REFERENCE

Army Regulation 40-66

s/s by 3 MAY 1999

Medical Services

Medical Record Administration

Headquarters
Department of the Army
Washington, DC
20 July 1992

Unclassified

SUMMARY of CHANGE

AR 40-66
Medical Record Administration

This revision--

- Adds an index and a thumb index to assist in locating references.
- Deletes facility-wide quality assurance administration, patient-care assessment, utilization review, risk management, credentialing, and professional licensure. See AR 40-68.
- Deletes Army Medical Department Military Impaired Health Care Providers Program. See AR 40-68.
- Delineates access to medical records by chaplains (chap 1).
- Adds guidance on use of facsimile transmissions of information in emergency situations (chap 2).
- Moves and expands paragraph 7-2 (Forms and Documents) to chapter 3 to consolidate forms guidance for all medical records.
- Adds new requirements for documentation of therapeutic abortions (para 3-16).
- Refers reader to references for completing DA Form 3647 (Inpatient Treatment Record Cover Sheet) (chap 7) and recording surgical, diagnostic, and therapeutic procedures (chap 3).
- Adds and deletes abbreviations in appendix B and gives guidance on locally approved abbreviations (chap 3).
- Updates color sequence for retirement of records (chap 4).
- Adds guidance on automated forms (chap 3) and automated indexes (chaps 4 and 8).
- Modifies guidelines for construction of artificial 11-digit numbers (chap 4).
- Revises family member prefixes (chap 4).
- Revises guidance on identifying medical records of individuals qualified for the Personnel Reliability Program (chap 5).
- Changes filing guidelines for preprinted discharge instructions (para 5-3).
- Adds the four-part record jacket with updates of filing forms in health records (chap 5) and outpatient treatment records (chap 6).
- Revises chapter 5, section V, on maintenance of health records upon mobilization.
- Adds requirement for recording rubella titre results to SF 601 and PHS Form 731 (chaps 5 and 6).

- Adds guidance on contract medical records under Primary Care for the Uniformed Services and Uniformed Services Treatment Facilities (chaps 5 and 6).

- Adds copies of additional inpatient treatment record forms to be filed in health records and outpatient treatment records (chaps 5 and 6).

- Shortens requirements for filing of final autopsy reports to 60 days (chap 7).

- Adds requirements for maintenance of alcohol and drug abuse prevention and control outpatient medical records (chap 7).

- Adds guidance about living wills (advance directives) (para 8-2).

- Changes guidance about forwarding inpatient treatment records to other medical treatment facilities (para 8-8).

- Adds guidance on filing radiologic wet readings (para 8-20).

- Revises instructions for DD Form 1380 (chap 9).

- Delineates internal medical record quality-assurance requirements (chap 10).

- Describes requirements for handling medical records in risk management cases (para 10-4).

- Revises monthly and annual statistics guidelines (chap 11).

- Adds required files corresponding to AR 25-400-2.

- Prescribes the following new forms:

  --DA Form 8005 (Alphabetical and Terminal Digit File for Treatment Record (Orange)) (para 4-3).

  --DA Form 8005-1 (Alphabetical and Terminal Digit File for Treatment Record (Light Green)) (para 4-3).

  --DA Form 8005-2 (Alphabetical and Terminal Digit File for Treatment Record (Yellow)) (para 4-3).

  --DA Form 8005-3 (Alphabetical and Terminal Digit File for Treatment Record (Grey)) (para 4-3).

  --DA Form 8005-4 (Alphabetical and Terminal Digit File for Treatment Record (Tan)) (para 4-3).

  --DA Form 8005-5 (Alphabetical and Terminal Digit File for Treatment Record (Light Blue)) (para 4-3).

  --DA Form 8005-6 (Alphabetical and Terminal Digit File for Treatment Record (White)) (para 4-3).

  --DA Form 8005-7 (Alphabetical and Terminal Digit File for Treatment Record (Brown)) (para 4-3).

  --DA Form 8005-8 (Alphabetical and Terminal Digit File for Treatment Record (Pink)) (para 4-3).

  --DA Form 8005-9 (Alphabetical and Terminal Digit File for Treatment Record (Red)) (para 4-3).

--DA Form 8007 (Individual Medical History (IMH)) (para 5-30).

--DA Form 8006 (Pediatric Dentistry Diagnostic Form) (para 6-7).

--DA Form 7095 (ADAPCP Outpatient Discharge Summary) (para 7-9).

--DA Form 7096 (ADAPCP Outpatient Aftercare Plan) (para 7-9).

--DA Form 7097 (ADAPCP Outpatient Problem List and Treatment Plan Review) (para 7-9).

--DA Form 7098 (ADAPCP Outpatient Treatment Plan and Review) (para 7-9).

--DA Form 7099 (ADAPCP Outpatient Biopsychosocial Evaluation) (para 7-9).

--DA Form 8000 (ADAPCP Triage Instrument (For Unscheduled Patients)) (para 7-9).

--DA Form 8001 (Limits of Confidentiality) (para 7-9).

--DA Form 8002 (ADAPCP Outpatient Administrative Summary) (para 7-9).

--DA Form 8003 (ADAPCP Enrollment) (para 7-9).

--DA Form 8004-R (ADAPCP outpatient Medical Records--Privacy Act Information) (para 7-9).

Headquarters
Department of the Army
Washington, DC
20 July 1992

*Army Regulation 40–66

Effective 20 August 1992

Medical Services

Medical Record Administration

By Order of the Secretary of the Army:

GORDON R. SULLIVAN
General, United States Army
Chief of Staff

Official:

MILTON H. HAMILTON
Administrative Assistant to the Secretary of the Army

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

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

Applicability. This regulation applies to all Active Army medical treatment facilities. It also applies to the Army National Guard and the U.S. Army Reserve. This publication is applicable during mobilization.

Internal control systems. This regulation is subject to the requirements of AR 11–2. It contains the internal control provisions but does not contain checklists for conducting internal control reviews. These checklists will be published in a Department of the Army circular.

Supplementation. Supplementation of this regulation is prohibited without prior approval from HQDA (SGPS–PSA), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Interim changes. Interim changes to this regulation are not official unless they are authenticated by the Administrative Assistant to Assistant Secretary of the Army. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested Improvements. The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (SGPS–PSA), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Distribution. Distribution of this publication is made in accordance with the requirements on DA Form 12–09–E, block number 2063, intended for command levels A, B, C, and D for the Active Army, the Army National Guard, and the U.S. Army Reserve.

Contents (Listed by paragraph and page number)

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

Chapter 2
Confidentiality of Medical Information, *page 6*
General • 2–1, *page 6*
Protection of confidentiality • 2–2, *page 6*
Disclosure procedures • 2–3, *page 6*
Medical records containing classified defense information • 2–4, *page 7*
Medical records of teenage family members • 2–5, *page 7*
Research using medical records • 2–6, *page 8*
Alcohol and drug abuse records • 2–7, *page 8*
Civilian employee medical records • 2–8, *page 8*

Chapter 3
Preparation of Medical Records, *page 8*

Section I
Forms and Documents, page 8
Authorized forms • 3–1, *page 8*
Filing automated and computerized forms • 3–2, *page 8*
Guidelines for local forms and overprints • 3–3, *page 8*

Section II
Medical Record Entries, page 9
General • 3–4, *page 9*
Patient identification • 3–5, *page 10*
Facility identification • 3–6, *page 10*
Destruction of unidentifiable medical documents • 3–7, *page 10*

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

Section IV
Records for Carded-for-Record-Only Cases and Absent-Sick Status, page 14
Carded-for-record-only cases • 3–17, *page 14*
Absent-sick status • 3–18, *page 15*

*This regulation supersedes AR 40–66, 31 January 1985.

Chapter 4
Filing and Requesting Medical Records, *page 15*
Filing by social security number and family member prefix • 4–1, *page 15*
Terminal digit filing system • 4–2, *page 16*
Use of DA Form 3443-series, DA Form 3444-series, and DA Form 8005-series folders • 4–3, *page 16*
Preparation of DA Form 3444-series and DA Form 8005-series folders • 4–4, *page 16*
Preparation of DA Form 3443-series folders • 4–5, *page 18*
Record chargeout system • 4–6, *page 19*
Record requests • 4–7, *page 19*

Chapter 5
Health Records, *page 19*

Section I
General, page 19
Purpose of the health record • 5–1, *page 19*
Use of the health record • 5–2, *page 20*
For whom prepared and maintained • 5–3, *page 20*
Forms and documents of health records • 5–4, *page 20*
DA Form 5007–A–R and DA Form 5007–B–R • 5–5, *page 24*
DA Form 5008 • 5–6, *page 24*
DA Form 5181–R • 5–7, *page 24*
DA Form 5569–R • 5–8, *page 24*
DA Form 5570 • 5–9, *page 25*
DA Form 5571 • 5–10, *page 25*
DD Form 1380 • 5–11, *page 25*
DD Form 2482 • 5–12, *page 25*
SF 512 • 5–13, *page 25*
SF 558 • 5–14, *page 25*
SF 559 • 5–15, *page 25*
SF 600 • 5–16, *page 25*
SF 601 and PHS Form 731 • 5–17, *page 26*
SF 603 and SF 603A • 5–18, *page 27*
Other forms filed in the health record • 5–19, *page 28*
Military consultation service case files • 5–20, *page 29*
Access to health records • 5–21, *page 29*
Cross-servicing of health records • 5–22, *page 29*

Section II
Initiating, Keeping, and Disposing of Health Records, page 29
Initiating health records • 5–23, *page 29*
Transferring health records • 5–24, *page 30*
Establishing "temporary" and "new" health records • 5–25, *page 30*
Filing health records • 5–26, *page 31*
Disposing of health records • 5–27, *page 32*

Section III
Special Considerations for Personnel Reliability Program Health Records or Civilian Employee Medical Records, page 32
Screening Personnel Reliability Program records • 5–28, *page 32*
Maintaining Personnel Reliability Program records • 5–29, *page 32*

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

Chapter 6
Outpatient Treatment Records, *page 37*

Section I
General, page 37
For whom prepared • 6–1, *page 37*
Outpatient treatment record forms and documents • 6–2, *page 37*

Section II
Initiating, Keeping, and Disposing of Outpatient Treatment Records, page 41
Initiating and keeping outpatient treatment records • 6–3, *page 41*
Transferring outpatient treatment records • 6–4, *page 41*
Requests other than DD Form 2138 • 6–5, *page 42*
Disposition • 6–6, *page 42*

Section III
Preparation and Use of Outpatient Treatment Records, page 42
Preparation • 6–7, *page 42*
Use • 6–8, *page 42*

Chapter 7
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record, *page 43*

Section I
General, page 43
For whom prepared • 7–1, *page 43*
Access • 7–2, *page 43*
Disclosure of information • 7–3, *page 43*
Forms and documents • 7–4, *page 43*

Section II
Initiating, Maintaining, and Disposing of Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Records, page 43
Initiating and maintaining • 7–5, *page 43*
Transferring • 7–6, *page 44*
Requests other than DD Form 2138 • 7–7, *page 44*
Disposition • 7–8, *page 44*

Section III
Preparation and Use of Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Records, page 44
Preparation • 7–9, *page 44*
Use • 7–10, *page 44*

Chapter 8
Inpatient Treatment Records, *page 44*

Section I
General, page 44
For whom prepared • 8–1, *page 44*
Inpatient forms and documents • 8–2, *page 44*

Section II
Initiating, Keeping, and Disposing of Inpatient Treatment Records, page 47
General • 8–3, *page 47*
North Atlantic Treaty Organization Standardization Agreement 2348 requirements • 8–4, *page 47*
Inpatient treatment records of absent-without-leave patients • 8–5, *page 47*
Five-year inpatient treatment record maintenance • 8–6, *page 47*
Access and audit trail • 8–7, *page 48*

Disposition of inpatient treatment records • 8–8, *page 48*

Section III
Preparation and Use of Inpatient Treatment Records, page 48
Inpatient treatment records content • 8–9, *page 48*
Medical reports • 8–10, *page 48*
Countersignatures • 8–11, *page 50*

Section IV
DA Form 3647, page 50
General purpose • 8–12, *page 50*
Use • 8–13, *page 50*
Initiation and disposition • 8–14, *page 50*
Preparation • 8–15, *page 50*
Corrections and corrected copies • 8–16, *page 50*

Section V
Preparation and Use of Other Inpatient Treatment Record Forms, page 51
SF 539 • 8–17, *page 51*
Laboratory forms • 8–18, *page 51*
DA Form 4256 • 8–19, *page 52*
Radiologic forms (SF 519, SF 519A, and SF 519–B) • 8–20, *page 53*
DA Form 5009–R • 8–21, *page 53*

Chapter 9
DD Form 1380, *page 53*
Use • 9–1, *page 53*
Preparation • 9–2, *page 53*
Supplemental DD Form 1380 • 9–3, *page 54*
Disposition • 9–4, *page 54*
DA Form 4006 • 9–5, *page 54*

Chapter 10
Role of the Medical Department Activity or U.S. Army Medical Center Patient Administration Division in the Quality Assurance Program, *page 54*
General • 10–1, *page 54*
Internal Quality Assurance Program for medical record services • 10–2, *page 55*
Patient care assessment • 10–3, *page 55*
Patient administration division role in handling medical records in the Risk Management Program • 10–4, *page 55*

Chapter 11
Monthly and Annual Statistics, *page 56*
Terms to be used • 11–1, *page 56*
Monthly analysis of hospital services • 11–2, *page 57*
Annual analysis of hospital services • 11–3, *page 57*
Presentation of statistics • 11–4, *page 58*

Appendixes

A. References, *page 59*

B. Authorized Medical Records Abbreviations and Symbols, *page 65*

Table List

Table 2–1: File numbers, recordkeeping requirements, *page 7*
Table 4–1: Assignment of family member prefix, *page 15*
Table 4–2: Key to color folder assignment by terminal digits, *page 16*
Table 4–3: Key to tape colors for year in which records are to be retired, *page 17*
Table 4–4: Key for tape denoting patient status, *page 17*
Table 4–5: Last four digits—sponsor's social security number, *page 18*
Table 4–6: Retirement of radiology images and reports, DA Form 3443-series, *page 18*
Table 8–1: General instructions for preparing laboratory forms, *page 51*
Table 8–2: Specific instructions for preparing laboratory forms, *page 52*
Table 9–1: Instructions for preparing DD Form 1380, *page 53*
Table 11–1: Annual hospital rates, *page 57*

Figure List

Figure 2–1. Opinion from the DOD Privacy Board Legal Committee, 24 November 1980, *page 7*
Figure 5–1. Forms and documents of the HREC using DA Form 3444-series jackets, *page 20*
Figure 5–2. Forms and documents of the HREC using DA Form 8005-series jackets, *page 22*
Figure 5–3. Forms and documents of the HREC dental record, *page 24*
Figure 5–4. Sample message format for stray medical records, *page 34*
Figure 5–5. Sample entries on SF 600, *page 35*
Figure 5–5. Sample entries on SF 600—Continued, *page 36*
Figure 6–1. Forms and documents of the OTR using DA Form 3444-series jackets, *page 37*
Figure 6–2. Forms and documents of the OTR using DA Form 8005-series jackets, *page 38*
Figure 6–3. Forms and documents of the nonmilitary dental record, *page 40*
Figure 7–1. Forms and documents of the ADAPCP–OMR, *page 43*
Figure 8–1. Forms and documents of the ITR, *page 45*
Figure B–1. Medical symbols, *page 78*

Glossary

Index

Reproducible Forms

RESERVED

Chapter 1
Introduction

1–1. Purpose

This regulation sets policies and procedures for the preparation and use of Army medical records. The purpose of a medical record is to provide a complete medical and dental history for patient care, medicolegal support, and research and education. A medical record also provides a means of communication where necessary to fulfill other Army functions. The following types of health-care records will be used to document medical and dental care. All care provided to beneficiaries as hospital inpatients will be recorded in an inpatient treatment record (ITR). Outpatient care on a military member will be recorded in a health record (HREC) that includes a separate dental record. Care provided to nonmilitary beneficiaries will be documented in an outpatient treatment record (OTR) that includes a separate dental record. Both military and nonmilitary personnel enrolled in an alcohol and drug abuse prevention and control program (ADAPCP) will have an ADAPCP outpatient medical record (ADAPCP–OMR). Occupational and nonoccupational outpatient care provided to a civilian employee will be recorded in a civilian employee medical record (CEMR).

1–2. References

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

1–3. Explanation of abbreviations and terms

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

b. Abbreviations and symbols authorized for use in medical records are explained in appendix B. Dental terminology, abbreviations, and symbols are provided in TB MED 250. The use of locally approved abbreviations and symbols is authorized if the conditions in paragraph 3–8 are met.

1–4. Responsibilities

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

(1) Be the official custodian 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 duplicate panograph is on file with the Central Panographic Storage Facility.

b. Unit Commanders. Unit commanders will ensure that HRECs are always available to Army Medical Department (AMEDD) personnel. They will also ensure that information in HRECs is kept private and confidential. If a commander acquires HRECs or documents belonging in HRECs, he or she will ensure that they are treated confidentially (chap 2) and sent to the proper HREC custodian without delay. As an exception to *e*(1) below, some commanders may act as the custodians of their units' HRECs or appoint a competent person to do so if no AMEDD or military MTF personnel are available. Examples of units located away from military MTFs are recruiting stations, Reserve Officers' Training Corps detachments, professors of military science, and Reserve Components (RC) units receiving medical or dental care from civilian facilities. In such instances, HRECs would be maintained centrally at the unit, per this regulation with special attention to chapter 2. Questions about independent HREC maintenance in isolated units should be referred to the Army MTF with administrative responsibility for that health service area. OTRs for family members accompanying these active duty members should not be kept at the unit. Per paragraph 6–4, copies should be furnished to the family members, and the original records returned along with an explanatory letter to the military MTF that last provided medical care to the family member.

c. RC. State adjutants general will initiate, maintain, and dispose of Army National Guard (ARNG) HRECs. U.S. Army Reserve (USAR) unit commanders will initiate and dispose of HRECs of troop program unit members, and the Commanding General, USAR Personnel Center (USARPERCEN), will initiate and dispose of HRECs for Individual Ready Reserve members.

d. Military personnel officers. Military personnel officers will—

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

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

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

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

(5) Keep secure any defense information in HRECs (para 2–4). When military personnel officers acquire HRECs or documents belonging in HRECs, they will ensure that the records are treated confidentially (chap 2) and sent to the proper HREC custodian without delay.

e. AMEDD officers. AMEDD officers will—

(1) Serve as custodians of HRECs except in those instances where exception is granted as outlined in paragraphs 1–4*b* and 5–24*b*(1). They are in charge of the HRECs for members of the units to which they supply primary medical and dental care. They are also in charge of the HRECs of other individuals they are currently treating.

(2) Use HRECs for diagnoses and treatment. They will also use HRECs for conservation and improvement of health. In doing so, they will see that all needed information is promptly entered in the HRECs in their custody. If any such information is omitted, they will take the needed action to have it included.

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

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

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

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

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

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

i. Chaplains. Hospital chaplains are allowed access to medical records subject to standards contained in the American Hospital Association Guidelines—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, he or she might want to include additional information that would be helpful for the total care and treatment of the patient. Such information would be considered observational.

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

k. Research personnel. Research personnel will ensure that data collected from medical records are within guidelines of human use committees and maintain the confidentiality of patients.

1–5. Record ownership

a. Army medical records are the property of the Government. Thus, the same controls that apply to other Government documents apply to Army medical records. (See AR 25–55 for the laws and regulations on control of Government documents.)

b. Army medical records will remain in the custody of the military MTFs at all times, except when being transferred directly from one military MTF to another. This medical record is the Government's record of the medical care that it has rendered and must be protected. Upon request, the patient may be provided with a copy of his or her record but not the original record. Procedures should ensure conscientious Government control over medical records for good medical care, quality assurance, and risk management.

1–6. International standardization agreements

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

Chapter 2
Confidentiality of Medical Information

2–1. General

This chapter explains DA policies and procedures on the confidentiality of private medical information. Procedures pertaining to the confidentiality of medical quality assurance records are set forth in AR 40–68, paragraph 1–7.

