Army Regulation 40–66

Medical Services

Medical Record Administration and Healthcare Documentation

Headquarters
Department of the Army
Washington, DC
17 June 2008

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-66
Medical Record Administration and Healthcare Documentation

This rapid action revision, dated 17 June 2008--

- Emphasizes the use of electronic records, but maintains a requirement for retirement of paper records to the National Personnel Records Center (paras 1-5*c*, 1-6*b*, 4-4*a*(5), and 5-26*d*).

- Advises patients that restrictions on the uses and disclosures of their health information may make their health information inaccessible by most military treatment facility staff members (para 2-5*i*(3)).

- Covers documentation on detainees and adds a requirement for an internment serial number on all detainee documentation (chap 3, sec V).

- Requires a plan for documentation during periods when AHLTA is not available (para (5-2*b*(1)).

- Adds requirement to preparing medical records for deployed contract personnel (para 5-3).

- Directs use of AHLTA-T for documenting care under combat conditions or at deployed sites and requires use of DD Form 1380, when AHLTA-T is not available (paras 5-11, 5-32*a*(1), 5-33).

- Revises guidance on DD Forms 2766 and 2766C (para 5-13).

- Provides guidance on documenting and tracking all immunizations (paras 5-13*a*(2)).

- Recognizes the medical record as a legal document and addresses superseded forms (para 5-13*c*).

- Allows use of the AHLTA encounter note as the history and physical documentation and directs use of SF 600 or the electronic equivalent to document medical care when AHLTA is not available (paras 5-16 and 5-18*b*(3)).

- Addresses entries for physical examinations (para 5-18*d*).

- Ensures entry of immunization history and allergy information (para 5-19*a*).

- Addresses dental documentation in AHLTA (para 5-20).

- Provides guidance for mental health documentation (para 5-22).

- Requires entry of Personnel Reliability Program data into AHLTA (para 5-31*a*).

- Addresses DD Form 2766 and the Army Medical Surveillance Activity (para 5-35*a*(2)).

- Addresses preparation and use of the Army Substance Abuse Program Outpatient Medical Records (para 8-9).

- Adds the requirement to have electronic equivalents of certain DA and DD form numbers (throughout).

- Integrates the electronic outpatient record, AHLTA, and ESSENTRIS (the interim inpatient electronic medical record) (throughout).

- Replaces “health record (HREC)” with “service treatment record (STR)” (throughout).

Headquarters
Department of the Army
Washington, DC
17 June 2008

*Army Regulation 40–66

Effective 17 July 2008

Medical Services

Medical Record Administration and Healthcare Documentation

By Order of the Secretary of the Army:

GEORGE W. CASEY, JR.
General, United States Army
Chief of Staff

Official:

JOYCE E. MORROW
Administrative Assistant to the
Secretary of the Army

History. This publication is a rapid action revision. The portions affected by this rapid action revision are listed in the summary of change.

Summary. This regulation prescribes policies for preparing and using medical reports and records in accordance with North Atlantic Treaty Organization Standardization Agreements 2348 ED.3(1) and 2132 ED.2 and American–British–Canadian–Australian Quadripartite Standardization Agreement 470 ED.1.

Applicability. This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve unless otherwise stated. Also it applies to other members of the uniformed services of Allied nations who receive medical treatment or evaluation in an Army military treatment facility. During mobilization, the proponent may modify chapters and policies contained in this regulation.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated. (See appendix C.)

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from The Surgeon General (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 Office of The Surgeon General (DASG–HS–AP), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army, the Army National Guard/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*
Background • 1–5, *page 2*
Record ownership • 1–6, *page 3*
International standardization agreements • 1–7, *page 3*

*This regulation supersedes AR 40–66, dated 21 June 2006.

UNCLASSIFIED

Contents—Continued

Chapter 2
Confidentiality of PHI, *page 3*
General • 2–1, *page 3*
Policies governing protected health information • 2–2, *page 4*
Release of information when the patient consents to disclosure • 2–3, *page 5*
Disclosure without consent of the patient • 2–4, *page 6*
Processing requests for protected health information, restrictions, and revocations • 2–5, *page 7*
Medical records of teenage family members • 2–6, *page 9*
Disclosure of medical records containing classified defense information • 2–7, *page 10*
Research using military medical records • 2–8, *page 10*

Chapter 3
Preparation of Medical Records, *page 11*

Section I
Forms and Documents, page 11
Authorized forms and documents • 3–1, *page 11*
Filing electronic/computerized forms • 3–2, *page 11*
Guidelines for local forms and overprints • 3–3, *page 12*

Section II
Medical Record Entries, page 13
General • 3–4, *page 13*
Patient identification • 3–5, *page 14*
Facility identification • 3–6, *page 15*
Destruction of unidentifiable medical documents • 3–7, *page 15*

Section III
Recording Diagnoses and Procedures, page 15
Nomenclature used in recording diagnoses • 3–8, *page 15*
Special instructions for certain diseases • 3–9, *page 16*
Special instructions for certain diagnoses • 3–10, *page 16*
Recording psychiatric conditions • 3–11, *page 16*
Recording injuries • 3–12, *page 16*
Recording deaths • 3–13, *page 17*
Recording cases observed without treatment, undiagnosed cases, and causes of separation • 3–14, *page 18*
Recording surgical, diagnostic, and therapeutic procedures • 3–15, *page 18*
Recording therapeutic abortions • 3–16, *page 18*
Recording use of restraints/seclusion • 3–17, *page 18*
Recording videotaped documentation of episodes of medical care • 3–18, *page 18*

Section IV
Records for Carded–for–Record–Only Cases and Absent–Sick Status, page 19
Carded–for–record–only cases • 3–19, *page 19*
Absent–sick status • 3–20, *page 19*

Section V
Detainee Records, page 20
Documentation of detainee care • 3–21, *page 20*
Maintenance and transfer of records • 3–22, *page 21*
Release of information • 3–23, *page 21*

Chapter 4
Filing and Requesting Medical Records, *page 21*
Filing by Social Security number and family member prefix • 4–1, *page 21*
Terminal digit filing system • 4–2, *page 21*

Contents—Continued

Use of DA Form 3443–series, DA Form 3444–series, and DA Form 8005–series folders • 4–3, *page 22*
Preparation of DA Form 3444–series and DA Form 8005–series folders • 4–4, *page 22*
Preparation of DA Form 3443–series folders • 4–5, *page 24*
Record chargeout system • 4–6, *page 25*
Record requests • 4–7, *page 25*

Chapter 5
Service Treatment Records, *page 28*

Section I
General, page 28
Purpose of the service treatment record • 5–1, *page 28*
Use of the service treatment record • 5–2, *page 28*
For whom prepared and maintained • 5–3, *page 29*
Forms and documents of service treatment records • 5–4, *page 29*
DA Form 5007A and DA Form 5007B • 5–5, *page 29*
DA Form 5008 • 5–6, *page 30*
DA Form 5181 • 5–7, *page 30*
DA Form 5569 • 5–8, *page 30*
DA Form 5570 • 5–9, *page 30*
DD Form 2882 • 5–10, *page 30*
DD Form 1380 • 5–11, *page 30*
DD Form 2482 • 5–12, *page 30*
DD Form 2766 and DD Form 2766C • 5–13, *page 30*
DD Form 2813 • 5–14, *page 31*
SF 512 • 5–15, *page 31*
SF 558 • 5–16, *page 31*
SF 559 • 5–17, *page 31*
SF 600 • 5–18, *page 32*
Immunization documentation (DD Form 2766, SF 601, and HHS Form PHS 731) • 5–19, *page 33*
SF 603 and SF 603A • 5–20, *page 34*
Other forms filed in the service treatment record • 5–21, *page 36*
Mental service treatment records • 5–22, *page 37*
Access to service treatment records • 5–23, *page 38*
Cross–servicing of service treatment records • 5–24, *page 38*

Section II
Initiating, Keeping, and Disposing of Service Treatment Records, page 38
Initiating service treatment records • 5–25, *page 38*
Transferring service treatment records • 5–26, *page 39*
Establishing “temporary” and “new” service treatment records • 5–27, *page 40*
Filing service treatment records • 5–28, *page 41*
Disposing of service treatment records • 5–29, *page 42*

Section III
Special Considerations for Personnel Reliability Program Service Treatment Records and Civilian Employee Medical Records, page 42
Screening Personnel Reliability Program records • 5–30, *page 42*
Maintaining Personnel Reliability Program records • 5–31, *page 43*

Section IV
Maintenance of Service Treatment Records and Civilian Employee Medical Records Upon Mobilization, page 43
Paper service treatment records of deployed military members and deployed civilians • 5–32, *page 43*
Preparation of service treatment record forms • 5–33, *page 44*
Use of field files/DD Form 2766 • 5–34, *page 44*

Contents—Continued

Health assessments after deployment • 5–35, *page 44*
Operation after hostilities cease • 5–36, *page 44*

Chapter 6
Outpatient Treatment Records, *page 62*

Section I
General, page 62
For whom prepared • 6–1, *page 62*
Outpatient treatment record forms and documents: Guidelines for paper record preparation and use • 6–2, *page 62*

Section II
Initiating, Keeping, and Disposing of Outpatient Treatment Records, page 63
Initiating and keeping outpatient treatment records • 6–3, *page 63*
Transferring outpatient treatment records • 6–4, *page 63*
Requests other than DD Form 2138 • 6–5, *page 64*
Disposition • 6–6, *page 64*

Section III
Preparation and Use of Outpatient Treatment Records, page 64
Preparation • 6–7, *page 64*
Use • 6–8, *page 65*

Chapter 7
Occupational Health Program Civilian Employee Medical Record, *page 78*

Section I
General, page 78
Compliance • 7–1, *page 78*
Definition and purpose of the civilian employee medical record • 7–2, *page 78*
For whom prepared • 7–3, *page 78*
Civilian employee medical records folder and forms • 7–4, *page 78*

Section II
Maintaining, Transferring, and Disposing of Civilian Employee Medical Records and Retention of Job–Related X–Ray Films, page 79
Custody and maintenance of civilian employee medical records • 7–5, *page 79*
Medical record entries • 7–6, *page 79*
Recording occupational injuries and illnesses • 7–7, *page 79*
Cross–coding of medical records • 7–8, *page 79*
Transferring and retiring civilian employee medical records • 7–9, *page 80*
Retention of job–related x–ray films • 7–10, *page 80*

Section III
Confidentiality of PHI, Access to Civilian Employee Medical Records, and Performance Improvement, page 80
Protection of confidentiality and disclosure procedures • 7–11, *page 80*
Civilian employee medical record review • 7–12, *page 80*

Chapter 8
Army Substance Abuse Program Outpatient Medical Record, *page 85*

Section I
General, page 85
For whom prepared • 8–1, *page 85*
Access • 8–2, *page 85*
Disclosure of information • 8–3, *page 85*

Contents—Continued

Forms and documents • 8–4, *page 86*

Section II
Initiating, Maintaining, and Disposing of Army Substance Abuse Program Outpatient Medical Records, page 86
Initiating and maintaining • 8–5, *page 86*
Transferring • 8–6, *page 86*
Requests other than DD Form 2138 • 8–7, *page 86*
Disposition • 8–8, *page 86*

Section III
Preparation and Use of Army Substance Abuse Program Outpatient Medical Records, page 86
Preparation • 8–9, *page 86*
Use • 8–10, *page 87*

Chapter 9
Inpatient Treatment Records, *page 89*

Section I
General, page 89
For whom prepared • 9–1, *page 89*
Inpatient forms and documents • 9–2, *page 90*
Fetal monitoring strips • 9–3, *page 90*

Section II
Initiating, Keeping, and Disposing of Inpatient Treatment Records, page 91
General • 9–4, *page 91*
Records for Ambulatory Procedure Visit patients • 9–5, *page 91*
NATO STANAG 2348 ED.3(1) requirements • 9–6, *page 91*
Inpatient treatment records of AWOL patients • 9–7, *page 91*
Five–year inpatient treatment record maintenance • 9–8, *page 91*
Access and audit trail • 9–9, *page 91*
Disposition of inpatient treatment records • 9–10, *page 92*

Section III
Preparation and Use of Inpatient Treatment Records, page 92
Inpatient treatment records content • 9–11, *page 92*
Medical reports • 9–12, *page 93*
Nursing process documentation • 9–13, *page 95*
Countersignatures • 9–14, *page 97*

Section IV
DA Form 3647, page 98
General purpose • 9–15, *page 98*
Use • 9–16, *page 98*
Initiation and disposition • 9–17, *page 98*
Preparation • 9–18, *page 98*
Corrections and corrected copies • 9–19, *page 98*

Section V
Preparation and Use of Other Inpatient Treatment Record Forms, page 99
DD Form 2569 • 9–20, *page 99*
DD Form 2770 • 9–21, *page 99*
DA Form 4359 • 9–22, *page 99*
DD Form 792 • 9–23, *page 99*
DA Form 3950 • 9–24, *page 99*
Laboratory test requisition and reporting forms • 9–25, *page 99*

Contents—Continued

DA Form 4256 • 9–26, *page 100*
DA Form 4677 • 9–27, *page 101*
DA Form 4678 • 9–28, *page 102*
DA Form 4107 • 9–29, *page 103*
DA Form 7001 • 9–30, *page 104*
DD Form 1924 • 9–31, *page 105*
DA Form 4108 • 9–32, *page 105*
DA Form 5179 • 9–33, *page 106*
DA Form 5179–1 • 9–34, *page 106*
SF 511 • 9–35, *page 107*
SF 519–B • 9–36, *page 107*
DA Form 5009 • 9–37, *page 108*

Chapter 10
Extended Ambulatory Records, *page 119*

Section I
General, page 119
Purpose of the extended ambulatory record • 10–1, *page 119*
For whom prepared • 10–2, *page 119*
Extended ambulatory record forms and documents • 10–3, *page 119*

Section II
Initiating, Keeping, and Disposing of Extended Ambulatory Records, page 119
Initiating extended ambulatory records • 10–4, *page 119*
Five–year/one–year extended ambulatory record maintenance • 10–5, *page 119*
Disposition of extended ambulatory records • 10–6, *page 120*

Section III
Preparation and Use of Extended Ambulatory Records, page 120
Preparation of extended ambulatory records • 10–7, *page 120*
Use of extended ambulatory records • 10–8, *page 120*

Chapter 11
DD Form 1380, *page 124*
Use • 11–1, *page 124*
Preparation • 11–2, *page 124*
Supplemental DD Form 1380 • 11–3, *page 125*
Disposition • 11–4, *page 125*
DA Form 4006 • 11–5, *page 125*

Chapter 12
Role of the Medical Department Activity or U.S. Army Medical Center Patient Administration Division in the Improving Organizational Performance Process, *page 127*
General • 12–1, *page 127*
Internal performance improvement process for medical record services • 12–2, *page 127*
Patient care assessment • 12–3, *page 127*
Patient Administration Division role in handling medical records in the Risk Management Program • 12–4, *page 128*

Chapter 13
DD Form 689, *page 129*
Purpose and use • 13–1, *page 129*
Issuing authority • 13–2, *page 129*
Procedures • 13–3, *page 129*
Service treatment record entry • 13–4, *page 131*

Contents—Continued

Disposition of DD Forms 689 • 13–5, *page 131*

Chapter 14
Medical Warning Tag and DA Label 162, *page 131*
Description and use • 14–1, *page 131*
Applicability • 14–2, *page 131*
Responsibilities • 14–3, *page 131*
Criteria for issue of Medical Warning Tags and DA Labels 162 • 14–4, *page 132*
Procedures • 14–5, *page 133*
Supply of tag blanks and forms • 14–6, *page 134*

Appendixes

A. References, *page 135*

B. Authorized Medical Records Abbreviations and Symbols, *page 152*

C. Management Control Evaluation Checklist, *page 182*

Table List

Table 3–1: AR 25–400–2, Army Records Information Management System (ARIMS) File numbers, record keeping requirements, *page 19*
Table 4–1: Assignment of family member prefix, *page 26*
Table 4–2: Key to color folder assignment by terminal digits, *page 27*
Table 4–3: Key for tape denoting patient status, *page 27*
Table 4–4: Last four digits–sponsor's Social Security number, *page 27*
Table 4–5: Retirement of radiology images and reports, DA Form 3443–series, *page 28*
Table 9–1: NATO national military medical authorities, *page 108*
Table 9–2: General instructions for preparing laboratory forms, *page 110*
Table 9–3: Specific instructions for preparing laboratory forms, *page 111*
Table 11–1: Instructions for preparing DD Form 1380, *page 126*

Figure List

Figure 2–1: Sample confidentiality notice accompanying facsimile transmissions, *page 7*
Figure 2–2: Defense Privacy Board Advisory Opinion—the Privacy Act and Minors, 23 September 1998, *page 10*
Figure 5–1: Forms and documents of the STR (treatment) using DA Form 3444–series jackets, *page 46*
Figure 5–1: Forms and documents of the STR (treatment) using DA Form 3444–series jackets—Continued, *page 47*
Figure 5–1: Forms and documents of the STR (treatment) using DA Form 3444–series jackets—Continued, *page 48*
Figure 5–1: Forms and documents of the STR (treatment) using DA Form 3444–series jackets—Continued, *page 49*
Figure 5–1: Forms and documents of the STR (treatment) using DA Form 3444–series jackets—Continued, *page 50*
Figure 5–1: Forms and documents of the STR (treatment) using DA Form 3444–series jackets—Continued, *page 51*
Figure 5–2: Forms and documents of the STR using DA Form 8005–series jackets, *page 52*
Figure 5–2: Forms and documents of the STR using DA Form 8005–series jackets—Continued, *page 53*
Figure 5–2: Forms and documents of the STR using DA Form 8005–series jackets—Continued, *page 54*
Figure 5–2: Forms and documents of the STR using DA Form 8005–series jackets—Continued, *page 55*
Figure 5–2: Forms and documents of the STR using DA Form 8005–series jackets—Continued, *page 56*
Figure 5–2: Forms and documents of the STR using DA Form 8005–series jackets—Continued, *page 57*
Figure 5–2: Forms and documents of the STR using DA Form 8005–series jackets—Continued, *page 58*
Figure 5–3: Forms and documents of the STR dental record, *page 59*
Figure 5–3: Forms and documents of the STR dental record—Continued, *page 60*
Figure 5–4: Sample entries on SF 600, *page 61*
Figure 6–1: Forms and documents of the OTR using DA Form 3444–series jackets, *page 66*
Figure 6–1: Forms and documents of the OTR using DA Form 3444–series jackets—Continued, *page 67*
Figure 6–1: Forms and documents of the OTR using DA Form 3444–series jackets—Continued, *page 68*
Figure 6–1: Forms and documents of the OTR using DA Form 3444–series jackets—Continued, *page 69*
Figure 6–1: Forms and documents of the OTR using DA Form 3444–series jackets—Continued, *page 70*

Contents—Continued

Figure 6–2: Forms and documents of the OTR using DA Form 8005–series jackets, *page 71*
Figure 6–2: Forms and documents of the OTR using DA Form 8005–series jackets—Continued, *page 72*
Figure 6–2: Forms and documents of the OTR using DA Form 8005–series jackets—Continued, *page 73*
Figure 6–2: Forms and documents of the OTR using DA Form 8005–series jackets—Continued, *page 74*
Figure 6–2: Forms and documents of the OTR using DA Form 8005–series jackets—Continued, *page 75*
Figure 6–2: Forms and documents of the OTR using DA Form 8005–series jackets—Continued, *page 76*
Figure 6–3: Forms and documents of the nonmilitary dental record, *page 77*
Figure 6–3: Forms and documents of the nonmilitary dental record—Continued, *page 78*
Figure 7–1: Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders, *page 81*
Figure 7–1: Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders—Continued, *page 82*
Figure 7–1: Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders—Continued, *page 83*
Figure 7–1: Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders—Continued, *page 84*
Figure 7–1: Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders—Continued, *page 85*
Figure 8–1: Forms and documents of the ASAP–OMR, *page 88*
Figure 8–1: Forms and documents of the ASAP–OMR—Continued, *page 89*
Figure 9–1: Forms and documents of the ITR, *page 113*
Figure 9–1: Forms and documents of the ITR—Continued, *page 114*
Figure 9–1: Forms and documents of the ITR—Continued, *page 115*
Figure 9–1: Forms and documents of the ITR—Continued, *page 116*
Figure 9–1: Forms and documents of the ITR—Continued, *page 117*
Figure 9–1: Forms and documents of the ITR—Continued, *page 118*
Figure 9–2: Examples for calculations of episodes of OR nursing and episodes of anesthesia, *page 118*
Figure 10–1: Forms and documents of the EAR, *page 121*
Figure 10–1: Forms and documents of the EAR—Continued, *page 122*
Figure 10–1: Forms and documents of the EAR—Continued, *page 123*
Figure 13–1: Sample of a completed DD Form 689, *page 130*
Figure 14–1: DA Label 162 (Emergency Medical Identification Symbol), shown actual size, *page 131*
Figure 14–2: Sample letter to be presented to patients upon issuance of Medical Warning Tag, *page 132*
Figure 14–3: Example of completed "Tag Content" section, DA Form 3365 (Authorization for Medical Warning Tag), *page 133*
Figure B–1: Medical Symbols, *page 181*

Glossary

Chapter 1
Introduction

1–1. Purpose

This regulation sets policies and procedures for the preparation, disposition, and use of Army electronic and paper medical records and other healthcare documentation.

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 of this regulation are met. When electronic systems are utilized, users must resolve any inconsistencies concerning local abbreviations and capitalization.

1–4. Responsibilities

a. Military 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 Armed Forces Repository of Specimen Samples for the Identification of Remains for all military members and deploying civilians.

(6) Ensure compliance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) (Public Law (PL) 104–191), DOD 6025.18–R, and with the process of investigations of privacy violations.

b. Unit commanders. If a commander acquires STRs or documents belonging in STRs, the commander will ensure that the documents are properly secured and sent to the proper STR custodian without delay. As an exception to *e*(1), below, if no Army medical department (AMEDD) or MTF personnel are available to act as the custodian of unit STRs, a unit commander may act as the custodian of his or her unit's STRs, or, as an alternative, appoint a competent person of the unit as the custodian. Unit commanders will also ensure that information in STRs is kept private and confidential in accordance with law and regulation. Examples of situations in which unit STRs may be maintained centrally at a unit in the custody of the unit commander or competent designee include those units located away from an 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. STRs 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 STR maintenance in isolated units will be referred to the Army Regional Medical Command with administrative responsibility for that geographic area. OTRs for family members accompanying those active duty military members assigned to isolated units will not be maintained at the unit. In accordance with 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 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) STRs.

(2) The Commander, HRC–Stl will initiate, maintain, and dispose of STRs for Individual Ready Reserve (IRR) members.

(3) The Commanding General, Army Human Resources Command (AR–AHRC), will initiate and dispose of STRs for Individual Ready Reserve (IRR) members.

(4) The commander or assigned agency head will maintain and dispose of STRs for Individual Mobilized Augmentees (IMAs).

d. Military personnel officers. Military personnel officers will—

(1) Initiate STRs and send them to the proper STR custodian.

(2) Ensure that the copies of all paper-based records are sent to the next duty station for Servicemembers, Family members, or other beneficiaries who are changing stations.

(3) Tell the STR custodian of impending unit or personnel movements 1 month prior to movement or as soon as possible.

(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 STRs (para 2–7). When military personnel officers acquire STRs or documents belonging in STRs, they will ensure that the records are maintained confidentially (chap 2) and sent to the proper STR custodian without delay.

e. AMEDD officers. AMEDD officers will—

(1) Serve as custodians of STRs, except in those instances where exception is granted as outlined in *b* and *c*, above, and in paragraph 5–26*b*(1). AMEDD officers are in charge of the STRs for members of the units to which they supply primary medical and dental care. They are also in charge of the STRs of other individuals they are currently treating.

(2) Use STRs for diagnoses and treatment. STRs are important for the conservation and improvement of patient health. Therefore, AMEDD medical and administrative staff will ensure that all pertinent paper-based medical documentation is promptly entered into the paper STR in their custody or electronically entered into AHLTA. If any such pertinent information has been omitted, AMEDD personnel will take immediate action to obtain such information from the proper authority and include it in the STR.

(3) Send a copy of non-AHLTA generated records to the military member's STR custodian when an AMEDD provider examines or treats a person whose STR is not in his/her custody. Original outpatient documentation stays at the MTF where it was created. These non-AHLTA generated 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 and grade)." Name, grade, and sponsor's Social Security number (SSN) will be plainly marked on the internal (not external) sealed envelope. The member's unit of assignment will also be shown on both internal and external envelopes. If the STR custodian is not known, the document will be sent to the medical department activity (MEDDAC), U.S. Army Medical Center (MEDCEN), or dental activity (DENTAC) commander of the member's assigned installation.

(4) At least annually, conduct risk assessments. Consistently, throughout the year, monitor internal policies to ensure compliance with the HIPAA Privacy Rule provisions outlined in DOD 6025.18–R.

f. MTF chief, patient administration division. The MTF chief, patient administration division will—

(1) 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 healthcare documentation.

(2) Record documents prepared and received from other MTFs, DTFs, or civilian agencies and identify them for filing in AHLTA or the paper-based medical record, as appropriate.

g. Medical and dental officers and other AMEDD providers. Medical and dental providers will ensure that—

(1) AHLTA is used as the primary mode of outpatient medical record documentation.

(2) Information is promptly and accurately recorded on medical and dental forms, either electronically in AHLTA or manually on paper.

(3) All patient observations, treatment, and care are promptly and correctly recorded.

h. 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.

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

j. 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. Background

a. 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).

b. The following types of healthcare records will be used to document medical and dental care:

(1) *Inpatient.* All care provided to beneficiaries as hospital inpatients will be recorded in an inpatient treatment record (ITR).

(2) *Outpatient.* Outpatient care on a military member will be primarily (and to the fullest extent possible) recorded

in the member's longitudinal electronic medical record (that is, AHLTA) with the STR (military member paper record) or outpatient treatment record (OTR) (nonmilitary paper record) being used on a limited basis.

(3) *Dental.* Dental care on a military member will be primarily (and to the fullest extent possible) recorded in the AHLTA dental module once it is fully deployed. Historically, separate medical and dental outpatient records were maintained. With the deployment of the AHLTA dental module, the medical record and dental record (which together are considered an STR) will no longer be separate.

(4) *Army Substance Abuse Program (ASAP).* Both military and nonmilitary personnel enrolled in the ASAP will have an ASAP outpatient medical record (ASAP–OMR). ASAP records of family members and civilians must not be entered into AHLTA without a formal waiver signed by the patient. If this waiver is not present, a separate paper OTR must be maintained for these individuals at the ASAP facility. Refer to paragraph 6-7h of this regulation for additional guidance as to the appropriate content of behavioral health notes in AHLTA.

(5) *Occupation health care.* Occupational health care will be recorded in AHLTA, and the local MTF will not create a separate and duplicate occupational health record in the legacy CHCS. As necessary, MTFs may maintain separate paper-based occupational health records containing printed AHLTA encounters pertaining to occupational health.

c. The ability to retrieve the documentation of care provided to patients is paramount. Documentation generated in AHLTA or stored in AHLTA as a scanned image requires maintenance in a paper format. When a record is ready for retirement, it will be sent to the National Personnel Records Center (NPRC). For paper-based medical documentation that has not been scanned into AHLTA, the original paper documentation will be maintained at the MTF where it was created or received. A copy of manually-generated documents will be maintained in STRs and in OTRs. A copy of these paper-based documents must be available for a new MTF or a civilian healthcare organization if medically required or requested by the patient. As the transition to a fully electronic STR progresses, it is imperative to realize that specific paper forms that are currently used may or may not appear in exactly the same format in the electronic medical record. Throughout this document, all referrals to a specific paper form will also infer an electronic equivalent, which will contain the same relevant information, but may not appear exactly the same as the paper form. These electronic forms and their printed version will have the same official status as any of their paper equivalents. Any exceptions to this will be specifically addressed in the relevant section.

1–6. 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 DODI 6040.43, 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 MTFs at all times. RC records will remain in the custody of the appointed STR custodian. The AHLTA medical record will remain in the custody of the AMEDD and DOD via electronic storage, and a hard copy of the ITR and OTR will be retired to the NPRC in accordance with the records disposition schedule in AR 25-400-2. A copy of the STR (including dental record) will be retired to the Veterans Affairs Records Center. This medical record is the Government's record of the medical care that it has rendered and must be protected. The patient will not transport the STR, OTR, or CEMR. 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. Limit access to all open record storage areas and to electronic records to authorized personnel only. Only authorized personnel will have access to all open record storage areas and to electronic records. (The National Archives and Records Administration sets the standards for records facilities and their fire protection (36CFR1228K at http://archives.gov/about/regulations/part-1228/k.html).

1–7. International standardization agreements

Some provisions of this regulation are covered by North Atlantic Treaty Organization (NATO) Standardization Agreements (STANAGs) 2348 ED.3(1) and 2132 ED.2 and American–British–Canadian–Australian (ABCA) Quadripartite Standardization Agreement (QSTAG) 470 ED.1. 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 PHI

2–1. General

This chapter explains DA policies and procedures governing the release of PHI pertaining to individual patients. The policies expressed in this chapter will be used in coordination with those expressed in AR 25–55, AR 340–21, and DOD 6025.18–R. Note that no information pertaining to the identity, treatment, prognosis, diagnosis, or participation in

the ASAP will be released, except in accordance with AR 600–85, chapter 6, and chapter 8 of this regulation. Refer to AR 40–68, paragraph 2–5, for information pertaining to the confidentiality of medical quality assurance records.

2–2. Policies governing protected health information

DA policy mandates that the confidentiality of PHI of both living and deceased individuals will be ensured to the fullest extent possible. PHI will be disclosed only if authorized by law and regulation.

a. Within DA, PHI may be used for treatment, payment, healthcare operations, and preventive care of patients. PHI may also be used within DA to monitor the delivery of healthcare services, to conduct medical research, to provide medical education, to facilitate hospital accreditation, and to satisfy other official purposes.

b. Each Army MTF/DTF will give patients a copy of the Notice of Privacy Practices (NOPP) unless a patient-signed copy has previously been stored in AHLTA by any MTF/DTF. DOD 6025.18–R defines the period after which an NOPP must be re-executed. If the NOPP contents/form is updated, the MTF/DTF will then store the updated and executed document in AHLTA (and the paper record where AHLTA is unavailable). The NOPP explains to beneficiaries how their PHI may be used as well as their patient rights concerning PHI. Beneficiaries will sign the NOPP acknowledgment (see para 4–4) showing that they received this notice. Note: A military prison inmate does not complete the NOPP acknowledgment.

c. Unless authorized by law or regulation, no person or organization will be granted access to PHI.

d. Any person who, without proper authorization, discloses PHI may be subject to adverse administrative action or disciplinary proceedings. Under HIPAA, penalties for misuse or misappropriation of PHI include both civil monetary penalties and criminal penalties. Civil penalties range from $100 for each violation to a maximum of $25,000 per year for the same violations. Criminal penalties vary from $50,000 and/or 1–year imprisonment to $250,000 and/or 10–years imprisonment (Sections 1320d–5 and 1320d–6, Title 42, United States Code). Report all possible violations of this regulation to the Privacy Officer and/or the commander, who will consult with the servicing legal office to determine a proper disposition for the reported violation.

e. PHI is 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 PHI are trained in their obligation to maintain the confidentiality and privacy of PHI. Required training includes web–based program modules covering health information privacy laws and procedures for using or disclosing PHI.

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

g. All business associate arrangements in the form of contracts or other more informal memoranda involving PHI will establish satisfactory assurances to—

(1) Ensure that the information is used only for intended purposes.

(2) Safeguard the information from misuse.

h. The policy and the procedures contained herein do not apply specifically when members of the workforce exercise their right to—

(1) File a complaint with the Department of Health and Human Services (HHS).

(2) Testify, assist, or participate in an investigation, compliance review, proceeding, or hearing under the Social Security Act.

(3) Oppose any act made unlawful by the privacy laws, provided the individual or person has a good faith belief that the act opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of PHI in violation of the privacy laws.

(4) Disclose PHI as a whistleblower and the disclosure is to a health oversight agency, public health authority, or an attorney retained by the individual for purposes of determining the individual's legal options with regard to the whistleblower activity.

(5) Disclose PHI to a law enforcement official if the employee is a victim of a crime and provided that the PHI is about a suspected perpetrator of the criminal act and is only limited to identification information. In response to law enforcement requests for limited information for identification and location purposes, the MTF may disclose only items listed in (a) through (h) below. (Note: PHI for the purpose of identification or location does not include DNA or DNA analysis, dental records or typing, samples or analysis of body fluids or tissue (see DOD 6025.18–R, para C.7.6.2.2).)

(a) Name and address.

(b) Date and place of birth.

(c) Social Security number.

(d) ABO blood type and Rh factor.

(e) Type of injury.

(f) Date and time of treatment.

(g) Date and time of death, if applicable.

(h) A description of distinguishing physical characteristics, including height, weight, gender, race, and eye color; presence or absence of facial hair (beard or mustache); scars; and tattoos.

(i) All sanctioning of employees, business associates, and limited data set recipients will be documented and retained for at least six years from the date of its creation.

(j) Individuals may file a complaint when they believe that PHI relating to them has been used or disclosed improperly; that an employee has improperly handled the information; that they have wrongfully been denied access to or opportunity to amend the information; or that the entity's notice does not accurately reflect its information practices. All such complaints must be in writing.

(k) The Freedom of Information Act/Privacy Official is the primary point of contact for individuals to file complaints pursuant to this policy.

(l) As stated in the NOPP, individuals may also complain to the HHS if they believe their privacy rights have been violated. If an individual chooses to file a complaint with HHS, the complaint must—

1. Be filed in writing, either on paper or electronically;

2. Name the entity that is the subject of the complaint and describe the actions that have allegedly been violations of the privacy standards; and

3. Be filed within 180 days of when the complainant knew or should have known that the violation occurred.

(m) All workforce members are prohibited from retaliating against individuals filing a complaint or requiring individuals to waive their rights to file a complaint with the HHS as a condition of the provision of treatment, payment, enrollment, or eligibility for benefits.

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 a copy of the 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 DD Form 2870 (Authorization for Disclosure of Medical or Dental Information); if the form is not available to the patient, he or she may submit a letter detailing the request for information or documents. This form is available at the Department of Defense Forms Management Program Web site (www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm). 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 use of medical information. Accordingly, that part of DD Form 2870 need not be completed by a patient who is requesting information or documents from his or her own record.

