603. See paragraph 5-18.

d. SF 603A. SF 603A will be used when needed and will be filed on top of the original SF 603. See paragraph 5-18.

e. DA Form 8006-R (Pediatric Dentistry Diagnostic Form). DA

Form 8006-R will be used for recording the examination, diagnosis, and treatment planning of pediatric dentistry patients. DA Form 8006-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy of this form is located at the back of this regulation. It isalso available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site. Instructions for completing the form are self-explanatory.

f. Preparation of the OTR folder for patients allergic to medications. On the outside front cover of the DA Form 3444-series folder or DA Form 8005-series folder, the "Medical Condition" block will be marked, and DA Label 162 affixed when SF 601, PHS Form 731, or DA Form 3365 (Authorization for Medical Warning Tag) is prepared. (See AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E and chap 13 of this regulation.)

g. Obstetrical cases. A pregnancy diagnosis will be entered on SF 600. After the pregnancy, all forms related to it will be filed in the ITR. When the records are filed, the following information will be entered on SF 600: "Prenatal care records filed in ITR of (patient's name, FMP, and SSN), (location of MTF), and (date)." If the patient does not return for prenatal care and or hospitalization, a notation will be made on SF 533 (Medical Record—Prenatal and Pregnancy), which will be filed in the OTR.

h. Civilian consultation service case files (mental health). When outpatient treatment is recorded in civilian consultation service case files, the following notation will be made on SF 600: "Patient seen, refer to file number 40-216b" (civilian consultation service case). (See AR 25-400-2 and table 3-1 of this regulation.)

6–8. Use

The OTR will be given to physicians, dentists, and other medical personnel attending an outpatient or inpatient. When an outpatient is to be treated over a short period in a clinic, the OTR may be kept in that clinic; however, it will be made available to other medical or dental personnel when required during this period. Furthermore, the OTR will accompany a patient admitted to a military MTF and will be constantly available for use by the attending physician.

a. Chargeout system. A strict audit trail will be kept for OTRs temporarily out of the file. Use of an automated record tracking system is encouraged. (See para 4-6.)

b. Protection of medical information. See chapter 2.

Until the new four-part folder is fully assimilated into the system (fig 6-2), the following order will be used for forms of the OTR using DA Form 3444-series jackets (excluding dental).

All forms should be filed in an upright position on both sides of the folder. Order given below is from top to bottom of the record.

LEFT SIDE OF FOLDER

DA Form 5571[1,2]
Master Problem List. (See paras 3-10g(3), 5-10, 5-24b(2)(f), 7-4b(4), and 9-5e.)

DA Form 3180-R
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-28a, 5-29c, and 7-4b(7) of this regulation.)

DA Form 4186
Medical Recommendation for Flying Duty. (See AR 40-501 and para 5-19b(6) of this regulation.)

DA Form 5862-R
Army Exceptional Family Member Program Medical Summary. (See AR 608-75 and para 6-2g of this regulation.)

DA Form 5291-R
Army Exceptional Family Member Program Educational Summary. (See AR 608-75 and para 6-2g of this regulation.)

Automated Exceptional Family Member Program Summary. When available, this printout replaces either DA Form 5862-R or DA Form 5291-R, or both. (See AR 608-75 and para 6-2g of this regulation.)

Civilian source pediatric growth charts. (See para 6-2d.)

SF 601[1,2]
Health Record—Immunization Record. (See paras 5-17, 5-23e(3), 5-25c(1), and 6-7b.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3-2, 5-13, and 9-25.)

SF 512[1]
Clinical Record—Plotting Chart. (See para 5-13.)

SF 545[1,2]
Laboratory Report Display. (See paras 3-2 and 9-25.) Instructions for completing this form are provided in tables 9-2 and 9-3.

SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 556; SF 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; Immunohematology; Miscellaneous. Attach to SF 545 in reverse chronological order. (See para 9-25.) Instructions for completing these forms are provided in tables 9-2 and 9-3.

SF 507[1]
Report on or Continuation of SF. File with the standard form being continued.

SF 519-B[1]
Radiologic Consultation Request/Report. (See para 9-37.)

SF 519; SF 519A
Medical Record—Radiographic Report. SF 519 and SF 519A are obsolete; use for file purposes only if already in existence.

OF 520[1]
Clinical Record—Electrocardiographic Record (formerly SF 520). Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of OF 520 or on another attached sheet of paper. CAPOC or other automated tracings may substitute for the OF 520.

Figure 6-1. Forms and documents of the OTR using DA Form 3444-series jackets—Continued

SF 560
Medical Record—Electroencephalogram Request and History (formerly DA Form 4530). SF 560 is obsolete; use for file purposes only if already in existence.

DA Form 2631-R
Medical Care—Third Party Liability Notification. (See AR 40-16.)

DA Form 3647
Inpatient Treatment Record Cover Sheet or CHCS automated equivalent. File with it copies of SF 502 (if prepared), SF 515, SF 509, SF 516, and DD Form 2770 or SF 539. Include a copy of SF 535 (Clinical Record—Newborn)1 here for newborns. Also file AF Form 565, NAVMED 6300-5, DD Form 1380, or any other narrative summaries from the VA, PHS, or other Government MTF here. (See AR 40-400 and paras 3-12a(1), 3-13b, 3-18a, 3-19b, 5-2a, 5-19a, 6-7, 9-5d, 9-9, 9-15, 9-16, 9-17, 9-18, 9-19, and 10-2.)

OF 275
Medical Record Report. File in order of the number of the form it replaces. (See paras 3-3f, 9-12c, and 9-12e.)

DD Form 2770[1]
Abbreviated Medical Record (outpatient) (formerly SF 539). (See paras 9-5d(2) and 9-21.)

DA Form 4254-R[1]
Request for Private Medical Information. (See para 2-4a.)

DA Form 4876-R[1]
Request and Release of Medical Information to Communications Media. (See para 2-3b(3).)

DA Form 5006-R[1]
Medical Record—Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. (See paras 2-3a(1) and 2-3b(1).)

DA Form 5303-R
Volunteer Agreement Affidavit. (See AR 40-38 and para 6-2h of this regulation.)

DA Form 3365
Authorization for Medical Warning Tag. (See paras 6-7f, 13-1, 13-3c, and 13-5.)

DD Form 2569
Third Party Collection Program—Insurance Information. (See paras 5-19a, 6-2i, and 9-20.)

Administrative documents and other correspondence including advance directives (durable powers of attorney for health care, living wills, etc.). (See paras 6-2j and 9-2c(2).)

DA Form 4410-R[2]
Disclosure Accounting Record. DA Form 4410-R is printed on the folder. The separate form is obsolete; use for file purposes only if already in existence.

RIGHT SIDE OF FOLDER

DA Form 4515
Personnel Reliability Program Record Identifier. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-29c, and 7-4b(7) of this regulation.)

Interfile the following five forms in reverse chronological order with the most recent on top.

SF 600[1,2]; SF 558[1],; DA Form 5181-R[1]; SF 513[1]; DD Form 2161[1]
Health Record—Chronological Record of Medical Care; Medical Record—Emergency Care and Treatment; Screening Note of Acute Medical Care; Medical Record—Consultation Sheet; Referral for Civilian Medical Care. File any other basic chronological medical care records here, for example, AMOSIST or other forms completed at civilian facilities. (See paras 5-7, 5-14, 5-16, 9-5d(3)(h), and 9-12.)

State ambulance forms. File behind corresponding SF 558. (See para 5-19b(7).)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5-6 and 9-5d(3)(h).)

DA Form 3824[1]
Urologic Examination.

Figure 6-1. Forms and documents of the OTR using DA Form 3444-series jackets—Continued

DD Form 2493-1
Asbestos Exposure Part I—Initial Medical Questionnaire. (See AR 40-5 and para 5-19b(9) of this regulation.)

DD Form 2493-2
Asbestos Exposure Part II—Periodic Medical Questionnaire. (See AR 40-5 and para 5-19b(9) of this regulation.)

DA Form 5568-R[1]
Chronological Record of Well-Baby Care. (See para 6-2f.)

DA Form 5694[1]
Denver Developmental Screening Test. (See para 6-2e.)

DA Form 3763
Community Health Nursing—Case Referral. (See paras 5-4 and 6-2.)

Home health care documentation.

DA Form 5569-R[1]
Isoniazid (INH) Clinic Flow Sheet. (See para 5-8.)

SF 602
Health Record—Syphilis Record. (See paras 5-16, 5-19b(10), and 5-24.)

DA Form 4700[1]
Medical Record—Supplemental Medical Data. When DA Form 4700 is used, it should be referenced on SF 600. Undersized reports should be mounted on DA Form 4700 display sheets and filed with reports to which they most closely relate. (See paras 3-2a, 3-3, 5-19b(7), 9-2b, and 11-4b(4).)

DA Form 5551-R
Spirometry Flow Sheet. (See TB MED 509.)

DA Form 4970-E
Medical Screening Summary—Cardiovascular Risk Screening Program. (See AR 40-501.)

SF 88[2]
Report of Medical Examination. (See AR 40-501 and paras 3-10g, 5-16d, 5-19b(1), and 5-23e(5) of this regulation.)

SF 93[2]
Report of Medical History. File any other medical history form here. (See AR 40-501 and paras 5-19b(1), 5-23e(5), and 7-4b(2) of this regulation.)

DA Form 7389[1]
Medical Record—Anesthesia (formerly SF 517 and OF 517). Outpatient surgery only. (See paras 9-5d(3)(f) and 9-12.)

OF 522[1] or State mandated forms
Medical Record—Request for Administration of Anesthesia and Performance of Operations and Other Procedures (formerly SF 522). File all other special consent forms here. (See paras 3-3 and 9-5d(3)(b).)

SF 559[1]
Medical Record—Allergen Extract Prescription, New and Refill. (See paras 5-5 and 5-15.)

DD Form 2482[1]
Venom Extract Prescription. (See para 5-12.)

DA Form 5007A-R[1]; DA Form 5007B-R[1]
Medical Record—Allergy Immunotherapy Record—-Single Extract; Medical Record—Allergy Immunotherapy Record—-Double Extract. (See para 5-5.)

Other SF 500-series forms. File here in numerical sequence with like form numbers together in reverse chronological order.

DD Form 741[1]
Eye Consultation.

Figure 6-1. Forms and documents of the OTR using DA Form 3444-series jackets—Continued

DD Form 771
Eyewear Prescription. (See AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3 and para 5-19b(2) of this regulation.)

DD Form 2215[1]
Reference Audiogram. (See AR 40-5 and DA Pam 40-501.)

DD Form 2216
Hearing Conservation Data. Also file any correspondence on hearing aids here. (See AR 40-5 and DA Pam 40-501.)

DA Form 4465-R
Patient Intake/Screening Record. Also file any other authorized alcohol and drug forms here. (See AR 600-85 and paras 5-19b(4) and 8-9k of this regulation.)

DD Form 2005[2]
Privacy Act Statement—Health Care Records. DD Form 2005 is always the bottom form or is printed on the folder. (See paras 4-4a(9), 5-25a, 7-4a, and 9-5d(1).)

Notes:

[1] Instructions for completing this form are self-explanatory.

[2] This form must be included in all OTRs.

Figure 6-1. Forms and documents of the OTR using DA Form 3444-series jackets

All forms should be filed in an upright position on both sides of the folder. Order given below is from top to bottom of the record.

PART I

DA Form 5571[1,2]
Master Problem List. DA Form 5571 is always the top form. (See paras 3-10g(3), 5-10, 5-24b(2)(f), and 7-4b(4).)

DA Form 3180-R
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-28a, 5-29c, and 7-4b(7) of this regulation.)

DA Form 5862-R
Army Exceptional Family Member Program Medical Summary. (See AR 608-75 and para 6-2g of this regulation.)

DA Form 5291-R
Army Exceptional Family Member Program Educational Summary. (See AR 608-75 and para 6-2g of this regulation.)

Automated Exceptional Family Member Program Summary. When available, this printout replaces either DA Form 5862-R or DA Form 5291-R, or both. (See AR 608-75 and para 6-2g of this regulation.)

Civilian source pediatric growth charts. (See para 6-2d.)

DD Form 2493-1
Asbestos Exposure Part I—Initial Medical Questionnaire. (See AR 40-5 and para 5-19b(9) of this regulation.)

DD Form 2493-2
Asbestos Exposure Part II—Periodic Medical Questionnaire. (See AR 40-5 and para 5-19b(9) of this regulation.)

SF 601[1,2]
Health Record—Immunization Record. (See paras 5-17, 5-23e(3), 5-25c(1), and 6-7b.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3-2, 5-13, and 9-25.)

SF 512[1]
Clinical Record—Plotting Chart. (See para 5-13.)

SF 545[1,2]
Laboratory Report Display. (See paras 3-2 and 9-25.) Instructions for completing this form are provided in tables 9-2 and 9-3.

SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 556; SF 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; Immunohematology; Miscellaneous. Attach to SF 545 in reverse chronological order. (See para 9-25.) Instructions for completing these forms are provided in tables 9-2 and 9-3.

SF 507[1]
Report on or Continuation of SF. File with the standard form being continued.

SF 519-B[1]
Radiologic Consultation Request/Report. (See para 9-37.)

SF 519; SF 519A
Medical Record—Radiographic Report. SF 519 and SF 519A are obsolete; use for file purposes only if already in existence.

OF 520[1]
Clinical Record—Electrocardiographic Record (formerly SF 520). Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of OF 520 or on another attached sheet of paper. CAPOC or other automated tracings may substitute for the OF 520.

Figure 6-2. Forms and documents of the OTR using DA Form 8005-series jackets—Continued

SF 524[1]
Medical Record—Radiation Therapy.

SF 525[1]
Medical Record—Radiation Therapy Summary.

SF 526[1]
Medical Record—Interstitial/Intercavitary Therapy.

SF 541[1]
Medical Record—Gynecologic Cytology.

SF 560
Medical Record—Electroencephalogram Request and History (formerly DA Form 4530). SF 560 is obsolete; use for file purposes only if already in existence.

DD Form 2482[1]
Venom Extract Prescription. (See para 5-12.)

SF 559[1]
Medical Record—Allergen Extract Prescription, New and Refill. (See paras 5-5 and 5-15.)

DA Form 5007A-R[1]; DA Form 5007B-R[1]
Medical Record—Allergy Immunotherapy Record—Single Extract; Medical Record—Allergy Immunotherapy Record—Double Extract. (See para 5-5.)

DA Form 5551-R
Spirometry Flow Sheet. (See TB MED 509.)

DA Form 4060
Report of Optometric Examination. DA Form 4060 is obsolete; use for file purposes only if already in existence.

DD Form 741[1]
Eye Consultation.

DD Form 771
Eyewear Prescription. (See AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3 and para 5-19b(2) of this regulation.)

DD Form 2215[1]
Reference Audiogram. (See AR 40-5 and DA Pam 40-501.)

DD Form 2216
Hearing Conservation Data. Also file any correspondence on hearing aids here. (See AR 40-5 and DA Pam 40-501.)

PART II

DA Form 4515
Personnel Reliability Program Record Identifier. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-29c, and 7-4b(7) of this regulation.)

DA Form 4186
Medical Recommendation for Flying Duty. (See AR 40-501 and para 5-19b(6) of this regulation.)

Interfile the following five forms in reverse chronological order—most recent visit on top.

SF 600[1,2]; SF 558[1]; DA Form 5181-R[1]; SF 513[1]; DD Form 2161[1]
Health Record—Chronological Record of Medical Care; Medical Record—Emergency Care and Treatment; Screening Note of Acute Medical Care; Medical Record—Consultation Sheet; Referral for Civilian Medical Care. File any other basic chronological medical care records here, for example, AMOSIST or other forms completed at civilian facilities. (See paras 5-7, 5-14, 5-16, 9-5d(3)(h), and 9-12.)

State ambulance forms. File behind corresponding SF 558. (See para 5-19b(7).)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5-6 and 9-5d(3)(h).)

Figure 6-2. Forms and documents of the OTR using DA Form 8005-series jackets—Continued

DA Form 3824[1]
Urologic Examination.

DA Form 5568-R[1]
Chronological Record of Well-Baby Care. (See para 6-2f.)

DA Form 5694[1]
Denver Developmental Screening Test. (See para 6-2e.)

SF 602
Health Record—Syphilis Record. (See paras 5-16, 5-19b(10), and 5-24.)

DA Form 3763
Community Health Nursing—Case Referral. (See paras 5-4 and 6-2.)

Home health care documentation.

DA Form 5569-R[1]
Isoniazid (INH) Clinic Flow Sheet. (See para 5-8.)

Other SF 500-series forms. File here in numerical sequence with like form numbers together in reverse chronological order.

SF 527[1]
Group Muscle Strength, Joint R.O.M. Girth and Length Measurements.

SF 528[1]
Clinical Record—Muscle and/or Nerve Evaluation—Manual and Electrical: Upper Extremity.

SF 529[1]
Medical Record—Muscle Function by Nerve Distribution: Trunk and Lower Extremity.

DA Form 4700[1]
Medical Record—Supplemental Medical Data. When DA Form 4700 is used, it should be referenced on SF 600. Undersized reports should be mounted on DA Form 4700 display sheets and filed with reports to which they most closely relate. (See paras 3-2a, 3-3, 5-19b(7), 9-2b, and 11-4b(4).)

DA Form 7389[1]
Medical Record—Anesthesia (formerly SF 517 and OF 517). Outpatient surgery only. (See paras 9-5d(3)(f) and 9-12.)

OF 522[1] or State mandated forms
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures (formerly SF 522). File all other special consent forms here. (See paras 3-3 and 9-5d(3)(b).)

SF 518[1]
Medical Record—Blood or Blood Component Transfusion.

SF 88[2]
Report of Medical Examination. (See AR 40-501 and paras 3-10g, 5-16d, 5-19b(1), and 5-23e(5) of this regulation.)

SF 93[2]
Report of Medical History. File any other medical history form here. (See AR 40-501 and paras 5-19b(1), 5-23e(5), and 7-4b(2) of this regulation.)

DA Form 4970-E
Medical Screening Summary—Cardiovascular Risk Screening Program. (See AR 40-501.)

DA Form 4465-R
Patient Intake/Screening Record. Also file any other authorized alcohol and drug forms here. (See AR 600-85 and paras 5-19b(4) and 8-9k of this regulation.)

PART III

DA Form 2631-R
Medical Care—Third Party Liability Notification. (See AR 40-16.)

DA Form 3365
Authorization for Medical Warning Tag. (See paras 6-7f, 13-1, 13-3c, and 13-5.)

Figure 6-2. Forms and documents of the OTR using DA Form 8005-series jackets—Continued

DD Form 2569
Third Party Collection Program—Insurance Information. (See paras 5-19a, 6-2i, and 9-20.)

DA Form 4254-R[1]
Request for Private Medical Information. (See para 2-4a.)

DA Form 4876-R[1]
Request and Release of Medical Information to Communications Media. (See para 2-3b(3).)

DA Form 5006-R[1]
Medical Record—Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. (See paras 2-3a(1) and 2-3b(1).)

DA Form 5303-R
Volunteer Agreement Affidavit. (See AR 40-38 and para 6-2h of this regulation.)

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care, living wills, etc.). (See paras 6-2j and 9-2c(2).)

DA Form 4410-R[2]
Disclosure Accounting Record. DA Form 4410-R is printed on the folder. The separate form is obsolete; use for file purposes only if already in existence.

PART IV

Group copies of the following forms by hospitalization episode, with most recent on top[3].

DA Form 3647[3]
Inpatient Treatment Record Cover Sheet or CHCS automated equivalent. File it with copies of SF 502 (if prepared), SF 515, SF 509, SF 516, and DD Form 2770 or SF 539. Include a copy of SF 535[1] here for newborns. Also file AF Form 565, NAVMED 6300-5, DD Form 1380, or any other narrative summaries from the VA, PHS, or other Government MTF here. (See AR 40-400 and paras 3-12a(1), 3-13b, 3-18a, 3-19b, 5-2a, 5-19a, 6-7, 9-5d, 9-9b, 9-15, 9-16, 9-17, 9-18, 9-19, and 10-2 of this regulation.)

OF 275[3]
Medical Record Report. File in order of the number of the form it replaces. (See paras 3-3f, 9-12c, and 9-12e.)

SF 502[3]
Clinical Record—Narrative Summary (outpatient). (See para 9-12.)

DD Form 2770[1]
Abbreviated Medical Record (outpatient) (formerly SF 539). (See paras 9-5d(2) and 9-21.)

SF 509[3]
Medical Record—Progress Notes. SF 509 is the final discharge note. (See paras 9-5d(3)(g) and 9-12.)

SF 515[3]
Medical Record—Tissue Examination (outpatient). (See paras 5-2, 5-19, and 9-5d(3)(e).)

SF 516[3]
Medical Record—Operation Report (outpatient). (See paras 9-5d(3)(d) and 9-12.)

SF 531[1]
Clinical Record—Anatomical Figure.

SF 533[1]
Medical Record—Prenatal and Pregnancy. File any forms belonging to pregnancy episode not delivered in MTF here. (See para 6-7.)

DD Form 2005[2]
Privacy Act Statement—Health Care Records. DD Form 2005 is always the bottom form or is printed on the folder. (See paras 4-4a(9), 5-25a, 7-4a, and 9-5d(1).)

Notes:

[1] Instructions for completing this form are self-explanatory.

[2] This form must be included in all OTRs.

[3] These forms will usually be copies of inpatient forms, except for SF 533 when patient is not admitted to the MTF for delivery.

Figure 6-2. Forms and documents of the OTR using DA Form 8005-series jackets

All forms should be filed in an upright position on both sides of the folder. Order given below is from top to bottom of the record.

LEFT SIDE OF FOLDER

DA Form 5570[1,2]
Health Questionnaire for Dental Treatment. DA Form 5570 is printed on the radiograph storage envelope. Radiographs will be stored in the envelope. (See paras 5-9 and 5-25b.)

Other radiographs too large to be included in the DA Form 5570 envelope.

DA Form 4410-R[1]
Disclosure Accounting Record. DA Form 4410-R is printed on the folder. The separate form is obsolete; use for file purposes only if already in existence.

RIGHT SIDE OF FOLDER

SF 603[1]
Health Record—Dental. File in reverse chronological order with original SF 603 on the bottom. Also file SF 603A here when needed as a continuation of section III (Attendance Record) of SF 603. (See paras 5-2c, 5-18, 5-23e(4), 5-24c, 5-25b, 5-25c(3), 5-20a(2), 5-31c, and 6-7.)

DA Form 4700
Medical Record—Supplemental Medical Data. (See paras 3-2a, 3-3, 5-19b(7), 9-2b, and 11-4b(4).)

DA Form 8006-R[2]
Pediatric Dentistry Diagnostic Form. (See para 6-7e.)

DA Form 3984
Dental Treatment Plan. (See TB MED 250.)

SF 513[2]
Medical Record—Consultation Sheet. (See para 9-12.)

SF 507[1]
Report on or Continuation of SF. File with the standard form being continued.

SF 519-B[2]
Radiographic Consultation Request/Report. (See para 9-37.)

SF 519; SF 519A
Medical Record—Radiographic Report. SF 519 and SF 519A are obsolete; use for file purposes only if already in existence.

SF 521
Clinical Record—Dental. SF 521 is obsolete; use for file purposes only if already in existence.

OF 522[2] or State mandated forms
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures (formerly SF 522). File all other special consent forms here. (See paras 3-3 and 9-5d(3)(b).)

DA Form 8-115
Register of Dental Patients. DA Form 8-115 is obsolete; use for file purposes only if already in existence.

Other medical or dental records important to the patient's care.

DD Form 2005[1]
Privacy Act Statement—Health Care Records. DA Form 2005 is always the bottom form or is printed on the folder. (See paras 4-4a(9), 5-25a, 7-4a, and 9-5d(1).)

Notes:

[1] This form must be included in all nonmilitary dental records.

[2] Instructions for completing this form are self-explanatory.

Figure 6-3. Forms and documents of the nonmilitary dental record

Chapter 7
Occupational Health Program Civilian Employee Medical Record

Section I
General

7–1. Compliance
The purpose of this chapter is to explain how the initiation, maintenance, and disposition of CEMRs will meet the requirements of DOD Instruction (DODI) 6055.5, the Occupational Safety and Health Administration (OSHA) (29 CFR 1904, 29 CFR 1910, and 29 CFR 1960), and regulations of the Office of Personnel Management (5 CFR 293.501, Subpart E).

7–2. Definition and purpose of the civilian employee medical record
a. The CEMR is defined as a chronological, cumulative record of both occupational and non-occupational information about health status developed on an employee during the course of employment. It includes personal and occupational health histories, exposure records, medical surveillance records, Office of Workers' Compensation Programs (OWCP) records, and the written opinions and evaluations generated by health care providers in the course of examinations, treatment, and counseling.

b. The purpose of the CEMR is to provide a complete medical and occupational exposure history for employee care, medicolegal support, research, and education.

c. CEMRs are not maintained on soldiers. Occupational health related documentation, such as exposure records, medical surveillance records, x-ray reports, etc., are filed in the OTR.

7–3. For whom prepared
A CEMR will be prepared for each permanent civilian employee upon employment. A medical record will be prepared for all nonpermanent employees who receive any type of occupational health services.

7–4. Civilian employee medical records folder and forms
a. The CEMR may be maintained either in the terminal digit filing system DA Form 3444-series or the SF 66D during the course of employment. When the DA Form 3444-series folders are used, they will be prepared and filed according to chapter 4. When the SF 66D folders are used, they will be filed alphabetically by last name. The name (last, first, M.I.), date of birth, and SSN of the employee will be typed on a label and affixed to the SF 66D on the indicated space on the folder. Ensure the civilian employee completes a separate DD Form 2005 regardless of the type folder used. The CEMR will be retired or transferred in the SF 66D folder, therefore the employee does not need to complete the preprinted DD Form 2005 on the inside of the folder when the DD Form 3444-series is used.

b. The forms authorized for use in CEMRs are listed in figure 7-1 below. These forms will be filed from top to bottom in the order they are listed in the figure. Copies of the same form will be grouped and filed in reverse chronological order (the latest on top). Specialized occupational health forms may be maintained in CEMRs, but must have prior approval by the supporting MEDDAC/MEDCEN (chap 3, sec I). When it is necessary to use a DD form, DA form, or SF that is not listed in figure 7-1 but is listed in this regulation, file it in the order listed in the relevant figure of chapter 5 or chapter 6.

(1) SF 78 (U.S. Civil Service Commission, Certificate of Medical Examination) will be used to record preemployment physical examination results for appropriated fund employees, and may be used to record periodic job-related physical examination results. Parts A, B, and C of the SF 78 are authorized for filing in the CEMR and parts D, E, and F are forwarded to the Civilian Personnel Office (CPO).

(2) SF 93 will be used to obtain a health history from civilian workers and to initiate a medical record on employment and subsequent job-related medical surveillance or other purposes as required.

(3) DA Form 3437 (Nonappropriated Funds Certificate of Medical Examination), will be used to record preemployment physical examination results for nonappropriated funds employees and may be used to record periodic job-related physical examination results. DA Form 3437 is authorized for filing in the CEMR.

(4) DA Form 5571 provides a summary of known past and current diagnoses or problems, and currently or recently used medications.

(5) DD Form 1141 or ADR is used to record results of all personal monitoring, to include film badge readings for each person occupationally exposed to ionizing radiation. DD Form 1141 or ADR is a medical record and is filed in the CEMR (AR 40-14/DLAR 1000.28 and para 5-19b(5) of this regulation).

(6) DA Form 4515 and DA Form 3180-R are used according to AR 50-5 and AR 50-6 to identify and evaluate all individuals working in the nuclear or chemical surety programs.

(7) Copies of the following OWCP medical forms are authorized to be maintained in the CEMR:

(a) Department of Labor (DOL) Form CA-16 (Authorization for Examination and or Treatment).

(b) DOL Form CA-17 (Duty Status Report).

(c) DOL Form CA-20 (Attending Physicians Report).

(d) DOL Form CA-20a (Attending Physicians Supplemental Report).

(8) In addition, a copy of DOL Form CA-1 (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation) is maintained in the CEMR when the employee files a claim with OWCP for an occupational traumatic injury, but the original DOL Form CA-1 is placed in the medical record if a claim is not filed. A copy of DOL Form CA-2 (Federal Employee's Notice of Occupational Disease and Claim for Compensation) is authorized to be maintained in the CEMR when the employee is claiming an occupational disease (5 CFR 293.501).

(9) Copies of the following nonmedical forms may be filed in the CEMR to provide supplementary medical data:

(a) OF 345 (Physical Fitness Inquiry for Motor Vehicle Operators).

(b) SF 177 (Statement of Physical Ability for Light Duty Work).

Section II
Maintaining, Transferring and Disposing of Civilian Employee Medical Records and Retention of Job-Related X-Ray Films

7–5. Custody and maintenance of civilian employee medical records
The MTF commander is the official custodian of all medical records at his or her facility including CEMRs. The Chief, Patient Administration Division, of an MTF will act for the commander to handle medical records. The CEMRs will usually be maintained in the outpatient record room of the MTF when the occupational health service/clinic is collocated with a hospital. The CEMRs will be maintained in the U.S. Army Health Clinic or Occupational Health Clinic or Occupational Health Nursing Office when the clinic is not collocated with a hospital.

7–6. Medical record entries
Medical record entries in the CEMR will be made in accordance with paragraph 3-5.

7–7. Recording occupational injuries and illnesses
a. Record all injury or illness incurred as the result of performance of duty by individual personnel. Identify the injury or illness as "occupational." The recording of an occupational injury must include the details below.

(1) The exact nature of the injury.

(2) The part or parts of the body affected.

(3) The external causative agent. In the case of acute poisoning, the poison must be named.

(4) How the injury occurred.

(5) The place where injured. State the building and or area.

(6) The date of the injury.

b. For the recording of injuries or diseases caused by chemical or bacteriological agents or by ionizing radiation, see paragraph 3-12c.

7–8. Cross-coding of medical records

Civilian employees who are military medical beneficiaries will have two medical records, the CEMR and the OTR. These records will be cross-indexed to identify the dual status, to facilitate care, and to ensure appropriate identification and reporting of occupational illnesses and injuries.

7–9. Transferring and retiring civilian employee medical records

The CEMR of an employee transferring to another Federal agency or separating from Federal service will be forwarded to the CPO identified in the SF 66D within 10 days of transfer or separation (AR 25-400-2). The CPO will forward the CEMR to the appropriate custodian.

7–10. Retention of job-related x-ray films

a. Legal and regulatory requirements dictate that x-ray films performed for exposure to work place hazards must be preserved and maintained for at least the duration of employment plus 30 years, or for 40 years, whichever is greater (29 CFR 1910.20, 5 CFR 293.501, and DODI 6055.5).

b. Civilian employee x-ray films performed for exposures to work place hazards are part of the CEMR. X-ray films 8 1/2- by 11 inches or smaller will fit within the CEMR file folder and will be transferred to another Federal employing agency or retired with the medical record. Oversized chest/torso x-ray films cannot fit into the CEMR and will not be sent with the record to storage; however, they will be sent with the CEMR to a new Federal employing agency. When the CEMR is sent to storage, oversized films must be retained in their original state by the last MTF that provided occupational health services to the employee until such time as they may be destroyed. (See *a* above.) Radiographic results will be included in the CEMR and a notation will be entered on the SF 600 and include the location of any film not present in the record and how it can be obtained. A microfiche copy of any type x ray except chest may be placed in the CEMR instead of the original x ray. 29 CFR 1910.20(d)(2) requires that chest x-ray films be preserved in their original state.

c. See paragraphs 6-4d(2) and 6-6c for transfer and retention of x-ray films taken for medical surveillance purposes on military members exposed to toxic substances or harmful physical agents in their work environment.

Section III
Confidentiality of Medical Information, Access to Civilian Employee Medical Records, and Performance Improvement

7–11. Protection of confidentiality and disclosure procedures

a. All CEMRs and medical information pertaining to civilian employees will be treated as private information. The provisions of chapter 2 of this regulation will be followed in protecting the confidentiality of medical information contained in CEMRs and in responding to requests for the disclosure of such information. In addition, OSHA and OPM rules (29 CFR 1910.20, 5 CFR 293.504, 5 CFR 297.204-205, and 5 CFR 297.401(c)) provide for access by the employee or his or her representative as designated in writing, and by OSHA representatives (compliance officers and National Institute for Occupational Safety and Health personnel) to examine or copy medical records or medical information that bears directly on the employee's exposure to toxic materials and harmful physical agents. The employee or his or her designated representative must be provided one copy of this data upon request without cost to the employee or his or her representative. The information must be provided within 15 working days of the employee's request.

b. Workers' compensation claims directly involve the employer and all facts relevant to the case become the concern of management. All medical records relating to the injury, illness, or death of an employee entitled to Federal Employee Compensation Act benefits are the official records of the Office of Personnel Management and are not the records of any agency having the care or use of such records (5 CFR 293.506). For all OWCP cases that are treated by a physician, a medical report is required. This report may be made on DOL Forms CA-16, CA-17, CA-20, or CA-20a; a narrative report on the physician's letterhead stationary; or in the form of an EC/ED summary. A copy of these reports is maintained in the CEMR.

c. When required, with the knowledge and permission of the employee, an interpretation of medical findings may be given to the CPO or responsible management personnel to assure safe and effective use of manpower.

7–12. Civilian employee medical record review

CEMRs will be included in the Patient Administration Division performance improvement processes. Medical records will be reviewed for accuracy, timeliness, completeness, clinical pertinence, and adequacy as medicolegal documents. All guidance and standards in paragraph 11-3 that are applicable to the CEMR will be used in this review.

All forms should be filed in an upright position on both sides of the folder. Order given below is from top to bottom of the record.

LEFT SIDE OF FOLDER

DA Form 5571[1,2]
Master Problem List. DA Form 5571 is always the top form. (See paras 3-10g(3), 5-10, 5-24b(2)(f), and 7-4b(4).)

DA Form 3180-R
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-28a, 5-29c, and 7-4b(7) of this regulation.)

DA Form 8007-R
Individual Medical History. (See paras 5-24b(2)(g), 5-30a, and 11-3a(9).)

DA Form 4186
Medical Recommendation for Flying Duty. (See AR 40-501 and para 5-19b(6) of this regulation.)

Documents and correspondence on flying status; that is, restrictions, removal of restrictions, suspensions, and termination of suspensions. (See AR 600-105.)

DD Form 1141; ADR
Record of Occupational Exposure to Ionizing Radiation; Automated Dosimetry Record. (See AR 40-14/DLAR 1000.28 and paras 5-19b(5) and 7-4b(5) of this regulation.)

DD Form 2493-1
Asbestos Exposure—Part I—Initial Medical Questionnaire. (See AR 40-5 and para 5-19b(9) of this regulation.)

DD Form 2493-2
Asbestos Exposure—Part II—Periodic Medical Questionnaire. (See AR 40-5 and para 5-19b(9) of this regulation.)

OF 345
Physical Fitness Inquiry for Motor Vehicle Operators. (See AR 40-5 and para 7-4b(11) of this regulation.)

SF 177
Statement of Physical Ability for Light Duty Work. (See AR 40-5 and para 7-4b(11) of this regulation.)

SF 601[1,2]
Health Record—Immunization Record. (See paras 5-17, 5-23e(3), 5-25c(1), and 6-7b.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3-2, 5-13, and 9-25.)

SF 512[1]
Clinical Record—Plotting Chart. (See para 5-13.)

SF 545[1,2]
Laboratory Report Display. (See paras 3-2 and 9-25.) Instructions for completing this form are provided in tables 9-2 and 9-3.

SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 556; SF 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; Immunohematology; Miscellaneous. Attach to SF 545 in reverse chronological order. (See para 9-25.) Instructions for completing these forms are provided in tables 9-2 and 9-3.

SF 507[1]
Report on or Continuation of SF. File with the standard form being continued.

SF 519-B[1]
Radiographic Consultation Request/Report. (See para 9-37.)

Figure 7-1. Forms and documents of the CEMR using DA Form 3444-series jackets or SF 66D folders—Continued

SF 519; SF 519A
Medical Record—Radiographic Report. SF 519 and SF 519A are obsolete; use for file purposes only if already in existence.

OF 520[1]
Clinical Record—Electrocardiographic Record (formerly SF 520). Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of OF 520 or on another attached sheet of paper. CAPOC or other automated tracings may substitute for the OF 520.

DA Form 5551-R
Spirometry Flow Sheet. (See TB MED 509.)

DA Form 4060
Report of Optometric Examination. DA Form 4060 is obsolete; use for file purposes only if already in existence.

DD Form 741[1]
Eye Consultation.

DD Form 771
Eyewear Prescription. (See AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3 and para 5-19b(2) of this regulation.)

DD Form 2215[1]
Reference Audiogram. (See AR 40-5 and DA Pam 40-501.)

DD Form 2216
Hearing Conservation Data. Also file any correspondence on hearing aids here. (See AR 40-5 and DA Pam 40-501.)

Reports or certificates prepared by neuropsychiatric consultation services or psychiatrists.

DA Form 3365
Authorization for Medical Warning Tag. (See paras 6-7f, 13-1, 13-3c, and 13-5.)

DA Form 4254-R[1]
Request for Private Medical Information. (See para 2-4a.)

DA Form 4876-R[1]
Request and Release of Medical Information to Communications Media. (See para 2-3b(3).)

DA Form 5006-R[1]
Medical Record—Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. (See paras 2-3a(1) and 2-3b(1).)

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care, living wills, etc.). (See paras 6-2j and 9-2c(2).)

DA Form 4410-R[2]
Disclosure Accounting Record. The DA Form 4410-R is printed on the folder. The separate form is obsolete; use for file purposes only if already in existence.

RIGHT SIDE OF FOLDER

DA Form 4515
Personnel Reliability Program Record Identifier. (See AR 50-5, 50-6, and paras 5-19b(8), 5-29c, and 7-4b(7) of this regulation.)

Interfile the next four forms in reverse chronological order—most recent visit on top.