2–2. Protection of confidentiality

DA policy states that medical confidentiality for all patients will be protected as fully as possible.

a. Within DA, medical information will be used in diagnosis, treatment, and prevention of medical and dental conditions. It will also be used in connection with the health of a command to monitor the delivery of health services, medical research, medical education, and other official purposes.

b. Personnel not involved in a patient's care or in medical research will never have access to a patient's record. Exceptions to this restriction are allowed when access is required by law, regulation, or judicial proceedings; when access is needed for hospital accreditation; or when access is authorized by the patient.

(1) Medical information is seen by clerical and administrative personnel (such as secretaries, transcriptionists, and medical record practitioners). This access is necessary for an MTF to process medical records properly; however, it does not give those persons any inherent right of access. All of them have a professional and ethical obligation to keep medical information confidential and private.

(2) Unauthorized disclosure of medical information is grounds for administrative or disciplinary action against the informant.

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

2–3. Disclosure procedures

Although medical information is private and confidential, it may be disclosed under certain conditions. All requests for medical information will be handled by the patient administrator or the medical record practitioner. In his or her absence, requests will be handled by another chosen representative of the MTF commander. Medical information obtained from non military sources will be filed with, but not considered a part of, the patient's medical record and will not be released when Army medical records are released. Such information is available for further diagnosis and treatment of the patient and for other official DA uses. Any further redisclosure is prohibited. This information is the property of the nonmilitary facility and can be released only by that facility. The patient or other requester will be told that additional information is contained in the record and that it may be requested from the originating facility. This additional information does not apply to medical information on patients treated under supplemental or cooperative care. Such information may be released as a part of the patient's medical record. In urgent situations, facsimile transmissions of the authorization and the release of medical information will be acceptable if appropriate measures are taken to ensure that the information is sent to the correct party.

a. Official DA requests. Army personnel seeking medical information about a patient must request it in writing from the MTF commander. They must present their official credentials and state their need, citing the authority supporting the need.

(1) DA Form 4254–R (Request for Private Medical Information) will be used for requests. (DA Form 4254–R will be locally reproduced on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.) Submitted forms are filed under AR 25–400–2, file number 40 (general medical services correspondence files), by the receiving MTF. (See table 2–1 for a list of file numbers and their titles. This regulation requires the creation, maintenance, and use of the specific records in table 2–1.)

(2) MTF commanders or patient administrators will determine the legitimacy of the request. Advice of the local staff judge advocate or medical claims judge advocate (MCJA) should be sought if there is any doubt about the need for information or about the credentials of the requester.

(3) In certain situations (for example, cases of emergency care, rape, assault, child abuse, or death) the need for information may be urgent. In these cases, both the request for information and permission for disclosing it may be given verbally. Immediately after giving permission, the MTF commander or his or her representative will prepare a memorandum on the release. The requesting agent will follow up the verbal request with a written one using DA Form 4254–R. In urgent situations, a facsimile copy of the requested medical information may be sent to other hospitals (military or civilian) if the request first meets requirements in this chapter and if appropriate measures are taken to ensure that the record is transmitted to the correct party.

b. Official requests from personnel outside DA. See AR 340–21, chapter 3.

c. Unofficial requests.

(1) Other persons requesting medical information must include an authorization for release of information. DA Form 5006–R (Medical Record—Authorization for Disclosure of Information) will be used whenever possible. (DA Form 5006–R will be locally reproduced on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.) In all instances, authorizations must—

(a) Be submitted in writing.

(b) Be signed and dated by the patient. A parent or legal guardian may sign if the patient is a minor or mentally incompetent; next-of-kin, an executor, or an administrator may sign if the patient has died. The request must be submitted within a reasonable period after being signed.

(c) State the period of hospitalization or treatment for which information is requested. Only information on specific periods will be released. Health histories will be released only when a patient is aplying for insurance coverage.

(d) Name the individual or organization to whom the information is to be released.

(e) State the purpose for which the information may be used.

(2) A copy of the released information and authorization will be filed with the request in the patient's medical record. (Copies should be made on SF 544 (Clinical Record—Statement of Patient's Treatment) when possible.) If a copy cannot be made, the request must be annotated to show the information released. When requests are made for information from both inpatient and outpatient records at the same time, both the request and authorization for release will be filed in the inpatient record; the other record will be properly cross-referenced. (See AR 25–55, chap 6, for fees and charges for copying, certifying, and searching records.)

d. Requests from patients. If a patient requests information from his or her medical record or copies of documents in it, it will be provided. Access to the information will be denied, however, if a physician or dentist judges that it could adversely affect the patient's physical or mental health. When such a decision has been made, the information may be released to another physician or dentist named by the patient. In such a case, the patient must be told that he or she may name the physician or dentist (AR 340–21, para 2–5.) Such medical records will be identified with a conspicuous strip of tape. (See para 4–4*a*(10).) Direct access of a patient to his or her original record will be allowed only in the presence of the custodian or designee.

e. Release of medical information to members of the public. See AR 25–55, paragraph 3–200. DA Form 4876–R (Request and Release of Medical Information to Communications Media) will be used for release of medical information to communications media. (DA Form 4876–R will be locally reproduced on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.)

f. Release of medical information from community health nurse files. Routine communications written by the community health nurse and directed to civilian health or social welfare agencies, related organizations, and treatment facilities pertaining to prescribed treatment or followup care may be released by the health nurse if written consent for the release is obtained from the patient and filed in the appropriate medical record. Communications pertaining to potential or actual medicolegal matters, insurance companies, law enforcement agencies, and so on will continue to be routed to the patient administrator for approval and release.

2–4. Medical records containing classified defense information

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

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

2–5. Medical records of teenage family members

a. Disclosure of information.

(1) The law of the State in which the medical record of a teenage family member is located governs the disclosure of information from the record. This information pertains to 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 Department of Defense (DOD) Privacy Board Legal Committee (24 November 1980) will be used. See figure 2–1.

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

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

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

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

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

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

Figure 2–1. Opinion from the DOD Privacy Board Legal Committee, 24 November 1980

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

Table 2–1
File numbers, recordkeeping requirements

File number	Title
40	General medical services correspondence files
40–14a	Personnel dosimetry files
40–66a	Health records
40–66b	Dental health records
40–66e	Foreign national inpatient treatment records
40–66f	Military inpatient treatment records
40–66g	Civilian inpatient treatment records
40–66i	NATO personnel inpatient treatment records
40–66j	Military outpatient records
40–66k	Civilian outpatient records
40–66m	Foreign national outpatient records
40–66q	NATO personnel outpatient records
40–66x	Troop and health clinic clinical record cover sheets

Table 2–1
File numbers, recordkeeping requirements—Continued

File number	Title
40–66y	Photograph and duplicate medical files
40–66ii	Military dental files
40–66jj	Civilian dental files
40–66kk	Foreign national dental files
40–66mm	American Red Cross dental files
40–216a	Military consultation service cases
40–216b	Civilian consultation service cases
40–216e	Clinical psychology individual cases
40–216f	Social work individual cases

2–6. Research using medical records

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

a. Approval of requests.

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

(2) The MTF or DENTAC commanders will approve requests from personnel under their command whose research projects involve medical records at that facility.

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 HQDA (SGPS–PSA), 5109 Leesburg Pike, Falls Church, VA 22041–3258. Such requests will—

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

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

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

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

(5) Name the particular records needed and their location.

(6) Give inclusive dates when access is wanted.

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

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

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

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

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

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

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

2–7. Alcohol and drug abuse records

No information on the treatment, identity, prognosis, or diagnosis for alcohol or drug abuse patients will be released except per AR 600–85. See chapter 7.

2–8. Civilian employee medical records

Guidance in this chapter will be followed to protect the confidentiality of medical information and usual disclosure procedures in CEMRs. See FPM Supplement 293–31, paragraph S6–4. In addition, Occupational Safety and Health Act rules (29 CFR 1910.2 and 29 CFR 1913.10d) provide access by the employee or his or her representative as designated in writing and by Occupational Safety and Health Administration representatives to examine or copy medical records or medical information that bears directly on the employee's exposure to toxic materials and harmful physical agents. The employee or his or her designated representative must be provided one copy of these data upon request without cost to the employee or his or her representative within 15 working days.

Chapter 3
Preparation of Medical Records

Section I
Forms and Documents

3–1. Authorized forms

The forms authorized for use in medical and dental records are listed in the figures in chapters 5, 6, 7, and 8. 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 by attending physicians and dentists or the filing of other documents as summaries or brief extracts. If filed, their source and the physician or dentist under whom they were prepared must be identified.)

3–2. Filing automated and computerized forms

a. Automated and computerized medical reports may be filed in Army medical records. Examples of such reports are electrocardiograms, coronary care unit or intensive care unit vital-sign-monitoring records, scans, anesthesia monitoring records, and laboratory test results. They should be filed with the SFs, DD forms, and DA forms to which they most closely relate (for example, electrocardiogram and cardiac monitoring with SF 520 (Clinical Record—Electrocardiographic Record), anesthesia monitoring with SF 517 (Clinical Record—Anesthesia), and laboratory test results with SF 545 (Laboratory Report Display). Undersized reports, such as monitoring strips, should be mounted on DA Form 4700 (Medical Record—Supplemental Medical Data) overprints identified as display sheets, except for cardiac rhythm strips, which may be mounted on the corresponding SF 510 (Clinical Record—Nursing Notes). (Also see paras 3–3, 8–2, and 10–4 for information on DA Form 4700.)

b. When a computerized or automated summary of all previous laboratory tests is provided, only the cumulative final report will be filed. All other results will be discarded.

c. Computerized or automated versions of recognized forms should include reference to "Automated version of (form number)" in lower left corner.

3–3. Guidelines for local forms and overprints

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

a. Local forms and overprints should 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 should appear under the form number and edition date on each form or overprint. On SF overprints, the entry "approved by U.S. Army Publications and Printing Command" must be printed under the overprint number.

b. All overprinting of SFs, 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—Doctor's 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 committee that has medical record review function is directly responsible for review and approval of local forms and overprints.

d. Local forms and overprints submitted to the MTF or DENTAC committee for review and approval will be accompanied by written justification.

e. Creation of a form for which a higher echelon form exists (for example, a local anesthesia form as a substitute for SF 517) 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), a continuous report form, may be used in ITRs, HRECs, and OTRs. OF 275 may be used for the transcription of dictated reports or it may replace approved overprints on DA Form 4700. When OF 275 is used, the title and number of the form that it replaces are noted in the lower left corner. All standard information needed on the report form replaced by OF 275 will be entered on OF 275, including subtitles and name and address of MTF. OF 275 will be filed in the ITR, HREC, or OTR, according to the number of the form that it replaces. (Also see para 8–10 for information on OF 275.)

g. Overprints on SFs, 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, DD forms, or DA forms. Lined overprints superimposed on lined SFs, DD forms, and DA forms create serious printing and user problems.

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

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

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

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

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

n. When preprinted instructions are given to the patient and family, the patient's record will so indicate, and a sample of the instruction sheet will be retained in the ITR, HREC, or OTR.

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

p. Approval for entering doctors' orders on DA Form 4256 (Doctors Orders) and DA Form 4700 is not required, including orders that are handwritten, taken over the phone by authorized personnel, or overprinted as standing orders. See paragraph 8–19.

q. SF 522 (Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures) will be used to meet the requirements of counseling and authorization required for sterilization and abortion. There should be no approval for local consent forms designed specifically for these procedures.

r. Use of abbreviations on forms and overprints should be in strict compliance with those included in appendix B or locally approved per paragraph 8c. Otherwise the abbreviations must be spelled out.

Section II
Medical Record Entries

3–4. General

a. Content. Entries will be made in a record by the health-care provider who observes, treats, or cares for the patient. While this regulation prescribes the amount of information that must be given for some entries, health-care providers must always remember that entries serve as a useful record for continued and future care. Thus, all entries must be clinically pertinent and kept up-to-date. No health-care practitioner is permitted to complete a medical record on a patient unfamiliar to him or her. In unusual extenuating circumstances (for example, death of a provider), the committee chartered with medical record review will ensure that all means have been exhausted to complete the record. If this action is impossible, they will 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. They should be typed but may be handwritten. (However, radiology, pathology, and operative reports, as well as narrative summaries, will be typewritten.) Handwritten entries will be made in permanent black or blue-black ink, except when pencil entries are either directed or necessary under field conditions. Rubber stamps may be used only for standardized entries, such as routine orders.

c. Signatures. All entries must be signed. The first entry made by a person will be signed; later entries on the same page by that person will be signed or initialed. (A military member must add grade and corps; a civilian must add his title or certification.) Rubber-stamped signatures will not be used in place of written signatures or initialing. However, the use of (rubber) block stamps or handprinted name under written signatures is recommended because it establishes a method to identify the authors of entries. Block stamps for military members should contain printed name, grade, and corps; block stamps for civilians should contain printed name and title or certification. Electronic signatures on a medical record will not jeopardize the admissibility of the record in court.

d. Dating entries. All entries must be dated. Dates will be written in the day-month-year sequence; months will be stated by name, not by number. For example, a correct entry is "17 Jun 90."

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.

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

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

3–5. Patient identification

The patient identification section will be completed when each record document is begun. The patient's recording card will be used for the HREC and OTR; the inpatient identification plate will be used for the ITR. When mechanical imprinting is not available, patient identification will be typed 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); date of birth; code for MTF that maintains records; and his or her register number (if any).

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

(1) The patient's recording card should be prepared when the patient is first examined or treated in a troop medical clinic, health clinic, or other MTF. The patient's DD Form 1173 (Uniformed Services Identification and Privilege Card) or DD Form 2A(ACT) (Active Duty Military ID Card), DD Form 2A(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 for it.

(2) The information that may be embossed on the patient's recording card is given below. Format may vary at MTFs using the Composite Health-Care System (CHCS). The optical card reader font will be used for the FMP and SSN to make the filing of records easier. The suggested format for this card is described in *(a)* through *(e)* below.

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

(b) Line 2. All spaces—Blank.

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

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

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

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

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

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

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

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

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

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

(a) Lines 1 and 2. All spaces—Blank.

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

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

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

(2) When not in use, the patient's identification plate will be filed in an alphabetical locator file. When a patient is transferred to another nursing unit, the plate will be attached to his or her chart and sent with him or her. When the patient is ready for final disposition, local procedure will cover the use of the plate.

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

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

(2) Rank, grade, or status.

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

(4) Date of admission.

3–6. Facility identification

The MTF or DTF providing care will be clearly named in all medical records and reports. (Such entries on SF 600 will be made by rubber stamp when possible.) Because patients are often treated at several MTFs, the MTF that is custodian of the patient's records will also be named. For OTRs and HRECs, this identification may be done 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. Before destroying the document, the patient administrator will send a report to the MTF or DENTAC committee that audits medical records, listing the type of document (for example, laboratory form or x-ray report) and the number of each type to be destroyed. This report and the committee's action on it will be entered in the committee minutes. Following the committee's approval, the patient administrator will destroy the unidentifiable documents.

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 diagnosis and procedures, to include abbreviations and symbols, are provided in TB MED 250.

3–9. Special instructions for certain diseases

a. Infective and parasitic diseases. For infective disease, the causative organism will be named unless it is implicit in the diagnosis itself. For parasitic diseases, the species will be named.

b. Occupational diseases. The fact of occupational origin will be stated.

c. Food poisoning and food infection. These terms refer to certain diseases in which the causative organism or agent enters the body via food or drink. Food infection applies to disease caused by ingesting pathogenic organisms that lodge in the gastrointestinal tract. Food poisoning applies to disease caused by ingesting food that contains a preformed toxin of bacterial origin. Neither term is correct for recording illness from nonbacterial poisons. Illness due to food that was toxic in its natural state (for example, fungi or shellfish) should be recorded as "Toxic effect of noxious foodstuffs" (naming the food). Illness due to food that became adulterated with nonbacterial poison (for example, cadmium) during preparation will be recorded as a poisoning, and the cause will be named. In all cases, the suspected food and the organism or causative agent will be named.

d. Malaria. When malaria is recorded, the type of plasmodia must be named. Drug-resistant cases will be recorded as follows: "Malaria, Plasmodium (species) resistant to (drug or drugs). Infection was probably incurred in (region or area) of (State or nation). Curative therapy employed was (drug or drugs)."

e. Neoplasms. Records of neoplastic diseases must state the following:

(1) Whether it is malignant or its behavior is uncertain or not determined.

(2) The body part affected unless the condition is by nature not localized (for example, lymphosarcoma).

(3) Whether diagnosis was confirmed by histological or cytological examination.

(4) The histological type.

(5) The site of primary origin and the exact tissue (if possible) when the neoplasm is malignant. When the primary site is known and metastasis has occurred, add the phrase "with metastasis" and name the metastatic sites. If generalized metastasis has occurred, so state. If the primary site is not known, give the site of the clinical manifestation and state that it is secondary (for example, "Adenocarcinoma, liver, secondary; primary site undetermined").

3–10. Special instructions for certain diagnoses

a. Alcoholism and nondependent abuse of alcohol. The term "alcoholism" is used only for persons whose alcohol intake is great enough to damage their physical health or their personal or social functioning. The term is also used when alcohol has become necessary to a person's normal functioning. For other individuals whose use of alcohol has brought them to medical attention, the appropriate term is "nondependent abuse of alcohol." This term applies to people formerly diagnosed as cases of "simple drunkenness." It also applies to people not suffering from alcoholism but who are seen by a physician because of driving-while-intoxicated charges, altercations involving alcohol, absences without leave (AWOLs) or absences from work due to overuse of alcohol, and so forth.

b. Nondependent abuse of drugs (improper use of drugs). This term is used for a person who is treated or observed because of the effects of drug use (including positive test findings). It is not used for people addicted to or dependent on drugs. The known or suspected drug will be named.

c. Malingerer. This term is used for a person who claims to be ill or unduly exaggerates a disability. It is used only when the medical officer believes that there is no actual illness or disability or only a slight one (section 915, title 10, United States Code (10 USC 915)). When the diagnosis is added to the ITR, the record must reflect review and concurrence by the Deputy Chief of Clinical Services.

d. Reactions to prophylactic procedures. When recording such reactions, state—

(1) The substance given and, if possible, the manufacturer's name and the lot number.

(2) The dates that it was given.

(3) The reasons for its being given.

(4) Any other pertinent facts.

e. Skin immunity and sensitization tests. When reading tuberculin skin tests, results should be noted in millimeters (mm) of induration only. For reactions to tuberculin skin tests, the term "converter" will only apply to those individuals whose tuberculin skin test using purified protein derivative has increased by at least 6 mm, from less than 10 mm in diameter to 10 mm or more in diameter, within 24 months.

f. Child abuse. When recording injuries to a child that seem to be part of a maltreated child syndrome, battered child syndrome, or abused child syndrome, add to the diagnosis the term "maltreated child syndrome." This term should be qualified by "known," "probable," or "suspected."

3–11. Recording psychiatric conditions

Psychiatric conditions will be recorded using the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised as nomenclature. In addition, statements on severity, chronicity, external precipitating stress, premorbid personality and predisposition, degree of impairment, and improvement or recovery will be recorded.

a. Recording diagnoses.

(1) The specific types of conditions are well enough defined to be used without the terms for the broad disorder groups. In recording a psychiatric condition, the lowest subclassification of the disorder will be used.

(2) In addition to naming the condition, the diagnosis will describe the severity and chronicity of the condition. (These conditions should not be determined solely by the degree of ineffectiveness; underlying defective attitude or other psychiatric or physical conditions might have contributed to the total ineffectiveness.) Severity will be described as "mild," "moderate," or "severe." Such terms as "moderately severe" or "mildly severe" are not authorized. The condition will be further described as either "acute" or "chronic." In addition, conspicuous symptoms may be added to the diagnosis, for example, "Anxiety neurosis, mild, chronic, manifested by loss of appetite and insomnia." If the condition was severe and acute upon admission, any improvement resulting from treatment will be noted, for example, "Reactive depression, severe, acute, improved."

b. Complementary diagnostic evaluations. Stating only the diagnosis does not give the full clinical picture for some conditions. For example, a diagnosis of anxiety reaction neither states whether the illness has occurred in a previously normal or in a previously neurotic personality nor states the degree and nature of the external stress or the degree of functional impairment. Thus, for certain conditions, a complementary diagnostic evaluation will be entered in the medical records. These conditions are transient situational disturbances, alcoholism, drug dependence, neuroses, physical disorders of presumably psychogenic origin, and psychosis. (No complementary evaluation will be made for personality disorders, sexual deviation, mental retardation, and psychiatric disorders due to structural changes in the brain.) The complementary information for such cases will be recorded at the MTF

where the medical officer has the information to make the evaluation. (When he or she does not have this information, the medical officer should enter "undetermined" in the record.) When making these evaluations, medical officers must recognize that the time element is all important; the diagnosis on one day may (and in many cases should) be changed on a later date. For example, a patient may show marked impairment upon admission to a hospital, but a few days later, he or she may be able to return to duty with minor or no impairment. The factors to be evaluated and then reported in the medical record are described in (1) through (3) below.