(2) If a physician or dentist determines that a patient's access to his or her own health record could adversely affect the patient's physical, mental, or emotional health, the patient will be asked to designate a physician or dentist to receive the record. 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. However, the failure or refusal of a patient to designate a physician to receive information from his or her health record does not relieve the Army of the obligation to eventually provide the requested information to the patient. In this circumstance, competent medical authority will institute and adhere to appropriate procedures to ensure that the actual or perceived harm to the patient by disclosure of the health record is minimized. All such medical records will be identified with a conspicuous strip of tape on the health record jacket (see para 4–4*a*(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) PHI obtained from nonmilitary sources will be filed with the patient's paper medical record and may be scanned into AHLTA. Once scanned in a readable fashion, it is necessary to maintain a paper copy of both inpatient and outpatient records for retirement to the NPRC. The MTF will release a copy of the information to the individual if requested to do so but will caution the patient that the copy is not certified as a correct and true copy. The patient or other requester will be told that the original PHI is the property of the nonmilitary facility and may be requested from the originating facility. This does not apply to PHI on patients treated under supplemental 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) PHI 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, DD Form 2870 will be completed by a patient to document the patient's consent to disclose PHI; if the form is not available to the patient, a letter may be used. The original DD Form 2870 or patient letter must be submitted by the third party with that party's request for a patient's PHI. In all cases, the DD Form 2870 or letter 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. A minor child is any person who has not attained the age of 18 years and who is not emancipated as determined by the

law of the State in which the MTF is located. (See the definition of a "patient with decision making capacity" in AR 40–3, glossary.)

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 one year from the date on which the form was signed by the patient. Consent forms older than one year are not valid.

(d) State the specific PHI 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 PHI. PHI 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 PHI to be used upon disclosure to a third party.

(2) Consult with the local judge advocate to determine the validity of the information provided on a DD Form 2870.

(3) DA Form 4876 (Request and Release of Medical Information to Communications Media) will be used for release of PHI to communications media. This form is available on the AEL CD–ROM and at the APD Web site (www.apd.army.mil). (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) PHI may be disclosed to officers and employees of the DOD who have an official need for access in the performance of their duties; patient consent is not required.

(2) The MTF/DTF may, subject to specific terms and conditions addressed in DOD 6025.18–R, chapter 7, use or disclose PHI in the following situations without the individual's authorization or opportunity to object:

(a) When required by law or Government regulation.

(b) For public health purposes.

(c) About victims of abuse or neglect.

(d) For health oversight activities authorized by law.

(e) For judicial or administrative proceedings.

(f) For law enforcement purposes.

(g) Concerning decedents in limited circumstances.

(h) For cadaveric organ, eye, or tissue donation purposes.

(i) For research involving minimal risk.

(j) To avert a serious threat to health or safety.

(k) For specialized Government functions, including certain activities relating to Armed Forces personnel. Part 164, Title 45, Code of Federal Regulations (45 CFR 164) and DOD 6025.18–R allow a covered entity (including a covered entity not part of or affiliated with the DOD) to use and disclose the PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. The purposes for which any and all of the PHI of an individual who is a member of the Armed Forces may be used or disclosed are the following:

1. To determine the member's fitness for duty, including but not limited to the member's compliance with standards and all other activities carried out under the authority of AR 40–501, AR 50–5, AR 635–40, and similar requirements.

2. To determine the member's fitness to perform any particular mission, assignment, order, or duty, including compliance with any actions required as a precondition to performance of such mission, assignment, order, or duty.

3. To carry out activities under the authority of DOD Directive (DODD) 6490.2.

4. To report on casualties in any military operation or activity according to applicable military regulations or procedures.

5. To carry out any other activity necessary to the proper execution of the mission of the Armed Forces.

(l) For workers' compensation programs. PHI may be disclosed to comply with workers' compensation or other similar programs established by law that provide benefits for work–related injuries or illness without regard to fault.

(3) DOD personnel will submit requests for PHI on DA From 4254 (Request for Private Medical Information) (available on the AEL CD–ROM and at the Army Publishing Directorate Wed site (www.apd.army.mil)). Ordinarily, direct access to medical records will not be permitted. Only the minimum necessary PHI will be provided to satisfy the intended purpose. When requesting disclosure of a patient's PHI, DA personnel will present their official credentials and document their official need to know the requested information.

(4) The receiving MTF will file all DA Forms 4254 received according to AR 25–400–2.

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

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

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

(3) A completed DSS 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 DSS agent desires to interview a physician for evaluation or opinion of the individual's case.

c. Other requests. All other requests for disclosure of PHI will be analyzed and processed according to AR 25–55 and AR 340–21.

2–5. Processing requests for protected health information, restrictions, and revocations

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 PHI. In the absence of the patient administrator, the acting patient administrator will assume this responsibility.

b. All requests for patient PHI must be submitted in writing using DD Form 2870; if the form is unavailable to the patient, a letter may be submitted instead. Requests will be acted on within 30 days. 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 according to law and regulation, at the first available opportunity.

c. Authorization for the release of PHI will normally be documented in writing. However, in certain emergency situations, the MTF commander or patient administrator may verbally authorize the release of PHI, 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 PHI 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 PHI 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 PHI. 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 PHI.

CONFIDENTIALITY NOTICE

The documents accompanying this facsimile 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

---

f. Only that specific PHI required to satisfy the terms of a request will be authorized for disclosure. If the request is for psychotherapy notes, the patient administrator or his/her representative will obtain an authorization for use or disclosure except—

(1) To carry out the following treatment, payment, or healthcare operations:

(a) Use by the originator of the psychotherapy notes for treatment.

(b) Use or disclosure by the covered entity for its own training programs that students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

(c) Use or disclosure by the covered entity to defend itself (or to defend the United States in a claim or action brought under the Federal Tort Claims Act or Military Claims Act, in a legal action, or other proceeding brought by the individual).

(2) A use or disclosure that is—

(a) Required by the Secretary of HHS in relation to compliance activities of the Secretary of HHS.

(b) Required by law.

(c) Pertaining to uses and disclosures for health oversight activities, with respect to the oversight of the originator of the psychotherapy notes.

(d) Pertaining to uses and disclosures about decedents to coroners and medical examiners.

(e) Pertaining to uses and disclosures to avert a serious and imminent threat to health or safety of a person or the public, which may include a serious and imminent threat to military personnel or members of the public or a serious or imminent threat to a specific military mission or national security under circumstances which in turn create a serious and imminent threat to a person or the public.

g. If a request for certified disclosure of all or part of the request for patient PHI is approved, certified copies of that information or record will be released. (See AR 27–40 and paragraph 12–4*b*(3) of this regulation for the use of DA Form 4 (Department of the Army Certification for Authentication of Records) to certify records.) 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 disclosure of PHI, a copy of any consent form, together with copies of the disclosure authorization and a notation of which records have been disclosed, will be filed in the patient's outpatient or electronic medical record. If these copies cannot be made, the request will be annotated to reflect the specific information disclosed. When requests are made for information from both inpatient and outpatient records at the same time, the request and an annotation of which copies were disclosed will be filed in the inpatient record. The outpatient/AHLTA record will be properly cross–referenced.

i. A patient has the right to request restrictions on the uses and disclosures of their medical record.

(1) The MTF/DTF is not required to agree to the restriction. The restriction should be denied if the MTF/DTF cannot reasonably accommodate the restriction, if it conflicts with this regulation or any other applicable DOD or DA directive, or for any other appropriate reason. A response to a request for restriction should be provided to the individual requesting it as soon as practicable and should include the rationale for denying it, if the request is denied in whole or part.

(2) The MTF/DTF commander or designee must act on requests to restrict information in a timely manner and do so in writing. No restriction will be effective above the management authority level that agreed to the restriction. No restriction will be effective unless the person agreeing to the restriction is actually authorized to agree to it and establishes a written record of the restriction.

(3) The needs of the patient should be weighed against the burden that would be put on the facility to comply with the request. If the restriction is granted, the patient should be informed that the restriction is not permanent, that it only applies to the individual or MTF that granted the restriction, and that it does not transfer to another individual or MTF. The patient must be advised that such a restriction in AHLTA may make their outpatient health information inaccessible for medical care by most MTF staff members.

j. An individual may revoke an authorization provided under this section at any time, if the revocation is in writing, except if the MTF/DTF has already taken action on the authorization. The MTF/DTF will document and retain any signed authorization and/or revocation.

k. An individual has a right to receive an accounting of PHI disclosures made by a covered entity in the six years prior to the date that the accounting is requested, except for disclosures—

(1) To carry out treatment, payment, and healthcare operations as provided in DOD 6025.18–R, chapter 4.

(2) To individuals of PHI about themselves.

(3) Pursuant to an authorization under DOD 6025.18–R, chapter 5.

(4) For the facility's directory or to persons involved in the individual's care or other notification purposes as provided in DOD 6025.18–R, chapter 6.

(5) For national security or intelligence purposes as provided in DOD 6025.18–R, paragraph C7.11.4.

(6) To correctional institutions or law enforcement officials as provided in DOD 6025.18–R, paragraph C7.11.6.

(7) As part of a limited data set according to DOD 6025.18–R, section C8.3.

(8) Incident to a use or disclosure otherwise permitted or required by DOD 6025.18–R, section C8.4.

(9) That occurred prior to 14 April 2003.

l. Information for each disclosure will include—

(1) The date of the disclosure.

(2) The name of the entity or person who received the PHI and, if known, the address of such entity or person.

(3) A brief description of the PHI disclosed.

(4) A brief statement that reasonably informs the individual of the basis for the disclosure; or, in lieu of such statement, a copy of a written request for disclosure under DOD 6025.18–R, section C2.5, or chapter 8, if any.

m. The covered entity will provide the first accounting to an individual in any 12–month period without charge. The covered entity may impose a reasonable, cost–based fee according to AR 25–55 for each subsequent request for an accounting by the same individual within the 12–month period, if the covered entity informs the individual in advance of the fee and provides the individual with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

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

o. Continued coordination with a judge advocate is encouraged on all matters pertaining to the request for and disclosure of patient PHI.

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 the medical records of their minor children under the Privacy Act, 5 USC 552*a*(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 (23 September 1998) will be used. (See fig 2–2.)

The Privacy Act applies to any "individual" which is defined as "a citizen of the United States or an alien lawfully admitted for permanent residence" (5 USC section 552a(a)(2)). With respect to any rights granted the individual, no restriction is imposed on the basis of age; therefore, minors have the same rights and protections under the Privacy Act as do adults.

The Privacy Act provides that "the parent of any minor . . . may act on behalf of the individual" (5 USC section 552a(h)). This subsection ensures that minors have a means of exercising their rights under the Privacy Act (Office of Management and Budget Privacy Act Guidelines (OMB Guidelines), 40 Federal Register 28949, 28970 (July 9, 1975)). It does not preclude minors from exercising rights on their own behalf, independent of any parental exercise. Parental exercise of the minor's Privacy Act rights is discretionary. A Department of Defense (DOD) component may permit parental exercise of a minor's Privacy Act rights at its discretion, but the parent has no absolute right to exercise the minor's rights absent a court order or the minor's consent. See OMB Guidelines, 40 Federal Register 56741, 56742 (December 4,1975). Further, the parent exercising a minor's rights under the Privacy Act must be doing so on behalf of the minor and not merely for the parent's benefit (DePlanche v. Califano, 549 F. Supp. 685 (W.D. Mich. 1982)).

The age at which an individual is no longer a minor becomes crucial when an agency must determine whether a parent may exercise the individual's Privacy Act rights. With respect to records maintained by DOD components, the age of majority is 18 years unless a court order states otherwise or the individual, at an earlier age, marries, enlists in the military, or takes some other action that legally signifies attainment of majority status. Once an individual attains the age of majority, Privacy Act rights based solely on parenthood cease.

Figure 2–2. Defense Privacy Board Advisory Opinion—the Privacy Act and Minors, 23 September 1998

b. Medical confidentiality. So that medical confidentiality will not be compromised, medical records of minors that contain information mentioned in *a*(1)*(a)* through *a*(1)*(d)*, above, will be maintained as "Mental Health Records (Minors)." Because PHI in these records may be an important part of continued and follow–up care, SF 600 (Medical Record—Chronological Record of Medical Care) will note "Patient seen, refer to file number 40–216k2" and will be filed in the patient's OTR. Disposition of these records will be in accordance with AR 25–400–2, file number 40–216k2, (mental health records (minors). (See table 3–1 and para 6–7*h* of this regulation.)

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 according to AR 380–5. The custodian of the record will state on SF 600 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, USA HRC–Alexandria, ATTN: AHRC–MSO, Alexandria, VA 22332–0002. Those documents in records of enlisted personnel will be sent to the Commander, AHRC–RP, 8899 56th Street, Indianapolis, IN 46249.

2–8. Research using military medical records

Qualified people may have access to Army medical records—electronic or paper—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/DTF 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 32 CFR 219 and obtain approval from the Institutional Review Board.

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. Patient Administration Systems and Biostatistics Activity, ATTN: MCHS–IN, 1216 Stanley Rd., Ste. 25, Fort Sam Houston, TX 78234–6000. Such requests will—

(1) Provide the names and addresses 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. Health information that does not identify an individual and there is no reasonable basis to believe that the information can be used to identify an individual is not considered individually identifiable health information.

(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; health information administrator) when requesting access to records at the MTF level.

d. Clinical use of electronic mail. Clinical use of electronic mail in provider–to–patient communications will be in accordance with MEDCOM guidance.

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, 9, and 10. As noted, documentation in AHLTA may replace these forms. 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, and so forth), 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. Photographs may be mounted on authorized paper forms and filed in medical and dental records or scanned/attached into AHLTA. They may be mounted on various forms, depending on the size of the photo and the interpretation location. Examples of forms that may be used for this purpose are DA Form 4700 (Medical Record—Supplemental Medical Data), Department of Defense (DD) Form 2161 (Referral for Civilian Medical Care), SF 513 (Medical Record—Consultation Sheet), and SF 600.

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

3–2. Filing electronic/computerized forms

a. Electronic/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, commercially available emergency room charting systems, 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 Optional Form (OF) 520 (Clinical Record—Electrocardiographic Record) (formerly SF 520),

anesthesia monitoring with DA Form 7389 (Medical Record—Anesthesia) (formerly SF 517 and OF 517), commercially available emergency room charting systems with SF 558 (Medical Record — Emergency Care and Treatment), and laboratory test results with SF 545 (Laboratory Report Display). Undersized reports, such as monitoring strips, will be mounted on DA Form 4700 overprints identified as display sheets, except for cardiac rhythm strips, which may be mounted on the corresponding SF 510 (Medical Record—Nursing Notes). When DA Form 4700 is used, it should be referenced on SF 600. (Also see paras 3–3, 9–2, and 12–4 for information on DA Form 4700.)

b. When a computerized or electronic 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 healthcare providers not document PHI or opinions on the daily lab reports because they will not be retained.

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

d. The Interagency Committee on Medical Records, with approval of the General Services Administration, has eliminated the requirement that every electronic version of a medical standard or optional form be reviewed and granted an exception. The elements required for electronic versions of these forms have been published in the Federal Register. These elements must be included in any electronic versions of these forms.

e. MTFs may discontinue the daily filing of laboratory and radiology results in the medical record and maintain these results electronically within the Composite Health Care System (CHCS), CHCS II, or ESSENTRIS. (NOTE: ESSENTRIS is the current accepted interim AHLTA inpatient electronic medical record.) MTFs planning to implement this practice will develop a migration plan before converting to the electronic storage of test results. These plans will include the following, at a minimum:

(1) Procedures for ensuring laboratory and radiology reports will be properly authenticated in CHCS, CHCS II, or ESSENTRIS by authorized MTF staff members according to CHCS, CHCS II, or ESSENTRIS functionality and business rules.

(2) Procedures for providing information during CHCS, CHCS II, or ESSENTRIS unavailability and for entering any results obtained if or when the system is unavailable.

(3) Mechanism for retrieval of archived information.

(4) Procedures for ensuring cumulative laboratory and radiology results are filed in medical records upon permanent change of station (PCS), referral for treatment to other facilities, record retirement, and valid request.

(5) Procedures for ensuring test results for active duty members assigned to deployable units are included in DD Form 2766 (Adult Preventive and Chronic Care Flowsheet), or other applicable documents created during a deployment, and ultimately placed in the active duty member's OTR/STR.

3–3. Guidelines for local forms and overprints

The approval of overprinted paper or electronic medical forms and proposed forms using the DA Form 4700 overprint not listed in figures in chapters 5, 6, 7, 8, 9, and 10 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 Army Publishing Directorate" 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 paper 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.

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) may be used in ITRs, STRs, 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 bottom part of the form. 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, STR, 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. Multi–page 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, STR, or OTR on a DA Form 4700 overprint. In AHLTA, the record will reflect the type and nature of the instructions provided to the patient. Local policy will dictate how classes, videos, and other types of learning activities are dictated. (Also see para 3–18.)

o. Preprinted instructions to the healthcare 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 para 9–26.)

q. OF 522 (Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures) (formerly SF 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. Local consent forms will not be used in place of these forms. An electronic form in AHLTA containing the data elements of the OF 522 or a State-mandated consent form may be used.

r. Use of abbreviations on forms and overprints should be in strict compliance with those included in appendix B or locally approved in accordance with paragraph 3–3*c*. 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 healthcare provider who observes, treats, or cares for the patient and in accordance with the locally defined patient assessment policy. No healthcare practitioner is permitted to complete the documentation for 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 they 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.

(1) Electronic signatures on a medical record are usually admissible and will not normally jeopardize the admissibility of the record in court. However, courts address this issue on a case–by–case basis. (See the definition of"electronic signature" in the glossary, sec II.)

(2) The first entry made by a person will be signed (first and last name); 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.) To verify initials that are on ITR documents, a DA Form 4700 with the typed name of each staff member, their payroll signature, and their initials must be placed in each ITR. Initials must be legible and correspond to the individual's name.

(3) 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 names 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 and timing entries. All entries must be dated and timed. 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 2005 @ 1400 hours.

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.

(1) Under HIPAA, individuals have the right to request an amendment or correction to their PHI. MTFs/DTFs will have procedures in place to address this issue.

(2) MTFs/DTFs may deny any individual's request for amendment, if they determine that the PHI that is subject to the request—

(a) Was not created by the covered entity, unless the individual provides a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment.

(b) Would not be available for inspection under DOD 6025.18–R, chapter 11; or

(c) Is accurate and complete.

(3) If the MTF/DTF denies the requested amendment, in whole or in part, they will provide the individual with a timely, written denial, written in plain language, that will contain—

(a) The basis for the denial.

(b) A statement of the individual's right to submit a written statement disagreeing with the denial.

(c) A description of how the individual may file such a statement.

(d) A description of how the individual may complain to the MTF/DTF, to include the name, title, and telephone number of the contact person or office designated to receive such complaints.

(e) A description of how the individual may file a complaint with the HHS.

(f) A statement that, if the individual does not submit a statement of disagreement, he or she may request that the MTF/DTF provide his or her request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.

(4) Medical records will be amended according to 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 STR 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 STR; it is used with the ward or clinic identification plate. (See *b*, below.) The card also may 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 AHLTA (including CHCS and CHCS II) and ESSENTRIS. 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, and so forth.).

(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, as well as any other locally required information, may be imprinted on the card.

(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 in accordance with AR 40–400.

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 AHLTA/ESSENTRIS facilities. The 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 STRs, 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. Encounters that are created in AHLTA, but not completed in AHLTA due to AHLTA availability or other issues, will be administratively closed by established practices. These practices will be covered in the MTF information management plan.

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 Tri–Service 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, (in accordance with AR 600–110, para 2–10):

a. For force surveillance testing, an entry will be made on SF 600 that will include the date and location of testing. Recording of test results in the medical record of Active Duty Soldiers is required when the Soldier is being processed for overseas PCS. (See AR 600–110 for complete testing requirements.) 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 DD Form 2808 (Report of Medical Examination), item 49, 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) or electronic version. 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 Soldiers will be marked only by affixing a DA Label 162 (Emergency Medical Identification Symbol) in accordance with chapter 14 of this regulation. DD Form 2766 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 by mail or courier. 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 Tri–Service Disease and Procedure ICD–9–CM Coding Guidelines (app A).) Record on DA Form 3647 (Inpatient Treatment Record Cover Sheet), item 33, CHCS, CHCS II, or ESSENTRIS electronic 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, accidentally 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. Accidentally 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 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 biological 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, CHCS, CHCS II, or ESSENTRIS electronic 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, CHCS, CHCS II, or ESSENTRIS electronic 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 of Death (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 one hour after birth," "Neonatal death, age 22 hours," and "Neonatal death, age 26 days." (For more information, see the Hospitals' and Physicians' Handbook on Birth Registration and Fetal Death Reporting (app A).)

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 Tri–Service 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. To ensure compliance with 10 USC 1093, the following are required.

a. 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. As an added control, the chief of obstetrics and gynecology, deputy commander for clinical services, or the hospital commander must countersign the physician's statement before the procedure is performed. The legal advice of a judge advocate will be solicited if deemed necessary.

d. For guidance on all other categories of abortion, see AR 40–400, paragraph 2–18.

3–17. Recording use of restraints/seclusion

Documentation of the use of restraints/seclusion will conform to local policy and the current The Joint Commission (TJC) standards.

3–18. Recording videotaped documentation of episodes of medical care

a. When an episode of health care (for example, surgical procedures, medical evaluation, telemedicine consultation, and so forth) is to be documented on videotape, the patient must provide written consent for the taping (unless the taping is for the documentation of neglect or abuse). The patient (if identifiable) must provide written consent.

b. Consent will be recorded on an OF 522 or a State–mandated consent form in accordance with paragraph 3–3*q*.

c. The episode of health care will be documented in the medical record as is normally done. Written documentation of the consultation will be done by providers on both ends of a telemedicine encounter. The videotape will be erased after standard documentation is complete, unless the videotape is required for a specified interval for a specific reason, such as documentation of neglect, abuse, or possible criminal activity. In cases where adverse administrative, nonjudicial, or judicial proceedings may be contemplated because of possible criminal activity, consult with the local judge

advocate before erasing the videotape. The provider will indicate in the final documentation whether or not the image was erased, or where the videotape will be maintained. The videotape will not become part of the medical record.

d. Exceptions to the prohibition against retaining videotapes may be permitted for cases with exceptional educational value or cases where adverse administrative, nonjudicial, or judicial proceedings may be contemplated because of possible criminal activity. Tapes are not usually filed by any type of personal identifier. If they are, then all Privacy Act regulations must be followed. Any MTF which chooses to keep such images on file for educational purposes must develop appropriate policies and standing operating procedures and review them periodically.

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

3–19. Carded–for–record–only cases

a. Certain cases not admitted to an MTF will be carded–for–record–only (CRO) cases and will be documented both in the medical record and through the Standard Inpatient Data Record (SIDR). This includes only the deaths of active duty military personnel. These deaths will be reported in one of the following ways:

(1) If an active duty Soldier dies during a hospital stay, it is considered a hospital death and is reported through the SIDR.

(2) If the Soldier dies while hospitalized in a civilian hospital, it is reported as an absent–sick death and reported through the SIDR.

(3) If the Soldier is dead on arrival (DOA), it is reported as a CRO through the SIDR.

(4) If the Soldier dies in the emergency room, it is reported as a CRO through the SIDR.

b. The MTF with geographic control is responsible for initiating the CRO and is required to monitor and coordinate with the civilian facilities in that geographic area. Coordination must occur through the respective command surgeon's office.

c. For these cases, DA Form 3647, CHCS, CHCS II, or ESSENTRIS electronic 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.

d. Deaths of other than active duty military personnel may be CRO if they are considered to have medical, legal, or other significance. However, they are CRO cases only if an ITR has not already been prepared for them.

3–20. Absent–sick status

An Army patient admitted to a nonmilitary treatment facility is in an absent–sick status. (See AR 40–400, para 10–11*a*.)

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, CHCS, CHCS II, or ESSENTRIS electronic 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 DA Form 3647 and DA Form 2985 do not need to be completed for these cases.

Table 3–1
AR 25–400–2, Army Records Information Management System (ARIMS)
File numbers, record keeping requirements

File number	Title
11–9	Personnel dosimetry files
40	General medical services correspondence files
40–5h	Civilian Employee Medical 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

Table 3–1
AR 25–400–2, Army Records Information Management System (ARIMS)
File numbers, record keeping requirements—Continued

File number	Title
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	PHI 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
40–66pp	Army Substance Abuse Program outpatient records
40–216h	Electroencephalographic tracings
40–216i	NATO consultation service cases
40–216k1	Mental Health Records (Adults)
40–216k2	Mental Health Records (Minors)
40–407f	Register of operations

Section V
Detainee Records

3–21. Documentation of detainee care

a. Accurate and complete outpatient and, when required, inpatient medical records on each detainee will be created and maintained according to the provisions of this regulation and AR 190-8. The detainee information number or internment serial number (ISN) will be used as the patient identification number. A medical record in AHLTA or AHLTA-T will be developed and used where it is available.

b. Entries should be made into detainee medical records in the same manner as for any other patient. Detainee entitlement to copies of their medical records will be subject to requirements of this regulation (chap 2). Before any copies of records are released, all healthcare provider information, including names of all who delivered care of any nature and other identifying information must be stricken from the copied medical records.

c. Detainees shall be assigned an ISN as soon as possible after coming under DOD control, normally within 14 days of capture. (See DODD 2310.01E.)

3–22. Maintenance and transfer of records

a. HIPAA does not apply to detainee medical records. All applicable regulations governing the release of information will be followed. Commanders and other officials who have an official need to know can access information in detainee medical records following procedures in chapter 2 of this regulation, using DA Form 4254. Patient consent is not required.

b. The MTF commander (or designee) will determine what information is appropriate for release. Only the specific medical information required to satisfy the terms of the legitimate request will be authorized for disclosure.

c. Releasable medical information on detainees includes that which is necessary to supervise the general state of health, nutrition, and cleanliness of detainees, and to detect contagious diseases.

3–23. Release of information

Medical records will be maintained at the MTF with responsibility for the detainee's health care. If a detainee is transferred to another U.S. Armed Forces detention facility, the paper medical records will be forwarded to the appropriate MTF depository. All original medical records remain the property of the U.S. Government. An appropriate depository for inactive detainee medical records will be established.

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 paper medical records under the terminal digit filing system.

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's 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, a newborn child'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. 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 printed/paper ITRs, STRs, and OTRs (including dental); ASAP-OMRs; and CEMRs. It may also be used to file STRs (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 4–1*b*). 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 nondental x–ray films. Similarly, the DA Form 3444–series and DA Form 8005–series are the only folders authorized for filing ITRs, OTRs, STRs, CEMRs, and nuclear medicine files. Only DA Form 3444–series folders will be used for dental records, ITRs, ASAP–OMRs, and CEMRs. DA Form 8005–series folders will be used only for STRs 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, STRs, 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 Directorate of Logistics, Media Distribution Division, 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 paper 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 STR, 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 electronic record system, place the bar code on the upper right corner of the folder.

(5) ITRs and OTRs are retired following Electronic Medical Record Tracking and Retirement System procedures. Paper records will be produced as required by this regulation for retirement to the NPRC. Paper STRs should be forwarded to the Veterans Affairs Record Center. MTFs send electronic index files listing retirement eligible records to the National Personnel Records Center (NPRC) as advance notices of the pending shipments. Upon approval of the advance notice files, NPRC notifies the MTFs to ship the records. Training for the new system for retirement of ITRs and OTRs should be done with the User Guide found on http://pad.amedd.army.mil or https://kx.afms.mil/hipaa/mrtr2/.

(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 4–3.

(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 or the electronic equivalent within the electronic medical record. 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 2–3*a*(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 3–5*a*). 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 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 (NATO personnel ITRs). (See table 3–1 of this regulation.)

c. Special instructions for retirement OTRs and ITRs are as follows:

(1) Prepare and attach an identification label as described in *b*(1), above, or affix the bar coded label from CHCS, AHLTA, or ESSENTRIS. 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) Attach an NOPP acknowledgement label to the center of the back outside cover of the OTR (either the 3444–series or DA 8005–series folders). These labels may be obtained from www.fhinc.net/tricare/default.asp.

(3) The retirement date for OTRs will be two years after the end of the year in which last medical treatment was given. Retirement dates for paper records follow the Army Records Information Management System (ARIMS).

(4) 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 STRs 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.

(5) The Medical Registry System (MRS) has been developed to automate the accessioning and retrieval of inpatient and outpatient records retired to the NPRC from MTFs worldwide. Facilities send electronic index files (listing retirement–eligible records) to NPRC as advance notices of the pending shipments. Upon approval of the advance notice files, the facilities are notified to ship the records. The related indices are used to generate labels for the records and to build the MRS master file. The MRS master file is used to manage and to retrieve inpatient and outpatient treatment records. The system provides the capability for the automated assignment of accession numbers, shelf locations, and registry numbers. Users at the medical facilities and at NPRC have online access to the MRS master file through a secure Web site. Authorized users may submit inquiries and order records electronically.

(6) All laboratory and radiology reports must be printed out before the record is prepared for retirement.

d. The folder version of DD Form 2766 will be prepared according to paragraph 5–13*c*(1) and inserted into the DA

Form 3444–series or DA Form 8005–series folders used for STRs of active duty, USAR, and ARNGUS Soldiers and CEMRs of deployable civilians. DD Form 2766 is placed on the fastener on the lower left side of the DA Form 3444–series or DA Form 8005–series folders.

e. 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.

f. 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 DA Form 3443–series consists of one master folder, one report folder, one subfolder, and one loan folder. Duplication of master folders is not authorized except as needed to contain large volumes of images.

a. Preparation of the 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 4–4.

(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: 1995 would be "0" (orange); 2000 would be "5" (blue). Films would begin to be retired by the year code in 1995. Retirement of records will be according to the scheme shown in table 4–5.

(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 DA Form 3443–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 4–2*b*.)

(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) *electronic systems.* Labels generated by electronic systems may replace handwritten information. All information required by *a*(1), (3), and (5) above will be provided by such systems, whether electronic, 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. For health and outpatient records withdrawn from the files and transferred to another MTF, see paragraphs 5–27 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) or an electronic equivalent 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 DD Form 877-l or electronic equivalent, 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.

(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, USA HRC, ATTN: AHRC–EPO–P, 2461 Eisenhower Avenue, Alexandria, VA 22331–0410.

(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 St., Indianapolis, IN 46249–5301.

(c) Requests for STRs of USAR personnel not in the Active Army will be addressed to the appropriate commander as follows:

1. Active Guard and Reserve, IRR, and IMA — Commander, HRC–Stl, 1 Reserve Way, St. Louis, MO 63132–5200.

2. Troop Program Unit (TPU) — Commander, USARC, G1, 1401 Deshler Street SW, Fort McPherson, GA 30330–2000.

(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 Records Center, P.O. Box 5020, 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
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 to 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

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 40–400.)

[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.

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 for tape denoting patient status

File number[1]	General group	Color
40–66a (STRs) 40–66b (dental STRs)	Active Army STR (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 4–4
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 4–5
Retirement of radiology images and reports, DA Form 3443–series

Year	Color
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)
2011	White (6)
2012	Brown (7)
2013	Pink (8)
2014	Red (9)
2015	Orange (repeat 10–year cycle)

Chapter 5
Service Treatment Records

Section I
General

5–1. Purpose of the service treatment record

a. The STR 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 STRs are maintained primarily within AHLTA, but separate medical and dental folders are prepared as necessary for retirement to the NPRC.

b. The primary purpose of the STR is to provide a complete, concise medical and dental history of everyone in the Active Army or in the RC as well as Family members and other beneficiaries. The STR is used for patient care, medicolegal support, and research and education. The STR 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 STR 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 service treatment record

a. General. Throughout the person's military career, each outpatient contact with the AMEDD or MHS is recorded in the STR. The STR may also include documentation from an inpatient stay for purposes of providing continuity of care. Such contacts may be described/included on paper copies, or in ESSENTRIS equivalents of DA Form 3647, SF 502 (Medical Record — Narrative Summary), SF 516 (Medical Record — Operation Report), possibly, SF 515 (Medical Record — Tissue Examination), or any other inpatient documents that the physician or dentist deems necessary for proper outpatient follow-up care. Care rendered under DD Form 689 (Individual Sick Slip) should be recorded. Medical care provided at MTFs or DTFs that do not maintain the permanent STR should be recorded in the electronic STR. If AHLTA is not available, the documentation created outside of AHLTA will be sent to the STR custodian for scanning into AHLTA, as appropriate, or filing in the permanent paper record.

b. Use in outpatient medical care.

(1) With the use of AHLTA, the paper OTR will be pulled only for clinical care when requested by the clinic or per MTF SOP. There is no requirement to pull the record for every visit. The findings and treatment will be recorded in AHLTA unless the system is not available. The MTF must have a plan in place to accomplish medical record documentation during periods when AHLTA is not available.

(2) When an MTF or DTF refers a patient elsewhere for outpatient care, necessary documents from the paper-based record and/or AHLTA (to include reason for referral and clinical details of current care) will be sent to the referral facility. The necessary information may be mailed, sent by courier, or given to the patient for delivery to the referred provider. The MTF medical records section will provide the needed documentation. These consultations will be completed in AHLTA unless the system is not available. In these cases, SF 513/DD Form 2161 or their electronic equivalents will be included in the STR. (See also para 9-12*d*.)

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

c. Use in inpatient medical care. A copy or electronic version of the STR, when a copy or electronic version is received, will be sent to the patient's ward.

(1) Normally, the STR will be sent to the MTF when a person is admitted for treatment except when there exists a complete AHLTA record and it is available to the physician. (See paras 5–33 through 5–36 for information on patients from combat areas.) When an MTF receives an STR, or a part of it, the patient administrator becomes the custodian and will ensure that it is accessible to AMEDD personnel. When received, the STR 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 paper or electronic copy of each of the forms required for the STR and prepared by the MTF are put in the STR (see para 5-3) and that the entries needed for inpatients on SF 600 or electronic equivalent are made. (See para 5-18.)

(2) When inpatient dental care is given, MTF dental personnel will try to obtain the patient's paper dental record if a complete AHLTA record is not available. 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. However, any extractions, restorations, or other oral or dental treatment rendered must be entered on SF 603 (Health Record — Dental), or electronic equivalent, of the permanent or temporary dental record.

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

(a) Attached patients returned to duty (RTD). Mail or courier the STR 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, mail or courier the STR to the MEDDAC or DENTAC or MEDCEN commander of the person's assigned installation.

(b) Assigned patients RTD (where there is no local MTF or medical records room). Mail or courier the STR to the military personnel officer of the person's assigned unit. If the person is locally reassigned, mail or courier the STR to the custodian as in *(a)*, above.