SF 600[1,2]; SF 558[1]; SF 513[1]; DD Form 2161[1]
Chronological Record of Medical Care; Medical Record—Emergency Care and Treatment; Medical Record—Consultation Sheet; Referral for Civilian Medical Care. File any other basic chronological medical care records here, for example, AMOSIST or other forms completed at civilian facilities. (See paras 5-7, 5-14, 5-16, 9-5d(3)(h), and 9-12.)

DA Form 5008
Telephone Medical Advice Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5-6 and 9-5d(3)(h).)

Other SF 500-series forms. File here in numerical sequence with like form numbers together in reverse chronological order.

Figure 7-1. Forms and documents of the CEMR using DA Form 3444-series jackets or SF 66D folders—Continued

DA Form 4700[1]
Medical Record—Supplemental Medical Data. When DA Form 4700 is used, it should be referenced on SF 600. Undersized reports should be mounted on DA Form 4700 display sheets and filed with reports to which they most closely relate. (See paras 3-2a, 3-3, 5-19b(7), 9-2b, and 11-4b(4).) File here any other forms used to record the results of atmospheric sampling.

SF 88
Report of Medical Examination. (See AR 40-501 and paras 3-10g, 5-16d, 5-19b(1), and 5-23e(5) of this regulation.)

SF 78
U.S. Civil Service Commission, Certificate of Medical Examination. (See para 7-4b(1).)

DA Form 3437
Nonappropriated Fund Certificate of Medical Examination. (See para 7-4b(3).)

SF 93[2]
Report of Medical History. File any other medical history form here. (See AR 40-501 and paras 5-19b(1), 5-23e(5), and 7-4b(2) of this regulation.)

DOL Form CA-1
Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation. (See para 7-4b.)

DOL Form CA-2
Federal Employee's Notice of Occupational Disease and Claim for Compensation. (See para 7-4b.)

DOL Form CA-16
Authorization for Examination and or Treatment. (See para 7-4b.)

DOL Form CA-17
Duty Status Report. (See para 7-4b.)

DOL Form CA-20
ttending Physicians Report. (See para 7-4b.)

DOL Form CA-20a
Attending Physicians Supplemental Report. (See para 7-4b.)

DD Form 2005[2]
Privacy Act Statement. DD Form 2005 is always the bottom form in the CEMR. (See paras 4-4a(9), 5-25a, 7-4a, and 9-5d(1).) A separate DD Form 2005 must be in the CEMR as the CEMR must be retired or transferred in SF 66D folder, which does not have a preprinted DD Form 2005.

Notes:

[1] Instructions for completing this form are self-explanatory.

[2] This form must be included in all CEMRs.

Figure 7-1. Forms and documents of the CEMR using DA Form 3444-series jackets or SF 66D folders

Chapter 8
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical

Section I
General

8–1. For whom prepared
An ADAPCP-OMR will be prepared for each patient enrolled in the ADAPCP.

8–2. Access
All personnel having access to ADAPCP-OMRs will protect the privacy of medical information. Care will be taken to prevent unauthorized release of any information on the treatment, identity, prognosis, or diagnosis for alcohol or drug abuse patients. Requests for release of information will be handled in accordance with chapter 2 of this regulation and AR 600-85, chapter 6, using DA Form 5018-R (ADAPCP Client's Consent Statement for Release of Treatment Information).

8–3. Disclosure of information
a. Requests for release of information from ADAPCP-OMRs will be handled by the Patient Administration Division in accordance with AR 600-85 and chapter 2 of this regulation. DA Form 5018-R must be completed. Information will be released only under the authority of the Patient Administration Division.

b. The following drug and alcohol laws take precedence over other directives pertaining to access to drug and alcohol rehabilitation information.

(1) 42 USC 290dd-2 prohibits the disclosure of records of the identity, diagnosis, prognosis, or treatment of any patient maintained

in connection with a Federal substance abuse program, except under the following circumstances:

(a) The patient consents in writing;

(b) The disclosure is allowed by a court order; or

(c) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

(2) 42 USC 290dd-2 provides no exceptions for civilian employees participating in the Nuclear or Chemical Surety Personnel Reliability Programs (AR 50-5 and AR 50-6), or any DOD or Army personnel security program (AR 380-67).

(3) A "patient" is defined in 42 CFR 2.11 as "any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a Federally-assisted program." An employee does not have to be enrolled in the program in order to be protected by the provisions of 42 USC 290dd-2, so long as the employee falls within this definition of patient.

(4) During the initial screening, or as soon thereafter as possible, the patient will be notified of the Federal confidentiality requirements and will be given a summary in writing of the Federal laws and regulations. A sample notice is contained in 42 CFR 2.22.

(5) A patient may have access to his or her own records, including the opportunity to inspect and copy any records that the program maintains about the patient. A patient's written request for such access, although not required, is encouraged.

(6) ADAPCP civilian service records will be maintained in accordance with 42 CFR 2.16, 49 CFR part 382, and this regulation.

(7) The Privacy Act of 1974, 5 USC 552a, also applies to all information maintained in a system of records retrievable by reference to an employee name or other personal indentifier.

c. When information is released (except as authorized in *b* above), the disclosure must be accompanied by the following statement: "Prohibition on redisclosure. This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR part 1 (21 USC 1175 and 42 USC 4582)) prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose."

8–4. Forms and documents

a. The forms and documents used in ADAPCP-OMRs are listed in figure 8-1 and are available through normal publications supply channels.

b. The current treatment record jacket (DA Form 3444-series) with fasteners on the left and right sides will be used as ADAPCP-OMR file folders. ADAPCP-OMRs may be filed in either alphabetical or terminal digit order.

c. Tabbed separators that delineate the content areas will be placed between all documents on the left and right sides of the folder as described in (1) and (2) below.

(1) On the left side, tabbed separators will be placed between the documents in the order listed in figure 8-1, left side. Tabs will be located with the starting point at the bottom left of the first or most top document and will be stairstepped from left to right across the bottom.

(2) On the right side, the first tab protrudes from the top and the others stairstep down the right side, starting from the top document to the bottom document. The tabs should be identified beginning with the most top document to the bottom document as listed in figure 8-1, right side.

Section II
Initiating, Maintaining, and Disposing of Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Records

8–5. Initiating and maintaining

When a patient is enrolled in the ADAPCP, the following notation will be made on the SF 600 maintained in either the HREC, the OTR, or the CEMR corresponding to the patient's category: Date patient seen, refer to file number 40-66pp. After being initiated, the ADAPCP-OMR will be maintained by and appropriately secured in the Community Counseling Center (CCC). The Chief, Patient Administration Division, will provide technical advice on maintenance of ADAPCP-OMRs. For each person, only one ADAPCP-OMR will be kept at the CCC.

8–6. Transferring

a. To assist in providing continuity of care for ADAPCP patients, upon patient PCS, ADAPCP-OMRs should be transferred by certified mail to the next MTF or CCC. Upon notification of PCS of an active duty member, ADAPCP-OMRs of individuals actively involved in the ADAPCP will be mailed to the next MTF or CCC. All PCSs or reassignments will be handled in accordance with AR 600-85.

b. ADAPCP-OMRs of patients lost to the AMEDD system (that is, sponsor is being released from military service in conjunction with the move or is being assigned to a remote location not serviced by an Army MTF) will be retained by the losing MTF and retired per AR 25-400-2, file number 600-85d.

c. ADAPCP-OMRs of civilian employees will be transferred to the next MTF or CCC.

8–7. Requests other than DD Form 2138

Although DD Form 2138 is the only form authorized for use as a request for transferring ADAPCP-OMRs in ordinary circumstances, this restriction does not preclude prompt responses to other types of requests. Chargeout information for such requests will be filed and kept at the losing MTF as described in paragraph 6-4a(2)(c).

8–8. Disposition

ADAPCP-OMRs will be disposed of per AR 25-400-2.

Section III
Preparation and Use of Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Records

8–9. Preparation

Each contact with the ADAPCP will be recorded in the ADAPCP-OMR.

a. DA Form 7095 (ADAPCP Outpatient Discharge Summary) will be prepared when treatment is completed. It will be used to summarize the clinical course by concisely describing the reason for admission, treatment rendered, the patient's response, the patient's status at the time of discharge, and prognosis for future success.

b. DA Form 7096 (ADAPCP Outpatient Aftercare Plan) will be prepared when treatment is completed and will describe further rehabilitative responsibilities required for continued success. It will include the patient's rehabilitation status at the time of discharge, ADAPCP clinical responsibilities, medications (if applicable), and support group involvement.

c. DA Form 7097 (ADAPCP Outpatient Problem List and Treatment Plan Review) will be used to document the periodic review and evaluation of patient progress in relationship to each identified problem. It is prepared at the time of scheduled multidisciplinary case conferences. DA Form 7097 is equivalent to DA Form 5571.

d. DA Form 7098 (ADAPCP Outpatient Treatment Plan and Review) will be a written, individualized plan of care based on the patient's clinical needs. It will be prepared within 72 hours of patient enrollment and includes problem statements, patient outcomes written in measurable terms, interventions, and staff responsibilities for facilitating behavioral and lifestyle changes. Dates associated with problem identification and resolution must also be included.

e. DA Form 7099 (ADAPCP Outpatient Biopsychosocial Evaluation) will be prepared upon initial screening and will be used to document assessment data relative to the patient's alcohol and other drug use and legal, physical, psychosocial, military or educational, and employment or vocational backgrounds.

f. DA Form 8000 (ADAPCP Triage Instrument (for Unscheduled Patients)) will be used to gather salient information that can be used to determine the need and urgency for treatment of patients who do not have scheduled appointments. It will be prepared at the time that the patient is seen and includes the presenting problem(s), a brief history of alcohol and other drug use, and suicidal potential.

g. DA Form 8001 (Limits of Confidentiality) will be used to briefly explain the meaning of confidentiality and conditions under which disclosure of patient information to third parties must occur. It will be discussed with the patient and signed before DA Form 7099 is completed.

h. DA Form 8002 (ADAPCP Outpatient Administrative Summary) will be used to briefly summarize rehabilitation efforts from date of patient enrollment to current date or termination of ADAPCP services. It will be initiated when the patient is enrolled in the program and updated at the time of each scheduled event.

i. DA Form 8003 (ADAPCP Enrollment) will be used to make an ADAPCP referral and to gather pertinent information needed to make an enrollment decision. It will be initiated by the commander at the time the problem is identified and completed by the ADAPCP clinical staff at the conclusion of the rehabilitation team meeting.

j. DA Form 8004-R (ADAPCP Outpatient Medical Records—Privacy Act Information) will be signed by the patient after he or she reads it. DA Form 8004-R explains the provisions of the Privacy Act as they pertain to ADAPCP-OMRs. A copy of this form is located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site.

k. DA Form 4465-R will be used to document initial screening data needed to determine the nature and severity of the problem. It will be completed upon screening and or enrollment in the ADAPCP or when a medical evaluation is needed. (See AR 600-85 for instructions on completing this form.)

l. DA Form 4466-R (Patient Progress Report) will be used to document patient progress. It will be used to document patient progress (at 90-, 180-, 270-, and 360-day intervals following enrollment) upon inpatient enrollment and or discharge, to change the diagnosis or basis for enrollment, patient PCS, or patient reassignment, or to release the patient from the program. (See AR 600-85 for instructions on completing the form.)

8–10. Use

a. ADAPCP-OMRs will be provided to physicians, dentists, and other health-care practitioners attending the ADAPCP patient for continuing patient care.

b. A strict audit trail will be kept for ADAPCP-OMRs temporarily removed from the file. (See para 4-6.) A strict record will be kept of any ADAPCP record/information disclosed to any person or organization.

All forms should be filed in an upright position on both sides of the folder. Order given below is from top to bottom of the record.

LEFT SIDE OF FOLDER

DA Form 3180-R
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-28a, 5-29c, and 7-4b(7) of this regulation.)

DA Form 7097[1]
ADAPCP Outpatient Problem List and Treatment Plan Review. (See para 8-9c.)

DA Form 8002[1]
ADAPCP Outpatient Administrative Summary. (See para 8-9h.)

DA Form 4465-R
Patient Intake/Screening Record. (See AR 600-85 and paras 5-19b(4) and 8-9k of this regulation.)

DA Form 4466-R
Patient Progress Report. (See AR 600-85 and para 8-9l of this regulation.)

SF 513[1]; DD Form 2161[1]
Medical Record—Consultation Sheet; Referral for Civilian Medical Care. File any forms completed at civilian facilities here. (See paras 5-16 and 9-12 of this regulation.)

Psychological evaluation reports.

SF 545[1]
Laboratory Report Display. (See paras 3-2 and 9-25.) Instructions for completing this form are provided in tables 9-2 and 9-3.

SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 556; SF 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; Immunohematology; Miscellaneous. Attach to SF 545 in reverse chronological order. (See para 9-25.) Instructions for completing these forms are provided in tables 9-2 and 9-3.

SF 507[1]
Report on or Continuation of SF. File with the standard form being continued.

SF 519-B[1]
Radiologic Consultation Request/Report. (See para 9-37.)

SF 519; SF 519A
Medical Record—Radiographic Report. SF 519 and SF 519A are obsolete; use for file purposes only if already in existence.

DA Form 8003[1]
ADAPCP Enrollment. (See para 8-9i.)

Special forms and other administrative correspondence. File most recent form on top. Include court reports, letters, memoranda, consent forms, release of information requests, and orders.

RIGHT SIDE OF FOLDER

DA Form 4515
Personnel Reliability Program Record Identifier. (See AR 50-5, AR 50-6, and paras 5-19b(8), 5-29c, and 7-4b(7) of this regulation.)

DA Form 7095[1]
ADAPCP Outpatient Discharge Summary. (See para 8-9a.)

DA Form 7096[1]
ADAPCP Outpatient Aftercare Plan. (See para 8-9b.)

DA Form 7098[1]
ADAPCP Outpatient Treatment Plan and Review. (See para 8-9d.)

Figure 8-1. Forms and documents of the ADAPCP-OMR—Continued

SF 600[1]
Health Record—Chronological Record of Medical Care. (See para 5-16.)

DA Form 7099[1]
ADAPCP Outpatient Biopsychosocial Evaluation. (See para 8-9e.)

DA Form 8000[1]
ADAPCP Triage Instrument (For Unscheduled Patients). (See para 8-9f.)

Miscellaneous treatment and information.

DA Form 8001[1]
Limits of Confidentiality. (See para 8-9g.)

DA Form 8004-R[1]
ADAPCP-OMR—Privacy Act Information. (See para 8-9j.)

Notes:

[1] Instructions for completing this form are self-explanatory.

Figure 8-1. Forms and documents of the ADAPCP-OMR

Chapter 9
Inpatient Treatment Records

Section I
General

9–1. For whom prepared

a. An ITR will be prepared for—

(1) Every bed patient (military or civilian) in a fixed or field hospital (FH), fixed health clinic, or convalescent center.

(2) Every APV patient.

(3) Each liveborn infant delivered in one of those MTFs.

(4) CRO cases (para 3-18).

(5) NATO patients (para 9-6).

b. An ITR will not be prepared for—

(1) Stillbirths. (There will be no separate record made for the stillbirth. Forms and information pertaining to the stillbirth will be included in the mother's ITR.)

(2) MTFs supporting combat operations if the theatre surgeon or equivalent considers their use impractical and if DD Form 1380 has been approved for use.

c. For a nonfixed MTF using ITRs, instructions for preparation will be provided by the MEDDAC or MEDCEN in whose geographical area the nonfixed facility is operating. Disposition will be per AR 25-400-2.

9–2. Inpatient forms and documents

a. See paragraph 3-3 for guidance concerning approval of forms and documents.

b. All ITR forms will be fastened into the proper DA Form 3444-series folder. During treatment, the forms will be arranged in the order prescribed by the MTF commander. When the patient is discharged or transferred, the forms will be arranged in the order in which they are listed in figure 9-1. The forms listed in figure 9-1 are available through normal publications supply channels. The same numbered forms will be grouped chronologically, except for laboratory and radiology reports, which will be filed in reverse chronological order. DA Form 4700 may be filed immediately after an SF or DA form when it is supplemental to that form (excluding SF 600). DA Form 4700 will identify the SF or DA form in the lower right identification block following "Other." In all other instances, DA Form 4700 will be filed per figure 9-1.

(1) ITRs for previous admissions (except those already retired per AR 25-400-2) will be filed in the same folder. They will be put in reverse chronological order (the most recent admissions on top) and separated by locally devised dividers.

(2) All copies of ITRs transferred with a patient will be kept as a part of his or her current ITR. However, copies of forms from transferred records will not be interfiled with the forms of the current ITR.

c. Although administrative documents are not a part of the ITR itself, they should be filed in the ITR folder.

(1) The ITR will include a copy of any notification to an emergency addressee or next-of-kin (AR 600-8-1). It will also include copies of any reports to military or civil authorities, including birth and death certificates (AR 40-400). Copies of reports to military or civil authorities may not be available, for example, when made by telephone or by summary report form. In this case, the following information will be put in a memorandum for record:

(a) The fact and date of notification.

(b) The diagnostic terminology used.

(c) The name and title of the person notified. (The original memorandum for record will be filed in the ITR; a copy of it will be sent immediately to the patient's attending physician for his or her information.)

(2) Advance directives (durable powers of attorney for health care, living wills, etc.), are one way in which a patient can communicate his or her intent with regard to the provision of health care in the event the patient is incapacitated. 42 USC 1395cc(f)(1)(A) requires MTFs and other health care facilities to provide written information to each patient on that patient's right under the law of the State in which the MTF is located, to make decisions regarding medical care in the event the patient is incapacitated. This includes the patient's right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Further, the MTF must provide the patient with the MTFs policies regarding the implementation of the patient's rights with regard to advance directives. Such information must be provided to a patient at the time of the patient's admission to the MTF in an inpatient status. 42 USC 1395cc(f)(1) requires all MTFs and other medical care facilities to document in an individual's medical record whether or not that person has executed an advance directive. In accordance with 10 USC 1044c and AR 40-3, chapter 19, advance directives shall be given legal effect in accordance with State law. The MTF commander will consult with a judge advocate for legal advice in each case involving the implementation or interpretation of an advance directive. Advance directives should be filed with administrative documents on the left side of the folder in ITRs and on the right side of the folder in HRECs, OTRs, and CEMRs.

(3) Unless authorized by this regulation, only documents prepared by authorized AMEDD personnel will be filed in the ITR. However, this restriction does not prohibit the use of other documents by attending physicians and does not prohibit the filing of other documents in the ITR as summaries or pertinent brief extracts. If filed, patient identification data as well as the source and the physician under whom the reports were prepared must be identified.

9–3. Fetal monitoring strips

a. Identification procedures for fetal monitoring strips are provided in (1) through (5) below.

(1) Identify and file fetal monitoring strips in envelopes that can be filed efficiently in the standard fiberboard boxes that are used to retire records. (For example, two rows of 6 1/2- by 9 1/2-inch envelopes can be filed in these boxes.) Keep the strips on the obstetrical unit with the prenatal record until delivery.

(2) After delivery, put the information described in (a) through (d) below on the envelopes that contain the fetal monitoring strips. Put the data on the plate imprint to the left margin.

(a) Name and register number of infant. If the infant has not been named, record "baby boy" or "baby girl" with the last name.

(b) Sponsor's name and SSN.

(c) Name of MTF.

(d) Date of birth.

(3) Inside the envelope, file the additional locator card received from admissions and dispositions. Use this locator card when the fetal monitoring strips are retired.

(4) Record the infant's first name on the locator card or if not named, "baby boy" or "baby girl" with the last name.

(5) When the infant is discharged, send the monitoring strips to inpatient records.

b. Disposition procedures for fetal monitoring strips are provided in (1) through (6) below.

(1) The inpatient records section will maintain the fetal monitoring strips as a separate file; strips will be filed in register number sequence.

(2) The locator card received from admissions and dispositions with the monitoring strips will be stapled on the outside of the envelope or kept in a separate alphabetical file until the strips are retired.

(3) Medical records personnel will write the register number of the infant at the top of each envelope where it will be clearly visible when records are filed in boxes for retirement. The maximum use of filing space is possible when envelopes are arranged in two rows in the boxes. A label from the CHCS Medical Record Tracking Option may be affixed to the envelope. Add items of identification not printed on the label.

(4) Fetal monitoring strips will be retained under the original register number of the infant and will not be brought forward to subsequent register numbers.

(5) Special cases are described in (a) through (d) below.

(a) Transfer of an undelivered patient. When an undelivered patient is transferred, copies of all fetal monitoring strips prepared are sent with the copy of the ITR of the patient.

(b) Transfer of newborn. When a newborn infant is transferred during initial hospitalization, a copy of the fetal monitoring strip is forwarded with the patient.

(c) Stillborn infants. Fetal monitoring strips for stillborn infants are filed under the register number of the mother.

(d) Other special cases. When it cannot be determined that prenatal care terminated in hospitalization or delivery, the outpatient fetal monitoring strips are sent to the inpatient medical records section. These strips are filed alphabetically and retired alphabetically in the last box of fetal monitoring strips being retired for that year. A locator card is also prepared for these strips, and "No Register Number" is entered on the card.

(6) Fetal monitoring strips will be retired in accordance with AR 25-400-2: MEDCENs will retire the strips 5 years after the end of the year of birth; Army community hospitals will retire the strips 1 year after the end of the year of birth. Fetal monitoring strips will be retired in register number sequence (except as described in (5)(d) above). Locator cards will be retired in alphabetical order and shipped with the fetal monitoring strips.

c. The USAMEDCOM or the 18th Medical Command must approve filing fetal monitoring strips in microform, compact disc, or other format.

Section II
Initiating, Keeping, and Disposing of Inpatient Treatment Records

9–4. General

An ITR will be initiated when a patient is admitted or is a CRO or APV case. (See para 3-18 for information on CRO cases; see para 9-5 for information on APV cases.) The ITR will be prepared and reviewed per this regulation and locally established procedures.

9–5. Records for Ambulatory Procedure Visit patients

a. The APV will not be CRO. All documentation related to the APV will be filed on the left side of the appropriate DA Form 3444-series folder (para 4-3). If there is no existing ITR, or if the MTF does not provide inpatient services, a DA Form 3444-series folder will be prepared according to paragraph 4-4.

b. Documentation for the APV must meet the documentation standards for a short term stay (abbreviated medical record) and must comply with current JCAHO documentation standards.

c. The official biostatistical collection of the APV is the Ambulatory Data System (ADS). Providers will select the appropriate International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) diagnoses and the Current Procedural Terminology medical procedures and evaluation and management services relevant to the APV. (The ICD-9-CM is on file in each Army MTF, and is available from the source listed in app A.) Nursing personnel are responsible for properly annotating any nursing related care and services associated with ADS.

d. At a minimum, the documentation in the medical record will include—

(1) DD Form 2005.

(2) DD Form 2770 (Abbreviated Medical Record).

(3) An ongoing, interdisciplinary assessment of patient needs and patient plan of care which includes, but is not limited to—

(a) Preprocedure and postprocedure patient instructions, to include a brief physician summary of care provided, and advance directives.

(b) DA Form 4256.

(c) OF 522 or State mandated form.

(d) SF 516.

(e) SF 515.

(f) DA Form 7389.

(g) SF 509.

(h) All appropriate therapeutic documentation, to include postprocedure follow-up telephone call (DA Form 5008); SF 558, if an APV occurs subsequent to treatment in an EC/ED; and all diagnostic and laboratory reports.

e. A copy of the patient's postprocedure instructions with a summary of care (for example, SF 509 or DD Form 2770, etc.) will be forwarded to the HREC/OTR. The original APV record will not be integrated into the HREC/OTR. The APV will be annotated on DA Form 5571 in the HREC/OTR.

f. The MTF will develop a mechanism for internal tracking of the APV. APV records will be stored in a limited access area of the MTF, for example, the inpatient records section.

9–6. North Atlantic Treaty Organization Standardization Agreement 2348 requirements

The ITRs of NATO personnel who are treated by Army MTFs are prepared in the same manner as ITRs for other patients. (This requirement also applies to DD Form 1380 and DD Form 602.) In addition, the policies listed in *a* and *b* below apply to North Atlantic Treaty Organization (NATO) personnel.

a. Copies of an ITR and associated inpatient documents, including x-rays, will accompany a NATO member who is transferred to a hospital of another nation. When he or she is discharged from an Army MTF, the original ITR will be sent to his or her national military medical authority. (See table 9-1 for a list of these authorities.) Sometimes DD Form 1380 or DD Form 602 (STANAG 2132) will be prepared as well as an ITR. If so, copies of these forms will go with the copy of the ITR. The original DD Form 602 should be stapled to the SF 502.

b. The amount of information put in an ITR should be standard for all forces. All items normally recorded for U.S. personnel will be recorded for NATO personnel. In addition, the marital status of the NATO member will be recorded.

9–7. Inpatient treatment records of absent-without-leave patients

The ITR of a patient who has been absent-without-leave (AWOL) for 10 consecutive days will be closed and disposed of per file numbers 40-66f (military ITRs) and 40-66i (NATO personnel ITRs). (See AR 25-400-2 and table 3-1 of this regulation.)

9–8. Five-year inpatient treatment record maintenance

MEDCENs will keep ITR files for 5 years and will keep APV records for 5 years after the end of the year of the last inpatient disposition or APV. (MEDDACs will retire APV records 1 year after the end of the year of the last inpatient disposition or APV.) These MEDCENs are—

a. Brooke Army Medical Center, Fort Sam Houston, TX 78234-6200.

b. Madigan Army Medical Center, Tacoma, WA 98431-5055.

c. Tripler Army Medical Center, HI 96859-5000.

d. William Beaumont Army Medical Center, El Paso, TX 79920-5001.

e. Walter Reed Army Medical Center, Washington, DC 20307-5000.

f. Dwight David Eisenhower Medical Center, Fort Gordon, GA 30905-5650.

g. Womack Army Medical Center, Fort Bragg, NC 28307-5000.

9–9. Access and audit trail

Access must be given to ITRs on file or to cases having register numbers. In addition, a record audit trail must be kept. The two indexes described in *a* and *b* below will be kept for these purposes. When an automated database, for example, CHCS, is used to consolidate the admission and disposition history of individual inpatients, a manual inpatient nominal index is no longer necessary.

a. Nominal index. The nominal index will include a card for each patient assigned a register number. Each card will list the patient's name, SSN with FMP, and register number. The cards will be filed alphabetically by last name. If the patient is transferred, the date of transfer and the name of the receiving MTF will be noted on the card. In the case of a readmission, information from previous admissions will be attached to or recorded on the current card. A manual nominal index is not required in those facilities maintaining CHCS, or other automated patient data systems.

b. Register number index. MEDDACs will maintain a register number index for 5 years. MEDCENS do not need to maintain this index because the ITRs are maintained at the MEDCEN for 5 years. The register number index will include a copy of DA Form 3647 for each patient assigned a register number. A copy of SF 502 (when prepared) may be attached to DA Form 3647. This index will be kept in register number sequence. For transfer cases, a copy of the transmittal form will be attached to DA Form 3647 or CHCS automated equivalent.

c. Diagnostic index. This index identifies each patient by FMP/SSN and register number. It lists up to eight diagnoses for each patient. This index is arranged in diagnostic code number sequence.

d. Operative index. This index identifies each patient by FMP/SSN and register number. It lists up to eight surgical, diagnostic, or therapeutic procedures per patient. This index is arranged in procedure code sequence.

9–10. Disposition of inpatient treatment records

a. Inpatient transfer. When a patient is transferred to a U.S. Army MTF, to an Air Force or Navy MTF, or to a VA Medical Center, a copy of the ITR will be sent along and will become a part of the receiving MTF's ITR (para 9-2b(2)). As a minimum, this copy should include SF 513, DD Form 2161 (Referral for Civilian Medical Care), SF 504 (Clinical Record—History—Part I), SF 505 (Clinical Record—History—Parts II and II), SF 506 (Clinical Record—Physical Examination), SF 535 (Clinical Record—Newborn), DA Form 7389, SF 515, SF 509 (2 weeks prior to transfer), DA Form 3647 or CHCS automated equivalent, SF 502, lab reports, and diagnostic reports (radiology, ultrasound, echocardiography, and EKG tracings). When a patient is moved to another type of MTF, extracts, summaries, or copies of the ITR will be sent; the original ITR will be kept by the Army MTF and disposed of per AR 25-400-2, file numbers 40-66f (military ITRs), 40-66g (civilian ITRs), and 44-66i (NATO personnel ITRs). (See table 3-1.)

b. Microscope slide transfer. Copies of slides of surgical specimens may go with the ITR of a patient being transferred to another hospital. They will be sent when the histopathologic findings have a direct bearing on diagnosis and treatment (AR 40-31/BUMEDINST 6510.2F/AFR 160-55). In such cases, the attending physician will tell the Patient Administration Division that the slides are to go with the patient. On the cover sheet, the patient administrator will enter "Copy of microscope slide (or number of microscope slides) forwarded with copy of ITR" and will then send the slides with the patient's records. If the patient is a "transient" (that is, en route to another hospital), the patient administrator will send copies of the slides with the copy of the ITR when the patient departs.

c. Normal retirement procedures. For disposition instructions, see AR 25-400-2, file numbers 40-66e (foreign national ITRs), 40-66f (military ITRs), 40-66g (civilian ITRs), and 40-66i (NATO personnel ITRs). (See table 3-1.)

Section III
Preparation and Use of Inpatient Treatment Records

9–11. Inpatient treatment records content

ITRs must be accurate, complete, and current. The ITR must reflect the patient's current status and treatment. After discharge of a patient, the practitioner will complete the final progress note on SF 509, SF 502, and DA Form 3647 or CHCS automated equivalent within 4 working days. If a test result is pending, 7 working days will be allowed. If the transcription of dictated reports is delayed, the practitioner will have met his or her requirements as pertains to the completion of the ITR. Each MTF will establish internal policy to satisfy the requirement of the JCAHO for a completed ITR. Records will be completed using available findings; delayed reports will be filed in the ITR when received and, if needed, a corrected DA Form 3647 or CHCS automated equivalent will be prepared. Records will be reviewed per this chapter and paragraph 11-3.

a. If requested by the attending physician, ITRs from previous admissions, OTRs, HRECs, and medical records for transferred patients will be provided.

b. Reports needed for the ITR will be completed promptly. (See para 9-12.) As laboratory, consultation, or other reports are completed, they will be added to the ITR along with any progress notes (SF 509) (para 9-12b) and other notes made by health-care providers.

c. When the patient is discharged, the attending physician will prepare SF 502 (para 9-12e), complete the DA Form 3647 worksheet (section IV) or CHCS automated equivalent, and send the completed ITR through channels to the Patient Administration Division. Copies of ITRs received with a transferred patient will be sent with the completed ITR to the Patient Administration Division and filed in the DA Form 3444-series folder (para 9-2b(2)). OTRs and HRECs will be returned to the proper records custodian.

d. In obstetrical cases, an ITR will be prepared when the patient

is hospitalized at termination of pregnancy. All prenatal care records will be filed in this ITR.

e. The disposition of a patient will not be delayed to complete a record. If a case ends in death and an autopsy is to be performed, the attending physician must send the ITR to the pathologist for use in the autopsy, along with a sufficient summary of the case, which may be informal, even oral. The pathologist will return the ITR to the attending physician as soon as possible, but no later than 7 days, so that it may be completed and sent to the Patient Administration Division. (See para 9-12f.)

9–12. Medical reports

The forms and reports to be filed in an ITR depend on the nature of the case and the treatment given. All forms and reports needed for a case will be included. (Automated versions of forms, basic policies for these reports, and the recording of diagnoses are discussed in chap 3.) Specific reporting needs are described in *a* through *f* below.

a. History and physical. An admission workup will be prepared on SF 504, SF 505, and SF 506 within 24 hours of admission. These forms will be as pertinent and complete as needed for proper patient management. Before surgery under general anesthesia is performed, the ITR must include a complete history and a current, thorough physical examination. (The cardiopulmonary system findings will be fully recorded; terms such as "normal," "wnl," and "negative" will not be used.) These reports are not needed, however, in emergencies. For emergency surgery, the physician will report only vital signs, pertinent physical findings, and any allergies (if known). (Also see paras 9-13 and 9-21 for information on SF 504, SF 505, and SF 506.)

(1) *Transfer-in cases.* If an adequate history and physical arrive with a transfer-in patient, an interval progress note (SF 509) stating that there has been no change will suffice. If there are important changes, they will be clearly and fully reported. If the patient arrives without a history and physical or with inadequate ones, the needed reports will be prepared by the servicing MTF. (If this inadequacy was caused by negligence, the commander of the transferring MTF will be advised of it and corrective action will be requested.) (Also see paras 5-16b(3) and 9-14 for information on SF 509.)

(2) *Readmission.* When a patient is readmitted within 30 days, an interval history and physical will be written in the progress notes (SF 509). These reports will describe any pertinent changes. However, these interval reports are allowed only if a copy of the original history and physical is also sent to the attending physician. If a history and physical were performed in an ambulatory setting, they may be used upon admission if they were done within 30 days of the date of admission. The attending physician will initial or sign and date a statement in the progress notes showing that the previous history and physical were reviewed.

(3) *Documentation on SF 504, SF 505, and SF 506.* Admission history and physical examinations will be recorded on SF 504, SF 505, and SF 506 only by staff physicians, qualifying oral and maxillofacial surgeons, residents, and certified midwives as appropriate. Podiatrists may record and perform admission histories and physical examinations on podiatry patients only with regard to the podiatry problem on SF 504, SF 505, and SF 506. The medical history and physical examination (head, eyes, ears, lungs, heart, and so forth) must be performed and signed by a physician (doctor of medicine or doctor of osteopathy). In programs for children and adolescents, developmental age factors will be evaluated, educational needs will be considered, and this information will be included, as appropriate. All surgery performed by podiatrists will be restricted to the foot that is distal to the tibiotalar or ankle joint, and the surgery will be under supervision of an orthopedic surgeon. If a podiatrist is stationed at an MTF where no orthopedic surgeon is available, the surgery will be limited to outpatient procedures in the clinic area only. PAs may perform medical histories and physical examinations provided the findings are countersigned by the attending physician.

b. SF 509. SF 509 will describe chronologically the clinical course of the patient. SF 509 should reflect any change in condition and the results of treatment. SF 509 will be recorded by the person giving the treatment or making the observation. If integrated progress notes are approved for use by the Executive Committee of the MTF, pertinent data must be recorded on the SF 509 in chronological order by all disciplines involved in the care of the patient. Each entry must be clearly identified (for example, nurse's note), dated and signed. (See para 3-4c.)

(1) *Progress notes by doctors.* In addition to the information described in *b* above, doctors' progress notes, documented on SF 509, will analyze the patient's clinical course and outline the rationale for specific medical decisions. Doctors' progress notes (SF 509) begin with an admission note, continue with notes during hospitalization, and conclude with a final note on discharge, transfer, or death.

(a) The admission note will record briefly the clinical circumstances that brought the patient to the hospital, will summarize the proposed diagnostic workup, and will suggest the type of therapeutic management. For emergency patients, SF 558 will be put in the ITR and may be used as the admission note. (See para 5-14.) A copy of the SF 558 will be filed in the OTR/HREC. Associated consultations and diagnostic test reports will also be filed in the ITR. At the time of intrahospital transfer, a note will be written to summarize the course of the patient's illness and his or her treatment.

(b) For surgical patients, the admission note may serve as the preoperative note. In addition to giving the information in (a) above, these notes will justify the surgery and state the procedure proposed. If surgery scheduled within 24 hours of admission is not performed within 2 days, another preoperative note will be written by the surgeon. This note must again justify the surgery. When the operative report is not placed in the record immediately after surgery, a progress note is entered immediately.

(c) The anesthetist's preanesthesia note that explains the choice of anesthesia for the proposed procedure will be recorded on DA Form 7389. A postanesthetic note will be made after the patient has left the postanesthesia care unit or other recovery area. It will record the presence or absence of anesthesia-related complications, vital signs and level of consciousness, medications (including intravenous fluids) and blood and blood components.

(d) For the postoperative patient, progress notes (SF 509) will record the condition of the surgical wound, any indication of infection, and the removal of sutures and drains. Per JCAHO standards, the postanesthetic note may be recorded by a qualified, licensed independent practitioner or by the use of medical staff-approved criteria. Progress notes (SF 509) will also record examinations of chest and legs until the patient is ambulatory and afebrile, the use of casts or splints, and any other pertinent data.

(e) The final progress note (SF 509) will record the patient's general condition on discharge, the final diagnosis, and postdischarge care, including activity permitted, diet, medications, dressings, and the date and clinic for followup care or other actions recommended to address concerns identified during this hospitalization.

(f) In hospital death cases, the final note (SF 509) will describe the terminal circumstances, findings, and final diagnosis. It should also state whether or not an autopsy was performed.

(g) The frequency of progress notes (SF 509) depends on the condition of the patient. In no case, however, will more than 7 days pass without a progress note.

(2) *Progress notes by nurse anesthetists, nurse practitioners, clinical nurse specialists, and PAs.* These personnel will record their progress notes on SF 509, as described in (1) above.

(3) *Progress notes by nurses.* Nurses' notes, documented on SF 510 (or SF 509 in those MTFs using integrated progress notes), will describe chronologically the nursing care given the patient. (See para 9-13.)

(4) *Dietetic progress notes.* The treatment given inpatients will be recorded on SF 509. When the entry is long and complex, SF 513 will be used, with reference made on SF 509. Each entry will be identified as "Dietitian's Note."

(5) *Physical and occupational therapy notes.* Treatment given inpatients will be recorded on SF 509. When the entry is long and

complex, SF 513 will be used, with reference made on SF 509. Each entry will be identified as a physical therapy or occupational therapy note; worksheets will not become a permanent part of the ITR.

(a) The therapist's first ITR entry should be the first evaluation of the patient, including the goals of the treatment program and the plan of care.

(b) Later entries should be periodic status reports, including the patient's response to treatment and any important changes in his or her condition or treatment program.

(c) The final summary note will be an evaluation of the therapy given, including the patient's progress, goal achievement, and any recommendations for postdischarge care.

(6) *Social service notes.* Social service personnel will record their notes on SF 509. These notes will include—

(a) Medicosocial study of the patient who needs social services.

(b) Social therapy and rehabilitation.