(1) *External precipitating stress.* The external stress precipitating the condition is to be evaluated for type, degree, and duration. When describing type, refer to the environmental situation, military or otherwise, that is the direct cause of the patient's reaction. Unconscious internal conflicts will not be considered external stresses.

(a) A judgment of military stress can be made most accurately by the medical officer of the patient's unit; he or she is most familiar with the patient's environment. The opinion of the individual's commanding officer should also be of value. It may be more difficult for the hospital psychiatrist to evaluate the stress; whenever it cannot be determined, it should be recorded as "undetermined."

(b) For all types of stress (combat, regimentation, training, isolation, and so on), the degree of stress is evaluated the same way; it must be determined by its effect on the "average person" of the group. A particular environmental stress is not severe because one or even several people react poorly to it; these people may have poor resistance to stress.

(c) Stress will be classified as "severe," "moderate," or "minimal." "Severe stress" is stress that causes the average person to develop disabling psychiatric symptoms. "Moderate stress" is stress that creates a measurable cause and effect between symptoms and the precipitating factors. "Minimal stress" is stress to which the average person could be exposed without developing psychiatric symptoms.

(d) Examples of recording stress are as follows: "Severe stress of 60 days under continuous combat as a rifleman," "severe stress of 60 days under continuous general quarters," "severe stress of 30 hazardous amphibious operations," "moderate stress of serious chronic domestic problems," and "stress unknown."

(2) *Premorbid personality and predisposition.* Predisposition will be described in a brief statement covering the patient's outstanding personality traits or weaknesses, both inherited and developed. The degree of predisposition will also be noted; this predisposition is determined by the patient's history and personality traits.

(a) No predisposition evident. This term is used when the patient's illness does not appear related to previous personality traits. It is also used when there is no history of psychoneurotic or other mental illness in the immediate family.

(b) Mild predisposition. This term is used when the patient's history shows mild transient psychological (emotional) upsets, abnormal personality traits, or defects of intelligence, but these conditions did not significantly disable the patient or require medical care. It is also used when there is a history of mental illness in the patient's family.

(c) Moderate predisposition. This term is used when the patient has a history of partially disabling psychological (emotional) upsets, abnormal personality traits, or defects in intelligence. It is used when these conditions resulted in social maladjustment.

(d) Severe predisposition. This term is used when the patient has a definite history of overt emotional or mental illness or disorder.

(3) *Degree of psychiatric impairment (to be used for military patients only).* Psychiatric disability is the degree to which a person's functional capacity has been impaired by his or her psychiatric condition. The medical officer must judge how much the person's capacity to perform military service is impaired. When judging this degree of impairment, the medical officer must remember that the degree of impairment often is different before and after treatment. It is the degree of impairment after treatment (residual impairment) that the medical officer must evaluate and record. He or she must also remember that psychiatric impairment is not necessarily the same as general ineffectiveness. Effectiveness in a particular job is judged by more than the degree and type of psychiatric impairment; it also depends on the person's emotional stability, intellect, physical condition, attitude, training, and so on. This distinction means that, because of other factors, a person with moderate impairment may be more effective than a person with only minimal impairment. Therefore, "degree of impairment" refers only to ineffectiveness caused by psychiatric impairment; other factors are not to be considered.

(a) No impairment. This term is used when there are no medical reasons for changing the patient's current assignment or duty. Although a person may have certain symptoms, there may be no medical reason for his or her not performing full duty. For example, most people have symptoms of anxiety in combat; individuals returned to duty with mild symptoms may fail to function because of their attitude and not because of their illness.

(b) Minimal impairment. This term is used to describe a slight residual impairment in the patient's ability to perform his or her current duty.

(c) Moderate impairment. This term is used to describe a residual impairment that seriously interferes with the patient's ability to perform his or her current duty.

(d) Marked impairment. This term is used to describe a residual impairment that totally prevents the patient from performing his or her current duty. The impairment may be temporary or permanent.

c. Manner of recording diagnoses. Diagnoses will continue to be numbered ordinally (first diagnosis being the cause of admission). However, the proper axis number (I, II, or III) will be placed in parentheses following the ordinal number. Axis I represents clinical syndromes, conditions not attributable to a mental disorder that are a focus of attention or treatment, and additional codes. Axis II represents personality disorders and specific developmental disorders. Axis III represents physical disorders and conditions. Examples are provided in (1) through (5) below.

(1) Case of a soldier presented for medical evaluation board:

(a) (Axis III) Concussion syndrome, secondary to fist blow to face, acute, resolving, manifested by headache, nausea; line of duty (LOD): undetermined, pending investigation.

(b) (Axis I) Paranoid state, acute, severe, manifested by fixed delusion of wife's infidelity and impaired judgment and insight; stress, minimal, routine military duty; impairment for military duty, marked, and for social and industrial adaptability, slight; LOD: yes.

(c) (Axis I) Psychogenic amnesia, acute, severe, in remission, manifested by 15 minutes of amnesia; stress, moderate, found wife in bed with friend; predisposition, marked, see *(d)* below; impairment for military duty and social and industrial adaptability, none; LOD: yes.

(d) (Axis II) Paranoid personality, severe, manifested by suspicion, litigiousness, aggressive outbursts, and impaired judgment and insight; impairment, marked for military duty, none for social and industrial adaptability; LOD: no, existed prior to service (EPTS).

(2) Case of a soldier being returned to duty for administrative separation: (Axis II) Antisocial personality, severe, manifested by history of repeated burglary and other delinquency; impairment, marked for military duty, none for social and industrial adaptability; LOD: no, EPTS.

(3) Case of a family member: (Axis I) Fetishism, mild, manifested by sexual arousal associated with kewpie dolls; impairment for social and industrial adaptability, none.

d. Psychiatric combat casualties. Psychiatric combat casualties consist of a unique group of military patients for whom the diagnosis has strong possibilities for adversely affecting recovery. The term "battle fatigue" is ideal because it suggests a nearly normal

response, is relatively nonspecific in allowing for labeling of the great variety of symptom syndromes known to occur, and, most important, suggests a rapid resolution. The disadvantage is that many psychiatric casualties occur so soon in combat that fatigue cannot reasonably be presumed to be a factor. Patients in whom fatigue can reasonably be considered a factor will continue to be diagnosed as battle fatigue while others will be diagnosed as transient battle reaction. The terms should be considered roughly equivalent, and both terms will be coded under mixed disorders as reaction to stress. Technical terms that can be regarded as diagnoses should be avoided, for example, anxiety, conversion, or paralysis. Examples are provided in (1) and (2) below.

(1) Case of an unwounded soldier with tremor, tachycardia, sweating, paralysis of right arm, and glove anesthesia of right hand 10 minutes after seeing a friend killed in the first hour of battle: (Axis I) Transient battle reaction manifested by numbness and weakness of right arm and hand, sweating, and rapid pulse.

(2) Case of an unwounded soldier with fatigue, tremor, tachycardia, sweating, paralysis of right arm, and glove anesthesia of right hand following 36 hours of sustained combat exposure: (Axis I) Transient battle fatigue manifested by numbness and weakness of right arm and hand, sweating, and rapid pulse.

e. Alcohol- and drug-related diagnoses. Alcohol- and drug-related diagnoses will be recorded per DOD regulations. However, Axis I will be placed in parentheses following the ordinal number, and the Diagnostic and Statistical Manual of Mental Disorders Third Edition, Revised, diagnosis will be placed in parentheses immediately following the DOD diagnosis. Examples are provided in (1) and (2) below.

(1) (Axis I) Single drug dependency, heroin, with alcohol dependency (alcohol dependence, episodic; opioid dependence, continuous) manifested by injection of five "bags" of heroin daily and signs of tolerance and withdrawal, and by repeated loss of jobs due to inebriation.

(2) (Axis III) Cirrhosis of liver, secondary to alcoholism.

f. Brain syndrome. This syndrome of organic brain disorder is caused by a diffuse impairment of brain tissue function. The syndrome may be the only mental disturbance, or it may be associated with psychotic manifestations, psychoneurotic manifestations, or behavioral disturbances. Any psychiatric manifestations will be specified, and the etiology of the brain syndrome will be stated.

3–12. Recording injuries

a. Details to be recorded.

(1) The same details will be given and the same terms used when both battle and nonbattle injuries are recorded. To be complete, the recording of an injury must include the details given in *(a)* through *(g)* below. (For information needed for proper coding, see Triservice Disease and Procedure ICD–9–CM Coding Guidelines, which may be obtained by contacting Commander, Patient Administration Systems and Biostatistics Activity (PASBA), ATTN: HSHI–QZ, Fort Sam Houston, TX 78234–6070.) Record on DA Form 3647 (Inpatient Treatment Record Cover Sheet) in item 33 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 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, or drilling). 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 place and the person's status (for example, home or leave or in transit while AWOL).

(g) The date of the injury.

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

(a) "Fracture, open comminuted, upper third of shaft of femur, left, no nerve or artery involvement; bullet entering anterior upper portion of left thigh and lodging in femur. Caused by rifle bullet, accidently incurred when patient's rifle discharged while he was cleaning it in Barracks A, Fort Dix, NJ, 8 Jul 79."

(b) "Bursitis, acute, knee, right, due to contusion, anterior aspect. Accidently incurred when patient tripped and fell, striking knee on floor while entering Barracks 26, Fort Lewis, WA, 2 Dec 78."

b. Wound or injury incurred in combat.

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

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

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

(c) The time that the wound occurred.

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

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

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

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

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

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

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

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

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

3–13. Recording deaths

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

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

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

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

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

(1) The train of events leading to death will be recorded in items 7*a* and *b* of DA Form 3894 (Hospital Report of Death). The immediate cause will be entered in item 7*a*, and the underlying cause will be entered in item 7*b*. Only one cause should be entered on each line of items 7*a* and *b*; no entry is needed in 7*b* if the immediate cause of death given in 7*a* describes completely the train of events. To record the example given in *b* above, cerebral hemorrhage would be entered in 7*a* as the condition directly leading to death; hypertension would be entered in 7*b*(1) as the antecedent cause or condition leading to the immediate cause; and myocarditis would be entered in 8*a* 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 should be the same as the diagnosis given on DA Form 3894 and on the Certificate of Death. On the Certificate of Death, the underlying cause of death is shown on line c. If line c has no entry, it is on line b; and if lines b and c are blank, it is on line a. (For more information, see the Physicians Handbook on Medical Certification: Death, Fetal Death, Birth. In the United States, to obtain this handbook, write to the health department of the State where the MTF is located; outside the United States, write to the National Center for Health Statistics, Department of Health and Human Services, 3700 East-West Highway, Hyattsville, MD 20782–9102.)

c. Recording neonatal deaths. When recording deaths of infants under 28 days of age, use the term "neonatal death," and state the infant's age at death. For deaths in the first 24 hours of life, state the age in number of hours lived; for deaths after the first day of life, state the number of days lived. Examples of these entries are "Neonatal death less than 1 hour after birth," "Neonatal death, age 22 hours," and "Neonatal death, age 26 days."

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

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

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

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

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

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

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

Principles for coding and sequencing surgical, diagnostic, and therapeutic procedures are found in the Triservice Disease and Procedure ICD–9–CM Coding Guidelines.

3–16. Recording therapeutic abortions

Section 1093, title 10, United States Code (10 USC 1093) states that funds available to DOD may not be used to perform abortions except when the mother's life would be endangered if the fetus were carried to term.

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

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

c. 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.

d. The legal advice of the judge advocate will be solicited if deemed necessary.

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

3–17. Carded-for-record-only cases

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

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

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

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

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

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

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

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

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

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

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

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

(a) U.S. military personnel separated or retired for medical conditions under AR 635–40, AR 635–100, or AR 635–200. These personnel are CRO cases only if they were not in an inpatient status on the date of separation. The MTF serving the person's unit of assignment at the time of separation will prepare the CRO record. The commander of the unit effecting separation will notify the serving MTF and supply sufficient information.

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

(5) *Other.*

(a) Any outpatient abortion procedures.

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

3–18. Absent-sick status

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

a. Only Active Army personnel, USAR personnel on active duty for training, ARNG personnel on full-time training duty, and U.S. Military Academy cadets can be classified in an absent-sick status.

b. DA Form 3647 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. Additional information on absent-sick patients placed in quarters by civilian physicians is given in AR 40–3, paragraph 18–2*b*; DA Form 3647 and DA Form 2985 do not need to be completed for these cases.

Chapter 4
Filing and Requesting Medical Records

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

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

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

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 series	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	90–95	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 [5]

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 they become the sponsor's dependents. 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 service 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.

[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. Dependents of former spouses are coded in the 90–95 series.

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

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

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

4–2. Terminal digit filing system

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

a. Under the terminal digit filing system, the sponsor's SSN is divided into three groups (para 4–1*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, HRECs, CEMRs, and nuclear medicine files. Only DA Form 3444-series folders will be used for dental records, ITRs, ADAPCP–OMRs, and CEMRs. DA Form 8005-series will be used only for HRECs and OTRs. DA Form 8005-series folders will replace DA Form 3444-series folders only when they have deteriorated or when beneficiaries are entering the system for the first time. Nuclear medicine departments will ensure that their folders are conspicuously stamped to eliminate the possibility of mixing them with ITRs, HRECs, OTRs, or CEMRs. DA Form 3443 (Terminal Digit—X-Ray Film Preserver), DA Form 3443X (Terminal Digit—X-Ray Film Negative Preserver (Loan)), DA Form 3443Y (Terminal Digit—X-Ray Film Negative Preserver (Insert)), DA Form 3443Z (Terminal Digit—X-Ray Film Negative Preserver (Report Insert)), DA Form 3444 (Terminal Digit File for Treatment Record (Orange)), DA Form 3444–1 (Terminal Digit File for Treatment Record (Light Green)), DA Form 3444–2 (Terminal Digit File for Treatment Record (Yellow)), DA Form 3444–3 (Terminal Digit File for Treatment Record (Gray)), DA Form 3444–4 (Terminal Digit File for Treatment Record (Tan)), DA Form 3444–5 (Terminal Digit File for Treatment Record (Light Blue)), DA Form 3444–6 (Terminal Digit File for Treatment Record (White)), DA Form 3444–7 (Terminal Digit File for Treatment Record (Brown)), DA Form 3444–8 (Terminal Digit File for Treatment Record (Pink)), DA Form 3444–9 (Terminal Digit File for Treatment Record (Red)), DA Form 8005 (Alphabetical and Terminal Digit File for Treatment Record (Orange)), DA Form 8005–1 (Alphabetical and Terminal Digit File for Treatment Record (Light Green)), DA Form 8005–2 (Alphabetical and Terminal Digit File for Treatment Record (Yellow)), DA Form 8005–3 (Alphabetical and Terminal Digit File for Treatment Record (Gray)), DA Form 8005–4 (Alphabetical and Terminal Digit File for Treatment Record (Tan)), DA Form 8005–5 (Alphabetical and Terminal Digit File for Treatment Record (Light Blue)), DA Form 8005–6 (Alphabetical and Terminal Digit File for Treatment Record (White)), DA Form 8005–7 (Alphabetical and Terminal Digit File for Treatment Record (Brown)), DA Form 8005–8 (Alphabetical and Terminal Digit File for Treatment Record (Pink)), and DA Form 8005–9 (Alphabetical and Terminal Digit File for Treatment Record (Red)) are available through normal publications supply channels and can be requisitioned from the U.S. Army Printing and Publications Command. Instructions for completing the forms are self-explanatory. Priority for distribution of all folders in the DA Form 3444-series and DA Form 8005-series remains with the Chief, patient administration division. Because these folders were designed primarily for primary care records, it is essential that they have 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. The old DA Form 3444-series (dated 1 November 1968) and DA Form 3444-series (dated 1 January 1979) will be used for HRECs and OTRs until current stocks are depleted. Similarly, old DD Form 722 (Health Record) and DD Form 722–1 (Health Record—Dental), which were superseded by the DA Form 3444-series, will be used until current stocks are depleted. Further, DD Form 722 and DD Form 722–1 folders will not be replaced with new DA Form 3444-series folders unless the old folders have deteriorated or the MTF converts to the terminal digit filing system. Whether medical records are filed in new folders or old folders, they will be transferred and retired in the folders holding them at the time.

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.

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	Gray	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

(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 ½ inch of black tape over the number on the right edge that is the same as the last digit. The tape should be long enough to wrap around the edge of the folder and cover the number on the back also; a 1-inch length should be sufficient. (Instead of tape, the numbers of the front and back may be blocked out with black ink.) Then enter the last digit in the far right block on the upper edge of the folder. For the HREC, this coding will be done when the MTF uses the terminal data filing system.

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

(5) On ITRs and OTRs, show the retirement date by putting ½ inch of colored tape over the block marked "R" on the back also. If the retirement date changes (for example, a patient treated in 1990 is treated again in 1991), this block will be recoded. The colors of tape to be used are shown in table 4–3. HRECs are never retired using these procedures. For disposition of HRECs, see paragraph 5–27. On HRECs, the "R" block may be used at local discretion (for example, coded for semiannual inventory). (See *b*(2) and *c*(2) below for instructions on the retirement of ITRs and OTRs.)

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

Year records to be retired	Color
1989	Blue
1990	Green
1991	Yellow
1992	Silver or white
1993	Black
1994	Orange
1995	Red
1996	Blue
1997	Green
1998	Yellow
1999	Silver or white
2000	Black
2001	Orange
2002	Red

(6) Show the status of the patient by putting ½ inch of colored tape over the block marked "S" on the right edge of the folder. Wrap the tape around the edge to cover the "S" on the back also. The colors of tape to be used are shown in table 4–4.

Table 4–4
Key for tape denoting patient status

File number [1]	General group	Color
40–66a (HRECs), 40–66b (dental HRECs)	Active duty military HREC (and dental) and RC personnel on active duty or active duty training for more than 30 days	Red
40–66f (military ITRs)	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 less lan 30 days	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	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 2–1 of this regulation.

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

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

(9) Ensure that the patient completes the preprinted DD Form 2005 (Privacy Act Statement—Health Care Records) on the inside of the folder. If the patient's DD Form 2005 is already completed, he or she does not need to complete a new one.

(10) For special category patients, the empty block on the lower right edge of the front cover should be taped. (See paras 2–3*d* and 2–5 of this regulation and AR 340–21, para 2–5.) 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 (AR 40–400, table 2–2) may be used to stamp the folder.)

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

c. Special instructions for OTRs are as follows:

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

(2) The retirement date for OTRs will be 3 years after the end of the year in which last medical treatment was given. For example, if a record is initiated in 1990, it is color-coded for tentative retirement in January 1994 by placing a strip of orange tape over the block printed "R." If the record is used during 1991, the orange tape is covered with red tape to show a new tentative retirement date of January 1995. Dental records (nonmilitary) are retired 2 years after the end of the year in which the last treatment was given; therefore, dental records begun in 1990 are color-coded black for tentative retirement in January 1993.

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

d. To color code the DA Form 3444-series folder as a dental folder, place a piece of colored tape on the upper right margin of

the rear flap just above the "O" block to indicate each dental fitness classification. The colors used for each class are blue for Class 1, white for Class 2, red for Class 3, and green for Class 4.

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

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

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

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

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

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

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

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

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

(e) Date of birth. Use letters for the month, for example, 17 Jun 81.

(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 1⅞- by 1⅞-inch will be used. Facilities maintaining 25,000 or fewer files will identify only the last two SSN digits by taping the lower two SSN boxes. Facilities maintaining more than 25,000 files will identify the last four SSN digits by taping all four SSN boxes. The colors used are shown in table 4–5.

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

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

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

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

Year	Color
1989	Black (4)
1990	Blue (5)
1991	White (6)
1992	Brown (7)
1993	Pink (8)
1994	Red (9)
1995	Orange
1996	Green (1)
1997	Yellow (2)
1998	Gray (3)
1999	Black (4)
2000	Blue (5) (repeat 10-year cycle)

(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. The facility radiologist will determine the codes according to the needs of his or her facility, with the following two exceptions: "0" (orange) will be used by all facilities for all subfolders transferred from another facility, and "9" (red) will be used when the report folder is also used to hold small images such as ultrasound, computerized tomography, nuclear medicine, and mammography.