(c) Patients transferred to another MTF. Mail or courier the STR with a copy of the inpatient record to the other MTF if the Soldier is expected to have an extended length of stay or is not expected to return to the original unit.

(d) Deceased patients. Mail or courier the STR to the casualty affairs officer holding the patient's personnel file.

(e) Patients transferred to VA Medical Centers. Mail or courier the STR to the correct center. Also mail or courier a copy of the patient's inpatient records unless they have been sent to the physical evaluation board (PEB) for examination (AR 635–40).

(f) Other patients separated from service. Mail or courier the STR to the military personnel officer handling the separation at the transition point. He or she will dispose of them as stated in paragraph 5–29.

(g) Patients AWOL longer than 10 days. Upon request, mail or courier the STR to the officer holding the person's personnel file.

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

5–3. For whom prepared and maintained

STRs will be prepared and maintained for all Army members. This includes Active Army and RC members, ROTC cadets, and cadets of the United States Military Academy to include the United States Army Preparatory School. ARNGUS and USAR STRs will be prepared and maintained by the custodian of the personnel files. (These STRs will be prepared in accordance with paragraph 4–1, but they will be filed in alphabetical sequence.) When transferred to Army custody, STRs for members of the Navy and Air Force will also be maintained. STRs for military prisoners will be kept as long as they are confined in U.S. military facilities. Medical records, including AHLTA records, will be prepared for all individuals receiving medical care at the MTF, to include emergency care for contract personnel.

5–4. Forms and documents of service treatment records

a. The medical and dental forms authorized for use in the STR are listed in figures 5–1, 5–2, and 5–3. As noted, the electronic equivalents in AHLTA can also be used and should be defined by a "form number." To facilitate access to information in paper 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 either electronically or through normal publications supply channels.

b. The folders of USAR and ARNGUS members on active duty for training (ADT) 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 and DA Form 5007B

Documentation of hyposensitization injections will be performed in AHLTA using medically-appropriate data entry. When AHLTA is not available, DA Form 5007A (Medical Record — Allergy Immunotherapy Record — Single Extract) and DA Form 5007B (Medical Record — Allergy Immunotherapy Record — Double Extract), or electronic

equivalents, will be used to document hyposensitization injections as prescribed on SF 559 (Medical Record — Allergen Extract Prescription, New and Refill). DA Form 5007A is intended for patients on single injection immunotherapy, while DA Form 5007B is intended for patients on two separate immunotherapy prescriptions. These forms are available on the AEL CD-ROM and at the APD Web site (www.apd.army.mil).

5–6. DA Form 5008

Documentation of telephonic medical advice/consultation will be performed in AHLTA using medically-appropriate data entry. When AHLTA is not available, DA Form 5008 (Telephone Medical Advice/Consultation Record), or electronic equivalent, 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. If completed in a paper form, DA Form 5008 is attached to SF 600 when filed.

5–7. DA Form 5181

Documentation of a screening note for acute medical care will be performed in AHLTA using medically-appropriate data entry. When AHLTA is not available, DA Form 5181 (Screening Note of Acute Medical Care), or electronic equivalent, will be used in conjunction with the Enlisted Screener Program in battalion aid stations and troop medical clinics. This form is available on the AEL CD-ROM and at the APD Web site (www.apd.army.mil).

5–8. DA Form 5569

Documentation of insoniazid treatment will be performed in AHLTA using medically-appropriate data entry. When AHLTA is not available, DA Form 5569 (Isoniazid (INH) Clinic Flow Sheet), or electronic equivalent, will be used to document Isoniazid (INH) clinic visits. This form is available on the AEL CD-ROM and at the APD Web site (www.apd.army.mil).

5–9. DA Form 5570

Documentation of the Health Questionnaire for Dental Treatment will be performed in AHLTA using a dental-appropriate data entry. When AHLTA is not available, DA Form 5570 (Health Questionnaire for Dental Treatment), or electronic equivalent, 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. DD Form 2882

The reminders module of AHLTA will be used to track pediatric and adolescent care. When AHLTA is not available, DD Form 2882 (Pediatric and Adolescent Preventive and Chronic Care Flow Sheet), or electronic equivalent, will be used instead of DD Form 2766 for pediatric patients. This form can be obtained through the local forms management officer or on the APD Web site.

5–11. DD Form 1380

AHLTA-T will be used for documenting care under combat conditions. When AHLTA-T is not available, DD Form 1380, or electronic equivalent, will be used as described in chapter 11 and paragraph 5-33 (as an STR document under combat conditions). Instructions for the use and preparation of DD Form 1380 are provided in chapter 11.

5–12. DD Form 2482

DD Form 2482 (Venom Extract Prescription), or electronic equivalent, 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. DD Form 2766 and DD Form 2766C

a. DD Form 2766—

(1) Will be utilized in AHLTA for active duty, U.S. Army Reserve (USAR), and Army National Guard of the United States Soldiers (ARNGUS), non-active duty adult beneficiaries, civilian employees, and contractors receiving care in MTFs as part of their employment.

(2) AHLTA will be used for documenting and tracking all immunizations when it is available. This includes documentation for active duty, USAR, and ARNGUS Soldiers, as well as all immunizations to other beneficiaries and individuals receiving medical care in the MTF. When AHLTA is not available, active duty immunization should be entered into the Medical Protection System (MEDPROS) using the model driven web engineering (MDWE) module.

b. DD Form 2766 is available electronically in AHLTA and is available in two paper-based constructions (folder and cut sheet). Both constructions are available through normal publishing channels.

(1) The folder construction will be inserted into the paper-based record for active duty, USAR and ARNGUS personnel, and for deployable civilians. During normal use, the folder is placed on the fasteners inside the existing DA Form 3444-series or DA Form 8005-series treatment folders. (See figs 5-1 and 5-2.) During deployments, DD Form

2766 will be removed from the treatment folder and accompany the individual to the field. (See para 5-32.) File the most recent DA Form 4186 (Medical Recommendation for Flying Duty) and DD Form 2808 in DD Form 2766.

(2) The cut sheet construction will be used for non-active duty adult beneficiaries (those 18 years of age and older) and non-deployable civilians where AHLTA is not available. File the cut sheet construction according to figures 6-1 and 6-2.

c. All information documented in the medical record is considered a part of the legal document. Forms superseded by others when a pediatric patient reaches the age of 18, such as DD Form 2882 and DA Form 8007-R, will not be discarded from the medical record at any time.

(1) Relevant data should be transcribed from DD Form 2882 or DA Form 8007-R to the AHLTA 2766 or to the paper equivalent. A line will be drawn through the information and the phrase "Transcribed into AHLTA/2766 on date" will be written along the line.

(2) DD Form 2882 and DA Form 8007-R will remain with the paper-based medical record and will be placed behind the current DD Form 2766 and the Health Enrollment/Evaluation Assessment Review (HEAR) Primary Care Manager (PCM) Report (when available). (See figs 5-1, 5-2, 6-1, and 6-2.)

d. With the implementation of AHLTA, DD Form 2766 will be maintained in AHLTA through established processes. Information noted on the paper DD Form 2766 should be transcribed into AHLTA, a line drawn through the written information, and the phrase "Transcribed into AHLTA on date" will be written along the line. The AHLTA 2766 printout can be placed in the paper OTR.

e. Where AHLTA is not available for medical care, instructions for completion of a hard copy DD Form 2766 are as follows:

(1) For example, if personnel run out of space for deployment history in the six fields in block 11, data fields on DD Form 2766C can be changed to reflect the type of information required.

(2) Document the use of any chemoprophylactic agents on DD Form 2766C.

(3) When DD Form 2766C is used as a continuation form for the DD Form 2766 folder, file it by placing it on the fastener on the right side of the folder (figs 5–1 and 5–2.). When this form is used as a continuation form for the DD Form 2766 cut sheet, file according to figures 6–1 and 6–2.

5–14. DD Form 2813

Documentation of Department of Defense Reserve Forces dental examination will be performed in AHLTA. When AHLTA is not available, DD Form 2813 (Department of Defense Reserve Forces Dental Examination) is used to obtain the dental health status of RC members for deployment readiness. The form will be completed by members' civilian dentists and provided to the members' military organization for entry into an electronic tracking system.

5–15. SF 512

AHLTA will be used to track and plot any single laboratory item deemed clinically significant. When AHLTA is not available, SF 512 (Clinical Record — Plotting Chart), or electronic equivalent, will be filed in STRs, OTRs, CEMRs, and ITRs to record cholinesterase levels and any single item deemed clinically significant. SF 512 will be filed immediately above SF 545.

5–16. SF 558

a. AHLTA will be used to document care in the emergency center/emergency department (EC/ED). Scanning of documents, as well as other free text entry methods such as voice recognition dictation, may be used as needed. When AHLTA is not available, SF 558, ER templates, or electronic equivalents, will be used instead of SF 600 to record all care provided to patients in the 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, the AHLTA note, SF 558, or electronic equivalents, will be the admission note filed in the patient's ITR. A copy of any State ambulance forms will be filed with SF 558 in the ITR.

5–17. SF 559

SF 559, or electronic equivalent 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 3–5*a*). 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, Bldg. 512, Forest Glen Annex, Silver Spring, MD 20910.

5–18. SF 600

AHLTA will be used for documenting medical care. SF 600, or electronic equivalent will be used only in the STRs, OTRs, CEMRs, and ASAP–OMRs. It is the chronological record of outpatient treatment and thus is the basic form of the STR. When AHLTA is not available, 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 they will usually be written in ink; if written, entries must be legible. Entries on the form may be typed, electronically entered, written in ink, or printed. 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 3–4*c*). (See fig 5–4 for examples of entries on SF 600.)

a. SF 600. When AHLTA is not available, one copy of SF 600 will be put in the STR. The parts of the form to be completed are shown in (1) through (8), below. These entries will be typed, electronically entered, written in ink, 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 follow–up care; record all prescribed drugs.

(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 a patient is admitted from an outpatient visit, the AHLTA electronic note can be used as the inpatient history and physical documentation for the admission provided necessary documentation is present. For admission from the EC/ED, see paragraph 5-16.

(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), the treatment provided will be annotated for each occurrence of care. In addition, a final summary will be provided when the special procedures or therapy is ended. The final summary will include the following:

(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) Documentation of outpatient care received at civilian facilities will also be placed and retained in the paper STR/OTR. As appropriate, the care received in the civilian facility should have the diagnosis and treatment entered into the AHLTA record and/or appropriate documentation scanned or otherwise electronically transferred into AHLTA.

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 Examinations" will be documented in AHLTA. As necessary, the results of the examination will be printed from AHLTA using DD Form 2808 or electronic equivalent.

e. Entries for orthopedic footwear. When a person is authorized the issue of orthopedic footwear, the words "orthopedic footwear authorized" will be entered on an encounter note in AHLTA or in the medical record.

f. Entries for board proceedings. When copies of PEB or medical board proceedings are put in the STR, 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 treatment of sexually transmitted diseases. The preparation of SF 602 (Medical Record—Serology Record), or electronic equivalent 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 substance abuse treatment. When a person has been determined by clinical evaluation to be a substance abuser, entries will be made into AHLTA per current policy and on a paper SF 600, if required, for filing in the STR.

i. Entries for a pregnancy diagnosis. After a pregnancy is medically confirmed, 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 STR.

j. Entries for DNA blood samples. An entry will be made on SF 600, or electronic equivalent, when a blood sample is taken for DNA identification. The hard copy version of the SF 600 will be stamped with the date, the time, and a DNA stamp, and then filed in the STR. The date when the sample was taken will be entered in block 10a of DD Form 2766 or its electronic equivalent.

5–19. Immunization documentation (DD Form 2766, SF 601, and HHS Form PHS 731)

Active duty, USAR, and ARNGUS Soldiers and deployable civilians will have their immunizations documented in AHLTA. When AHLTA is not available, immunizations will be recorded on DD Form 2766, or electronic equivalent, and entered in the MDWE module of MEDPROS. Non-active duty adult beneficiaries and non-deployable civilians will have their immunizations entered into AHLTA. All beneficiaries should also have immunization documentation entered in HHS Form PHS 731 (International Certificates of Vaccination), a personal record of immunizations received that is normally needed for international travel. Usually, Active Army and USAR members have custody of their HHS Form PHS 731 and will ensure its safekeeping. HHS Form PHS 731 for RC personnel is usually issued to the person for safekeeping upon mobilization or when traveling internationally. ARNGUS units may retain HHS Form PHS 731.

a. DD Form 2766 or electronic equivalent. At reception stations, procedures will be established to ensure that immunization history and allergy information is entered in the immunization and allergies modules of AHLTA,

respectively. If AHLTA is unavailable or a paper STR is being created for persons allergic to medications, the "Medical Condition" block on the front of the STR folder will be checked and block 1 on DD Form 2766 will be annotated. In addition, DA Label 162 will be placed on the STR folder and DD Form 2766 according to chapter 14. Paragraph 5-13*d*(10) contains instructions for documenting immunizations in block 9 of DD Form 2766.

b. HHS Form PHS 731. A paper copy of HHS Form PHS 731 may be used, or the military member or beneficiary may be given a printout of the AHLTA 2766c.

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 brigade surgeon, or his or her designee, 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 in AHLTA, or on DD Form 2766 or electronic equivalent where AHLTA is not used, as well as administer, record, and properly authenticate required immunizations. Note: HHS Form PHS 731 is not filed in the medical record.

d. Authentication of entries. In accordance with international rules, entries on HHS Form PHS 731 for immunizations against smallpox, yellow fever, and cholera will be authenticated. Each entry must contain the signature/electronic signature of the medical officer or his/her chosen representative (AFJI 48-110/AR 40-562/ BUMEDINST 6230.15/CG COMDTINST M6230.4E). For other entries on HHS Form PHS 731 and entries in block 9 of DD Form 2766, the signature block may be stamped or typewritten and authenticated by initialing.

e. Entries.

(1) Immunizations and sensitivity tests will be recorded in AHLTA, or on DD Form 2766 or electronic equivalent where AHLTA is not used. Rubella titer results must be recorded on DD Form 2766.

(2) Remarks and recommendations concerning immunization and sensitivity tests may be added by MTF personnel. 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 DD Form 2766 or HHS Form PHS 731. If a HHS Form PHS 731 is lost, a duplicate will be made by transcribing the information on DD Form 2766, or electronic equivalent. If a DD Form 2766 is lost, a duplicate will be made by transcribing HHS Form PHS 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 HHS Form PHS 731 or a printed copy of the 2766c from AHLTA for future use.

5–20. SF 603 and SF 603A

When available, AHLTA will be used for dental documentation. If AHLTA is not available, SF 603, or electronic equivalent, is the basic form used in the STR 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), or electronic equivalent, is the related form used as a continuation sheet when space on SF 603 is insufficient.

a. One copy of SF 603 will be inserted in the dental record if the AHLTA record is not available. The identification parts of this form will be completed as described for SF 600 in paragraph 5–18.

(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.) 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 or electronic equivalent 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 STR will contain, at a minimum, an SF 603 or electronic equivalent 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 or electronic equivalent. 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 (in accordance with 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, and so forth, 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 STRs 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.

5–21. Other forms filed in the service treatment record

a. AHLTA is the primary system for entering health information. When the following paper forms are prepared, one legible copy will be filed in the STR:

(1) DA Form 3647 or electronic equivalent.

(2) SF 502 or electronic equivalent.

(3) If the physician deems it necessary for proper outpatient follow-up care, SF 515, SF 509, SF 516, and other physician-designated forms (may be electronic versions).

(4) DA Form 199 (Physical Evaluation Board (PEB) Proceedings) (AR 635-40). (See app A for information on obtaining copies.)

(5) DA Form 3947 (Medical Evaluation Board Proceedings) (AR 40-400).

(6) DA Form 4707 (Entrance Physical Standards Board (EPSBD) Proceedings) (AR 40-400).

(7) DD Form 2569 (may be electronic version) (Third Party Collection Program — Insurance Information).

b. Copies of other STR forms will be prepared and filed as described in (1) through (12), below.

(1) *DD Form 2808, DD Form 2807-1 (Report of Medical History), DA Form 7349 (Initial Medical Review—Annual Medical Certificate), and DD Form 2697 (Report of Medical Assessment) or electronic versions.* The original of each of these forms will be filed and a copy of DD Form 2697 will be sent through the Transition Center to the Department of Veteran's Affairs, Records Management Center, P.O. Box 5020, St. Louis, MO 63115-0020 (AR 40-501).

(2) *DD Form 771 (Eyewear Prescription), or electronic equivalent, in the Spectacle Request Transmission System module of AHLTA when available.* Each time DD Form 771 is prepared, a copy will be filed permanently in the STR.

(3) *DA Form 3349 (Physical Profile).* If the Soldier's profile is not created in AHLTA, the original DA Form 3349 will be put in the STR when a profile serial is revised in accordance with AR 40-501.

(4) *DA Form 4465 (Patient Intake/Screening Record (PIR)) and DA Form 4466 (Patient Progress Report (PPR)) or electronic versions.* These two forms will be prepared, kept, and used in accordance with DA Pam 600-85. When available, the AHLTA application will be used to capture this information.

(5) *DD Form 1141.* DD Form 1141 (Record of Occupational Exposure to Ionizing Radiation), or electronic equivalent, or electronic Dosimetry Records (ADRs) of personnel dosimetry must be kept in the STR. When a person changes station or leaves the service, these records will be moved with his/her STR. The dosimetry records of personnel whose work exposes them to ionizing radiation may be removed from their STRs and filed separately when the medical officer or other authority who keeps and uses the records does not have easy access to the STRs of these personnel. In these cases, the separate file of dosimetry records will be kept as described in AR 11-9. (See AR 25-400-2, file number 11-9a, personnel dosimetry files, and table 3-1 of this regulation.) When available, the AHLTA application will be used to capture this information.

(a) When dosimetry records are temporarily withdrawn from the paper STR, OF 23 will be filed 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 STR until the dosimetry records have been returned.

(6) *DA Form 4186.* File the most recent DA Form 4186 or electronic equivalent, according to figures 5-1 and 5-2 . Additional DA Forms 4186 will be filed in order according to the guidelines in (a)-(c) below. Destroy other DA Forms 4186. Block 8b of DD Form 2766 will be updated in pencil to show the current flying status. When available, the AHLTA application will be used to capture this information.

(a) The most recent DA Form 4186 that shows a medical restriction from flying if the person is granted clearance to fly.

(b) The most recent DA Forms 4186 showing that a waiver has been granted for any cause of medical unfitness for flying.

(c) Any additional DA Form(s) 4186 that the flight surgeon determines to be required as a permanent record. (Enter "Permanent Record" in “Remarks” section.)

(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 The Joint Commission (TJC) 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. When available, the AHLTA application will be used to capture this information.

(8) *DA Form 3180 (Personnel Screening and Evaluation Record) and DA Form 4515 (Personnel Reliability Program Record Identifier).* DA Form 3180 and DA Form 4515 will be used to identify the medical records of individuals qualified for the Nuclear or Chemical Personnel Reliability Programs in accordance with 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 according to figures 5-1 and 5-2. (See para 5-31.) When available, the AHLTA application will be used to capture this information.

(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 II — 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. When available, the AHLTA application will be used to capture this information.

(10) *SF 602.*

(a) AHLTA will be used for all documentation and treatment related to a diagnosis of a sexually transmitted disease. When AHLTA is not available, the medical officer who diagnoses a sexually transmitted disease will prepare SF 602 (original only). 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 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 and all pertinent findings will be recorded in sections I and II. A detailed account of all treatments and all laboratory studies will be entered in sections III and IV. In section I, the patient will sign and date his/her statement. Section VII of SF 602 will not be used.

(b) The medical officer treating or observing the case will record each periodic follow-up in section V of SF 602. The medical officer who treats and follows up on cases of sexually transmitted diseases 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 STR. The record will be closed if treatment and follow-up 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 record will be reopened for relapse (in which case the record filed in the STR will be used for needed information and 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 follow-up 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 record will be prepared.

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

(11) *DD Form 2795 and DD Form 2796.* These documents are used to record the results of pre- and post-deployment health assessments of deployed military personnel and may be used for deployed civilians and contractors injured during deployments. AHLTA will be used to document these assessments when available. When not available, other electronic versions that provide their result to the Army Medical Surveillance Activity should be used. If paper-based forms are used, these forms will be prepared according to paragraphs 5-32*a* and 5-35*a*.

(12) *DD Form 2808 and DD Form 2766 or electronic equivalents.* File the most recent DA Form 4186 and DD Form 2808 in DD Form 2766. AHLTA will be used to document these forms when available.

5–22. Mental service treatment records

Mental STRs will be recorded in AHLTA, and all mental STRs should have the AHLTA sensitive button checked. (See AR 25-400-2 and table 3-1 of this regulation. Also see para 6-7*h* of this regulation.)

5–23. Access to service treatment records

All personnel having access to STRs will protect the privacy of PHI. (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 STRs 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 STR 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. However, the failure or refusal of a patient to designate a physician to receive information from his or her STR does not relieve the Army of the obligation to eventually provide the requested information to the patient. In this circumstance, competent medical authority will institute and adhere to appropriate procedures to ensure that the actual or perceived harm to the patient by disclosure of the STR is minimized.

c. Inspectors. Personnel inspecting MTF, DENTAC, or USAR records are allowed direct access to STRs. These personnel include Inspector General personnel conducting Nuclear Surety Program and Chemical Surety Program inspections in accordance with AR 50–5 and AR 50–6 (AR 20–1); it also includes Defense Nuclear Agency inspectors conducting Defense Nuclear Surety Inspections in accordance with AR 50–5. Inspectors may have access to STRs to evaluate the compliance of AMEDD personnel with regulations. All inspectors must respect the confidentiality of the STRs they inspect. Inspectors do not have unlimited access to ASAP–OMRs in accordance with 42 USC 290dd–2.

d. Mortuary affairs personnel. Mortuary affairs personnel are allowed direct access to the STRs 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 STR 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 STR 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 2–3*a*.) Persons designated as certifying and reviewing officials in accordance with the terms of the Personnel Reliability Program, in accordance with 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 ASAP–OMRs is limited. (See guidance in 42 USC 290dd–2.)

5–24. Cross–servicing of service treatment records

AHLTA is part of the MHS and, as such, all Services have access to the electronic STR.

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 STRs. These STRs will be maintained as discussed in this regulation.

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

Section II
Initiating, Keeping, and Disposing of Service Treatment Records

5–25. Initiating service treatment records

a. STRs for personnel entering on active duty. These STRs 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 STRs prepared by the custodian of their personnel file. AHLTA electronic STRs will be created by the AMEDD/MHS facility at the Soldier's first duty station, including training stations.

b. STRs for personnel reentering service. For personnel reentering service, STRs will be prepared as described in *a*, above and *d* and *e*, below. Any past STR will be acquired; the documents in the temporary STR (see para 5–27) will be put into the past one. Requests for past STRs 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 STRs should be sent to VA Records Center, P.O. Box 5020, St. Louis, MO 63115–8950. For ARNGUS, the STR for a person reentering ARNG should be requested from the State Adjutant General of the State from which he or she was separated. Previously existing AHLTA records will be used. If none exist, AHLTA/CHCS electronic STRs will be created by the AMEDD/MHS facility at the Soldier's first duty station, including training stations.

c. STRs for cadets of the U.S. Military Academy. STRs will be initiated for cadets as described in *a*, above and *d*

and *e*, below. These STRs will continue in use when cadets enter active duty. AHLTA electronic STRs will be created by the cadets' supporting MTF.

d. Custody of STRs. A copy of the STR prepared for a person entering military service will not be sent to an STR 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 personnel file will retain custody of the STR; 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 STR 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 STRs, but must be locally approved. Electronic equivalents may be used and must only be printed out for record retirement as dictated by the situation and local policy.

(1) *DA Form 3444–series or DA Form 8005–series folders.* For preparation of these folders, see paragraph 4–4. For STRs, 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) *DD Form 2766.* See paragraphs 4–4*d*, 5–13, and 5–19.

(3) *SF 600.* See paragraph 5–18.

(4) *SF 603 and SF 603A.* See paragraph 5–20.

(5) *DD Form 2808 and DD Form 2807–1.* The original copies of DD Form 2808 and DD Form 2807–1 will be put in the STR.

(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 STR under the DD Form 2766. (See para 5–26*b*(2)*(l)*.)

5–26. Transferring service treatment records

a. Sending STRs. Both parts (treatment and dental) of a military member's STR are transferred when a Soldier is transferred or changes MTFs. 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 STR from their custodians. The STR will be transferred except when—

(1) A Soldier travels OCONUS on PCS or moves to a remote duty station. In this case, the Soldier may hand carry his/her paper STR to the new duty station. The Soldier will be instructed to turn in his/her STR upon reporting to the new duty station. Soldiers must present orders to the record custodian prior to receiving the STR.

(2) An MTF commander determines that it is in the best interest of patient care to allow for hand carrying of paper medical records. Note: If an exception to hand carrying the paper record is granted, the Soldier and/or Family member will sign DA Form 3705 (Receipt for Outpatient Treatment/Dental Records).

(3) 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 paper STR custodians about the unit change. The person's unit designation will be changed on the folders of the paper treatment and dental records.

(4) An inpatient is assigned to a warrior transition unit that already has the paper STR. The MTF commander will inform the military personnel officer that the MTF has the STR. When requesting the personnel file, the MTF commander will also request the paper dental record.

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

b. Receiving paper STRs.

(1) *Military personnel officers.* When a person transfers into the unit, the MTF must send the personnel officer both parts of the person's paper STR and the personnel officer must send them promptly to the officer in charge of the activity giving primary medical and dental care to the unit.

(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 STR is reviewed when received. Review of STRs may be made by the medical officer, a physician's assistant (PA) (area of concentration 65D), or other qualified individuals. Review of Personnel Reliability Program records is discussed in paragraphs 5–30 and 5–31. Each MTF will set the qualifications that people who are not physicians must possess to review STRs. 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 STRs are referred to medical officers when needed. The responsible medical officer will develop written guidelines for the review of STRs by nonmedical officers. These guidelines will ensure that reviews check for pending actions, healthcare problems, and record inadequacies. When

writing guidelines, the medical officer must ensure that reviews include the actions listed in (*b*) through (*l*), 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) DD Form 2766, 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) DD Form 2766 will be updated to include verified ABO/Rh blood type. (See para 5–32*a*.)

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

(i) The STR will be checked to ensure that any allergic reaction to medication was entered (para 5–19*a*) and that DA Label 162 was affixed (chap 14).

(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 STR 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 a substance 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 5–25*e*(6)), the medical officer will immediately have the person examined and start an SF 602, if needed (para 5–21b(10)). If necessary, 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 STR and destroyed.

c. STRs not received. If an STR is not received and if there is no information that the STR 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. A copy of this request will be kept in the person's STR until a reply has been received. If the person is transferred before the reply arrives, a new memorandum with the requested information will be sent to his/her next unit. When the request reaches the person's next unit, it will be put in his/her "temporary" STR. (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 STR in accordance with 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 STRs 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 STRs will be sent to the record custodian of the MTF that provides care during the move. The unit commander is responsible for ensuring that medical records are safely routed to their final destination. With the implementation of the AHLTA dental module, the availability of medical and dental information will be shared and paper transfer normally will not be necessary unless requested by the healthcare provider or required for record retirement to the National Personnel Records Center.

e. 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, and the x rays will be identified. The x rays will then be sent in a mailer in accordance with paragraph 4–5.

(2) Mammograms may be transferred to an MTF or given to a patient directly.

5–27. Establishing "temporary" and "new" service treatment 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 STR 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 STR. If a delayed STR is not received within 60 days after a temporary record is prepared, a new STR will be prepared. This new STR will also be prepared when information is received that a record has been destroyed.

(1) When a new STR is prepared, DD Form 2766 will be added.

(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 medical 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 medical 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 STR will be acquired and continued in use.

5–28. Filing service treatment records

a. STR files. STRs will be filed at the MTF or DTF (includes Family Health Center 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 MTF or AMEDD personnel, the STR will be filed at the unit under the custodianship of the commander. (See para 1–4*b*.) The records may be filed alphabetically or in terminal digit sequence. (See chap 4.) A chargeout system will be used when the STR is temporarily removed from the record room. (See para 4–6.)

b. Keeping STR files current. The procedures described in (1) through (3), below, will be followed to keep STR 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 the MTFs and DTFs personnel rosters of the units that they serve. At a minimum, these rosters will be provided quarterly.

(3) STR 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 STR or medical form is held by the wrong custodian, MTF records personnel will send the documents to the current custodian.

c. Handling identifiable STRs 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 STRs and forms will be handled as follows:

(1) When a Soldier outprocesses at an MTF/DTF, the MTF/DTF will mail the serving MILPO the Soldier's paper STR. The Soldier may not handcarry the STR to the gaining MTF/DTF. Both sections should be mailed or couriered with the personnel file to the new custodian according to paragraph 5–26*a*.

(2) When the MTF or DTF cannot find the member's STR, it will prepare a suspense card with the member's name, rank, and SSN, the complete address of his or her new unit, the name of 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, which will be kept in the member's records file. 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 or may, as appropriate, be scanned or electronically transferred into AHLTA for inclusion into the STR.

(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. (The worldwide locator service requires 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 the 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 one 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 include a complete name and SSN 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, and DEERS) and if the MILPO provides a forwarding active duty address, send the records or forms to the forwarding address. If the member retired or was discharged or separated to an inactive USAR status, send the records or forms to VA Records Center, P.O. Box 5020, St. Louis, MO 63115–8950 for standard postal service. Federal Express, United Parcel Service, or overnight delivery service, send records/forms to VA Records Center, 4300 Goodfellow Blvd., Bldg 104 N, St. Louis, MO 63115-8950. If an address from orders or DD Form 214 (Certificate of Release or Discharge from Active Duty) assigns the member to a USAR troop program unit (TPU) or releases the USAR member from active duty for training or initial active duty for training, send the records or forms to the VA Records Center, P.O. Box 5020, St. Louis, MO 63115–8950 for standard postal service. For Federal

Express, United Parcel Service, or overnight delivery service, send records/forms to VA Records Center, 4300 Goodfellow Blvd., Bldg 104 N, St. Louis, MO 63115-8950. 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 the records or forms 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 the records or forms to the servicing separation transfer point. Another system to locate Soldier's present duty station is by accessing the Soldier's name and SSN in the PAD module of the Military Occupational Data System. If no information and no record is available, send a request for locator service, listing the member's full name and his or her sponsor's SSN, to the Commander, HRC–Ind, ATTN: AHRC–EF, 8899 East 56th St., Indianapolis, IN 46249–5301. Requests for locator service may also be submitted via facsimile at (317) 510–3685. The Locator Service Office can be contacted at 699–3682 (DSN) or (317) 542–3682, but locator information will not be provided over the phone. Hold the records or forms until receiving a response identifying a disposition address.

1. Rule 1a. If records belong to a member of the USAR and a status and location can not be determined, MTFs will contact the U.S. Army Reserve Command Surgeon at (404) 464-8214/8216.

2. Rule 1b. If records belong to a member of the ARNG and a status and location can not be determined, the record will be forwarded to: SAIC, Suite #250, ATTN: STR, 7125 Columbia Gateway Drive, Columbia, MD 21046.

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

(c) Rule 3. If the records or forms include a complete name and SSN and are Marine Corps records or forms, send them to Commandant of the Marine Corps, Headquarters USMC, Medical Records Unit (MMSB-16) 2008 Elliot Road, Quantico, VA 22134.

(d) Rule 4. If the records or forms include a complete name and SSN and are Air Force records or forms, send them to Air Force Medical Operations Agency, AFMOA/SG3SA, 110 Luke Ave., Rm 321, Bolling AFB DC 20032.

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

(f) Rule 6. If the records or forms include a complete name and SSN 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 identifying the person to whom it belongs is impossible. (See para 3–7.)

5–29. Disposing of service treatment records

a. Upon discharge, release from active duty, retirement, death, or transfer from USAR to ARNGUS, the member's STR will be forwarded to the transition point. If the member is separating, the transition point will forward the STR to the VA Records Center, P.O. Box 5020, St. Louis, MO 63115–8950 for standard postal service. For Federal Express, United Parcel Service , or overnight delivery service, send records/forms to VA Records Center, 4300 Goodfellow Blvd., Bldg 104 N, St. Louis, MO 63115-8950. If the member is filing a claim, the transition point will forward STRs to the VA Regional Office where the veteran is receiving care. ARNGUS STRs will be disposed of, as are personnel files. (For enlisted personnel, see NGR 600–200.)

b. If loose documents containing medical treatment information are found after the applicable record has been transferred to the VA Regional Office, contact the VA Records Center for guidance on how to retire these loose documents and, as appropriate, scan or electronically attach the document into the patient's AHLTA record.

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

5–30. Screening Personnel Reliability Program records

a. In accordance with AR 50–5, paragraph 2–16, or AR 50–6, paragraph 2–15, each Personnel Reliability Program candidate must be medically evaluated as part of the screening process; this includes a review of the individual's medical records. STRs 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. MTF commander to screen medical records and complete part III, DA Form 3180.

b. Personnel Reliability Program STRs or CEMRs will be screened in accordance with 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. Using AHLTA, the screening will be annotated in an encounter note and, when

available, in the Personnel Reliability Program or other patient-specific flagging mechanism. In the paper record, 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.

5–31. Maintaining Personnel Reliability Program records

a. Personnel Reliability Program STRs or CEMRs will be maintained under continuing evaluation after screening has been accomplished. As necessary, the MTF will maintain printed copies of AHLTA encounters that occur as part of Personnel Reliability Program or CEMR activity in a separate paper record, which will be segregated from other records.

b. Personnel Reliability Program STR 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 and DA Form 4515 as described in paragraph 5–21*b*. The Personnel Reliability Program block on the record folder will be marked to indicate participation in the program. Block 8a of DD Form 2766 will also be marked.

Section IV
Maintenance of Service Treatment Records and Civilian Employee Medical Records Upon Mobilization

5–32. Paper service treatment records of deployed military members and deployed civilians

a. STRs of deployed military members and CEMRs of deployed civilians. STRs or CEMRs of deployed individuals will not accompany them to deployed areas.

(1) If an individual deploys, DD Forms 2766 and 2766C will be printed using AHLTA and placed in DD Form 2766 to accompany the individual to the field. DD Form 2766 will serve as the treatment folder while the individual is deployed. Other forms, such as DD Form 2766C, DD Form 2795, DD Form 1380, and SF 600, will be filed on the fastener inside DD Form 2766 if not documented in AHLTA-T. Copies of DD Forms 2766 and 2766C will be removed and shredded when the originals are placed back into the STR or CEMR. Forms that had been filed inside DD Form 2766 will be removed and filed in the regular treatment folder according to figures 5-1, 5-2, or 7-1.