(c) Social service summary. (When the entry is long and complex, SF 513 will be used, with a reference made on SF 509. Each entry will be identified as a social work entry; social work case files will not become a part of the patient's ITR (file number 40-216f, social work individual cases).) (See AR 25-400-2 and table 3-1 of this regulation.)

(7) *Psychology notes.* Clinical psychologists may only admit patients to the MTF if a physician member of the active medical staff conducts the physical examination, assuming responsibility for the care of a the patient's medical problems present at the time of admission, or which may arise during hospitalization which are outside the psychologist's lawful scope of practice (AR 40-48). Psychology officers (area of concentration 73B) will record their notes on SF 509. The notes will include—

(a) Name, rank, branch, and professional title of the psychologist.

(b) Dates seen.

(c) Organizational unit where the consultation was performed (for example, (number) Division Psychologist or (name) Hospital Psychology Service).

(d) Reference to any consultation done on the patient and reported in more detail on SF 513.

(e) Any diagnostic or therapeutic services provided and any findings, diagnoses, or therapeutic outcomes.

(f) Any significant consultation contacts concerning the patient with other personnel, such as unit commanders, lawyers, teachers, family members, and so on.

(g) A summary at the completion of treatment.

(h) The psychologist's discharge order, which must be countersigned by the attending physician.

(i) A summary of extensive contacts and a complete reference made to SF 513 or other full reports. Clinical psychology case files will not become a part of the ITR (file number 40-216e, clinical psychology individual cases). (See AR 25-400-2 and table 3-1 of this regulation.)

c. SF 516. Reports for all cases involving surgery including operative or other invasive procedures such as cardiac catheterizations in the operating room or ambulatory surgery unit, even when performed under local anesthesia, will be dictated immediately after surgery and transcribed on SF 516, OF 275, or automated equivalents. (See para 3-3 for information on OF 275.) When the operative report is not placed in the record immediately after surgery (for example, there is a transcription or filing delay), an operative progress note is entered in the medical record immediately after surgery. SF 516 will be filed in the ITR as soon as possible after surgery. All procedures performed anywhere other than the operating room or ambulatory surgery unit (for example, ward, clinic, or EC/ED) will be described in the progress notes (SF 509). Procedural terminology on the SF 516 or SF 509, SF 502, and DA Form 3647 will be the same. SF 516 will include—

(1) The pre- and postoperative diagnosis.

(2) The name of the operation.

(3) A full description of the findings, both normal and abnormal, of all organs explored.

(4) A detailed account of the technique used and the tissue removed.

(5) The condition of the patient at the end of the operation.

(6) Name of primary surgeon and any assistants.

d. SF 513. A consultant is a health-care provider who gives professional advice or services on request. SF 513 will include the matters on which the requesting practitioner sought an opinion, consultant's review of the patient's medical record, and the consultant's findings and recommendations. Also see paragraph 5-2b(2).

e. SF 502. The narrative summary will be dictated promptly at transfer-out or discharge of the patient and transcribed onto SF 502, OF 275, or automated equivalent. SF 502 should be concise (rarely more than one typewritten, single-spaced sheet). Diagnostic and procedural terminology on SF 502 or progress note (SF 509) (see (2) below) and DA Form 3647 or CHCS automated equivalent will be the same. (See paras 5-2, 5-19, 6-7, 9-9, 9-11, 9-17, and 9-21 for more information on SF 502.)

(1) SF 502 (in narrative form) will include—

(a) The reason for hospitalization, including a brief clinical statement of the chief complaint and history of the present illness.

(b) All significant findings.

(c) All procedures performed and treatment given, including patient's response, complications, and consultations. (Any prosthetic device that is permanently implanted in the body will be identified, including nomenclature of prosthesis, manufacturer, and serial numbers as provided.)

(d) The condition of the patient on transfer or discharge.

(e) The discharge instructions given to the patient or his or her family (that is, physical activity permitted, medication, diet, and followup care).

(f) All relevant diagnoses (including complications) made by the time of discharge or transfer.

(2) A progress note (SF 509) summarizing the case may be substituted for the narrative summary (SF 502) when—

(a) A transfer or discharge occurs within 48 hours after admission. (See para 9-21e.)

(b) An obstetrical case has a normal, uncomplicated delivery.

(c) A patient's problem is minor. (See para 9-21.)

(3) All hospital death cases require a narrative summary.

f. SF 503 (Clinical Record—Autopsy Protocol). The pathologist's provisional anatomic diagnoses will be entered in the ITR within 72 hours of death; the complete protocol will be recorded on SF 503 within 60 days of death. SF 503 will include—

(1) Gross anatomical findings and toxicological analyses.

(2) Provisional pathologic diagnoses.

(3) Final diagnoses based on the definitive microscopic findings and toxicological analyses.

9–13. Nursing process documentation

a. General.

(1) The nursing process provides the basis for assessing, planning, implementing, and evaluating nursing care delivery. Elements of the nursing process which are documented in a clinical pathway format or on local interdisciplinary forms do not require duplication.

(2) Use of DA Form 3888 (Medical Record—Nursing History and Assessment) and DA Form 3888-2 is optional for cases of a minor nature that require no more than 48 hours of hospitalization or for military members who are hospitalized for uncomplicated conditions that do not generally require hospitalization in the civilian sector. A modified nursing history and assessment can be documented on SF 510 or SF 509 when integrated progress notes are in use. The MTF policy for patient assessment will address the specific assessment requirements of various categories of short-stay patients.

(3) Admission assessment documentation requirements for same diagnosis re-admissions will be stipulated in hospital policy. The previous admission nursing assessment will be reviewed and referenced in the clinical record on SF 509, SF 510, DA Form 3888, or DA Form 3888-2. Any changes in physical condition or presenting symptoms will be annotated.

b. DA Form 3888.

(1) *Purpose.* DA Form 3888 documents a baseline nursing history and assessment on each patient requiring nursing care. It may serve as the admission nursing note.

(2) *General.* The nursing history and assessment will be completed within the time specified in unit policy. The RN will use a variety of sources of data from which a plan of care is developed. Regardless of what data are collected, and by whom, the RN is responsible for their accuracy and completeness. Although all nursing personnel may participate in data collection, the assessment must be completed and documented by the RN. Guides for the nursing history and assessment may be overprinted on the forms in accordance with the appropriate local or command policy.

(3) *Preparation.* Enter all patient data as indicated on the forms.

(4) *Content.* Data entered on DA Form 3888 represent baseline health status information used by the nurse to plan care. The information may be obtained from the patient, other informed persons, and or the patient's records.

(a) The front portion of the form, containing a brief series of questions, provides a guideline for the interview.

1. Date and time of admission and admitting diagnosis are recorded in the provided space.

2. Responses by the patient to the interview questions are recorded next to the questions in the area provided.

3. Spaces are provided for recording information to assist in contacting the next of kin, or in their absence, another person designated as a point of contact for concerns arising as a result of the hospital episode (for example, support person, company commander, first sergeant, etc.).

4. The person collecting the data is to sign his or her name, rank, and title and specify the informant from whom the data were obtained by name and relationship (for example, patient, CPT Jones or aunt, Mrs. Allen).

5. A space is provided for noting the disposition of articles brought to the hospital. Initialing by the interviewer attests to where such items were consigned. It does not mean the interviewer was the one who actually placed the article(s) in the designated area.

(b) The reverse side of DA Form 3888 provides spaces for recording admission vital signs and for completing the nursing history and nursing assessment.

1. Categories of assessment, with guidelines, are provided at the bottom of the page for assistance in making the nursing assessment. Data on the biophysical parameters for the listed items should be collected as appropriate for planning care.

2. The date and time are recorded on the DA Form 3888 with the signature of the RN who completed the nursing assessment. If the DA Form 3888 is completed at the time of admission, an admission note is not required in the nursing notes. However, an entry will be made in the nursing notes to refer to the DA Form 3888 for the admission note.

c. DA Form 3888-2.

(1) *Purpose.* DA Form 3888-2 is used to document identified patient care problems with patient focused goals derived from the problems and discharge considerations to include patient and family educational needs. The RN is responsible for its preparation, implementation, update, and evaluation. It is used by all nursing personnel caring for the patient.

(2) *Preparation.* Enter all patient identification data as indicated on the form. If the DA Form 3888 is completed at the time of admission, an admission note is not required in the nursing notes and SF 510 (or SF 509 in those MTFs using integrated progress notes).

(3) *Content.* The nursing plan of care will reflect current nursing standards and measures which will facilitate the prescribed medical care and restore, maintain, and promote the patient's well being. It is used in conjunction with DA Form 4677 (Clinical Record—Therapeutic Documentation Care Plan (Non-Medication) and DA Form 4678 (Clinical Record—Therapeutic Documentation Care Plan (Medication) that list the nursing actions and other prescribed orders related to implementing the doctor's orders and to achieving the specified goals.

(a) Record the date, nursing diagnoses and or patient problems identified, the initials of the RN, and the sequence number of the problem in the appropriate columns.

(b) The primary problems or nursing diagnoses to be addressed during this hospitalization will be listed in the appropriate column. Nursing diagnoses describe the patient's actual or potential health problems. As patient problems (or nursing diagnoses) are identified, they are recorded in the appropriate column and numbered in sequence. The RN is responsible for review and revision of the problems/nursing diagnoses to reflect the changing needs of the patient. For each identified problem and or nursing diagnosis, a nursing order(s) must be written on DA Form 4677 and or DA Form 4678.

(c) Expected outcomes (goals) are to be stated as patient outcomes. These should be mutually set with the patient and or family. The goals will be realistic, measurable, and consistent with the multidisciplinary plan of care. When a problem no longer exists or the goal was accomplished, the date the goal was accomplished or revised will be entered in the Date Accomplished column. Corresponding nursing orders will be discontinued and, if indicated, new orders will be written.

(d) In those instances when there are no individual patient care problems identified on admission, the RN will document this on the DA Form 3888-2. Each patient's status will be reassessed as established in unit specific policy.

(e) Discharge considerations identified prior to or at admission, and throughout hospitalization, will be noted in the space provided on DA Form 3888-2.

d. SF 510.

(1) *General.* Nursing notes provide a chronological record of the nursing care provided, the patient's status, and responses to routine or emergent nursing interventions. The documentation will reflect change in condition and results of treatment. Subjective patient comments will be documented. The SF 510 is not required when nursing notes are integrated on the SF 509.

(2) *Preparation.* Enter all patient identification data as indicated on the form. Each entry by nursing personnel will be preceded with the date and time of the entry. If applicable, reference the patient problem/nursing diagnosis being addressed. Each entry will be appropriately signed.

(3) *Admission note.* If the DA Form 3888 is completed at the time of admission, an admission note does not need to be recorded in the nursing notes. If DA Form 3888 was not completed at the time of admission, an admission nursing note must be recorded that includes the date, time, manner of admission, reported known allergies and a brief but clear description of the patient's status.

(4) *Discharge note.* If DA Form 3888-3 (Medical Record—Nursing Discharge Summary) or a computerized integrated discharge summary form is completed, a discharge note does not need to be recorded. A notation will be made in the nursing notes referencing the patient discharge and the discharge summary form.

(5) *Content.* Documentation of nursing care is pertinent, concise, and reflects patient status. Therapeutic interventions are noted, including the patient's response to medical orders and to the implementation of the individualized nursing plan of care and nursing standards of care.

(a) Format of notations. Format is determined by local policy. However, components of the nursing process; that is, assessing, planning, implementing, and evaluating, will be evident in the notes.

1. Each notation will be preceded with the date and time of the entry. The specific time the note is being written should be indicated. Block charting (for example, 0700-1500) is not authorized.

2. All notes will be appropriately signed. As necessary a line will be drawn to eliminate any unused space between the entry and the signature.

(b) Delayed entries. An entry may be made out of chronological order by noting the date and time of the entry followed by a statement that this recording is out of sequence.

(6) *Frequency of charting.* The minimum charting frequency of the patient's status for category 4, 5 and 6 patients is one entry per shift, category 2 and 3 patients once a day and category 1 patients once a week. More frequent charting will be dictated by local

policy, changes in the patient's condition, the patient's response to treatment, incidental occurrences and the judgement of the RN responsible for the care of the patient.

(a) If no notation appears, it indicates that there has been no significant change in the patient's status. The patient received care as ordered; no abnormal observations were made and no unusual activities or incidents were noted.

(b) Any "STAT" procedures and medications which were necessitated by a change in the patient's condition must be documented in the nursing notes.

(c) Documentation of patient transfer to and from the following areas is mandatory: OR, recovery room, treatment both within and off the MTF premises, and to another nursing unit.

(7) *Documentation.* Documentation by nursing personnel other than the RN does not absolve the RN (that is, clinical head nurse, charge nurse, team leader, etc.) of the responsibility for professional supervision to include the review of both the appropriateness of the nursing care delivered and the documentation of that care.

(8) *Student charting.* The policy for student charting will be determined by the Chief Nurse of the MTF and the faculty representative of the nursing program.

e. DA Form 3888-3.

(1) *Purpose.* DA Form 3888-3 is used to facilitate summarizing the patient's plan of care at the time of discharge from the MTF. An entry will be made in the nursing notes to refer to the DA Form 3888-3. This form is not required when a computerized integrated discharge summary form is in use.

(2) *Preparation.* DA Form 3888-3 is a three-copy carbonless form. The original copy becomes part of the patient's ITR (filed in DA Form 3444 series folder); the second copy is reviewed with the patient and retained by the patient or family, and the third copy is placed in the HREC or OTR.

(a) Entries can be made by all nursing personnel. The RN is responsible for ensuring the accuracy and completeness of the entries, and for reviewing the instructions with the patient or significant other person prior to discharge.

(b) All patient identification information is to be entered in the space provided on the form.

(3) *Content.* Information on this form will be pertinent, factual, and written in terms understood by the patient and family.

(a) Complete the form as specified by each section of the summary.

(b) The writer's initials, followed by "yes" or "no," as appropriate, are recorded in all blocks related to patient understanding of instructions.

(c) "N/A" is placed in those spaces not applicable, or where notation is unnecessary.

9–14. Countersignatures

a. The following ITR reports and entries will be countersigned by the supervising physician or, when appropriate, by a qualified oral and maxillofacial surgeon. Exceptions to this requirement for countersignature may be granted by the MTF commander though the privileging process.

(1) Histories and physical examinations performed by someone other than the senior resident, staff physician, qualified oral and maxillofacial surgeon, or certified midwife.

(2) Operation reports (SF 516) written or dictated by someone other than the surgeon.

(3) Narrative summaries (SF 502) written or dictated by someone other than the attending physician, dentist, podiatrist, or midwife in charge of the case.

(4) Doctors' verbal and telephone orders (DA Form 4256). (These orders will be countersigned by the prescribing physician.)

b. Progress notes (SFs 509) do not require the countersignature of the supervising physician or nurse.

c. When personnel in approved graduate medical education programs are involved in patient care, the care provided will be documented on SF 509 and SF 510, as appropriate. Sufficient evidence will be documented in the medical record to substantiate active participation in and supervision of the patient's care by the responsible program preceptor. Documentation of histories and physicals (SF 504, SF 505, and SF 506) and doctors' orders (DA Form 4256), when an integral part of the program, will be countersigned by the preceptor physician or, when appropriate, by a qualified oral and maxillofacial surgeon.

Section IV
DA Form 3647

9–15. General purpose

DA Form 3647 or CHCS automated equivalent is a medical and administrative summary of each case and will be prepared for each case that requires an ITR. (For CRO cases, DA Form 3647 or CHCS automated equivalent may be the entire ITR.) DA Form 3647 or CHCS automated equivalent is also an essential document for HRECs and OTRs and serves as a source document for statistical information of major military and medical interest. In facilities using CHCS, an automated version of DA Form 3647 may be used. A worksheet copy may not be provided in CHCS.

9–16. Use

Paragraph 9-1a names the kinds of MTFs that use DA Form 3647 or CHCS automated equivalent. In addition, DA Form 3647 may be used in overseas commands by clearing stations chosen and staffed to be run as nonfixed hospitals. The theater surgeon will determine if these holding stations will use DA Form 3647 or CHCS automated equivalent by the mission and function of the holding unit. When such units serve only as a triage on an airfield holding point, DA Form 3647 or CHCS automated equivalent is not needed; a note on the patient's medical record giving the date and name of the holding station is sufficient.

9–17. Initiation and disposition

DA Form 3647 or CHCS automated equivalent is initiated when a patient is admitted to the MTF and completed when the patient is transferred, is discharged, dies, or is a CRO case. The original copy of the completed DA Form 3647 or CHCS automated equivalent and the optional worksheet copy of the DA Form 3647 will both be filed in the ITR, with the worksheet, if used, inserted behind the original. If the worksheet is legible, it can serve as the original and be machine copied. For allied and neutral military personnel, an additional copy is filed with the ITR. A copy of the DA Form 3647 or CHCS automated equivalent and SF 502 (when prepared) will also be filed in HRECs and OTRs. Copies of DA Form 3647 or CHCS automated equivalent and SF 502 on PHS or Coast Guard commissioned corps officers should be forwarded to Medical Branch, 5600 Fishers Lane, Parklawn Building, Room 4-35, Rockville, MD 20857-0435.

9–18. Preparation

Instructions for completing DA Form 3647 or CHCS automated equivalent are found in the IPDS User's Manual. Also see the ICD-9-CM and the Triservice Disease and Procedure ICD-9-CM Coding Guidelines. Diagnostic entries on the worksheet copy of DA Form 3647 or CHCS automated equivalent will be made only by the attending physician, dentist, podiatrist, or midwife in charge of the case. In addition, only these people will sign the worksheet copy or final DA Form 3647 or CHCS automated equivalent.

9–19. Corrections and corrected copies

Corrections to DA Form 3647 or CHCS automated equivalent will be made when necessary. (See para 3-4e.)

Section V
Preparation and Use of Other Inpatient Treatment Record Forms

9–20. DD Form 2569

Insurance information obtained on DD Form 2569 will be filed in the OTR and the ITR according to figures 6-1, 6-2, and 9-1. The

original signed DD Form 2569 will be filed in the medical record applicable to the type of care, and a copy will be filed in the other type of medical record. For example, if the information is obtained during an inpatient visit, file the original in the ITR and a copy in the OTR. File one copy in the HREC and forward one copy to the billing office.

9–21. DD Form 2770

a. DD Form 2770 (Abbreviated Medical Record) (formerly SF 539) is used for cases of a minor nature that require no more than 48 hours' hospitalization. For example, it is used for lacerations, plaster casts, removal of superficial growths, and accident cases held for observation. It is also used for APV cases. DD Form 2770 will not be used for death cases, admission by transfer, probable medical-board cases, and cases involving serious medical incidents.

b. DD Form 2770 may also be used when military members are hospitalized for uncomplicated conditions not normally requiring hospitalization in the civilian sector, for example, measles or upper respiratory infection. If the case becomes complicated, *d* below applies.

c. DD Form 2770 may be used for cases in which general anesthesia was given only if—

(1) The patient is classified as American Society of Anesthesiologists Class I or II; that is, the patient has no organic, physiologic, biochemical, or psychiatric disturbance, or the systemic disturbance is well controlled, or the pathologic process to be operated on is localized and does not entail a systemic disturbance.

(2) The patient will be hospitalized no more than 48 hours. When DD Form 2770 is used for these cases, the physical examination section must fully describe the cardiopulmonary findings. (Terms such a "normal," "wnl," and "negative" will not be used.) It must also describe any exceptions or other pertinent findings.

d. DD Form 2770 will never be used for American Society of Anesthesiologists Class III patients, no matter what the length of stay.

e. When DD Form 2770 is used, SF 502 may be replaced by a final progress note (SF 509). However, when hospitalization exceeds 48 hours, SF 502 must be prepared. In such cases, SF 504, SF 505, and SF 506 need not be completed in addition to DD Form 2770; the reasons for the extended stay will be fully recorded in the progress notes (SF 509). Conversely, when a long stay is expected but the patient is discharged within 48 hours, DD Form 2770 will not be prepared in addition to the already completed SF 504, SF 505, and SF 506, and the case may be summarized in the progress notes (SF 509) instead of in SF 502.

9–22. DA Form 4359-R

Consent for admission of patients to psychiatric treatment units will be recorded on DA Form 4359-R (Authorization for Psychiatric Service Treatment). DA Form 4359-R will be reproduced locally on 8 1/2- by 11-inch paper. A copy of this form is located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site.

9–23. DD Form 792

DD Form 792 (Twenty-Four Hour Patient Intake and Output Worksheet) is a worksheet used to record all fluid intake and output. It is completed by nursing personnel. After the totals have been recorded on the graphic records (DD Form 2770 or SF 511 (Medical Record—Vital Signs Record)), the worksheets should be destroyed. The worksheet should not be filed in the ITR.

9–24. DA Form 3950

DA Form 3950 (Flowsheet For Vital Signs and Other Parameters) is a worksheet or a flowsheet to record temperature, pulse, blood pressure, and respiration or the columns may be labeled as needed. Vital signs for a group of patients can be recorded and subsequently transcribed to the graphic record (SF 511) of the individual patient. The worksheet may be destroyed after the readings have been transcribed to the individual patient's graphic record. When used as a flowsheet to record frequent vital signs or other parameters for an individual patient, the DA Form 3950 will be filed in the patient's ITR.

9–25. Laboratory test requisition and reporting forms

a. Laboratory test requisition and reporting forms (SF 545, SF 546, SF 547, SF 548, SF 549, SF 550, SF 551, SF 552, SF 553, SF 554, SF 555, SF 556, and SF 557) and automated versions of these forms are used to request laboratory tests and to report the results of those tests. The forms are three-part sets (original and two copies). When a test is requested, the whole set is sent to the laboratory. After the results are recorded, the third copy is kept in the laboratory files. The original is routed for immediate filing in the ITR or OTR or outpatient HREC. The second copy is routed to the requesting practitioner for use and disposition. Carbon copies of laboratory reports will not be filed in the ITR, OTR, or outpatient HREC.

b. Automated methods of reporting and requisitioning laboratory tests are authorized using CHCS and other approved hospital or laboratory information systems. When computerized or automated cumulative final reports are provided and filed in the medical record, the daily or weekly summary report for the period of time covered by the cumulative final report should be discarded.

c. The MTF commander will ensure that each patient's laboratory test requisitions and reports are prepared correctly. General instructions for preparing these forms are given in table 9-2. Instructions for each form are given in table 9-3.

d. Health care practitioners should refrain from making handwritten notations on the laboratory reports; such notes belong in the progress notes (SF 509). Results of provider-performed microscopy tests should also be noted on SF 509. When used for laboratory reports, the laboratory forms listed in *a* above are restricted for use by recognized organizational laboratories only. These forms will not be used to make extra copies of telephonic reports, to record waived or minimally complex laboratory testing performed by nursing personnel, or to record provider-performed microscopy.

e. To meet the requirements of accrediting bodies and the DOD Clinical Laboratory Improvement Program, the laboratory must ensure that test requisitions include—

(1) The patient's name or other unique identifier;

(2) The name of the authorized practitioner requesting the test, and if appropriate, the individual to contact to enable reporting of imminent life-threatening laboratory results;

(3) The test(s) to be performed;

(4) The date of specimen collection; and

(5) Any additional clinical information relevant and necessary to a specific test request to ensure accurate and timely testing and reporting of results.

f. To meet the requirements of accrediting bodies and the DOD Clinical Laboratory Improvement Program, the laboratory must ensure that test reports are sent promptly to the test requester, that the original report or an exact duplicate (paper or electronic copy) of each test report, including final and preliminary reports, are retained by the testing laboratory for a period of at least 2 years after the date of reporting. (Immunohematology reports under 21 CFR 606, Subpart I, and 42 CFR 493.1107-1109, must be retained for at least 5 years after records have been completed, or 6 months after the latest expiration date for the individual product, whichever is later; pathology reports must be retained for a minimum of 10 years. See TM 8-227-3/NAVMED P-5101/AFM 41-119, chap 23, for records requirements pertaining to the testing of blood and blood components.) The laboratory test report must indicate—

(1) The name and address of the laboratory location at which the test(s) was performed;

(2) The test(s) performed;

(3) The test result(s); and, if applicable, the units of measurement; and

(4) Pertinent reference ranges, as determined by the laboratory performing the test, either on the report form or available in the patient's medical record.

9–26. DA Form 4256

a. Use of DA Form 4256. DA Form 4256 is a three-copy, carbonless form. The original copy (white) remains with the patient's permanent record. The second copy (pink) is sent to the pharmacy, where it is kept until the patient is discharged. (The pharmacy must receive a copy of all orders to ensure appropriate surveillance of food-drug and laboratory-drug interactions.) The ward copy (yellow) may be used as a medication or treatment reminder and will be discarded when no longer needed. Instructions for completing DA Form 4256 are provided in *b* through *g* below.

b. Preparation. All entries will be made with ball-point pen using blue-black or black ink, or will be computer entries. Entries must be legible on all three copies. In each Patient Identification section, addressograph plates should be used. (See paras 3-5b and 3-6.) The Nursing Unit, Room Number, and Bed Number blocks should also be completed.

c. Method of writing orders. More than one order may be written in each section of DA Form 4256, but no more than one order may be written on a single line. The prescriber will record the date, the time, and sign each entry. Standard orders overprinted on DA Form 4256 also must include the date, the time, and the signature of the prescriber.

d. Method of accounting for orders. Actions taken to comply with written orders will be noted in the far right column of DA Form 4256, the "List Time Order Noted and Sign" column.

(1) The clerk or nurse who notes two or more orders may enclose the orders in brackets, list the time orders are noted, and sign or initial his or her name. All STAT orders, however, must be individually accounted for with the time the order is noted and the signature or initials of the clerk or nurse. This entry implies that proper action has been taken or the order, as written, has been transcribed on DA Form 4677 or DA Form 4678.

(2) Single action orders need not be transcribed to the DA Form 4677 or DA Form 4678 if the order is carried out by the RN. A single action order is a one-time order that is completed within the verifying nurse's tour of duty. It should require no further nursing activity once signed off. Documentation of the efficacy of the intervention, as appropriate, is required. In the right hand column of the form, the RN will write "Done" with his or her signature and the date and time that the order was completed. Each single action order must be accounted for individually; brackets will not be used to sign off a group of single action or "STAT" orders. If the single action is not completed within the responsible RN's tour of duty, the order will be transcribed to the DA Form 4677 or DA Form 4678.

e. Method of discontinuing orders. To discontinue a medication or treatment, the prescriber must write and sign the stop order. (Automatic stop orders (for example, for antibiotic or controlled drugs) will be governed by written local policy.) When an order is stopped, it must be accounted for (see *d* above) and then noted on DA Form 4677 or DA Form 4678 by putting "DC (discontinued)/date/initials" and drawing a single line through the HR (hour) and Date Completed/Dispensed blocks beside the stopped order. Corresponding annotations in an automated system such as CHCS are acceptable.

f. Verbal orders. Verbal orders will be used only for emergency STAT orders. The RN who accepts the order must write it on DA Form 4256 and enter after it "Verbal order (doctor's/nurse's name, rank, Army Nurse Corps, or RN)." The prescriber must countersign the order as soon as possible, but no later than 24 hours after the emergency.

g. Telephone orders. Telephone orders will be held to the minimum and accepted only by an RN; they must be countersigned by the prescriber within 24 hours. The RN accepting the order(s) must record the order(s) on the DA Form 4256 followed by the notation "Telephone Order(s)"; the physician's name; and the RN's name, rank, and title.

9–27. DA Form 4677

a. Purpose. DA Form 4677, printed on green paper, is used for non-medication doctors' and nurses' orders and to document the patient's acuity category. Medical orders will be transcribed from DA Form 4256. Nursing orders will be indicated by writing "NIO" for nursing initiated order and the RN's initials are noted in the Initials column. Nursing orders may relate to identified nursing problems and or nursing diagnoses, or reflect established standards of care. Nursing orders that reflect standards of care may be written without a corresponding problem. Overprints of orders may be printed on the form per appropriate local or command policy.

b. Preparation. Enter all patient identification data as indicated on the form.

c. Content.

(1) *Allergies.* Specify the presence or absence of allergies. When known, indicate the specific allergen.

(2) *Primary medical diagnosis.* Enter the current diagnosis. Add other diagnoses if they significantly affect care to be given.

(3) *Recurring actions.*

(a) Order date. Enter the date that the current order was written.

(b) Initialing. The clerk or nurse who transcribes an order must initial the appropriate block on the form. If a ward clerk or an LPN transcribes the order, an RN must initial in the lower portion of the box. The RN's initials indicate that the RN verified the transcribed order with the original order on DA Form 4256 and is, therefore, accountable for its accurate transcription and its appropriateness from a nursing standpoint.

(c) Recurring actions, frequency, time. This section is used for actions that are scheduled and repetitive. The complete order, as originally written, must be transcribed to this section.

1. Hour. Specific times for the order to be accomplished are listed vertically. Each space is for a separate time of action. Orders that are in effect throughout the shift and are not time-related (for example, seizure precautions, intake and output) are indicated by designating the inclusive times for each shift; for example, 07-15, 15-23, 23-07. The abbreviations D, E, and N will not be used.

2. Date. The top row of spaces is used to indicate the date the action is accomplished.

3. Initialing. The person responsible for carrying out the order or for verifying completion will initial the block opposite the specific hour for action and under the appropriate date column.

4. Use of DA Form 4677 to document patient acuity. The Workload Management System for Nursing (WMSN) acuity category is documented on this form. An entry should be made in the Recurring Actions/Frequency/Time column: "WMSN Category." Two lines are used. The patient's WMSN acuity category is recorded on the first line under the appropriate date, and the initials of the RN who determined the acuity category are recorded in the block directly beneath the category.

5. Use of DA Form 4677 as a flowsheet. To reduce the writing of narrative notes, DA Form 4677 can be used to document patient information requiring frequent recording and or the patients' response to medical orders and nursing interventions. All assessment or measurement components must be specified in the order written on DA Form 4677, for example, check pedal pulses and right leg circumference every 4 hours. The findings related to this assessment are likewise recorded on DA Form 4677. A local policy is required to explain this method of documentation and to code the patient's response to care. For example, initials only indicate that the order has been completed; initials and "+" indicate that the nursing intervention and or patient response was satisfactory and or within normal limits; initials and "O" indicate the results of the nursing intervention and or patient response were unsatisfactory, not observed or omitted. All negative or unexpected responses or unfavorable patient outcomes require documentation in nursing notes. Any codes used must be defined on the DA Form 4677.

6. Discontinued order. When a multiple line order is discontinued, draw a diagonal line across the unused blocks. For a single line order, draw a horizontal line; "DC/date/time/initials" will be written above the line drawn. For quick, visual recognition of a discontinued order, a yellow highlighter or accent pen which will not penetrate the paper or obliterate the writing may be used to line over the order and the associated blocks.

d. Single Actions. If a single action order is not completed within

the responsible RN's tour of duty, the order becomes a delayed order and is transcribed to the Single Actions column.

(1) *Order Date.* Same as in c(3)(a) above.

(2) *Initialing.* Same as in c(3)(b) above.

(3) *Single Actions.* The complete order, as originally written, must be transcribed to this column.

(4) *Date and Time to Be Done.* If known, enter the date and time the action is to be taken. Indicate "on call" if so ordered.

(5) *Completed order.* The Date/Time/Initial blocks show that the order was accomplished. If the order was not completed, do not initial. Place a circle(s) in the Date/Time/Initial block(s) and explain in the nursing notes.

e. Pro re nata (PRN) actions. Use this when the time of an order is not predictable. Leave sufficient space on the DA Form 4677 to accommodate the expected frequency of the PRN action and annotate the patient's response per local policy and the direction provided in c(3) above.

(1) *Order/Expir (expiration) Date.* Enter the date the current order is written in the top portion. If applicable, enter the expiration date in the bottom portion.

(2) *Initialing.* Same as in c(3)(b) above.

(3) *PRN Action, Frequency.* Indicate the action to be taken and its frequency.

(4) *Time/Date/Completed.* Each block indicates a separate action. The person completing the action enters the date, time, and initials at the time of completion.

f. Recopied orders.

(1) When space in the Date Completed column is filled, a double line is drawn across the entire page just below the last entry. Directly below the double line, or on a blank DA Form 4677, write "Recopied Orders." The upcoming dates are filled in, for each order still in effect, and the date of the original order is recopied. The individual copying the order, if other than an RN, and the verifying RN will follow the initialing procedures as previously described in c(3)(b) above. If the RN recopies the orders, the only required authentication will be the nurse's signature at the end of the recopied orders.

(2) In the event that orders need to be recopied before the Date Completed columns are filled, the order is indicated as recopied by a diagonal or single line drawn across the remaining blocks. Recopied/date/initials are noted above the line. Existing initials are bracketed to indicate no further use of the remaining blocks.

9–28. DA Form 4678

a. Purpose. DA Form 4678, printed on white paper, is for medication orders and accompanying nursing orders which pertain to the administration of the ordered medication. Medication orders will be transcribed from DA Form 4256. Nursing orders pertinent to medication administration, initiated by the RN, and written on this form, will be indicated by placing NIO/nurse's initials in the Verify By Initialing column. Overprints of physician or nurse orders may be printed on the form per appropriate command or local policy.

b. Preparation. Enter all patient identification data as indicated on the form.

c. Content.

(1) *Allergies.* Specify the presence or absence of allergies. Indicate specific allergies.

(2) *Primary diagnosis.* Enter current diagnosis. Add other diagnoses that significantly affect patient care requirements.

(3) *Recurring medications.*

(a) Order date. Enter the date of the current order.

(b) Initialing (transcribed order). The clerk or nurse who transcribes an order must initial the appropriate block on the form. If a ward clerk or an LPN transcribes the order, an RN must initial in the lower portion of the box. The RN's initials indicate that the RN verified the transcribed order with the original order on DA Form 4256 and is, therefore, accountable for its accurate transcription and its appropriateness from a nursing standpoint.

(c) Recurring Medications, Dose, Frequency. This column is used for recurring drug administration, including controlled substances, or actions when compliance with the order is repetitive and scheduled. The complete order, as originally written, must be transcribed to this section.

(d) Hour. Specific times for the order to be accomplished are listed vertically. Each space is for a separate time of administration. Orders that are continuous throughout the shift and are not time-related (for example, intravenous (IV) rates, oxygen administration) are indicated by designating the inclusive times for each shift; for example, 07-15, 15-23, and 23-07. The abbreviations D, E, and N will not be used.

(e) Date. The top row of spaces is used to indicate the date the action is accomplished or medication is administered.

(f) Initialing (medication administration). The nurse will initial the block opposite the specified time for administration and under the appropriate date column. The patient's response to the medication may also be indicated. When placed in the designated block, the nurse's initials indicate that the medication has been administered. The nurse's initials with the letter "(E)" indicate that the administered medication was effective and achieved the desired results (for example, meperidine given for pain relieved the pain). The nurse's initials with "(I)" indicate that the administered medication was ineffective. This notation requires a nursing note to describe the patient's status and the actions taken to address the patient's condition.

(g) Discontinued order. When a multiple line order is discontinued, draw a diagonal line across the unused blocks. For a single line order, draw a horizontal line; "DC/date/time/initials" will be written above the lines drawn. For quick, visual recognition of a discontinued order, a yellow highlighter or accent pen, which will not penetrate the paper or obliterate the writing, may be used to line over the order and the associated blocks.

d. Single order action, pre-operatives. A single action medication order which is not completed within the verifying RN's tour of duty becomes a delayed order and is transcribed to the single order, pre-operatives column.

(1) *Order date.* Self-explanatory.

(2) *Initialing.* Same as in c(3)(b) above.

(3) *Single Order, Pre-operative.* The complete order, as originally written, must be transcribed to this column.

(4) *Date/Time To Be Given.* If known, enter the date and time the drug is to be administered. Note "on call" if so ordered.

(5) *Completed order.* The nurse who administers the medication enters the date, time, and his or her initials. Do not initial an order that is not implemented. Place a circle(s) in the Date/Time/Initials block(s) and specify the reason in the nursing notes.

e. PRN medications. Use when the time of administration is not predictable.

(1) *Order/Expir Date.* Enter the date the current order is written in the top portion. If applicable, enter the expiration date in the bottom portion.

(2) *Initialing.* Same as c(3)(b) above.

(3) *PRN Medication, Dose, Frequency.* Indicate the medication to be administered, dose, route, frequency, and reason for the medication (for example, benadryl 25 mg, po HS prn, sleep). The patient response may be documented as described in c(3)(f) above in the nursing notes.

(4) *Time/Date Dispensed.* Each block indicates a separate action. The person administering the medication enters the time, date, and initials at the time of completion.

f. Recopied orders. When space in the Date Dispensed column is filled, a double line is drawn across the entire page just below the last entry. Directly below the double line, or on a blank DA Form 4678, write "Recopied Orders." The upcoming dates are filled in for each order still in effect and the date the original order is recopied. Initialing procedures are described in c(3)(b) above. If the RN recopies the orders, the only required authentication will be the nurse's signature at the end of the recopied orders.

g. DA Form 4028 (Prescribed Medication). When unit dose is not provided, DA Form 4028 will be prepared whenever a medication is prescribed. The purpose is to ensure that patients receive

medications as prescribed. The card will be destroyed upon change of orders. This card is not used when unit dose pharmacy support is provided.

9–29. DA Form 4107

a. General. The medical or dental officer responsible for the patient's operation or special treatment will initiate and complete section A, DA Form 4107 (Operation Request and Worksheet), except for items 20 and 21. Section B will be completed by the anesthesia provider and or the circulating RN. The anesthesia provider will complete items 32-39; the circulating RN will complete items 40-42 and 45-47. All other items can be completed by either the anesthesia provider or the circulating RN. DA Form 7001 (Operating Room Schedule) and DA Form 4108 (Register of Operations) are based on accuracy and completeness of DA Form 4107.

b. Purpose. This form is intended for concurrent and sequential use to schedule and record all surgical procedures performed in the main ORs and ambulatory surgery center. When anesthesia and or OR nursing personnel are required to attend or monitor patients, DA Form 4107 will be used (for example, labor and delivery, special procedures x-ray clinic, cardiac catheterization).

c. Detailed instructions.