(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. If small images are filed, the report folder containing the reports will be identified with "9" (red) tape.

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

b. Use of the revised series folder.

(1) *Master folder.* The master folder will not leave the radiology file until the entire record is retired. It will contain all radiology images and reports, as well as chargeout information for images that have been removed. All facilities will file these folders in terminal digit order. (See para 4–2*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 ½-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 non-contrast 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.*

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

(b) Images such as ultrasound, computerized tomography, and nuclear medicine, which are small enough to be filed in a report folder, will be filed separately therein. A tape code established by the radiology department will identify the examination contained in these folders. Examinations in these report folders will not be removed from the radiology department or transferred from the facility. Only copies will be released and only as requested in writing.

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

(5) *Automated systems.* Labels generated by automated systems may replace handwritten information. All information required by *a*(1), (3), and (5) above will be provided by such systems, whether automated, handwritten, or a combination of the two. Tracking labels will be affixed to the appropriate box on the face of the insert and loan folders.

4–6. Record chargeout system

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

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

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

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

b. For records withdrawn from the files and transferred to another MTF, see paragraphs 5–25, 6–4, and 8–9.

4–7. Record requests

DD Form 877 (Request for Medical/Dental Records or Information) may be used for requesting medical records. This form will be typewritten; it is designed for use with a window envelope. Procedures for handling requests are given in *a* through *c* below.

a. The requesting MTF or DTF must—

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

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

(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—

(a) Complete items 8b and 11 through 14 of DD Form 877; check the appropriate boxes in item 8b to indicate whether military records, VA records, or both are sent.

(b) Send the original copy of DD Form 877 and the requested records to the addressee shown in item 19.

(c) File the duplicate copy of DD Form 877 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 received from (address). These records covered treatment during (inclusive dates)." When the records return, destroy the duplicate copy of DD Form 877, 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 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 return both copies of DD Form 877 to the requesting activity, first completing items 11 through 14.

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 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 DD Form 877 will be sent as an enclosure.

(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 will be destroyed.

Chapter 5
Health Records

Section I
General

5–1. Purpose of the health record

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

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

5–2. Use of the health record

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

b. Use in outpatient medical care.

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

(2) When an MTF or DTF refers a patient elsewhere for outpatient care, the HREC may be sent also. The referring or the consulting practitioner makes this decision. If it is sent, the consulting practitioner will comment in the record on his or her findings and treatment. If it is not sent, the consulting practitioner will enter his or her findings on SF 513 (Medical Record—Consultation Sheet) or any other medical forms (including SF 600) that he or she deems proper. These consultation (SF 513) and treatment records will be filed in the HREC. Also see paragraph 8–10*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 HREC.

c. Use in inpatient medical care.

(1) Normally, the HREC will be sent to the MTF when a person is admitted for treatment. (See paras 5–31 through 5–34 for information on patients from combat areas.) When an MTF receives an HREC, or a part of it, the patient administrator becomes the custodian and will ensure that it is accessible to AMEDD personnel. When received, the HREC will be sent to the patient's ward. It will be kept there during the patient's stay for use by the attending physician or dentist and other medical personnel involved in the case. The patient administrator will ensure that a copy of each of the forms required for the HREC prepared by the MTF are put in the HREC (para 5–3) and that the entries needed for inpatients on SF 600 are made. (See para 5–16.)

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

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

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

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

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

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

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

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

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

(h) RC patients not on active duty. Send the HREC to the custodian of MPRJ.

5–3. For whom prepared and maintained

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

5–4. Forms and documents of health records

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

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

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

LEFT SIDE OF FOLDER

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

DA Form 3180–R
Personnel Screening and Evaluation Record. (See AR 50–5, AR 50–6, and para 5–19b(8) of this regulation.)

DA Form 5571 [1]
Master Problem List. (See para 5–10.)

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

SF 601 [1,2]
Health Record—Immunization Record. (See paras 5–17 and 6–7.)

DD Form 1141
Record of Occupational Exposure to Ionizing Radiation or automated dosimetry records. (See AR 40–14 and para 5–19b(5) of this regulation.)

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

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

SF 545 [1,2]
Laboratory Report Display (formerly SF 514). File with mounted SF 546 (Chemistry I), SF 547 (Chemistry II), SF 548 (Chemistry III (Urine)), SF 549 (Hematology), SF 550 (Urinalysis), SF 551 (Serology), SF 552 (Parasitology), SF 553 (Microbiology I), SF 554 (Microbiology II), SF 555 (Spinal Fluid), SF 556 (Immunohematology), and SF 557 (Miscellaneous). (See para 8–18.) Instructions for completing these forms are provided in tables 8–1 and 8–2.

SF 519 [1,2] **; SF 519A** [1,2]
Medical Record—Radiographic Report. (See para 8–20.) SF 519 and 519A are obsolete; use for file purposes only.

SF 519–B [1]
Radiologic Consultation Request/Report. (See para 8–20.)

SF 520 [1]
Clinical Record—Electrocardiographic Record. Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of SF 520 or on another attached sheet of paper.

SF 560 [1]
Medical Record—Electroencephalogram Request and History (formerly DA Form 4530).

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

DA Form 3647
Inpatient Treatment Record Cover Sheet (formerly DA Form 8–275-series and DD Form 481-series). File it with a copy of SF 502 (if prepared), SF 515, SF 509, and SF 516. Also file here AF Form 565 (Record of Inpatient Treatment), NAVMED 6300–5 (Admission/Disposition Record, Inpatient), DD Form 1380 (formerly DA Form 8–27 (Emergency Medical Tag)), or any other narrative summaries from the VA, Public Health Service, or other Government MTF. (See AR 40–400 and paras 3–12a(1), 3–13b, 3–17a, 3–18b, 5–2a, 5–19a, 6–7, 8–7b, 8–12, 8–13, 8–14, 8–15, 8–16, and 9–2 of this regulation.)

DA Form 5006–R [1]
Medical Record—Authorization for Disclosure of Information. (See para 2–3.)

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

DA Form 3365
Authorization for Medical Warning Tag. (See AR 40–15.)

RIGHT SIDE OF FOLDER

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

SF 600 [1,2] **; SF 558** [1,2] **; DA Form 5181–R** [1,2]
Health Record—Chronological Record of Medical Care; Medical Record—Emergency Care and Treatment; Screening Note of Acute Medical Care. File here also any other basic chronological medical care records, for example, SF 558, ambulance forms (filed behind corresponding SF 558), DA Form 5181–R, and Automated Military Outpatient System (AMOSIST) local encounter forms. (See paras 5–7, 5–14, and 5–16.)

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

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

DA Form 3763
Community Health Nursing—Case Referral. (See AR 40–407, para 4–2b.)

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

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

State ambulance forms. (See para 5–19b(7).)

SF 602
Formerly DA Form 8–114. Civilian or foreign military treatment records. (See paras 5–19b(10) and 5–24.)

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

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

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

DA Form 3947
Medical Evaluation Board Proceedings (formerly DA Form 8–118). (See AR 40–3.)

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

DA Form 4530
Electroencephalogram Request and History. (See SF 560.) DA Form 4530 is obsolete; use for file purposes only.

DA Form 4700 [1]
Medical Record—Supplemental Medical Data. (See chap 3.)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600. (See para 5–6 for completion instructions.)

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

DA Form 4970
Medical Screening Summary—Over-40 Physical Fitness Program. (See AR 40–501.)

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

SF 88 [2] **; DA Form 4497–R** [2] **; FAA Form 8500–8** [2]
Report of Medical Examination (statement in lieu of medical examination (NGR 40–501) for ARNG); Interim Medical Examination—Flying Personnel (Original) (AR 40–501); Medical Certificate—Class and Student Pilot Certificate (Photocopy) (AR 40–501). (See paras 5–6, 5–19, and 5–23.)

SF 93 [2]
Report of Medical History (formerly SF 89). File here any other medical history form. (See AR 40–501 and paras 5–19 and 5–23 of this regulation.)

SF 513 [1] **; DD Form 2161** [1]
Medical Record—Consultation Sheet; Referral for Civilian Medical Care. (See para 8–10.)

SF 522 [1]
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures.

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

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

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

Other SF 500-series forms.
File in numerical sequence.

DD Form 741 [1]
Eye Consultation.

DD Form 771
Eyewear Prescription. (See AR 40–63 and para 5–19b(2) of this regulation.)

DD Form 2215 [1,2]
Reference Audiogram.

DD Form 2216
Hearing Conservation Data. (See AR 40–5.)

Reports or certificates prepared by neuropsychiatric consultation services or psychiatrists.

Correspondence on hearing aids.

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

Other medical and administrative documents important enough to keep on file, including care provided in civilian treatment facilities, correspondence on release of medical information, statements instead of physical examinations for the promotion of officers and warrant officers, living wills (advance directives), and so on.

DA Form 4465
Client Intake Record. Also file here any other authorized alcohol and drug forms. (See AR 600–85 and paras 5–19b(4) and 7–9 of this regulation.)

DA Form 4410 [2]
Disclosure Accounting Record. DA Form 4410 is always the bottom form or is printed on the folder. It is obsolete; use for file purposes only.

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 AR 40–2 and para 4–4 of this regulation.)

Notes:

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

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

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

PART I

DA Form 5571 [1,2]
Master Problem List. DA Form 5571 is always the top form. (See para 5–10.)

DD Form 1141
Record of Occupational Exposure to Ionizing Radiation or automated dosimetry record. (See AR 40–14 and para 5–19b(5) of this regulation.)

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

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

SF 601 [1,2]
Health Record—Immunization Record. (See paras 5–17 and 6–7.)

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

SF 512 [2]
Clinical Record—Plotting Chart. Automated laboratory report forms. File like forms in reverse chronological order. (See para 5–13.)

SF 545 [1]
Laboratory Report Display (formerly SF 514). (See paras 3–2, 8–18, and 10–4.) Instructions for completing this form are provided in tables 8–1 and 8–2.

SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 556; SF 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; Immunohematology; Miscellaneous. Attach to SF 545 in reverse chronological order. (See para 8–18.) Instructions for completing these forms are provided in tables 8–1 and 8–2.

SF 519 [1,2] **; SF 519A** [1,2]
Medical Record—Radiographic Report. (See para 8–20. SF 519 and SF 519A are obsolete; use for file purposes only.)

SF 519–B [2]
Radiographic Consultation Request/Report. (See para 8–20.)

SF 520 [2]
Clinical Record—Electrocardiographic Record. Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of SF 520 or on another attached sheet of paper.

SF 524 [2]
Medical-Record—Radiation Therapy.

SF 525 [2]
Medical Record—Radiation Therapy Summary.

SF 526 [2]
Medical Record—Interstitial/Intercavitary Therapy.

SF 541 [2]
Medical Record—Gynecologic Cytology.

SF 560 [2]
Medical Record—Electroencephalogram Request and History (formerly DA Form 4530, Electroencephalogram Request and History).

DD Form 2482 [2]
Venom Extract Prescription. (See para 5–12.)

SF 559 [2]
Medical Record—Allergen Extract Prescription, New and Refill. (See para 5–15.)

DA Form 5007–A–R [2] **; DA Form 5007–B–R** [2]
Medical Record—Allergy Immunotherapy Record—Single Extract; Medical Record—Allergy Immunotherapy Record—Single Extract. (See para 5–15.)

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

DA Form 4060
Record of Optometric Examination. This form is obsolete; use for file purposes only.

DD Form 741 [2]
Eye Consultation.

DD Form 771
Eyewear Prescription. (See AR 40–63 and para 5–19b(2) of this regulation.)

DD Form 2215 [2]
Reference Audiogram.

DD Form 2216
Hearing Conservation Data. Also file any correspondence on hearing aids. (See AR 40–5.)

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

PART II

DA Form 4515
Personnel Reliability Program Record Identifier. (See AR 50–5 or AR 50–6, and para 5–19b(8) of this regulation.)

DA Form 3180–R
Personnel Screening and Reliability Record. (See AR 50–5, AR 50–6, and para 5–19b(8) of this regulation.)

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

Documents and correspondence on flying status, that is, restrictions, removal of restrictions, suspensions, and termination of suspensions.

Interfile the following six forms in reverse chronological order—most recent visit on top.

SF 600 [1,2]
Health Record—Chronological Record of Medical Care. (See para 5–16.)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600 in chronological order. (See para 5–6 for completion instructions.)

SF 558 [2]
Emergency Care and Treatment. Interfile with SF 600 in chronological order. (See para 5–14.)

DA Form 3824 [2]
Urologic Examination.

DA Form 5181–R [2]
Screening Note of Acute Medical Care. (See para 5–7.)

State ambulance forms. (See para 5–19b(7)).

SF 513 [2]
Medical Record—Consultation Sheet. (See para 8–10.)

DD Form 2161
Referral for Civilian Medical Care. (See AR 40–5.)

SF 602
Health Record—Syphilis Record. (See paras 5–19b(10) and 5–24.)

DA Form 3763
Community Health Nursing—Case Referral. (See AR 40–407.)

DA Form 5569–R [2]
Isoniazid (INH) Clinic Flow Sheet. (See para 5–8.)

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

SF 527 [2]
Group Muscle Strength, Joint R.O.M. Girth and Length Measurements.

SF 528 [2]
Clinical Record—Muscle and/or Nerve Evaluation—Manual and Electrical: Upper Extremity.

SF 529 [2]
Medical Record—Muscle Function by Nerve Distribution: Trunk and Lower Extremity.

DA Form 4700 [2]
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 chap 3.)

SF 517 [2]
Clinical Record—Anesthesia. Outpatient surgery only. (See para 8–10.)

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

SF 522 [2]
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures. All other special consent forms. (See para 3–3.)

SF 518 [2]
Medical Record—Blood or Blood Component Transfusion.

SF 88 [1]
Report of Medical Examination. (See AR 40–501 and paras 5–6, 5–19, and 5–23 of this regulation.)

SF 93 [1]
Report of Medical History (formerly SF 89). File here any other medical history form. (See AR 40–501 and paras 5–19 and 5–23 of this regulation.)

DA Form 4970
Medical Screening Summary—Over-40 Physical Fitness Program. (See AR 40–501.)

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

DA Form 4465
Client Intake Record. Also file here any other authorized alcohol and drug forms. (See AR 600–85 and paras 5–19b(4) and 7–9 of this regulation.)

PART III

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

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

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

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

DA Form 3365
Authorization for Medical Warning Tag. (See AR 40–15.)

DA Form 3947
Medical Evaluation Proceedings (formerly DA Form 8–118). (See AR 40–3.)

DA Form 4254–R [2]
Request for Private Medical Information. (See para 2–3.)

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

DA Form 5006–R [2]
Medical Record—Authorization for Disclosure of Information. (See para 2–3.)

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

Correspondence on release of medical information.

Other administrative documents important enough to keep on file, including living wills (advance directives).

DA Form 4410 [1]
Disclosure Accounting Record. DA Form 4410 is always the bottom form or is printed on the folder. It is obsolete; use for file purposes only.

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

PART IV
Group copies of the following forms by hospitalization episode; with most recent on top.[3]

DA Form 3647[1]
Inpatient Treatment Record Cover Sheet (formerly DA Form 8–275-series and DD Form 481-series). File it with a copy of SF 502 (if prepared), SF 515, SF 509, and SF 516. Also file here AF Form 565, NAVMED 6300–5, DD Form 1380 (formerly DA Form 8–27), or any other narrative summaries from the VA, Public Health Service, or other Government MTF. (See AR 40–400 and paras 3–12a(1), 3–13b, 3–17a, 3–18b, 5–2a, 5–19a, 6–7, 8–7b, 8–12, 8–13, 8–14, 8–15, 8–16, and 9–2 of this regulation.)

OF 275[1,2]
Medical Record Report. File in order of the number of the form it replaces. (See para 3–3.)

SF 502[1,2]
Clinical Record—Narrative Summary. (See para 8–10.)

SF 539[2]
Medical Record—Abbreviated Medical Record. (See para 8–17.)

SF 509[1,2]
Medical Record—Doctors Progress Notes. SF 509 is the final discharge note. (See para 8–10.)

SF 515[1,2]
Medical Record—Tissue Examination. (See paras 5–2 and 5–19.)

SF 516[1,2]
Medical Record—Operation Report. (See para 8–10.)

SF 518[2]
Medical Record—Blood or Blood Composition Transfusion. Outpatient only.

SF 531[2]
Medical Record—Anatomical Figure.

SF 533[2]
Medical Record—Prenatal and Pregnancy. File here any forms belonging to pregnancy episode not delivered in MTF. (See para 6–7.)

Copies of civilian treatment facilities records[3]

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 AR 40–2 and para 4–4 of this regulation.)

Notes:
[1] This form must be included in all HRECs.
[2] Instructions for completing this form are self-explanatory.
[3] These forms will usually be copies of inpatient forms, except for SF 533 when patient is not admitted to the MTF for delivery.

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

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 5–25.)

Panograph.[1] The panograph includes other radiographs too large to be included in the DA Form 5570 envelope.

RIGHT SIDE OF FOLDER

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

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

SF 603[1]
Health Record—Dental. File in reverse chronological order with original SF 603 on the bottom. Also file here SF 603A (Health Record—Dental Continuation) when needed as a continuation of section III (Attendance Record) of SF 603. (See para 5–18 for instructions on completing SF 603 and SF 603A. Also see para 6–7.)

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

SF 513[2]
Medical Record—Consultation Sheet. (See para 8–10.)

SF 519[2] **; SF 519A**[2]
Medical Record—Radiographic Report. (See para 8–20.) SF 519 and 519A are obsolete; use for file purposes only.

SF 519–B[2]
Radiologic Consultation Request/Report. (See para 8–20.)

SF 521
Clinical Record—Dental. This form is obsolete; use for file purposes only.

SF 522[2]
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures. (See para 3–3.)

DA Form 8–115
Register of Dental Patients. This form is obsolete; use for file purposes only.

Other medical or dental records important to the patient's care.

DA Form 4410[1]
Disclosure Accounting Record. DA Form 4410 is always the bottom form or is printed on the folder. It is obsolete; use for file purposes only.

DD Form 2005[1]
Privacy Act Statement—Health Cae Records. DD Form 2005 is always the bottom form or is printed on the folder. (See AR 40–2 and para 4–4 of this regulation.)

Notes:
[1] This form must be included in all dental military records.
[2] Instructions for completing this form are self-explanatory.

Figure 5–3. Forms and documents of the HREC dental record—Continued

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

DA Form 5007–A–R and DA Form 5007–B–R will be used to document hyposensitization injections as prescribed on SF 559 (Medical Record—Allergen Extract Prescription, New and Refill). DA Form 5007–A–R is intended for patients on single injection immunotherapy, while DA Form 5007–B–R is intended for patients on two separate immunotherapy prescriptions. (DA Form 5007–A–R and DA Form 5007–B–R will be locally reproduced on 8½- by 11-inch paper. Copies for reproduction purposes are located at the back of this regulation.)

5–6. DA Form 5008

DA Form 5008 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.

5–7. DA Form 5181–R

DA Form 5181–R will be used in conjunction with the Enlisted Screener Program in battalion aid stations and troop medical clinics. (DA Form 5181–R will be locally reproduced on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.)

5–8. DA Form 5569–R

DA Form 5569–R will be used to document INH clinic visits. (DA Form 5569–R will be locally reproduced on 8½- by 11-inch

paper. A copy for reproduction purposes is located at the back of this regulation.)

5–9. DA Form 5570

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

5–10. DA Form 5571

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

5–11. DD Form 1380

DD Form 1380 will be used as described in chapter 9 and paragraph 5–31 (as an HREC document under combat conditions). Instructions for the use and preparation of DD Form 1380 are provided in chapter 9.

5–12. DD Form 2482

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

5–13. SF 512

SF 512 will be filed in HRECs, OTRs, and CEMRs to record cholinesterase levels and any single item deemed clinically significant. SF 512 will be filed immediately above SF 545.

5–14. SF 558

a. SF 558 will be used instead of SF 600 to record all care given to patients in the emergency room. Self-explanatory instructions for completion are on the back of SF 558.

b. When the patient is admitted as an inpatient through the emergency room, SF 558 will be the admission note filed in the patient's ITR. Whenever possible a notation should be made on SF 600: "Patient admitted to (name of MTF), (date)."