(2) When processing individuals for deployment, the MTF and DTF will audit each individual's STR or CEMR and record essential health and dental care information into AHLTA so that the data updates DD Form 2766.

(3) DODD 6490.2 and DOD Instruction (DODI) 6490.3 state that, to the extent applicable, medical surveillance activities will include essential DOD civilian and contractor personnel directly supporting deployed forces, consistent with plans established under DODI 1400.32 and DODI 3020.37. If DD Form 2795 is used for civilians, the original form will remain in the CEMR and AHLTA can be utilized to complete this form. All contractors receiving care in the MTF will have an AHLTA medical record. A copy of the form will be filed on the fastener inside DD Form 2766, and a copy will be sent to the Army Medical Surveillance Activity.

(4) If the deployed individual is taking part in a classified operation, the pre-deployment evaluation (DD Form 2795) is still required.

(5) The completed DD Form 2766 and a copy of any printout from an electronic immunization tracking system will be provided to the individual's command, or to the individual if he or she is an individual replacement, and then transferred to the MTF in the area of operation responsible for providing primary medical care to that individual. That MTF will maintain DD Form 2766 as an outpatient field file for reference as needed. The unit commander is responsible for ensuring that medical records are safely routed to their final destination.

(6) The MTF personnel will ensure that the ABO/Rh blood type from a verified blood bank typing is recorded in block 10.

(7) The field file will consist of, in part, DD Form 2766, DD Form 2795, and possibly DD Form 2766C, as well as DD Form 2796, SF 600, SF 558, SF 603, and/or DD Form 1380. These forms will be filed on the fastener inside DD Form 2766.

(8) If DD Form 2766 is not available, the individual's field file may be managed as a "drop" file (forms not attached) and integrated into DD Form 2766 when it is available.

b. Engagement forces. If time permits, follow guidance in *a*(1), (2), and (3), above. If not, process when time permits.

c. Smaller scale contingencies. Retain the STR at the MTF and DTF providing primary care. If the servicing primary care facility closes, forward the STR to the MTF or DTF indicated by the servicing MEDDAC and DENTAC. If full mobilization occurs, follow guidance in *a*(1), (2), and (3), 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.

5–33. Preparation of service treatment record forms

a. AHLTA-T. AHLTA-T will be utilized for documenting care in the operational setting when available.

b. DD Form 1380. Instructions for preparing DD Form 1380 are provided in chapter 11. When DD Form 1380 is put into the record, 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.

c. SF 600. SF 600 is prepared the same during combat conditions as during peacetime. (See para 5–18.)

d. SF 603A. Dental encounters will be recorded in the dental module of AHLTA-T when available. Until the system's availability, 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.

5–34. Use of field files/DD Form 2766

a. If a member's primary MTF changes, the field file/DD Form 2766 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/DD Form 2766. The file will be returned to the member's primary MTF if disposition is "RTD."

5–35. Health assessments after deployment

a. DD Form 2796 or electronic equivalent will be used for post-deployment health assessments as described below. It will be completed electronically wherever possible.

(1) All military personnel will complete DD Form 2796 (electronically wherever possible) prior to leaving the area of operation.

(a) The individual being screened will fill out the section entitled "Demographics" on page 1, and the section entitled "Health Assessment" on page 2. These sections are self–explanatory.

(b) The administrator will fill out the boxed area on page 1 entitled "Administrator Use Only," and will answer the user's questions on filling out the form. The administrator will document the deployment location (if this information is missing) and the completion date of the post–deployment evaluation on DD Form 2766, Block 11–Pre/Post Deployment History. This does not apply to classified operations.

(c) The healthcare provider will fill out the section entitled "Post–Deployment Health Provider Review" on page 2.

(2) If a situation does not allow this health screening prior to departure, the individual's commander will ensure that the health assessment is completed and submitted to the local MTF commander within 30 days of the individual's return. The MEDPROS used to complete DD Form 2766 must have a mechanism to deliver the information on the form to the Army Medical Surveillance Activity and have the data available in AHLTA.

(3) RC personnel must complete DD Form 2796 prior to release from active duty if the form was not completed before redeployment. RC personnel who have been deployed will also complete DD Form 2697 according to AR 40–501. RC personnel who are called to active duty but never actually deployed will only complete DD Form 2697.

(4) If DD Form 2796 is used for civilians, the electronic form will be completed prior to leaving the area of operation. If a situation does not allow this health screening prior to departure, the individual's commander will ensure that the health assessment is completed within 30 days of the individual's return. If the DD Form 2796 is completed prior to leaving the area of operation, the original form will be filed in the DD Form 2766 folder until it can be integrated into the CEMR according to figure 7–1. The local commander will ensure that a procedure is in place for submitting a copy of the DD Form 2796 to the Army Medical Surveillance Activity and for filing the original in the CEMR.

(5) If the deployed individual is taking part in a classified operation, the post-deployment evaluation (DD Form 2796) is still required and will be completed electronically where possible.

b. All post-deployment related care will be documented in AHLTA consistent with other longitudinal health care. Current post-deployment evaluation recommendations should be utilized.

5–36. Operation after hostilities cease

a. Field files/DD Form 2766 will be integrated with the STR or CEMR after demobilization at home station or mobilization stations.

(1) On return to the MTF (post deployment), any paper-based forms such as SF 600 will be removed from the DD Form 2766 folder and placed with the other SFs 600 in the medical record.

(2) The paper copies of the DD Form 2766 and DD Form 2766C will also be removed and shredded when the originals are placed back into the record. Field files/DD Form 2766 will be forwarded to AR–AHRC for those members whose STR is maintained at AR–AHRC.

b. Each MTF within the continental United States (CONUS) must request records from AR–AHRC 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

DD Form 2766[2]
Adult Preventive and Chronic Care Flowsheet (folder construction). (See paras 3-10*c*, 4-4*d*, 5-13, 5-19, 5-26*b*(2), 5-32*a*, 5-36*a*, 6-7*f*, 7-4*b*(4), 10-7*b*, and 12-3*a*(9).)

DD Form 2882
Pediatric and Adolescent Preventive and Chronic Care Flowsheet. (See paras 5-10, 6-2*f*, 10-7*b*, and figs 6-1 and 6-2.)

DD Form 2766C, SF 601[1]
Adult Preventive and Chronic Care Flowsheet-Continuation Sheet; Health Record-Immunization Record. Attach DD Form 2766C and SF 601 to the inside fastener of DD Form 2766. Attach any automated immunization tracking system printout. (See paras 5-13*a*(2), 5-13*b*(3)*(b)*, 5-13*c*(10), 5-13*d*, 5-19, 5-27*c*(2), 5-32*a*, 5-36*a*, and 6-7*b*.)

DA Form 3180
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-21*b*(8), 5-30*a*, 5-31*c*, and 7-4*b*(8) of this regulation.)

DA Form 4186
Medical Recommendation for Flying Duty. (See AR 40-501 and para 5-21*b*(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.)

Health Enrollment/Evaluation Assessment Review (HEAR) Primary Care Managers (PCM) Report, (See para 5-13*b*(3) and 5-13*c*(6).)

DA Form 5571
Master Problem List. This form is obsolete; use for file purposes only if already in existence.

DA Form 8007-R
Individual Medical History. This form is obsolete; use for file purposes only if already in existence. (See para 5-13*b*.)

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

DD Form 1141; ADR
Record of Occupational Exposure to Ionizing Radiation; Automated Dosimetry Record. (See paras 5-21*b*(5) and 7-4*b*(6) of this regulation.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3-2, 5-15, and 9-25.)

SF 512[1]
Clinical Record-Plotting Chart. (See para 5-15.)

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.

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

SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 557 Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; 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 556
Immunohematology. SF 556 is obsolete; use for file purposes only if already in existence.

SF 507[1]
Medical Record—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.

DA Form 2631
Medical Care—Third Party Liability Notification. (See AR 40-400.)

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 treatment facility here. (See AR 40-400 and paras 3–12*a*(1), 3–13*b*, 3–17*a*, 3–19*b*, 5–2*a*, 5–21*a*, 6–7, 9–9*b*, 9–15, 9–16, 9–17, 9–18, 9–19, and 11–2 of this regulation.)

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

DD Form 2770[1]
Abbreviated Medical Record (outpatient) (formerly SF 539). (See paras 9–21 and 10–3*a*(2).)

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

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

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

DD Form 2870
Authorization for Disclosure of Medical or Dental Information. (See paras 2-3*a*(1) and 2-3*b*(1) and figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1, and 10-1.)

DA Form 5006
Medical Record-Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. This form is obsolete; use for file purposes only if already in existence. File DA Form 5006 after DD form 2870.

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

DA Form 3365
Authorization for Medical Warning Tag. (See paras 6-7*f*, 14-1, 14-3*c*, and 14-5.)

DD Form 2569
Third Party Collection Program-Insurance Information. (See paras 5-21*a*, 6-2*h*, and 9-20.)

ABO/Rh blood type SF 600 overprint.

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care, living wills, and so forth). (See paras 6-2*i*, 9-2*c*(2), and 10-3*a*(4).)

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 5-21*b*(8), 5-31*c*, and 7-4*b*(8) of this regulation.)

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

SF 600[1,2], DD Form 2844 (TEST); SF 558[1], DA Form 5181[1], SF 513[1], DD Form 2161[1] Medical Record-Chronological Record of Medical Care; Medical Record-Post Deployment Medical Assessment; Medical Record-Emergency Care and Treatment; Screening Note of Acute Medical Care; Medical Record-Consultation Sheet; Referral for Civilian Medical Care. If DD Form 2844 (TEST) is present, file it with the associated SF 600; include any associated patient questionnaires. File any other basic chronological medical care records here, for example, commercially available emergency room charting systems, Automated Military Outpatient System (AMOSIST) or other forms completed at civilian facilities. (See paras 5-7, 5-16, 5-18, 5-35*b*, 9-12, and 10-3*b*(6)*(b)*.)

DD Form 2341
Report of Animal Bite-Potential Rabies Exposure. File behind corresponding SF 558. (See AR 40-905/SECNAVINST 6401.1A/AFI 48-131.)

State ambulance forms. File behind corresponding SF 558. (See para 5-21*b*(7).)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5-6 and 10-3*b*(6)*(a)*.)

DA Form 3824[1]
Urologic Examination.

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

DD Form 2493-1
Asbestos Exposure Part I—Initial Medical Questionnaire. (See AR 40-5 and para 5–21*b*(9) of this regulation.)

DD Form 2493-2
Asbestos Exposure Part II—Periodic Medical Questionnaire. (See AR 40-5 and para 5–21*b*(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[1]
Isoniazid (INH) Clinic Flow Sheet. (See para 5–8.)

SF 602
Medical Record—Serology Record. Also file any civilian or foreign military treatment records here. (See paras 5–18*g*, 5–21*b*(10), and 5–26*b*(2)*(l)*.)

DA Form 4707
Entrance Physical Standards Board (EPSBD) Proceedings. (See AR 40-400 and para 5–21*a*(6) of this regulation.)

DA Form 3947
Medical Evaluation Board Proceedings. (See AR 40-400 and para 5–21*a*(5) of this regulation.)

DA Form 199
Physical Evaluation Board (PEB) Proceedings. (See AR 635-40 and para 5–21*a*(4) of this regulation.)

DA Form 2173
Statement of Medical Examination and Duty Status. (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 5–21*b*(3) 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 3–2*a*, 3–3, 5–21*b*(7), 9–2*b*, and 12–4*b*(4).)

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

DA Form 4970-E
Medical Screening Summary—Cardiovascular Risk Screening Program. This form is obsolete; use for file purposes only if already in existence.

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

DD Form 2808[2]; DA Form 7349; DD Form 2697; DA Form 4497; FAA Form 8500-8
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 3–10*g*, 5–6, 5–18*d*, 5–21*b*(1), 5–25*e*(5), and 7–4*b* of this regulation.)

SF 88
Report of Medical Examination. This form is obsolete; use for file purposes only if already in existence.

DD Form 2795; DD Form 2796
Pre-Deployment Health Assessment; Post-Deployment Health Assessment. File the DD Form 2795 and the associated DD Form 2796 as a set. (See paras 5–32*a*, 5–35*a*, 5–36*a*(2), and 7–4*b*(5).)

DD Form 2807-1[2]
Report of Medical History. File any other medical history form here. (See AR 40-501 and paras 5–21*b*(1), 5–25*e*(5), and 7–4*b*(2) of this regulation.)

SF 93
Report of Medical History. This form is obsolete; use for file purposes only if already in existence.

OSHA Respirator Medical Evaluation Questionnaire. (See para 7–4*b*(8).)

DA Form 7389[1]
Medical Record—Anesthesia (formerly SF 517 and OF 517). Outpatient surgery only. (See paras 9–12 and 10–3*b*(1).)

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). (See paras 3–3 and 10–3*b*(3).)

SF 559[1]
Medical Record—Allergen Extract Prescription, New and Refill. (See paras 5–5 and 5–17.)

DA Form 5007A[1]; DA Form 5007B[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.

DD Form 771
Eyewear Prescription. (See AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3 and para 5–21*b*(2) of this regulation.)

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

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

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 4465
Patient Intake/Screening Record (PIR). Also file any other authorized alcohol and drug forms here. (See DA Pam 600-85 and paras 5–21*b*(4) and 8–9*k* of this regulation.)

DA Form 4466
Patient Progress Report (PPR). (See DA Pam 600-85 and paras 5–21*b*(4) and 8–9*l* of this regulation.)

SF 533[1]
Medical Record—Prenatal and Pregnancy. File any forms belonging to pregnancy episode not delivered in MTF here. (See para 6–7*g*.)

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 4–4*a*(9), 5–27*a*, 7–4*a*, and 10–3*a*(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 STR (treatment) using DA Form 3444–series jackets—Continued

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 1

DD Form 2882
Pediatric and Adolescent Preventive and Chronic Care Flowsheet. (See paras 5-10, 6-2*f*, 10-7*b*, and figs 6-1 and 6-2.)

DD Form 2766[2]
Adult Preventive and Chronic Care Flowsheet (folder construction). (See paras 3-10*c*, 4-4*d*, 5-13, 5-19, 5-26*b*(2), 5-32*a*, 5-36*a*, 6-7*f*, 7-4*b*(4), 10-7*b*, and 12-3*a*(9).)

DD Form 2766C, SF 601[1]
Adult Preventive and Chronic Care Flowsheet-Continuation Sheet; Health Record-Immunization Record. Attach DD Form 2766C and SF 601 to the inside fastener of DD Form 2766. Attach any automated immunization tracking system printout. (See paras 5-13*a*(2), 5-13*b*(3)*(b)*, 5-13*c*(10), 5-13*d*, 5-19, 5-27*c*(2), 5-32*a*, 5-36*a*, and 6-7*b*.)

Health Enrollment/Evaluation Assessment Review (HEAR) Primary Care Managers (PCM) Report, (See para 5-13*b*(3) and 5-13*c*(6).)

DA Form 5571
Master Problem List. This form is obsolete; use for file purposes only if already in existence.

DA Form 8007-R
Individual Medical History. This form is obsolete; use for file purposes only if already in existence. (See para 5-13*b*.)

DD Form 1141; ADR
Record of Occupational Exposure to Ionizing Radiation; Automated Dosimetry Record. (See paras 5-21*b*(5) and 7-4*b*(6) of this regulation.)

DD Form 2493-1
Asbestos Exposure Part I-Initial Medical Questionnaire. (See AR 40-5 and para 5-21*b*(9) of this regulation.)

DD Form 2493-2
Asbestos Exposure Part II-Periodic Medical Questionnaire. (See AR 40-5 and para 5-21*b*(9) of this regulation.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3-2, 5-15, and 9-25.)

SF 512[1]
Clinical Record-Plotting Chart. (See para 5-15.)

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 557
Chemistry I; Chemistry II, Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; 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 556
Immunohematology. SF 556 is obsolete; use for file purpose only if already in existence.

Figure 5–2. Forms and documents of the STR using DA Form 8005–series jackets

SF 507[1]
Medical Record—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.

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 5–17.)

DA Form 5007A[1]; DA Form 5007B[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/NAVMEDCOMINST 6810.1/AFR 167-3 and para 5–21*b*(2) of this regulation.)

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

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 5–21*b*(8), 5–31*c*, and 7–4*b*(8) of this regulation.)

DA Form 3180
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5–21*b*(8), 5–30*a*, 5–31*c*, and 7–4*b*(8) of this regulation.)

DA Form 4186
Medical Recommendation for Flying Duty. (See AR 40-501 and para 5–21*b*(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]; DD Form 2844 (TEST); SF 558[1]; DA Form 5181[1]; SF 513[1]; DD Form 2161[1]
Medical Record—Chronological Record of Medical Care; Medical Record—Post Deployment Medical Assessment; Medical Record—Emergency Care and Treatment; Screening Note of Acute Medical Care; Medical Record—Consultation Sheet; Referral for Civilian Medical Care. If DD Form 2844 (TEST) is present, file it with the associated SF 600; include any associated patient questionnaires. File any other basic chronological medical care records here, for example, commercially available emergency room charting systems, AMOSIST or other forms completed at civilian facilities. (See paras 5–7, 5–16, 5–18, 5–35*b*, 9–12, and 10–3*b*(6)*(b)*.)

DD Form 2341
Report of Animal Bite—Potential Rabies Exposure. File behind corresponding SF 558. (See AR 40-905/SECNAVINST 6401.1A/AFI 48-131.)

State ambulance forms. File behind corresponding SF 558. (See para 5–21*b*(7).)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5–6 and 10–3*b*(6)*(a)*.)

DA Form 3824[1]
Urologic Examination.

SF 602
Medical Record—Serology Record. Also file any civilian or foreign military treatment records here. (See paras 5–18*g*, 5–21*b*(10), and 5–26*b*(2)*(l)*.)

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

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

Home health care documentation.

DA Form 5569[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 3–2*a*, 3–3, 5–21*b*(7), 9–2*b*, and 12–4*b*(4).)

DA Form 7389[1]
Medical Record—Anesthesia (formerly SF 517 and OF 517). Outpatient surgery only. (See paras 9–12 and 10–3*b*(2).)

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). (See paras 3–3 and 10–3*b*(3).)

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

DD Form 2808[2]; DA Form 7349; DD Form 2697; DA Form 4497; FAA Form 8500-8
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 3–10*g*, 5–6, 5–18*d*, 5–21*b*(1), 5–25*e*(5), and 7–4*b* of this regulation.)

SF 88
Report of Medical Examination. This form is obsolete; use for file purposes only if already in existence.

DD Form 2795; DD Form 2796
Pre-Deployment Health Assessment; Post-Deployment Health Assessment. File the DD Form 2795 and the associated DD Form 2796 as a set. (See paras 5–32*a*, 5–35*a*, 5–36*a*(2), and 7–4*b*(5).)

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

DD Form 2807-1[2]
Report of Medical History. File any other medical history form here. (See AR 40-501 and paras 5–21*b*(1), 5–25*e*(5), and 7–4*b*(2) of this regulation.)

SF 93
Report of Medical History. This form is obsolete; use for file purposes only if already in existence.

OSHA Respirator Medical Evaluation Questionnaire. (See para 7–4*b*(8).)

DA Form 4970-E
Medical Screening Summary—Cardiovascular Risk Screening Program. This form is obsolete; use for file purposes only if already in existence.

DA Form 4465
Patient Intake/Screening Record (PIR). Also file any other authorized alcohol and drug forms here. (See DA Pam 600-85 and paras 5–21*b*(4) and 8–9*k* of this regulation.)

DA Form 4466
Patient Progress Report (PPR). (See DA Pam 600-85 and paras 5–21*b*(4) and 8–9l of this regulation.)

PART III

DA Form 2631
Medical Care—Third Party Liability Notification. (See AR 40-400.)

DA Form 3365
Authorization for Medical Warning Tag. (See paras 6–7f, 14–1, 14–3*c*, and 14–5.)

DD Form 2569
Third Party Collection Program—Insurance Information. (See paras 5–21*a*, 6–2*h*, and 9–20.)

DA Form 4707
Entrance Physical Standards Board (EPSBD) Proceedings. (See AR 40-400 and para 5–21*a*(6) of this regulation.)

DA Form 3947
Medical Evaluation Board Proceedings. (See AR 40-400 and para 5–21*a*(5) of this regulation.)

DA Form 199
Physical Evaluation Board (PEB) Proceedings. (See AR 635-40 and para 5–21*a*(4) of this regulation.)

DA Form 2173
Statement of Medical Examination and Duty Status. (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 5–21*b*(3) of this regulation.)

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

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

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

DD Form 2870
Authorization for Disclosure of Medical or Dental Information. (See paras 2-3*a*(1) and 2-3*b*(1) and figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1, and 10-1.)

DA Form 5006
Medical Record-Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. This form is obsolete; use for file purposes only if already in existence. File DA Form 5006 after DD form 2870.

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

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care and living wills). (See paras 6-2*i*, 9-2*c*(2), and 10-2*a*(4).)

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
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 treatment facility here. (See AR 40-400 and paras 3-12*a*(1), 3-13*b*, 3-17*a*, 3-19*b*, 5-2*a*, 5-21*a*, 6-7, 9-9*b*, 9-15, 9-16, 9-17, 9-18, 9-19, and 11-2 of this regulation.)

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

SF 502[1]
Clinical Record-Narrative Summary (outpatient). (See para 9-12.)

DD Form 2770[1]
Abbreviated Medical Record (outpatient) (formerly SF 539). (See paras 9-21 and 10-3*a*(2).)

SF 509[1,2]
Medical Record-Progress Notes. SF 509 includes the final discharge note. (See paras 9-12 and 10-3*b*(5).)

SF 515[1]
Medical Record-Tissue Examination (outpatient). (See paras 5-2, 5-21, and 10-3*b*(1).)

SF 516[1]
Medical Record-Operation Report (outpatient). (See paras 9-12 and 10-3*b*(4).)

SF 531[1]
Medical Record-Anatomical Figure.

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

SF 533[1]
Medical Record—Prenatal and Pregnancy. File any forms belonging to pregnancy episode not delivered in MTF here. (See para 6–7*g*.)

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 4–4*a*(9), 5–27*a,* 7–4*a*, and 10–3*a*(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 STR using DA Form 8005–series jackets—Continued

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
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5–21*b*(8), 5–30*a*, 5–31*c*, and 7–4*b*(9) 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 5–27*b*.)

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 5–21*b*(8), 5–31*c*, and 7–4*b*(9) 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 5–2*c*, 5–20, 5–25*e*(4), 5–26*c*, 5–27*b*, 5–27*c*(3), 5–32*a*(2), 5–33*c*, and 6–7.)

DD Form 2813[2]
Department of Defense Reserve Forces Dental Examination. (See para 5–14.)

DA Form 4700
Medical Record—Supplemental Medical Data. (See paras 3–2*a*, 3–3, 5–21*b*(7), 9–2*b*, and 12–4*b*(4).)

DA Form 3984
Dental Treatment Plan. (See TB MED 250.)

SF 513[2]
Medical Record—Consultation Sheet. (See para 9–12.)

SF 507[2]
Medical Record—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.

Figure 5–3. Forms and documents of the STR dental record

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). (See paras 3–3 and 10–3*b*(3).)

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, including advance directives (durable powers of attorney for health care, living wills, and so forth). (See paras 6–2*i*, 9–2*c*(2), and 10–3*a*(4).)

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 4–4*a*(9), 5–27*a*, 7–4*a*, and 10–3*a*(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 STR dental record—Continued

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 AD	DEPART./SERVICE Army	RECORDS MAINTAINED AT
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.)* Walker, Paula C. 20 32932 99 93 F 1966 SSG	REGISTER NO.	WARD NO.

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 5–4. Sample entries on SF 600

Chapter 6
Outpatient Treatment Records

Section I
General

The electronic encounter documentation form in AHLTA (currently labeled SF 600) will be utilized to document all outpatient care when it is available. The AHLTA SF 600 and its other electronic printouts are a substitute for the paper-based forms noted below. Paper-based forms should be used when AHLTA is not available and as a general content guideline. Any update to these forms should use the International Business Machines workflow forms tools and contain Extensible Markup Language data mapping to AHLTA when available. External documents may be scanned or included in AHLTA by other electronic means, provided the document can be verified as belonging to a specific patient and meets current guidelines for inclusion into AHLTA. Documents that can be verified as belonging to a specific patient, but do not meet current guidelines for inclusion in AHLTA, will be filed in the paper OTR.

6–1. For whom prepared

An 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 STR is not prepared. The AHLTA system will be utilized when available for official record-keeping purposes and will subsume any separate use of paper versions of the medical forms, except in specific instances where a given form without electronic substitute is needed. 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 or other scenarios, record forms filed under the former SSN should be brought forward to the number currently in DEERS ensuring that the current family member prefix is used. Merging of any duplicate patient records in CHCS or AHLTA will occur as a matter of course. 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: Guidelines for paper record preparation and use

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 paper-based medical OTRs are listed in figures 6–1 and 6–2. Use of AHLTA to capture the information contained on these forms precludes use of the paper form, except as previously noted. Information captured in AHLTA will not be filed in the paper STR, except as previously noted. Paper-based forms utilized when AHLTA is not available 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 either electronically or 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 5568 (Chronological Record of Well–Baby Care) will be used to document well–baby visits. A copy of this form is available on the AEL CD–ROM and at the Army Publishing Directorate Web site (www.apd.army.mil).

f. DD Form 2792 (Exceptional Family Member Medical Summary), DD Form 2792–1 (Exceptional Family Member Special Education/Early Intervention Summary), DD Form 2882, and the electronic Exceptional Family Member Program Summary will be filed on the left side of the folder, according to figures 6–1 and 6–2. (See AR 608–75.)

g. 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 STR.

h. 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, or file one copy in the STR and forward one copy to the billing office.

i. Advance directives (durable power of attorney for health care, living wills) will be recorded in accordance with paragraph 9–2*c*(2).

Section II
Initiating, Keeping, and Disposing of Outpatient Treatment Records

6–3. Initiating and keeping outpatient treatment records

a. The creation of an OTR in AHLTA involves patient registration in CHCS. Until a single enterprise-wide AHLTA registration system is available, registration must occur at each MTF with a host CHCS server.

(1) MTFs will utilize only the full registration function and not use mini-registration, except in the rare instances where use of mini-registration is essential for immediate clinical care.

(2) MTFs will register all patients in CHCS who receive care at the MTF, regardless of their employment or beneficiary status. This includes contractors receiving care related to CEMR and civilian emergencies.

(3) MTFs will establish central patient registration SOPs to ensure data quality and prevent patient duplication. Patient registration should not occur within clinic activities, except in the rare instances where clinic registration is essential for immediate clinical care.

(4) Prior to registering a patient in a local CHCS host, existing patient data in AHLTA should be reviewed if present. Use of these data will help decrease patient record duplication issues.

(5) Current guidance on registration provided by the TRICARE Management Activity should be followed to help prevent registration errors and duplicate patient registration.

b. A paper OTR, as well as an electronic AHLTA OTR, will be prepared by the first MTF/DTF to which a person reports for outpatient treatment. After being initiated, the OTR will be kept at the MTF/DTF (including a separate record at Family Health Center clinics) that provides the patient's primary care. MTF/DTF commanders will establish local operating policies for continuing to maintain a legible, chronological longitudinal STR, OTR, or CEMR at the MTF providing primary care. This record will contain copies of all treatment episodes. This includes all treatment documentation resulting from referral visits to TRICARE prime, extra, and standard providers; transporting outpatient records from location to location; and discontinuing the use of patients as a means of transport. MTFs/DTFs will continue to provide the patient with copies of medical documentation maintained by the MTF/DTF as requested. MTF/DTF commanders will coordinate the retrieval of pertinent records or associated medical/dental documents as requested by the patient from all applicable MTFs/DTFs/civilian network providers for inclusion in the chronological, longitudinal record. Patients enrolled in TRICARE Prime Remote will maintain the STR and OTR at the closest MTF/DTF until the sponsor is reassigned to an installation supported by an MTF/DTF. MTF/DTF commanders will market this policy and educate beneficiaries, providers, and clinical staff regarding the new processes, accountability of medical records, and duties required for successful implementation.

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 PCS. 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 in accordance with 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 MTF where care will be sought.

a. Mailing OTRs.

(1) When a patient moves, his/her OTR must be transported to the next MTF without patient touching. Special category records will also be mailed. (See definition of "special category record" in the glossary, sec II.)

(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.

b. 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.

c. 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 also be identified on SF 600. The x rays will be mailed in a sealed envelope or mailer to the gaining MTF/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 STR to the new duty station MTF. Transfer of x rays will be handled according to instructions on transferring x rays in (1) above.

d. Family health center OTRs. Medical care provided in family health center clinics to other than STR beneficiaries will be documented in an OTR maintained by the family health center clinic. This OTR is the property of the U.S. Government and includes the same standard forms used in DOD MTFs. Release of information from family health center records is the responsibility of the PAD at the sponsoring MTF. Upon the sponsor's PCS and presentation of orders, records of family members will be mailed to the next duty station. (See para 2–6 for protection of medical records of teenage family members.) Upon presentation of the sponsor's orders authorizing the concurrent travel of family member and a valid identification card, the OTR will be mailed to the next duty station. The record will be integrated into the OTR at the next MTF.

6–5. Requests other than DD Form 2138

Although DD Form 2138 (Request for Transfer of Outpatient Record) is the only form authorized for use as a request for transferring patients' ASAP-OMRs in ordinary circumstances, this restriction does not preclude prompt responses to other types of requests.

6–6. Disposition

a. OTRs will be retired to the NPRC in accordance with AR 25–400–2. (See para 3–7 of this regulation for information on destroying unidentifiable OTRs.) If loose documents containing medical treatment information are found after the applicable record has been transferred to the NPRC, staple them together and place them in a manila folder with the name and SSN of the Soldier or the sponsor and/or family member written on the top of the folder. NPRC will accept these documents for interfile if prepared in this way and retired as an accession. Do not send documents that have no identifying information. These loose documents will be retired through medical records tracking in CHCS, CHCS II, or ESSENTRIS.

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. See paragraph 4-4c for guidance on retirement of inpatient and outpatient records.

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 STR. 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. Xrays stored on electronic media (for example, computerized disks and so on) are not currently eligible for retirement to NPRC in OTR record folders.

Section III
Preparation and Use of Outpatient Treatment Records

6–7. Preparation

a. Outpatient documentation. Each contact with the AMEDD as an outpatient will be recorded in the OTR. Each contact with the AMEDD as an outpatient will be recorded in the OTR.Periods of treatment as an inpatient will be

recorded in the ITR. A copy of the discharge summary and narrative summary (SF 502) from each admission will be included in the OTR. Inpatient dental treatment will be recorded in the dental record on SF 603 until the dental module of AHLTA is fielded. At this point, such dental treatment will be recorded in AHLTA if needed functionality is present. Participation in research as a human subject will also be fully recorded in the OTR (para 5–18). Occupational health–related medical care will be recorded in AHLTA. Administrative medical forms related to occupational health will be kept in the CEMR in either paper or electronic versions.

b. Immunization documentation. The reasons for waiving any immunization will be recorded in the AHLTA immunization module. Additional information should be added as necessary to the encounter note to allow for future medical evaluation. Any disease outbreaks for which immunizing agents were used must be noted. The year and place of outbreak must also be given. Any adverse reactions to immunizations (including vaccines, sera, or other biologicals) will be recorded. Immunizations documented in AHLTA must include the name of the ordering provider.

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 para 5–20.)

d. SF 603A. SF 603A will be used, when needed, and will be filed on top of the original SF 603. (See para 5–20.)

e. DA Form 8006 (Pediatric Dentistry Diagnostic Form). DA Form 8006 will be used for recording the examination, diagnosis, and treatment planning of pediatric dentistry patients. This form is available on the AEL CD–ROM and at the APD Web site (www.apd.army.mil). Instructions for completing the form are self–explanatory.

f. Preparation of the paper 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 the medication allergy clearly identified.

g. Obstetrical cases. A pregnancy diagnosis will be entered in AHLTA. At the time of admission for delivery or other inpatient obstetrical treatment, the AHLTA encounter notes, along with any paper-based charting concerning the pregnancy for which the admission occurs, will be filed in the ITR.

h. Behavioral health records. Documentation of clinical encounters by behavioral healthcare providers will be in the AHLTA. Clinical documentation is defined as the documentation required for the observation, treatment, or care of the patient. Functional data sets requiring documentation within the OTR/STR are intake/initial behavioral health evaluation, assessment of risk, progress note, and termination note. Legal and administrative information, such as that currently obtained by the Family Advocacy Program (FAP) and ASAP, will continue to be maintained in separate records as per the relevant regulations. Behavioral healthcare providers should take great care when documenting the following data domains of significant sensitivity to patients, and support their desire for maximum confidentiality and privacy: sexual history/concerns, legal history/concerns, substance abuse history/concerns, financial history/concerns, data concerning others, operational/mission related data, and psycho–dynamic interpretations/hypotheses. Only information that supports the rendering of an accurate diagnosis and/or aids in constructing a treatment plan and/or assists the provider in rendering a humane and constructive disposition will be documented in the OTR/STR. (Also see para 5-22 of this regulation.)

6–8. Use

The paper OTR will only be provided to clinics for outpatient care based upon established local rules or by specific provider request. When an outpatient is to be treated over a short period in a clinic, the paper 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, a copy of the paper OTR will be forwarded to an MTF when the patient is admitted to that MTF and will be constantly available for use by the attending physician.

a. Chargeout system. A strict audit trail will be kept for paper OTRs temporarily out of the file. Use of an electronic record tracking system is encouraged. (See para 4–6.)

b. Protection of PHI. See chapter 2.

Until the DA Form 8005-series 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

DD Form 2766[2]; DA Form 5571
Adult Preventive and Chronic Care Flowsheet (cut sheet construction); Master Problem List. DD Form 2766 is used for non-active duty adult beneficiaries and non-deployable civilians; DA Form 5571 is used for pediatric patients. DA Form 5571 is obsolete; use for file purposes only if already in existence. (See paras 3-10*c*, 4-4*d*, 5-10, 5-13, 5-19, 5-26*b*(2), 5-32*a*, 5-36*a*, 6-7*f*, 7-4*b*(4), 10-7*b*, and 12-3*a*(9).)

DD Form 2766C
Adult Preventive and Chronic Care Flowsheet-Continuation Sheet. (See paras 5-13*b*(3)*(b)*, 5-13*d*, 5-32*a*, and 5-36*a*.)