(1) *Section A—Request for Surgery.*

(a) Items 1 through 14. Self-explanatory.

(b) Item 15. Apply the National Research Council Criteria for Wound Classification.

(c) Item 16. Self-explanatory.

(d) Item 17. Self-explanatory.

(e) Item 18. Self-explanatory.

(f) Item 19. Note special instructions, to include special solutions for prepping.

(g) Item 20. Chief, operating room nursing section or designee will note name(s) of scrub person(s) followed by name(s) of circulator(s).

(h) Item 21. The chief of anesthesia and operative service or designee will complete.

(i) Item 22. Indicate type of anesthesia desired (for example, general, regional, local, or topical).

(j) Item 23. Indicate special instruments and or equipment other than routine (for example, power equipment, tray, tourniquet, etc.). In addition, indicate patient limitations (for example, deaf, mute, language barrier), which will assist operating room staff in planning patient care.

(k) Item 24. Self-explanatory.

(2) *Section B—Operation Worksheet.*

(a) Items 25 and 26. Self-explanatory.

(b) Item 27. Septic is defined by using classification of the operative wound, and applying the National Research Council criteria: Clean wounds, clean-contaminated wounds, contaminated wounds, and dirty-infected wounds.

(c) Items 28-32. Self-explanatory.

(d) Item 33. Anesthesia Time: "Time Began" is defined as the beginning of patient preparation after the patient has arrived in the holding area of the surgical suite or satellite facility. This time commences with chart review and placement of IV lines, invasive monitors, and or noninvasive procedures by anesthesia personnel. "Time Ended" means actual clock time at which the anesthesia provider leaves the patient in the post anesthesia recovery unit, intensive care unit, or other post surgical unit.

(e) Items 34-38. Enter agents and techniques. If none, indicate by lining out the appropriate space(s).

(f) Item 39. Note adjunctive procedures not intrinsically a part of delivery or routine anesthesia such as hypothermia, anesthesia by tracheostomy, central venous pressure monitoring, Swan-Ganz monitoring, transvenous pacemakers, and arterial lines.

(g) Item 40. "Time Began" means the actual clock time the nursing team began preparation in the room assigned for the case. "Time Ended" means actual clock time the cleaning of the room is completed and ready to receive the next patient. Note, these times will not be the same as anesthesia or operation times.

(h) Items 41-44. Self-explanatory.

(i) Item 45. Note number(s) and type(s) of drain(s).

(j) Item 46. Indicate "None," "Correct," or "Incorrect." Enter the last name of the professional nurse who performed and verified the sponge count.

(k) Item 47. Identify the specimen and disposition (if other than pathology).

(l) Item 48. Clearly state the operative diagnosis. (Do not use "same as item 7.")

(m) Item 49. Clearly state the entire operation performed. (Do not use "same as item 9.") Indicate the total number of episodes by using the following definitions.

1. Episode of OR Nursing. An episode of OR nursing is based on a combination of two factors: OR personnel and time. One episode of OR nursing is assigned for the initial 3 hours or fraction thereof, for one nursing team. An OR nursing team consists of one scrub person and one circulator person. OR nursing personnel are permanently assigned to the OR. Each additional OR nursing person for a particular case equals 0.5 episode. The additional OR nursing person does not include an individual providing break and or lunch relief.

2. Episode of Anesthesia. An episode of anesthesia is also based on a combination of two factors: anesthesia personnel and time. One episode of anesthesia is counted for the initial 3 hours or fraction thereof for one anesthesia provider. Any fraction over the initial 3-hour period is an additional episode. One episode is also added for each additional anesthesia provider fully assigned to the case.

3. Method of Calculation. The case scenarios shown in figure 9-2 provide examples for calculation of episodes of OR nursing and episodes of anesthesia.

(n) Item 50. Enter any complications that occurred in the OR or those unusual situations in the preoperative period that relate to the anesthesia or surgical experience.

(o) Item 51. When a dictation capability exists, the physician will sign after completion of dictation.

(p) Recorded in Register. After the case has been recorded on the DA Form 4108 or entered into the automated data processing system, the person initiating this task will indicate completion by initialing.

d. Disposition. The form consists of four copies. Upon completion of section B, DA Form 4107 is separated. Retain the original copy in the OR section until the information is transcribed to DA Form 4108 and SF 516. Distribution of additional copies will be determined by the chief, anesthesiology and operative service. All copies may be destroyed when no longer needed as deemed appropriate according to local policy.

9–30. DA Form 7001

a. General. DA Form 7001 is prepared daily for the next day reflecting all scheduled operative and anesthesia procedures, additional procedures, such as emergencies, and for changes to the OR schedule. Incorporating elements from section A of DA Form 4107, prepare DA Form 7001 either on the cutsheet version or on offset masters for printing of duplicate copies.

b. Preparation and distribution. Entries may be typed or handwritten, if they are legible. Additionally, DA Form 7001 can be prepared electronically and may be duplicated for distribution. It serves as a central communication tool concerning surgery. DA Form 7001 covers a 24-hour period beginning at 0000 and ending at 2400. Cases beginning on one day and ending on the next day should be posted on the beginning day's schedule. (For example, the case started at 2300, 24 Sep 96 and ended at 0200, 25 Sep 96. The case should be recorded on the schedule for 24 Sep 96.)

c. Use. The original DA Form 7001 can be used to verify data recorded on DA Form 4107 prior to entry onto DA Form 4108. Duplicated DA Form 7001 can be used for patient transport identification slips, individual operating room case slips, centralized materiel service instrumentation verification, performance tracking and trending, pre- and postoperative statistical data, anesthesia interview assignments, progression of operative schedule, completion and or cancellation of cases, mass casualty exercises, staffing of personnel,

and any other pertinent patient information (for example, isolation precautions, special care needs for transport).

d. Detailed instructions.

(1) *Item 1.* Enter the name of the MTF.

(2) *Item 2.* Self-explanatory.

(3) *Item 3.* Enter the time the case is scheduled to begin and in what specific (number) OR; for example, 0730, OR #1.

(4) *Item 4.* Enter the patient's full name, identification category, age, and religion; for example, Williams, John D., AD, 18, P.

(5) *Item 5.* Self-explanatory.

(6) *Item 6.* Enter ward from which the patient is sent to surgery and the ward or specialty care unit to which the patient will go after surgery (for example, from 64 to RR).

(7) *Item 7.* Enter the proposed surgery as recorded on DA Form 4107, item 9 (for example, exploratory laparotomy, possible bowel resection).

(8) *Item 8.* Enter the names of all operating surgeons with the primary surgeon first (for example, Dr. White and Dr. Smith).

(9) *Item 9.* Enter the name and status of the OR nursing personnel scrubbing and circulating. Indicate scrub with (S) and circulator with (C) (for example, SGT Tamp (S) and CPT Rowe (C)).

(10) *Item 10.* Enter the names of all the anesthesia providers to include physician staff personnel (for example, Major Down, MC or Dr. Jones).

(11) *Item 11.* Enter the anesthetic as indicated on DA Form 4107, item 22. Enter blood and associated products as indicated on DA Form 4107, item 14 (for example, General/WB 2000 cc FFP 1500 cc).

e. Disposition. Destroy upon completion of entry of data onto DA Form 4108, or when no longer needed as deemed by local policy.

9–31. DD Form 1924

DD Form 1924 (Surgical Checklist) will be placed on the front of each patient's chart prior to surgery. It provides a visual check of the medical forms and procedures required prior to arrival in the operating suite. The DD Form 1924 is designed to permit use of the addressograph to complete the patient's identification. Nursing personnel will place their initials in the proper columns as each preoperative check and procedure is completed. The RN releasing the patient to the OR staff members will sign this form at the time of release. The form will be destroyed when no longer required.

9–32. DA Form 4108

a. General. DA Form 4108 is a record of all surgical procedures performed. Normally, it will be kept and maintained in the OR suite. Where surgical procedures or anesthesia monitoring is undertaken outside the OR suite (for example, obstetrical suite, urology, cardiology, plastic, dental clinic, etc.), an individual DA Form 4108 will be maintained by the respective department, service, or clinic. Information from the completed DA Form 4107 will be transposed to DA Form 4108. Accuracy and completeness of the register is imperative since this document may be used for statistical computations, research, feeder reports to higher headquarters, and hospital accreditation, as well as support for staffing and space requirements.

b. Availability. Covers for the chronological collection of each year's DA Forms 4108 are available through supply channels.

c. Arrangement. Arrange pages chronologically with monthly recapitulation of total procedures. Sequence number 1 is the first procedure begun from 0001 on the first day of the month. The final sequence number for the month is the last procedure begun before 2400 on the last day of that month. Pages will be numbered in the space provided in the upper right corner. Both sides will be used. At the end of each month, tally figures may be entered in the margin, and the cumulative total carried to the upper left corner of a new page to begin a new month's record. Suitable tabs may be affixed to identify the month.

d. Recording data. Entries may be typed or handwritten if they are legible. Entries are adaptable for computer input.

e. Correcting errors. Erasures are prohibited. A line will be drawn through an incorrect entry. Initials of the person making the entry will be placed above the lined portion. Correct information will be recorded following the lined entry.

f. Detailed instructions.

(1) *Hospital.* Enter the name and location.

(2) *OR number.* Enter #1, #2, #3, etc.

(3) *Emergency.* Indicate with an "X" if an emergency procedure is used.

(4) *Case number.* Sequence within the particular OR number noted in (2) above.

(5) *Surgeon(s).* The surgeon is listed first, followed by the assistants in descending order.

(6) *Combat.* Use currently acceptable medical letter combination or abbreviation to indicate the source of injury if the result of hostile fire.

(7) *Nursing time.* Indicate time "Began" and time "Ended" from DA Form 4107.

(8) *Counts.* Indicate after each (for example, sponge, needle or sharp, instrument) "C" for correct, "IC" for incorrect, or none.

g. Disposition. These binders will be disposed of under AR 25-400-2. Maintain at least from one JCAHO visit to the next. Additionally, maintain as deemed by local policy.

9–33. DA Form 5179

a. General. DA Form 5179 (Medical Record—Preoperative/ Postoperative Nursing Document) consists of a nursing assessment and generalized plan of care for patients undergoing an operative procedure, and a postoperative evaluation. This form is to be prepared by an RN and will be a permanent part of the patient's clinical record. Data collection and review of the plan of care is to be accomplished with the patient prior to the operative procedure. If unable to obtain data; for example, emergency surgery, document this in item 5. Item 11 is to be completed within 24 hours of the operative procedure.

b. Purpose. This form provides a record of the continuation of the nursing process from the time the patient leaves the ward or unit to go to the OR until the patient returns to a receiving unit.

c. Detailed instructions.

(1) *Items 1-4.* Self-explanatory.

(2) *Item 5.* Provides space for additional information such as family requests, information not identified in items 6 to 8 of the form.

(3) *Item 6.* Lists potential problems and or needs of the patient. If the stated problem is relevant to the patient, an "X" should be placed in the area provided at the beginning of each statement and the problem statement completed by filling in each blank. A space is provided to write additional problems and or needs.

(4) *Item 7.* States expected goals and outcomes. A space is provided to write additional goals and outcomes, if necessary.

(5) *Item 8.* Lists OR nursing interventions. The interventions not applicable to the patient are to be lined out and initialed. Space is provided for documenting additional interventions.

(6) *Item 9.* Self-explanatory.

(7) *Item 10.* Signature of RN completing Item 8.

(8) *Item 11.* Must be completed within 24 hours after completion of the operative procedure. Each patient problem and or need identified in Item 6 must be evaluated here.

(9) *Items 12-13.* Self-explanatory.

9–34. DA Form 5179-1

a. General. DA Form 5179-1 (Medical Record—Intraoperative Document) documents the care of each patient undergoing an operative procedure. The form is to be initiated prior to the operative procedure and completed after the operation. The form is to be prepared by an RN and will be filed on the right side of the ITR (DA Form 3444-series).

b. Detailed instructions.

(1) *Item 1.* Record how the patient arrived; that is, via litter, wheelchair, or bed; and by whom transported.

(2) *Item 2.* Verify, by RN, with payroll signature with rank and corps or civilian grade; for example, Mary S. Smith, CPT, AN or Betty T. Jones, RN, GS-10.

(3) *Item 3.* Specify day, month, year; use the military time the patient entered the main operating suite door.

(4) *Item 4.* Record the time the patient enters the OR and specify OR number plus case number for that room; for example, OR #l case 1.

(5) *Item 5.* Check descriptive word that best describes patient's preoperative status and any other appropriate comments.

(6) *Item 6.* Record names and titles of assigned personnel (permanent staff) and others such as student personnel, relief (meals, changes of shift) personnel.

(7) *Item 7.* Specify intraoperative position of the patient; record any other position(s); for example, split leg, and all positional devices or aids under comments. Draw or annotate any device or aid and its placement in Item 9.

(8) *Item 8.* Indicate the hair removal method in the appropriate box with "X" if hair removal is done by OR personnel; record the name of the individual performing procedure. Record type of site preparation solution and its strength (for example, 1 percent, 2 percent); site of preparation, and who performed preparation. Insert any appropriate comments such as skin conditions or reactions, for either task.

(9) *Item 9.* Record placement of indicated items by appropriate legend. Record other external devices such as blood pressure cuff, electrocardiogram electrodes or any other devices that are required by local facility policy or standing operating procedure.

(10) *Item 10.* Check YES (done) or NO (not done) for each count listed. Record each count as correct "C" or incorrect "IC"; if incorrect make an explanatory entry in section 19. If "Other" is YES, add type of count and body space or cavity; for example, urinary bladder. Signature of the circulating RN responsible for the count is made across the three lines or on each individual line. Print the name of the scrub person that performed the count with the circulating RN.

(11) *Item 11.* Self-explanatory.

(12) *Item 12.* Record if electrosurgical unit (ESU) was used by placing an "X" in the YES or NO block. Enter medical maintenance control number for every ESU and bipolar unit used and any other information required by local facility policy (for example, manufacturer and model number). Record grounding pad(s) used (brand and lot number) and any other information required; that is, name of individual applying or removing pad.

(13) *Item 13.* List prosthesis or implant (for example, bone, screws, plates, vascular grafts, hulka clips, etc.) with manufacturer and identification numbers (lot number, quality control number) if available; attach sticker labels from implants if available.

(14) *Item 14.* Record any medications that the patient receives in the operating room not given by anesthesia personnel. Note wound irrigations as follows: NSS = normal saline solution; BSS = balanced salt solution; method of irrigation (for example, pulse, asepto, lavage), and when indicated; for example, for pediatric patients, note amount. Medications and orders are to be signed by the physician as the same verbal orders on DA Form 4256. Other orders or treatments are those performed during the operative procedures; for example, catheterization.

(15) *Item 15.* Record x rays and sites as indicated; specify special techniques (for example, fluoroscopy), and or equipment, (for example, C arm).

(16) *Item 16.* Enter "X" in the YES or NO blocks for specimens sent to the laboratory. Identify in NAME spaces the specimens sent to the laboratory by type and source or tissue; use FS for frozen section and C for culture. Examples: FS, nodule left vocal cord; C, anaerobic, gallbladder. If there are more than 11 specimens, record them in item 19.

(17) *Item 17.* Identify tubes, drains, and packings used by type, size, and site; for example, "vaseline gauze, 1/4 inch, L nostril."

(18) *Item 18.* Record any immobilizers used, type(s) of dressing applied and location(s). Examples: Posterior splint cast, Telfa, xeroform, dry sponge, etc., also see item 17.

(19) *Use this section for further documentation or for reporting additional information on other items.*

(20) *Item 20, 21.* Self-explanatory.

(21) *Item 22.* Signed by the RN with payroll signature with rank and corps or civilian grade.

c. This form is adaptable for computer inputs.

9–35. SF 511

a. Preparation. Enter the patient's identification data here and in the space at the bottom of the form.

b. Recording data. Number the "Hospital Day" line of blocks consecutively starting with the day of admission as 1. Use the post-day line as applicable. The day of surgery is the operative day and the day following surgery is the first post-operative day. Label the day and hour blocks. Graph the temperature by the use of dots (.) placed between the columns and rows of dots and joined by straight lines. If the temperature is other than oral, document this by (R) for rectal, (A) for axillary, or (TM) for tympanic. Graph the pulse by use of a circle (O) connected by straight lines. Enter the respiration and blood pressure on the rows below the graphic portion of the form. Graph frequent blood pressure readings by entering an "X" between the columns and rows of dots, at points equivalent to systolic and diastolic levels. Connect the two with a vertical solid line. Use blank lines at the bottom of the sheet to record special data such as the 24-hour total of the patient's intake and output.

9–36. SF 536

SF 536 (Clinical Record—Pediatric Nursing Notes) may be used for pediatric patients instead of the SF 510.

9–37. SF 519-B

a. SF 519-B (Radiologic Consultation Request/Report) will be used to request and report results of radiologic examinations except in instances where the request and or report results are generated/stored electronically by the hospital information system. SF 519-B is constructed in three-part sets (original and two copies). When an examination is requested, the whole set is sent to the radiology department. After the results are recorded, the third copy is kept in the radiology department files. (For disposition instructions, see AR 25-400-2, file number 40-66y, photograph and duplicate medical files, and table 3-1 of this regulation.) The original is routed for immediate filing in the ITR, OTR, or HREC. The second copy is routed to the requesting practitioner for use and disposition. Carbon copies of radiologic reports will not be filed in the medical record.

b. Whether a typewritten, automated, handwritten, or verbal report, the results of all "wet" readings must be documented in the patient's medical record. This documentation can be found on SF 519-B, SF 600, or SF 558.

9–38. DA Form 5009-R

DA Form 5009-R (Medical Record—Release Against Medical Advice) will be used when the patient leaves the MTF against the advice of hospital authorities and attending practitioners. A parent or legal guardian will complete the "statement of representative" portion of the form if the patient is a minor or mentally incompetent. (DA Form 5009-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy of this form is located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site.

Table 9–1
NATO national military medical authorities

Country	Address
Belgium	Etat-Major Du Service Medical Section Techniques Medicales Quartier Reine Elisabeth Rue d'Evere B-1140 Brussels, Belgium
Canada	National Defence HQ Ottawa, Ontario Canada KIA OK2 Attention: Chief, Medical Services
Denmark	Danish Armed Forces Health Services Jaegersborg Kaserne PO Box 96 DK-2820 Gentofte Denmark
France	Direction Centrale du Service de Sante Armees Hotel des Invalides F-75997 Paris France
Federal Republic of Germany	Institut fur Wehrmedizinalstatistik und Berichtswesen BergstraBe 38 D-53424 REMAGEN Germany
Greece	Hellenic Army General Staff Medical Corps Directorate Stratopedon Papagou Holargos—Athens Greece
Italy	Minestera della Difesa Direzione Generale Della Sanita' Militare Via S. Stefano Rotondo, 4 00184 Roma Italy
Luxembourg	Luxembourg Army HQ Post Box 1873 L-1018 Luxembourg
Netherlands	Inspectie Geneeskundige Dienst Koninklijke Landmacht Postbus 90824 2509 LV Den Haag The Netherlands
Norway	Joint Norwegian Medical Service Oslo mil/Huseby N 0016 Oslo Norway
Portugal	Ministerio Da Defesa Nacional Direccao-Geral de Pessoal Divisao de Saude Militar AV. Ilha dea Madeira, l, 4o 1400 Lisboa Portugal
Spain	Excmo. Sr General Director De La Disan Cuartel General Del Ejercito C/ Prim No 4 28014 Madrid Spain
Turkey	Genelkurmay Baskanligi Saglik Daire Baskanligi Ankara Turkey

Table 9–1
NATO national military medical authorities—Continued

Country	Address
United Kingdom	Ministry of Defence Directorate of Medical Operations and Plans JHQ 224 Northwood Middlesex England HA6 3HP
United States	
a. Army	Commander U.S. Army Medical Command ATTN: MCHO-CL Fort Sam Houston, TX 78234-6000
b. Air Force	Surgeon, U.S. Air Forces in Europe Ramstein Air Base Ramstein, Germany
c. Navy	Naval Military Personnel Command ATTN: NMPC-036 Navy Worldwide Locator Service Washington, DC 20370-5000

Table 9–2
General instructions for preparing laboratory forms

Block: Patient Identification.
Completed by: Clinic or ward.
Instructions: Enter patient's name, register number and FMP or SSN of inpatient (only FMP or SSN of outpatient), treating MTF, ward or clinic, and date test is requested.
Remarks: Enter this information correctly. If possible, enter it by mechanical imprinting, using the ward plate or patient's recording card. If not, use ball-point pen or typewriter.

Block: Urgency.
Completed by: Clinic or ward.
Instructions: Check the proper box.
Remarks: This block is not on SF 553 or SF 554.

Block: Specimen/Lab. Rpt. No.
Completed by: Laboratory.
Instructions: Enter the specimen or laboratory report number.
Remarks: This entry may be used to identify and monitor the request form in the laboratory.

Block: Patient Status.
Completed by: Clinic or ward.
Instructions: Check the proper box.
Remarks: "NP" and "DOM" are not used by the Army.

Block: Specimen Source.
Completed by: Clinic or ward.
Instructions: Check the proper box or write in the needed information.
Remarks: Some forms request other specimen information:

a. On SF 548, given specimen interval information.

b. On SF 553 and SF 554, given infection information. Extra information is needed on these forms to identify sensitivities and infecting organisms. Enter this information in the Clinical Information and Antibacterial Therapy blocks.

c. On SF 556, give specimen source information for obstetric patients.

Block: Requesting Physician's Signature.
Completed by: Clinic or ward.

Table 9–2
General instructions for preparing laboratory forms—Continued

Instructions: Enter clearly the name of the practitioner ordering the test. If he or she is a military member, enter grade and corps.
Remarks: The signature is not needed.

Block: Reported by.
Completed by: Laboratory.
Instructions: The technologist signs here after the test results have been verified.
Remarks: The chief of the laboratory ensures that test results are accurate.

Block: Date.
Completed by: Laboratory.
Instructions: Enter date that the report is completed by the laboratory.
Remarks: N/A.

Block: Lab. ID No.
Completed by: Laboratory.
Instructions: Enter laboratory identification number.
Remarks: Like the Specimen/Lab. Rpt. No. block, this entry may be used to identify and monitor the request form.

Block: Remarks.
Completed by: Laboratory.
Instructions: Enter any special information for the practitioner or the patient's records.
Remarks: N/A.

Block: Specimen Taken.
Completed by: Laboratory, Clinic or ward.
Instructions: Enter date and time the specimen is taken.
Remarks: This block is completed by whoever takes the specimen, either laboratory or ward or clinic personnel.

Block: Tests Requested.
Completed by: Clinic or ward.
Instructions: Put an "X" beside the test that is needed. For tests not listed, write their names at the bottom of the list.
Remarks: On most forms, the correct box is marked "X."

Block: Results or Report.
Completed by: Laboratory.

Table 9–2
General instructions for preparing laboratory forms—Continued

Instructions: Write or stamp the results of each test performed.
Remarks: N/A.

Table 9–3
Specific instructions for preparing laboratory forms

Form: SF 545
Use: To mount laboratory forms.
Remarks: Instructions for mounting laboratory forms are printed on the bottom of SF 545. When a patient needs the same type of test several times, use the same display sheet for each test result form. When only a few tests are made, mount the forms on alternate strips (that is, 1, 3, 5, and 7). When there is a mixed assortment of forms, mount them in the most practical sequence. After mounting the forms, check the proper boxes in the lower right corner to show which forms are displayed.

Form: SF 546
Use: To request blood chemistry tests.
Remarks: At the bottom of the list of tests, there is a block requesting a battery or profile of tests. When requesting this battery, enter the name of the profile.

Form: SF 547
Use: To request blood gas measurements, T3, T4, serum iron, iron-binding capacity, glucose tolerance, and other chemistry tests.
Remarks: N/A

Form: SF 548
Use: To request chemistry tests performed using urine specimens.
Remarks: Explain a check in the "Other" box under "Specimen Interval."

Form: SF 549
Use: To request routine hematology (including differential morphology), coagulation measurements, and other hematology tests.
Remarks: N/A

Form: SF 550
Use: To request urinalysis tests, both routine and microscopic.
Remarks: Use "HCG" to request and report measurements of human chorionic gonadotropin. Use "PSP" to request and report phenolsulfonphthalein measurements.

Form: SF 551
Use: To request tests that measure serum antibodies, including tests for syphilis.
Remarks: Definitions for the serology test abbreviations are as follows:
RPR—rapid plasma reagin card test for syphilis.
COLD AGG—cold agglutinins.
ASO—antistreptolysin 0 titers.
CRP—C-reactive protein.
FTA-ABS—fluorescent treponemal antibody-absorption test.
FEBRILE AGG—febrile agglutinins.
COMP FIX—complement fixation.
HAI—hemagglutination-inhibition.
TPHA—Treponema pallidum hemagglutination.
Write the name of the specific antibody determination in the COMP FIX or HAI block.

Form: SF 552
Use: To request tests for intestinal parasites, blood parasites such as malaria, and other tests performed using feces.
Remarks: N/A

Form: SF 553
Use: To request most bacterial identifications and antibiotic susceptibility testing.

Table 9–3
Specific instructions for preparing laboratory forms—Continued

Remarks: See table 9-2 (Specimen Source block) for information on preparing the Infection, Clinical Information, and Antibacterial Therapy blocks.

Form: SF 554
Use: To request tests for fungi, acid-fast bacteria (tuberculosis), and viruses.
Remarks: See table 9-2 (Specimen Source block) for information on preparing the Infection, Clinical Information, and Antibacterial Therapy blocks.

Form: SF 555
Use: To request tests using spinal fluid.
Remarks: To request bacteriological studies on spinal fluid specimens, also submit SF 553 or SF 554. When requesting electrophoresis measurements or other miscellaneous tests performed on spinal fluid, also submit SF 557.

Form: SF 556
Use: To request blood grouping, blood typing, and blood bank tests.
Remarks: Do not use this form as a request for blood crossmatching or type and screen procedures; such requests are made on SF 518. Specimen source information (for example, cord blood or maternal blood) is needed for obstetric patients.

Form: SF 557
Use: To request tests, such as electrophoresis and assays of coagulation factors, which are not ordered on other forms.
Remarks: N/A

All forms should be filed in an upright position on both sides of the folder. The order given below is from top to bottom of the record.

LEFT SIDE OF FOLDER

DA Form 5571[1]
Master Problem List. Filing in ITR is optional. (See paras 3-10g(3), 5-10, 5-24b(2)(f), 7-4b(4), and 9-5e.)

DA Form 3947
Medical Evaluation Board Proceedings (formerly DA Form 8-118). (See AR 40-3 and para 5-19a(5) of this regulation.)

DA Form 3349
Physical Profile (formerly DA Form 8-274). (See AR 40-501 and para 5-19b(3) of this regulation.)

DA Form 3894
Hospital Report of Death. Use to meet the requirements of STANAG 2046. (See AR 40-2 and para 3-13b(1) of this regulation.)

DA Form 2631-R
Medical Care—Third Party Liability Notification. (See AR 40-16.)

DA Form 2984
Very Seriously Ill/Seriously Ill/Special Category Patient Report. (See AR 40-2.)

DA Form 4254-R[1]
Request for Private Medical Information. (See para 2-4a.)

DA Form 4876-R[1]
Request and Release of Medical Information to Communications Media. (See para 2-3b(3).)

DA Form 5006-R[1]
Medical Record—Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. (See paras 2-3a(1) and 2-3b(2).)

DA Form 5009-R[1]
Medical Record—Release Against Medical Advice. (See para 9-38.)

DD Form 2569
Third Party Collection Program—Insurance Information. (See paras 5-19a(6), 6-2i, and 9-20.)

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care, living wills, etc.). (See paras 6-2j and 9-2c(2).)

DA Form 5303-R
Volunteer Agreement Affidavit. (See AR 40-38 and para 6-2h of this regulation.)

DA Form 4410-R
Disclosure Accounting Record. DA Form 4410-R is printed on the folder. The separate form is obsolete; use for file purposes only if already in existence.

RIGHT SIDE OF FOLDER

DA Form 4515
Personnel Reliability Program Record Identifier. Use when patient is participating in the Personnel Reliability Program. (See AR 50-5, AR 50-6, and paras 5-19b(8) 5-29c, and 7-4b(7) of this regulation.)

DA Form 3647
Inpatient Treatment Record Cover Sheet or CHCS automated equivalent. (See AR 40-400 and paras 3-12a(1), 3-13b, 3-18a, 3-19b, 5-2a, 5-19a, 6-7, 9-9b, 9-10a, 9-11, 9-15, 9-16, 9-17, 9-18, and 9-19 of this regulation.)

DA Form 3647-1
Inpatient Treatment Record Cover Sheet (For Plate Imprinting). (See AR 40-400.)

OF 275
Medical Record Report. File in order of the number of the form it replaces. (See paras 3-3f, 9-12c, and 9-12e.)

Figure 9-1. Forms and documents of the ITR—Continued

SF 502[1]
Clinical Record—Narrative Summary. (See paras 5-2a, 5-19a(2), and 9-12.)

SF 503[1]
Clinical Record—Autopsy Protocol. Use as a summary for detailed autopsy reports. (See para 9-12f.)

DD Form 2770[1]
Abbreviated Medical Record (formerly SF 539). (See paras 9-5d(2) and 9-21.)

SF 504[1]
Clinical Record—History—Part I. (See paras 9-10a, 9-12a, 9-14c, and 9-21e.)

SF 505[1]
Clinical Record—History—Parts II and III. (See paras 9-10a, 9-12a, 9-14c, and 9-21e.)

SF 506[1]
Clinical Record—Physical Examination. (See paras 9-10a, 9-12a, 9-14c, and 9-21e.)

SF 535[1]
Clinical Record—Newborn. Also file civilian source pediatric growth charts here. (See para 6-2d.)

DA Form 5694[1]
Denver Developmental Screening Test. (See para 6-2e.)

SF 507[1]
Clinical Record—Report on or Continuation of SF. File with the standard form being continued.

SF 509[1]; SF 558[1]; SF 513[1]; DD Form 2161[1]
Medical Record—Progress Notes; Medical Record—Emergency Care and Treatment; Medical Record—Consultation Sheet; Referral for Civilian Medical Care. File in chronological order. (See paras 3-3k, 5-14, 5-16b(3), 5-19a(3), 9-5d(3)(g), 9-5d(3)(h), 9-10a, 9-11, 9-12, 9-13, 9-14b, 9-14c, 9-21e, and 9-25d.)

DA Form 3888
Medical Record—Nursing History and Assessment. (See paras 3-3b and 9-13.)

DA Form 3888-2
Medical Record—Nursing Care Plan. (See para 9-13.)

DA Form 3888-3
Medical Record—Nursing Discharge Summary. (See para 9-13.)

SF 510
Clinical Record—Nursing Notes. (See paras 3-2a, 9-12b(3), 9-13, and 9-14c.)

DA Form 5179
Medical Record—Preoperative/Postoperative Nursing Document. (See para 9-33.)

DA Form 5179-1
Medical Record—Intraoperative Document. (See para 9-34.)

DA Form 3950
Flowsheet for Vital Signs and Other Parameters. (See para 9-24.)

SF 511[1]
Medical Record—Vital Signs Record. (See paras 9-23, 9-24, and 9-35.)

SF 512[1]
Clinical Record—Plotting Chart. (See para 5-13.)

SF 545[1]
Laboratory Report Display. (See paras 3-2 and 9-25.) Instructions for completing this form are provided in tables 9-2 and 9-3.

SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 556; SF 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; Immunohematology; Miscellaneous. Attach to SF 545 in reverse chronological order. (See para 9-25.) Instructions for completing these forms are provided in tables 9-2 and 9-3.

SF 515[1]
Medical Record—Tissue Examination. (See paras 5-2, 5-19, and 9-5d(3)(e).)

Armed Forces Institute of Pathology Consultation Report on Contributor Material.

Figure 9-1. Forms and documents of the ITR—Continued

SF 516[1]
Medical Record—Operation Report. (See paras 9-5d(3)(d) and 9-12.)

DA Form 7389[1]
Medical Record—Anesthesia (formerly SF 517 and OF 517). (See paras 9-5d(3)(f) and 9-12.)

SF 518[1]
Medical Record—Blood or Blood Component Transfusion.

SF 519-B[1]
Radiologic Consultation Request/Report. (See para 9-37.)

SF 519; 519A
Medical Record—Radiographic Report. SF 519 and SF 519A are obsolete; use for file purposes only if already in existence.

OF 520[1]
Clinical Record—Electrocardiographic Record (formerly SF 520). Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of OF 520 or on another attached sheet of paper. CAPOC or equivalent tracings may substitute for the OF 520.

OF 522[1] or State mandated forms
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures (formerly SF 522). File all other special consent forms here. (See paras 3-3 and 9-5d(3)(c).)

SF 523[1]
Clinical Record—Authorization for Autopsy.

SF 523A[1]
Medical Record—Disposition of Body.

OF 523-B[1]
Medical Record—Authorization for Tissue Donation (formerly SF 523-B).

SF 524[1]
Medical Record—Radiation Therapy.

SF 525[1]
Medical Record—Radiation Therapy Summary.

SF 526[1]
Medical Record—Interstitial/Intercavitary Therapy.

SF 527[1]
Group Muscle Strength, Joint R.O.M. Girth and Length Measurements.

SF 528[1]
Clinical Record—Muscle and/or Nerve Evaluation—Manual and Electrical: Upper Extremity.

SF 529[1]
Medical Record—Muscle Function by Nerve Distribution: Trunk and Lower Extremity.

SF 530[1]
Clinical Record—Neurological Examination.

SF 531[1]
Medical Record—Anatomical Figure.

SF 533[1]
Medical Record—Prenatal and Pregnancy. Also file related prenatal documents here. (See para 6-7g.)

SF 534[1]
Medical Record—Labor.

SF 536[1]
Clinical Record—Pediatric Nursing Notes.

SF 537[1]
Medical Record—Pediatric Graphic Chart. SF 537 is obsolete; use for file purposes only if already in existence.

SF 538[1]
Clinical Record—Pediatric.

Figure 9-1. Forms and documents of the ITR—Continued

SF 541[1]
Medical Record—Gynecological Cytology.

SF 560
Medical Record—Electroencephalogram Request and History (formerly DA Form 4530). SF 560 is obsolete; use for file purposes only if already in existence.

DA Form 3824[1]
Urologic Examination.

DA Form 4221[1]
Diabetic Record.

DA Form 4256
Doctors Orders. (See paras 3-3p, 9-5d(3)(b), 9-14a(4), 9-14c, and 9-26.)

DA Form 4677
Therapeutic Documentation Care Plan (Non-Medications). (See paras 9-13c, 9-26d, 9-26e, and 9-27.)

DA Form 4678
Therapeutic Documentation Care Plan (Medication). (See paras 9-13c, 9-26d, 9-26e, and 9-28.)

DA Form 4700[1]
Medical Record—Supplemental Medical Data. (See paras 3-2a, 3-3, 5-19b(7), 9-2b, and 11-4b(4).)

DA Form 5128[1]
Clinical Record—Visual Field Examination (formerly DD Form 742).

DD Form 602
Patient Evacuation Tag. Staple to SF 502. (See AR 40-40/AFR 164-3/BUMEDINST 4650.2A and para 9-6 of this regulation.)

DD Form 741[1]
Eye Consultation.

DD Form 742
Clinical Record—Visual Field Examination. (See DA Form 5128.) DD Form 742 is obsolete; use for file purposes only if already in existence.

DD Form 749
Clinical Record—Head Injury. DD Form 749 is obsolete; use for file purposes only if already in existence.

DD Form 1380
U.S. Field Medical Card. (See paras 3-18a, 5-11, 5-30a(2), 5-31a, 9-1b(2), 9-6, and chap 10.)

DA Form 4359-R
Authorization for Psychiatric Service Treatment. (See para 9-22.)

Medical reports (for example, autopsy report and fetal death certificate) on a stillborn infant. File in the mother's ITR.

DA Form 2985
Admission and Coding Information. (See AR 40-400 and para 3-19b of this regulation.)

DD Form 2005[2]
Privacy Act Statement—Health Care Records. DD Form 2005 is always the bottom form or is printed on the folder. (See paras 4-4a(9), 5-25a, 7-4a, and 9-5d(1).)

Notes:

[1] Instructions for completing this form are self-explanatory.

[2] This form must be included in all ITRs.

Figure 9-1. Forms and documents of the ITR

Example 1

The personnel needed for the patient undergoing myringotomy with tube insertion taking 45 minutes: There is one OR nursing team and one anesthesia provider. The case equals one episode of OR nursing and one episode of anesthesia.

Example 2

The personnel needed for a patient undergoing a cholecystectomy with intraoperative cholangiogram taking 4 hours: There is one OR nursing team and one additional circulator who is used for 1 hour and there is one anesthesia provider. The case equals 2.5 episodes of OR nursing and two episodes of anesthesia.

Example 3

The personnel needed for the patient undergoing an exploratory laparotomy for repair of a ruptured abdominal aneurysm taking 10 hours: For 3 hours there is one OR nursing team plus an additional scrub and two additional circulators, for the next 4 hours, there is one OR nursing team and two additional circulators, for the last 3 hours there is one OR nursing team, there are two anesthesia providers for the first 6 hours of the case, and for the next 4 hours there is one anesthesia provider. The case equals seven and one-half OR nursing episodes and six episodes of anesthesia; there is one anesthesia provider.

Figure 9-2. Examples for calculation of episodes of OR nursing and episodes of anesthesia

Chapter 10
DD Form 1380

10–1. Use

a. DD Form 1380 will be used to record basic patient identification data and to describe the problem requiring medical attention and the care provided. NATO STANAG 2132 and QSTAG 470 govern the use of DD Form 1380. Instructions for completing the form are provided in table 10-1.

b. The four echelons or levels of medical care mentioned in c(1) through c(4) below are defined as follows (FM 8-10-1 and FM 8-10-14):

(1) *Level-I.* This level represents emergency medical care provided by self or buddy aid followed by trained enlisted medical personnel who provide emergency medical care and convey or direct the casualty to the next level of medical care. An aid station that provides routine sick call and advanced trauma management, and prepares patients for further evacuation is the principal Echelon I MTF at this level.