5–15. SF 559

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

a. Use the patient's recording card to complete the patient's identification block in the lower left corner of SF 559 (para 3–5*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 (OTSG) 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 at the U.S. Army Centralized Allergen Extract Laboratory for the prescribing physician.

5–16. SF 600

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

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

(1) Person's name.
(2) Sex.
(3) Year of birth.
(4) Component. (Do not include branch.)
(5) Department.
(6) Rank.
(7) Organization.
(8) SSN.

b. Entries for outpatient care.

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

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

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

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

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

(2) Each visit will be recorded and the complaint described even if the patient is returned to duty without treatment. If a patient leaves before being seen, this fact will also be stated.

(3) When admission as an inpatient is imminent, the entries discussed in (1) above may be made on SF 509 instead of SF 600. SF 509 will be the inpatient admission note filed in the patient's inpatient record. For emergency room admissions, see paragraph 5–14*b*. Other referred or deferred inpatient admissions will be recorded on SF 600.

(4) All requests for consultation, prescriptions, or other services will be recorded on SF 600.

(5) For patients seen repeatedly for special procedures or therapy (for example, physical and occupational therapy, renal dialysis, or radiation), the therapy will be noted on SF 600, and interim

progress statements will be recorded. In addition, a final summary will be given when the special procedures or therapy are ended. This summary will include data shown in *(a)* through *(h)* below. Initial notes, interim progress notes, and any summaries may be recorded on any authorized form but must be referenced on SF 600.

(a) Results of evaluative procedures.

(b) Treatment given.

(c) Number of visits.

(d) Reaction to treatment.

(e) Progress noted.

(f) Condition on discharge.

(g) Instructions to patient.

(h) Any other pertinent observations.

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

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

(a) Drugs given or appropriate identifying code.

(b) Investigative procedures performed.

(c) Significant observations, including effects.

(d) Physical and mental state of the subject.

(e) Tests and laboratory procedures performed.

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

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

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

(a) Time and date of admission.

(b) Name and location of the MTF.

(c) Cause of admission.

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

(a) Care given.

(b) Estimated duration.

(c) Extensions of quarters status.

(d) Instructions to patient.

(e) When the patient will be returned to duty.

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

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

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

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

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

h. Entries for drug abuse treatment. When a person has been determined by clinical evaluation to be an alcohol or other drug abuser, entries will be made on the SF 600, which will be filed in the HREC. (See also AR 600–85, para 3–11.)

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

5–17. SF 601 and PHS Form 731

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

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

b. PHS Form 731. A copy of PHS Form 731 will be sent with the HREC for later entries of immunization data. PHS Form 731 should be clipped or fastened to SF 601; it will not be punched like permanent documents in the record. The name and SSN of the person will be typed or written in ink on the front of the form. The address put on the form for officers and warrant officers is the Commander, PERSCOM, ATTN: TAPC–POR–R, Alexandria, VA 22332–0002. The address for enlisted personnel is Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE–RF, Fort Benjamin Harrison, IN 46249–5301. The name of the person's unit will be entered below the double line at the bottom of the form; it will not be entered until he or she reaches his or her first training or duty station.

c. Tasks.

(1) The unit commander will ensure that each assigned or attached member receives the immunizations required by AR 40–562. He or she will periodically check the immunization status of each unit member and consult with the local medical officer to ensure that immunizations are given when due.

(2) The unit personnel officer, acting on behalf of the commander, will notify members that immunizations are needed according to the schedule in AR 40–562.

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

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

e. Entries.

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

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

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

If that SF 601 is lost, a duplicate will be made by transcribing PHS Form 731. If both forms are lost, new forms will be prepared.

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

5–18. SF 603 and SF 603A

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

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

(1) Personnel entering active service or active duty for training for more than 30 days. All such personnel will have a panographic radiograph of the teeth and surrounding tissues taken. The radiograph will be taken during inprocessing. If a panographic x-ray capability is unavailable, the radiograph will be taken as soon as possible. This radiograph will be used for identification. In addition, these personnel will be inspected for disqualifying dental defects. (Determination of disqualifying dental defects will be made by a dental officer.) Except as indicated in *(d)* below, charts 4 and 5 in section I of SF 603 will no longer be used to record any dental defects that are found; chart 16 in section III 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 active service. When a service member has received a complete dental examination and all dental services within 90 days before discharge or release, the remarks section of the SF 603 will include the following statement: "The service 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 dental treatment facility 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, ARNG, 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 ARNG and USAR AMEDD officers) or those individuals without panographic x-ray (initial entry service was prior to this policy) will have a dental record initiated. The dental records portion of the HREC will contain, at a minimum, an SF 603 with section I (items 1 through 4) and section II (items 6 through 14) completed. This information will be used for identification. This examination should be performed by dental officers of the RC who are not on active duty.

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

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

(2) *SF 603, section I.*

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

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

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

(3) *SF 603, section II.*

(a) Permanent entries. The following entries are made by the military personnel officer or by the DTF. Entries will be typewritten or printed in permanent black ink. Sex (item 6); Enter M for male or F for female. Race (item 7); This entry is optional. If it is used, enter Cau for Caucasian, Bl for black, Oth for a member of any other race, and Unk for unknown. Component or Branch (item 10); Enter the applicable code. See 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 or 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. Remarks block—Normally this space requires no entries. It should be annotated, however, to reflect that there is a significant item in the medical history.

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

(c) Entries in block 17—Services Rendered. All entries will be made legibly in black ink. Entries will include every treatment as well as major steps involved in multivisit treatments. Extensive narrative entries may be entered across the entire page when necessary. Date column—Enter the current year on the first line. Subsequent dates on the following lines will include only the day and month of each treatment visit. When the year changes, enter the new year on the next line. Diagnosis—Treatment column. Treatments should be entered in chronological order as performed during the appointment. Whenever possible, a tabular format for treatments performed should be used. This format greatly aids searching for data about a specific tooth, or area, and speeds record audits. See TB MED 250. Dental fitness classification (per AR 40–35) is performed at all examinations in which the dental record is present, to include screening examinations, preparation of replacements for oversea movement examinations, etc., and is recorded in the "Class" column of block 17 of SF 603 and SF 603A. Fitness classifications apply to active duty soldiers 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. Any record of oral or dental care provided by personnel who did not have access to the permanent HRECs and dental records (for example, during field operations, from civilian or foreign sources, from other DTF or MTF, and so on) will be transferred to SF 603 or SF 603A in the permanent record, and the original document will be filed in the DA Form 3444-series folder. This task will be accomplished as soon as the temporary records are made available and will be performed by the record custodian or dental providers authorized such entries by the custodian.

5–19. Other forms filed in the health record

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

(1) DA Form 3647.

(2) SF 502.

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

(4) DA Form 199 (AR 635–40).

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

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

(1) *SF 88 and SF 93.* The original of each of these forms will be filed (AR 40–501).

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

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

(4) *DA Form 4465.* DA Form 4465 will be prepared, kept, and used per AR 600–85.

(5) *DD Form 1141.* DD Form 1141 or automated dosimetry records of personnel dosimetry must be kept in the HREC per AR 40–14. When a person changes station or leaves the service, these records will be moved with his or her HREC. The dosimetry records of personnel whose work exposes them to ionizing radiation may be removed from their HRECs and filed separately when the medical officer or other authority who keeps and uses the records does not have easy access to the HRECs of these personnel. In these cases, the separate file of dosimetry records will be kept as described in AR 40–14. (See AR 25–400–2, file number 40–14a, personnel dosimetry files, and table 2–1 of this regulation.)

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

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

(6) *DA Form 4186.* Per figure 5–1, file the most recent DA Form 4186 on top left. If the person is granted clearance to fly, then file the most recent DA Form 4186 next, if any, that shows a medical restriction from flying. If a waiver has been granted for any cause of medical unfitness for flying, file the most recent DA Form(s) 4186 showing such waiver(s) next. File any additional DA Forms 4186 that the flight surgeon determines to be required as a permanent record next. (Enter "Permanent Record" in Remarks section.) Destroy other DA Forms 4186.

(7) *State ambulance forms.* By their design and content, State ambulance forms facilitate comprehensive documentation of prehospital treatment and therefore enhance the quality of the hospital medical records in which they are filed. Although the use of State ambulance forms is encouraged, it is not mandatory. MTFs that want to continue using local ambulance forms (DA Form 4700 overprints) may do so. The use of State ambulance forms in the OTR is also encouraged.

(8) *DA Form 3180–R (Personnel Screening and Evaluation Record) and DA Form 4515 (Personnel Reliability Program Record Identifier).* DA Form 3180–R and DA Form 4515 will be used to identify the medical records of individuals qualified for the Nuclear or Chemical Personnel Reliability Programs per AR 50–5 and AR 50–6. The records manager will insert DA Form 4515 as the top document on the right side of the folder and file DA Form 3180–R as the top document on the left side of the folder. See paragraphs 5–29 and 5–30.

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

(10) *SF 602.*

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

(b) The medical officer treating or observing the case will record each periodic followup in section V of SF 602. The period of followup examinations required before the record may be closed is provided in TB MED 230. The medical officer who treats and follows up syphilis cases will keep suspense files or appointment records needed to ensure that current cases are observed long enough.

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

(d) A syphilis record will be reopened for relapse (The record filed in the HREC will be used for needed information; entries

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

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

5–20. Military consultation service case files

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

5–21. Access to health records

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

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

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

c. Inspectors. Personnel inspecting MTF, DENTAC, or USAR records are allowed direct access to HRECs. These personnel include Inspector General personnel conducting Nuclear Surety Program and Chemical Surety Program inspections per AR 50–5 and AR 50–6 (AR 20–1); it also includes Defense Nuclear Agency inspectors conducting Defense Nuclear Surety Inspections per TM 39–25–1 and AR 50–5. Inspectors may have access to HRECs to evaluate the compliance of AMEDD personnel with regulations. All inspectors must respect the confidentiality of the HRECs they inspect.

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

e. Other nonmedical Army personnel. Nonmedical personnel may need information from a person's HREC for official reasons. These personnel include unit commanders; inspectors general; officers, civilian attorneys, and military and civilian investigators 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. When officially needed, information from the HREC or copies of documents in it will be supplied by the MTF or DENTAC commander, patient administrator, or RC record custodian. (See para 2–3*a*.) Certifying and reviewing officials (commanders) are authorized to review medical records of candidates and members of the Personnel Reliability Program in conjunction with proper medical authority per AR 50–5 or AR 50–6.

5–22. Cross-servicing of health records

This regulation and similar ones in the other Services allow and direct cross-servicing of HRECs. Procedures for maintaining and transferring Navy and Air Force HRECs are similar to those described for Army HRECs.

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

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

Section II
Initiating, Keeping, and Disposing of Health Records

5–23. Initiating health records

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

b. HRECs for personnel reentering service. For personnel reentering service, HRECs will be prepared as described in *a* above and *d* and *e* below. Any past HREC will be acquired; the documents in the temporary HREC (para 5–25) will be put into the past one. Requests for past HRECs will be made by the military personnel officer of the first unit to which the person is assigned for training or other prolonged duty. Requests will not be made by reception station personnel. Requests for past HRECs should be sent to Commander, USARPERCEN, ATTN: DARP–P–AS, 9700 Page Boulevard, St. Louis, MO 63132–5200. For ARNG, the HREC for a person reentering ARNG should be requested from the State adjutant general of the State from which he or she was separated.

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

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

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

(1) *DA Form 3444-series or DA Form 8005-series folders.* For preparation of these folders, see paragraph 4–4. For HRECs, check the "Health" box under "Type of Record"; for dental records, using only DA Form 3444-series folders, check the "Health (Dental)" box. Contents of any remaining DD Form 722–1 (old record jacket) will be transferred to DA Form 3444-series folders or DA Form 8005-series folders. Handwritten entries will be made in dark ink and boldly printed. (The member's current organization (for example, "Co A, 163 Inf") will be handwritten in pencil.)

(2) *SF 600.* See paragraph 5–16.

(3) *SF 601.* See paragraphs 5–17 and 6–7.

(4) *SF 603 and SF 603A.* See paragraphs 5–18 and 6–7.

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

(6) *CDC Form 9.2936A (Venereal Disease Epidemiologic Report).* If a CDC 9.2936A has been received with a person's

records, it will be stapled to a blank letter-sized sheet of paper and fastened in the HREC under SF 601. (See para 5–24*b*(2)*(l)*.) CDC Form 9.2936A is sponsored by the Centers for Disease Control, Mail Stop E–11, 1600 Cliston Road, Atlanta, GA 30333.

5–24. Transferring health records

a. Sending HRECs. Both parts (health and dental) of a service member's HREC are transferred (may be hand-carried) when his or her MPRJ is transferred (AR 640–10). When a service member is to be transferred to another unit or station, the military personnel officer of the losing unit will receive both parts of the HREC from their custodians. The HREC will be sent with the MPRJ except when—

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

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

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

b. Receiving HRECs.

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

(2) *AMEDD personnel.*

(a) The officer in charge must ensure that any health problems of a newly arrived person are treated, and thus that the person's HREC is reviewed when received. Review of HRECs may be made by the medical officer, a physician's assistant (military occupational specialty 911A), or other qualified individuals. Review of Personnel Reliability Program records is discussed in paragraphs 5–28 and 5–29. Each MTF will set the qualifications that people who are not physicians must possess to review HRECs. Each MTF will also audit reviews to ensure that HRECs are referred to medical officers when needed. The responsible medical officer will develop written guidelines for the review of HRECs by nonmedical officers. These guidelines will ensure that reviews check for pending actions, health-care problems, and record inadequacies. When writing guidelines, the medical officer must ensure that reviews include the actions listed in *(b)* through *(i)* below. He or she may modify or expand these actions to fit the local situation.

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

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

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

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

(f) DA Form 5571, which includes significant medical diagnoses, surgical procedures, current medications, and allergies/reactions to drugs, will be completed.

(g) DA Form 8007 (Individual Medical History (IMH)) will be updated. (See para 5–30.)

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

(i) The HREC will be checked to ensure that any allergic reaction to medication was entered (para 5–17*a* and that DA Label 162 was affixed (AR 40–15).

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

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

(l) If CDC Form 9.2936A is present in the person's record (para 5–23*e*(6)), the medical officer will immediately have the person examined and start an SF 602, if needed (para 5–19*b*(10)). If CDC Form 9.2936A is not for syphilis, comments on the examination and treatment given will be made on SF 600. When no longer useful in the case, the CDC Form 9.2936A will be removed from the HREC and destroyed.

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

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

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

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

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

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

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

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

(2) New permanent dental records replacing lost records are prepared in accordance with guidance in TB MED 250. A new panographic x ray will be taken in duplicate; the original is for the new record, and the duplicate is sent to the Central Panograph Storage Facility.

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

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

5–26. Filing health records

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

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

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

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

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

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

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

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

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

(1) The records and forms will be screened against the MTF or DTF files, including the suspense cards. Those files that can be identified (that is, matched with a record or suspense card) will be sent to the proper custodian. The letter of transmittal will name 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 Systems (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 unit at assignment if possible. The list will be sent to the MILPO with a cover letter requesting that the names be checked. The local MILPO should determine the appropriate section within its organization to complete the required action on the list. (Some installations have In/Out Processing Sections where installations rosters and clearance files can be checked; at other installations, these functions are handled in the consolidation of military personnel activities.) After the MILPO has searched its files, the list should be forwarded to the post locator or to the installation activity that maintains the worldwide locator file. The MILPO or post locator response will be kept by the MTF or DTF in a file (file number 40 (general medical services correspondence files)) for 1 year. (See AR 25–400–2 for information on nonaction paper files.) (See table 2–1.)

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

(a) Rule 1. If the records or forms have a complete name and SSN on them and are Army records or forms (officers, warrant officers, and enlisted personnel) (based on a check of outprocessing and separation files, the local Standard Installation/Division Personnel System alpha roster, DEERS, and the worldwide locator microfiche) and if the MILPO provides a forwarding active duty address, then send them to the forwarding address. If the soldier retired or was discharged or separated to an inactive USAR status then send them to Commander, USARPERCEN, ATTN: DARP–P–AS, 9700 Page Boulevard, St. Louis, MO 63132–5200. If an address from orders or DD Form 214 (Certificate of Release or Discharge from Active Duty) assigns the soldiers to a USAR troop program unit or releases the USAR soldier from active duty for training or initial active duty for training then send them to the soldier's USAR unit. If an address from orders or DD Form 214 releases the ARNG soldier from active duty for training or initial active duty for training then send them to the appropriate State adjutant general. If the soldier has departed on terminal leave but has not reached his or her actual separation date then send them to the servicing separation transfer point. If no information and no record are available then send a request for locator service to the Commander, U.S. Army Enlisted Records Center, ATTN: PC–RE–RF, Fort Benjamin Harrison, IN 96249–5301, using the message format in figure 5–4. Hold the records or forms for the message response containing a disposition address.

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

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

(d) Rule 4. If the records or forms have a complete name and SSN on them and are Air Force records or forms, then send them to HQ, U.S. Air Force, ATTN: AFMPC/DPMDR, Randolph Air Force Base, TX 78150–6001.

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

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

e. Handling unidentifiable records and forms. An unidentifiable record or form is one that contains either no data or such a small amount of data that trying to identify the person to whom it belongs is impossible. Before destroying these records, the patient administrator will send a report to the MTF or DTF committee that audits medical and dental records, listing the type of record (laboratory forms, x-rays reports, SF 600, and so on) and the number of each type to be destroyed. This report and the committee's action on it will be entered in the committee minutes. Following the committee's approval, the patient administrator or his or her chosen representative will destroy these records and forms.

5–27. Disposing of health records

Upon discharge, release from active duty, retirement, death, or transfer from USAR to ARNG, the member's HREC will be disposed of per AR 640–10, paragraphs 2–9 and 2–10. ARNG HRECs will be disposed of as are MPRJs (For officers and warrant officers, see NGR 640–100; for enlisted personnel, see NGR 600–200.)

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

5–28. Screening Personnel Reliability Program records

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

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

5–29. Maintaining Personnel Reliability Program records

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

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

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

Section IV
Maintenance of Health Records Upon Mobilization

5–30. Health records of deployed soldiers

a. HRECs of deployed soldiers. HRECs of deployed soldiers will not accompany them to combat areas. When processing soldiers for deployment, the MTF and DTF will audit each soldier's HREC and record essential health- and dental-care information on DA Form 8007. DA Form 8007 is a single-page document that will be prepared for every soldier in the continental United States and outside the continental United States. DA Form 8007 should be initiated and/or updated during record screening (para 5–24*b*(2)(*g*)). DA Form 8007 is intended for use until an electronic device that stores medical or dental, personnel, and finance data is fielded. The preparation and use of DA Form 8007 is applicable as well to civilian employees who may accompany deploying units. Units in the continental United States and outside the continental United States are encouraged to use DA Form 8007 during training exercises. (See also para 5–24.)

(1) If an HREC is not available, DA Form 8007 will be completed based on soldier interviews and any other locally available data. An HREC may not be available for most Individual Ready Reserve, Individual Mobilization Augementee, and retired personnel because these HRECs may remain on file at the USARPERCEN.

(2) The completed DA Form 8007 will be provided to the soldier's command, or to the soldier if an individual replacement, and then handed off to the MTF in the area of operation responsible for providing primary medical care. That MTF will maintain DA Form 8007 in an outpatient field file for reference as needed. The field file will consist of, in part, DA Form 8007 and possibly SF 600, SF 558, SF 603, or DD Form 1380.

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

(4) MTFs and DTFs at the mobilization site(s) will follow the procedure in AR 640–10 for incorporating the HREC into the MPRJ.

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

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

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

5–31. Preparation of health record forms

a. DD Form 1380. Instructions for preparing DD Form 1380 are provided in chapter 9. When DD Form 1380 is put into the

HREC, it will be mounted on SF 600. To mount it, staple only along the top margin so that no entries on SF 600 are hidden and so that both sides of DD Form 1380 can be read.