DA Form 3180
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-21*b*(8), 5-30*a*, 5-31*c*, and 7-4*b*(8) of this regulation.)

DA Form 4186
Medical Recommendation for Flying Duty. (See AR 40-501 and para 5-21*b*(6) of this regulation.)

Health Enrollment/Evaluation Assessment Review (HEAR) Primary Care Managers (PCM) Report. (See para 5-13*b*(3) and 5-13*c*(6).)

DD Form 2882
Pediatric and Adolescent Preventive and Chronic Care Flowsheet. (See paras 5-10, 6-2*f*, 10-7*b*, and figs 6-1 and 6-2.)

DA Form 5571
Master Problem List. This form is obsolete; use for file purposes only if already in existence.

DD Form 2792-1
Exceptional Family Member Special Education/Early Intervention Summary.

Automated Exceptional Family Member Program Summary. (See AR 608-75 and para 6-2*f* of this regulation.)

Civilian source pediatric growth charts. (See para 6-2*d*.)

SF 601[1,2]
Health Record-Immunization Record. File any automated immunization tracking system printout here. (See paras 5-13*a*(2), 5-13*c*(10), 5-19, 5-27*c*(1), and 6-7*b*.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3-2, 5-15, and 9-25.)

SF 512[1]
Clinical Record-Plotting Chart. (See para 5-15.)

Figure 6–1. Forms and documents of the OTR using DA Form 3444–series jackets

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 557 Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; 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 556
Immunohematology. SF 556 is obsolete; use for file purposes only if already in existence.

SF 507[1]
Medical Record—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.

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
Medical Care—Third Party Liability Notification. (See AR 40-400.)

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 treatment facility here. (See AR 40-400 and paras 3–12*a*(1), 3–13*b*, 3–19*a*, 3–20*b*, 5–2*a*, 5–21*a*, 6–7, 9–9, 9–15, 9–16, 9–17, 9–18, 9–19, and 11–2.)

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

DD Form 2770[1]
Abbreviated Medical Record (outpatient) (formerly SF 539). (See paras 9–21 and 10–3*a*(2).)

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

Figure 6–1. Forms and documents of the OTR using DA Form 3444–series jackets—Continued

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

DD Form 2870
Authorization for Disclosure of Medical or Dental Information. (See paras 2-3*a*(1) and 2-3*b*(1) and figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1, and 10-1.)

DA Form 5006
Medical Record-Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. This form is obsolete; use for file purposes only if already in existence. File DA Form 5006 after DD form 2870.

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

DA Form 3365
Authorization for Medical Warning Tag. (See paras 6-7*f*, 14-1, 14-3*c*, and 14-5.)

DD Form 2569
Third Party Collection Program-Insurance Information. (See paras 5-21*a*, 6-2*h*, and 9-20.)

Administrative documents and other correspondence including advance directives (durable powers of attorney for health care, living wills, and so forth). (See paras 6-2*i*, 9-2*c*(2), and 10-3*a*(4).)

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 5-21*b*(8), 5-31*c*, and 7-4*b*(8) 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[1], SF 513[1], DD Form 2161[1]
Medical 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, commercially available emergency room charting systems, AMOSIST or other forms completed at civilian facilities. (See paras 5-7, 5-16, 5-18, 5-35*b*, 9-12, and 10-3*b*(6)*(b)*.)

DD Form 2341
Report of Animal Bite-Potential Rabies Exposure. File behind corresponding SF 558. (See AR 40-905/SECNAVINST 6401.1A/AFI 48-131.)

State ambulance forms. File behind corresponding SF 558. (See para 5-21*b*(7).)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5-6 and 10-3*b*(6)*(a)*.)

DA Form 3824[1]
Urologic Examination.

DD Form 2493-1
Asbestos Exposure Part 1-Initial Medical Questionnaire. (See AR 40-5 and para 5-21*b*(9) of this regulation.)

Figure 6–1. Forms and documents of the OTR using DA Form 3444–series jackets—Continued

DD Form 2493-2
Asbestos Exposure Part II—Periodic Medical Questionnaire. (See AR 40-5 and para 5–21*b*(9) of this regulation.)

DA Form 5568[1]
Chronological Record of Well-Baby Care. (See para 6–2*e*.)

DA Form 5694
Denver Developmental Screening Test. This form is obsolete; use for file purposes only if already in existence.

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

Home health care documentation.

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

SF 602
Medical Record—Serology Record. (See paras 5–18*g*, 5–21*b*(10), and 5–26*b*(2)*(l)*.)

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 3–2*a*, 3–3, 5–21*b*(7), 9–2*b*, and 12–4*b*(4).)

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

DA Form 4970–E
Medical Screening Summary—Cardiovascular Risk Screening Program. This form is obsolete; use for file purposes only if already in existence.

DD Form 2808[2]
Report of Medical Examination. (See AR 40-501 and paras 3–10*g*, 5–18*d*, 5–21*b*(1), and 5–25*e*(5) of this regulation.)

SF 88
Report of Medical Examination. This form is obsolete; use for file purposes only if already in existence.

DD Form 2807-1[2]
Report of Medical History. File any other medical history form here. (See AR 40-501 and paras 5–21*b*(1), 5–25*e*(5), and 7–4*b*(2) of this regulation.)

SF 93
Report of Medical History. This form is obsolete; use for file purposes only if already in existence.

DA Form 7389[1]
Medical Record—Anesthesia (formerly SF 517 and OF 517). Outpatient surgery only. (See paras 9–12 and 10–3*b*(2).)

Figure 6–1. Forms and documents of the OTR using DA Form 3444–series jackets—Continued

OF 522[1] or State-mandated forms
Medical Record—Request for Administration of Anesthesia and Performance of Operations and Other Procedures (formerly SF 522). (See paras 3–3 and 10–3*b*(3).)

SF 559[1]
Medical Record—Allergen Extract Prescription, New and Refill. (See paras 5–5 and 5–17.)

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

DA Form 5007A[1]; DA Form 5007B[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.

DD Form 771
Eyewear Prescription. (See AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3 and para 5–21*b*(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
Patient Intake/Screening Record (PIR). Also file any other authorized alcohol and drug forms here. (See DA Pam 600-85 and paras 5–21*b*(4) and 8–9*k* of this regulation.)

DA Form 4466
Patient Progress Report (PPR). (See DA Pam 600-85 and paras 5–21*b*(4) and 8–9*l* of this regulation.)

SF 533[1]
Medical Record—Prenatal and Pregnancy. File any forms belonging to pregnancy episode not delivered in MTF here. (See para 6–7*g*.)

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 4–4*a*(9), 5–27*a*, 7–4*a*, and 10–3*a*(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—Continued

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 1

DD Form 2766[2]
Adult Preventive and Chronic Care Flowsheet (cut sheet construction). DD Form 2766 is used for non-active duty adult beneficiaries and non-deployable civilians; DA Form 5571 is used for pediatric patients. (See paras 3-10*c*, 4-4*d*, 5-10, 5-13, 5-19, 5-26*b*(2), 5-32*a*, 5-36*a*, 6-7*f*, 7-4*b*(4), 10-7*b*, and 12-3*a*(9).)

DD Form 2766C
Adult Preventive and Chronic Care Flowsheet-Continuation Sheet. (See paras 5-13*b*(3)*(b)*, 5-13*d*, 5-32*a*, and 5-36*a*.)

DD Form 2882
Pediatric and Adolescent Preventive and Chronic Care Flowsheet. (See paras 5-10, 6-2*f*, 10-7*b*, and figs 6-1 and 6-2.)

Health Enrollment/Evaluation Assessment Review (HEAR) Primary Care Managers (PCM) Report, (See para 5-13*b*(3) and 5-13*c*(6).)

DA Form 5571
Master Problem List. This form is obsolete; use for file purposes only if already in existence.

DD Form 2792
Exceptional Family Member Medical Summary. (See AR 608-75 and para 6-2*f* of this regulation.)

DD Form 2792-1
Exceptional Family Member Special Education/Early Intervention Summary. (See AR 608-75 and para 6-2*f* of this regulation.)

Automated Exceptional Family Member Program Summary. (See AR 608-75 and para 6-2*f* of this regulation.)

Civilian source pediatric growth charts. (See para 6-2*d*.)

DD Form 2493-1
Asbestos Exposure Part I-Initial Medical Questionnaire. (See AR 40-5 and para 5-21*b*(9) of this regulation.)

DD Form 2493-2
Asbestos Exposure Part II-Periodic Medical Questionnaire. (See AR 40-5 and para 5-21*b*(9) of this regulation.)

SF 601[1,2]
Health Record-Immunization Record. File any automated immunization tracking system printout here. (See paras 5-13*a*(2), 5-13*c*(10), 5-19, 5-27*c*(1), and 6-7*b*.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3-2, 5-15, and 9-25.)

SF 512[1]
Clinical Record-Plotting Chart. (See para 5-15.)

Figure 6–2. Forms and documents of the OTR using DA Form 8005–series jackets

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 557 Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; 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 556
Immunohematology. SF 556 is obsolete; use for file purposes only if already in existence.

SF 507[1]
Medical Record—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.

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 5–17.)

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

Figure 6–2. Forms and documents of the OTR using DA Form 8005–series jackets—Continued

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 5–21*b*(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 5–21*b*(8), 5–31*c*, and 7–4*b*(8) of this regulation.)

DA Form 3180
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5–21*b*(8), 5–30*a*, 5–31*c*, and 7–4*b*(8) of this regulation.)

DA Form 4186
Medical Recommendation for Flying Duty. (See AR 40-501 and para 5–21*b*(6) 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[1]; SF 513[1]; DD Form 2161[1]
Medical 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, commercially available emergency room charting systems, AMOSIST or other forms completed at civilian facilities. (See paras 5–7, 5–16, 5–18, 9–12, and 10–3*b*(6)*(b)*.)

DD Form 2341
Report of Animal Bite—Potential Rabies Exposure. File behind corresponding SF 558. (See AR 40-905/SECNAVINST 6401.1A/AFI 48-131.)

State ambulance forms. File behind corresponding SF 558. (See para 5–21*b*(7).)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5–6 and 10–3*b*(6)*(a)*.)

DA Form 3824[1]
Urologic Examination.

Figure 6–2. Forms and documents of the OTR using DA Form 8005–series jackets—Continued

DA Form 5568[1]
Chronological Record of Well-Baby Care. (See para 6–2*e*.)

DA Form 5694
Denver Developmental Screening Test. This form is obsolete; use for file purposes only if already in existence.

SF 602
Medical Record—Serology Record. (See paras 5–18*g*, 5–21*b*(10), and 5–26*b*(2)*(l)*.)

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

Home health care documentation.

DA Form 5569[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 3–2*a*, 3–3, 5–21*b*(7), 9–2*b*, and 12–4*b*(4).)

DA Form 7389[1]
Medical Record—Anesthesia (formerly SF 517 and OF 517). Outpatient surgery only. (See paras 9–12 and 10–3*b*(2).)

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). (See paras 3–3 and 10–3*b*(3).)

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

DD Form 2808[2]
Report of Medical Examination. (See AR 40-501 and paras 3–10*g*, 5–18*d*, 5–21*b*(1), and 5–25*e*(5) of this regulation.)

SF 88
Report of Medical Examination. This form is obsolete; use for file purposes only if already in existence.

Figure 6–2. Forms and documents of the OTR using DA Form 8005–series jackets—Continued

DD Form 2807-1[2]
Report of Medical History. File any other medical history from here. (See AR 40-501 and paras 5-21*b*(1), 5-25*e*(5), and 7-4*b*(2) of this regulation.)

SF 93
Report of Medical History. This form is obsolete; use for file purposes only if already in existence.

DA Form 4870-E
Medical Screening Summary-Cardiovascular Risk Screening Program. This form is obsolete; use for file purposes only if already in existence.

DA Form 4465
Patient Intake/Screening Record (PIR). Also file any other authorized alcohol and drug forms here. (See DA Pam 600-85 and paras 5-21*b*(4) and 8-9*k* of this regulation.)

DA Form 4466
Patient Progress Report (PPR). (See DA Pam 600-85 and paras 5-21*b*(4) and 8-9*l* of this regulation.)

PART III

DA Form 2631
Medical Care-Third Party Liability Notification. (See AR 40-400.)

DA Form 3365
Authorization for Medical Warning Tag. (See paras 6-7*f*, 14-1, 14-3*c*, and 14-5.)

DD Form 2569
Third Party Collection Program-Insurance Information. (See paras 5-21*a*, 6-2*h*, and 9-20.)

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

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

DD Form 2870
Authorization for Disclosure of Medical or Dental Information. (See paras 2-3*a*(1) and 2-3*b*(1) and figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1, and 10-1.)

DA Form 5006
Medical Record-Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. This form is obsolete; use for file purposes only if already in existence. File DA Form 5006 after DD form 2870.

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

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care, living wills, etc.). (See paras 6-2*i*, 9-2*c*(2), and 10-3*a*(4).)

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].

Figure 6–2. Forms and documents of the OTR using DA Form 8005–series jackets—Continued

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 treatment facility here. (See AR 40-400 and paras 3–12*a*(1), 3–13*b*, 3–19*a*, 3–20*b*, 5–2*a*, 5–21*a*, 6–7, 9–9*b*, 9–15, 9–16, 9–17, 9–18, 9–19, and 11–2 of this regulation.)

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

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 9–21 and 10–3*a*(2).)

SF 509[3]
Medical Record—Progress Notes. SF 509 is the final discharge note. (See paras 9–12 and 10–3*b*(5).)

SF 515[3]
Medical Record—Tissue Examination (outpatient). (See paras 5–2, 5–21 and 10–3*b*(1).)

SF 516[3]
Medical Record—Operation Report (outpatient). (See paras 9–12 and 10–3*b*(4).)

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 4–4*a*(9), 5–27*a*, 7–4*a*, and 10–3*a*(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—Continued

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 5–27*b*.)

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 5–2*c*, 5–20, 5–25*e*(4), 5–26*c*, 5–27*b*, 5–27*c*(3), 5–30*a*(2), 5–33*c*, and 6–7.)

DA Form 4700
Medical Record—Supplemental Medical Data. (See paras 3–2*a*, 3–3, 5–21*b*(7), 9–2*b*, and 12–4*b*(4).)

DA Form 8006[2]
Pediatric Dentistry Diagnostic Form. (See para 6–7*e*.)

DA Form 3984
Dental Treatment Plan. (See TB MED 250.)

SF 513[2]
Medical Record—Consultation Sheet. (See para 9–12.)

SF 507[2]
Medical Record—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). (See paras 3–3 and 10–3*b*(3).)

DA Form 8-115
Register of Dental Patients. DA Form 8-115 is obsolete; use for file purposes only if already in existence.

Figure 6–3. Forms and documents of the nonmilitary dental record

Other medical or dental records important to the patient's care, including advance directives (durable powers of attorney for health care, living wills, etc.). (See paras 6–2*i*, 9–2*c*(2), and 10–3*a*(4).)

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 4–4*a*(9), 5–27*a*, 7–4*a*, and 10–3*a*(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—Continued

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 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 healthcare 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, and so forth, are filed in the OTR.

d. The original documentation will be retained at the MTF where the treatment was rendered. Continue to maintain an additional legible, chronological, longitudinal record copy of all treatment episodes.

7–3. For whom prepared

A CEMR, including AHLTA/CHCS registration, will be prepared for each permanent civilian employee upon employment. A CEMR, including AHLTA/CHCS registration, will also be prepared for all nonpermanent employees and volunteers 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, middle initial), 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. Attach an NOPP acknowledgment label to the center of the back outside cover of the SF 66D. 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. These forms will be filed from top to bottom in the order they are listed in the figure. Additionally, all printed AHLTA encounters that pertain to the patient's occupational health will be kept in chronological order in the CEMR. 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 they 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 shown in chapter 5 or chapter 6.

c. CEMR records may be held electronically (without printing) if that meets the MTF needs regarding occupational health documentation.

(1) AHLTA will be used to capture information consistent with SF 78 (U.S. Civil Service Commission, Certificate of Medical Examination), which is used to record preemployment physical examination results for appropriated fund employees, and may be used to record periodic job–related physical examination results.

(2) 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 (see para 5–21b(5)).

(3) DA Form 4515 and DA Form 3180 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.

(4) The mandatory OSHA Respirator Medical Evaluation Questionnaire will be used according to 29 CFR 1910.134. (See DOD 6055.05-M for additional information on this questionnaire.)

(5) 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 Physician's Report).

(6) 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. 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).

(7) 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) DA Form 3666 (Department of the Army Nonappropriated Funds 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, including CEMRs, at his or her facility. 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 3–4.

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 following details:

(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 biological agents or by ionizing radiation, see paragraph 3–12*c*.

7–8. Cross–coding of medical records

a. Civilian employees who are military medical beneficiaries will have a single AHLTA record, but may have a second paper-based CEMR for occupational health records, if necessary.

b. The CEMRs of civilian employees who are also family member beneficiaries will have only one AHLTA record.

The practice of creating a second CHCS record can result in patient safety issues (for example, issues related to patient record merges). A paper CEMR will continue to be maintained under the civilian employee's SSN and name.

7–9. Transferring and retiring civilian employee medical records

The paper copy of 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–ay films be preserved in their original state. Radiographic and lab results pertinent to the CEMR may be printed and included in the record. Digital radiographs will be kept in the system of record with reports as appropriate being placed in the CEMR.

c. See paragraphs 6–4*d*(2) and 6–6*c* 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 PHI, Access to Civilian Employee Medical Records, and Performance Improvement

7–11. Protection of confidentiality and disclosure procedures

a. All CEMRs and PHI 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 PHI 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 PHI 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, or CA–20; 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 12–3 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

DD Form 2766[2]
Adult Preventive and Chronic Care Flowsheet (cut sheet construction). (See paras 3-10*c*, 4-4*d*, 5-13, 5-19, 5-26*b*(2), 5-32*a*, 5-36*a*, 6-7*f*, 7-4*b*(4), 10-7*b*, and 12-3*a*(9).)

DD Form 2766C, SF 601[1]
Adult Preventive and Chronic Care Flowsheet-Continuation Sheet; Health Record-Immunization Record. If using the folder construction of DD Form 2766 (deployable civilians), attach DD form 2766C, SF 601, and any automated immunization tracking system printout to the inside fastener of DD Form 2766. If using the cut sheet construction of DD Form 2766 (nondeployable civilians), place DD Form 2766C below DD Form 2766 and place SF 601 and any automated immunization tracking system printout where noted below. (See paras 5-13*a*(2), 5-13*b*(3)*(b)*, 5-13*c*(10), 5-13*d*, 5-19, 5-27*c*(1), 5-32*a*, 5-36*a*, and 6-7*b*.)

DA Form 5571
Master Problem List. This form is obsolete; use for file purposes only if already in existence.

DA Form 8007-R
Individual Medical History. This form is obsolete; use for file purposes only if already in existence. (See para 5-13*b*.)

DA Form 3180
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-21*b*(8), 5-30*a*, 5-31*c*, and 7-4*b*(8) of this regulation.)

DA Form 4186
Medical Recommendation for Flying Duty. (See AR 40-501 and para 5-21*b*(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 paras 5-21*b*(5) and 7-4*b*(6) of this regulation.)

DD Form 2493-1
Asbestos Exposure Part I-Initial Medical Questionnaire. (See AR 40-5 and para 5-21*b*(9) of this regulation.)

DD Form 2493-2
Asbestos Exposure Part II-Periodic Medical Questionnaire. (See AR 40-5 and para 5-21*b*(9) of this regulation.)

OF 345
Physical Fitness Inquiry for Motor Vehicle Operators. (See AR 40-5 and para 7-4*b*(11)*(a)* of this regulation.)

DA Form 3666
Department of the Army Nonappropriated Funds Statement of Physical Ability for Light Duty Work. (See AR 215-3 and para 7-4*b*(11)*(b)* of this regulation.)

Figure 7–1. Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders

SF 177
Statement of Physical Ability for Light Duty Work. This form is obsolete; use for file purposes only if already in existence.

SF 601[1]
Health Record—Immunization Record. Place this form here only if using the cut sheet construction of DD Form 2766. File any automated immunization tracking system printout here. (See paras 5–19, 5–25*e*(3), 5–27*c*(1), and 6–7*b*.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3–2, 5–15, and 9–25.)

SF 512[1]
Clinical Record—Plotting Chart. (See para 5–15.)

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 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; 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 556
Immunohematology. SF 556 is obsolete; use for file purposes only if already in existence.

SF 507[1]
Medical Record—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.

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.

Figure 7–1. Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders—Continued

DD Form 771
Eyewear Prescription. (See AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3 and para 5-21b(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 of certificates prepared by neuropsychiatric consultation services or psychiatrists.

DA Form 3365
Authorization for Medical Warning Tag. (See paras 6-7*f*, 14-1, 14-3*c*, and 14-5.)

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

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

DD Form 2870
Authorization for Disclosure of Medical or Dental Information. (See paras 2-3*a*(1) and 2-3*b*(1) and figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1, and 10-1.)

DA Form 5006
Medical Record-Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. This form is obsolete; use for file purposes only if already in existence. File DA Form 5006 after DD form 2870.

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care, living wills, and so forth). (See paras 6-2*i*, 9-2*c*(2), and 10-3*a*(4).)

DA Form 4410-R[2]
Disclosure Accounting Record. The DA Form 4410-R is printed on the DA Form 3444-series 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 5-21*b*(8), 5-31*c*, and 7-4*b*(8) of this regulation.)

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

SF 600[1,2], DD Form 2844 (TEST); SF 558[1], SF 513[1], DD Form 2161[1]
Medical Record-Chronological Record of Medical Care; Medical Record-Post Deployment Medical Assessment; Medical Record-Emergency Care and Treatment; Medical Record-Consultation Sheet; Referral for Civilian Medical Care. If DD Form 2844 (TEST) is present, file it with the associated SF 600; include any associated patient questionnaires. File any other basic chronological medical care records here, for example, commercially available emergency room charting systems, AMOSIST or other forms completed at civilian facilities. (See paras 5-7, 5-16, 5-18, 5-35*b*, 9-12, and 10-3*b*(6)*(b)*.)

DD Form 2341
Report of Animal Bite-Potential Rabies Exposure. File behind corresponding SF 558. (See AR 40-905/SECNAVINST 6401.1A/AFI 48-131.)

Figure 7–1. Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders—Continued

DA Form 5008
Telephone Medical Advice Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5–6 and 10–3*b*(6)*(a)*.)

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

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 3–2*a*, 3–3, 5–21*b*(7), 9–2*b*, and 12–4*b*(4).) File here any other forms used to record the results of atmospheric sampling.

DD Form 2808
Report of Medical Examination. (See AR 40-501 and paras 3–10*g*, 5–18*d*, 5–21*b*(1), and 5–25*e*(5) of this regulation.)

SF 88
Report of Medical Examination. This form is obsolete; use for file purposes only if already in existence.

DD Form 2795; DD Form 2796
Pre-Deployment Health Assessment; Post-Deployment Health Assessment. File any DD Form 2795 and the associated DD Form 2796 as a set. (See paras 5–32*a*, 5–35*a*, 5–36*a*(2), and 7–4*b*(5).)

OSHA Respirator Medical Evaluation Questionnaire. (See para 7–4*b*(8).)

SF 78
U.S. Civil Service Commission, Certificate of Medical Examination. (See para 7–4*b*(1).)

DA Form 3437
Department of the Army Nonappropriated Funds Certificate of Medical Examination. (See para 7-4*b*(3).)

DD Form 2807-1[2]
Report of Medical History. File any other medical history form here. (See AR 40-501 and paras 5-21*b*(1), 5–25*e*(5), and 7–4*b*(2) of this regulation.)

SF 93
Report of Medical History. This form is obsolete; use for file purposes only if already in existence.

DOL Form CA-1
Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation. (See para 7–4*b*.)

DOL Form CA-2
Federal Employee's Notice of Occupational Disease and Claim for Compensation. (See para 7–4*b*.)

DOL Form CA-16
Authorization for Examination and/or Treatment. (See para 7–4*b*.)

DOL Form CA-17
Duty Status Report. (See para 7–4*b*.)

Figure 7–1. Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders—Continued

DOL Form CA-20
Attending Physician's Report. (See para 7–4*b*.)

DD Form 2005[2]
Privacy Act Statement—Health Care Records. DD Form 2005 is always the bottom form in the CEMR. (See paras 4–4*a*(9), 5–27*a*, 7–4*a*, and 10–3*a*(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—Continued

Chapter 8
Army Substance Abuse Program Outpatient Medical Record

Section I
General

8–1. For whom prepared
An ASAP–OMR will be prepared for each patient enrolled in the ASAP.

8–2. Access
All personnel having access to ASAP–OMRs will protect the privacy of PHI. Care will be taken to prevent unauthorized release of any information on the treatment, identity, prognosis, or diagnosis for substance 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 (Army Substance Abuse Program (ASAP) Client's Consent Statement for Release of Treatment Information).

8–3. Disclosure of information
a. Requests for release of information from ASAP–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 and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a 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) ASAP civilian service records will be maintained in accordance with 42 CFR 2.16, 49 CFR 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 identifier.

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 USC 290dd–2) 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 ASAP–OMRs are listed in figure 8–1 and are available either electronically or 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 ASAP–OMR file folders. ASAP–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 stair–stepped from left to right across the bottom.

(2) On the right side, the first tab protrudes from the top and the others stair–step down the right side, starting from the top document to the bottom document. The tabs should be identified beginning with the top most document to the bottom document, as listed in figure 8–1, right side.

Section II
Initiating, Maintaining, and Disposing of Army Substance Abuse Program Outpatient Medical Records

8–5. Initiating and maintaining

When a patient is enrolled in the ASAP, the following notation will be made on the SF 600 maintained in either the STR, the OTR, or the CEMR corresponding to the patient's category: Date patient seen, refer to file number 40–66pp. After being initiated, the ASAP–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 ASAP–OMRs. For each person, only one ASAP–OMR will be kept at the CCC.

8–6. Transferring

a. To assist in providing continuity of care for ASAP-enrolled civilians and Soldiers, documentation that they are enrolled in the ASAP program will be recorded in the ASAP-OMR.

b. ASAP–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 ASAP–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 6–4*a*(2)*(c)*.

8–8. Disposition

ASAP–OMRs for both civilians and Soldiers will be disposed of in accordance with AR 25–400–2 (file number 600–85a).

Section III
Preparation and Use of Army Substance Abuse Program Outpatient Medical Records

8–9. Preparation

Each contact with the ASAP will be recorded in the ASAP-OMR for both civilians and Soldiers.

a. DA Form 7095 (ASAP Outpatient Discharge Summary) will be prepared when treatment is completed. Termination of Soldiers' care will also be entered into the ASAP template in AHLTA, along with a summary of the clinical course describing the reason for admission, treatment rendered, the patient's response, the patient's status at the time of discharge, and the patient's prognosis for future success.

b. DA Form 7096 (ASAP 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, ASAP clinical responsibilities, medications (if applicable), and support group involvement.

c. DA Form 7097 (ASAP 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.

d. DA Form 7098 (ASAP 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 (ASAP 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 (ASAP 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 (ASAP Outpatient Administrative Summary) will be used to briefly summarize rehabilitation efforts from date of patient enrollment to current date or termination of ASAP 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 (ASAP Enrollment) will be used to make an ASAP 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 ASAP clinical staff at the conclusion of the rehabilitation team meeting.

j. DA Form 8004 (ASAP Outpatient Medical Records—Privacy Act Information) will be signed by the patient after he or she reads it. (See figure 8–1.) DA Form 8004 explains the provisions of the Privacy Act as they pertain to ASAP–OMRs. This form is available on the AEL CD–ROM and at the APD Web site (www.apd.army.mil).

k. DA Form 4465 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 ASAP or when a medical evaluation is needed. (See DA Pam 600–85 for instructions on completing this form.)

l. DA Form 4466 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 DA Pam 600–85 for instructions on completing the form.)

8–10. Use

a. ASAP–OMRs will be provided to physicians, dentists, and other healthcare practitioners attending the ASAP patient for continuing patient care.

b. A strict audit trail will be kept for ASAP–OMRs temporarily removed from the file. (See para 4–6.) A strict record will be kept of any ASAP 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
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5–21*b*(8), 5–30*a*, 5–31*c*, and 7–4*b*(9) of this regulation.)

DA Form 7097[1]
ASAP Outpatient Problem List and Treatment Plan Review. (See para 8–9*c*.)

DA Form 8002[1]
ASAP Outpatient Administrative Summary. (See para 8–9*h*.)

DA Form 4465
Patient Intake/Screening Record (PIR). (See DA Pam 600-85 and paras 5–21*b*(4) and 8–9*k* of this regulation.)

DA Form 4466
Patient Progress Report (PPR). (See DA Pam 600-85 and paras 5–21*b*(4) and 8–9*l* 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 5–18 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 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; 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 556
Immunohematology. SF 556 is obsolete; use for file purposes only if already in existence.

SF 507[1]
Medical Record—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]
ASAP Enrollment. (See para 8–9*i*.)

Figure 8–1. Forms and documents of the ASAP–OMR

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.

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 5–21*b*(8), 5–31*c*, and 7–4*b*(9) of this regulation.)

DA Form 7095[1]
ASAP Outpatient Discharge Summary. (See para 8–9*a*.)

DA Form 7096[1]
ASAP Outpatient Aftercare Plan. (See para 8–9*b*.)

DA Form 7098[1]
ASAP Outpatient Treatment Plan and Review. (See para 8–9*d*.)

SF 600[1]
Medical Record—Chronological Record of Medical Care. (See para 5–18.)

DA Form 7099[1]
ASAP Outpatient Biopsychosocial Evaluation. (See para 8–9*e*.)

DA Form 8000[1]
ASAP Triage Instrument (For Unscheduled Patients). (See para 8–9*f*.)

Miscellaneous treatment and information.

DA Form 8001[1]
Limits of Confidentiality. (See para 8–9*g*.)

DA Form 8004[1]
ASAP-OMR—Privacy Act Information. (See para 8–9*j*.)

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

Figure 8–1. Forms and documents of the ASAP–OMR—Continued

Chapter 9
Inpatient Treatment Records

Section I
General

9–1. For whom prepared

a. An ITR (paper, ESSENTRIS, or other equivalent) will be prepared for—
(1) Every bed patient (military or civilian) in a fixed or field hospital, fixed health clinic, or convalescent center.
(2) Each liveborn infant delivered in one of those MTFs.
(3) CRO cases (para 3–19).

(4) 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 in accordance with 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 (Medical Record — Supplemental Medical Data) 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 in accordance with figure 9–1.

(1) ITRs for previous admissions (except those already retired in accordance with AR 25–400–2) will be filed in a separate folder.

(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, and so forth), 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 healthcare 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 2, advance directives will be given legal effect in accordance with State law. DODD 1350.4 gives requirements for the preparation of military advance directives. 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 also be filed with administrative documents on the left side of the folder in the DA Form 3444–series folders and on the right side of the folder in the DA Form 8005–series folders.

(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

(For guidance on retirement of fetal monitors, see The Medical Record Tracking, Retirement, Retrieval User Guide, appendix D, at https://kx.atms.mil/hipaa/mrtr2/. An Army Knowledge Online (AKO) account is required.)

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. An extended ambulatory record (EAR) will be initiated when a patient undergoes an extended ambulatory encounter. (See para 3–19 for information on CRO cases; see chap 10 for information on EARs.) The ITR will be prepared and reviewed in accordance with this regulation and locally established procedures.

9–5. Records for Ambulatory Procedure Visit patients
An Ambulatory Procedure Visit (APV) is one of the services provided as an extended ambulatory encounter (para 10–1). APV records that have already been initiated in this way do not need to be refiled to meet the current EAR requirements in chapter 10. An APV will be filled in a separate folder (DA Fom 3444–series). EARs should be retired through CHCS, AHLTA, or ESSENTRIS.

9–6. NATO STANAG 2348 ED.3(1) 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 (Patient Evacuation Tag).) In addition, the policies listed in *a* and *b*, below, apply to 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 (NATO STANAG 2132 ED.2) 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.

c. X–rays stored on electronic media (for example, CDs) are not currently eligible for retirement to NPRC.

9–7. Inpatient treatment records of AWOL patients
The ITR of a patient who has been AWOL for 10 consecutive days will be closed and disposed of in accordance with 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 five years after the end of the year of the last inpatient disposition. (See para 10–5 for EAR maintenance.) 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.
h. Landstuhl Regional Medical Center, MCEUL–PAD (CMR 402), APO AE 09180–3460.

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 electronic database, for example, CHCS, AHLTA, or ESSENTRIS 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/AHLTA/ESSENTRIS or other electronic inpatient data systems.

b. Register number index. MEDDACs will maintain a register number index for five years. MEDCENS do not need to maintain this index because the ITRs are maintained at the MEDCEN for five 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/AHLTA/ESSENTRIS or electronic 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 for each 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, an Air Force or Navy MTF, or 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 9–2*b*(2)). At a minimum, this copy should include SF 513, DD Form 2161, SF 504 (Clinical Record—History—Part I), SF 505 (Clinical Record—History—Parts II and III), 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, CHCS, CHCS II, or ESSENTRIS electronic 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 in accordance with 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, Medical Records Tracking, Retirement, Retrieval User Guide, and http://pad.amedd.army.mil or https://kx.afms.mil/hipaa/mrtr2/, must have an AKO account.)

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 ESSENTRIS note or other electronic equivalent within four working days. If a test result is pending, seven 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 TJC for a completed ITR within 30 days from the day of a patient's discharge. (See para 12–3*c*(5).) 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, CHCS, AHLTA, ESSENTRIS, or electronic equivalent will be prepared. Records will be reviewed in accordance with this chapter and paragraph 12–3.

a. If requested by the attending physician, ITRs from previous admissions, OTRs, STRs, 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 9–12*b*) and other notes made by healthcare providers.

c. When the patient is discharged, the attending physician will prepare SF 502 (para 9–12*e*), complete the DA Form 3647 worksheet (section IV), or provide similar information using an electronic 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 9–2*b*(2)).

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 in no later than seven days, so that it may be completed and sent to the Patient Administration Division. (See para 9–12*f*.)

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. (electronic 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 within 24 hours of admission using an SF 504, SF 505, and SF 506, or electronic equivalent, or an AHLTA encounter note containing appropriate information. 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 9–14*c* 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 5–18*b*(3) and 9–14 for information on SF 509.)