(2) *Level-II.* This echelon of care is provided in a clearing station operated by divisional and nondivisional medical companies. Here the patient is evaluated to determine his or her priority for continued evacuation to the rear, or is treated and returned to duty (RTD). Emergency care, including beginning resuscitation, is continued, and if required, urgent initial surgery is performed.

(3) *Level-III.* At this level (Echelon III), care is provided by a combat support hospital (CSH), which is staffed and equipped to provide care for all categories of patients. At the CSH, patients are stabilized for continued evacuation or RTD. Those patients who are expected to RTD within the theater evacuation policy are regulated to an MTF for further definitive care, to include physical reconditioning and rehabilitation.

(4) *Level-IV.* At this level (Echelon IV), the patient is treated at a general hospital (GH) or an FH. The GH is staffed and equipped for general and specialized medical and surgical care. Those patients not expected to RTD within the theater evacuation policy are stabilized and evacuated to CONUS. At the FH, reconditioning and rehabilitating services are provided for those patients who will be RTD within the theater evacuation policy.

(5) *Level-V.* At this level (Echelon V), care is provided in CONUS. Hospitalization is provided by DOD hospitals (military hospitals of the Tri-Services) and VA hospitals. Under the National Disaster Medical System, patients overflowing DOD and VA hospitals will be cared for in designated civilian hospitals. Echelon V hospitals provide a full range of medical, surgical, reconditioning, and rehabilitation services. Active duty patients that are cared for in VA and civilian hospitals will be transferred to DOD hospitals for final disposition. In DOD hospitals, patients are treated, reconditioned, rehabilitated, and RTD, or discharged from military service.

c. Combat medics, aid stations, and MTFs will use DD Form 1380 as outlined in (1) through (4) below.

(1) The combat medic, the first respondent attending battle casualties, will initiate DD Form 1380 by completing blocks 1, 3, 4, 7, and 9 and by entering as much information in the remaining blocks as time permits. He or she will enter his or her initials in the far right side of the signature block (Block 11).

(2) Aid stations will record medical care provided on DD Form 1380 any time that the aid station is operational and does not have access to the patient's HREC or OTR.

(3) MTFs providing Echelon I medical care will use DD Form 1380 any time that care is provided and the patient's HREC is not readily available. If a patient is treated in a holding section or is expected to return for additional treatment or evaluation, an OTR may be initiated using standard medical record forms. The OTR need not be filed in a DA Form 3444-series record. When the patient is RTD or when treatment and evaluation are completed, the medical officer will summarize care provided on DD Form 1380, and DD Form 1380 will be dispositioned in accordance with paragraph 10-4. When the patient is evacuated, treatment will be summarized on DD Form 1380. DD Form 1380 and all forms and records initiated will accompany the patient during evacuation.

(4) MTFs where the primary mission is to provide Echelon III or Echelon IV medical care will use DD Form 1380 to record outpatient care provided when the patient's HREC is not readily available as stated in (1), (2), and (3) above.

10–2. Preparation

a. A medical officer will complete DD Form 1380 or supervise its completion. When DD Form 1380 has been initiated by a combat

medic, the supervising AMEDD officer will complete, review, and sign DD Form 1380.

b. In a theater of operations (TO), DD Form 1380 will be prepared for any patient treated at one of the MTFs listed in paragraph 10-1 and may also be used for CRO cases (para 3-18). For transfer cases, DD Form 1380 will be attached to the patient's clothing, where it will remain until the patient arrives at a hospital or RTD. If the patient dies, DD Form 1380 will remain attached to the body until internment, when it will be removed. If the body cannot be identified, the registration number given the remains by the Mortuary Affairs Service will be noted on DD Form 1380.

c. Under conditions of extreme stress, DD Form 1380 for patients being transferred may be only partially completed. Otherwise, all entries will be completed as fully as possible. Detailed instructions for preparing DD Form 1380 are given in table 10-1. All abbreviations authorized for use on DA Form 3647 or CHCS automated equivalent may also be used on DD Form 1380. Except for those listed below, however, abbreviations may not be used for diagnostic terminology.

(1) Abr W—Abraded wound.
(2) Cont W—Contused wound.
(3) FC—Fracture (compound) open.
(4) FCC—Fracture (compound) open comminuted.
(5) FS—Fracture (simple) closed.
(6) LW—Lacerated wound.
(7) MW—Multiple wounds.
(8) Pen W—Penetrating wound.
(9) Perf W—Perforating wound.
(10) SV—Severe.
(11) SL—Slight.

10–3. Supplemental DD Form 1380

When more space is needed, another DD Form 1380 will be attached to the original. This second form will be labeled in the upper right corner "DD Form 1380 #2" and will show the patient's name, grade, and SSN.

10–4. Disposition

In a TO, if DD Form 1380 is generated but the patient is not admitted to a hospital, the form will be sent to the medical command and control headquarters or the command surgeon for statistical coding.

a. After coding, DD Form 1380 will be disposed of per AR 25-400-2 as described in (1) through (4) below.

(1) Forms pertaining to military personnel will be disposed of as follows.

(a) Forms pertaining to Active Army officers will be sent to Commander, PERSCOM, ATTN: TAPC-MSR, 200 Stovall Street, Alexandria, VA 22332-0400 for insertion in official military personnel file.

(b) Forms pertaining to Active Army enlisted personnel will be sent to Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE-RP, 8899 East 56th Street, Indianapolis, IN 46249-5301 for insertion in official military personnel file.

(c) Forms pertaining to Active Navy or Marine Corps personnel will be sent to The Surgeon General, Naval Medical Command, ATTN: Code 33, Department of the Navy, Washington, DC 20372-5120.

(d) Forms pertaining to Active Air Force personnel will be sent to AFOMS/SGSB, Brooks Air Force Base, TX 78235-5000.

(e) Forms pertaining to all other U.S. uniformed personnel will be sent to USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6000.

(2) Forms pertaining to civilian personnel will be sent to the NPRC (Civilian), 111 Winnebago Street, St. Louis, MO 63118-4199.

(3) Forms pertaining to foreign nationals within the overseas area will be forwarded to the appropriate authorities. Within the USAMEDCOM, forward to USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6000.

(4) Forms pertaining to prisoners of war will be sent to Office of the Deputy Chief of Staff for Personnel, ATTN: DAPE-HRE, 200 Stovall Street, Alexandria, VA 20314-0300.

b. When a transferred patient arrives at a hospital, his or her DD Form 1380 will be used to prepare the ITR. DD Form 1380 will then become part of the ITR. (See fig 9-1.)

c. The original DD Form 1380 used to record outpatient treatment in peacetime operations or during training exercises will be forwarded to the custodian of the patient's HREC or OTR for inclusion in the record.

d. All carbon copies of DD Form 1380 will be disposed of per AR 25-400-2.

10–5. DA Form 4006

DA Form 4006 (Field Medical Record Jacket) may be used as an envelope for DD Form 1380. DA Form 4006 is available through normal publications supply channels. Instructions for completing the form are self-explanatory. To keep the jacket from being opened while the patient is in transit, pertinent personnel and medical data on the patient may be recorded on the outside. The movement of the patient may also be recorded. When the jacket has been used in this fashion, it must become a part of the ITR.

Table 10–1
Instructions for preparing DD Form 1380

Block: 1 **Instructions:** Enter patient's name, rank, and complete SSN. For foreign military personnel (including prisoners of war), enter military service number. Enter military occupational specialty or area of concentration for specialty code. Enter religion. Check appropriate box for sex.
Block: 2 **Instructions:** Enter patient's unit of assignment and the country of whose armed forces the patient is a member. Check armed service of the patient, that is, A/T = Army, AF/A = Air Force, N/M = Navy, and MC/M = Marine.
Block: 3 **Instructions:** Use figures to show location of injury or injuries. Check appropriate boxes to describe patient injury or injuries.
Block: 4 **Instructions:** Check appropriate box.
Block: 5 **Instructions:** Write in the pulse rate and the time that the pulse was measured.
Block: 6 **Instructions:** Check yes or no box. Write in date and time that tourniquet was applied.
Block: 7 **Instructions:** Check yes or no box. Write in dose administered. Write in date and time administered.
Block: 8 **Instructions:** Write in type of solution. Write in time and location given. If additional space is required, use Block 9.
Block: 9 **Instructions:** Write in information requested. If additional space is needed, use Block 14.

Table 10–1
Instructions for preparing DD Form 1380—Continued

Block: 10
Instructions: Check appropriate box. Write in date and time of disposition.

Block: 11
Instructions: Write in signature and unit of medical officer completing form. Write in initials of combat medics initiating form on the right side of block.

Block: 12
Instructions: Write in date and time of arrival. Record blood pressure, pulse, and respirations in space provided.

Block: 13
Instructions: Document appropriate comments by date and time of observation.

Block: 14
Instructions: Document provider's orders by date and time. Record dose of tetanus administered and time administered. Record type and dose of antibiotic administered and time administered.

Block: 15
Instructions: Write in signature of provider or medical officer.

Block: 16
Instructions: Check appropriate box. Enter date and time.

Block: 17
Instructions: This block will be completed by the Unit Ministry Team. Check appropriate box of service provided. Write in signature of chaplain providing service.

Chapter 11
Role of the Medical Department Activity or U.S. Army Medical Center Patient Administration Division in the Improving Organizational Performance Process

11–1. General

The Improving Organizational Performance (IOP) process will follow guidelines contained in the current JCAHO standards. The Patient Administration Division will conduct administrative record reviews and provide administrative support to the IOP processes outlined in local policy. The extent of assistance to individuals, departments, services, or others will be contingent on availability of personnel and automation resources. Trends and findings made during the conduct of IOP activities are protected under the provisions of AR 40-68.

a. ITR review. When a patient's record is processed after discharge, the Patient Administration Division will review the ITR for completeness. Errors or deficiencies should be corrected on an individual basis without referral of the ITR within the MTF IOP structure. However, trends in errors or deficiencies or large numbers of errors or deficiencies are a proper subject for discussion and action within the MTF IOP structure; the Patient Administration Division will refer these and the necessary supporting records as appropriate within the MTF-specific IOP structure.

b. Administrative support for patient care assessment studies. The Patient Administration Division will be responsible for providing the following administrative support for these studies: retrieving medical records; compiling data for MTF-wide studies; and referring ITRs, OTRs, CEMRs, and HRECs to the appropriate person/group within the MTF-specific IOP structure.

11–2. Internal performance improvement process for medical record services

Medical record personnel will implement an internal performance improvement process that will demonstrate an improvement in medical records services over time. This process will be integrated with the MTF IOP structure, and documentation will provide evidence of ongoing improvement of the major functional areas listed in *a* through *i* below.

a. Administration or management.
b. Record review and analysis.
c. Retrieving, filing, and controlling records.
d. Correspondence and release of medical information.
e. Coding and abstracting.
f. Medical statistics.
g. Medical transcription.
h. Hospital information management system (such as CHCS or Clinical Information System).
i. Security and confidentiality of health information.

11–3. Patient care assessment

a. Documentation review of medical records for accuracy, timeliness, completeness, clinical pertinence, authentication, and adequacy as medicolegal documents. This review is required on a quarterly basis and should involve the health information management staff, the management staff, the medical staff, the nursing staff, and representatives of all other disciplines involved in the assessment and treatment of patients. The review should include a sample of randomly selected OTRs, ITRs, CEMRs, and HRECs. (Random selection must be based on some characteristic of the record, such as a certain digit or digits or the register number, and not on the nature of the case.) The random sample can include any combination of OTRs, ITRs, CEMRs, and HRECs, depending on the size and degree of specialization of the MTF concerned. The random selection process must ensure that over a 1-year period of time, every privileged provider's documentation has been included with the results of the review forwarded to the individual provider's activity file for reference by the credential committee at the time of reappointment. The DENTAC commander will establish a dental record review program to ensure quality records. The ITRs to be used will be those of patients currently on the wards and those of discharged patients. This review is made to ensure that the records conform to the standards described in (1) through (10) below.

(1) The medical record clearly identifies the patient, the treating AMEDD facility, and the treating personnel. In addition, enough information is given to support the diagnoses, to justify the treatment, and to provide for follow-up care.

(2) The ITRs of current inpatients describe the progress and the current status and treatment of the patient so that the case can be fully understood at any time. HRECs and OTRs will be reviewed for clinical pertinence and completeness, that is, appropriate documentation of visit or episode, up-to-date problem list, and diagnostic test results filed.

(3) Each medical record includes all completed forms and reports needed by the nature of the case and the treatment given.

(4) Final diagnoses are fully recorded; symbols and abbreviations have not been used.

(5) All entries are current, clinically pertinent, and legible; entries do not contain provider accusations or derogatory (ventilated) comments.

(6) All entries are dated and signed.

(7) Discharge instructions, including restrictions, medications, and follow-up provisions, are adequate.

(8) Documentation of all deaths clearly shows the condition of the patient on admission and the events leading to the patient's death. The record will be reviewed for completeness, including any ordered laboratory tests or studies.

(9) HRECs include review and updating of DA Form 8007-R.

(10) The record complies with all other provisions of this regulation.

b. Entry deficiencies. Deficiencies of all missing, untimely, inappropriate, conflicting, or altered entries identified during the review process will be documented. This documentation will be used for problem identification, notification of the risk manager and medical claims judge advocate (MCJA) of potential liability, in-service education, and preparation of reports as required by the MTF-specific IOP process. For corrections to medical records, see paragraph 3-4e.

c. Record delinquencies. On a quarterly basis, trends from a sampling of the following medical record delinquencies will be reported as required in the MTF-specific IOP process:

(1) History and physical not done within 24 hours after admission.

(2) Operative report not dictated within 24 hours of the completion of surgery.

(3) Narrative summary not dictated within 4 working days of patient discharge.

(4) DA Form 3647 (worksheet) not completed within 4 working days of patient discharge.

(5) ITRs not completed within 30 days of patient discharge.

11–4. Patient Administration Division role in handling medical records in the Risk Management Program

a. In all cases of potential compensable events or Federal tort claims, original medical or dental records will not be released by the record custodian directly to the patient or his or her authorized representative. The MCJA or claims judge advocate (CJA) or U.S. Army Claims Service (USARCS), as appropriate, will release copies of the records. (This restriction does not apply to cases in which the claim is being filed with an individual or agency outside the U.S. Government.) Original records will not be released unless requested by a Government attorney defending the United States in a malpractice lawsuit. Any such request for medical or dental records must be in writing, specifying the dates of treatment and the names of the MTFs or DTFs involved. The records will be released, if at all, per AR 340-21 and AR 27-20. Release of medical or dental records is limited to records defined in figures 5-1, 5-2, 5-3, 6-1, 6-2, 6-3, 8-1, and 9-1. Records kept by various departments, services, and clinics in an MTF or DTF (for example, x rays, wet tissue, paraffin blocks, microscopic slides, surgical and autopsy specimens, tumor death reports, and fetal monitoring strips) will not be released unless requested by the Litigation Division, Office of The Judge Advocate General (OTJAG), or USARCS. Original x rays, paraffin blocks, and slides will not be released. When medical or dental records are needed for treatment purposes elsewhere, copies or appropriate extracts of the records will be furnished. Before the disposition of these records to the NPRC, consult USARCS or the Litigation Division, OTJAG, ATTN: JALS-LT, 901 West Stewart Street, Arlington, VA 22203-1837.

b. Special attention will be given to the handling of medical or dental records involved in litigation or adjudication to ensure accuracy and correlation of evidential documentation. The practices described in (1) through (6) below will be followed.

(1) Before any action (for example, photocopy; release to local CJA; transmittal to Litigation Division, OTJAG; or response to subpoena), the original medical or dental record will be reviewed for completion by the Patient Administration Division or the DENTAC and will be assembled in the appropriate order prescribed in this regulation. All undersized reports (x-ray reports, laboratory reports, electrocardiographic tracings, or special tracings) will be attached to their respective display or mounting sheets. Medical or dental records involved in litigation or adjudication require special safeguarding in the Patient Administration Division and will be maintained separately in locked filing cabinets or safes. Complete records filed separately will be accounted for in the central file area with a chargeout guide. Periodic review of records in this secure area with CJA may allow closed cases to be returned to file. Care must be taken to notify the NPRC of records not retired per disposition schedule in AR 25-400-2, and records retired out of schedule. Portions of records (for example, reports of special examinations) maintained separately will be cross-referenced by an annotation in the basic record (for example, on SF 600). (See para 2-6.)

(2) Reproductions must be legible (that is, the print will not be blurred or too light to read); words and portions of words will not be cut off because of improper positioning of the original copies in the copying equipment; and there will be a photocopy page to correspond with every original page. All pages will be numbered consecutively regardless of the number of hospitalizations. (Pages will be numbered before copying.) To ensure legible reproduction of laboratory reports mounted on SF 545, each laboratory report will be detached from the display form and individually numbered.

(3) The Patient Administration Division will be the only office in the MTF in which an official (authenticated) photocopy of a medical record may be made for purposes cited in *a* above. Use of DA Form 4 (Department of the Army Certification for Authentication of Records) for certification of record copies is encouraged.

(4) If medical or dental records are released to CJA or USARCS, the Patient Administration Division will append a list to the record identifying signatures and initials appearing in the record. (Signature and initial verification lists will be maintained for practitioners involved in medical or dental record documentation.) These lists will be recorded on DA Form 4700 and will be filed in the patient's medical or dental record.

(5) Copies of all correspondence concerning the case will be appended to the record. Copies of correspondence will also be maintained by the CJA.

(6) When medical or dental records have been retired to the NPRC, the CJA or USARCS, not the MEDDAC, MEDCEN, or DENTAC, will notify NPRC not to release the record to the patient or his or her representative. They will also request any records needed from NPRC.

c. Medical records will be copied and given to the risk manager as soon as the priority system will allow.

Chapter 12
DD Form 689

12–1. Purpose and use

a. This chapter prescribes policy and procedures for the preparation, use, and disposition of DD Form 689 (Individual Sick Slip).

b. The DD Form 689 will be issued to a patient who either requests or receives medical or dental treatment or evaluation at an Army MTF. The DD Form 689 may be used at any time as a means of communication between the attending AMEDD personnel and the unit commander of the military member (hereinafter referred to as the patient). Examples are:

(1) To assign a temporary profile, not to exceed 30 days, under AR 40-501, chapter 9.

(2) To furnish information concerning height and weight, as required in AR 600-9.

(3) To communicate to the patient's commander any limitations when DA Form 3349 is inappropriate.

12–2. Issuing authority

The issuing authority is responsible for the accuracy of the data entered on the DD Form 689. Issuing authority is as follows:

a. Unit commander or authorized representative.

b. Confinement officer of disciplinary facilities or authorized representative.

c. Attending AMEDD personnel or authorized representative. When a patient is authorized to report directly to the MTF, and medical limitations are imposed, AMEDD personnel will issue the DD Form 689.

12–3. Procedures

a. The DD Form 689 will be initiated in two copies. Identification data may be completed by or for the patient. The form consists

of three sections to be completed in accordance with the following instructions (see fig 12-1):

(1) *"Illness" and "injury" blocks.* Check "Illness" or "Injury."

(2) *"Line of Duty" (LOD) block.* Leave blank. Action regarding LOD will be taken under the provisions of AR 600-8-1, as appropriate.

(3) *"Remarks" block.* The following information will be entered in the "Remarks" block when a DD Form 689 is prepared for individuals referred to an MTF:

(a) Duty status at time of condition (for example, Duty, Leave, AWOL, etc.).

(b) For nonbattle injuries, the circumstances of how, when, and where injury occurred.

(c) Any specific request to the MTF. For example: "Request psychiatric examination," "Can this individual do KP," etc.

(d) Other information which may be helpful to the AMEDD personnel.

(4) *"Signature of Unit Commander" block.* The commander or his or her designee will sign this section.

b. The medical officer's section will be completed by AMEDD personnel in accordance with the following:

(1) *"Line of duty" block.* See paragraph a(2) above.

(2) *"Disposition of patient" block.* The disposition of the patient will be indicated by a check mark in the appropriate space provided on the form as follows:

(a) DUTY: When the patient is returned to his or her unit for full duty without restrictions.

(b) QUARTERS: When the patient is returned to his or her unit or home for medically directed self-treatment and is not to perform military duty until a medical officer indicates that he or she may perform such duties. (Note: The medical officer will indicate in the Remarks section the duration of the quarters status in number of hours, and indicate the inclusive period (for example, Quarters, 24 hours, 0730, 17 May until 0730, 18 May 95). Quarters status will normally not exceed 72 hours.

(c) SICK BAY: Not used by Army MTFs.

(d) HOSPITAL: When the patient is admitted to a hospital for inpatient care.

(e) NOT EXAMINED: Must be explained in "Remarks" block if checked (for example, to report to eye clinic next Tuesday, 0900).

(f) OTHER: May be used by itself or in conjunction with any of the other disposition instructions above. When a temporary profile is assigned, this block must be checked.

(3) *"Remarks" block.* Indicate in this block the time and date the patient was released for the disposition indicated. If a temporary profile is assigned, this profiling official will record the profile, using the appropriate PULHES designator, and specific limitations (example: TL3—No continuous wearing of combat boots for 10 days). Other comments the examiner may want to relay to the patient's commander may be entered.

(4) *"Signature of Medical Officer" block.* The signature of the examining official or his or her authorized representative is required on all DD Forms 689 prepared at Army MTFs. When the patient is from an organization that is not normally serviced by the medical facility forwarding the DD Form 689, the name and location of that facility will be entered in the "Signature of Medical Officer" block.

12–4. Health record entry (treatment record)

The examining AMEDD personnel will enter on an SF 600 the findings of the examination or evaluation, recommended treatment, disposition, profile, as applicable, and any specific duty limitations and instructions.

12–5. Disposition of DD Forms 689

a. Normally, the DD Form 689 will be hand-carried by the patient or by an individual responsible for escorting the patient. When completed, the original of the DD Form 689 will be provided to the patient and the duplicate will be maintained by the patient's commander.

b. Commanders may destroy a DD Form 689 when a temporary profile or quarters status has terminated.

INDIVIDUAL SICK SLIP ☐ ILLNESS ☒ INJURY		DATE 17 May 96
LAST NAME-FIRST NAME-MIDDLE INITIAL OF PATIENT Jones, John J.		ORGANIZATION AND STATION Co A, 122 ORD BN Camp Piney, SC
SERVICE NUMBER/SSN 111-22-3333	GRADE/RATE PFC	
UNIT COMMANDER'S SECTION		MEDICAL OFFICER'S SECTION
IN LINE OF DUTY		IN LINE OF DUTY
REMARKS Injured his left knee while playing basketball in post gym at 2100, 16 May 96.		DISPOSITION OF PATIENT ☐ DUTY ☐ QUARTERS ☐ SICK BAY ☐ HOSPITAL ☐ NOT EXAMINED ☒ OTHER *(Specify)*: REMARKS TL3 No strenuous exercise for 24 hours. Returned to duty 1000, 17 May 96. Return to sick call 18 May 96.
SIGNATURE OF UNIT COMMANDER J. E. Smith, CPT, ORDC		SIGNATURE OF MEDICAL OFFICER R. L. Wilson, CPT, MC

DD FORM 689, MAR 63 PREVIOUS EDITIONS ARE OBSOLETE.

Figure 12-1. Sample of a completed DD Form 689

Chapter 13
Medical Warning Tag and DA Label 162

13–1. Description and use

a. The Medical Warning Tag is made of aluminum of bright red color the size and shape of the Army Identification Tag (AR 600-8-14). It serves as a means of rapid recognition of selected health problems when records are not available and the individual requiring medical treatment is unable to give a medical history. (For example, when an unconscious soldier has had a reaction to penicillin in the past, circumstances might lead a person rendering treatment to administer penicillin unless knowledge of the allergy is available.)

b. DA Label 162 is a self-adhesive label depicting the "Star of Life" (fig 13-1). It consists of a white serpent on a white staff superimposed on a red star with a white background. DA Label 162 is affixed to the HREC, OTR, and CEMR to assist in the recognition of selected health problems documented within these records. It will be affixed to these records in conjunction with issuance of the Medical Warning Tag.

13–2. Applicability

a. In CONUS, provisions of this chapter will be implemented at Army MTFs and designated embossing units.

b. Army overseas commanders will implement provisions of this chapter as feasible, with such adaptions as may be required.

13–3. Responsibilities

a. MEDCEN/MEDDAC commanders will—

(1) Train AMEDD personnel to look for, recognize, and use the information on the tag.

(2) Ensure that DA Label 162 is affixed to the HREC, OTR, and CEMR whenever DA Form 3365 is initiated.

(3) Ensure availability of material necessary to support this program.

(4) Ensure that information concerning the tag is incorporated into first aid instructions provided to the individual soldier.

b. Medical officers (includes civilian doctors of medicine, dentistry, and osteopathy) and PAs will—

(1) Determine when issuance of a tag and label are necessary.

(2) Counsel patients as to the tag's importance.

(3) Ensure that the tag is furnished to the patient along with a locally prepared letter of instruction similar to that shown in figure 13-2.

c. Installation or organization commanders, when requested by an MTF, will designate a unit or units (which are equipped to emboss Army Identification Tags) to emboss Medical Warning Tags on receipt of DA Form 3365.

d. Activities embossing medical warning tags will—

(1) Establish procedures which facilitate immediate preparation and delivery.

(2) Ensure Medical Warning Tag blanks are not used for any other purpose.

e. Individuals will wear the tag at all times for protection.

13–4. Criteria for issue of Medical Warning Tags and DA Labels 162

a. DA Label 162 will be affixed to the patients HREC, OTR, or CEMR and a Medical Warning Tag will be issued to any individual receiving care at a military MTF when a medical officer determines that a patient has a medical condition meeting the criteria described below.

b. Medical conditions warranting such identification should satisfy the following criteria:

(1) Be permanent in nature.

(2) Be well established with definite diagnosis.

(3) Be of such a nature that, if the individual were unable to give a history of the problem, indicated medical care might be improper, delayed, or otherwise compromised.

c. Examples of conditions that warrant authorizing patient and record identification include, but are not necessarily limited to, the following:

(1) Allergy to antibiotics or drugs such as penicillin or barbiturates.

(2) Sensitivity to biological products such as horse sera.

(3) Sensitivity to immunizing agents when exemption is justified under the provisions of AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E, paragraph 8.

(4) Convulsive disorder.

(5) Diabetes mellitus.

(6) Special medication requirements such as anticoagulants or anticonvulsants, corticosteroids, antihypertensive drugs, or antabuse.

(7) Sensitivity to insect stings.

(8) Sickle Cell disease (specify).

(9) Adrenal insufficiency.

(10) Wearing contact lenses.

13–5. Procedures

a. Preparation of DA Form 3365. This form will be prepared in original and at least two copies. The medical officer or PA will sign the original and forward it to the embossing unit. The form includes a section representing the tag with an embossing format of five plate lines, 18 blocks each. This section is illustrated in figure 13-3. Each entry will begin in the first block of a new line. Abbreviations, except for initials in the name, are not authorized. If a word requires more than 18 spaces, enter a dash after the last syllable that can be completed and continue the word on the next line. Only one letter per block will be entered in this section. The following information will be provided:

(1) *First line (individual identification).* Enter the patient's name (last, first, middle initial) or last name and initials. Enter the sponsor's SSN following the middle initial. When space is insufficient for name and SSN on this line, use line two for continuation.

(2) *Second or following unused line (drug, serum, or other allergy).* Enter allergy on the next unused line beginning in block number one, and on the next unused line (beginning in block number one), the drug, serum, or other agent, for example, PENICILLIN.

(3) *Third or next unused line (specific conditions or potential problems).* Enter the name of the condition or potential problem on the next unused line beginning in block number one, for example, CONTACT LENSES, DIABETES MELLITUS.

(4) *Fourth or next unused line (specific drug therapy).* If a specific drug has been prescribed, enter on this line: "I take (name of drug), for example, INSULIN." In addition, if individual has more than one condition or is taking more than one medication, list those on the next unused line.

b. Additional data. Additional medical data related to items in a(1) through (4) above may be entered in the "Remarks" section of the copy of the form which will be filed in the HREC, OTR, or CEMR.

c. Administrative entries. Space is provided on DA Form 3365 for signature of issuing officer, date the tag was presented, and name of sponsor, parent, or other individuals to be informed when tags are ready for pickup by someone other than the patient.

d. Distribution of DA Form 3365. DA Form 3365 used during embossing of the tag will be destroyed when no longer needed. One copy of the form will be retained in a suspense file at the MTF until the tag has been received and presented to the patient; at that time it will be destroyed. The third copy will be filed in the patient's HREC, OTR, or CEMR.

e. Preparation and distribution of Medical Warning Tag. The tag will be prepared from data contained on DA Form 3365. Information will be embossed in sequence reflected on lines one through five of the tag content section of DA Form 3365. These tags may be embossed by the same embossing machines which are already in use for preparation of the Army Identification Tag. The embossed tag will be provided expeditiously to the patient after its preparation.

f. Utilization of DA Label 162. DA Label 162 will be affixed to the outside cover (front) of the HREC, OTR, or CEMR of those individuals who have conditions which warrant the issuance of a medical warning tag. The DA Label 162 will be affixed at the time that the DA Form 3365 is placed in the record.

13–6. Supply of tag blanks and forms

Metal blanks (Tag, Medical Warning: NSN 6530-00-142-8775) will be requisitioned through normal supply channels. DA Form 3365 and DA Label 162 will be requisitioned through normal publications supply channels.

Figure 13-1. DA Label 162 (Emergency Medical Identification Symbol), shown actual size

United States Army Hospital
Fort Blank, Virginia

MEDPAD Issuance date

Name of Patient to whom tag is issued

Dear

Your physician has determined that a medical warning tag should be issued to you because your medical condition cannot be easily recognized, or certain routine treatment procedures, if administered, may precipitate a serious reaction that could be life-threatening.

The tag has been issued to you to alert personnel to adverse conditions when you are unable to make these facts known to them while they are rendering assistance. The medical warning tag that you have been given performs the same function as a medical alert bracelet or necklace which are recognized worldwide. It is imperative that you wear this tag suspended from your neck at all times or procure at your own expense a similar commercial device, so that your personal safety can be assured.

Should your medical warning tag become lost, another may be procured from the nearest Uniformed Services medical treatment facility.

Sincerely,

Name and Signature of MTF

Commander

Figure 13-2. Sample letter to be presented to patients upon issuance of Medical Warning

TAG CONTENT																		
LINE NO.	SPACE NUMBER																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1	B	L	A	N	D	E	N	S	H	I	P		W	I	N	F	I	-
2	E	L	D		F		1	1	1	2	2	3	3	3	3			
3	A	L	L	E	R	G	Y											
4	P	E	N	I	C	I	L	L	I	N								
5	C	O	N	T	A	C	T		L	E	N	S	E	S				

Figure 13-3. Example of completed "Tag Content" section, DA Form 3365 (Authorization for Medical Warning Tag)

Appendix A
References

Section I
Required Publications

AFJI 48–110/AR 40–562/BUMEDINST 6230.15/CG COMDTINST M6230.4E
Immunizations and Chemoprophylaxis. (Cited in paras 5-17c(1), 5-17c(2), 5-17d, 6-7b(4), 6-7f, and 13-4c(3).)

AR 25–55
The Department of the Army Freedom of Information Act Program. (Cited in paras 1-5a, 2-1, 2-3b(3), 2-4c, and 2-5i.)

AR 25–400–2
The Modern Army Recordkeeping System (MARKS). (Cited in paras 1-5a, 2-4a(3), 2-6b, 4-4b(2), 5-19b(5), 5-20, 5-26d(2), 6-1, 6-4, 6-6a, 6-7h, 7-9, 8-6b, 8-8, 9-1c, 9-2b(1), 9-3b(6), 9-7, 9-10a, 9-10c, 9-12b(6)(c), 9-12b(7)(i), 9-32g, 9-37a, 10-4a, 10-4d, and 11-4b(1), and table 4-4.)

AR 27–20
Claims. (Cited in para 11-4.)

AR 40–2
Army Medical Treatment Facilities: General Administration. (Cited in fig 9-1.)

AR 40–3
Medical, Dental, and Veterinary Care. (Cited in paras 2-3b(1)(b)1, 3-5a(4), 3-16d, 3-19, 5-16b(8), 5-19a(5), and 9-2c(2), table 4-1, and figs 5-1, 5-2, and 9-1.)

AR 40–5
Preventive Medicine. (Cited in para 5-19b(9) and figs 5-1, 5-2, 6-1, 6-2, 7-1, and 8-1.)

AR 40–14/DLAR 1000.28
Occupational Ionizing Radiation Personnel Dosimetry. (Cited in paras 5-19b(5) and 7-4b(5), and figs 5-1, 5-2, and 7-1.)

AR 40–16
Special Notification—Injury Cases. (Cited in figs 5-1, 5-2, 6-1, 6-2, and 9-1.)

AR 40–38
Clinical Investigation Program. (Cited in paras 1-4k, 2-7a(2), and 6-2h, and figs 5-1, 5-2, 6-1, 6-2, and 9-1.)

AR 40–40/AFR 164–3/BUMEDINST 4650.2A
Documentation Accompanying Patients Aboard Military Common Carriers. (Cited in fig 9-1.)

AR 40–63/NAVMEDCOMINST 6810.1/AFR 167–3
Ophthalmic Services. (Cited in figs 5-1, 5-2, 6-1, 6-2, and 7-1.)

AR 40–68
Quality Assurance Administration. (Cited in paras 2-1 and 11-1.)

AR 40–400
Patient Administration. (Cited in paras 3-12b(1)(a), 4-4b(1), and 9-2c(1), and figs 5-1, 5-2, 6-1, 6-2, and 9-1.)

AR 40–501
Standards of Medical Fitness. (Cited in paras 5-19b(1), 5-19b(3), and 12-1b(1), and figs 5-1, 5-2, 6-1, 6-2, 7-1, and 9-1.)

AR 50–5
Nuclear and Chemical Weapons and Materiel—Nuclear Surety. (Cited in paras 5-19b(8), 5-21c, 5-21e, 5-28a, 5-28h, 7-4b(7), and 8-3b(2), and figs 5-1, 5-2, 5-3, 6-1, 6-2, 7-1, 8-1, and 9-1.)

AR 50–6
Nuclear and Chemical Weapons and Materiel—Chemical Surety. (Cited in paras 5-19b(8), 5-21c, 5-21e, 5-28a, 5-28b, 7-4b(7), and 8-3b(2), and figs 5-1, 5-2, 5-3, 6-1, 6-2, 7-1, 8-1, and 9-1.)

AR 340–21
The Army Privacy Program. (Cited in paras 1-5a, 2-1, 2-4c, 3-4f, 4-4a(10), 5-21b, and 11-4a.)

AR 380–5
Department of the Army Information Security Program. (Cited in para 2-6a.)

AR 600–8–1
Army Casualty Operations/Assistance/Insurance Investigations. (Cited in paras 9-2c(1) and 12-3a(2), and figs 5-1 and 5-2.)

AR 600–8–104
Military Personnel Information Management/Records. (Cited in paras 5-24a, 5-27, and 5-30a(4).)

AR 600–85
Alcohol and Drug Abuse Prevention and Control Program. (Cited in paras 2-1, 5-19b(4), 5-24b(2)(k), 8-2, 8-3a, 8-6a, 8-9k, and 8-9l, and figs 5-1, 5-2, 6-1, 6-2, and 8-1.)

AR 600–105
Aviation Service of Rated Army Officers. (Cited in figs 5-1, 5-2, and 7-1.)

AR 600–110
Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV). (Cited in para 3-10.)

AR 608–75
Exceptional Family Member Program. (Cited in para 6-2g and figs 6-1 and 6-2.)

AR 635–40
Physical Evaluation for Retention, Retirement or Separation. (Cited in paras 3-18b(4)(a), 5-2c(3)(e), and 5-19a(4), and figs 5-1 and 5-2.)

DA Pam 40–501
Hearing Conservation. (Cited in figs 5-1, 5-2, 6-1, 6-2, and 7-1.)

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised.
(Cited in para 3-11.) (This publication is available from the American Psychiatric Association, Washington, DC.)

ICD–9–CM (Clinical Modification)
International Classification of Diseases (ICD)—Ninth Revision—Clinical Modification. (Cited in paras 9-5c and 9-18.) (Copies of this 3-volume set may be obtained from the Superintendent of Documents, Government Printing Office, Washington, DC 20402-9325.)

ICD–9–CM (Coding Guidelines)
Triservice Disease and Procedure ICD-9-CM Coding Guidelines. (Cited in paras 3-9, 3-12a(1), 3-15, and 9-18.) (Copies of this publication may be obtained from Commander, Patient Administration Systems and Biostatistics Activity (PASBA), ATTN: MCHI-QZ, 1216 Stanley Road, Fort Sam Houston, TX 78234-6070.)

IPDS User s Manual
Individual Patient Data System User's Manual. (Cited in paras 3-19b and 9-18.) (Copies of this publication may be obtained from Commander, Patient Administration Systems and Biostatistics Activity (PASBA), ATTN: MCHI-QZ, 1216 Stanley Road, Fort Sam Houston, TX 78234-6070.)

NGR 40–501
Standards of Medical Fitness. (Cited in fig 5-1.) (Applies only to National Guard personnel.)

NGR 600–200
Enlisted Personnel Management. (Cited in para 5-27.) (Applies only to National Guard personnel.)

NGR 640–100
Officers and Warrant Officers Military Personnel Records Jacket. (Cited in para 5-27.) (Applies only to National Guard personnel.)

Physicians Handbook on Medical Certification: Death, Fetal Death, and Birth.
(Cited in para 3-13b(2).) (To obtain this handbook in the United States, write to the health department of the State where the MTF is located; outside the United States, write to the National Center for Health Statistics, Department of Health and Human Services, 3700 East-West Highway, Hyattsville, MD 20782-9102.)

TB MED 250
Recording Dental Examinations, Diagnoses, and Treatments; and Appointment Control. (Cited in paras 1-3b, 3-8d, 5-18b, and 5-25c, figs 5-3 and 6-3, and app B.)