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

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

5–32. Use of field files

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

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

5–33. Operation after hostilities cease

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

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

JOINT MESSAGEFORM										SECURITY CLASSIFICATION
PAGE	DTG RELEASER TIME			PRECEDENCE		CLASS	SPECAT	LMF	CIC	ORIG MSG IDENT
	DATE TIME	MONTH	YR	ACT	INFO					
OF						UNCLAS		CT	DDEB	
BOOK	MESSAGE HANDLING INSTRUCTIONS									

FROM:

TO: CHIEF RECORDS LOCATOR SVC//FT BEN HARRISON IN//PCRE-O//

UNCLAS

SUBJECT: MEDICAL/DENTAL RECORD LOCATOR SERVICE

ADDED INSTRUCTIONS:

1. LMF - MUST BE CT.

2. CIC - MUST BE DDEB.

3. ORIG/MSG IDENT - MUST BE SENDER'S ROUTING INDICATOR CODE {RIC}.

4. COMMUNICATIONS CENTER MUST ROUTE MSG TO RIC: RUFEHOS.

5. SUBJECT MUST BE AS SHOWN.

6. DATA FORMAT MUST BE:

LAST NAME {SPACE} FIRST NAME {SPACE} MIDDLE NAME/SSN. THE PARTS OF THE NAME MUST BE SEPARATED BY A SPACE. A SLASH {/} MUST SEPARATE THE NAME AND SSN. ALL NUMBERS OF THE SSN MUST RUN TOGETHER.

7. FORMAT EXAMPLE: DOE JOHN M/777889999

6
5
4
3
2
1
0

DISTR

DRAFTER TYPED NAME TITLE OFFICE SYMBOL PHONE	SPECIAL INSTRUCTIONS	
RELEASER: TYPED NAME TITLE OFFICE SYMBOL AND PHONE		
SIGNATURE	SECURITY CLASSIFICATION	DATE TIME GROUP

DD FORM 1 MAR 79 173/2 *(OCR)* PREVIOUS EDITION IS OBSOLETE S/N 0102-LF-000 1715 U.S. GOVERNMENT PRINTING OFFICE: 1985-498-243

Figure 5–4. Sample message format for stray medical records

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
GEN OUTPNT CLINIC USA Med Center	
Ft Splendid, TX 4 Feb 73 1130	Hx: Pt with history of pain in L shoulder x 1 week. Progressively worse with radiation of pain to elbow and forearm. No hx of trauma or stress. No previous hx of shoulder or joint pain. Exam: Limited motion of L shoulder, especially to active abduction and rotation. Point tenderness over anterior cuff glenohumeral joint. No evidence of nerve involvement in arm, forearm or hand.
	Lab: X-ray demonstrated calcification in bursa. Dx: Calcific bursitis, L shoulder
	Plan: 1) Uric acid, RF. 2) Refer to Phys Therapy for evaluation and approp. treatment. Goal--relief of pain and normal range of motion. 3) Profile: Temp U-3, Code G, 30 days. 4) If no improvement in 1 month--return for re-evaluation.
	L T Smith L. T. Smith, MAJ, MC
PHYSICAL THERAPY SECT USA Med Center	
Ft Splendid, TX 4 Feb 73 1300	Pt with L shoulder pain was evaluated and found to have limitation of L shoulder motion and pain on act. abd. beyond 40°. Active ROM L shoulder is: Abd. 65°; Flex. 95°; Int. rot. 65 ; Ext rot. 45 . Rx of ice massage to glenohumeral joint followed by ROM exercises L shoulder initiated daily x 5.
	Mary Thomas Mary Thomas, 1LT, AMSC
PHYSICAL THERAPY SECT USA Med Center	
Ft. Splendid, TX 24 Feb 73 0900	Pt received 5 treatments of ice massage to glenohumeral joint and ROM exercises to L shoulder. Pt was then instructed in home program of ice massage and exercise and asked to return in two weeks. Pt returned this date with L shoulder asymptomatic and ROM within normal limits. Treatment discontinued.
	Mary Thomas Mary Thomas, 1LT, AMSC

PATIENT'S IDENTIFICATION *(Use this Space for Mechanical Imprint)*

PATIENT'S NAME *(Last, First, Middle initial)*			SEX
Walker, Paul C.			M
YEAR OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS	DEPART/SERVICE
1946		AD	Army
SPONSOR'S NAME			RANK/GRADE
			SSG
SSAN OR IDENTIFICATION NO.		ORGANIZATION	
20 32932 99 93		HQ, Ft Splendid, TX	

CHRONOLOGICAL RECORD OF MEDICAL CARE
Standard Form 600
September 1971
General Services Administration and
Interagency Comm. on Medical Records
FPMR 101-11.809-5
600-19401

Figure 5–5. Sample entries on SF 600

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
TROOP HEALTH	CLINIC #6
FT Splendid,	TX
20 March 73	
0800	Hx: 27 year old EM with pain low back following lifting of footlocker
	at home (3200 N. Jones St., Arlington, VA) 1930 hours 19 March 73.
	Immediate pain at L-S area but gradual resolution last evening. Awoke
	this AM with severe pain. Unable to get out of chair without pain. No
	neurological symptoms. No scietic radiation. No past hx of similar
	process.
	PE: Restriction forward flexion with paravertebral muscle spasm and
	tenderness. No neurological deficit.
	X-ray: L-S spine neg.
	Dx: Prob. acute low back sprain
	Rx: 1) Diazepam 5 mg QID (warned about driving, etc.)
	2) Bed board
	3) Quarters 24 hours
	4) Return in AM
	R. J. Jones
	R. J. Jones, MAJ, MC
TROOP HEALTH	CLINIC #6
FT Splendid,	TX
21 March 73	
0915	Hx: Back pain much better, minimal discomfort.
	PE: Slight tenderness but full ROM.
	Rx: Duty (clerical job, no Profile Change required)
	R. J. Jones
	R. J. Jones, MAJ, MC

Figure 5–5. Sample entries on SF 600—Continued

Chapter 6
Outpatient Treatment Records

Section I
General

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 HREC is not prepared. CEMRs will be maintained according to Federal Personnel Manual (FPM) Supplement 293–31 (Basic Personnel Records and Files System). If a beneficiary has received medical care under two different SSNs as a result of remarriage to another military sponsor, record forms filed under the former SSN should be brought forward to the number currently in DEERS. For future inquiries, the previous folder should remain in its original place in the file, cross-referenced with the new number, and retired in accordance with AR 25–400–2 at the normal retirement date.

6–2. Outpatient treatment record forms and documents

a. DA Form 8805-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. Contents of any remaining DD Form 722–1 (old record jacket) should be transferred to DA Form 3444-series folders. On these folders, the "Outpatient Treatment" box will be checked if the folder will be used as a medical record, and the "Dental (Nonmilitary)" box will be checked if the folder will be used as a dental record. (For the preparation and filing of the DA Form 3444-series and DA Form 8005-series folders, see chap 4.)

b. The forms used in medical OTRs are listed in figures 6–1 and 6–2. These forms will be filed from top to bottom in the order that they are listed in the figures. Retrieved files will be converted to this order. Do not attempt to convert an existing file until it is retrieved and used. Copies of the same form will be grouped and filed in reverse chronological order (that is, the latest on top). (For authorization of forms and overprinting, see chap 3, sec I.) Specialized occupational health forms may be contained in CEMRs but must be locally approved. The forms listed in figures 6–1 and 6–2 are available through normal publications supply channels.

c. The forms and documents used in the dental OTR are listed in figure 6–3. These forms will be filed from top to bottom in the order that they are listed in the figure. The forms listed in figure 6–3 are available through normal publications supply channels. Copies of the same form will be grouped and filed in reverse chronological order.

Until a new four-part folder is fully assimilated into the system (See fig 6–2), the following order will be used for forms in the old DA Form 3444-series jackets for OTRs (not dental).

LEFT SIDE OF FOLDER

DA Form 4186

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

DA Form 3180–R

Personnel Screening and Evaluation Record. (See AR 50–5, AR 50–6, and para 5–19b(8) of this regulation.)

DA Form 5571 [1]

Master Problem List. (See para 5–10.)

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

DA Form 5862–R

Army Exceptional Family Member Program Functional Medical Summary. Filed directly below DA Form 5571. (See AR 600–75, chap 3, and para 6–2g of this regulation.)

DA Form 5291–R

Army Exceptional Family Member Program Educational Questionnaire. (See AR 600–75 and para 6–2g of this regulation.)

DA Form 5288

Exceptional Family Member Program Needs Booklet. When available, DA Form 5288 replaces either DA Form 5862–R or DA Form 5291–R, or both. (See AR 600–75 and para 6–2g of this regulation.)

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

DA Form 5694 [1]

Denver Developmental Screening Test. (See para 6–2e of this regulation.)

SF 601 [1,2]

Health Record—Immunization Record. (See paras 5–17 and 6–7.)

SF 512 [1]

Clinical Record—Plotting Chart. (See para 5–13.)

SF 545 [2]

Laboratory Report Display. File with SF 546 through SF 557 mounted. (See para 8–18). Instructions for completing SF 545 are provided in tables 8–1 and 8–2.

SF 519 [1,2] **; SF 519A** [1,2]

Medical Record—Radiographic Report. (See para 8–20.) SF 519 and SF 519A are obsolete; use for file purposes only.

SF 519–B [1]

Radiologic Consultation Request/Report. (See para 8–20.)

SF 520 [1]

Clinical Record—Electrocardiographic Record. Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of SF 520 or on another attached sheet of paper.

SF 560 [1]

Medical Record—Electroencephalogram Request and History (formerly DA Form 4530).

DA Form 2631–R

Medical Care—Third Party Liability Notification. (See AR 40–16.)

DA Form 3647

Inpatient Treatment Record Cover Sheet (formerly DA Forms 8–275-series and DD Forms 481-series). File with it a copy of SF 502 (if prepared), SF 515, SF 516, and SF 509. Include here for newborns a copy of SF 535 (Clinical Record—Newborn) [1] . Also file here AF Form 565 (Record of Inpatient Treatment), NAVMED 6300–5 (Admission/Disposition Record, Inpatient), or DD Form 1380 (formerly DA Form 8–27). (See AR 40–400 and paras 3–12a(1), 3–13b, 3–17a, 3–18b, 5–2a, 5–19a, 6–7, 8–7, 8–12, 8–13, 8–14, 8–15, 8–16, and 9–2.)

DA Form 5006–R [1]

Medical Record—Authorization for Disclosure of Information. (See para 2–3.)

DA Form 5303–R

Volunteer Agreement Affidavit. (See AR 40–38 and para 6–2h of this regulation.)

DA Form 3365

Authorization for Medical Warning Tag. File on left side when new folders are started. (See AR 40–15.)

Administrative documents and other correspondence including living wills (advance directives).

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

RIGHT SIDE OF FOLDER

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

SF 600 [1,2] **; SF 558** [1,2]
Health Record—Chronological Record of Medical Care; Emergency Care and Treatment. Also file here any other basic chronological medical care records, for example, SF 558 and AMOSIST local encounter forms. (See paras 5-14 and 5-16.)

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

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

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

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

DA Form 3763
Community Health Nursing—Case Referral. (See AR 40-407, para 4-2b.)

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

DA Form 4530
Electroencephalogram Request and History. (See SF 560.) DA Form 4530 is obsolete; use for file purposes only.

DA Form 4700 [1]
Medical Record—Supplemental Medical Data. (See chap 3.)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600. (See para 5-6 for completion instructions.)

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

SF 513 [1] **; DD Form 2161** [1]
Medical Record—Consultation Sheet; Referral for Civilian Medical Care. (See para 8-10.)

SF 522 [1]
Medical Record—Request for Administration of Anesthesia and Performance of Operations and Other Procedures.

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

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

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

Other SF 500-series forms.
File in numerical sequence.

DD Form 741 [1]
Eye Consultation.

DD Form 771-1
Eyewear Prescription/Eyewear Prescription—Plastic Lenses. DD Form 771-1 is obsolete; use for file purposes only.

DD Form 2215 [1]
Reference Audiogram.

DD Form 2216
Hearing Conservation Data. (See AR 40-5.)

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

Reports or certificates prepared by neuropsychiatric consultation services.

Correspondence on hearing aids.

Medical documents from civilian sources.

DA Form 4465
Client Intake Record. Also file here any other authorized alcohol and drug forms. (See AR 600-85 and paras 5-19b(4) and 7-9 of this regulation.)

DA Form 4410
Disclosure Accounting Record. Include DA Form 4410 when preprinted DA Form 3444-series folders are not used. DA Form 4410 is obsolete; use for file purposes only.

DD Form 2005
Privacy Act Statement—Health Care Records. Include when preprinted DA Form 3444-series folders are not used. (See AR 40-2 and para 4-4 of this regulation.)

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

PART I

DA Form 5571 [1,2]
Master Problem List. DA Form 5571 is always the top form. (See para 5-10.)

DA Form 5862-R
Army Exceptional Family Member Program Functional Medical Summary. (See AR 600-75 and para 6-2g of this regulation.)

DA Form 5291-R
Army Exceptional Family Member Program Educational Questionnaire. (See AR 600-75 and para 6-2g of this regulation.)

DA Form 5288
Exceptional Family Member Program Summary Report. When available, DA Form 5288 replaces either DA Form 5862-R and DA Form 5291-R, or both. (See AR 600-75 and para 6-2g of this regulation.)

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

DA Form 5694 [2]
Denver Developmental Screening Test. (See para 6-2e of this regulation.)

DD Form 1141
Record of Occupational Exposure to Ionizing Radiation or automated dosimetry record. (See AR 40-14 and para 5-19b(5) of this regulation.)

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

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

SF 601 [1,2]
Health Record—Immunization Record. (See paras 5-17 and 6-7.)

SF 512 [2]
Clinical Record—Plotting Chart. (See para 5-13.)

Automated laboratory report forms. File like forms in reverse chronological order.

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

SF 545 [1]
Laboratory Report Display (formerly SF 514). (See para 8–18.) Instructions for completing this form are provided in tables 8–1 and 8–2.

SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 556; SF 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; Immunohematology; Miscellaneous. Attach to SF 545 in reverse chronological order. (See para 8–18.) Instructions for completing these forms are provided in tables 8–1 and 8–2.

SF 519 [1,2] **; SF 519A** [1,2]
Medical Record—Radiographic Report. (See para 8–20. SF 519 and SF 519A are obsolete; use for file purposes only.)

SF 519–B [2]
Radiologic Consultation Request/Report. (See para 8–20.)

SF 520 [2]
Clinical Record—Electrocardiographic Record. Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of SF 520 or on another attached sheet of paper.

SF 524 [2]
Medical Record—Radiation Therapy.

SF 525 [2]
Medical Record—Radiation Therapy Summary.

SF 526 [2]
Medical Record—Interstitial/Intercavitary Therapy.

SF 541 [2]
Medical Record—Gynecologic Cytology.

SF 560 [2]
Medical Record—Electroencephalogram Request and History (formerly DA Form 4530, Electroencephalogram Request and History.)

DD Form 2482 [2]
Venom Extract Prescription. (See para 5–12.)

SF 559 [2]
Medical Record—Allergen Extract Prescription, New and Refill. (See para 5–15.)

DA Form 5007–A–R [2] **; DA Form 5007–B–R** [2]
Medical Record—Allergy Immunotherapy Record—Single Extract; Medical Record—Allergy Immunotherapy Record—Double Extract. (See para 5–5.)

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

DA Form 4060
Report of Optometric Examination. This form is obsolete; use for file purposes only.

DD Form 741 [2]
Eye Consultation.

DD Form 771
Eyewear Prescription. (See AR 40–63 and para 5–19*b* (2) of this regulation.)

DD Form 2215 [2]
Reference Audiogram.

DD Form 2216
Hearing Conservation Data. Also file any correspondence on hearing aids. (See AR 40–5.)

PART II

DA Form 4515
Personnel Reliability Program Record Identifier. (See AR 50–5 or AR 50–6, and para 5–19*b*(8) of this regulation.)

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

DA Form 3180–R
Personnel Screening and Evaluation Record. (See AR 50–5, AR 50–6, and para 5–19*b*(8)of this regulation.)

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

Documents and correspondence on flying status, that is, restrictions, removal of restrictions, suspensions, and termination of suspensions.

Interfile the following seven forms in reverse chronological order—most recent visit on top.

SF 600 [1,2]
Health Record—Chronological Record of Medical Care. (See para 5–16.)

DA Form 5008
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600 in chronological order. (See para 5–6 for completion instructions.)

SF 558 [2]
Emergency Care and Treatment. Interfile with SF 600 in chronological order. (See para 5–14.)

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

DA Form 3824 [2]
Urologic Examination.

DA Form 5181–R [2]
Screening Note of Acute Medical Care. (See para 5–7.)

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

SF 513 [2]
Medical Record—Consultation Sheet. (See para 8–10.)

DD Form 2161
Referral for Civilian Medical Care. (See AR 40–5.)

SF 602
Health Record—Syphilis Record. (See paras 5–19b(10) and 5–24.)

DA Form 3763
Community Health Nursing—Case Referral. (See AR 40–407.)

DA Form 5569–R [2]
Isoniazid (INH) Clinic Flow Sheet. (See para 5–8.)

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

SF 527 [2]
Group Muscle Strength, Joint R.O.M. Girth and Length Measurements.

SF 528 [2]
Clinical Record—Muscle and/or Nerve Evaluation—Manual and Electrical: Upper Extremity.

SF 529 [2]
Medical Record—Muscle Function by Nerve Distribution: Trunk and Lower Extremity.

DA Form 4700 [2]
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 chap 3.)

SF 517 [2]
Clinical Record—Anesthesia. Outpatient surgery only. (See para 8–10.)

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

SF 522 [2]
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures. (All other special consent forms.) (See para 3–3.)

SF 518 [2]
Medical Record—Blood or Blood Composition Transfusion.

SF 88 [1]
Report of Medical Examination. (See AR 40–501 and paras 5–6, 5–19, and 5–23 of this regulation.)

SF 93 [1]
Report of Medical History (formerly SF 89). File here any other medical history form. (See AR 40–501 and paras 5–19 and 5–23 of this regulation.)

DA Form 4970
Medical Screening Summary—Over-40 Physical Fitness Program. (See AR 40–501.)

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

DA Form 4465
Client Intake Record. Also file here any other authorized alcohol and drug forms. (See AR 600–85 and paras 5–19*b*(4) and 7–9 of this regulation.)

PART III

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

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

DA Form 3365
Authorization for Medical Warning Tag. (See AR 40–15.)

DA Form 4254–R [2]
Request for Private Medical Information. (See para 2–3.)

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

DA Form 5006–R [2]
Medical Record—Authorization for Disclosure of Information. (See para 2–3.)

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

Correspondence on release of medical information.

Other administrative documents important enough to keep on file, including living wills (advance directives).

DA Form 4410 [1]
Disclosure Accounting Record. DA Form 4410 is always the bottom form or is printed on the folder. It is obsolete; use for file purposes only.

PART IV

Group [3] copies of the following forms by hospitalization episode, with most recent on top.

DA Form 3647 [3]
Inpatient Treatment Record Cover Sheet (or automated replacement) (formerly DA Form 8–275-series and DD Form 481-series). File it with a copy of SF 502 (if prepared), SF 515, SF 509, and SF 516. Also file here AF Form 565, NAVMED 6300–5, DD Form 1380 (formerly DA Form 8–27), or any other narrative summaries from the VA, Public Health Service, or other Government MTF. (See AR 40–400 and paras 3–12a(1), 3–13b, 3–17a, 3–18b, 5–2a, 5–19a, 6–7, 8–7b, 8–12, 8–13, 8–14, 8–15, 8–16, and 9–2 of this regulation.)

OF 275 [3]
Medical Record Report. File in order of the number of the form it replaces. (See para 3–3.)

SF 502 [3]
Clinical Record—Narrative Summary. (See para 8–10.)

SF 539 [2]
Medical Record—Abbreviated Medical Record. (See para 8–17.)

SF 509 [3]
Medical Record—Doctors Progress Notes. SF 509 is the final discharge note. (See para 8–10.)

SF 515 [3]
Medical Record—Tissue Examination. (See paras 5–2 and 5–19.)

SF 516 [3]
Medical Record—Operation Report. (See para 8–10.)

SF 518 [2]
Medical Record—Blood or Blood Component Transfusion. Outpatient only.

SF 531 [2]
Clinical Record—Anatomical Figure.

SF 533 [2]
Medical Record—Prenatal and Pregnancy. File here any forms belonging to pregnancy episode not delivered in MTF. (See para 6–7.)

SF 535 [2]
Clinical Record—Newborn.

Copies of civilian treatment facilities records. [3]

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 AR 40–2 and para 4–4 of this regulation.)

Notes:
[1] This form must be included in all OTRs.
[2] Instructions for completing this form are self-explanatory.
[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

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 5–25.)

Other radiographs too large to be included in the DA Form 5570 envelope.