(2) *Readmission.* When a patient is readmitted within 30 days for the same condition, an interval history and physical will be written in the progress notes (SF 509), the electronic equivalent, or documented in an AHLTA encounter note on the day of admission. 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 of admission history and physical exam.* Documentation may be done with an AHLTA encounter note completed on the day of admission or on SF 504, SF 505, and SF 506, or electronic equivalents.

b. SF 509 or electronic equivalent. 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 3–4*c*.)

(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 5–16.) A copy of the SF 558 will be filed in the OTR/STR. 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 two 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. In accordance with TJC 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 follow–up 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 seven 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 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 40–68). 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 and OF 275 or electronic equivalents. (See para 3–3 of this regulation 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 healthcare 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 5–2*b*(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 electronic 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, CHCS/AHLTA/ESSENTRIS or electronic equivalent will be the same. (See paras 5–2, 5–21, 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 follow–up 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 9–21*e*.)

(b) An obstetrical case has a normal, uncomplicated delivery. If a patient stay (mother and newborn) lasts more than 48 hours with no complications, a narrative summary is not required. Instead a progress note can be substituted for a narrative summary; the progress note will include the patient's condition at discharge, discharge instructions, and required follow–up care.

(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 that 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 readmissions 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, and so forth).

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 for each 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 judgment 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 used.

(2) *Preparation.* DA Form 3888–3 is a three–part 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 STR 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, except as noted in *c*, below. Exceptions to this requirement for countersignature may be granted by the MTF commander through the privileging process.

(1) Histories and physical examinations performed by someone other than the senior resident, staff physician, qualified oral and maxillofacial surgeon, certified midwife, or qualified podiatrist.

(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. If the prescribing physician is unable to countersign the telephone order, he or she may contact the covering physician and discuss the order. The covering physician may then countersign the telephone order for 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) signed by medical students in an approved graduate medical education program, when completed as 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, CHCS, AHLTA, or ESSENTRIS or electronic equivalent is a medical and administrative summary of each case and will be prepared for each ITR. (For CRO cases, DA Form 3647, CHCS, AHLTA , or ESSENTRIS, electronic equivalent may be the entire ITR.) DA Form 3647, CHCS, AHLTA, or ESSENTRIS electronic equivalent is also an essential document for STRs and OTRs and serves as a source document for statistical information of major military and medical interest. In facilities using CHCS, AHLTA , or ESSENTRIS, an electronic version of DA Form 3647 may be used.

9–16. Use

Paragraph 9–1*a*(1) identifies the types of MTFs that use DA Form 3647, CHCS, AHLTA, or ESSENTRIS electronic 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, CHCS, AHLTA , or ESSENTRIS, electronic 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, CHCS, AHLTA , or ESSENTRIS electronic 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, AHLTA or electronic 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, AHLTA or electronic 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, CHCS, AHLTA, ESSENTRIS or electronic equivalent and SF 502 (when prepared) will also be filed in STRs and OTRs. Copies of DA Form 3647, CHCS, AHLTA, ESSENTRIS or electronic equivalent and SF 502 on PHS or Coast Guard commissioned corps officers should be forwarded to Medical Branch, 5600 Fishers Ln., Parklawn Bldg., Room 4–35, Rockville, MD 20857–0435.

9–18. Preparation

Instructions for completing DA Form 3647, AHLTA, ESSENTRIS, or electronic equivalent are found in the IPDS User's Manual. Also see the International Classification of Diseases, Ninth Edition: Clinical Modification (ICD–9–CM) and the Tri–Service Disease and Procedure ICD–9–CM Coding Guidelines. Diagnostic entries on the worksheet copy of DA Form 3647, AHLTA, ESSENTRIS, or electronic 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, AHLTA, ESSENTRIS, or electronic equivalent.

9–19. Corrections and corrected copies

Corrections to DA Form 3647, AHLTA, ESSENTRIS, or electronic equivalent will be made when necessary. (See para 3–4*e*.)

Section V
Preparation and Use of Other Inpatient Treatment Record Forms

9–20. DD Form 2569

Insurance information obtained on DD Form 2569 or electronic equivalent 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 STR 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 conditions.

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 ASA 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.) The physical examination section must also describe any exceptions or other pertinent findings.

d. DD Form 2770 will never be used for ASA Class III patients, no matter 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

Consent for admission of patients to psychiatric treatment units will be recorded on DA Form 4359 (Authorization for Psychiatric Service Treatment). This form is available on the AEL CD–ROM and at the APD Web site (www.apd.army.mil).

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, and SF 557) and electronic 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 STR. 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 STR.

b. Electronic methods of reporting and requisitioning laboratory tests are authorized using CHCS, AHLTA, ESSENTRIS, or other approved hospital or laboratory information systems. When computerized or electronic 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. Results of outpatient labs must be printed out and filed in the record before retirement. (X–rays must also be printed out. See para 4–4*c*5, above.)

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. Healthcare practitioners should refrain from making hand–written 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 two years after the date of reporting. (Immunohematology reports under 21 CFR 606, Subpart I, and 42 CFR 493.1107 and 1109, must be retained for at least five years after records have been completed, or six 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/AFMAN(I) 41–119, 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 they will be computer entries. Entries must be legible on all three copies. In each Patient Identification section, addressograph plates should be used. (See paras 3–5*b* 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 "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 electronic system such as CHCS or ESSENTRIS 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. If the prescribing physician is unable to countersign the telephone order, he or she may contact the covering physician and discuss the order. The covering physician may then countersign the telephone order for the prescribing physician.

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 in accordance with 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 patient's 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 four 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; "discontinued/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 in accordance with 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 that pertain to the administration of the ordered medication. (See figure 9–1.) 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 in accordance with 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; "discontinued/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 that 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 at bed time, 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 three 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 three hours or fraction thereof for one anesthesia provider. Any fraction over the initial three–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 electronic 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 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 cubic centimeters FFP 1500 cubic centimeters).

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, and so forth), 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 TJC 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, in 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, and so forth) 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, ¼ 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, and so forth. (Also see item 17.)

(19) Use this section for further documentation or for reporting additional information on other items.

(20) *Items 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 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 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 STR. 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, electronic, 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.

c. All SF 519–B reports must be printed out and added to outpatient records (STR, OTR, CEMR).

9–37. DA Form 5009

DA Form 5009 (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. This form is available on the Army Electronic Library (AEL) CD–ROM and at the APD Web site (www.apd.army.mil).

Table 9–1
NATO national military medical authorities

Country	Address
Belgium	État–Major Du Service Médical Section Techniques Médicales Quartier Reine Elisabeth Rue d'Evere B–1140 Brussels, Belgium
Bulgaria	Military Medical Academy — Sofia 3 Gregory Soflisky Blvd 1606 Sofia, Bulgaria
Canada	National Defence HQ KIA OK2 Attention: Chief, Medical Services Ottawa, Ontario Canada
Czech Republic	Surgeon General's Office, General Staff of the Czech Armed Forces Vitezne Namesti 5 160 01 Praha 6, Czech Republic
Denmark	Danish Armed Forces Health Services Jaegersborg Kaserne PO Box 96 DK–2820 Gentofte, Denmark
Estonia	Surgeon General Estonian Defence Forces, General Staff EDF, 58 Juhkentali Street 15007 Tallinn, Estonia Fax: +372.717 1458
France	Direction Centrale du Service de Santé Armées Hôtel 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
Hungary	Medical Directorate, General Staff Ministry of Defense (Hungarian Defense Forces) Budapest 1885, POB 25, Hungary
Iceland	State Social Securtiy Institute, Langavegur 114–116 150 Reykjavik, Iceland
Italy	Minestera della Difesa Direzione Generale Della Sanita' Militare Via S. Stefano Rotondo, 4 00184 Roma, Italy
Latvia	Chief Medical Division, Ministry of Defence of the Republic of Latvia, National Armed Forces 10/12 Kr. Valdemara Street RIGA, LV 1473

Table 9–1
NATO national military medical authorities—Continued

Country	Address
Lithuania	Deputy Commander, Lithuanian Armed Forces Military Medical Service, Vytauto 49, LT– 44331 Kaunas, LITHUANIA Fax: +370.37.204.602
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
Poland	Directorate of Military Service Polish Armed Forces General Staff, A1. Niepodleglosci 643 A 00–909 Warsaw, Poland
Portugal	Ministerio Da Defesa Nacional Direccao–Geral de Pessoal Divisao de Saude Militar AV. Ilha dea Madeira, l, 4o 1400 Lisboa, Portugal
Romania	Surgeon General, Ministry of National Defence, Medical Directorate 3–5 Institutional Medico–Militar Street 010919 Bucharest–1, Romania Fax: +40–21–220–5453
Slovakia	Chief of the Veterinary Corps, Ministry of Defence of the Slovak Republic, Military Medical Office Za Kasarnu 5 832 47, Bratislava
Slovenia	Surgeon General Slovenian Armed Forces, Medical Advisor of the Chief of General Staff, Ministry of Defence, Slovenian Armed Forces — General Staff, Kardeljeva ploscad 25, SI–1000 Ljubljana, Slovenia Fax: +386 1 471 1653
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
United Kingdom	Ministry of Defence Directorate of Medical Operations and Plans JHQ 224 Northwood, Middlesex HA6 3HP England
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 ballpoint 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.

Block: Requesting Physician's Signature.
Completed by: Clinic or ward.
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.

Table 9–2
General instructions for preparing laboratory forms—Continued

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.
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

Table 9–3
Specific instructions for preparing laboratory forms—Continued

Form: SF 553
Use: To request most bacterial identifications and antibiotic susceptibility testing.
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 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

DD Form 2870
Authorization for Disclosure of Medical or Dental Information. (See paras 2-3*a*(1) and 2-3*b*(1) and figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1, and 10-1.)

DD Form 2882
Pediatric and Adolescent Preventive and Chronic Care Flowsheet. (See paras 5-10, 6-2*f*, 10-7*b*, and figs 6-1 and 6-2.)

DA Form 5571
Master Problem List. This form is obsolete; use for file purposes only if already in existence. Filing of this form in the ITR is optional for pediatric patients. (See para 5-13*b*.)

DA Form 3947
Medical Evaluation Board Proceedings (formerly DA Form 8-118). (See AR 40-400 and para 5-21*a*(5) of this regulation.)

DA Form 3349
Physical Profile (formerly DA Form 8-274). (See AR 40-501 and para 5-21*b*(3) of this regulation.)

DA Form 3894
Hospital Report of Death. Use to meet the requirements of STANAG 2046. (See AR 40-400 and para 3-13*b*(1) of this regulation.)

DA Form 2631
Medical Care-Third Party Liability Notification. (See AR 40-400.)

DA Form 2984
Very Seriously Ill/Seriously Ill/Special Category Patient Record. (See AR 40-400.)

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

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

DD Form 2870
Authorization for Disclosure of Medical or Dental Information. (See paras 2-3*a*(1) and 2-3*b*(1) and figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1, and 10-1.)

DA Form 5006
Medical Record-Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. This form is obsolete; use for file purposes only if already in existence. File DA Form 5006 after DD form 2870.

DA Form 5009[1]
Medical Record-Release Against Medical Advice. (See para 9-38.)

DD Form 2569
Third Party Collection Program-Insurance Information. (See paras 5-21*a*(7), 6-2*h*, and 9-20.)

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care, living wills, and so forth). (See paras 6-2*i*, 9-2*c*(2), and 10-3*a*(4).)

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

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.

Figure 9–1. Forms and documents of the ITR

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 5–21*b*(8), 5–31*c*, and 7–4*b*(8) of this regulation.)

DA Form 3647
Inpatient Treatment Record Cover Sheet or CHCS automated equivalent. (See AR 40-400 and paras 3–12*a*(1), 3–13*b*, 3–19*a*, 3–20*b*, 5–2*a*, 5–21*a*, 6–7, 9–9*b*, 9–10*a*, 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 3–3*f*, 9–12*c*, and 9–12*e*.)

SF 502[1]
Clinical Record—Narrative Summary. (See paras 5–2*a*, 5–21*a*(2), and 9–12.)

SF 503[1]
Clinical Record—Autopsy Protocol. Use as a summary for detailed autopsy reports. (See para 9–12*f*.)

DD Form 2770[1]
Abbreviated Medical Record (formerly SF 539). (See paras 9–21 and 10–3*a*(2).)

SF 504[1]
Clinical Record—History—Part I. (See paras 9–10*a*, 9–12*a*, 9–14*c*, and 9–21*e*.)

SF 505[1]
Clinical Record—History—Parts II and III. (See paras 9–10*a*, 9–12*a*, 9–14*c*, and 9–21*e*.)

SF 506[1]
Clinical Record—Physical Examination. (See paras 9–10*a*, 9–12*a*, 9–14*c*, and 9–21*e*.)

SF 535[1]
Clinical Record—Newborn. Also file civilian source pediatric growth charts here. (See para 6–2*d*.)

DA Form 5694
Denver Developmental Screening Test. This form is obsolete; use for file purposes only if already in existence.

SF 507[1]
Medical 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 3–3*k*, 5–16, 5–18*b*(3), 5–21*a*(3), 9–10*a*, 9–11, 9–12, 9–13, 9–14*b*, 9–14*c*, 9–21*e*, 9–25*d*, 10–3*b*(5), and 10–3*b*(6)*(b)*.)

Figure 9–1. Forms and documents of the ITR—Continued

DD Form 2341
Report of Animal Bite—Potential Rabies Exposure. File behind corresponding SF 558. (See AR 40-905/SECNAVINST 6401.1A/AFI 48-131.)

DA Form 3888
Medical Record—Nursing History and Assessment. (See paras 3–3*b* 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 3–2*a*, 9–12*b*(3), 9–13, and 9–14*c*.)

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 5–15.)

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 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; 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 556
Immunohematology. SF 556 is obsolete; use for file purposes only if already in existence.

SF 515[1]
Medical Record—Tissue Examination. (See paras 5–2, 5–21, and 10–3*b*(1).)

Armed Forces Institute of Pathology Consultation Report on Contributor Material.

SF 516[1]
Medical Record—Operation Report. (See paras 9–12 and 10–3*b*(4).)

DA Form 7389[1]
Medical Record—Anesthesia (formerly SF 517 and OF 517). (See paras 9–12 and 10–3*b*(2).)

Figure 9–1. Forms and documents of the ITR—Continued

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). (See paras 3–3 and 10–3*b*(3).)

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]
Medical 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 6–7*g*.)

Figure 9–1. Forms and documents of the ITR—Continued

SF 534[1]
Medical Record-Labor.

SF 537
Medical Record-Pediatric Graphic Chart. SF 537 is obsolete; use for file purposes only if already in existence.

SF 538[1]
Clinical Record-Pediatric.

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
Doctor's Orders. (See paras 3-*3p*, 9-*14a*(4), 9-*14c*, 9-26, and 10-*3a*(5).)

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-*21b*(7), 9-*2b*, and 12-*4b*(4).)

DA Form 5128
Clinical Record-Visual Field Examination. This form is obsolete; use for file purposes only if already in existence.

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. DD Form 742 is obsolete; use for file purposes only if already in existence.

Figure 9–1. Forms and documents of the ITR—Continued

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 3–19*a*, 5–11, 5–32*a*(2), 5–33*a*, 9–1*b*(2), 9–6, and chap 11.)

DA Form 4359
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 3–20*b* 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 4–4*a*(9), 5–27*a*, 7–4*a*, and 10–3*a*(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—Continued

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 calculations of episodes of OR nursing and episodes of anesthesia

Chapter 10
Extended Ambulatory Records

Section I
General

10–1. Purpose of the extended ambulatory record

The EAR is a separate category of medical treatment record used to document extended ambulatory encounters. The types of services currently defined as extended ambulatory encounters include the following. (These terms are defined in the glossary, sec II.) Not all of the services listed below are presently provided by all Army facilities.

a. Ambulatory Procedure Visit (APV).

b. Observation (OBS).

c. Subacute care (SC).

d. Home health (HH).

e. Partial hospitalization (PH).

f. Skilled nursing facility (SNF).

10–2. For whom prepared

An EAR will be prepared for each military or civilian patient who undergoes an extended ambulatory encounter, as listed in paragraph 10–1.

10–3. Extended ambulatory record forms and documents

a. At a minimum, the EAR documentation will include the following:

(1) DD Form 2005.

(2) DD Form 2770.

(3) Ongoing, interdisciplinary assessment of patient needs and plan of care, to include, but not limited to, pre–procedure and post–procedure patient instructions and a physician's summary of care provided (for example, SF 509 or DD Form 2770, etc.). A copy will be forwarded to the STR/OTR.

(4) Advance directive.

(5) DA Form 4256.

b. The EAR will include the following forms, if they are applicable:

(1) SF 515.

(2) DA Form 7389.

(3) OF 522, or State–mandated form.

(4) SF 516. A copy will be forwarded to the STR/OTR.

(5) SF 509.

(6) All appropriate therapeutic documentation, to include—

(a) Post–procedure follow–up telephone call (DA Form 5008).

(b) SF 558, if any care occurs after treatment in an EC/ED.

(c) Diagnostic reports, such as laboratory, radiology, or electrocardiogram reports.

c. File these forms according to figure 10–1. This figure lists other forms that may be used as needed.

Section II
Initiating, Keeping, and Disposing of Extended Ambulatory Records

10–4. Initiating extended ambulatory records

An EAR will be prepared by the MTF that provides a person's primary care when a patient is first treated for an extended ambulatory encounter.

10–5. Five–year/one–year extended ambulatory record maintenance

MEDCENs will keep EAR files for five years after the end of the year of the last ambulatory encounter, or after the end of the year of the last inpatient disposition, whichever is the latest. (MEDDACs will retire EARs one year after the end of the year of the last ambulatory encounter, or after the end of the year of the last inpatient disposition, whichever is latest.)

10–6. Disposition of extended ambulatory records

a. Routine retirement. ITRs and EARs retired under the same series, but filed in separate folders. The EAR folder will be placed in back of the associated ITR when both exist and are eligible for retirement. (Note: If a related fetal monitoring strip exists, the retirement order of the folder is— ITR, FMS, EAR. Each folder will have an entry on the related index which accompanies the retired records, and that index will serve as input to update the NPRC MRS (see para 9–3 for disposition of fetal monitoring strips).

b. Supplemental shipments.

(1) If any EARs or the associated ITRs are overlooked/unavailable at retirement time, either may be retired in subsequent supplemental shipments. Supplemental shipments must contain records of the same series and include an index, but they may reflect multiple last dates of treatment.

(2) Upon receipt at NPRC, records sent in supplemental shipments will be accessioned in the same manner as the primary shipment.

(3) Each record folder in the primary and in the supplemental shipment will be identified as a separate entry on the NPRC's MRS, and each will have a separate file location. If records for a patient are retired in primary and supplemental shipments, a subsequent inquiry to the MRS will then yield multiple locations to retrieve the records.

(4) Records must be retired in increments of one cubic foot or more to simplify processing and handling.

Section III
Preparation and Use of Extended Ambulatory Records

10–7. Preparation of extended ambulatory records

a. Preparation.

(1) A DA Form 3444–series folder will be prepared according to paragraph 4–4 (annotated with patient's name, FMP, and sponsor's SSN, and so forth). "EAR" will be stamped on the front of the folder.

(2) Use a separate folder for each EAR.

(3) MTFs that have implemented the CHCS, CHCS II, or ESSENTRIS 4.6 APV tracking function will annotate the divider tab for an APV episode with the APV tracking number generated by CHCS, CHCS II, or ESSENTRIS.

b. DD Form 2766. The ambulatory encounter will be annotated in the STR/OTR on DD Form 2766 (block 4, Hospitalizations/Surgeries) or on DD Form 2882.

c. Documentation. Documentation for the EAR must meet the standards for a short–term stay (abbreviated medical record), comply with the current TJC documentation standards, and conform to applicable State requirements.

d. Data collection.

(1) Collect biostatistics and biometrics data in accordance with applicable internal tracking systems policies and procedures for the completion of records and the respective Concept of Operations (CONOPS) appropriate to the extended ambulatory encounter.

(2) The official biostatistical collection of the APV is the Ambulatory Data System (ADS). Providers will select the appropriate 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.

10–8. Use of extended ambulatory records

a. An EAR will be kept at the MTF or DTF that provides a person's primary care.

b. EARs will be stored adjacent to inpatient treatment records with similar controlled, limited access. MTFs without inpatient services will file EARs by terminal digit, similar to the instructions for filing inpatient treatment records.

c. The EAR will be available to healthcare providers attending a patient in an ambulatory capacity.

d. The MTF will develop a mechanism for internal tracking of the APV (unless the MTF is using the CHCS, CHCS II, or ESSENTRIS tracking function).

e. When a patient is transferred, the EAR will be managed in the same way as the inpatient record.

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

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

DD Form 2870
Authorization for Disclosure of Medical or Dental Information. (See paras 2-3*a*(1) and 2-3*b*(1) and figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1, and 10-1.)

DA Form 5006
Medical Record-Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. This form is obsolete; use for file purposes only if already in existence. File DA Form 5006 after DD form 2870.

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care, living wills, and so forth). (See paras 6-2*i*, 9-2*c*(2), and 10-3*a*(4).)

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

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

DD Form 2770[2]
Abbreviated Medical Record (formerly SF 539). (See paras 9-21 and 10-3*a*(2).)

SF 507[1]
Medical 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 3-3*k*, 5-16, 5-18*b*(3), 5-21*a*(3), 9-10*a*, 9-11, 9-12, 9-13, 9-14*b*, 9-14*c*, 9-21*e*, 9-25*d*, 10-3*b*(5), and 10-3*b*(6)*(b)*.)

DD Form 2341
Report of Animal Bite-Potential Rabies Exposure. File behind corresponding SF 558. (See AR 40-905/SECNAVINST 6401.1A/AFI 48-131.)

State ambulance forms. File behind corresponding SF 558. (See para 5-21*b*(7).)

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.)

Figure 10–1. Forms and documents of the EAR

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.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3–2, 5–15, and 9–25.)

SF 512[1]
Clinical Record—Plotting Chart. (See para 5–15.)

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 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; 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 556
Immunohematology. SF 556 is obsolete; use for file purposes only if already in existence.

SF 515[1]
Medical Record—Tissue Examination. (See paras 5–2, 5–21, and 10–3*b*(2).)

Armed Forces Institute of Pathology Consultation Report on Contributor Material.

SF 516[1]
Medical Record—Operation Report. (See paras 9–12 and 10–3*b*(4).)

DA Form 7389[1]
Medical Record—Anesthesia (formerly SF 517 and OF 517). (See paras 9–12 and 10–3*b*(2).)

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

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

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). (See paras 3–3 and 10–3*b*(3).)

SF 524[1]
Medical Record—Radiation Therapy.

Figure 10–1. Forms and documents of the EAR—Continued

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]
Medical Record—Neurological Examination.

SF 531[1]
Medical Record—Anatomical Figure.

SF 541[1]
Medical Record—Gynecological Cytology.

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5–6 and 10–3*b*(6)*(a)*.)

DA Form 3824[1]
Urologic Examination.

DA Form 4256
Doctor's Orders. (See paras 3–3*p*, 9–14*a*(4), 9–14*c*, 9–26, and 10–3*a*(5).)

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

Home health care documentation.

DA Form 4700[1]
Medical Record—Supplemental Medical Data. (See paras 3–2*a*, 3–3, 5–21*b*(7), 9–2*b*, and 12–4*b*(4).)

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

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 4–4*a*(9), 5–27*a*, 7–4*a*, and 10–3*a*(1).)

Notes:
[1]Instructions for completing this form are self-explanatory.
[2]This form must be included in all EARs.

Figure 10–1. Forms and documents of the EAR—Continued

Chapter 11
DD Form 1380

11–1. 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 ED.2 and ABCA QSTAG 470 ED. 1 govern the use of DD Form 1380. (Instructions for completing the form are provided in table 11–1.)

b. The four echelons or levels of medical care are defined as follows (see FM 4–02.6 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 or a field hospital. The general hospital 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 field hospital, 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 STR or OTR.

(3) MTFs providing Echelon I medical care will use DD Form 1380 any time that care is provided and the patient's STR 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 11–4. 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 STR is not readily available as stated in (1), (2), and (3) above.

11–2. 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, DD Form 1380 will be prepared for any patient treated at one of the MTFs mentioned in paragraph 11–1 and may also be used for CRO cases (para 3–19). 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 11–1. All abbreviations authorized for use on DA Form 3647, CHCS, AHLTA, or ESSENTRIS

electronic 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.

11–3. 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.

11–4. Disposition

In a theater of operations, 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 in accordance with 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, AHRC, ATTN: AHRC–MSR, 200 Stovall St., 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 St., 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 Rd., Fort Sam Houston, TX 78234–6000.

(2) Forms pertaining to civilian personnel will be sent to the NPRC (Civilian), 111 Winnebago St., 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 Rd., Fort Sam Houston, TX 78234–6000.

(4) Forms pertaining to prisoners of war will be sent to DCS, G–1, ATTN: DAPE–HRE, 200 Stovall St., 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 STR or OTR for inclusion in the record.

d. All carbon copies of DD Form 1380 will be disposed of in accordance with AR 25–400–2.

11–5. 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 11–1
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 box(es) 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.

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 12
Role of the Medical Department Activity or U.S. Army Medical Center Patient Administration Division in the Improving Organizational Performance Process

12–1. General

The Improving Organizational Performance (IOP) process will follow guidelines contained in the current TJC 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 STRs to the appropriate person/group within the MTF–specific IOP structure.

12–2. 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 PHI.
e. Coding and abstracting.
f. Medical statistics.
g. Medical transcription.
h. Hospital information management system (such as CHCS, AHLTA, or ESSENTRIS).
i. Security and confidentiality of health information.

12–3. 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 STRs. (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 STRs, depending on the size and degree of specialization of the MTF concerned. The random selection process must ensure that over a one–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. STRs 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 accessible.

(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) STRs include review and updating of DD Form 2766.

(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 3–4*e*.

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 four working days of patient discharge.

(4) DA Form 3647 (worksheet) not completed within four working days of patient discharge.

(5) ITRs not completed within 30 days of patient discharge.

(6) STR, OTR, CEMR.

12–4. 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, in accordance with 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, U.S. Army Legal Services Agency, 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, Bldg. 4411 Llewellyn Ave., Fort Meade, MD 20755–5360, or the Litigation Division, U.S. Army Legal Services Agency, ATTN: JALS–LT, 901 North Stuart St., 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, U.S. Army Legal Services Agency; 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 in accordance with 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 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 13
DD Form 689

13–1. Purpose and use

a. This chapter prescribes policy and procedures for the preparation, use, and disposition of DD Form 689.

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, in accordance with AR 40–501, chapter 7.

(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.

13–2. 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.

13–3. 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 13–1).

(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 that 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.

INDIVIDUAL SICK SLIP

☐ ILLNESS ☒ INJURY

DATE: 17 May 96

LAST NAME-FIRST NAME-MIDDLE INITIAL OF PATIENT: Jones, John J.

SERVICE NUMBER/SSN: 111-22-3333

GRADE/RATE: PFC

ORGANIZATION AND STATION: Co A, 122 ORD BN, Camp Piney, SC

UNIT COMMANDER'S SECTION

IN LINE OF DUTY

REMARKS

Injured his left knee while playing basketball in post gym at 2100, 16 May 96.

SIGNATURE OF UNIT COMMANDER: J. E. Smith, CPT, ORDC

MEDICAL OFFICER'S SECTION

IN LINE OF DUTY

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 MEDICAL OFFICER: R. L. Wilson, CPT, MC

DD FORM 689, MAR 63 PREVIOUS EDITIONS ARE OBSOLETE.

Figure 13–1. Sample of a completed DD Form 689

13–4. Service treatment record entry

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.

13–5. 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.

Chapter 14
Medical Warning Tag and DA Label 162

14–1. 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 (AFI 36–3026 (I)/AR 600–8–14/BUPERS INSTR 1750.10B/MCO P5512.1C/CIM 5512.1/COMM Corps Pers Manual 29.2, Instr 1 and 2/NCD, Chap 1, Part 5). 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 14–1). 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 STR, OTR, CEMR, and DD Form 2766 (folder construction only) 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.

Figure 14–1. DA Label 162 (Emergency Medical Identification Symbol), shown actual size

14–2. 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.

14–3. 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 STR, OTR, CEMR, and DD Form 2766 (folder construction only) 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 is 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 14–2.

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 14–2. Sample letter to be presented to patients upon issuance of Medical Warning Tag

---

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.

14–4. Criteria for issue of Medical Warning Tags and DA Labels 162

a. DA Label 162 will be affixed to the patients STR, OTR, DD Form 2766 (folder construction only), or CEMR and a Medical Warning Tag will be issued to any individual receiving care at an 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.

14–5. 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 14–3. 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 will be entered in each block in this section. The following information will be provided:

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 14–3. Example of completed "Tag Content" section, DA Form 3365 (Authorization for Medical Warning Tag)

(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 STR, 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 STR, 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 STR, OTR, or CEMR and to page 4 of the DD Form 2766 (folder construction only) 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.

14–6. Supply of tag blanks and forms

Metal blanks (Tag, Medical Warning: NSN 6530–00–142–8775) will be requisitioned through normal supply channels. DA Label 162 will be requisitioned through normal publications supply channels.

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 5–19*c*(1), 5–19*c*(2), 5–19*d*, 6–7*b*(6), 6–7*f*, and 14–4*c*(3).)

AR 25–55
The Department of the Army Freedom of Information Act Program. (Cited in paras 1–6*a*, 2–1, 2–3*b*(3), 2–4*c*, and 2–5*i*.)

AR 25–400–2
The Army Records Information Management System (ARIMS). (Cited in paras 1–6*a* and *b*, 2–4*a*(4), 2–6*b*, 4–4*b*(2), 5–21*b*(5), 5–22, 5–28*d*(2), 6–1, 6–4, 6–6*a*, 6–7*h*, 7–9, 8–8, 9–1*c*, 9–2*b*(1), 9–3*b*(6), 9–7, 9–10*a*, 9–10*c*, 9–12*b*(6)*(c)*, 9–12*b*(7)*(i)*, 9–32*g*, 9–37*a*, 11–4*a*, 11–4*d*, and 12–4*b*(1), and table 4–4.)

AR 27–20
Claims. (Cited in para 12–4.)

AR 27–40
Litigation. (Cited in para 2–5*g*.)

AR 40–3
Medical, Dental, and Veterinary Care. (Cited in paras 2–3*b*(1)*(b)*1, and 9–2*c*(2).)

AR 40–5
Preventive Medicine. (Cited in para 5–21*b*(9) and figs 5–1, 5–2, 6–1, 6–2, and 7–1.)

AR 40–38
Clinical Investigation Program. (Cited in paras 1–4*k* and 6–2*g*, and figs 5–1, 5–2, 6–1, and 6–2.)

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
Clinical Quality Management. (Cited in paras 2–1 and 12–1.)

AR 40–400
Patient Administration. (Cited in paras 3–5*a*(4), 3–12*b*(1)*(a)*, 3–16*d*, 5–21*a*(5), and 9–2*c*(1), table 4–1, and figs 5–1, 5–2, 6–1, 6–2, and 9–1.)

AR 40–501
Standards of Medical Fitness. (Cited in paras 2–4*a*(2)(*k*)1, 5–21*b*(1), 5–21*b*(3), and 13–1*b*(1), and figs 5–1, 5–2, 6–1, 6–2, 7–1, and 9–1.)

AR 40–905/SECNAVINST 6401.1A/AFI 48–131
Veterinary Health Services. (Cited in figs 5–1, 5–2, 6–1, 6–2, 7–1, and 9–1.)

AR 50–5
Nuclear Surety. (Cited in paras 2–4*a*(2)(*k*)1, 5–21*b*(8), 5–23*c*, 5–23*e*, 5–30*a*, 5–30*b*, 7–4*b*(7), and 8–3*b*(2), and figs 5–1, 5–2, 5–3, 6–1, 6–2, 7–1, 8–1, and 9–1.)

AR 50–6
Chemical Surety. (Cited in paras 5–21*b*(8), 5–23*c*, 5–23*e*, 5–30*a*, 5–30*b*, 7–4*b*(7), and 8–3*b*(2), and figs 5–1, 5–2, 5–3, 6–1, 6–2, 7–1, 8–1, and 9–1.)

AR 190–8
Enemy Prisoners Of War, Retained Personnel, Civilian Internees and Other Detainees. (Cited in para 3–21*a*.)

AR 340–21
The Army Privacy Program. (Cited in paras 1–6*a*, 2–1, 2–4*c*, 3–4*f*, 4–4*a*(10), 5–23*b*, and 12–4*a*.)

AR 380–5
Department of the Army Information Security Program. (Cited in para 2–7*a*.)

AR 600–8–1
Army Casualty Operations/Assistance/Insurance. (Cited in paras 9–2*c*(1) and 13–3*a*(2), and figs 5–1 and 5–2.)

AR 600–8–104
Military Personnel Information Management/Records. (Cited in para 5–26*a*.)

AR 600–85
Army Substance Abuse Program (ASAP). (Cited in paras 2–1, 5–26*b*(2)*(k)*, 8–2, and 8–3*a*.)

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 6–2*f* and figs 6–1 and 6–2.)

AR 635–40
Physical Evaluation for Retention, Retirement, or Separation. (Cited in paras 2–4*a*(2)(*k*)1, 5–2*c*(3)*(e)*, and 5–21*a*(4), and figs 5–1 and 5–2.)

DA Pam 40–501
Hearing Conservation Program. (Cited in figs 5–1, 5–2, 6–1, 6–2, and 7–1.)

DA Pam 600–85
Army Substance Abuse Program Civilian Services. (Cited in paras 5–21*b*(4), 8–9*k*, and 8–9*l*, and figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

DOD 6025.18–R
DOD Health Information Privacy Regulation. (Cited in paras 1–4*a*(6), 1–4*e*(4), 2–1, 2–2*b* and *h*(5), 2–4*a*(2)(*k*), 2–5*k*, and 2–5l.) (Available at http://www.dtic.mil/whs/directives.)

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised
Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised. (Cited in para 3–11.) (Available from American Psychiatric Publishing, Inc., 1000 Wilson Blvd., Ste. 1825, Arlington, VA 22209–3901, or at http://www.appi.org.)

Hospitals' and Physicians' Handbook on Birth Registration and Fetal Death Reporting
(Cited in para 3–13*c*.) (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 Hwy., Hyattsville, MD 20782–9102. Also available at http://www.cdc.gov/nchs.)

ICD–9–CM (Clinical Modification)
International Classification of Diseases–Ninth Revision: Clinical Modification. (Cited in paras 9–18, and 10–7*d*(2).) (Available from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250–7954, or at http://bookstore.gpo.gov.)