TB MED 509
Spirometry in Occupational Health Surveillance. (Cited in figs 5-1, 5-2, 6-1, 6-2, and 7-1.)

TM 8–227–3/NAVMED P–5101/AFM 41–119
The Technical Manual of the American Association of Blood Banks. (Cited in para 9-25f.)

Section II
Related Publications

A related publication is merely a source of additional information. The user does not have to read it to understand this publication.

American Hospital Association Guidelines for Recording Chaplains' Notes in Medical Records.
(Available from The American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611-2431.)

AR 20–1
Inspector General Activities and Procedures

AR 40–31/BUMEDINST 6510.2F/AFR 160–55
Armed Forces Institute of Pathology and Armed Forces Histopathology Centers

AR 40–35
Preventive Dentistry

AR 40–48
Nonphysician Health Care Providers

AR 380–67
The Department of the Army Personnel Security Program

AR 600–8–14
Identification Cards, Tags, and Badges

AR 600–8–24
Officer Transfers and Discharges

AR 600–9
The Army Weight Control Program

AR 635–200
Enlisted Personnel

DOD Instruction 6055.5
Industrial Hygiene and Occupational Health.
(Available on the World Wide Web at the following address: http://web7.whs.osd.smil/dodiss/directives/direct2.htm.)

FM 8–10–1
The Medical Company, Tactics, Techniques, and Procedures

FM 8–10–14
Employment of the Combat Support Hospital, Tactics, Techniques, and Procedures

National Research Council Criteria for Wound Classification.
(Available from the National Academy Press, 2101 Constitution Avenue, NW, Lockbox 285, Washington, DC 20055.)

QSTAG 470
Documentation Relative to Medical Evacuation, Treatment, and Cause of Death of Patients.
(Copies of this publication may be obtained from the DOD Single Stock Point, 5801 Tabor Avenue, Philadelphia, PA 19120-5099.)

NATO STANAG 2132
Documentation Relative to Medical Evacuation, Treatment, and Cause of Death of Patients.
(Copies of this publication may be obtained from the DOD Single Stock Point, 5801 Tabor Avenue, Philadelphia, PA 19120-5099.)

NATO STANAG 2348
Basic Military Hospital (Clinic) Records.
(Copies of this publication may be obtained from the DOD Single Stock Point, 5801 Tabor Avenue, Philadelphia, PA 19120-5099.)

Section III
Prescribed Forms

DA Form 3365
Authorization for Medical Warning Tag. (Prescribed in paras 6-7f, 13-1, 13-3c, and 13-5, and figs 5-1, 5-2, 6-1, 6-2, and 7-1.)

DA Form 3443
Terminal Digit—X-Ray Film Preserver. (Prescribed in paras 4-3, 4-4, and 4-5.)

DA Form 3443X
Terminal Digit—X-Ray Film Negative Preserver (Loan). (Prescribed in paras 4-3, 4-4, and 4-5.)

DA Form 3443Y
Terminal Digit—X-Ray Film Negative Preserver (Insert). (Prescribed in paras 4-3, 4-4, and 4-5.)

DA Form 3443Z
Terminal Digit—X-Ray Film Negative Preserver (Report Insert). (Prescribed in paras 4-3, 4-4, and 4-5.)

DA Form 3444
Alphabetical and Terminal Digit File for Treatment Record (Orange). (Prescribed in paras 4-3, 4-4, 5-23e(1), 6-2a, 7-4a, 8-4b, 9-2b, and 9-5.)

DA Form 3444–1
Alphabetical and Terminal Digit File for Treatment Record (Light Green). (Prescribed in paras 4-3, 4-4, 5-23e(1), 6-2a, 7-4a, 8-4b, 9-2b, and 9-5.)

DA Form 3444–2
Alphabetical and Terminal Digit File for Treatment Record (Yellow). (Prescribed in paras 4-3, 4-4, 5-23e(1), 6-2a, 7-4a, 8-4b, 9-2b, and 9-5.)

DA Form 3444–3
Alphabetical and Terminal Digit File for Treatment Record (Grey). (Prescribed in paras 4-3, 4-4, 5-23e(1), 6-2a, 7-4a, 8-4b, 9-2b, and 9-5.)

DA Form 3444–4
Alphabetical and Terminal Digit File for Treatment Record (Tan). (Prescribed in paras 4-3, 4-4, 5-23e(1), 6-2a, 7-4a, 8-4b, 9-2b, and 9-5.)

DA Form 3444–5
Alphabetical and Terminal Digit File for Treatment Record (Light Blue). (Prescribed in paras 4-3, 4-4, 5-23e(1), 6-2a, 7-4a, 8-4b, 9-2b, and 9-5.)

DA Form 3444–6
Alphabetical and Terminal Digit File for Treatment Record (White). (Prescribed in paras 4-3, 4-4, 5-23e(1), 6-2a, 7-4a, 8-4b, 9-2b, and 9-5.)

DA Form 3444–7
Alphabetical and Terminal Digit File for Treatment Record (Brown). (Prescribed in paras 4-3, 4-4, 5-23e(1), 6-2a, 7-4a, 8-4b, 9-2b, and 9-5.)

DA Form 3444–8
Alphabetical and Terminal Digit File for Treatment Record (Pink). (Prescribed in paras 4-3, 4-4, 5-23e(1), 6-2a, 7-4a, 8-4b, 9-2b, and 9-5.)

DA Form 3444–9
Alphabetical and Terminal Digit File for Treatment Records (Red). (Prescribed in paras 4-3, 4-4, 5-23e(1), 6-2a, 7-4a, 8-4b, 9-2b, and 9-5.)

DA Form 3705
Receipt for Outpatient Treatment/Dental Records. (Prescribed in para 6-4b(1).)

DA Form 3824
Urologic Examination. (Prescribed in figs 5-1, 5-2, 6-1, 6-2, and 9-1.)

DA Form 3888
Medical Record—Nursing History and Assessment. (Prescribed in para 9-13 and fig 9-1.)

DA Form 3888–2
Medical Record—Nursing Care Plan. (Prescribed in para 9-13 and fig 9-1.)

DA Form 3888–3
Medical Record—Nursing Discharge Summary. (Prescribed in para 9-13 and fig 9-1.)

DA Form 3950
Flowsheet for Vital Signs and Other Parameters. (Prescribed in para 9-24 and fig 9-1.)

DA Form 4006
Field Medical Record Jacket. (Prescribed in para 10-5.)

DA Form 4028
Prescribed Medication. (Prescribed in para 9-28g.)

DA Form 4107
Operation Request and Worksheet. (Prescribed in para 9-29.)

DA Form 4108
Register of Operations. (Prescribed in paras 9-29a, 9-29c, and 9-32.)

DA Form 4221
Diabetic Record. (Prescribed in fig 9-1.)

DA Form 4254–R
Request for Private Medical Information. (Prescribed in para 2-4a and figs 5-1, 5-2, 6-1, 6-2, 7-1, and 9-1.)

DA Form 4256
Doctors Orders. (Prescribed in paras 3-3p, 9-5d(3)(b), 9-14a(4), 9-14c, and 9-26, and fig 9-1.)

DA Form 4359–R
Authorization for Psychiatric Service Treatment. (Prescribed in para 9-22 and fig 9-1.)

DA Form 4677
Clinical Record—Therapeutic Documentation Care Plan (Non-Medication). (Prescribed in paras 9-13c, 9-26d, 9-26e, and 9-27, and fig 9-1.)

DA Form 4678
Clinical Record—Therapeutic Documentation Care Plan (Medication). (Prescribed in paras 9-13c, 9-26d, 9-26e, and 9-28, and fig 9-1.)

DA Form 4700
Medical Record—Supplemental Medical Data. (Prescribed in paras 3-2a, 3-3, 5-19b(7), 9-2b, and 11-4b(4), and figs 5-1, 5-2, 5-3, 6-1, 6-2, 6-3, 7-1, and 9-1.)

DA Form 4876–R
Request and Release of Medical Information to Communications Media. (Prescribed in para 2-3b(3) and figs 5-1, 5-2, 6-1, 6-2, 7-1, and 9-1.)

DA Form 5006–R
Medical Record—Authorization for Disclosure of Information. (Prescribed in paras 2-3a(1) and 2-3b(1), and figs 5-1, 5-2, 6-1, 6-2, 7-1, and 9-1.)

DA Form 5007A–R
Medical Record—Allergy Immunotherapy Record—Single Extract. (Prescribed in para 5-5 and figs 5-1, 5-2, 6-1, and 6-2.)

DA Form 5007B–R
Medical Record—Allergy Immunotherapy Record—Double Extract. (Prescribed in para 5-5 and figs 5-1, 5-2, 6-1, and 6-2.)

DA Form 5008
Telephone Medical Advice/Consultation Record. (Prescribed in paras 5-6 and 9-5d(3)(h), and figs 5-1, 5-2, 6-1, 6-2, and 7-1.)

DA Form 5009–R
Medical Record—Release Against Medical Advice. (Prescribed in para 9-38 and fig 9-1.)

DA Form 5128
Clinical Record—Visual Field Examination. (Prescribed in fig 9-1.)

DA Form 5179
Medical Record—Preoperative/Postoperative Nursing Document. (Prescribed in para 9-33 and fig 9-1.)

DA Form 5179–1
Medical Record—Intraoperative Document. (Prescribed in para 9-34 and fig 9-1.)

DA Form 5181–R
Screening Note of Acute Medical Care. (Prescribed in para 5-7 and figs 5-1, 5-2, 6-1, and 6-2.)

DA Form 5568–R
Chronological Record of Well-Baby Care. (Prescribed in para 6-2 and figs 6-1 and 6-2.)

DA Form 5569–R
Isoniazid (INH) Clinic Flow Sheet. (Prescribed in para 5-8 and figs 5-1, 5-2, 6-1, and 6-2.)

DA Form 5570
Health Questionnaire for Dental Treatment. (Prescribed in paras 5-9 and 5-25b, and figs 5-3 and 6-3.)

DA Form 5571
Master Problem List. (Prescribed in paras 3-10c, 5-10, 5-24b(2)(f), 7-4b(4), and 9-5e, and figs 5-1, 5-2, 6-1, 6-2, 7-1, and 9-1.)

DA Form 5694
Denver Developmental Screening Test. (Prescribed in para 6-2e and figs 6-1, 6-2, and 9-1.)

DA Form 7001
Operating Room Schedule. (Prescribed in paras 9-29a and 9-30.)

DA Form 7095
ADAPCP Outpatient Discharge Summary. (Prescribed in para 8-9a and fig 8-1.)

DA Form 7096
ADAPCP Outpatient Aftercare Plan. (Prescribed in para 8-9b and fig 8-1.)

DA Form 7097
ADAPCP Outpatient Problem List and Treatment Plan Review. (Prescribed in para 8-9c and fig 8-1.)

DA Form 7098
ADAPCP Outpatient Treatment Plan and Review. (Prescribed in para 8-9d and fig 8-1.)

DA Form 7099
ADAPCP Outpatient Biopsychosocial Evaluation. (Prescribed in para 8-9e and fig 8-1.)

DA Form 8000
ADAPCP Triage Instrument (for Unscheduled Patients). (Prescribed in para 8-9f and fig 8-1.)

DA Form 8001
Limits of Confidentiality. (Prescribed in para 8-9g and fig 8-1.)

DA Form 8002
ADAPCP Outpatient Administrative Summary. (Prescribed in para 8-9h and fig 8-1.)

DA Form 8003
Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) Enrollment. (Prescribed in para 8-9i and fig 8-1.)

DA Form 8004–R
Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) Outpatient Medical Records—Privacy Act Information. (Prescribed in para 8-9j and fig 8-1.)

DA Form 8005
Outpatient Medical Record (OMR) (Orange). (Prescribed in paras 4-3, 4-4, 5-23e, 5-25, and 6-2a.)

DA Form 8005–1
Outpatient Medical Record (OMR) (Light Green). (Prescribed in paras 4-3, 4-4, 5-23e, 5-25, and 6-2a.)

DA Form 8005–2
Outpatient Medical Record (OMR) (Yellow). (Prescribed in paras 4-3, 4-4, 5-23e, 5-25, and 6-2a.)

DA Form 8005–3
Outpatient Medical Record (OMR) (Grey). (Prescribed in paras 4-3, 4-4, 5-23e, 5-25, and 6-2a.)

DA Form 8005–4
Outpatient Medical Record (OMR) (Tan). (Prescribed in paras 4-3, 4-4, 5-23e, 5-25, and 6-2a.)

DA Form 8005–5
Outpatient Medical Record (OMR) (Light Blue). (Prescribed in paras 4-3, 4-4, 5-23e, 5-25, and 6-2a.)

DA Form 8005–6
Outpatient Medical Record (OMR) (White). (Prescribed in paras 4-3, 4-4, 5-23e, 5-25, and 6-2a.)

DA Form 8005–7
Outpatient Medical Record (OMR) (Brown). (Prescribed in paras 4-3, 4-4, 5-23e, 5-25, and 6-2a.)

DA Form 8005–8
Outpatient Medical Record (OMR) (Pink). (Prescribed in paras 4-3, 4-4, 5-23e, 5-25, and 6-2a.)

DA Form 8005–9
Outpatient Medical Record (OMR) (Red). (Prescribed in paras 4-3, 4-4, 5-23e, 5-25, and 6-2a.)

DA Form 8006–R
Pediatric Dentistry Diagnostic Form. (Prescribed in para 6-7e and fig 6-3.)

DA Form 8007–R
Individual Medical History. (Prescribed in paras 5-24b(2)(g), 5-30a, and 11-3a(9), and figs 5-1, 5-2, and 7-1.)

DA Form 7389
Medical Record—Anesthesia. (Prescribed in paras 3-2a, 9-5d(3)(f), 9-10a, and 9-12b(1)(c), and figs 5-1, 5-2, 6-1, 6-2, and 9-1.)

DA Label 162
Emergency Medical Identification Symbol. (Prescribed in paras 3-10c, 5-17a, 5-24b(2)(i), 6-7f, 13-1b, 13-3, 13-4, and 13-5.)

DD Form 689
Individual Sick Slip. (Prescribed in paras 12-1, 12-2, 12-3, and 12-5.)

DD Form 741
Eye Consultation. (Prescribed in figs 5-1, 5-2, 6-1, 6-2, 7-1, and 9-1.)

DD Form 792
Twenty-Four Hour Patient Input and Output Worksheet. (Prescribed in para 9-23.)

DD Form 877
Request for Medical/Dental Records or Information. (Prescribed in para 4-7.)

DD Form 877–1
Request for Medical/Dental Records from the National Personnel Records Center (NPRC), St. Louis, MO. (Prescribed in para 4-7.)

DD Form 1380
U.S. Field Medical Card. (Prescribed in paras 3-17a, 5-11, 5-30a(2), 5-31a, 9-1b(2), 9-4, 10-1, 10-2, 10-3, 10-4, and 10-5, and figs 5-1, 5-2, 6-1, 6-2, and 9-1.)

DD Form 1924
Surgical Checklist. (Prescribed in para 9-31.)

DD Form 2005
Privacy Act Statement—Health Care Records. (Prescribed in paras 4-4a(9), 5-25a, 7-4a, and 9-5d, and figs 5-1, 5-2, 5-3, 6-1, 6-2, 6-3, 7-1, and 9-1.)

DD Form 2138
Request for Transfer of Outpatient Records. (Prescribed in paras 6-4a(2)(b), 6-4a(2)(c), 6-4b(1), 6-5, and 8-7.)

DD Form 2482
Venom Extract Prescription. (Prescribed in para 5-12 and figs 5-1, 5-2, 6-1, and 6-2.)

DD Form 2770
Abbreviated Medical Record. (Prescribed in paras 9-5d and 9-21, and figs 5-1, 5-2, 6-1, 6-2, and 9-1.)

OF 275
Medical Record Report. (Prescribed in paras 3-3f, 9-12c, and 9-12e, and figs 5-1, 5-2, 6-1, 6-2, and 9-1.)

OF 520
Clinical Record—Electrocardiographic Record. (Prescribed in para 3-2a and figs 5-1, 5-2, 6-1, 6-2, 7-1, and 9-1.)

OF 522
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures. (Prescribed in paras 3-3e, 3-3q, and 9-5d(3)(c), and figs 5-1, 5-2, 5-3, 6-1, 6-2, 6-3, and 9-1.)

OF 523–B
Medical Record—Authorization for Tissue Donation. (Prescribed in fig 9-1.)

SF 502
Clinical Record—Narrative Summary. (Prescribed in para 9-12 and figs 5-2, 6-2, and 9-1.)

SF 503
Clinical Record—Autopsy Protocol. (Prescribed in para 9-12f and fig 9-1.)

SF 504
Clinical Record—History—Part I. (Prescribed in paras 9-10a, 9-12a, 9-14c, and 9-21e, and fig 9-1.)

SF 505
Clinical Record—History—Parts II and III. (Prescribed in paras 9-10a, 9-12a, 9-14c, and 9-21e, and fig 9-1.)

SF 506
Clinical Record—Physical Examination. (Prescribed in paras 9-10a, 9-12a, 9-14c, and 9-21e, and fig 9-1.)

SF 507
Clinical Record—Report on or Continuation of SF. (Prescribed in figs 5-1, 5-2, 5-3, 6-1, 6-2, 6-3, 7-1, 8-1, and 9-1.)

SF 509
Medical Record—Progress Notes. (Prescribed in paras 3-3k, 5-16b(3), 5-19a(3), 9-5d(3)(g), 9-10a, 9-11, 9-12, 9-13, 9-14b, 9-14c, 9-21e, and 9-25d, and figs 5-1, 5-2, 6-1, 6-2, and 9-1.)

SF 510
Clinical Record—Nursing Notes. (Prescribed in paras 3-2a, 9-12b(3), 9-13, and 9-14c, and fig 9-1.)

SF 511
Medical Record—Vital Signs Record. (Prescribed in paras 9-23, 9-24, 9-35, and fig 9-1.)

SF 512
Clinical Record—Plotting Chart. (Prescribed in para 5-13 and figs 5-1, 5-2, 6-1, 6-2, 7-1, and 9-1.)

SF 513
Medical Record—Consultation Sheet. (Prescribed in para 9-12 and figs 5-1, 5-2, 5-3, 6-1, 6-2, 6-3, 7-1, 8-1, and 9-1.)

SF 515
Medical Record—Tissue Examination. (Prescribed in para 9-5d(3)(e) and figs 5-1, 5-2, 6-1, 6-2, and 9-1.)

SF 516
Medical Record—Operation Report. (Prescribed in paras 9-5d(3)(d) and 9-12, and figs 5-1, 5-2, 6-1, 6-2, and 9-1.)

SF 518
Medical Record—Blood or Blood Component Transfusion. (Prescribed in figs 5-2, 6-2, and 9-1.)

SF 519–B
Radiologic Consultation Request/Report. (Prescribed in para 9-37 and figs 5-1, 5-2, 5-3, 6-1, 6-2, 6-3, 7-1, and 9-1.)

SF 523
Clinical Record—Authorization for Autopsy. (Prescribed in fig 9-1.)

SF 523A
Medical Record—Disposition of Body. (Prescribed in fig 9-1.)

SF 524
Medical Record—Radiation Therapy. (Prescribed in figs 5-2, 6-2, and 9-1.)

SF 525
Medical Record—Radiation Therapy Summary. (Prescribed in figs 5-2, 6-2, and 9-1.)

SF 526
Medical Record—Interstitial/Intercavitary Therapy. (Prescribed in figs 5-2, 6-2, and 9-1.)

SF 527
Group Muscle Strength, Joint R.O.M. Girth and Length Measurements. (Prescribed in figs 5-2, 6-2, and 9-1.)

SF 528
Clinical Record—Muscle and/or Nerve Evaluation—Manual and Electrical: Upper Extremity. (Prescribed in figs 5-2, 6-2, and 9-1.)

SF 529
Medical Record—Muscle Function by Nerve Distribution: Trunk and Lower Extremity. (Prescribed in figs 5-2, 6-2, and 9-1.)

SF 530
Clinical Record—Neurological Examination. (Prescribed in fig 9-1.)

SF 531
Medical Record—Anatomical Figure. (Prescribed in figs 5-2, 6-2, and 9-1.)

SF 533
Medical Record—Prenatal and Pregnancy. (Prescribed in figs 5-2, 6-2, and 9-1.)

SF 534
Medical Record—Labor. (Prescribed in fig 9-1.)

SF 535
Clinical Record—Newborn. (Prescribed in figs 6-1, 6-2, and 9-1.)

SF 536
Clinical Record—Pediatric Nursing Notes. (Prescribed in fig 9-1.)

SF 538
Clinical Record—Pediatric. (Prescribed in fig 9-1.)

SF 541
Medical Record—Gynecologic Cytology. (Prescribed in figs 5-2, 6-2, and 9-1.)

SF 545
Laboratory Report Display. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 546
Chemistry I. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 547
Chemistry II. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 548
Chemistry III (Urine). (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 549
Hematology. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 550
Urinalysis. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 551
Serology. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 552
Parasitology. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 553
Microbiology I. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 554
Microbiology II. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 555
Spinal Fluid. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 556
Immunohematology. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 557
Miscellaneous. (Prescribed in para 9-25 and figs 5-1, 5-2, 6-1, 6-2, 7-1, 8-1, and 9-1, and tables 9-2 and 9-3.)

SF 558
Medical Record—Emergency Care and Treatment. (Prescribed in paras 5-14 and 9-5d(3)(h), and figs 5-1, 5-2, 6-1, 6-2, 7-1, and 9-1.)

SF 559
Medical Record—Allergen Extract Prescription, New and Refill. (Prescribed in paras 5-5 and 5-15, and figs 5-1, 5-2, 6-1, and 6-2.)

SF 600
Health Record—Chronological Record of Medical Care. (Prescribed in paras 2-6a and 5-16, and figs 5-1, 5-2, 6-1, 6-2, 7-1, and 8-1.)

SF 601
Health Record—Immunization Record. (Prescribed in paras 5-17, 5-23e(3), 5-25c(1), and 6-7b, and figs 5-1, 5-2, 6-1, 6-2, and 7-1.)

SF 602
Health Record—Syphilis Record. (Prescribed in paras 5-16, 5-19b(10), and 5-24, and figs 5-1, 5-2, 6-1, and 6-2.)

SF 603
Health Record—Dental. (Prescribed in paras 5-18 and 6-7, and figs 5-3 and 6-3.)

SF 603A
Health Record—Dental Continuation. (Prescribed in paras 5-18 and 6-7, and figs 5-3 and 6-3.)

Section IV
Referenced Forms

AF Form 565
Record of Inpatient Treatment

DA Form 2
Personnel Qualification Record—Part I (For Army Reserve Use Only)

DA Form 2–1
Personnel Qualification Record—Part II

DA Form 4
Department of the Army Certification for Authentication of Records

DA Form 11–2–R
Management Control Evaluation Certification Statement

DA Form 199
Physical Evaluation Board (PEB) Proceedings

DA Form 2173
Statement of Medical Examination and Duty Status

DA Form 2631–R
Medical Care—Third Party Liability Notification

DA Form 2984
Very Seriously Ill/Seriously Ill/Special Category Patient Report

DA Form 2985
Admission and Coding Information

DA Form 3180–R
Personnel Screening and Evaluation Record

DA Form 3349
Physical Profile

DA Form 3437
Nonappropriated Fund Certificate of Medical Examination

DA Form 3647
Inpatient Treatment Record Cover Sheet

DA Form 3647–1
Inpatient Treatment Record Cover Sheet (For Plate Imprinting)

DA Form 3763
Community Health Nursing—Case Referral

DA Form 3894
Hospital Report of Death

DA Form 3947
Medical Evaluation Board Proceedings

DA Form 3984
Dental Treatment Plan

DA Form 4186
Medical Recommendation for Flying Duty

DA Form 4465–R
Patient Intake/Screening Record

DA Form 4466–R
Patient Progress Report

DA Form 4497–R
Interim Medical Examination—Flying Personnel

DA Form 4515
Personnel Reliability Program Record Identifier

DA Form 4970–E
Medical Screening Summary—Over-40 Physical Fitness Program

DA Form 5018–R
ADAPCP Client's Consent Statement for Release of Treatment Information

DA Form 5291–R
Army Exceptional Family Member Program Educational Summary

DA Form 5303–R
Volunteer Agreement Affidavit

DA Form 5551–R
Spirometry Flow Sheet

DA Form 5862–R
Army Exceptional Family Member Program Medical Summary

DA Form 7349–R
Initial Medical Review—Annual Medical Certificate

DD Form 2(ACT)
Armed Forces of the United States Identification Card (Active)

DD Form 2(RES)
Armed Forces of the United States Identification Card (Reserve)

DD Form 2(RET)
United States Uniformed Services Identification Card (Retired)

DD Form 214
Certificate of Release or Discharge from Active Duty

DD Form 602
Patient Evacuation Tag

DD Form 771
Eyewear Prescription

DD Form 1141; ADR
Record of Occupational Exposure to Ionizing Radiation; Automated Dosimetry Record

DD Form 1173
Uniformed Services Identification and Privilege Card

DD Form 1425
Specifications and Standards Requisition

DD Form 2161
Referral for Civilian Medical Care

DD Form 2215
Reference Audiogram

DD Form 2216
Hearing Conservation Data

DD Form 2493–1
Asbestos Exposure Part I—Initial Medical Questionnaire

DD Form 2493–2
Asbestos Exposure Part II—Periodic Medical Questionnaire

DD Form 2569
Third Party Collection Program—Insurance Information

DD Form 2697
Report of Medical Assessment

DIS Form 16
Doctor/Patient Release Statement

DIS Form 40
Alcohol and Drug Abuse Information Release and Consent to Redisclosure

DOL Form CA–1
Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

DOL Form CA–2
Federal Employee's Notice of Occupational Disease and Claim for Compensation

DOL Form CA–16
Authorization for Examination and/or Treatment

DOL Form CA–17
Duty Status Report

DOL Form CA–20
Attending Physicians Report

DOL Form CA–20a
Attending Physicians Supplemental Report

FAA Form 8500–8
Medical Certificate—Class and Student Pilot Certificate

HEW Form CDC 73–2936S
Field Report

NAVMED 6300–5
Admission/Disposition Record, Inpatient

OF 23
Charge-Out Record

OF 345
Physical Fitness Inquiry for Motor Vehicle Operators

PHS Form 731
International Certificates of Vaccination

SF 66D
Employee Medical Folder

SF 86
Questionnaire for National Security Positions

SF 78
U.S. Civil Service Commission, Certificate of Medical Examination

SF 88
Report of Medical Examination

SF 93
Report of Medical History

SF 177
Statement of Physical Ability for Light Duty Work

Appendix B
Authorized Medical Records Abbreviations and Symbols

B–1. Medical abbreviations

A list of medical abbreviations authorized to be used in medical records is shown below. (For abbreviations used in dental records, see TB MED 250.)

AA
Alcoholics Anonymous

ab
abortion

ABE
acute bacterial endocarditis

ABG
arterial blood gases

abnl
abnormal

A/B ratio
acid/base ratio

ac
before meals

ACTH
adrenocorticotropic hormone

ACVD
acute cardiovascular disease

AD
right ear

A&D
admission and discharge

ADAPCP
Alcohol and Drug Abuse Prevention and Control Program

ADCO
alcohol and drug control officer

ADH
antidiuretic hormone (vasopressin)

ADL
activities of daily living

ad lib
as desired

adm
admission; admit; admitted

AE
above elbow

A/E
air evacuation

AFB
acid-fast bacilli

afeb
afebrile; without fever

AFib/AFlut
atrial fibrillation/atrial flutter

AFIP
Armed Forces Institute of Pathology

AGA
appropriate for gestational age

A/G ratio
albumin/globin ratio

AHD
atherosclerotic heart disease

AIDS
acquired immune deficiency syndrome

AK
above knee

AKA
above-the-knee amputation

ALL
acute lymphoblastic or lymphocytic leukemia

ALS
amyotrophic lateral sclerosis

AMA
against medical advice

amb
ambulatory

AMI
acute myocardial infarction

AMIC
Acute Minor Illness Clinic

AML
acute myelocytic/myeloblastic leukemia

AMNIO
amniocentesis

Amox
amoxicillin

amt
amount

anesth; anes
anesthesia

ant
anterior

ante
before

AP
anterior-posterior

A&P
anscultation and percussion

AP&Lat
anteroposterior and lateral

approx
approximate

ASA
acetylsalicylic acid (aspirin)

ASA Grades I-IV
American Society of Anesthesiology surgical risk classification

ASAP
as soon as possible

ASD
atrial septal defect

ASHD
arteriosclerotic heart disease

assoc
associate; associated; association

AU
both ears

Audio
audiology

Ausc
auscultation

AV, A-V
arteriovenous; atrioventricular

av
average

BAC
blood alcohol concentration

bact
bacterium (-ia) (-ial) (-iology)

B. asthma
bronchial asthma

BAT
blood alcohol test

BBB
bundle branch block

BCG
Bacillus Calmette-Guerin (vaccine)

BCP
birth control pills

BE
barium enema

bicarb
bicarbonate

bid
twice a day

bil or bilat
bilateral

bili
bilirubin

BK
below knee

BKA
below-knee amputation

bl
blood

bl; bld
blood; bleeding

BM
bowel movement

BMR
basal metabolic rate

BP
blood pressure

BPH
benign prostatic hypertrophy

BR
bed rest

BSO
bilateral salpingo-oophorectomy

BSR
blood sedimentation rate

BTL
bilateral tubal ligation

BUN
blood urea nitrogen

bw
birth weight

Bx
biopsy

C
Celsius or centigrade

C1 to C7
cervical nerves or vertebrae 1 to 7

c
with

Ca
calcium; cancer; carcinoma

CABG
coronary artery bypass graft

CAD
coronary artery disease

card
cardiac; cardiology

CAT
computerized axial tomography

cath
catheter

cau
Caucasian

CBC
complete blood count

CC
chief or current complaint

cc
cubic centimeter

CCU
coronary care unit

CDC
Centers for Disease Control

cerv
cervical

CF
cystic fibrosis

ChE
cholinesterase

CHF
congestive heart failure

Chol
cholesterol

chr
chronic

circ
circulation; circumcision; circumferences

Cl
chloride

cm
centimeter

CNS
central nervous system

CO_2
carbon dioxide

Co
cobalt

c/o
complains of

conv
convalescent; convalescence

COPD
chronic obstructive pulmonary disease

CPD
cephalopelvic disproportion

CPK
creatine phosphokinase

CPR
cardiopulmonary resuscitation

CRF
chronic renal failure

CRNA
certified registered nurse anesthetist

C/S
cesarean section

C&S
culture and sensitivity

C-section
cesarean section

CT
computerized tomography

ct
count

cu ft
cubic foot

cu in
cubic inch

cu m
cubic meter

cu mm
cubic millimeter

CVA
cerebrovascular accident

CVD
cardiovascular disease

CVP
central venous pressure

cx
cervix

CXR
chest x-ray

cysto
cystogram; cystoscope; cyctoscopy

dB
decibel

dbl
double

D/C
discharge or discontinue

D&C
dilatation and curettage or curettement

DDS
Doctor of Dental Surgery

D&E
dilatation and evacuation

def
deficiency

Dept
department

Derm
dermatology

DES
diethylstilbestrol

dev
deviation

dil
dilute; diluted

dis
disease

disp
disposition

DJD
degenerative joint disease

DM
diabetes mellitus

DNA
deoxyribonucleic acid

DNR
do not resuscitate

DO
Doctor of Osteopathy

DOA
dead on arrival

DOB
date of birth

DOE
dyspnea on exertion

DT
diphtheria toxoid and tetanus toxoid (for children under 7 years of age)

DTP
diphtheria toxoid, tetanus toxoid, pertussis vaccine

dtd
dated

DTR
deep tendon reflexes

DTs
delirium tremens

DUB
dysfunctional uterine bleeding

DUI
driving under the influence

DVT
deep vein thrombosis

DWI
driving while intoxicated

Dx
diagnosis

EBL
estimated blood loss

EBV
Epstein-Barr virus

ECG; EKG
electrocardiogram

E. coli
Escherichia coli

ECT
electroconvulsive therapy

EDC
estimated date of confinement

EEG
electroencephalogram

EGA
estimated gestational age

EGD
esophagogastroduodenoscopy

EKG; ECG
electrocardiogram

ELISA
enzyme-linked immunosuppressant assay

EMG
electromyogram

EMS
emergency medical service

E-mycin
erythromycin

Endo
endocrinology

ENT
ear, nose, and throat

EOM
extraocular movement

eos
eosinophil

epis
episiotomy

epith
epithelium or epithelial

eq; equiv
equivalent

EC/ED
emergency center/emergency department

esp
especially

ESR
erythrocyte sedimentation rate

ESRD
end-stage renal disease

EST
electroshock therapy

est
estimated

ESWL
extracorporeal shock wave lithotripsy

ET
endotracheal tube

etc.
et cetera

etiol
etiology

ETOH
ethyl alcohol

eval
evaluate; evaluation

exam
examine

exp
expired

expir
expiration; expiratory

ext
external

F
Fahrenheit

FACMT
Family Advocacy Case Management Team

FB
foreign body

FBS
fasting blood sugar

FDA
Food and Drug Administration

Fe
iron

FFP
fresh frozen plasma

FHR
fetal heart rate

FHT
fetal heart tone

F Hx
family history

fib
fibrillation

Fl; fl
fluid

FP
family practice

freq
frequent; frequency

FS
frozen section

FSH
follicle-stimulating hormone

FT
full term

ft
foot; feet

F/U
followup

FUO
fever of unknown or undetermined origin

Fx
fracture

g
gram(s)

garg
gargle

GB
gallbladder

GC
gonococcus; gonococcal

Gen
general

Gest
gestation

GI
gastrointestinal

glu
glucose

gm
gram

GOT
glutamic-oxalacetic transaminase

GP
general practitioner

gr
grain

gr; grav
pregnant

Grav I, Grav II
one pregnancy, two pregnancies, and so on

GS
general surgery

GSW
gunshot wound

gt; gtt
drop; drops

GTT
glucose tolerance test

GU
genitourinary

GYN; Gyn
gynecology

H
hydrogen

H_2O
water

HA or H/A
headache

HAA
hepatitis-associated antigen

Hb; hgb
hemoglobin

HBP
high blood pressure

HBV
hepatitis B virus

HC
head circumference

HCl
hydrochloric acid

Hct
hematocrit

HDL
high-density lipoprotein

HEENT
head, eyes, ears, nose, and throat

HEM
hematology

Hgb; Hb
hemoglobin

HIV
human immunodeficiency virus

HMO
Health Maintenance Organization

HNP
herniated nucleus pulposus

H/O
history of

Hosp
hospitalization

H&P
history and physical

HPI
history of present illness

hr
hour

HR
heart rate

hs
at bedtime

ht
height

HTLV
human T-cell leukemia/lymphoma virus

HTN
hypertension

Hx
history

hypo
hypodermic

I^{131}
radioactive iodine

IAW
in accordance with

ICU
intensive care unit

I&D
incision and drainage

ID
identification

IDDM
insulin-dependent diabetes mellitus

IM
intramuscular (injection)

in
inch

incis.
incision

Ind
individual

inf
inferior

Inf Dis
infectious disease

info
information

Ing
inguinal

INH
insonicotinic acid hydrazide; isoniazid; isonicotinoylhydrazide

inj
injury; injured

int
internal

I&O
intake and output

IOP
intraocular pressure

IPPB
intermittent positive pressure breathing

IQ
intelligence quotient

IU
international unit

IUCD; IUD
intrauterine contraceptive device

IUP
interuterine pregnancy

IV
intravenous (injection)

IVP
intravenous pyelogram

jct
junction

jej
jejunum

jt
joint

K
potassium

kg
kilogram

KJ
knee jerk

kL
kiloliter

km
kilometer

KUB
kidney, ureter, and bladder

L
liter

lab
laboratory

lac
laceration

lap
laparotomy

laser; LASER
light amplification by stimulated emission of radiation

lat
lateral

lb
pound

L/B
live birth

LBBB
left bundle branch block

LBP
low back pain

LBW
low birth weight

L&D
labor and delivery

LDL
low-density lipoprotein

LE
lower extremity

lig
ligament

LLE
left lower extremity

LLL
left lower lobe (of lung)

LLQ
left lower quadrant

LMP
left mentoposterior (position of fetus); last menstrual period

LOC
loss of consciousness

LOD
line of duty

LOM
limitation of motion

LOS
length of stay

LP
lumbar puncture

LPN
licensed practical nurse

LQ
lower quadrant

L-S
lumbosacral

LSH
lutein-stimulating hormone

lt
left

LTG
long term goal

LUL
left upper lobe (of lung)

LUQ
left upper quadrant

LV
left ventricular

LVN
licensed vocational nurse

lymphs
lymphocytes

m
meter

max
maximum

mc; mCi
millicurie

mcg
microgram

MCHC
mean corpuscular hemoglobin concentration or count

MEB
medical evaluation board

med
medicine or medication

mEq
milliequivalent

MG
myasthenia gravis

mg
milligram

MI
myocardial infarction

MIA
missing in action

MICU
medical intensive care unit

min
minute

mL
milliliter

mm
millimeter

MMPI
Minnesota Multiphasic Personality Inventory

mod
moderate

Mono
mononucleosis

monos
monocytes

mos
months

MS
multiple sclerosis

msec
millisecond

NA
nursing assistant

Na^+
sodium

N/A
not applicable

NAD
no acute distress

NaPent
sodium pentothal

NB
newborn

N/C
no complaint

NCHS
National Center for Health Statistics

neg
negative

Neph
nephrology

Neuro
neurological, neurology

NICU
Neonatal Intensive Care Unit

NIDDM
non-insulin-dependent diabetes mellitus

NKA
no known allergies

NKDA
no known drug allergies

nl; norm
normal limits

NLT
not later than

NPH insulin
neutral protamine Hagedorn insulin

npo
nothing by mouth

NS
nervous system

nsg
nursing

NTG
nitroglycerin

nurs
nursery

NWB
non-weight bearing

O_2
oxygen; both eyes

OB
obstetrics

OB-GYN
obstetrics and gynecology

obj
objective

OBS
organic brain syndrome

OD
overdose; right eye

OS
left eye

Onc
oncology

OOB
out of bed

op
operation

OPC
outpatient clinic

OPD
outpatient department

ophth
ophthalmology

OPV
oral poliomyelitis vaccine

OR
operating room

Ortho
orthopedics

os, per os
mouth; by mouth

OT
occupational therapy

OTC
over the counter (drugs)

OU
each eye

oz
ounce

PA
physician's assistant

P&A
percussion and auscultation

PAC
premature atrial contractions

Pap test
Papanicolaou's test

path
pathology

pc
after meals

PDR
Physician's Desk Reference

PE
physical examination

PEB
Physical Evaluation Board

Ped
pediatrics

PERRLA
pupils equal, round, and react to light and accommodation

PE tubes
pressure-equalizing tubes

PH
past history

phar; pharm
pharmacy; pharmaceutical; pharmacopeia

PI
present illness

PID
pelvic inflammatory disease

Pit
Pitocin

pkg
package

PKU
phenolketonuria

PMH
past medical history

PO
postoperative

po
by mouth; orally

POD
postoperative day

Pod
podiatry

pos
positive

postop
postoperative

POW
prisoner of war

PP
post partum

PPB
positive pressure breathing

preg
pregnancy

Pre med
premedication

pre-op
preoperative

prep
preparation; prepare (for surgery)

prn
as needed

prog
prognosis

Psych
psychiatry

Psychol
psychology

PT
physical therapy

pt
patient

PTA
physical therapist assistant

PTCA
percutaneous transluminal coronary angioplasty

PUD
peptic ulcer disease

PULHES
physical profile factors: P--physical capacity or stamina; U--upper extremities; L--lower extremities; H--hearing and ears; E--eyes; S--psychiatric

pulm
pulmonary

PVC
premature ventricular contractions

q
every

qd
every day

qh
every hour

q2h, q3h, and so on
every 2 hours, every 3 hours, and so on

qid
four times a day

qn
every night

r
roentgen

RA
rheumatoid arthritis

Ra
radium

RBC
red blood cells or corpuscles

R.D.
registered dietitian

RDS
respiratory distress syndrome

Rec Rm
recovery room

reg
regular

rehab
rehabilitation

req
requirement

resp
respiratory

Rh factor
Rhesus blood factor

RLL
right lower lobe (of lung)

RLQ
right lower quadrant

RML
right middle lobe (of lung)

RN
registered nurse

R/O
rule out

ROM
range of motion

ROS
review of systems

RPR
reiter protein reagin

RR
recovery room

rt
right

RTC
return to clinic

RUL
right upper lobe (of lung)

RUQ
right upper quadrant

Rx
prescription; treatment; take

S
left

S-A; SA node
sino-atrial node

SB
stillborn

SBE
subacute bacterial endocarditis

SC
subcutaneous

sec
second; secondary

sed
sedentary

Sed rate
erythrocyte sedimentation rate

SGA
small for gestational age

SGOT
serum glutamin-oxaloacetic transaminase

SGPT
serum glutamic-pyruvic transaminase

SI
seriously ill

SICU
surgical intensive care unit

SIDS
sudden infant death syndrome

signif
significant

SLE
systemic lupus erythematosis

SLR
short leg raise

sm
small

SOAP
progress note format S—subject O—objective A—assessment P—plans

SOB
shortness of breath

S/P
status post

SQ
subcutaneous

staph
staphylococcus

STAT
immediately and once only

STD
sexually transmitted disease

STG
short term goal

strep
streptococcus

STS
serologic test for syphilis

Surg
surgery

Svc
Service

SWS
Social Work Service

sx
signs; symptoms

sys
system

T
temperature

T&A
tonsillectomy and adenoidectomy

tab
tablet

TAH
total abdominal hysterectomy

TB
tuberculosis

tbs; tbsp
tablespoon

Td
tetanus toxoid and diphtheria toxoid (for older children and adults)

temp
temperature

TIA
transient ischemic attacks

tid
three times a day

TMJ
temporomandibular joint

tng
training

TPR
temperature, pulse, and respiration

trf
transfer

TSH
thyroid-stimulating hormone

tsp
teaspoon

TURP
transurethral resection, prostate

TVH
total vaginal hysterectomy

UA
urinalysis

UE
upper extremity

UGI
upper gastrointestinal

unk
unknown

UQ
upper quadrant

URI
upper respiratory infection

urol
urology; urological

URQ
upper right quadrant

US
ultrasound

USPHS
U.S. Public Health Service

UTI
urinary tract infection

VA
Department of Veterans Affairs

vag
vaginal

VD
venereal disease

VDRL
venereal disease research laboratory test

vit
vitamin

VS
vital sign

vs
against

VSI
very seriously ill

WBC
white blood cell

wd
ward

WD/WN/BF
well-developed, well-nourished, black female

WD/WN/BM
well-developed, well-nourished, black male

WD/WN/WF
well-developed, well-nourished, white female

WD/WN/WM
well-developed, well-nourished, white male

WIA
wounded in action

WISC
Weschler Intelligence Scale for children (test)

wk
week

WNL
within normal limits

wt
weight

W/U
workup

X
times

y/o
year old

yr
year

B–2. Medical symbols

Medical symbols authorized to be used in medical records are shown in figure B-1.

female

♀

male

♂

increased; elevated

↑

decreased; depressed; lowered

↓

descended bilaterally

↓↓

causes; transfer to

→

is due to

←

less than

<

more than

>

systolic blood pressure

∨

diastolic blood pressure

∧

absent; none

0

negative, absent

—

positive, present

+

start of operation (anesthesia record only)

⊙

end of operation (anesthesia record only)

⊗

Upright. Vertical body position; body supported by lower extremities; torso upright.