RIGHT SIDE OF FOLDER

SF 603 [1]
Health Record—Dental. File in reverse chronological order with original SF 603 on the bottom. Also file here SF 603A when needed as a continuation of section III (Attendance Record) of SF 603. (See para 5–18 for instructions on completing SF 603 and SF 603A. Also see para 6–7.)

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

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

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

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

SF 513 [2]
Medical Record—Consultation Sheet. (See para 8–10.)

SF 519 [2] **; SF 519A** [2]
Medical Record—Radiographic Report. (See para 8–20. SF 519 and SF 519A are obsolete; use for file purposes only.)

SF 519–B [2]
Radiographic Consultation Request/Report. (See para 8–20.)

SF 521
Clinical Record—Dental. This form is obsolete; use for file purposes only.

SF 522 [2]
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures. (See para 3–3.)

DA Form 8–115
Register of Dental Patients. This form is obsolete; use for file purposes only.

Other medical or dental records important to the patient's care.

DA Form 4410 [1]
Disclosure Accounting Record. DA Form 440 is always the bottom form or is printed on the folder. It is obsolete; use for file purposes only.

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 AR 40–2 and para 4–4 of this regulation.)

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

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 and 8–1 indicate the location of these forms in the medical record. The source of supply is the responsibility of each MTF.

e. DA Form 5694 will be used to ensure adequate medical documentation of children enrolled in the Army Exceptional Family Member Program. A screening and developmental assessment on DA Form 5694 will be completed and filed on the left side of the OTR immediately below DA Form 5568–R (Chronological Record of Well-Baby Care).

f. DA Form 5568–R will be used to document well-baby visits. (DA Form 5568–R will be locally reproduced on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.)

g. DA Form 5862–R and DA Form 5291–R will be filed immediately below DA Form 5571 on the left side of the folder. DA Forms 5291–R and 5862–R will be destroyed and replaced by DA Form 5288 when it is received.

h. DA Form 5303–R 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 a provision of AR 40–38. A copy is provided only as a source of information for the clinician treating a patient. The original form will be retained by the clinical investigator or researcher. DA Form 5303–R will only be sent to a records custodian if the patient agrees to it. This responsibility is left to the clinical investigator or researcher. This form is authorized for filing in the HREC.

i. Living wills (advance directives) will be recorded per paragraph 8–2*c*(2).

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

6–3. Initiating and keeping outpatient treatment records

An OTR will be prepared by the first MTF or DTF to which a person reports for outpatient treatment. After being initiated, the OTR will be kept at the MTF or DTF (including PRIMUS clinics) that provides the person's primary care. For each person, only one medical OTR and one dental OTR will be kept at the MTF or DTF. Partial or multiple records are prohibited except in obstetrical cases (para 6–7*h*) or consultation service case files (para 6–7*i*). When receipt of an OTR is delayed, a temporary one will be prepared according to paragraph 5–25*a*.

6–4. Transferring outpatient treatment records

To ensure that a patient's outpatient records are complete, the MTF providing the care will include in the OTR all outpatient records prepared at other facilities. To this end, OTRs should be transferred to the next MTF when patients change residences. OTRs of patients who may be lost to the AMEDD system (that is, sponsor is being released from military service in conjunction with the move or is being assigned to a remote location not serviced by an Army MTF) will be retained by the losing MTF per AR 25–400–2. Upon request, the patient may be given a copy of pertinent parts of his or her OTR.

a. Mailing OTRs.

(1) When a patient moves, his or her OTR may be hand-carried or mailed to the next MTF. However, special category records will be mailed. (See glossary.)

(2) When an OTR is mailed to the next MTF, the procedures described in *(a)* through *(d)* below will be followed.

(a) Before leaving the old station, the sponsor will report to the MTF that provides care to his or her dependents 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 and instruct the sponsor to present the card at the next MTF or DTF. (Also see paras 6–5 and 7–7 for information on DD Form 2138.)

(c) When the losing MTF or DTF receives DD Form 2138, it will mail the OTR to the requesting MTF or DTF. The losing MTF or DTF will file DD Form 2138 alphabetically and keep the form until the retirement of that year's records, at which time it will be destroyed.

(d) Medical OTRs will be mailed to the commander of the next MTF and directed to the patient administration division. Dental OTRs will be mailed to the commander of the next DENTAC. They will not be sent to installation, organization, or area commanders or to personnel officers.

(3) A person whose OTR must be mailed ((1) above) may be given a copy of certain parts of his or her OTR or an extract from his or her OTR if the person needs care en route to or upon arrival at another MTF or DTF. The extract or copies will be given to the person or any other authorized person as described in *b* below. Documentation of the treatment en route should be included in the original OTR; the patient should be told to give this documentation to the next MTF or DTF.

b. Hand-carrying OTRs. If the patient (other than those described in *a*(1) above) requests, he or she may hand-carry his or her OTR to the next MTF or DTF. In the case of minor children, the parent or legal guardian may deliver their OTRs to the next MTF or DTF. The procedures in (1) and (2) below will be followed when OTRs are hand-carried.

(1) The patient will sign for the OTR on DA Form 3705. The parent or legal guardian will sign for the OTR of minor children. (When preparing DA Form 3705, complete the "address" blocks.) Once signed, DA Form 3705 will be filed as is DD Form 2138 (*a*(2)*(c)* above).

(2) An adult's OTR will not be released to anyone other than the patient unless a signed authorization and a valid patient identification card is presented to the MTF or DTF. Any statement approving release to another person will be acceptable if signed and dated by the patient. This statement will be attached to DA Form 3705.

c. Troop-unit changes of station. When troop units change station, the losing and gaining MTFs or DTFs will coordinate to transfer the OTRs of dependents accompanying their sponsors to the new station. For OTRs that are mailed, the losing MTF or DTF will securely package and seal all OTRs destined for the same MTF or DTF and send them by registered mail.

d. Transferring x rays. 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. On SF 600 also, the x rays will be identified. The x rays will then be sent in a sealed envelope or mailer.

e. PRIMUS—OTRs. Medical care provided in PRIMUS clinics to other than HREC beneficiaries will be documented in an OTR maintained by PRIMUS. This OTR is the property of the U.S. Government and includes the same standard forms used in DOD MTFs. Release of information from PRIMUS records is the responsibility of the patient administration division at the sponsoring MTF. Upon sponsor's PCS and presentation of orders, records of dependents less than 18 years of age will be given to sponsor. A patient over age 18 may pick up his or her medical record upon presentation of orders and a valid identification card. The sponsor may be given records of dependents over age 18 only by presenting a permission note from the dependent and, if possible, the patient's identification card. Upon inprocessing at the next MTF, the PRIMUS medical record will be integrated into the OTR.

6–5. Requests other than DD Form 2138

Although DD Form 2138 is the only form authorized for use as a request for transferring OTRs in ordinary circumstances, this restriction does not preclude prompt response to other types of requests. Chargeout information for such requests will be filed and kept at the losing MTR or DTF as described in paragraph 6–4*a*(2)*(c)*.

6–6. Disposition

a. OTRs will be disposed of per AR 25–400–2. (See para 3–7 for information on destroying unidentifiable OTRs.)

b. If any member of a family receives health care in the MTF or DTF during the year, the OTR of eligible members who did not receive care may be retained if the family is still in the area and expects to receive care at the facility. In this case, retape the retirement date per paragraph 4–4*a*(5).

Section III
Preparation and Use of Outpatient Treatment Records

6–7. Preparation

Each contact with the AMEDD as an outpatient will be recorded in the OTR. Periods of treatment as an inpatient will be described on DA Form 3647 and SF 502 and put into the OTR. Inpatient dental treatment will be recorded on SF 603 in the dental record. Participation in research as a human subject will also be fully recorded in the OTR (para 5–16).

a. Preparation and use of SF 600. SF 600 is the basic record form of the medical OTR. It is a chronological record of outpatient visits. For the preparation and use of SF 600, see paragraph 5–16 (disregard 5–16*b*(2)).

b. Preparation and use of SF 601 and PHS Form 731.

(1) SF 601 will be prepared and permanently kept for each person who has an OTR. It will be placed in the OTR when—

(a) The OTR is initiated.

(b) The patient next reports for immunization or sensitivity tests.

(c) Reactions are noted.

(2) PHS Form 731 will be prepared or posted when a patient reports to an MTF for immunizations. Only the following identification information will be entered on PHS Form 731:

(a) The patient's name on the "Traveler's Name" line.

(b) The patient's address on the address line.

(c) The county of the individual's address on its appropriate line.

(3) People preparing SF 601 and PHS Form 731 will ensure that all entries are recorded on both forms and that the forms are current with each other.

(4) Per international rules, entries on PHS Form 731 for immunization against smallpox, yellow fever, and cholera will be authenticated. Each entry must show the DOD Immunization Stamp and the signature of the medical officer or his or her chosen representative. (See AR 40–562.) For other entries on PHS Form 731 and all entries on SF 601, the signature block may be stamped or typewritten and initialed by the medical officer.

c. Preparation and use of SF 603. SF 603 is the basic dental treatment form. All dental treatments and all conditions noted on examination will be entered on SF 603. See paragraph 5–17.

d. SF 603A. SF 603A will be used when needed and will be filed on top of the original SF 603. See paragraph 5–17.

e. DA Form 8006. DA Form 8006 will be used for recording the examination, diagnosis, and treatment planning of pediatric dentistry patients. DA Form 8006 is available through normal publications supply channels. Instructions for completing the form are self-explanatory.

f. Preparation of the OTR folder for patients allergic to medications. On the outside front cover of the DA Form 3444-series folder or DA Form 8007-series folder, the "Medical Condition" block will be marked, and DA Label 162 affixed when SF 601, PHS Form 731, or DA Form 3365 is prepared. (See AR 40–15 and AR 40–562.)

g. Obstetrical cases. A pregnancy diagnosis will be entered on SF 600. After the pregnancy, all forms related to it will be filed in the ITR. When the records are filed, the following information will be entered on SF 600: "Prenatal care records filed in ITR of (patient's name, FMP, and SSN), (location of MTF), and (date)." If the patient does not return for prenatal care and/or hospitalization, a notation will be made on SF 533 (Medical Record—Prenatal and Pregnancy), which will be filed in the OTR.

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

6–8. Use

The OTR will be given to physicians, dentists, and other medical personnel attending an outpatient or inpatient. When an outpatient is to be treated over a short period in a clinic, the OTR may be kept in that clinic; however, it will be made available to other medical or dental personnel when required during this period. Furthermore, the OTR will accompany a patient admitted to a military MTF and will be constantly available for use by the attending physician.

a. Chargeout system. A strict audit trail will be kept for OTRs temporarily out of the file. (See para 4–6.)

b. Protection of medical information. See chapter 2.

Chapter 7
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record

Section I
General

7–1. For whom prepared

An ADAPCP–OMR will be prepared for each patient enrolled in the ADAPCP.

7–2. Access

All personnel having access to ADAPCP–OMRs will protect the privacy of medical information. Care will be taken to prevent release of any information on the treatment, identity, prognosis, or diagnosis for alcohol or drug abuse patients except per AR 600–85. Requests for release of information will be handled in accordance with chapter 2 of this regulation and AR 600–85, chapter 6, using DA Form 5018–R (ADAPCP Client's Consent Statement for Release of Treatment Information).

7–3. Disclosure of information

Requests for release of information from ADAPCP–OMRs will be handled by the patient administration division in accordance with chapter 2 of this regulation and AR 600-85, chapter 6. DA Form 5018–R must be completed. Information may be provided by ADAPCP personnel but will be released only under the authority of the patient administration division.

7–4. Forms and documents

a. The forms and documents used in ADAPCP–OMRs are listed in figure 7–1 and are available through normal publications supply channels.

b. The current treatment record jacket (DA Form 3444-series) with fasteners on the left and right sides will be used as ADAPCP–OMR file folders. ADAPCP–OMRs may be filed in either alphabetical or terminal digit order.

c. Tabbed separators that delineate the content areas will be placed between all documents on the left and right sides of the folder as described in (1) and (2) below.

(1) On the left side, tabbed separators will be placed between the documents in the order listed in figure 7–1, left side. Tabs will be located with the starting point at the bottom left of the first or most top document and will be stairstepped from left to right across the bottom.

(2) On the right side, the first tab protrudes from the top and the others stairstep down the right side, starting from the top document to the bottom document. The tabs should be identified beginning with the most top document to the bottom document as listed in figure 7–1, right side.

RIGHT SIDE OF FOLDER

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

DA Form 7095 [1]
ADAPCP Outpatient Discharge Summary. (See para 7–9a.)

DA Form 7096 [1]
ADAPCP Outpatient Aftercare Plan. (See para 7–9b.)

DA Form 7098 [1]
ADAPCP Outpatient Treatment Plan and Review. (See para 7–9d.)

Figure 7–1. Forms and documents of the ADAPCP–OMR

SF 600 [1]
Health Record—Chronological Record of Medical Care. (See para 5–16.)

DA Form 7099 [1]
ADAPCP Outpatient Biopsychosocial Evaluation. (See para 7–9e.)

DA Form 8000 [1]
ADAPCP Triage Instrument (For Unscheduled Patients). (See para 7–9f.)

Miscellaneous treatment and information

DA Form 8001 [1]
Limits of Confidentiality. (See para 7–9g.)

DA Form 8004–R [1]
ADAPCP–OMR—Privacy Act Information. (See para 7–9j.)

LEFT SIDE OF FOLDER

DA Form 3180–R
Personnel Screening and Evaluation Record. (See AR 50–5 or AR 50–6 and para 5–19b(8) of this regulation.)

DA Form 7097 [1]
ADAPCP Outpatient Problem List and Treatment Plan Review. (See para 7–9c.)

DA Form 8002 [1]
ADAPCP Outpatient Administrative Summary. (See para 7–9h.)

DA Form 4465
Client Intake Record. (See AR 600–85 and paras 5–9b(4) and 7–9 of this regulation.)

DA Form 4466
Patient Progress Report. (See AR 600–85 and para 7–91 of this regulation.)

SF Form 513 [1] **; DD Form 2161** [1]
Medical Record—Consultation Sheet; Referral for Civilian Medical Care. (See para 8–10.)

Psychological evaluations and diagnostic testing (Minnesota Multiphasic Personality Inventory)

SF 545
Laboratory Report Display. File with SF 546, SF 547, SF 548, SF 549, SF 550, SF 551, SF 552, SF 553, SF 554, SF 556, and SF 557 mounted. File here also automated laboratory forms and data profiles for antabuse and urinalysis test results. (See para 8–18.) Instructions for completing these forms are provided in tables 8–1 and 8–2.

SF 519–B [1]
Radiologic Consultation Request/Report. (See para 8–20.)

DA Form 8003 [1]
ADAPCP Enrollment. (See para 7–9i.)

Special forms and other administrative correspondence. File most recent form on top. Include court reports, letters, memoranda, consent forms, release of information requests, and orders.

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

Figure 7–1. Forms and documents of the ADAPCP–OMR—Continued

Section II
Initiating, Maintaining, and Disposing of Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Records

7–5. Initiating and maintaining

When a patient is enrolled in the ADAPCP, the following notation will be made on the SF 600 maintained in either the HREC or OTR corresponding to the patient's category: Date patient seen, refer to file number 40–66. After being initiated, the ADAPCP–OMR will be maintained by and appropriately secured in the Community Counseling Center (CCC). The Chief, patient

administration division, will provide technical advice on maintenance of ADAPCP–OMRs. For each person, only one ADAPCP–OMR will be kept at the CCC.

7–6. Transferring

a. To assist in providing continuity of care for ADAPCP patients, ADAPCP–OMRs should be transferred to the next MTF or CCC with PCS of patients. Upon notification of PCS of an active duty member, ADAPCP–OMRs of individuals actively involved in the ADAPCP will be mailed to the next MTF or CCC. All PCSs or reassignments will be handled in accordance with AR 600–85.

b. ADAPCP–OMRs of patients lost to the AMEDD system (that is, sponsor is being released from military service in conjunction with the move or is being assigned to a remote location not serviced by an Army MTF) will be retained by the losing MTF and retired per AR 25–400–2.

7–7. Requests other than DD Form 2138

Although DD Form 2138 is the only form authorized for use as a request for transferring ADAPCP–OMRs in the 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)*.

7–8. Disposition

ADAPCP–OMRs will be disposed of per AR 25–400–2.

Section III
Preparation and Use of Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Records

7–9. Preparation

Each contact with the ADAPCP will be recorded in the ADAPCP–OMR.

a. DA Form 7095 will be prepared when treatment is completed. It will be used to summarize the clinical course by concisely describing the reason for admission, treatment rendered, the patient's response, the patient's status at the time of discharge, and prognosis for future success.

b. DA Form 7096 will be prepared when treatment is completed and will describe further rehabilitative responsibilities required for continued success. It will include the patient's rehabilitation status at the time of discharge, ADAPCP clinical responsibilities, medications (if applicable), and support group involvement.

c. DA Form 7097 will be used to document the periodic review and evaluation of patient progress in relationship to each identified problem. It is prepared at the time of scheduled multidisciplinary case conferences. DA Form 7097 is equivalent to DA Form 5571.

d. DA Form 7098 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 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 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 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 will be used to briefly summarize rehabilitation efforts from date of patient enrollment to current date or termination of ADAPCP services. It will be initiated when the patient is enrolled in the program and updated at the time of each scheduled event.

i. DA Form 8003 will be used to make an ADAPCP referral and to gather pertinent information needed to make an enrollment decision. It will be initiated by the commander at the time the problem is identified and completed by the ADAPCP clinical staff at the conclusion of the rehabilitation team meeting.

j. DA Form 8004–R will be signed by the patient after he or she reads it. DA Form 8004–R explains the provisions of the Privacy Act as they pertain to ADAPCP–OMRs.

k. DA Form 4465–R will be used to document initial screening data needed to determine the nature and severity of the problem. It will be completed upon screening and/or enrollment in the ADAPCP or when a medical evaluation is needed. (See AR 600–85 for instructions on completing this form.)

l. DA Form 4466 will be used to document patient progress. It will be used to document patient progress (at 90-, 180-, 270-, and 360-day intervals following enrollment) upon inpatient enrollment and/or discharge, to change the diagnosis or basis for enrollment, patient PCS, or patient reassignment, or to release the patient from the program. (See AR 600–85 for instructions on completing the form.)

7–10. Use

a. ADAPCP–OMRs will be given to physicians, dentists, and other health-care practitioners attending the ADAPCP patient.

b. A strict audit trail will be kept for ADAPCP–OMRs temporarily out of file. (See para 4–6.)

Chapter 8
Inpatient Treatment Records

Section I
General

8–1. For whom prepared

a. An ITR 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 3–17).

(4) NATO patients (para 8–4).

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 surgeon considers their use impractical and if DD Form 1380 has been approved for use.

c. For a nonfixed MTF using ITRs, instructions for preparation will be provided by the MEDDAC or MEDCEN in whose geographical area the nonfixed facility is operating. Disposition will be per AR 25–400–2.

8–2. Inpatient forms and documents

a. See chapter 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 8–1. The forms listed in figure 8–1 are available through normal publications supply channels. The same numbered forms will be grouped chronologically, except for laboratory and radiology reports, which will be filed in reverse chronological order. DA Form 4700 may be filed immediately after an SF or DA form when it is supplemental to that form (excluding SF 600). DA Form 4700 will identify the SF or DA form in the lower right identification block following "Other". In all other instances, DA Form 4700 will be filed per figure 8–1.

LEFT SIDE OF FOLDER

DA Form 5571 [1]
Master Problem List. Filing in ITR is optional. (See para 5–10.)

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

DA Form 3349
Physical Profile. (See AR 40–501 and para 5–19b(3) of this regulation.)

DA Form 3894
Hospital Report of Death. Use to meet the requirements of STANAG 2046. (See AR 40–2 and para 3–13 of this regulation.)

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

DA Form 2984
Very Seriously Ill/Seriously Ill/Special Category Patient Report. (See AR 40–2.)

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

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

SF 544
Clinical Record—Statement of Patient's Treatment. File this form or copies of the information released or a synopsis of the information released with the authorization for release of medical information. (See AR 40–2.)

DA Form 5009–R [1]
Medical Record—Release Against Medical Advice. (See para 8–21.)

Administrative documents and other correspondence, including wills (advance directives). (See para 8–2.)

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

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 or AR 50–6 and paras 5–19b(8) and 5–29c of this regulation.)