ICD–9–CM (Coding Guidelines)
Tri–Service Disease and Procedure ICD–9–CM Coding Guidelines. (Cited in paras 3–9, 3–12*a*(1), 3–15, and 9–18.) (Available from U.S. Army Patient Administration Systems and Biostatistics Activity (PASBA), ATTN: MCHS–IN, 1216 Stanley Rd., Ste. 25, Fort Sam Houston, TX 78234–6000, or at http://bookstore.gpo.gov.)

IPDS User's Manual
Individual Patient Data System User's Manual. (Cited in paras 3–20*b* and 9–18.) (Available from U.S. Army Patient Administration Systems and Biostatistics Activity (PASBA), ATTN: MCHS–IN, 1216 Stanley Rd., Ste. 25, Fort Sam Houston, TX 78234–6000, or at http://www.tricare.osd.mil/org/pae/ubu/default.htm.)

NGR 40–501
Standards of Medical Fitness. (Cited in fig 5–1.) (Applies only to National Guard personnel) (Available at http://www.ngbpdc.ngb.army.mil/arngfiles.asp.)

NGR 600–200
Enlisted Personnel Management. (Cited in para 5–27.) (Applies only to National Guard personnel.) (Available at http://www.ngbpdc.ngb.army.mil/arngfiles.asp.)

Physicians' Handbook on Medical Certification of Death
(Cited in para 3–13*b*(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 Hwy., Hyattsville, MD 20782–9102. Also available at http://www.cdc.gov/nchs.)

PL 104–191
Health Insurance Portability and Accountability Act (HIPAA). (Cited in paras 1–4*a*(6), 1–4*e*(4), 2–2*d*, and 3–4*f*(1).) (Available at http://thomas.loc.gov.)

TB MED 250
Recording Dental Examinations, Diagnoses, and Treatments; and Appointment Control. (Cited in paras 1–3*b*, 3–8*d*, 5–20*b*, and 5–27*c*, figs 5–3 and 6–3, and app B.) (Available at http://chppm-www.apgea.army.mil.)

TB MED 509
Spirometry in Occupational Health Surveillance. (Cited in figs 5–1, 5–2, 6–1, 6–2, and 7–1.) (Available at http://chppm-www.apgea.army.mil.)

TM 8–227–3/NAVMED P–5101/AFMAN(I) 41–119
The Technical Manual of the American Association of Blood Banks. (Cited in para 9–25*f*.) (Available at http://www.aabb.org.)

Section II
Related Publications

A related publication is a source of additional information. The user does not have to read a related publication to understand this regulation. The United States Code is available at http://www.gpoaccess.gov/uscode/index.html. The Code of Federal Regulations is available at http://www.gpoaccess.gov/cfr/index.html.

AFI 36–3026 (I)/AR 600–8–14/BUPERS INSTR 1750.10B/MCO P5512.1C/CIM 5512.1/COMM Corps Pers Manual 29.2, Instr 1 and 2/NCD, Chap 1, Part 5
Identification Cards for Members of the Uniformed Services, Their Eligible Family Members, and Other Eligible Personnel

American Hospital Association Guidelines for Recording Chaplains' Notes in Medical Records
(These Guidelines are no longer being updated by the American Hospital Association. To obtain a copy of the Guidelines, last revised in 1990, call (703) 681–8028, or write to Armed Forces Medical Library, HQDA–AFML, Room 670, Skyline 6, 5109 Leesburg Pike, Falls Church, VA 22041–3258. The Armed Forces Medical Library (http://www.tricare.osd.mil/afml/default.cfm) may also be contacted via E–mail at afml@tma.osd.mil.)

AR 11–9
The Army Radiation Safety Program

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 215–3
Nonappropriated Funds Personnel Policy

AR 380–67
Personnel Security Program

AR 600–8–24
Officer Transfers and Discharges

AR 600–9
The Army Weight Control Program

AR 635–200
Active Duty Enlisted Administrative Separations

DOD 6055.05–M
Occupational Medical Examinations and Surveillance Manual

DODD 1308.1
DOD Physical Fitness and Body Fat Program (Available at http://www.dtic.mil/whs/directives.)

DODD 1350.4
Legal Assistance Matters (Available at http://www.dtic.mil/whs/directives.)

DODD 5210.42
Nuclear Weapons Personnel Reliability Program (Available at http://www.dtic.mil/whs/directives.)

DODD 6025.18
Privacy of Individually Identifiable Health Information in DOD Health Care Program. (Available at http://www.dtic.mil/whs/directives.)

DODD 6490.2
Joint Medical Surveillance. (Available at http://www.dtic.mil/whs/directives.)

DODI 1332.38
Physical Disability Evaluation (Available at http://www.dtic.mil/whs/directives.)

DODI 1400.32
DOD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures (Available at http://www.dtic.mil/whs/directives.)

DODI 2310–01E
The Department of Defense Detainee Program (Available at http://www.dtic.mil.whs/directives.)

DODI 3020.37
Continuation of Essential DOD Contractor Services During Crises (Available at http://www.dtic.mil/whs/directives.)

DODI 6040.43
Custody and Control of Outpatient Medical Records (Available at http://www.dtic.mil/whs/directives.)

DODI 6055.5
Industrial Hygiene and Occupational Health. (Available at http://www.dtic.mil/whs/directives.)

DODI 6490.3
Implementation and Application of Joint Medical Surveillance for Deployments. (Available at http://www.dtic.mil/whs/directives.)

FM 4–02.6
The Medical Company, Tactics, Techniques, and Procedures. (Available at http://www.adtdl.army.mil/atdls.htm.)

FM 8–10–14
Employment of the Combat Support Hospital, Tactics, Techniques, and Procedures. (Available at http://www.adtdl.army.mil/atdls.htm.)

MCM–0006–02
Joint Chiefs of Staff Memorandum, 1 Feb 02, Subject: Updated Procedures for Deployment Health Surveillance and Readiness. (Available at http://www.dtic.mil/doctrine/index.html.)

National Research Council Criteria for Wound Classification
(Available from the National Academies Press, 500 Fifth St., NW, Lockbox 285, Washington, DC 20055, or at http://www.nap.edu.)

NAVMED 6300–5
Inpatient Admission/Disposition Record. (Available at http://www.navymedicine.med.navy.mil.)

QSTAG 470 ED.1
Documentation Relative to Medical Evacuation, Treatment, and Cause of Death of Patients. (Available from the DOD Single Stock Point, Bldg. 4/D, 700 Robbins Ave., Philadelphia, PA 19111–5094, or at http://dodssp.daps.dla.mil/dodiss_index.htm.)

STANAG 2132 ED.2
Documentation Relative to Medical Evacuation, Treatment, and Cause of Death of Patients. (Available from the DOD Single Stock Point, Bldg. 4/D, 700 Robbins Ave., Philadelphia, PA 19111–5094, or at http://dodssp.daps.dla.mil/dodiss_index.htm.)

STANAG 2348 ED.3(1)
Basic Military Hospital (Clinical) Records. (Available from the DOD Single Stock Point, Bldg. 4/D, 700 Robbins Ave., Philadelphia, PA 19111–5094, or at http://dodssp.daps.dla.mil/dodiss_index.htm.)

The Medical Record Tracking, Retirement, Retrieval User Guide
(Available at https://kx.atms.mil/hipaa/mrtr2/, must have an AKO account.)

5 CFR 293
Personal records. (Available at http://www.gpoacess.gov/cfr/index.html.)

5 CFR 297
Privacy procedures for personal records. (Available at http://www.gpoacess.gov/cfr/index.html.)

5 USC 552
Records about individuals. (Available at http://www.gpoacess.gov/uscode/browse.html.)

10 USC 1044
Security requirements for protected disclosures under section 3164 of the National Defense Authorization Act for fiscal year 2000. (Available at http://www.gpoacess.gov/uscode/browse.html.)

10 USC 1093
Performance of abortions: restrictions. (Available at http://www.gpoacess.gov/uscode/browse.html.)

21 CFR 606
Current good manufacturing practice for blood and blood components (Available at http://www.gpoacess.gov/cfr/index.html.)

29 CFR 1904
Recording and reporting occupational injuries and illnesses. (Available at http://www.gpoacess.gov/cfr/index.html.)

29 CFR 1910
Occupational safety and health standards. (Available at http://www.gpoacess.gov/cfr/index.html.)

29 CFR 1960
Basic program elements for Federal employee occupational safety and health programs and related matters. (Available at http://www.gpoacess.gov/cfr/index.html.)

32 CFR 219
Protection of human subjects. (Available at http://www.gpoacess.gov/cfr/index.html.)

42 CFR 2
Confidentiality of alcohol and drug abuse patient records. (Available at http://www.gpoacess.gov/cfr/index.html.)

42 USC 290dd–2
Confidentiality of records. (Available at http://www.gpoacess.gov/uscode/browse.html.)

42 CFR 493
Laboratory requirements. (Available at http://www.gpoacess.gov/cfr/index.html.)

42 USC 1320d–5
General penalty for failure to comply with requirements and standards. (Available at http://www.gpoacess.gov/uscode/browse.html.)

42 USC 1320d–6
Wrongful disclosure of individually identifiable health information. (Available at http://www.gpoacess.gov/uscode/browse.html.)

42 USC 1395
Prohibition against any Federal interference. (Available at http://www.gpoacess.gov/uscode/browse.html.)

45 CFR 164
Security and privacy. (Available at http://www.gpoacess.gov/cfr/index.html.)

49 CFR 382
Controlled substance and alcohol use and testing. (Available at http://www.gpoacess.gov/cfr/index.html.)

Section III
Prescribed Forms

Except where otherwise indicated below, the following forms are available as follows: DA Forms are available on the AEL compact disc–read only memory (CD–ROM) (EM 0001) and at the APD Web site (www.apd.army.mil); DD Forms are available at the DOD Directorate for Information Operations and Reports Web site (www.dior.whs.mil/icdhome/forms.htm); and Standard and Optional Forms (SF and OF) are available at the GSA Web site (www.gsa.gov). In addition, the following series of forms are available through normal publishing channels: the DA Form 3443–series; the DA Form 3444–series; the DA Form 8005–series; SF 518 through SF 525; and SF 545 through SF 557.

DA Form 3365
Authorization for Medical Warning Tag. (Prescribed in paras 6–7*f*, 14–1, 14–3*c*, and 14–5, 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, 5–25*e*(1), 6–2*a*, 7–4*a*, 8–4*b*, 9–2*b*, 9–5, and 10–7.)

DA Form 3444–1
Alphabetical and Terminal Digit File for Treatment Record (Light Green). (Prescribed in paras 4–3, 4–4, 5–25*e*(1), 6–2*a*, 7–4*a*, 8–4*b*, 9–2*b*, 9–5, and 10–7.)

DA Form 3444–2
Alphabetical and Terminal Digit File for Treatment Record (Yellow). (Prescribed in paras 4–3, 4–4, 5–25*e*(1), 6–2*a*, 7–4*a*, 8–4*b*, 9–2*b*, 9–5, and 10–7.)

DA Form 3444–3
Alphabetical and Terminal Digit File for Treatment Record (Grey). (Prescribed in paras 4–3, 4–4, 5–25*e*(1), 6–2*a*, 7–4*a*, 8–4*b*, 9–2*b*, 9–5, and 10–7.)

DA Form 3444–4
Alphabetical and Terminal Digit File for Treatment Record (Tan). (Prescribed in paras 4–3, 4–4, 5–25*e*(1), 6–2*a*, 7–4*a*, 8–4*b*, 9–2*b*, 9–5, and 10–7.)

DA Form 3444–5
Alphabetical and Terminal Digit File for Treatment Record (Light Blue). (Prescribed in paras 4–3, 4–4, 5–25*e*(1), 6–2*a*, 7–4*a*, 8–4*b*, 9–2*b*, 9–5, and 10–7.)

DA Form 3444–6
Alphabetical and Terminal Digit File for Treatment Record (White). (Prescribed in paras 4–3, 4–4, 5–25*e*(1), 6–2*a*, 7–4*a*, 8–4*b*, 9–2*b*, 9–5, and 10–7.)

DA Form 3444–7
Alphabetical and Terminal Digit File for Treatment Record (Brown). (Prescribed in paras 4–3, 4–4, 5–25*e*(1), 6–2*a*, 7–4*a*, 8–4*b*, 9–2*b*, 9–5, and 10–7.)

DA Form 3444–8
Alphabetical and Terminal Digit File for Treatment Record (Pink). (Prescribed in paras 4–3, 4–4, 5–25*e*(1), 6–2*a*, 7–4*a*, 8–4*b*, 9–2*b*, 9–5, and 10–7.)

DA Form 3444–9
Alphabetical and Terminal Digit File for Treatment Records (Red). (Prescribed in paras 4–3, 4–4, 5–25*e*(1), 6–2*a*, 7–4*a*, 8–4*b*, 9–2*b*, 9–5, and 10–7.)

DA Form 3705
Receipt for Outpatient Treatment/Dental Records. (Prescribed in para 5–26*a*(2) 6–4*b*(1).)

DA Form 3824
Urologic Examination. (Prescribed in figs 5–1, 5–2, 6–1, 6–2, 9–1, and 10–1.)

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 figs 9–1 and 10–1.)

DA Form 4006
Field Medical Record Jacket. (Prescribed in para 11–5.) (Available through normal publishing channels.)

DA Form 4028
Prescribed Medication. (Prescribed in para 9–28*g*.) (Available through normal publishing channels.)

DA Form 4107
Operation Request and Worksheet. (Prescribed in para 9–29.)

DA Form 4108
Register of Operations. (Prescribed in paras 9–29*a*, 9–29*c*, and 9–32.) (Available through normal publishing channels.)

DA Form 4221
Diabetic Record. (Prescribed in fig 9–1.)

DA Form 4254
Request for Private Medical Information. (Prescribed in para 2–4*a*, 3–23*a* and figs 5–1, 5–2, 6–1, 6–2, 7–1, 9–1, and 10–1.)

DA Form 4256
Doctor's Orders. (Prescribed in paras 3–3*p*, 9–14*a*(4), 9–14*c*, 9–26, and 10–3*a*(5), and figs 9–1 and 10–1.) (Available through normal publishing channels.)

DA Form 4359
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 9–13*c*, 9–26*d*, 9–26*e*, and 9–27, and fig 9–1.)

DA Form 4678
Clinical Record—Therapeutic Documentation Care Plan (Medications). (Prescribed in paras 5–21, 9–13*c*, 9–26*d*, 9–26*e*, and 9–28, and fig 9–1.)

DA Form 4700
Medical Record—Supplemental Medical Data. (Prescribed in paras 3–2*a*, 3–3, 5–21*b*(7), 9–2*b*, and 12–4*b*(4), and figs 5–1, 5–2, 5–3, 6–1, 6–2, 6–3, 7–1, 9–1, and 10–1.)

DA Form 4876
Request and Release of Medical Information to Communications Media. (Prescribed in para 2–3*b*(3) and figs 5–1, 5–2, 6–1, 6–2, 7–1, 9–1, and 10–1.)

DA Form 5007A
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
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 10–3*b*(6)*(a)*, and figs 5–1, 5–2, 6–1, 6–2, 7–1, and 10–1.)

DA Form 5179
Medical Record—Preoperative/Postoperative Nursing Document. (Prescribed in para 9–33 and figs 9–1 and 10–1.)

DA Form 5179–1
Medical Record—Intraoperative Document. (Prescribed in para 9–34 and figs 9–1 and 10–1.)

DA Form 5181
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
Chronological Record of Well–Baby Care. (Prescribed in para 6–2 and figs 6–1 and 6–2.)

DA Form 5569
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 5–27*b*, and figs 5–3 and 6–3.) (Available through normal publishing channels.)

DA Form 7001
Operating Room Schedule. (Prescribed in paras 9–29*a* and 9–30.)

DA Form 7095
ASAP Outpatient Discharge Summary. (Prescribed in para 8–9*a* and fig 8–1.)

DA Form 7096
ASAP Outpatient Aftercare Plan. (Prescribed in para 8–9*b* and fig 8–1.)

DA Form 7097
ASAP Outpatient Problem List and Treatment Plan Review. (Prescribed in para 8–9*c* and fig 8–1.)

DA Form 7098
ASAP Outpatient Treatment Plan and Review. (Prescribed in para 8–9*d* and fig 8–1.)

DA Form 7099
ASAP Outpatient Biopsychosocial Evaluation. (Prescribed in para 8–9*e* and fig 8–1.)

DA Form 7389
Medical Record—Anesthesia. (Prescribed in paras 3–2*a*, 9–10*a*, and 9–12*b*(1)*(c)*, and figs 5–1, 5–2, 6–1, 6–2, 9–1, and 10–1.) (Available through normal publishing channels.)

DA Form 8000
ASAP Triage Instrument (for Unscheduled Patients). (Prescribed in para 8–9*f* and fig 8–1.)

DA Form 8001
Limits of Confidentiality. (Prescribed in para 8–9*g* and fig 8–1.)

DA Form 8002
ASAP Outpatient Administrative Summary. (Prescribed in para 8–9*h* and fig 8–1.)

DA Form 8003
Army Substance Abuse Program (ASAP) Enrollment. (Prescribed in para 8–9*i* and fig 8–1.)

DA Form 8004
Army Substance Abuse Program (ASAP) Outpatient Medical Records–Privacy Act Information. (Prescribed in para 8–9*j* and fig 8–1.)

DA Form 8005
Outpatient Medical Record (OMR) (Orange). (Prescribed in paras 4–3, 4–4, 5–25*e*, 5–27, and 6–2*a*.)

DA Form 8005–1
Outpatient Medical Record (OMR) (Light Green). (Prescribed in paras 4–3, 4–4, 5–25*e*, 5–27, and 6–2*a*.)

DA Form 8005–2
Outpatient Medical Record (OMR) (Yellow). (Prescribed in paras 4–3, 4–4, 5–25*e*, 5–27, and 6–2*a*.)

DA Form 8005–3
Outpatient Medical Record (OMR) (Grey). (Prescribed in paras 4–3, 4–4, 5–25*e*, 5–27, and 6–2*a*.)

DA Form 8005–4
Outpatient Medical Record (OMR) (Tan). (Prescribed in paras 4–3, 4–4, 5–25*e*, 5–27, and 6–2*a*.)

DA Form 8005–5
Outpatient Medical Record (OMR) (Light Blue). (Prescribed in paras 4–3, 4–4, 5–25*e*, 5–27, and 6–2*a*.)

DA Form 8005–6
Outpatient Medical Record (OMR) (White). (Prescribed in paras 4–3, 4–4, 5–25*e*, 5–27, and 6–2*a*.)

DA Form 8005–7
Outpatient Medical Record (OMR) (Brown). (Prescribed in paras 4–3, 4–4, 5–25*e*, 5–27, and 6–2*a*.)

DA Form 8005–8
Outpatient Medical Record (OMR) (Pink). (Prescribed in paras 4–3, 4–4, 5–25*e*, 5–27, and 6–2*a*.)

DA Form 8005–9
Outpatient Medical Record (OMR) (Red). (Prescribed in paras 4–3, 4–4, 5–25*e*, 5–27, and 6–2*a*.)

DA Form 8006
Pediatric Dentistry Diagnostic Form. (Prescribed in para 6–7*e* and fig 6–3.)

DA Label 162
Emergency Medical Identification Symbol. (Prescribed in paras 3–10*c*, 5–19*a*, 5–26*b*(2)*(i)*, 6–7*f*, 14–1*b*, 14–3, 14–4, and 14–5.) (Available through normal publishing channels.)

DD Form 689
Individual Sick Slip. (Prescribed in paras 5–2*a*, 13–1, 13–2, 13–3, and 13–5.)

DD Form 741
Eye Consultation. (Prescribed in figs 5–1, 5–2, 6–1, 6–2, 7–1, and 9–1.) (Available through normal publishing channels.)

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 3–17*a*, 5–11, 5–32*a*(1), 5–33*b*, 9–1*b*(2), 9–4, 11–1, 11–2, 11–3, 11–4, and 11–5, and figs 5–1, 5–2, 6–1, 6–2, and 9–1.) (Available through normal publishing channels.)

DD Form 1924
Surgical Checklist. (Prescribed in para 9–31.) (Available through normal publishing channels.)

DD Form 2005
Privacy Act Statement—Health Care Records. (Prescribed in paras 4–4*a*(9), 5–27*a*, 7–4*a*, and 10–3*a*(1), and figs 5–1, 5–2, 5–3, 6–1, 6–2, 6–3, 7–1, 9–1, and 10–1.)

DD Form 2138
Request for Transfer of Outpatient Records. (Prescribed in paras 6–4*a*(2)*(b)*, 6–4*a*(2)*(c)*, 6–4*b*(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.) (Available through normal publishing channels.)

DD Form 2766
Adult Preventive and Chronic Care Flowsheet. (Prescribed in paras 3–10*c*, 4–4*d*, 5–10, 5–13, 5–19, 5–21*b*(12), 5–26*b*(2), 5–32*a*, 5–35*a*(2) and (4), 5–36*a*, 6–7*f*, 7–4*b*(4), 10–7*b*, and 12–3*a*(9).) (Available through normal publishing channels.)

DD Form 2766C
Adult Preventive and Chronic Care Flowsheet—Continuation Sheet. (Prescribed in paras 5–13, 5–32*a*, and 5–36*a*.) (Available through normal publishing channels.)

DD Form 2770
Abbreviated Medical Record. (Prescribed in paras 9–21 and 10–3*a*(2), and figs 5–1, 5–2, 6–1, 6–2, 9–1, and 10–1.)

DD Form 2870
Authorization for Disclosure of Medical or Dental Information. (Prescribed in paras 2–3*a*(1) and 2–3*b*(1) and figs 5–1, 5–2, 6–1, 6–2, 7–1, 9–1, and 10–1.)

DD Form 2882
Pediatric and Adolescent Preventive and Chronic Care Flow Sheet. (Prescribed in paras 5–1, 5–10, 5–13, 6–2*f*, and 10–7*b* and figs 6–1 and 6–2.

OF 275
Medical Record Report. (Prescribed in paras 3–3*f*, 9–12*c*, and 9–12*e*, and figs 5–1, 5–2, 6–1, 6–2, 9–1, and 10–1.)

OF 520
Clinical Record—Electrocardiographic Record. (Prescribed in para 3–2*a* and figs 5–1, 5–2, 6–1, 6–2, 7–1, 9–1, and 10–1.) (Available through normal publishing channels.)

OF 522
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures. (Prescribed in paras 3–3*e*, 3–3*q*, and 10–3*b*(3), and figs 5–1, 5–2, 5–3, 6–1, 6–2, 6–3, 9–1, and 10–1.)

OF 523–B
Medical Record—Authorization for Tissue Donation. (Prescribed in fig 9–1.)

SF 502
Clinical Record—Narrative Summary. (Prescribed in para 5–2, 5–21, 6–7*a*, and figs 5–2, 6–2, and 9–1.) (Available through normal publishing channels.)

SF 503
Clinical Record—Autopsy Protocol. (Prescribed in para 9–12*f* and fig 9–1.)

SF 504
Clinical Record—History—Part I. (Prescribed in paras 9–10*a*, 9–12*a*, 9–14*c*, and 9–21*e*, and fig 9–1.)

SF 505
Clinical Record—History—Parts II and III. (Prescribed in paras 9–10*a*, 9–12*a*, 9–14*c*, and 9–21*e*, and fig 9–1.)

SF 506
Clinical Record—Physical Examination. (Prescribed in paras 9–10*a*, 9–12*a*, 9–14*c*, and 9–21*e*, and fig 9–1.)

SF 507
Medical 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, 9–1, and 10–1.)

SF 509
Medical Record—Progress Notes. (Prescribed in paras 3–3*k*, 5–21*a*(3), 9–10*a*, 9–11, 9–12, 9–13, 9–14*b*, 9–14*c*, 9–21*e*, 9–25*d*, and 10–3*b*(5) and figs 5–1, 5–2, 6–1, 6–2, 9–1, and 10–1.)

SF 510
Clinical Record—Nursing Notes. (Prescribed in paras 3–2*a*, 9–12*b*(3), 9–13, and 9–14*c*, and fig 9–1.)

SF 511
Medical Record—Vital Signs Record. (Prescribed in paras 9–23, 9–24, 9–35, and figs 9–1 and 10–1.) (Available through normal publishing channels.)

SF 512
Clinical Record—Plotting Chart. (Prescribed in para 5–15 and figs 5–1, 5–2, 6–1, 6–2, 7–1, 9–1 and 10–1.) (Available through normal publishing channels.)

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, 9–1, and 10–1.)

SF 515
Medical Record—Tissue Examination. (Prescribed in para 5–21*a*(3), 10–3*b*(1) and figs 5–1, 5–2, 6–1, 6–2, 9–1, and 10–1.)

SF 516
Medical Record—Operation Report. (Prescribed in paras 5–21*a*(3), 9–12, and 10–3*b*(4), and figs 5–1, 5–2, 6–1, 6–2, 9–1, and 10–1.)

SF 518
Medical Record—Blood or Blood Component Transfusion. (Prescribed in figs 5–2, 6–2, 9–1, and 10–1.)

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, 9–1, and 10–1.)

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, 9–1, and 10–1.)

SF 525
Medical Record—Radiation Therapy Summary. (Prescribed in figs 5–2, 6–2, 9–1, and 10–1.)

SF 526
Medical Record—Interstitial/Intercavitary Therapy. (Prescribed in figs 5–2, 6–2, 9–1, and 10–1.)

SF 527
Group Muscle Strength, Joint R.O.M. Girth and Length Measurements. (Prescribed in figs 5–2, 6–2, 9–1, and 10–1.)

SF 528
Clinical Record—Muscle and/or Nerve Evaluation—Manual and Electrical: Upper Extremity. (Prescribed in figs 5–2, 6–2, 9–1, and 10–1.) (Available through normal publishing channels.)

SF 529
Medical Record—Muscle Function by Nerve Distribution: Trunk and Lower Extremity. (Prescribed in figs 5–2, 6–2, 9–1, and 10–1.) (Available through normal publishing channels.)

SF 530
Medical Record—Neurological Examination. (Prescribed in figs 9–1 and 10–1.) (Available through normal publishing channels and also available on the AEL CD–ROM (EM 0001) and at the APD Web site (www.apd.army.mil).)

SF 531
Medical Record—Anatomical Figure. (Prescribed in figs 5–2, 6–2, 9–1, and 10–1.)

SF 533
Medical Record—Prenatal and Pregnancy. (Prescribed in figs 5–1, 5–2, 6–1, 6–2, and 9–1.)

SF 534
Medical Record—Labor. (Prescribed in fig 9–1.) (Available through normal publishing channels.)

SF 535
Clinical Record—Newborn. (Prescribed in figs 6–1, 6–2, and 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 5–15, 9–25 and figs 5–1, 5–2, 6–1, 6–2, 7–1, 8–1, 9–1, and 10–1, 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, 9–1, and 10–1, 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, 9–1, and 10–1, 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, 9–1, and 10–1, 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, 9–1, and 10–1, 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, 9–1, and 10–1, 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, 9–1, and 10–1, 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, 9–1, and 10–1, 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, 9–1, and 10–1, 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, 9–1, and 10–1, 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, 9–1, and 10–1, 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, 9–1, and 10–1, and tables 9–2 and 9–3.)

SF 558
Medical Record—Emergency Care and Treatment. (Prescribed in paras 5–16, 5–21, and 10–3*b*(6)*(b)*, and figs 5–1, 5–2, 6–1, 6–2, 7–1, 9–1, and 10–1.)

SF 559
Medical Record—Allergen Extract Prescription, New and Refill. (Prescribed in paras 5–5 and 5–17, and figs 5–1, 5–2, 6–1, and 6–2.)

SF 600
Medical Record—Chronological Record of Medical Care. (Prescribed in paras 2–6*a*, 5–2*c*(1), 5–32*a*(1) and (7), and 5–18, 5–33*b*, chap 6, and figs 5–1, 5–2, 6–1, 6–2, 7–1, and 8–1.)

SF 601
Health Record—Immunization Record. (Prescribed in paras 5–19, 5–25*e*(3), 5–27*c*(1), and 6–7*b*, and figs 5–1, 5–2, 6–1, 6–2, and 7–1.)

SF 602
Medical Record—Serology Record. (Prescribed in paras 5–18*g*, 5–21*b*(10), and 5–26*b*(2)*(l)*, and figs 5–1, 5–2, 6–1, and 6–2.)

SF 603
Health Record—Dental. (Prescribed in paras 5–20*c*, 5–20*a*(3) and (4), 5–32*a*(7), 5–33*b*, and 6–7*a*, *c*, and *d*, and figs 5–3 and 6–3.) (Available through normal publishing channels.)

SF 603A
Health Record—Dental Continuation. (Prescribed in paras 5–20 and 6–7, and figs 5–3 and 6–3.) (Available through normal publishing channels.)

Section IV
Referenced Forms

Except where otherwise indicated below, the following forms are available as follows: DA Forms are available on the AEL CD–ROM (EM 0001) and at the Army Publishing Directorate Web site (www.apd.army.mil); DD Forms are available at the DOD Directorate for Information Operations and Reports Web site (www.dior.whs.mil/icdhome/forms.htm); Standard and Optional Forms (SF and OF) are available at the GSA Web site (www.gsa.gov); and Department of Labor Forms are available on the DOL Web site (www.dol.gov/libraryforms/index.asp). In addition, the following two series of forms are available through normal publishing channels: DD Form 2(ACT) through DD Form 602 and DD Form 1141 through DD Form 1425. DSS Forms can be requested through the Defense Security Service Web site (www.dss.mil).

DA Form 2
Personnel Qualification Record—Part I (For Army Reserve Use Only). (Available through normal publishing channels.)

DA Form 2–1
Personnel Qualification Record—Part II. (Available through normal publishing channels.)

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 199 is a printed only form issued by the DCS, G-1 (pat.battle@us.army.mil). For multiple copies from St. Louis Army Depot, contact the local DOIM.

DA Form 2173
Statement of Medical Examination and Duty Status

DA Form 2631
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
Personnel Screening and Evaluation Record

DA Form 3349
Physical Profile

DA Form 3437
Department of the Army Nonappropriated Funds 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 3666
Department of the Army Nonappropriated Funds Statement of Physical Ability for Light Duty Work

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 4465
Patient Intake/Screening Record (PIR)

DA Form 4466
Patient Progress Report (PPR)

DA Form 4497
Interim (Abbreviated) Flying Duty Medical Examination

DA Form 4515
Personnel Reliability Program Record Identifier. (Available through normal publishing channels.)

DA Form 4707
Entrance Physical Standards Board (EPSBD) Proceedings

DA Form 5009
Medical Record—Release Against Medical Advice

DA Form 5018–R
ADAPCP Client's Consent Statement for Release of Treatment Information

DA Form 5303–R
Volunteer Agreement Affidavit

DA Form 5551–R
Spirometry Flow Sheet

DA Form 7349
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 Geneva Convention 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
Record of Occupational Exposure to Ionizing Radiation

DD Form 1173
Uniformed Services Identification and Privilege Card

DD Form 2161
Referral for Civilian Medical Care

DD Form 2215
Reference Audiogram

DD Form 2216
Hearing Conservation Data

DD Form 2341
Report of Animal Bite—Potential Rabies Exposure

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

DD Form 2792
Exceptional Family Member Medical Summary

DD Form 2792–1
Exceptional Family Member Special Education/Early Intervention Summary

DD Form 2795
Pre–Deployment Health Assessment

DD Form 2796
Post–Deployment Health Assessment

DD Form 2807–1
Report of Medical History

DD Form 2808
Report of Medical Examination

DD Form 2813
Department of Defense Active Duty/Reserve Forces Dental Examination

DD Form 2844 (TEST)
Medical Record—Post Deployment Medical Assessment

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–17
Duty Status Report

DOL Form CA–20
Attending Physician's Report

FAA Form 8500–8
Medical Certificate—Class and Student Pilot Certificate. (Available at www.aviationmedicine.com/forms.htm.)

HEW Form CDC 73–2936S
Field Report. (Available through normal publishing channels.)

NAVMED 6300–5
Admission/Disposition Record, Inpatient. (Available at http://navalmedicine.med.navy.mil.)

OF 23
Charge–Out Record. (Available through normal publishing channels.)

OF 345
Physical Fitness Inquiry for Motor Vehicle Operators. (Available through normal publishing channels.)

HHS Form PHS 731
International Certificates of Vaccination. (Available through normal publishing channels.)

SF 66–D
Employee Medical Folder. (Available through normal publishing channels.)

SF 86
Questionnaire for National Security Positions

SF 78
U.S. Civil Service Commission, Certificate of Medical Examination. (Available through normal publishing channels.)

Appendix B
Authorized Medical Records Abbreviations and Symbols

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.)