Lying down. Horizontal body position.

Leaning. Body trunk raised less than 90 degrees from primary supporting surface and supported by self or object.

Sitting. Weight of body resting on lower part of trunk, back raised greater than or equal to 90 degrees.

Leaning over. Dangling, any portion of body extended beyond the lower part of the trunk.

Kneeling. Supporting the body on the knees or legs.

primary, first degree

1°

changes

Δ

secondary, second degree

2°

amounts; dosages

i ii iii iv v vi

Angstrom unit

Å

of each

āā

before

ā

with

c̄

murmur

ⓜ

after; following

p̄

without

s̄

one-half

s̄s̄

dram; drachm

ʒ

ounce

℥

fluid dram; fluid ounce

f ʒ; f ℥

Figure B-1. Medical symbols

Appendix C
Management Control Evaluation Checklist

C–1. Function
The functions covered by this checklist are Medical Record and Health Care Documentation programs.

C–2. Purpose
The purpose of this checklist is to assist patient administration staff in medical treatment facilities in evaluating the key management controls listed below. It is not intended to cover all controls.

C–3. Instructions
Base answers on the actual testing of key management controls (for example, document analysis, direct observation, sampling, other). Explain answers that indicate deficiencies and indicate corrective action in supporting documentation. Document certification on DA Form 11-2-R (Management Control Evaluation Certification Statement). DA Form 11-2-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy of this form is located at the back of this regulation. It is also available on the Army Electronic Library (AEL) CD-ROM and the USAPA Web site.

C–4. Test Questions
a. Is there a current SOP on disclosure procedures for medical records with specified individuals responsible for disclosing medical information and annual in-service to educate all staff on disclosure procedures? (paras 1-4 and 2-2)

b. Are the appropriate forms used and retained for all requests for information (DA Form 4254-R for official, DA Form 5006-R for unofficial, DA Form 4876-R for communications media)? (para 2-3)

c. Are State laws adhered to when determining if records of minors in programs for drug/alcohol abuse, venereal diseases, birth control, or abortion can be released? (para 2-6)

d. Are classified documents in the records periodically reviewed for potential declassification, removed from records prior to transfer to the VA, and properly safeguarded in a limited access area? (para 2-7)

e. Do MTF Commanders approve requests by personnel in their commands for access to medical records for research purposes (para 2-7); ensure that requests for information on treatment, identity, prognosis, or diagnosis for alcohol or drug abuse patients are handled per AR 600-85 and chapter 7 of this regulation (para 2-1); and ensure that information on HIV is handled properly? (para 3-10)

f. Are locally produced overprints from MTFs supported by a letter of authorization from the designated authority within the MTF? (para 3-3)

g. Are all entries on medical documents signed, legible, and dated, and if erroneous, corrected properly with date and signature? (para 3-4)

h. Are the abbreviations used in the records authorized by appendix B to this regulation or by a locally approved supplement? (para 3-8)

i. Is the cause of injury and the general geographic location where the injury occurred recorded? (para 3-12)

j. Are injuries caused by chemical agents, bacteriological agents, or ionizing radiation thoroughly documented? (para 3-12)

k. Is each death documented on a State death certificate and or DA Form 3894 (Hospital Report of Death) including the immediate cause of death and any underlying causes of death? (para 3-13)

l. Is there a current SOP for maintenance of health records for all Army personnel? (para 5-3)

m. Is the inpatient treatment record (ITR) prepared for every admission, liveborn infant, stillbirth, and CRO case? (para 9-1)

n. Are DD Forms 1380 (Field Medical Cards (FMCs)) prepared by aidmen or one of the MTFs listed in this regulation with a minimum of patient name, grade, and SSN? (para 10-1)

o. Are the Medical Record Services included appropriately in the Improving Organizational Performance process within the MTF with an annual evaluation of performance improvement activities ongoing within the MTF? (paras 11-1 and 11-2)

p. Is there evidence of continuous improvement in the quality of all patient care related key functions as defined by JCAHO standards? (para 11-3)

C–5. Supersession
This checklist replaces the checklist for Medical Record Administration previously published in DA Circular 11-87-5.

C–6. Comments
Help make this a better tool for evaluating management controls. Submit comments to Office of the Surgeon General, ATTN: DASG-HS-AP, 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Glossary

Section I
Abbreviations

ADAPCP
Alcohol and Drug Abuse Prevention and Control Program

ADAPCP-OMR
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record

ADS
Ambulatory Data System

AMEDD
Army Medical Department

AMOSIST
Automated Military Outpatient System

APV
Ambulatory Procedure Visit

ARNGUS
Army National Guard of the United States

ARPERCEN
U.S. Army Reserve Personnel Center

AWOL
absent without leave

CAPOC
computer assisted practice of cardiology

CCC
Community Counseling Center

CEMR
civilian employee medical record

CFR
Code of Federal Regulations

CHCS
Composite Health-Care System

CJA
claims judge advocate

CONUS
continental United States

CPO
civilian personnel office

CRO
carded for record only

CSH
combat support hospital

DA
Department of the Army

DEERS
Defense Enrollment Eligibility Reporting System

DENTAC
United States Army Dental Activity

DIS
Defense Investigative Service

DOD
Department of Defense

DODD
Department of Defense Directive

DODI
Department of Defense Instruction

DOL
Department of Labor

DTF
dental treatment facility

ESU
electrosurgical unit

FH
field hospital

FMP
family member prefix

GH
general hospital

HREC
health record

IMP
Information Management Plan

IOP
Improving Organizational Performance

IPDS
Individual Patient Data System

IRR
Individual Ready Reserve

ITR
inpatient treatment record

JCAHO
Joint Commission on Accreditation of Healthcare Organizations

LOD
line of duty

LPN
licensed practical nurse

MCJA
Medical Claims Judge Advocate

MDRTS
Medical and Dental Record Tracking System

MEDCEN
United States Army Medical Center

MEDDAC
medical department activity

MILPO
military personnel office

MPRJ
Military Personnel Records Jacket

MTF
medical treatment facility

NATO
North Atlantic Treaty Organization

NIO
nursing initiated order

NPRC
National Personnel Records Center

OCONUS
outside the continental United States

OSHA
Occupational Safety and Health Act

OTJAG
Office of The Judge Advocate General

OTR
outpatient treatment record

OWCP
Office of Worker's Compensation Programs

PCS
permanent change of station

PEB
Physical Evaluation Board

PERSCOM
United States Total Army Personnel Command

PHS
Public Health Service

PRIMUS
Primary Care for the Uniformed Services

QSTAG
Quadripartite Standardization Agreement (ABCA)

RC
Reserve Components

RN
registered nurse

RTF
residential treatment facility

RTD
return(ed) to duty

SSN
Social Security Number

STANAG
Standardization Agreement

TO
theater of operations

TPU
Troop Program Unit

USAMEDCOM
U.S. Army Medical Command

USAR
United States Army Reserve

USARCS
United States Army Claims Service

USC
United States Code

VA
Department of Veteran's Affairs

WIA
wounded in action

WMSN
Workload Management System for Nursing

Section II
Terms

Absent sick
An Army member hospitalized in a nonmilitary hospital and for whom administrative responsibility has been assigned to an Army MTF.

Advance directives
A written declaration that—

a. Sets forth directions regarding the provision, withdrawal, or withholding of life-prolonging procedures, including hydration and sustenance, for the declarant, whenever the declarant has a terminal physical condition or is in a persistent vegetative state; or

b. Authorizes another person to make health care decisions for the declarant, under circumstances stated in the declaration, whenever the declarant is incapable of making informed health care decisions.

Alcohol and Drug Abuse Prevention and Control Program outpatient medical record (ADAPCP-OMR)
The outpatient medical record used for both military and nonmilitary persons enrolled in an Alcohol and Drug Abuse Prevention and Control Program.

Ambulatory Procedure Visit (APV)
A medical or surgical intervention requiring immediate (day of procedure) preprocedure, and immediate postprocedure care in an ambulatory type setting. The APV is determined by the complexity, intensity, and duration of care provided. A licensed or registered care practitioner will be directly involved in the health care intervention related to the APV in accordance with local standards of care. The total length of time that care is provided in the health care facility is less than 24 hours.

Battle casualty
Any person lost to an organization because of death, wound, missing, capture, or internment provided such loss is incurred in action. "In action" characterizes the casualty status as having been the direct result of hostile action; sustained in combat and related thereto; or sustained going to or returning from a combat mission provided that the occurrence was directly related to hostile action. Injuries due to self-inflicted wounds are not considered as sustained in action and are not interpreted as battle casualties.

Civilian employee medical record (CEMR)
The medical record used for the documentation of occupational and nonoccupational health information for civilian employees.

Confidentiality
Guarding the privacy of medical information. Information gained through the examination or treatment of a patient is private and confidential. Medical confidentiality is not, however, a security classification of confidential.

Drop file
Folder in which completed forms are placed, but not attached, such as a field file.

Electronic signature
Implementation of a system which allows the originator (care giver or device) to affix an electronic signature to an entry and detect if it has been altered.

Field medical card
United States medical card normally used in a theater of operations that provides pertinent data as to the casualty's/patient's identity, diagnosis, time/date, facility where tagged, treatment rendered, and disposition.

Fixed medical treatment facility (MTF)
A medical treatment facility designed to operate for an extended period of time at a specific site.

Health record (HREC)
The combination of the treatment record and the dental record of a military member.

Inpatient treatment record (ITR)
The record used at an MTF that has authorized beds for inpatient medical or dental care. It is begun on admission to the MTF and completed at the end of hospitalization. This record applies to all beneficiaries.

Medical information
All information that pertains to evaluation, findings, diagnosis, or treatment of a patient. The term also includes any other information given to AMEDD health personnel in the course of treatment or evaluation. Medical information is confidential and private. Paramedical documents, such as immunization registers and dosimetry records, are not considered medical information even though they are kept in the same file with medical records.

Medical record
Any military or civilian document that gives information on the evaluation, findings, diagnosis, and treatment of a patient. Included as medical records are the OTRs, HRECs, dental records, ITRs, CEMRs, ADAPCP-OMRs, and x rays. Paramedical documents, such as immunization registers and dosimetry records, are not considered medical records although they are kept in the same file with other medical records.

Medical record practitioner
A professional who collects, analyzes, and manages the patient information that steers the healthcare industry.

Nonfixed medical treatment facility (MTF)
An MTF designed to be moved from place to place, including MTFs afloat.

Outpatient treatment record (OTR)
The OTR and the dental record of the beneficiary for whom an HREC is not kept.

Private medical information
Medical or other information that belongs only to the patient and should not be open to public scrutiny. Such information, if divulged, may cause personal embarrassment or harm.

Privileged communication
A communication made within a confidential relationship that is protected as a matter of law, regulation, or public policy. Information disclosed by patients to AMEDD health personnel is not privileged.

Special category record
A record that is individually identified (para 4-4a(10)) and specially handled to reduce the risk of harming or embarrassing the patient and ensuring its medicolegal integrity.

Section III
Special Abbreviations and Terms
This section contains no entries.

Index

This index is organized alphabetically by topic and subtopic within a topic. Topics and subtopics are identified by paragraph number.

Abbreviations and terms, 1-3
Abbreviations used on DD Form 1380 (U. S. Field Medical Card), 11-2
Authorized medical records abbreviations and symbols, app B
Local abbreviations and symbols, 3-8
Abortion, recording therapeutics, 3-16
Absent-sick status, 3-19
Absent-without-leave patients, inpatient treatment record, 9-7
Access to inpatient treatment records, 9-9
Actions, documentation of, 9-27
Active Army personnel, absent-sick status, 3-19
Acuity classification, recording of, 9-27
Adjudication, review of medical records involved in, 11-3
Advance directives, 6-2, 9-2
AF Form 565 (Record of Inpatient Treatment), figs 5-1, 5-2, 6-1, 6-2
Alcohol abuse. See Drug and alcohol abuse
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record (ADAPCP-OMR)
Access, 8-2
Audit trail, 8-10
DA Form 3444-series folders used for, 4-3, 8-4
Description of, 1-1
Disclosure of information, 2-1, 8-2, 8-3
Disposition, 8-8
File folders for, 8-4
Forms and documents, 8-4
Initiating and maintaining, 8-5
Persons for whom prepared, 8-1
Preparation, 8-9
Requests other than DD Form 2138, 8-7
Terminal digit filing system for, 4-2
Transfer of, 8-6
Use, 8-10
Ambulatory Data System, 9-5
Ambulatory Procedure Visit treatment record, 9-5
AMEDD officers, responsibilities, 1-4
AMEDD personnel
Access to health records, 5-21
Transfer of health records, 5-24
Amendment of medical records, 3-4
American Hospital Association Guidelines, documentation by chaplains according to, 1-4
Anesthesia monitoring records, filing of, 3-2
Appointment card, patient's recording card as, 3-5
Army personnel, absent-sick status, 3-19
Audit trail
Alcohol and Drug Abuse Prevention and Control Program medical records, 8-10
Inpatient treatment records (ITR), 9-9
Authorized forms, 3-1

Bacteriological agent as cause of injury or disease, recording procedures, 3-12
Bar code, use on medical record folders, 4-4

Carded-for-record-only (CRO) cases, 3-18
Certificate of Death, 3-13
Chaplains, responsibilities, 1-4
Chemical agent as cause of injury or disease, recording procedures, 3-12
Chief, Patient Administration Division, responsibilities, 1-4
Civilian employee medical record (CEMR)
Confidentiality of medical information, 2-2, 7-11
Cross-coding of, 7-8
Custody of, 7-5
DA Form 3444-series folders used for, 4-3, 7-4
Description of, 1-1, 7-2
Disclosure of, 7-11
Maintenance of, 7-5
Preparation of, 7-3
Quality assurance, 7-12
Recording injuries and illnesses in, 7-7
Retiring, 7-9
SF 66D folders used for, 7-4
Terminal digit filing system for, 4-2
Transferring, 7-9
X ray film files, 7-10
Civilian personnel, disposition of DD Form 1380 (U.S. Field Medical Card), 10-4
Civilian source pediatric growth chart, 6-2
Classified defense information, medical records containing, 2-7
Clinic identification plate, 3-5
Combat, recording of injuries or wounds incurred in, 3-12
Commanding General, Army Reserve Personnel Center (ARPERCEN), responsibilities for health records (HREC), 1-4
Confidentiality of medical information
Civilian employee medical records (CEMR), 2-2, 7-11
Classified defense information, 2-7
Disclosure procedures, 2-3, 2-4, 2-5, 2-7, 7-11
Drug and alcohol abuse records, 2-1, 8-2
General, 2-1
Protection of, 2-2
Research using medical records, 2-8
Teenage family member medical records, 2-6
Content of medical record entries, 3-4
Correction of medical record entries, 3-4
Cross-servicing of health records, 5-22

DA Form 2 (Personnel Qualification Record—Part I), 5-23
DA Form 2-1 (Personnel Qualification Record—Part II), 5-23
DA Form 4 (Department of the Army Certification for Authentication of Records), 11-4
DA Form 11-2-R (Management Control Evaluation Certification Statement), app C
DA Form 8-115 (Register of Dental Patients), 5-4, 6-2
DA Form 199 (Physical Evaluation Board (PEB) Proceedings), 5-19
DA Form 2173 (Statement of Medical Examination and Duty Status), figs 5-1 and 5-2
DA Form 2631-R (Medical Care—Third Party Liability Notification), 5-4, 6-2, 9-2
DA Form 2984 (Very Seriously Ill/ Seriously Ill/Special Category Patient Report), 9-2
DA Form 2985 (Admission and Coding Information), 3-19
DA Form 3180-R (Personnel Screening and Evaluation Record), 5-19, 5-28, 5-29, 7-4
DA Form 3349 (Physical Profile), 5-19
DA Form 3365 (Authorization for Medical Warning Tag), 6-7, 13-1, 13-3, 13-5
DA Form 3437 (Nonappropriated Fund Certificate of Medical Examination), 7-4
DA Form 3443-series folders, 4-3
Preparation of, 4-5
DA Form 3443X (Terminal Digit—X-Ray Film Negative Preserver (Loan)), 4-3, 4-4, 4-5
DA Form 3443Y (Terminal Digit—X-Ray Film Negative Preserver (Insert)), 4-3, 4-4, 4-5
DA Form 3443Z (Terminal Digit—X-Ray Film Negative Preserver (Report Insert)), 4-3, 4-4, 4-5
DA Form 3444 (Alphabetical and Terminal Digit File for Treatment Record (Orange)), 4-3, 4-4, 5-23, 6-2, 7-4, 8-4, 9-2
DA Form 3444-1 (Alphabetical and Terminal Digit File for Treatment Record (Light Green)), 4-3, 4-4, 5-23, 6-2, 7-4, 8-4, 9-2
DA Form 3444-2 (Alphabetical and Terminal Digit File for Treatment Record (Yellow)), 4-3, 4-4, 5-23, 6-2, 7-4, 8-4, 9-2
DA Form 3444-3 (Alphabetical and Terminal Digit File for Treatment Record (Grey)), 4-3, 4-4, 5-23, 6-2, 7-4, 8-4, 9-2
DA Form 3444-4 (Alphabetical and Terminal Digit File for Treatment Record (Tan)), 4-3, 4-4, 5-23, 6-2, 7-4, 8-4, 9-2
DA Form 3444-5 (Alphabetical and Terminal Digit File for Treatment Record (Light Blue)), 4-3, 4-4, 5-23, 6-2, 7-4, 8-4, 9-2
DA Form 3444-6 (Alphabetical and Terminal Digit File for Treatment Record (White)), 4-3, 4-4, 5-23, 6-2, 7-4, 8-4, 9-2
DA Form 3444-7 (Alphabetical and Terminal Digit File for Treatment Record (Brown)), 4-3, 4-4, 5-23, 6-2, 7-4, 8-4, 9-2
DA Form 3444-8 (Alphabetical and Terminal Digit File for Treatment Record (Pink)), 4-3, 4-4, 5-23, 6-2, 7-4, 8-4, 9-2
DA Form 3444-9 (Alphabetical and Terminal Digit File for Treatment Record (Red)), 4-3, 4-4, 5-23, 6-2, 7-4, 8-4, 9-2
DA Form 3444-series folders, 4-3, 5-23, 7-4, 8-4, 9-2

Civilian employee medical record, 7-4
Outpatient treatment record (OTR), 6-2
Preparation of, 4-4
DA Form 3647 (Inpatient Treatment Record Cover Sheet), 3-12, 3-13, 3-18, 3-19, 5-2, 5-19, 6-7, 9-9, 9-10, 9-11, 9-15, 9-16, 9-17, 9-18, 9-19
Corrections, 9-19
General purpose, 9-15
Health record form, 5-4
Initiation and disposition, 9-17
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
Preparation, 9-18
Use, 9-16
DA Form 3647-1 (Inpatient Treatment Record Cover Sheet (For Plate Imprinting)), fig 9-1
DA Form 3705 (Receipt for Outpatient Treatment/Dental Records), 6-4
DA Form 3763 (Community Health Nursing—Case Referral), 5-4, 6-2
DA Form 3824 (Urologic Examination), 5-4, 6-2, 9-2
DA Form 3888 (Medical Record—Nursing History and Assessment), 9-13
DA Form 3888-2 (Medical Record—Nursing Care Plan), 9-13
DA Form 3888-3 (Medical Record—Nursing Discharge Summary), 9-13
DA Form 3894 (Hospital Report of Death), 3-13
DA Form 3947 (Medical Evaluation Board Proceedings), 5-19
DA Form 3950 (Flowsheet for Vital Signs and Other Parameters), 9-24
DA Form 3984 (Dental Treatment Plan), 5-4, 6-2
DA Form 4006 (Field Medical Record Jacket), 10-5
DA Form 4028 (Prescribed Medication), 9-28
DA Form 4060 (Record of Optometric Examination), 5-4, 6-2
DA Form 4107 (Operation Request and Worksheet), 9-29
DA Form 4108 (Register of Operations), 9-29, 9-32
DA Form 4186 (Medical Recommendation for Flying Duty), 5-19
DA Form 4221 (Diabetic Record), 9-2
DA Form 4254-R (Request for Private Medical Information), 2-4
DA Form 4256 (Doctors Orders), 3-3, 9-5, 9-14, 9-26
DA Form 4359-R (Authorization for Psychiatric Service Treatment), 9-22
DA Form 4410-R (Disclosure Accounting Record), 5-4, 6-2, 9-2
DA Form 4465-R (Patient Intake/Screening Record), 5-19, 8-9
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Outpatient treatment record form, 6-2
DA Form 4466-R (Patient Progress Report), 8-9
DA Form 4497-R (Interim (Abbreviated) Flying Duty Medical Examination), 5-4
DA Form 4515 (Personnel Reliability Program Record Identifier), 5-19, 5-29, 7-4
DA Form 4677 (Clinical Record—Therapeutic Documentation Care Plan (Non-Medications)), 9-12, 9-26, 9-27
DA Form 4678 (Clinical Record—Therapeutic Documentation Care Plan (Medication)), 9-12, 9-26, 9-28
DA Form 4700 (Medical Record—Supplemental Medical Data), 3-2, 3-3, 5-19, 9-2, 11-4
Mounting of undersized reports on, 3-2
DA Form 4876-R (Request and Release of Medical Information to Communications Media), 2-3
DA Form 4970-E (Medical Screening Program—Cardiovascular Risk Screening Program), 5-4, 6-2
DA Form 5006-R (Medical Record—Authorization for Disclosure of Information), 2-3
DA Form 5007A-R (Medical Record—Allergy Immunotherapy Record-Single Extract), 5-5
DA Form 5007B-R (Medical Record—Allergy Immunotherapy Record-Double Extract), 5-5
DA Form 5008 (Telephone Medical Advice/Consultation Record), 5-6, 9-5
DA Form 5009-R (Medical Record—Release Against Medical Advice), 9-22
DA Form 5018-R (ADAPCP Client's Consent Statement for Release of Treatment Information), 8-2, 8-3
DA Form 5128 (Clinical Record—Visual Field Examination), 9-2
DA Form 5179 (Medical Record—Preoperative/Postoperative Nursing Document), 9-33
DA Form 5179-1 (Medical Record—Intraoperative Document), 9-34
DA Form 5181-R (Screening Note of Acute Medical Care), 5-7
DA Form 5291-R (Army Exceptional Family Member Program Educational Summary), 6-2
DA Form 5303-R (Volunteer Agreement Affidavit), 6-2
DA Form 5551-R (Spirometry Flow Sheet), 5-4, 6-2
DA Form 5568-R (Chronological Record of Well-Baby Care), 6-2
DA Form 5569-R (Isoniazid (INH) Clinic Flow Sheet), 5-8
DA Form 5570 (Health Questionnaire for Dental Treatment), 5-9, 5-25
DA Form 5571 (Master Problem List), 3-10, 5-10, 5-24, 7-4, 9-5
DA Form 5694 (Denver Developmental Screening Test), 6-2
DA Form 5862-R (Army Exceptional Family Member Program Medical Summary), 6-2
DA Form 7001 (Operating Room Schedule), 9-29, 9-30
DA Form 7095 (ADAPCP Outpatient Discharge Summary), 8-9
DA Form 7096 (ADAPCP Outpatient Aftercare Plan), 8-9
DA Form 7097 (ADAPCP Outpatient Problem List and Treatment Plan Review), 8-9
DA Form 7098 (ADAPCP Outpatient Treatment Plan and Review), 8-9
DA Form 7099 (ADAPCP Outpatient Biopsychosocial Evaluation), 8-9
DA Form 7349-R (Initial Medical Review—Annual Medical Certificate), 5-19
DA Form 7389 (Medical Record—Anesthesia), 3-2, 9-5, 9-10, 9-12
Filing of anesthesia monitoring with, 3-2
DA Form 8000 (ADAPCP Triage Instrument (For Unscheduled Patients)), 8-9
DA Form 8001 (Limits of Confidentiality), 8-9
DA Form 8002 (ADAPCP Outpatient Administrative Summary), 8-9
DA Form 8003 (ADAPCP Enrollment), 8-9
DA Form 8004-R (ADAPCP-OMR-Privacy Act Information), 8-9
DA Form 8005 (Outpatient Medical Record (OMR) (Orange)), 4-3, 4-4, 5-23, 5-25, 6-2
DA Form 8005-1 (Outpatient Medical Record (OMR) (Light Green)), 4-3, 4-4, 5-23, 5-25, 6-2
DA Form 8005-2 (Outpatient Medical Record (OMR) (Yellow)), 4-3, 4-4, 5-23, 5-25, 6-2
DA Form 8005-3 (Outpatient Medical Record (OMR) (Grey)), 4-3, 4-4, 5-23, 5-25, 6-2
DA Form 8005-4 (Outpatient Medical Record (OMR) (Tan)), 4-3, 4-4, 5-23, 5-25, 6-2
DA Form 8005-5 (Outpatient Medical Record (OMR) (Light Blue)), 4-3, 4-4, 5-23, 5-25, 6-2
DA Form 8005-6 (Outpatient Medical Record (OMR) (White)), 4-3, 4-4, 5-23, 5-25, 6-2
DA Form 8005-7 (Outpatient Medical Record (OMR) (Brown)), 4-3, 4-4, 5-23, 5-25, 6-2
DA Form 8005-8 (Outpatient Medical Record (OMR) (Pink)), 4-3, 4-4, 5-23, 5-25, 6-2
DA Form 8005-9 (Outpatient Medical Record (OMR) (Red)), 4-3, 4-4, 5-23, 5-25, 6-2
DA Form 8005-series folders, 4-3, 4-4, 5-23, 5-25, 6-2
Preparation of, 4-4
DA Form 8006-R (Pediatric Dentistry Diagnostic Form), 6-7
DA Form 8007-R (Individual Medical History), 5-24, 5-30, 11-3
Deployed military members, 5-30
DA Label 162 (Emergency Medical Identification Symbol), 3-10, 5-17, 5-24, 6-7, 13-1, 13-3, 13-4, 13-5
Dating of medical record entries, 3-4
DD Form 2(ACT) (Armed Forces of the United States Identification Card (Active)), 3-5
DD Form 2(RES) (Armed Forces of the United States Identification Card (Reserve)), 3-5

DD Form 2(RET) (United States Uniformed Services Identification Card (Retired)), 3-5
DD Form 214 (Certificate of Release or Discharge from Active Duty), 5-26
DD Form 602 (Patient Evacuation Tag), 9-6
DD Form 689 (Individual Sick Slip), 12-1, 12-2, 12-3, 12-5
DD Form 741 (Eye Consultation), figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1
DD Form 742 (Clinical Record—Visual Field Examination), 9-2
DD Form 749 (Clinical Record—Head Injury), 9-2
DD Form 771 (Eyewear Prescription), 5-19
DD Form 792 (Twenty-Four Hour Patient Input and Output Worksheet), 9-23
DD Form 877 (Request for Medical/Dental Records or Information), 4-7
DD Form 877-1 (Request for Medical/ Dental Records from the National Personnel Records Center (NPRC), St. Louis, MO), 4-7
DD Form 1141 (Record of Occupational Exposure to Ionizing Radiation), or ADR (Automated Dosimetry Record), 5-19
DD Form 1173 (Uniformed Services Identification and Privilege Card), 3-5
DD Form 1380 (U.S. Field Medical Card), 3-18, 5-11, 5-30, 5-31, 9-1, 9-6
DD Form 4006 as field jacket for, 10-5
Disposition, 10-4
Preparation, 10-2
Supplemental, 10-3
Use, 10-1
DD Form 1924 (Surgical Checklist), 9-31
DD Form 2005 (Privacy Act Statement—Health Care Records), 4-4, 5-25, 7-4, 9-5
DD Form 2138 (Request for Transfer of Outpatient Records), 6-4, 6-5, 8-7
DD Form 2161 (Referral for Civilian Medical Care), 9-10
DD Form 2215 (Reference Audiogram), figs 5-1, 5-2, 6-1, 6-2, 7-1
DD Form 2216 (Hearing Conservation Data), figs 5-1, 5-2, 6-1, 6-2, 7-1
DD Form 2482 (Venom Extract Prescription), 5-12
DD Form 2493-1 (Asbestos Exposure Part I—Initial Medical Questionnaire), 5-19
DD Form 2493-2 (Asbestos Exposure Part II—Periodic Medical Questionnaire), 5-19
DD Form 2569 (Third Party Collection Program—Insurance Information), 5-19, 6-2, 9-20
DD Form 2697 (Report of Medical Assessment), 5-19
DD Form 2770 (Abbreviated Medical Record), 9-5, 9-21
Deaths, recording, 3-13
Carded-for-record-only (CRO) cases, 3-18
Dental activity (DENTAC) commander, approval of research projects, 2-8
Dental diagnosis and procedures, recording, 3-8
Dental officers, responsibilities, 1-4
Dental records, DA Form 3444-series folders used for, 4-2
Dental treatment facility (DTF)
Record request by, 4-7
Responsibilities, 1-4
Department of the Army (DA) agencies, responsibilities of persons within, 1-4
Deployed military members, health records of, 5-30
Destruction of unidentifiable medical documents, 3-7
Diagnoses and procedures, recording of
Alcoholism, 3-10
Child abuse, 3-10
Deaths, 3-13
Diagnostic nomenclature, 3-8
Diagnostic procedures, 3-15
Injuries, 3-12
Observation without need for further medical care, 3-14
Psychiatric conditions, 3-11
Separation, cause, 3-14
Surgical procedures, 3-15
Therapeutic abortions, 3-16
Therapeutic procedures, 3-15
Undiagnosed (undetermined diagnosis), 3-14
Diagnostic index, 9-9
Diagnostic nomenclature, 3-8
Diagnostic procedures, recording, 3-15
DIS Form 16 (Doctor/Patient Release Statement), 2-4
DIS Form 40 (Alcohol and Drug Abuse Information Release and Consent to Redisclosure), 2-4
Disclosure procedures for medical information, 2-3, 2-4, 2-5, 2-7
Disposal of health records, 5-27
Disposition
Alcohol and Drug Abuse Prevention and Control Program medical records, 8-8
DD Form 1380 (U.S. Field Medical Card), 10-4
Inpatient treatment records (ITR), 9-10
Outpatient treatment records (OTR), 6-6
DNA samples, 1-4
Documentation review of medical records, 11-3
Doctor's orders, 9-26
DOL Form CA-1 (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation), 7-4
DOL Form CA-2 (Federal Employee's Notice of Occupational Disease and Claim for Compensation), 7-4
DOL Form CA-16 (Authorization for Examination and or Treatment), 7-4
DOL Form CA-17 (Duty Status Report), 7-4
DOL Form CA-20 (Attending Physicians Report), 7-4
DOL Form CA-20a (Attending Physicians Supplemental Report), 7-4
Drug and alcohol abuse
Disclosure of information regarding, 2-1, 8-2, 8-3
Durable powers of attorney, 6-2, 9-2

Electrocardiograms, filing of, 3-2
Entries, medical records
Destruction of unidentifiable medical documents, 3-7
Facility identification, 3-6
Generally, 3-4
Patient identification, 3-5
Exceptional Family Member Program Summary (automated), 6-2

FAA Form 8500-8 (Medical Certificate—Class and Student Pilot Certificate), figs 5-1 and 5-2
Facility identification, 3-6
Facsimile requests, 2-5
Family member prefix (FMP), filing medical records by, 4-1
Fetal monitoring strips, 9-3
Field files, use of, 5-32
Filing health records, 5-26
Filing medical records
Folders, DA Form 3443-series, DA Form 3444-series, and DA Form 8005-series, 4-3
Preparation of DA Form 3443-series folders, 4-5
Preparation of DA Form 3444-series folders, 4-4
Preparation of DA Form 8005-series folders, 4-4
Record chargeout system, 4-6
Record requests, 4-7
Social security number (SSN) and family member prefix (FMP), 4-1
Terminal digit filing system, 4-2
Foreign nationals within overseas area, disposition of DD Form 1380 (U.S. Field Medical Card), 10-4
Forms and documents
Authorized, 3-1
Automated and or computerized forms, 3-2
Guidelines for local forms and overprints, 3-3

Health care providers, responsibilities, 1-4
Health record (HREC)
Access to, 5-21
Bar-coding, 4-4
Cross-servicing of, 5-22
Custody of, 5-23
DA Form 8005-series folders used for, 4-3
Deployed military member, 5-30
Description of, 1-1
Disposal of, 5-27
Filing, 5-26
Forms and documents of, 5-4
Initiating, 5-23
Maintenance in isolated units, 1-4
New, 5-25
Patient's recording card, 3-5
Persons for whom prepared and maintained, 5-3
Purpose of, 5-1
Responsibility regarding, 1-4
Review of, 11-3
"Temporary," 5-25
Terminal digit filing system for, 4-2
Transfer of, 5-24
Use of, 5-2
HEW Form CDC 73-2936S (Field Report), 5-23, 5-24
HIV testing, recording of results, 3-10

Improving Organizational Performance Program
General, 11-1
Medical record services, 11-2
Patient care assessment, 11-3
Risk management program, 11-4
Individual Mobilization Augmentee (IMA), health record (HREC) for, 5-30
Individual Patient Data System (IPDS) User's Manual, 3-19
Individual Ready Reserve, health record (HREC) for, 5-30
Initiation
Alcohol and Drug Abuse Prevention and Control Program medical records, 8-5
Health records, 5-23
Inpatient treatment records, 9-4
Outpatient treatment records, 6-3
Injuries, recording of, 3-12
Inpatient care, use of health record (HREC), 5-2
Inpatient identification plate, 3-5
Inpatient treatment record (ITR)
Absent-without-leave patients, 9-7
Access, 9-9
Audit trail, 9-9
Bar-coding, 4-4
DA Form 3444-series folders used for, 4-3, 9-2
Description of, 1-1
Disposition of, 9-10
Five-year maintenance, 9-8
Forms and documents, 9-2
Initiation, 9-4
Mechanical imprinting on identification label of folder, 4-4
Nominal card index for, 9-9
North Atlantic Treaty Organization Standardization Agreement 2348 requirements, 9-6
Patient transfer, 9-10
Persons for whom prepared, 9-1
Preparation and use, 9-11, 9-14
Improving Organizational Performance Program, 11-1
Register number index for, 9-9
Review of, 11-3
Terminal digit filing system for, 4-2
Timely preparation of, 1-4
Inspector, access to health records, 5-21
Integrated progress notes, 9-12
International standardization agreements, 1-6
Ionizing radiation as cause of injury or disease, recording procedures, 3-12

Laboratory forms, 9-25
Laboratory test results, filing of, 3-2
Legibility of medical record entries, 3-4
Litigation, review of medical records involved in, 11-3
Living wills, 6-2, 9-2
Local forms and overprints, guidelines for, 3-3

Maintenance of inpatient treatment records, 9-8
Management controls, app C
Medical and Dental Record Tracking System, 4-4
Medical officers, responsibilities, 1-4
Medical record, purpose of, 1-1
Medical record entries. See Entries, medical records
Medical record services, Improving Organizational Performance Program, 11-2
Medical treatment facility (MTF)
Army medical records custody of, 1-5
Local abbreviations and symbols, 3-8
Record request by, 4-7
Medical treatment facility (MTF) commanders
Approval of research projects, 2-8
Responsibilities, 1-4
Medical warning tags
Embossing of, 13-3
Issuing of, 13-4
Military consultation service case files, 5-20, 6-2
Military personnel, disposition of DD Form 1380 (U.S. Field Medical Card), 10-4
Military personnel officers, responsibilities, 1-4
Mobilization
Field files, 5-32
Maintenance of health records upon, 5-30
Operation after hostilities cease, 5-33
Preparation of health record forms, 5-31
Mortuary affairs personnel, access to health records, 5-21

NAVMED 6300-5 (Admission/Disposition Record, Inpatient), figs 5-1, 5-2, 6-1, 6-2
New health record, 5-25
Nonmedical personnel, access to health records, 5-21
North Atlantic Treaty Organization Standardization Agreement 2348 requirements, 9-6
Nuclear medicine files
DA Form 8005-series and 3444-series folders used for, 4-3
Folders conspicuously stamped to avoid confusion with other files, 4-3
Nursing initiated orders, 9-27
Nursing notes, 9-12

Observation without need for further medical care, recording of, 3-14
Occupational injury and illness, recording of, 3-12
OF 23 (Chargeout Record), 4-6, 5-19
OF 275 (Medical Record Report), 3-3, 9-12
OF 345 (Physical Fitness Inquiry for Motor Vehicle Operators), 7-4
OF 520 (Clinical Record—Electrocardiographic Record), 3-2
Filing of electrocardiogram and cardiac monitoring with, 3-2
OF 522 (Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures), 3-3, 9-5
OF 523-B (Medical Record—Authorization for Tissue Donation), fig 9-1
Operative index, 9-9
Outpatient care, use of health record (HREC), 5-2
Outpatient treatment record (OTR)
Bar-coding, 4-4
DA Form 3444-series folders used for, 6-2
DA Form 8005-series folders used for, 4-3
Description of, 1-1
Disposition, 6-6
Forms and documents, 6-2
Identification label of folder, 4-4
Initiating and keeping, 6-3
Mailing, 6-4
Nominal card index for, 4-4
Patient's recording card, 3-5
Persons for whom prepared, 6-1
Preparation of, 6-7
Requests other than DD Form 2138, 6-5
Review of, 11-3
Terminal digit filing system for, 4-2
Transfer of, 6-4
Use, 6-8
Overprints
Guidelines for, 3-3
Use of rubber stamps, 3-4

Patient, request for information from medical record, 2-3
Patient bed card, 3-5
Patient care assessment, 11-3
Patient's recording card, 3-5
Personnel reentering service, health record (HREC) for, 5-23
Personnel Reliability Program records
Maintenance of, 5-29
Screening, 5-28
PHS Form 731 (International Certificates of Vaccination), 5-17, 6-7
Pregnancy, preparation of outpatient treatment record (OTR), 6-7
Preparation
Alcohol and Drug Abuse Prevention and Control Program medical records, 8-9
Outpatient treatment records, 6-7
Preprinted instructions to patient, inclusion in local forms and overprints, 3-3
Prisoners of war, disposition of DD Form 1380 (U.S. Field Medical Card), 10-4
Progress notes, 9-12
Public, release of medical information to, 2-3, 2-4

Radiology images and reports, DA Form 3443-series folders used for, 4-5
Record chargeout system, 4-6, 6-8
Record ownership, 1-5
Record requests, 4-7
Release of medical records, 11-3
Research personnel, responsibilities, 1-4
Research using medical records, confidentiality of medical information, 2-8
Reserve commanders (RC), responsibilities, 1-4
Responsibilities, 1-4
Restraints, 3-17
Rubber stamp entries, 3-4

Scans, filing of, 3-2
Separation, recording cause of, 3-14
SF 66D (Employee Medical Folder), 4-3, 7-4
SF 78 (U.S. Civil Service Commission, Certificate of Medical Examination), 7-4

SF 86 (Questionnaire for National Security Positions), 2-4
SF 88 (Report of Medical Examination), 3-10, 5-16, 5-19, 5-23
SF 93 (Report of Medical History), 5-19, 5-23, 7-4
SF 177 (Statement of Physical Ability for Light Duty Work), 7-4
SF 502 (Clinical Record—Narrative Summary), 5-19, 9-12
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 503 (Clinical Record—Autopsy Protocol), 9-12
SF 504 (Clinical Record—History—Part I), 9-10, 9-12, 9-14, 9-20
SF 505 (Clinical Record—History—Parts II and III), 9-10, 9-12, 9-14, 9-20
SF 506 (Clinical Record—Physical Examination), 9-10, 9-12, 9-14, 9-20
SF 507 (Clinical Record—Report on or Continuation of SF), figs 5-1, 5-2, 5-3, 6-1, 6-2, 6-3, 7-1, 8-1, 9-1
SF 509 (Medical Record—Progress Report), 3-3, 5-16, 5-19, 9-5, 9-10, 9-11, 9-12, 9-13, 9-14, 9-20, 9-25
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 510 (Clinical Record—Nursing Notes), 3-2, 9-12, 9-13, 9-14
SF 511 (Medical Record—Vital Signs Record), 9-23, 9-24, 9-35
SF 512 (Clinical Record—Plotting Chart), 5-4, 5-13, 6-2, 9-2
SF 513 (Medical Record—Consultation Sheet), 5-2, 9-12
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 515 (Medical Record—Tissue Examination), 5-2, 5-4, 5-19, 6-2, 9-2, 9-5
SF 516 (Medical Record—Operation Report), 5-19, 9-5, 9-12
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 518 (Medical Record—Blood or Blood Component Transfusion), 5-4, 6-2, 9-2
SF 519-B (Radiologic Consultation Request/Report), 5-4, 6-2, 8-4, 9-2, 9-37
SF 521 (Clinical Record—Dental), 5-4, 6-2
SF 523 (Clinical Record—Authorization for Autopsy), 9-2
SF 523A (Medical Record—Disposition of Body), 9-2
SF 524 (Medical Record—Radiation Therapy), 5-4, 6-2, 9-2
SF 525 (Medical Record—Radiation Therapy Summary), 5-4, 6-2, 9-2
SF 526 (Medical Record—Interstitial/ Intercavitary Therapy), 5-4, 6-2, 9-2
SF 527 (Group Muscle Strength), 5-4, 6-2, 9-2
SF 528 (Clinical Record—Muscle and/or Nerve Evaluation-Manual and Electrical: Upper Extremity), 5-4, 9-2
SF 529 (Medical Record—Muscle Function by Nerve Distribution-Manual and Electrical: Trunk and Lower Extremity), 5-4, 6-2, 9-2
SF 530 (Clinical Record—Neurological Examination), 9-2
SF 531 (Medical Record—Anatomical Figure), 5-4, 6-2, 9-2
SF 533 (Medical Record—Prenatal and Pregnancy), 5-4, 6-2, 6-7, 9-2
SF 534 (Medical Record—Labor), 9-2
SF 535 (Clinical Record—Newborn), 6-2, 9-2
SF 536 (Clinical Record—Pediatric Nursing Notes), 9-2, 9-36
SF 538 (Clinical Record—Pediatric), 9-2
SF 541 (Medical Record—Gynecologic Cytology), 5-4, 6-2, 9-2
SF 544 (Clinical Record—Statement of Patient's Treatment), 9-2
SF 545 (Laboratory Report Display), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Filing of laboratory results with, 3-2
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 546 (Chemistry I), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 547 (Chemistry II), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 548 (Chemistry III (Urine)), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 549 (Hematology), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 550 (Urinalysis), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 551 (Serology), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 552 (Parasitology), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 553 (Microbiology I), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 554 (Microbiology II), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 555 (Spinal Fluid), 5-4, 6-2, 9-2, 9-25
SF 556 (Immunohematology), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 557 (Miscellaneous), 9-25
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 558 (Medical Record—Emergency Care and Treatment), 5-14, 9-5, 9-12
Health record form, 5-4
Inpatient treatment record form, 9-2
Outpatient treatment record form, 6-2
SF 559 (Medical Record—Allergen Extract Prescription, New and Refill), 5-5, 5-15
SF 600 (Health Record—Chronological Record of Medical Care), 2-7, 5-16, 5-20, 5-23, 6-7
Alcohol and Drug Abuse Prevention and Control Program outpatient medical record form, 8-4
Combat conditions, 5-31
Health record form, 5-4
Outpatient treatment record form, 6-2
SF 601 (Health Record—Immunization Record), 5-17, 5-23, 5-25, 6-7
Health record form, 5-4
Outpatient treatment record form, 6-2
SF 602 (Health Record—Syphilis Record), 5-16, 5-19, 5-24
SF 603 (Health Record—Dental), 5-18, 5-23, 6-7
Health record form, 5-4
Outpatient treatment record form, 6-2
SF 603A (Health Record—Dental Continuation), 5-18, 5-23, 6-7
Operational setting, 5-31
Sick slip
Disposition of, 12-5
Issuing, 12-2, 12-3

Purpose of, 12-1
Signatures on medical record entries, 3-4
Social security number (SSN), filing medical records by, 4-1
State adjutants general, responsibilities for health records (HREC), 1-4
State ambulance forms, 5-19
Stillborn infant, medical reports on, 9-2
Sudden death, recording, 3-13
Supplemental DD Form 1380 (U.S. Field Medical Card), 10-3
Surgical procedures, recording, 3-15

Teenage family members, confidentiality of medical record information, 2-6

"Temporary" health record, 5-25

Terminal digit filing system, 4-2
Therapeutic procedures, recording, 3-15
Transfer of Alcohol and Drug Abuse Prevention and Control Program medical records, 8-6
Transfer of health records, 5-24
Transfer of outpatient treatment records, 6-4
Triservice Disease and Procedure ICD-9-CM Coding Guidelines, 3-9, 3-12

Unauthorized disclosure of medical information, 2-2
Undersized reports, mounting on DA Form 4700 (Medical Record—Supplemental Medical Data), 3-2
Undiagnosed (undetermined diagnosis), recording of, 3-14
Unidentifiable medical documents, destruction of, 3-7
Unit commanders, responsibilities, 1-4
U.S. Army Reserve (USAR), absent-sick status, 3-19
U.S. Army Reserve (USAR) unit commanders, responsibilities for health records (HREC), 1-4
U.S. Military Academy cadets
Absent-sick status, 3-19
Health record (HREC) for, 5-23

Vital-sign-monitoring records, filing of, 3-2

Ward identification plate, 3-5
Workman's Compensation Claims, 7-11

X rays
Retention of, 7-10
Transfer of, 5-24

RESERVED

MANAGEMENT CONTROL EVALUATION CERTIFICATION STATEMENT For use of this form, see AR 11-2; the proponent agency is ASA(FM).	1. REGULATION NUMBER 2. DATE OF REGULATION

3. ASSESSABLE UNIT

4. FUNCTION

5. METHOD OF EVALUATION *(Check one)*

	a. CHECKLIST		b. ALTERNATIVE METHOD *(Indicate method)*
APPENDIX *(Enter appropriate letter)*			

6. EVALUATION CONDUCTED BY

a. NAME *(Last, First, MI)*	b. DATE OF EVALUATION

7. REMARKS *(Continue on reverse or use additional sheets of plain paper)*

8. CERTIFICATION

I certify that the key management controls in this function have been evaluated in accordance with provisions of AR 11-2, Army Management Control Process. I also certify that corrective action has been initiated to resolve any deficiencies detected. These deficiencies and corrective actions *(if any)* are described below or in attached documentation. This certification statement and any supporting documentation will be retained on file subject to audit/inspection until superseded by a subsequent management control evaluation.

a. ASSESSABLE UNIT MANAGER

(1) Typed Name and Title	b. DATE CERTIFIED
(2) Signature	

REQUEST FOR PRIVATE MEDICAL INFORMATION

For use of this form, see AR 40-66; the proponent agency is the OTSG

1. Date.

2. Patient's Name and SSN.

3. Medical Treatment Facility *(Name and Location)*

4. Reason for Request.

5. Private Medical Information Sought (*Specify dates of hospitalization or clinic visits and diagnosis, if known)*

6. Requestor's Name, Title, Organization and SSN.

FOR USE OF MEDICAL TREATMENT FACILITY ONLY

7. Check applicable box.

☐ Approved ☐ Disapproved *(State reason for disapproval)*

8. Summary of Private Medical Information Released.

9. Signature of Approving Official.

10. Date.

AUTHORIZATION FOR PSYCHIATRIC SERVICE TREATMENT

For use of this form see AR 40-3; the proponent agency is the Office of The Surgeon General.

STATEMENT OF AUTHORIZATION

1. I hereby request and consent to hospitalization in a treatment unit of the Psychiatry Service. I understand that this admission is required for adequate study and treatment of my case. I understand that I may be asked to remain on the ward or in the company of staff members at all times.

2. The policies of this treatment unit have been explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

3. I understand that my hospitalization is not a commitment and upon my written or verbal request for discharge, action will be initiated immediately to effect my discharge in accord with local and Federal laws and statutes.

4. I understand that photographs, including videotapes and moving pictures, may be taken while under treatment and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I also understand that medical students and other professional trainees may be present as observers in accordance with ordinary practices of this medical facility. I consent to the taking of such pictures and to observation by authorized personnel, subject to the following conditions:

a. Neither my name nor the names of my family will be used to identify said pictures.

b. Said pictures and any information gained from observation will be used only for purposes of medical study or research.

AUTHORIZING SIGNATURES

Patient *(or authorized person if other than patient)* — Date

Admitting physician or his specifically designated representative — Date

Witness *(Spouse or other appropriate relative should witness signature whenever possible.)* — Date

PATIENT'S IDENTIFICATION *(Mechanically Imprint, Type or Print:*

Patient's Name - last, first, middle initial; Sex; Year of Birth; Relationship to Sponsor; Component/Status; Department/Service. Sponsors Name - last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization).

TAB TAB TAB TAB

REQUEST AND RELEASE OF MEDICAL INFORMATION TO COMMUNICATIONS MEDIA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974

1. AUTHORITY: Section 3012, title 10, United States Code.

2. PRINCIPAL PURPOSE(S): This form provides for patient/parent/guardian consent to release requested personal medical information to news publication or broadcast.

3. ROUTINE USES: The requested information will be released on this form to the communications media. It will be used for news publication or broadcast.

4. MANDATORY OR VOLUNTARY DISCLOSURE: The release of this information is voluntary. There is no effect on the individual not providing the requested information.

SECTION I - PATIENT IDENTIFICATION

NAME *(Last, First, Middle)* ADDRESS

AGE SSN STATUS NAME OF MEDICAL TREATMENT FACILITY

SECTION II - TO BE COMPLETED BY REQUESTOR

I certify that I represent _____

(Name and Address of Communications Media)

_____ and that medical information on the above identified patient is requested for news publication or broadcast.

List specific information requested below:

DATE SIGNATURE OF PUBLIC AFFAIRS OFFICER SIGNATURE OF MEDIA REPRESENTATIVE

SECTION III - TO BE COMPLETED BY PATIENT/PARENT/GUARDIAN

I, _____, hereby request and authorize the release of the requested information concerning my illness or injury and hospital treatment (complete when other than patient gives consent - the illness or injury and hospital treatment of _____) while a patient in this medical treatment facility, to the above mentioned communications media. I hereby agree to hold the hospital, its physicians, and its staff free and harmless from any, and all liabilities or ill effects which might arise from the publication or broadcast of such information.

DATE SIGNATURE OF WITNESS SIGNATURE OF PATIENT/PARENT/GUARDIAN

M TAB

SECTION IV - TO BE COMPLETED BY ATTENDING PHYSICIAN

Information as requested and authorized is hereby furnished:

DATE SIGNATURE OF ATTENDING PHYSICIAN

SECTION V - TO BE COMPLETED BY PATIENT ADMINISTRATION DIVISION

Sections I through IV have been reviewed and is ( ) approved ( ) disapproved for release.

DATE SIGNATURE OF CHIEF, PATIENT ADMINISTRATION DIVISION (or designated representative)

Upon completion of this form, a copy will be placed in the patient's medical record and a copy will be returned to the Public Affairs Officer for release of the requested information to the media representative.

MEDICAL RECORD	AUTHORIZATION FOR DISCLOSURE OF INFORMATION

This form will not be used for authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. For authorization to disclose alcohol or drug abuse patient information, see 42 CFR 2 and AR 600-85.

(Pursuant to the Privacy Act of 1974, Public Law 93-579)

PHYSICIAN OR MEDICAL TREATMENT FACILITY AUTHORIZED TO RELEASE INFORMATION	It is understood that this authorization may be revoked at any time, if requested in writing, except to the extent that action will have already been taken.

PATIENT DATA

NAME *(Last, First, MI)*	DATE OF BIRTH	SOCIAL SECURITY/IDENTIFICATION NUMBER
PERIOD OF TREATMENT *(Month, Day, Year)*	TYPE OF TREATMENT ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

RESTRICTIONS ON INFORMATION *(Specify)*

USE OF MEDICAL INFORMATION

☐ FURTHER MEDICAL CARE ☐ INSURANCE CLAIM(S) ☐ ATTORNEY ☐ DISABILITY DETERMINATION
☐ OTHER *(Specify)*

INFORMATION DESTINATION

INDIVIDUAL OR ORGANIZATION TO WHOM INFORMATION SHOULD BE RELEASED *(Name and Address)*

(ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE)

RELEASE AUTHORIZATION

I hereby request and authorize the named physician/medical treatment facility to release the medical information described above to the named individual/organization indicated.	DATE
SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP TO PATIENT

IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE

MEDICAL RECORD	ALLERGY IMMUNOTHERAPY RECORD For use of this form, see AR 40-66; the proponent agency is the OTSG	SINGLE EXTRACT

START ALLERGY SHOT DATE

RE-EVALUATION DUE

PRESCRIPTION NUMBER

EXTRACT CONTENT

HISTORY OF SYSTEMIC SHOT REACTIONS? YES

ON BETA BLOCKERS? YES NO

DATE	TIME	VIAL #	STRENGTH (pnu/ml,wt/vol,AU/ml)	SCHEDULE A,B,C,D,E,F	DOSE (ml)	ARM	REACTIONS OR SPECIAL INSTRUCTIONS	TECH INITIALS

PATIENT'S IDENTIFICATION

(For typed or written entries give Name--last, first, middle, SSN;DOB;sex;treating facility)

NURSING PERSONNEL INITIALS			
NAME	INITIALS	NAME	INITIALS

MEDICAL RECORD	ALLERGY IMMUNOTHERAPY RECORD For use of this form, see AR 40-66; the proponent agency is the OTSG	DOUBLE EXTRACT

RE-EVALUATION DUE

PRESCRIPTION NUMBER

EXTRACT CONTENT

HISTORY OF SYSTEMIC SHOT REACTIONS? YES

DATE	TIME	ARM/ DOSE	REACTIONS OR SPECIAL INSTRUCTIONS	TECH INITIALS

RE-EVALUATION DUE

PRESCRIPTION NUMBER

EXTRACT CONTENT

ON BETA BLOCKERS? YES NO

DATE	TIME	ARM/ DOSE	REACTIONS OR SPECIAL INSTRUCTIONS	TECH INITIALS

PATIENT'S IDENTIFICATION

(For typed or written entries give Name - last, first, middle, SSN; DOB; sex; treating facility)

NURSING PERSONNEL INITIALS

NAME	INITIALS	NAME	INITIALS

MEDICAL RECORD	RELEASE AGAINST MEDICAL ADVICE For use of this form, see AR 40-66; proponent agency is the Office of The Surgeon General.

STATEMENT OF PATIENT RELEASING HOSPITAL FROM LIABILITY
UPON LEAVING HOSPITAL AGAINST MEDICAL ADVICE

1. This is to CERTIFY that I am leaving _____ (Name of Med Treatment Facility) at my own insistence and against the advice of the hospital authorities and my attending physician(s).

2. I have been advised of the dangers involved in leaving the hospital at this time.

3. I hereby release the hospital, its staff and the Federal Government of all responsibility for any ill effects brought about by my failure to remain in the hospital.

_____ (Signature of Patient)

_____ (Signature of Witness)

_____ (Date and Time)

STATEMENT OF REPRESENTATIVE OF PATIENT RELEASING HOSPITAL FROM LIABILITY
UPON LEAVING HOSPITAL AGAINST MEDICAL ADVICE

1. This is to CERTIFY that I _____ (Name), _____ (Relationship to Patient) of _____ (Name of Patient) insist that he/she be discharged from _____ (Name of Med Treatment Facility) without the authorization of the patient's attending physician(s).

2. I have been informed of the dangers to the patient in his/her leaving the hospital at this time, including the possibility that it may worsen or aggravate the patient's condition.

3. I hereby release the hospital, its staff and the Federal Government of all responsibility for any ill effects brought about by _____ (Name of Patient) leaving the hospital against medical advice.

_____ (Signature of Representative)

_____ (Signature of Witness)

_____ (Date and Time)

PATIENT IDENTIFICATION	REGISTER NUMBER	WARD NUMBER

TAB TAB TAB TAB

SCREENING NOTE OF ACUTE MEDICAL CARE

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

TIME PATIENT DEPARTS UNIT *(From DD Form 689)*	SCREENER LOCATION		
	TIME PATIENT ARRIVES	TIME ENCOUNTER BEGINS	TIME PATIENT LEAVES

DATE	SCREENER LOCATION	CHIEF COMPLAINT	DURATION

PATIENT RESIDENCE
( ) BARRACKS ( ) POST HOUSING
( ) OFF POST ( ) TRANSIENT

VITAL SIGNS
TEMPERATURE _____ ALLERGIES _____
PULSE _____ BP _____ RESP _____

FIRST VISIT FOR THIS COMPLAINT ( ) YES ( ) NO IF NO, WAS RETURN SCHEDULED/REQUESTED BY CARE PROVIDER?
( ) YES ( ) NO

ALGORITHM/CODE	ALGORITHM/CODE
ALGORITHM SUMMARY	ALGORITHM SUMMARY

COMMENTS *(Reasons for referral, method of referral, hospital appointments, self-care protocols, and patient instructions/precautions)*

PATIENT'S IDENTIFICATION *(Use mechanical imprint if available, for typed or written entries give: Name, SSN, Unit, Sex, Birthdate and Duty Phone)*

FINAL DISPOSITION
( ) I - PHYSICIAN STAT ( ) IV - SELF CARE PROTOCOL
( ) II - PA STAT ( ) V - HOSP CLINIC REFERRAL
( ) III - PA

AIDMAN'S SIGNATURE & CODE	AUDITOR'S INITIALS & DATE

TAB TAB TAB TAB TAB TAB

RECORD OF ACUTE MEDICAL CARE

(Entries on this record should be restricted to further evaluation and treatment of complaint(s) screened)

DATE	2ND CARE LOCATION	TIME PATIENT ARRIVES	TIME ENCOUNTER BEGINS	TIME PATIENT LEAVES

SIGNATURE OF HEATH CARE PROVIDER	SIGNATURE OF MEDICAL SUPERVISOR	AUDITOR'S INITIALS AND DATE

SPECIAL INSTRUCTIONS

This form will be utilized in lieu of SF 600 (Health Record-Chronological Record of Medical Care) at the BAS level and above when care is initiated by an ADTMC screener. The record of acute, medical care will accompany the patient to the next level of care or remain in the BAS depending on disposition reached. This form will be filed in the HREC when evaluation and audit are completed.

CHRONOLOGICAL RECORD OF WELL-BABY CARE

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

SIGNIFICANT NEONATAL HX	DOB	WEIGHT	HEIGHT	PKU

DATE OF VISIT		
AGE		
WEIGHT		
HEIGHT		
HEAD CIRCUMFERENCE		
SUBJECTIVE (HISTORY) 1. FEEDING 2. FORMULA/BREAST SOLIDS VITAMINS/FLOURIDE 2. ELIMINATION 3. GROWTH AND DEVELOPMENT 4. PARENTAL CONCERNS		
OBJECTIVE PHYSICAL EXAM		
NUTRITION		
HEAD/FONTANEL		
EENT		
NECK/CLAVICLES		
LUNGS		
HEART		
ABDOMEN		
GENITALIA/HERNIA		
HIPS/SPINE		
EXTREMITIES		
SKIN		
NEUROLOGICAL		
ASSESSMENT		
PLANS AND COUNSELING SAFETY FEEDING GROWTH AND DEVELOPMENT IMMUNIZATION NEXT VISIT		
	EXAMINED BY	EXAMINED BY

PATIENT's IDENTIFICATION (Name, last, first, middle, grade, date, hospital or medical facility)	REMARKS

SIGNIFICANT NEONATAL HX	DOB	WEIGHT	HEIGHT	PKU

DATE OF VISIT		
AGE		
WEIGHT		
HEIGHT		
HEAD CIRCUMFERENCE		
SUBJECTIVE (HISTORY)		
1. FEEDING		
2. FORMULA/BREAST		
SOLIDS		
VITAMINS/FLOURIDE		
2. ELIMINATION		
3. GROWTH AND DEVELOPMENT		
4. PARENTAL CONCERNS		
OBJECTIVE PHYSICAL EXAM		
NUTRITION		
HEAD/FONTANEL		
EENT		
NECK/CLAVICLES		
LUNGS		
HEART		
ABDOMEN		
GENITALIA/HERNIA		
HIPS/SPINE		
EXTREMITIES		
SKIN		
NEUROLOGICAL		
ASSESSMENT		
PLANS AND COUNSELING		
SAFETY		
FEEDING		
GROWTH AND DEVELOPMENT		
IMMUNIZATION		
NEXT VISIT		
	EXAMINED BY	EXAMINED BY

PATIENT's IDENTIFICATION (Name, last, first, middle, grade, date, hospital or medical facility)	REMARKS

ISONIAZID (INH) CLINIC FLOW SHEET

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

DATE STARTED INH			CODES O = *No* ✓ = *Yes* CS = *Comment Section*									
Today's date												
Time												
No. months of INH												
SUBJECTIVE												
Fatigue												
Nausea												
Loss of appetite												
Dark urine												
Light stools												
Joint pain												
Loss of weight												
Visual changes												
Elevated temperature												
Tingling hands/feet												
OBJECTIVE												
Rash												
Icterus												
Other												
ASSESSMENT												
Patient taking medication												
Side effects noted												
PLAN/ACTION												
Refill INH no. 30												
Start/refill B6 no. 30												
Patient guidance provided												
Repeat liver function tests												
Discontinue INH												
Refer to MD												
Referral to next duty sta												
Next appointment *(Date)*												
Interviewer's initials												

COMMENT SECTION

(Continue on reverse)

PATIENT'S IDENTIFICATION *(Use mechanical imprint if available. For typed or written entries give: Name, SSN, Unit, Sex, Birthdate and Duty Phone.)*

INTERVIEWER'S IDENTIFICATION DATA

SIGNATURE AND TITLE	INITIALS

ALCOHOL & DRUG ABUSE PREVENTION & CONTROL PROGRAM (ADAPCP) OUTPATIENT MEDICAL RECORDS - PRIVACY ACT INFORMATION

For use of this form, see AR 40-66; the proponent agency is OTSG

This form is not a consent form to release or use health care information about you.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN). Title V, Public Law 92-129; section 413, Public Law 92-255.

2. PRINCIPAL PURPOSES OF OUTPATIENT MEDICAL RECORDS.

a. To provide necessary information to evaluate the existence of and, if appropriate, the nature and extent of the patient's alcohol and other drug problem.

b. To provide baseline information for monitoring the patient's progress during rehabilitation in the ADAPCP.

c. To ensure continuity of care of patient enrolled in ADAPCP rehabilitation.

d. As part of the Active Army soldier's medical record, to provide information to military physicians in diagnosing other medical problems and in prescribing medication.

e. To provide statistical information for program evaluation.

3. ROUTINE USES.

a. Active Army Soldiers. Release of any information from this record is subject to the restrictions of 21 USC 1175 as amended by 88 Stat 137; 42 USC 4582 amended by 88 Stat 131 chapter 1, title 42, Code of Federal Regulations. Under these statutes and regulations, disclosure of information that would identify the patient as an abuser of alcohol or other drugs is authorized within the Armed Forces or to those components of the Veterans Administration, furnishing health care to veterans. AR 600-85 further limits disclosure within the Armed Forces to those individuals having an official need to know (for example, the physician or the patient's unit commander). All other disclosures require the written consent of the patient except disclosures (1) to medical personnel outside the Armed Forces to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial competent jurisdiction.

b. Civilian employees and other personnel. Release of any information from this record is subject to the restrictions of 21 USC 1175 as amended by 88 Stat 137-42 USC 4582 as amended by 88 Stat 131 and chapter 1, title 42, Code of Federal Regulations. All disclosures require the written consent of the patient except disclosures (1) to medical personnel to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial audits or program evaluation or (3) upon the order of a court of competent jurisdiction.

4. MANDATORY / VOLUNTARY DISCLOSURE AND EFFECT ON AN INDIVIDUAL NOT PROVIDING INFORMATION.

a. Disclosure is mandatory for Active Army soldiers. Failure to obey order from competent authority to provide required information may be subject to appropriate disciplinary action under the UCMJ.

b. Disclosure is voluntary for civilian employees and other personnel. The failure to disclose the information will result in a reduced capability of the program to provide treatment and services.

5. Signature of Patient or Sponsor	6. SSN of Member or Sponsor.	7. Date.

PEDIATRIC DENTISTRY DIAGNOSTIC FORM

For use of this form, see AR 40-66; the proponent agency is the OTSG

*All caries are to be noted on SF 603 (Diseases, Abnormalities, and X-rays chart).

1. Medical Alert.

2. Chief Complaint.

3. Age *(yrs, mos)*.

4. Weight *(Lbs/KG)*.

5. Occlusion:

Primary Molar Terminal Plane:

R		L
( )	Flush	( )
( )	Mesial Step	( )
( )	Distal Step	( )

Permanent Molar:

R		L
( )	Class I	( )
( )	Class II	( )
( )	End-on	( )
( )	Class III	( )

Cuspid Relationship:

R		L
( )	Class I	( )
( )	Class II	( )
( )	End-on	( )
( )	Class III	( )

6. Overjet mm.

7. Overbite %.

8. Openbite mm.

9. Midline:

	U	L
On		
Shift to Right		
Shift to Left		
mm		

10. Crossbite:

- None
- Unilateral R ☐ L ☐
- Bilateral
- Anterior
- Space Loss #
- Anterior Crowding
- Max
- Mand
- mm

11. Abnormalities.

a. Missing Teeth.

b. Supernumeraries.

c. Eruption Sequence.

12. Soft Tissue.

- WNL
- Abnormality *

* Note:

13. Oral Hygiene.

- Excellent
- Good
- Fair
- Poor

14. Behavior Assessment.

- Cooperative
- Noncooperative

15. FRANKL Behavior Scale.

++
+
-
–

16. Habits.

17. Facial Features.

- Concave
- Convex
- Straight

18. Mandibular Plane.

- Average
- Steep
- Flat

19. Date TX Initiated.

20. Proposed Length.

21. Appliances in Use.

22. Other Observations, Comments.

23. Planned Treatment & Sequence of Accomplishment.

24. Prepared by *(Signature & Title)*.

25. Department/Service/Clinic.

26. Date.

27. Patient's Identification *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*:

PCS Date

Phone Number

- ☐ Panograph
- ☐ Ortho Consult
- ☐ Cephalometrics
- ☐ Photos
- ☐ Study Models
- ☐ Other *(Specify)*
- ☐ Mixed Dentition Analysis

28. Tooth Size.

R L

29. Sum of widths of mandibular incisors.

30. Mandibular.

	R	L
Space available for cuspid and bicuspids.		
Predicted size of cuspid and bicuspids.		
Space left for molar adjustment.		

31. PROBABILITY CHART – 75% LEVEL

A. Sum Width	26,25	24, 23	19.5	20.4	20.5	21.0	21.5	22.0	22.5	23.0	23.5	24.0	24.5	25.0
B. Sum Width of Unerupted Permanent Cuspids and Bicuspids	MAX	20.6	20.9	21.2	21.5	21.8	22.0	22.3	22.6	22.9	23.1	23.4	23.7	
	MAND	20.1	20.4	20.7	21.0	21.3	21.6	21.9	22.2	22.5	22.8	23.1	23.4	

32. Approximate decrease in arch length due to mesial migration of the first permanent molars taking up "leeway space" during replacement of the deciduous molars by the bicuspids:

Mandible = 1.7 mm. per quadrant or 3.4 mm total
Maxilla = .9 mm. per quadrant or 1.8 mm total

33. CEPHALOMETRICS

A. TWEED ANALYSIS

(1) FMA			
(2) IMPA			
(3) FMIA			

B. STEINER ANALYSIS.

		Ref. Norm.		
(1) SNA	(angle)	82°		
(2) SNB	(angle)	80°		
(3) ANB	(angle)	2°		
(4) SND	(angle)	76° or 77°		
(5) $\underline{1}$ to NA	(mm)	4		
(6) $\underline{1}$ to NA	(angle)	22°		
(7) I to NB	(mm)	4		
(8) I to NB	(angle)	25°		
(9) Po to NB	(mm)	not est.		
(10)Po & I to NB	(Difference)			
(11)$\underline{1}$ to I	(angle)	131°		
(12)Occl to SN	(angle)	14°		
(13)GoGn to SN		32°		
(14)Arch length discrepancy				

INDIVIDUAL MEDICAL HISTORY

For use of this form, see AR 40-66; the proponent agency is the OTSG

1. Name.	2. Grade.	3. SSN.

4. Race.	5. DOB.	6. Blood Type.	7. Sex.	8. Religion.	9. HT.	10. WT.

11. Unit.	12. MOS/AOC.	13. Flight Status. YES NO	14. Flight Rating. YES NO	15. PRP. YES NO

16. P	U	L	H	E	S

17. Profiles: _____ Permanent *(Or)* _____ Temporary
Expires: _____
Reason for Profile: _____

	18. Date of last:
a. Physical exam	
b. Hearing exam	
c. HIV test	
d. DNA Sample	

19. Dental Readiness Classification: 1 2 3
(Circle correct Class.)
Complete Dental Record: Yes No
Dental Exam: _____

20. ALLERGY *(INCL MED)*
MEDICAL WARNING TAG: *(CIRCLE ONE)* YES NO
DATE ISSUED_____

21. VISION STATUS Last Exam: / / Requires: ☐ Eye glasses ☐ Mask Inserts ☐ Sunglasses ☐ Safety Glasses
Prescription:

eye	sph	cyl	axis	add	seg ht	other	best acuity
R							20 /
L							20 /

Frame: __ M __ F __ Flt __ Non-std
Mask Insert Type: _____
Size:_____Temple: ___ " ___ Spatula ___ Cable
Seg. type: _____
Contact Lens Wear: _____ No _____ Yes
Comments:

22. Date of Last Immunizations.		f. TB Test.	
a. Smallpox.		g. Typhoid.	
b. Yellow Fever.		h. Influenza.	
c. Cholera.		i. Immune Globulin.	
d. Tetanus-Diphtheria.			
e. Plague.			

23. Chemoprophylaxis.		
a. Name of Disease.	b. Medication.	c. Dosage.

24. PATIENT'S IDENTIFICATION: *(For typed or written entries give: Name (Last, First, Middle); grade; SSN; hospital or medical facility.)*

25. Remarks. *(Continue on reverse, if necessary.)*

26. Current Medical Condition / Medications:	
27. Remarks:	
28. SIGNATURE:	29. DATE:

REVERSE OF DA FORM 8007-R, NOV 96

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DATA FILE:	r40-66.fil
DOCUMENT:	AR 40–66
DOC STATUS:	NEW PUBLICATION