B–1. AA
Alcoholics Anonymous

B–2. ab
abortion

B–3. ABE
acute bacterial endocarditis

B–4. ABG
arterial blood gases

B–5. abnl
abnormal

B–6. A/B ratio
acid/base ratio

B–7. ac
before meals

B–8. ACS
acute coronary syndrome

B–9. ACTH
adrenocorticotropic hormone

B–10. ACVD
acute cardiovascular disease

B–11. A&D
admission and discharge

B–12. ADCO
alcohol and drug control officer

B–13. ADH
antidiuretic hormone (vasopressin)

B–14. ADL
activities of daily living

B–15. ad lib
as desired

B–16. adm
admission; admit; admitted

B–17. AE
above elbow

B–18. A/E
air evacuation

B–19. AFB
acid–fast bacilli

B–20. afeb
afebrile; without fever

B–21. AFib/AFlut
atrial fibrillation/atrial flutter

B–22. AFIP
Armed Forces Institute of Pathology

B–23. AGA
appropriate for gestational age

B–24. A/G ratio
albumin/globin ratio

B–25. AHD
atherosclerotic heart disease

B–26. AIDS
acquired immune deficiency syndrome

B–27. AK
above knee

B–28. AKA
above–the–knee amputation

B–29. ALL
acute lymphoblastic or lymphocytic leukemia

B–30. ALS
amyotrophic lateral sclerosis

B–31. AMA
against medical advice

B–32. amb
ambulatory

B–33. AMI
acute myocardial infarction

B–34. AMIC
Acute Minor Illness Clinic

B–35. AML
acute myelocytic/myeloblastic leukemia

B–36. AMNIO
amniocentesis

B–37. Amox
amoxicillin

B–38. amt
amount

B–39. anesth; anes
anesthesia

B–40. ant
anterior

B–41. ante
before

B–42. AP
anterior–posterior

B–43. A&P
auscultation and percussion

B–44. AP&Lat
anteroposterior and lateral

B–45. approx
approximate

B–46. ASA
acetylsalicylic acid (aspirin)

B–47. ASA Grades I–IV
American Society of Anesthesiology surgical risk classification

B–48. ASAP
as soon as possible

B–49. ASD
atrial septal defect

B–50. ASHD
arteriosclerotic heart disease

B–51. assoc
associate; associated; association

B–52. Audio
audiology

B–53. Ausc
auscultation

B–54. AV, A–V
arteriovenous; atrioventricular

B–55. av
average

B–56. BAC
blood alcohol concentration

B–57. bact
bacterium (–ia) (–ial) (–iology)

B–58. B. asthma
bronchial asthma

B–59. BAT
blood alcohol test

B–60. BBB
bundle branch block

B–61. BCG
Bacillus Calmette–Guerin (vaccine)

B–62. BCP
birth control pills

B–63. BE
barium enema

B–64. bicarb
bicarbonate

B–65. bid
twice a day

B–66. bil or bilat
bilateral

B–67. bili
bilirubin

B–68. BK
below knee

B–69. BKA
below–knee amputation

B–70. bl
blood

B–71. bl; bld
blood; bleeding

B–72. BM
bowel movement

B–73. BMR
basal metabolic rate

B–74. BP
blood pressure

B–75. BPH
benign prostatic hypertrophy

B–76. BR
bed rest

B–77. BSO
bilateral salpingo–oophorectomy

B–78. BSR
blood sedimentation rate

B–79. BTL
bilateral tubal ligation

B–80. BUN
blood urea nitrogen

B–81. bw
birth weight

B–82. Bx
biopsy

B–83. C
Celsius or centigrade

B–84. C1 to C7
cervical nerves or vertebrae 1 to 7

B–85. c
with

B–86. Ca
calcium; cancer; carcinoma

B–87. CABG
coronary artery bypass graft

B–88. CAD
coronary artery disease

B–89. card
cardiac; cardiology

B–90. CAT
computerized axial tomography

B–91. cath
catheter

B–92. cau
Caucasian

B–93. CBC
complete blood count

B–94. CC
chief or current complaint

B–95. CCU
coronary care unit

B–96. CDC
Centers for Disease Control

B–97. cerv
cervical

B–98. CF
cystic fibrosis

B–99. ChE
cholinesterase

B–100. CHF
congestive heart failure

B–101. Chol
cholesterol

B–102. chr
chronic

B–103. circ
circulation; circumcision; circumferences

B–104. Cl
chloride

B–105. cm
centimeter

B–106. CNS
central nervous system

B–107. CO_2
carbon dioxide

B–108. Co
cobalt

B–109. c/o
complains of

B–110. conv
convalescent; convalescence

B–111. COPD
chronic obstructive pulmonary disease

B–112. CPD
cephalopelvic disproportion

B–113. CPK
creatine phosphokinase

B–114. CPR
cardiopulmonary resuscitation

B–115. CRF
chronic renal failure

B–116. CRNA
certified registered nurse anesthetist

B–117. C/S
cesarean section

B–118. C&S
culture and sensitivity

B–119. C–section
cesarean section

B–120. CT
computerized tomography

B–121. ct
count

B–122. cu ft
cubic foot

B–123. cu in
cubic inch

B–124. cu m
cubic meter

B–125. cu mm
cubic millimeter

B–126. CVA
cerebrovascular accident

B–127. CVD
cardiovascular disease

B–128. CVP
central venous pressure

B–129. cx
cervix

B–130. CXR
chest x–ray

B–131. cysto
cystogram; cystoscope; cyctoscopy

B–132. dB
decibel

B–133. dbl
double

B–134. D&C
dilatation and curettage or curettement

B–135. DDS
Doctor of Dental Surgery

B–136. D&E
dilatation and evacuation

B–137. def
deficiency

B–138. Dept
department

B–139. Derm
dermatology

B–140. DES
diethylstilbestrol

B–141. dev
deviation

B–142. dil
dilute; diluted

B–143. dis
disease

B–144. disp
disposition

B–145. DJD
degenerative joint disease

B–146. DM
diabetes mellitus

B–147. DNA
deoxyribonucleic acid

B–148. DNR
do not resuscitate

B–149. DO
Doctor of Osteopathy

B–150. DOA
dead on arrival

B–151. DOB
date of birth

B–152. DOE
dyspnea on exertion

B–153. DT
diphtheria toxoid and tetanus toxoid (for children under 7 years of age)

B–154. DTap
diphtheria, tetanus, and acellular pertussis vaccine

B–155. dtd
dated

B–156. DTR
deep tendon reflexes

B–157. DTs
delirium tremens

B–158. DUB
dysfunctional uterine bleeding

B–159. DUI
driving under the influence

B–160. DVT
deep vein thrombosis

B–161. DWI
driving while intoxicated

B–162. Dx
diagnosis

B–163. EBL
estimated blood loss

B–164. EBV
Epstein–Barr virus

B–165. ECG; EKG
electrocardiogram

B–166. E. coli
Escherichia coli

B–167. ECT
electroconvulsive therapy

B–168. EDC
estimated date of confinement

B–169. EEG
electroencephalogram

B–170. EGA
estimated gestational age

B–171. EGD
esophagogastroduodenoscopy

B–172. EKG; ECG
electrocardiogram

B–173. ELISA
enzyme–linked immunosuppressant assay

B–174. EMG
electromyogram

B–175. EMS
emergency medical service

B–176. E–mycin
erythromycin

B–177. Endo
endocrinology

B–178. ENT
ear, nose, and throat

B–179. EOM
extraocular movement

B–180. eos
eosinophil

B–181. epis
episiotomy

B–182. epith
epithelium or epithelial

B–183. eq; equiv
equivalent

B–184. ER/EC/ED
emergency room/emergency center/emergency department

B–185. esp
especially

B–186. ESR
erythrocyte sedimentation rate

B–187. ESRD
end–stage renal disease

B–188. EST
electroshock therapy

B–189. est
estimated

B–190. ESWL
extracorporeal shock wave lithotripsy

B–191. ET
endotracheal tube

B–192. etc.
et cetera

B–193. etiol
etiology

B–194. ETOH
ethyl alcohol

B–195. eval
evaluate; evaluation

B–196. exam
examine

B–197. exp
expired

B–198. expir
expiration; expiratory

B–199. ext
external

B–200. F
Fahrenheit

B–201. FACMT
Family Advocacy Case Management Team

B–202. FB
foreign body

B–203. FBS
fasting blood sugar

B–204. FDA
Food and Drug Administration

B–205. Fe
iron

B–206. FFP
fresh frozen plasma

B–207. FHR
fetal heart rate

B–208. FHT
fetal heart tone

B–209. F Hx
family history

B–210. fib
fibrillation

B–211. Fl; fl
fluid

B–212. FP
family practice

B–213. freq
frequent; frequency

B–214. FS
frozen section

B–215. FSH
follicle–stimulating hormone

B–216. FT
full term

B–217. ft
foot; feet

B–218. F/U
follow–up

B–219. FUO
fever of unknown or undetermined origin

B–220. Fx
fracture

B–221. g
gram(s)

B–222. garg
gargle

B–223. GB
gallbladder

B–224. GC
gonococcus; gonococcal

B–225. Gen
general

B–226. Gest
gestation

B–227. GI
gastrointestinal

B–228. glu
glucose

B–229. gm
gram

B–230. GOT
glutamic–oxalacetic transaminase

B–231. GP
general practitioner

B–232. gr
grain

B–233. gr; grav
pregnant

B–234. Grav I, Grav II
one pregnancy, two pregnancies, and so on

B–235. GS
general surgery

B–236. GSW
gunshot wound

B–237. gt; gtt
drop; drops

B–238. GTT
glucose tolerance test

B–239. GU
genitourinary

B–240. GYN; Gyn
gynecology

B–241. H
hydrogen

B–242. H_2O
water

B–243. HA or H/A
headache

B–244. HAA
hepatitis–associated antigen

B–245. Hb; hgb
hemoglobin

B–246. HBP
high blood pressure

B–247. HBV
hepatitis B virus

B–248. HC
head circumference

B–249. HCl
hydrochloric acid

B–250. Hct
hematocrit

B–251. HDL
high–density lipoprotein

B–252. HEENT
head, eyes, ears, nose, and throat

B–253. HEM
hematology

B–254. Hgb; Hb
hemoglobin

B–255. HIV
Human Immunodeficiency Virus

B–256. HMO
Health Maintenance Organization

B–257. HNP
herniated nucleus pulposus

B–258. H/O
history of

B–259. Hosp
hospitalization

B–260. H&P
history and physical

B–261. HPI
history of present illness

B–262. hr
hour

B–263. HR
heart rate

B–264. ht
height

B–265. HTLV
human T–cell leukemia/lymphoma virus

B–266. HTN
hypertension

B–267. Hx
history

B–268. hypo
hypodermic

B–269. I^{131}
radioactive iodine

B–270. IAW
in accordance with

B–271. ICU
intensive care unit

B–272. I&D
incision and drainage

B–273. ID
identification

B–274. IDDM
insulin–dependent diabetes mellitus

B–275. IM
intramuscular (injection)

B–276. in
inch

B–277. incis.
incision

B–278. Ind
individual

B–279. inf
inferior

B–280. Inf Dis
infectious disease

B–281. info
information

B–282. Ing
inguinal

B–283. INH
insonicotinic acid hydrazide; isoniazid; isonicotinoylhydrazide

B–284. inj
injury; injured

B–285. int
internal

B–286. I&O
intake and output

B–287. IOP
intraocular pressure

B–288. IPPB
intermittent positive pressure breathing

B–289. IQ
intelligence quotient

B–290. IUCD; IUD
intrauterine contraceptive device

B–291. IUP
interuterine pregnancy

B–292. IV
intravenous (injection)

B–293. IVP
intravenous pyelogram

B–294. jct
junction

B–295. jej
jejunum

B–296. jt
joint

B–297. K
potassium

B–298. kg
kilogram

B–299. KJ
knee jerk

B–300. kL
kiloliter

B–301. km
kilometer

B–302. KUB
kidney, ureter, and bladder

B–303. L
liter

B–304. lab
laboratory

B–305. lac
laceration

B–306. lap
laparotomy

B–307. laser; LASER
light amplification by stimulated emission of radiation

B–308. lat
lateral

B–309. lb
pound

B–310. L/B
live birth

B–311. LBBB
left bundle branch block

B–312. LBP
low back pain

B–313. LBW
low birth weight

B–314. L&D
labor and delivery

B–315. LDL
low–density lipoprotein

B–316. LE
lower extremity

B–317. lig
ligament

B–318. LLE
left lower extremity

B–319. LLL
left lower lobe (of lung)

B–320. LLQ
left lower quadrant

B–321. LMP
left mentoposterior (position of fetus); last menstrual period

B–322. LOC
loss of consciousness

B–323. LOD
line of duty

B–324. LOM
limitation of motion

B–325. LOS
length of stay

B–326. LP
lumbar puncture

B–327. LPN
licensed practical nurse

B–328. LQ
lower quadrant

B–329. L–S
lumbosacral

B–330. LSH
lutein–stimulating hormone

B–331. lt
left

B–332. LTG
long term goal

B–333. LUL
left upper lobe (of lung)

B–334. LUQ
left upper quadrant

B–335. LV
left ventricular

B–336. LVN
licensed vocational nurse

B–337. lymphs
lymphocytes

B–338. m
meter

B–339. max
maximum

B–340. mc; mCi
millicurie

B–341. mcg
microgram

B–342. MCHC
mean corpuscular hemoglobin concentration or count

B–343. MEB
medical evaluation board

B–344. med
medicine or medication

B–345. mEq
milliequivalent

B–346. MG
myasthenia gravis

B–347. mg
milligram

B–348. MI
myocardial infarction

B–349. MIA
missing in action

B–350. MICU
medical intensive care unit

B–351. min
minute

B–352. mL
milliliter

B–353. mm
millimeter

B–354. MMPI
Minnesota Multiphasic Personality Inventory

B–355. mod
moderate

B–356. Mono
mononucleosis

B–357. monos
monocytes

B–358. mos
months

B–359. MRI
magnetic resonance imaging

B–360. msec
millisecond

B–361. NA
nursing assistant

B–362. Na^+
sodium

B–363. N/A
not applicable

B–364. NAD
no acute distress

B–365. NaPent
sodium pentothal

B–366. NB
newborn

B–367. N/C
no complaint

B–368. NCHS
National Center for Health Statistics

B–369. neg
negative

B–370. Neph
nephrology

B–371. Neuro
neurological, neurology

B–372. NICU
Neonatal Intensive Care Unit

B–373. NIDDM
non–insulin–dependent diabetes mellitus

B–374. NKA
no known allergies

B–375. NKDA
no known drug allergies

B–376. nl; norm
normal limits

B–377. NLT
not later than

B–378. NPH insulin
neutral protamine Hagedorn insulin

B–379. npo
nothing by mouth

B–380. NS
nervous system

B–381. nsg
nursing

B–382. NTG
nitroglycerin

B–383. nurs
nursery

B–384. NWB
non–weight bearing

B–385. O_2
oxygen; both eyes

B–386. OB
obstetrics

B–387. OB–GYN
obstetrics and gynecology

B–388. obj
objective

B–389. OBS
organic brain syndrome

B–390. OD
overdose; right eye

B–391. Onc
oncology

B–392. OOB
out of bed

B–393. op
operation

B–394. OPC
outpatient clinic

B–395. OPD
outpatient department

B–396. ophth
ophthalmology

B–397. OPV
oral poliomyelitis vaccine

B–398. OR
operating room

B–399. Ortho
orthopedics

B–400. OS
left eye

B–401. os, per os
mouth; by mouth

B–402. OT
occupational therapy

B–403. OTC
over the counter (drugs)

B–404. OU
both eyes together

B–405. oz
ounce

B–406. PA
physician's assistant

B–407. P&A
percussion and auscultation

B–408. PAC
premature atrial contractions

B–409. Pap test
Papanicolaou's test

B–410. path
pathology

B–411. pc
after meals

B–412. PDR
Physician's Desk Reference

B–413. PE
physical examination

B–414. PEB
Physical Evaluation Board

B–415. Ped
pediatrics

B–416. PERRLA
pupils equal, round, and react to light and accommodation

B–417. PE– tubes
pressure–equalizing tubes

B–418. PH
past history

B–419. phar; pharm
pharmacy; pharmaceutical; pharmacopeia

B–420. PI
present illness

B–421. PID
pelvic inflammatory disease

B–422. Pit
Pitocin

B–423. pkg
package

B–424. PKU
phenolketonuria

B–425. PMH
past medical history

B–426. PO
postoperative

B–427. po
by mouth; orally

B–428. POD
postoperative day

B–429. Pod
podiatry

B–430. pos
positive

B–431. postop
postoperative

B–432. POW
prisoner of war

B–433. PP
post partum

B–434. PPB
positive pressure breathing

B–435. preg
pregnancy

B–436. Pre–med
premedication

B–437. pre–op
preoperative

B–438. prep
preparation; prepare (for surgery)

B–439. prn
as needed

B–440. prog
prognosis

B–441. Psych
psychiatry

B–442. Psychol
psychology

B–443. PT
physical therapy

B–444. pt
patient

B–445. PTA
physical therapist assistant

B–446. PTCA
percutaneous transluminal coronary angioplasty

B–447. PUD
peptic ulcer disease

B–448. PULHES
physical profile factors: P—physical capacity or stamina; U—upper extremities; L—lower extremities; H—hearing and ears; E—eyes; S—psychiatric

B–449. pulm
pulmonary

B–450. PVC
premature ventricular contractions

B–451. q
every

B–452. qh
every hour

B–453. q2h, q3h, and so on
every two hours, every three hours, and so on

B–454. qid
four times a day

B–455. qn
every night

B–456. r
roentgen

B–457. RA
rheumatoid arthritis

B–458. Ra
radium

B–459. RBC
red blood cells or corpuscles

B–460. R.D.
registered dietitian

B–461. RDS
respiratory distress syndrome

B–462. Rec Rm
recovery room

B–463. reg
regular

B–464. rehab
rehabilitation

B–465. req
requirement

B–466. resp
respiratory

B–467. Rh factor
Rhesus blood factor

B–468. RLL
right lower lobe (of lung)

B–469. RLQ
right lower quadrant

B–470. RML
right middle lobe (of lung)

B–471. RN
registered nurse

B–472. R/O
rule out

B–473. ROM
range of motion

B–474. ROS
review of systems

B–475. RPR
reiter protein reagin

B–476. RR
recovery room

B–477. rt
right

B–478. RTC
return to clinic

B–479. RUL
right upper lobe (of lung)

B–480. RUQ
right upper quadrant

B–481. Rx
prescription; treatment; take

B–482. S
left

B–483. S–A; SA node
sino–atrial node

B–484. SB
stillborn

B–485. SBE
subacute bacterial endocarditis

B–486. sec
second; secondary

B–487. sed
sedentary

B–488. Sed rate
erythrocyte sedimentation rate

B–489. SGA
small for gestational age

B–490. SGOT
serum glutamin–oxaloacetic transaminase

B–491. SGPT
serum glutamic–pyruvic transaminase

B–492. SI
seriously ill

B–493. SICU
surgical intensive care unit

B–494. SIDS
sudden infant death syndrome

B–495. signif
significant

B–496. SLE
systemic lupus erythematosis

B–497. SLR
short leg raise

B–498. sm
small

B–499. SOAP
progress note format; S—subjective O—objective A—assessment P—plan

B–500. SOB
shortness of breath

B–501. S/P
status post

B–502. staph
staphylococcus

B–503. STAT
immediately and once only

B–504. STD
sexually transmitted disease

B–505. STG
short term goal

B–506. strep
streptococcus

B–507. STS
serologic test for syphilis

B–508. Surg
surgery

B–509. Svc
Service

B–510. SWS
Social Work Service

B–511. sx
signs; symptoms

B–512. sys
system

B–513. T
temperature

B–514. T&A
tonsillectomy and adenoidectomy

B–515. tab
tablet

B–516. TAH
total abdominal hysterectomy

B–517. TB
tuberculosis

B–518. tbs; tbsp
tablespoon

B–519. Td
tetanus toxoid and diphtheria toxoid (for older children and adults)

B–520. temp
temperature

B–521. TIA
transient ischemic attacks

B–522. tid
three times a day

B–523. TMJ
temporomandibular joint

B–524. tng
training

B–525. TPR
temperature, pulse, and respiration

B–526. trf
transfer

B–527. TSH
thyroid–stimulating hormone

B–528. tsp
teaspoon

B–529. TURP
transurethral resection, prostate

B–530. TVH
total vaginal hysterectomy

B–531. UA
urinalysis

B–532. UE
upper extremity

B–533. UGI
upper gastrointestinal

B–534. unk
unknown

B–535. UQ
upper quadrant

B–536. URI
upper respiratory infection

B–537. urol
urology; urological

B–538. URQ
upper right quadrant

B–539. US
ultrasound

B–540. USPHS
U.S. Public Health Service

B–541. UTI
urinary tract infection

B–542. VA
Department of Veterans Affairs

B–543. vag
vaginal

B–544. VCUG
voiding cysto–urethrogram

B–545. VD
venereal disease

B–546. VDRL
venereal disease research laboratory test

B–547. vit
vitamin

B–548. VLDL
very low density lipoproteins

B–549. VS
vital sign

B–550. vs
against

B–551. VSI
very seriously ill

B–552. WBC
white blood cell

B–553. wd
ward

B–554. WD/WN/BF
well–developed, well–nourished, black female

B–555. WD/WN/BM
well–developed, well–nourished, black male

B–556. WD/WN/WF
well–developed, well–nourished, white female

B–557. WD/WN/WM
well–developed, well–nourished, white male

B–558. WIA
wounded in action

B–559. WISC
Weschler Intelligence Scale for children (test)

B–560. wk
week

B–561. WNL
within normal limits

B–562. wt
weight

B–563. W/U
workup

B–564. X
times

B–565. y/o
year old

B–566. yr
year

B–567. 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

V

diastolic blood pressure

Λ

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

i̇ ii̇ iii̇ iv̇ v̇ vi̇

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

fʒ; 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 Healthcare Documentation programs.

C–2. Purpose

The purpose of this checklist is to assist patient administration staff in military 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. This form is available on the AEL CD–ROM and at the APD Web site (www.apd.army.mil).

C–4. Test questions

a. Is there a current SOP on accountability and disclosure procedures for medical records with specified individuals responsible for disclosing medical information and annual in–service and required web–based training to educate all staff on health information privacy laws and procedures for using or disclosing PHI? (paras 1–4 and 2–2)

b. Are the appropriate forms used and retained for all requests for information (DA Form 4254 for official, DD Form 2870 for unofficial, DA Form 4876 for communications media)? (para 2–3)

c. Is an accounting of all disclosures of PHI available to patients? (para 2–5)

d. Are State laws adhered to when determining if records of minors in programs for substance abuse, venereal diseases, birth control, or abortion can be released? (para 2–6)

e. 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)

f. Do MTF Commanders approve requests by personnel in their commands for access to medical records for research purposes (para 2–8); ensure that requests for information on treatment, identity, prognosis, or diagnosis for substance abuse patients are handled per AR 600–85 and chapter 8 of this regulation (para 2–1); and ensure that information on HIV is handled properly? (para 3–10)

g. Are locally produced overprints from MTFs supported by a letter of authorization from the designated authority within the MTF? (para 3–3)

h. Are all entries on medical documents signed, legible, and dated, and if erroneous, corrected properly with date and signature? (para 3–4)

i. Are the abbreviations used in the records authorized by appendix B to this regulation or by a locally approved supplement? (para 3–8)

j. Is the cause of injury and the general geographic location where the injury occurred recorded? (para 3–12)

k. Are injuries caused by chemical agents, bacteriological agents, or ionizing radiation thoroughly documented? (para 3–12)

l. 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)

m. Is there a current SOP for maintenance of STRs for all Army personnel? (para 5–3)

n. Is the inpatient treatment record (ITR) prepared for every admission, liveborn infant, and CRO case? (para 9–1)

o. 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 11–1)

p. 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 12–1 and 12–2)

q. Is there evidence of continuous improvement in the quality of all patient care related key functions as defined by TJC standards? (para 12–3)

r. Did medical record of 90 percent of patients transferred accompany them to the destination facility?

s. Did the medical record of 100 percent of patients transferred accompany them or were records forwarded within 24 hours of departure by the sending MTF?

C–5. Supersession

This checklist replaces the checklist for key management controls previously published in AR 40–66.

C–6. Comments

Help make this a better tool for evaluating management controls. Submit comments to Office of the Surgeon General (DASG–HS–AP), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Glossary

Section I
Abbreviations

ABCA
American–British–Canadian–Australian

ABO/Rh
American Board of Otolaryngology/Rhesus factor

ADS
Ambulatory Data System

ADT
active duty for training

AEL
Army Electronic Library

AKO
Army Knowledge Online

AMEDD
Army medical department

APD
Army Publishing Directorate

APV
Ambulatory Procedure Visit

ARIMS
Army Records Information Management System

ARNGUS
Army National Guard of the United States

AR–AHRC
U.S. Army Human Resources Command

ASA
American Society of Anesthesiologists

ASAP
Army Substance Abuse Program

AWOL
absent without leave

CCC
Community Counseling Center

CD–ROM
Compact Disk—Read Only Memory

CEMR
civilian employee medical record

CFR
Code of Federal Regulations

CHCS
Composite Health Care System

CJA
claims judge advocate

CONOPS
Concept of Operations

CONUS
continental United States

CPO
civilian personnel office

CRO
carded for record only

CSH
combat support hospital

DA
Department of the Army

DD
Department of Defense

DEERS
Defense Enrollment Eligibility Reporting System

DENTAC
U.S. Army dental activity

DNA
deoxyribonucleic acid

DOA
dead on arrival

DOD
Department of Defense

DODD
Department of Defense Directive

DODI
Department of Defense Instruction

DOL
Department of Labor

DSS
Defense Security Service

DTF
dental treatment facility

EAR
extended ambulatory record

EC/ED
emergency center/emergency department

ELISA
enzyme–linked immunosuppressant assay

ESPBD
entrance physical standards board

ESU
electrosurgical unit

FAP
Family Advocacy Program

FMP
family member prefix

HEAR
Health Enrollment/Evaluation Assessment Review

HH
home health

HHS
Department of Health and Human Services

HIPAA
Health Insurance Portability and Accountability Act

HIV
Human Immunodeficiency Virus

HRC
Human Resources Command

INH
isoniazed

IOP
Improving Organizational Performance

IPDS
Individual Patient Data System

IRR
Individual Ready Reserve

ISN
internment serial number

ITR
inpatient treatment record

LOD
line of duty

LPN
licensed practical nurse

MCJA
medical claims judge advocate

MDRTS
Medical and Dental Record Tracking System

MDWE
model driven web engineering

MEDCEN
U.S. Army Medical Center

MEDDAC
medical department activity

MEDPROS
Medical Protection System

MHS
Military Health System

MILPO
military personnel office

MTF
military treatment facility

NATO
North Atlantic Treaty Organization

NCT
nerve conduction time

NIO
nursing initiated order

NOPP
Notice of Privacy Practices

NPRC
National Personnel Records Center

OBS
observation

OCONUS
outside continental United States

OF
optional form

OMR
outpatient medical record

OSHA
Occupational Safety and Health Administration

OTR
outpatient treatment record

OWCP
Office of Workers' Compensation Programs

PA
physician's assistant

PCM
Primary Care Manager

PCS
permanent change of station

PEB
physical evaluation board

PH
partial hospitalization

PHI
protected health information

PHS
Public Health Service

PIR
patient intake/screening record

PL
Public Law

POM
Preparation for Overseas Movement

POR
Preparation of Replacements for Overseas Movement

PS
physical status

QSTAG
quadripartite standardization agreement

RC
Reserve Component

RN
registered nurse

RTD
return(ed) to duty

RTF
residential treatment facility

SC
subacute care

SF
standard form

SIDR
Standard Inpatient Data Record

SNF
skilled nursing facility

SOAP
subjective, objective, assessment, plan

SOP
standing operating procedures

SRP
Soldier Readiness Process

SSN
Social Security number

STANAG
standardization agreement

STR
service treatment record

TJC
The Joint Commission

TPU
troop program unit

USAMEDCOM
U.S. Army Medical Command

USAR
U.S. Army Reserve

USARCS
U.S. Army Claims Service

USC
U.S. Code

VA
Department of Veterans 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: 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; authorizes another person to make healthcare decisions for the declarant, under circumstances stated in the declaration, whenever the declarant is incapable of making informed healthcare decisions.

Ambulatory procedure unit
A location or organization within an MTF (or freestanding outpatient clinic) that is specially equipped, staffed, and designated for the purpose of providing the intensive level of care associated with APVs.

Ambulatory Procedure Visit (APV)
Refers to a medical or surgical intervention requiring immediate (day of procedure), pre–procedure, and immediate post–procedure care in an ambulatory procedure unit. The complexity, intensity, and duration of the care provided determine the APV. A licensed or registered care practitioner will be directly involved in the healthcare intervention related to the APV in accordance with local standards of care. The total length of time for care provided in the healthcare facility is less than 24 hours.

Army Substance Abuse Program outpatient medical record (ASAP–OMR)
The outpatient medical record used for both military and nonmilitary persons enrolled in an Army Substance Abuse Program.

Attending physician
An independently credentialed staff physician or fellow.

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 PHI. Information gained through the examination or treatment of a patient is private and confidential. Medical confidentiality is not, however, a security classification of confidential.

Covered entity
A health plan or a healthcare provider who transmits any health information in electronic form in connection with a transaction covered by DOD 6025.18–R. In the case of a health plan administered by the DOD, the covered entity is the DOD component (or subcomponent) that functions as the administrator of the health plan. To the extent that DOD 6025.18–R prescribes duties to be performed by covered entities, the term refers only to DOD covered entities. Under DOD 6025.18–R, paragraph C3.2.2, all covered entities of the Military Health System (including both health plans and healthcare providers) are designated as a single covered entity. Not all healthcare providers affiliated with the Armed Forces are covered entities; among those who are not are providers associated with Military Entrance Processing Stations and Reserve Components practicing outside the authority of military treatment facilities who do not engage in electronic transactions covered by DOD 6025.18–R and non–network civilian providers.

Covered functions
Those functions of a covered entity the performance of which makes the entity a health plan or healthcare provider.

Disclosure
The release, transfer, provision of access to, or divulging in any other manner of PHI outside the entity holding the information.

Drop file
Folder in which completed forms are placed, but not attached, such as a field file.

Electronic signature
Implementation of a system that 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
U. S. medical card normally used in a theater of operations that provides pertinent data about the casualty's/patient's identity, diagnosis, time/date, facility where tagged, treatment rendered, and disposition.

Fixed military treatment facility (MTF)
A military treatment facility designed to operate for an extended period of time at a specific site.

Healthcare operations
Any of the following activities of the covered entity to the extent that the activities are related to covered functions:

a. Conducting quality assessment and improvement activities, including evaluation and development of clinical guidelines outcome, if obtaining general knowledge is not the primary purpose of any studies resulting from such activities; population–based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, contacting of healthcare providers and patients with information about treatment alternatives; and related functions that do not include treatment.

b. Reviewing the competence or qualifications of healthcare professionals, evaluating practitioner, and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as healthcare providers, training of non–healthcare professionals, accreditation, certification, licensing, or credentialing activities.

c. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop–loss insurance and excess of loss insurance).

d. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

e. Business planning and development, such as conducting cost management and planning–related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.

f. Business management and general administrative activities of the entity, including, but not limited to:

(1) Management activities relating to implementation of and compliance with the requirements of DOD 6025.18–R;

(2) Customer service, if protected health information is not disclosed except as otherwise permitted by DOD 6025.18–R;

(3) Resolution of internal grievances;

(4) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity;

(5) Consistent with the applicable requirements of DOD 6025.18–R, chapter 8, creating de–identified health information or a limited data set, and fundraising for the benefit of the covered entity.

Healthcare provider
A healthcare professional (military or civilian) who is granted privileges to diagnose, initiate, alter, or terminate healthcare treatment regimens for patients.

Home health
Services for patients who are discharged but require skilled nursing care during convalescence. Home health is part–time skilled nursing care; physical, speech and occupational therapy, when medically necessary; and covered benefits. Services include changing dressings, catheter care, intravenous therapy, and other procedures requiring skilled delivery.

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.

Marketing
An arrangement between a covered entity and any other entity whereby the covered entity disclosed protected health information to the other entity, in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service. Marketing is also defined as an announcement of a product or service that encourages recipients of the communication to purchase or use the product or service, unless the communication is made—

a. To inform an individual who is a member of a Uniformed Service or a covered beneficiary of the Military Health System of benefits, services, coverage, limitations, costs, procedures, rights, obligations, options, and other information concerning the Military Health System as established by law and applicable regulations.

b. Otherwise to describe a health–related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication, including communication about: the entities participating in a healthcare provider network or health plan network; replacement of, or enhancements to, a health plan; and health–related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits.

c. For treatment of the individual.

d. For case management or care coordination of the individual, or to direct or recommend alternative treatments, therapies, healthcare providers, or settings of care to the individual.

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, STRs, dental records, ITRs, CEMRs, ASAP–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 records practitioner

A professional who collects, analyzes, and manages the patient information that steers the healthcare industry.

Military Health System (MHS)

All DOD health plans and all DOD healthcare providers that are, in the case of institutional providers, organized under the management authority of, or in the case of covered individual providers, assigned to or employed by, the TRICARE Management Activity, the Army, the Navy, or the Air Force.

Nonfixed military treatment facility (MTF)

An MTF designed to be moved from place to place, including MTFs afloat.

Observation

Those services, furnished by a hospital (the term hospital includes DOD clinics with resources to provide these services) on the hospital's premises, including the use of a bed and periodic monitoring by the hospital's nursing or other staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed 23 hours. However, in some instances, depending on medical necessity, up to 48 hours of observation services may be justified. The period of observation begins the moment the patient is placed in observation status.

Outpatient treatment record (OTR)

The OTR and the dental record of the beneficiary for whom an STR is not kept.

Partial hospitalization

A general term embracing day, evening, night, and weekend treatment programs that employ an integrated, comprehensive, multidisciplinary, and complementary schedule of recognized treatment approaches. Partial hospitalization is characterized by structured, daily, supervised outpatient activities over a prolonged period, tailored to treat or rehabilitate individuals who require crisis stabilization, intensive short–term treatment, or intermediate term treatment.

Preceptor physician

A senior resident or staff physician with supervisory responsibilities over a medical student.

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.

Protected health information (PHI)
Individually identifiable health information that is transmitted or maintained by electronic or any other form or medium (except as provided in DOD 6025.18–R, para DL1.1.28.2). Protected health information excludes individually identifiable health information in employment records held by a covered entity in its role as employer.

Psychotherapy notes
Notes recorded (in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Senior resident
At a minimum, a resident in the second year or subsequent years of post–graduate education.

Service treatment record
The chronological documentation of medical and dental care received by a military member during the course of his/her military service. Inpatient/clinical records are not included in the service treatment record.

Skilled nursing facility
An institution that is duly licensed as an extended care facility or convalescent facility and operates in accordance with governing laws and regulations; regularly provides inpatient skilled nursing care for payment during the active or convalescent stage of an injury or illness; is staffed with a physician or registered nurse on duty 24 hours a day; operates in accordance with medical policies supervised and established by a physician other than the patient's own physician; regularly maintains a daily medical record for each patient; is not, other than incidentally, a place for the aged, a substance abuse treatment facility, or a place for custodial care; and is recognized as an extended care facility or a skilled nursing facility under Medicare.

Special category record
A record that is individually identified (see para 4–4a(10)) and specially handled to reduce the risk of harming or embarrassing the patient and ensuring its medicolegal integrity.

Subacute care
Goal–oriented, comprehensive, inpatient care designed for an individual who has had an acute illness, injury, or exacerbation of a disease process. It is rendered immediately after or instead of acute hospitalization to treat one or more specific, active, complex medical conditions or to administer one or more technically complex treatments in the context of a person's underlying, long–term conditions and overall situation. Subacute care is a distinct form of healthcare service that fills the treatment gap between acute care and long–term care.

Treatment
The provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation among healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another.

Section III
Special Abbreviations and Terms
This section contains no entries.

USAPD

ELECTRONIC PUBLISHING SYSTEM
OneCol FORMATTER WIN32 Version 243

PIN:	045771–000
DATE:	06-17-08
TIME:	08:55:39
PAGES SET:	199
DATA FILE:	C:\wincomp\r40-66.fil
DOCUMENT:	AR 40–66
SECURITY:	UNCLASSIFIED
DOC STATUS:	REVISION