DA Form 3647
Inpatient Treatment Record Cover Sheet. All versions. (See AR 40–400 and paras 3–12a(1), 3–13b, 3–17a, 3–18b, 5–2a, 5–19a, 6–7, 8–7b, 8–12, 8–13, 8–14, 8–15, 8–16, and 9–2 of this regulation.)

DA Form 3647–1
Inpatient Treatment Record Cover Sheet (For Plate Imprinting). (See AR 40–400.)

SF 502 [1]
Clinical Record—Narrative Summary. (See para 8–10.)

Figure 8–1. Forms and documents of the ITR

SF 503 [1]
Clinical Record—Autopsy Protocol. Used as a summary for detailed autopsy reports. (See para 8–10f.)

SF 539 [1]
Medical Record—Abbreviated Medical Record. (See para 8–17.)

SF 504 [1]
Clinical Record—History—Part I. (See para 8–10.)

SF 505 [1]
Clinical Record—History—Parts II and III. (See para 8–10.)

SF 506 [1]
Clinical Record—Physical Examination. (See para 8–10.)

SF 535 [1]
Clinical Record—Newborn. Civilian source pediatric growth charts. (See para 6–2d.)

DA Form 5694 [1]
Denver Developmental Screening Test. (See para 6–2e of this regulation.)

SF 507 [1]
Clinical Record—Report on or Continuation of SF. File with the standard form being continued. (See para 8–10.)

SF 509 [1] **; SF 558** [1]
Medical Record—Doctor's Progress Notes; Medical Record—Emergency Care Treatment. (See paras 5–14 and 8–10.)

DA Form 3888
Nursing Assessment and Care Plan. (See AR 40–407 and para 3–3 of this regulation.)

DA Form 3888–2
Medical Record—Nursing Care Plan. (See AR 40–407.)

DA Form 3888–3
Medical Record—Nursing Discharge Summary. (See AR 40–407.)

SF 510
Clinical Record—Nursing Notes (formerly DD Form 640 and DA Form 4336). (See AR 40–407 and paras 3–2, 8–10, and 8–11 of this regulation.)

DA Form 5179
Medical Record—Preoperative/Postoperative Nursing Document. (See AR 40–407.)

DA Form 5179–1
Medical Record—Intraoperative Document. (See AR 40–407.)

DA Form 3950
Flowsheet for Vital Signs and Other Parameters. (See AR 40–407.)

SF 511 [1]
Medical Record—Vital Signs Record (formerly Temperature-Pulse-Respiration (Fahrenheit).

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

SF 513 [1] **; DD Form 2161**
Medical Record—Consultation Sheet; Referral for Civilian medical Care. (See para 8–10.)

SF 545
Laboratory Report Display. File with SF 546, SF 547, SF 548, SF 549, SF 550, SF 551, SF 552, SF 553, SF 554, SF 555, SF 556, and SF 557 mounted. (See para 8–18.) Instructions for completing these forms are provided in tables 8–1 and 8–2.

SF 515 [1]
Medical Record—Tissue Examination. (See paras 5–2 and 5–19.)

Armed Forces Institute of Pathology Consultation Report on Contributor Material

SF 516 [1]
Medical Record—Operation Report. (See para 8–10.)

SF 517 [1]
Clinical Record—Anesthesia. (See para 8–10.)

Figure 8–1. Forms and documents of the ITR—Continued

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

SF 519 [1] **; 519A** [1]
Medical Record—Radiographic Reports. (See para 8–20.) SF 519 and SF 519A are obsolete; use for file purposes only.

SF 519–B [1]
Radiologic Consultation Request/Report. (See para 8–20.)

SF 520 [1]
Clinical Record—Electrocardiographic Record.

SF 522 [1]
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures. (See para 3–3.)

SF 523 [1]
Clinical Record—Authorization for Autopsy.

SF 523A [1]
Medical Record—Disposition of Body.

SF 523B [1]
Medical Record—Authorization for Tissue Donation.

SF 524 [1]
Medical Record—Radiation Therapy.

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

SF 526 [1]
Medical Record—Interstitial/Intercavitary Therapy (formerly Radium Therapy).

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

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

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

SF 530 [1]
Clinical Record—Neurological Examination.

SF 531 [1]
Medical Record—Anatomical Figure.

SF 533 [1]
Medical Record—Prenatal and Pregnancy. Also file related prenatal documents. (See para 6–7h.)

SF 534 [1]
Medical Record—Labor.

SF 536 [1]
Clinical Record—Pediatric Nursing Notes.

SF 537 [1]
Medical Record—Pediatric Graphic Chart.

SF 538 [1]
Clinical Record—Pediatric.

SF 541 [1]
Medical Record—Gynecological Cytology (formerly Cytology Examination).

SF 560 [1]
Medical Record—Electroencephalogram Request and History (formerly DA Form 4530).

DA Form 3824 [1]
Urologic Examination.

DA Form 4221 [1]
Diabetic Record.

DA Form 4256
Doctors Orders. (See para 8–19 for completion instructions.)

Figure 8–1. Forms and documents of the ITR—Continued

DA Form 4677
Therapeutic Documentation Care Plan (Non-Medications). (See AR 40–407 and para 8–19 of this regulation.)

DA Form 4678
Therapeutic Documentation Care Plan (Medication). (See AR 40–407 and para 8–19 of this regulation.)

DA Form 4530
Electroencephalogram Request and History. (See SF 560.) DA Form 4530 is obsolete; use for file purposes only.

DA Form 4700 [1]
Medical Record—Supplemental Medical Data. (See chap 3.)

DA Form 5128 [1]
Clinical Record—Visual Field Examination (formerly DD Form 742).

DD Form 602
Patient Evacuation Tag. Staple to SF 502. (See AR 40–40 and para 8–4 of this regulation.)

DD Form 741 [1]
Eye Consultation.

DD Form 742
Clinical Record—Visual Field Examination. (See DA Form 5128.) DD Form 742 is obsolete; use for file purposes only.

• **DD Form 749**
Clinical Record—Head Injury. DD Form 749 is obsolete; use for file purposes only.

DD Form 1380
U.S. Field Medical Card. (See chap 9 for completion instructions.)

DA Form 4359–R
Authorization for Psychiatric Service Treatment. (See AR 40–3.)

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 3–18 of this regulation.)

DA Form 4410
Disclosure Accounting Record. Include when preprinted DA Form 3444-series folders are not used. DA Form 4410 is obsolete; use for file purposes only.

DD Form 2005
Privacy Act Statement—Health Care Records. To be included when preprinted DA Form 3444-series folders are not used. (See AR 40–2 and para 4–4 of this regulation.)

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

Figure 8–1. Forms and documents of the ITR—Continued

(1) ITRs for previous admissions (except those already retired per AR 25–400–2) will be filed in the same folder. They will be put in reverse chronological order (the most recent admissions on top) and separated by locally devised dividers.

(2) All ITRs transferred with a patient will be kept as a part of his or her current ITR. However, 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) When a patient executes a living will (also known as advance directives), it is his or her intent to communicate to health-care providers his or her wishes for what care he or she desires. Living wills are not legal, binding documents. It is the patient's responsibility to ensure that copies of the living will are given to MTF personnel at each admission and/or creation of a new outpatient record. Living wills should be filed with administrative documents on the left side of the folder in ITRs and on the right side of the folder in HRECs and OTRs.

(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, their source and the physician under whom they were prepared must be identified.

d. Identification procedures for fetal monitoring strips are provided in (1) through (5) below.

(1) Identify and file fetal monitoring strips in envelopes that can be filed efficiently in the standard fiberboard boxes that are used to retire records. (For example, two rows of 6½- by 9½-inch envelopes can be filed in these boxes.) Keep the strips on the obstetrical unit with the prenatal record until delivery.

(2) After delivery, put the information described in *(a)* through *(d)* below on the envelopes that contain the fetal monitoring strips. Put the data on the plate imprint to the left margin.

(a) Name and register number of infant. If the infant has not been named, record "baby boy" or "baby girl" with the last name.

(b) Sponsor's name and SSN.

(c) Name of MTF.

(d) Date of birth.

(3) Inside the envelope, file the additional locator card received from admissions and dispositions. Use this locator card when the fetal monitoring strips are retired.

(4) Record the infant's first name on the locator card or if not named, "baby boy" or "baby girl" with the last name.

(5) When the infant is discharged, send the monitoring strips to inpatient records.

e. Disposition procedures for fetal monitoring strips are provided in (1) through (6) below.

(1) The inpatient records section will maintain the fetal monitoring strips as a separate file; strips will be filed in register number sequence.

(2) The locator card received from admissions and dispositions with the monitoring strips will be stapled on the outside of the envelope or kept in a separate alphabetical file until the strips are retired.

(3) Medical records personnel will write the register number of the infant at the top of each envelope where it will be clearly visible when records are filed in boxes for retirement. The maximum use of filing space is possible when envelopes are arranged in two rows in the boxes.

(4) Fetal monitoring strips will be retained under the original register number of the infant and will not be brought forward to subsequent register numbers.

(5) Special cases are described in *(a)* through *(d)* below.

(a) Transfer of an undelivered patient. When an undelivered patient is transferred, all fetal monitoring strips prepared are sent with the ITR of the patient.

(b) Transfer of newborn. When a newborn infant is transferred during initial hospitalization, the fetal monitoring strip is forwarded with the patient.

(c) Stillborn infants. Fetal monitoring strips for stillborn infants are filed under the register number of the mother.

(d) Other special cases. When it cannot be determined that prenatal care terminated in hospitalization or delivery, the outpatient fetal monitoring strips are sent to the inpatient medical records section. These strips are filed alphabetically and retired alphabetically in the last box of fetal monitoring strips being retired for that year. A locator card is also prepared for these strips, and "No Register Number" is entered on the card.

(6) Fetal monitoring strips will be retired in register number sequence (except as described in (5)*(d)* above). Locator cards will be retired in alphabetical order and shipped with the fetal monitoring strips.

f. U.S. Army Health Services Command or medical command must approve filing fetal monitoring strips in microform, compact disc, or other format.

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

8–3. General

An ITR will be initiated when a patient is admitted or is a CRO case. (See para 3–17 for information on CRO cases.) The ITR will be prepared and reviewed per this regulation and locally established procedures.

8–4. North Atlantic Treaty Organization Standardization Agreement 2348 requirements

The ITRs of NATO personnel who are treated by Army MTFs are prepared in the same manner as ITRs for other patients. (This requirement also applies to DD Form 1380 and DD Form 602.) In addition, the policies listed in *a* and *b* below apply to NATO personnel.

a. The original 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 AR 40–400, table 2–5, for a list of these authorities.) Sometimes DA Form 1380 or DD Form 602 (STANAG 2132) will be prepared as well as an ITR. If so, these forms will go with the ITR.

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.

8–5. Inpatient treatment records of absent-without-leave patients

The ITR of a patient who has been AWOL for 10 consecutive days will be closed and disposed of per file numbers 40–66f (military ITRs) and 40–66i (NATO personnel ITRs). (See AR 25–400–2 and table 2–1 of this regulation.)

8–6. Five-year inpatient treatment record maintenance

Medical centers will keep ITR files for 5 years. These centers are—

a. Brooke Army Medical Center, Fort Sam Houston, TX 78234–6200.

b. Fitzsimons Army Medical Center, Aurora, CO 80045–5550.

c. Madigan Army Medical Center, Tacoma, WA 98431–5055.

d. Tripler Army Medical Center, HI 96859–5000.

e. William Beaumont Army Medical Center, El Paso, TX 79920–5001.

f. Walter Reed Army Medical Center, Washington, DC 20307–5000.

g. Dwight David Eisenhower Medical Center, Fort Gordon, GA 30905–5650.

h. Womack Army Medical Center, Fort Bragg, NC 28307–5000.

8–7. Access and audit trail

Access must be given to ITRs on file or to cases having register numbers. In addition, a record audit trail must be kept. The two indexes described in *a* and *b* below will be kept for these purposes. When an automated database (for example, Automated Quality of Care Evaluation Support System (AQCESS) and CHCS) is used to consolidate the admission and disposition history of individual inpatients, a manual inpatient nominal index is no longer necessary.

a. Nominal index. The nominal index will include a card for each patient assigned a register number. Each card will list the patient's name, SSN with FMP, and register number. The cards will be filed alphabetically by last name. If the patient is transferred, the date of transfer and the name of the receiving MTF will be noted on the card. In the case of a readmission, information from previous admissions will be attached to or recorded on the current card. A manual nominal index is not required in those facilities maintaining AQCESS, CHCS, or other automated patient data systems.

b. Register number index. MEDDACs will maintain a register number index for 5 years. MEDCENS do not need to maintain this index because the ITRs are maintained at the MEDCEN for 5 years. The register number index will include a copy of DA Form 3647 for each patient assigned a register number. A copy of SF 502 (when prepared) may be attached to DA Form 3647. This index will be kept in register number sequence. For transfer cases, a copy of the transmittal form will be attached to DA Form 3647.

8–8. Disposition of inpatient treatment records

a. Inpatient transfer. When a patient is transferred to a U.S. Army MTF, the original ITR will be sent along and will become a part of the receiving MTF's ITR (para 8–2*b*(2)). When a military patient is moved to an Air Force or Navy MTF or to a VA Medical Center, a copy of the ITR will be sent. When a patient is moved to another type of MTF, extracts, summaries, or copies of the ITR will be sent; the original ITR will be kept by the Army MTF and disposed of per AR 25–400–2, file numbers 40–66f (military ITRs), 40–66g (civilian ITRs), and 44–66i (NATO personnel ITRs). (See table 2–1.)

b. Microscope slide transfer. Duplicate slides of surgical specimens will 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. (See AR 40–31, para 14*j*.) 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 "Microscope slide (or number of microscope slides) forwarded with 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 the slides with the ITR when the patient departs.

c. Normal retirement procedures. For these 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 2–1.)

Section III
Preparation and Use of Inpatient Treatment Records

8–9. 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 within 4 working days. If a test result is pending, 7 working days will be allowed. If the transcription of dictated reports is delayed, the practitioner will have met his or her requirements as pertains to the completion of the ITR. Each MTF will establish internal policy to satisfy the requirement of the Joint Commission on Accreditation of Healthcare Organizations for a completed ITR. Records will be completed using available findings; delayed reports will be filed in the ITR when received and, if needed, a corrected DA Form 3647 will be prepared. Records will be reviewed per this chapter and paragraph 10–3.

a. If requested by the attending physician, ITRs from previous admissions, OTRs, HRECs, and medical records for transferred patients will be provided.

b. Reports needed for the ITR will be completed promptly. (See para 8–10.) As laboratory, consultation, or other reports are completed, they will be added to the ITR along with any progress notes (SF 509) (para 8–10*b*) and other notes made by health-care providers.

c. When the patient is discharged, the attending physician will prepare SF 502 (para 8–10*e*), complete the DA Form 3647 worksheet (section IV), and send the completed ITR through channels to the patient administration division. 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 8–2*b*(2)). OTRs and HRECs will be returned to the proper records custodian.

d. In obstetrical cases, an ITR will be prepared when the patient is hospitalized for 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 so that it may be completed and sent to the patient administration division. (See para 8–10*f*.)

8–10. Medical reports

The forms and reports to be filed in an ITR depend on the nature of the case and the treatment given. All forms and reports needed for a case will be included. (Automated versions of forms, basic policies for these reports, and the recording of diagnoses are discussed in chap 3.) Specific reporting needs are described in *a* through *f* below.

a. History and physical. An admission workup will be prepared on SF 504 (Clinical Record—History—Part I), SF 505 (Clinical Record—History—Parts II and III), and SF 506 (Clinical Record—Physical Examination) within 24 hours of admission. These forms will be as pertinent and complete as needed for proper patient management. Before surgery under general anesthesia is performed, the ITR must include a complete history and a current, thorough physical examination. (The cardiopulmonary system findings will be fully recorded; terms such as "normal," "wnl," and "negative" will not be used.) These reports are not needed, however, in emergencies; for emergency surgery, the physician will report only vital signs, pertinent physical findings, and any allergies (if known). (Also see paras 8–11 and 8–17 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 5–16*b*(3) and 8–11 for information on SF 509.)

(2) *Readmission.* When a patient is readmitted within 30 days for the same or a related condition, an interval history and physical will be written in the progress notes (SF 509). These reports will describe any pertinent changes. However, these interval reports are allowed only if the ITR with the original history and physical is also sent to the attending physician.

(3) *Documentation on SF 504, SF 505, and SF 506.* Admission history and physical examinations will be recorded on SF 504, SF 505, and SF 506 only by staff physicians, qualifying oral and maxillofacial surgeons, residents, and certified midwives as appropriate. Podiatrists may record and perform admission histories and physical examinations on podiatry patients only on the podiatry problem on SF 504, SF 505, and SF 506. The medical history and physical examination (head, eyes, ears, lungs, heart, and so forth) must be performed and signed by a physician (doctor of medicine or doctor of osteopathy). In programs for children and adolescents, developmental age factors will be evaluated, educational needs will be considered, and this information will be included, as appropriate. All surgery performed by podiatrists will be restricted to the foot that is distal to the tibiotalar or ankle joint, and the surgery will be under supervision of an orthopedic surgeon. If a podiatrist is stationed at an MTF where no orthopedic surgeon is available, the surgery will be limited to outpatient procedures in the clinic area only. Physician assistants may record admission history and physical examinations if these findings have been carefully reviewed by the attending physician and if he or she so attests when countersigning the documents.

b. SF 509. SF 509 will describe chronologically the clinical course of the patient. SF 509 should reflect any change in condition and the results of treatment. SF 509 will be recorded by the person giving the treatment or making the observation.

(1) *Progress notes by doctors.* In addition to the information described in *b* above, doctors' progress notes, documented on SF 509, will analyze the patient's clinical course and outline the rationale for specific medical decisions. Doctors' progress notes (SF 509) begin with an admission note, continue with notes during hospitalization, and conclude with a final note on discharge, transfer, or death.

(a) The admission note will record briefly the clinical circumstances that brought the patient to the hospital, will summarize the proposed diagnostic workup, and will suggest the type of therapeutic management. For emergency patients, SF 558 will be put in the ITR and may be used as the admission note. (See para 5–14.) Associated consultations and diagnostic test reports will also be filed in the ITR. At the time of intrahospital transfer, a note will be written to summarize the course of the patient's illness and his or her treatment.

(b) For surgical patients, the admission note may serve as the preoperative note. In addition to giving the information in *(a)* above, these notes will justify the surgery and state the procedure proposed. If surgery scheduled within 24 hours of admission is not performed within 2 days, another preoperative note will be written by the surgeon. This note must again justify the surgery.

(c) The anesthetist's preanesthesia note that explains the choice of anesthesia for the proposed procedure will be recorded on SF 517. If there is not enough space on the back of SF 517, SF 507 (Clinical Record—Report on Continuation of SF) will be used for the remainder of the documentation. 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.

(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. Progress notes (SF 509) will also record examinations of chest and legs until the patient is ambulatory and afebrile, the use of casts or splints, and any other pertinent data.

(e) The final progress note (SF 509) will record the patient's general condition on discharge, the final diagnosis, and postdischarge care, including activity permitted, diet, medications, dressings, and the date and clinic for followup care.

(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. They should be written every day or even every few hours during the acute phase of the illness. For surgical patients, there will be a daily note for at least the first 4 postoperative days. For convalescent patients and fracture patients with no complications, notes will not be needed as often as for patients receiving active treatment. In no case, however, will more than 7 days pass without a progress note.

(2) *Progress notes by nurse anesthetists, nurse practitioners, clinical nurse specialists, and physician assistants.* 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, will describe chronologically the nursing care given the patient. (See AR 40–407.)

(4) *Dietetic progress notes.* See AR 40–2, paragraph 9–13*e*.

(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 2–1 of this regulation.)

(7) *Psychology notes.* Psychology officers (area of concentration 68S) 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) 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 2–1 of this regulation.)

c. SF 516. Reports for all cases involving surgery in the operating room or ambulatory surgery unit, even when performed under local anesthesia, will be dictated immediately after surgery and transcribed on SF 516, OF 275, or automated equivalents. (See para 3–3 for information on OF 275.) 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 emergency room) 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.

d. SF 513. A consultant is a health-care provider who gives professional advice or services on request. A consultant must be well qualified in the field; qualifications are determined by the credentials committee. SF 513 will include the matters on which the requesting practitioner sought an opinion and the consultant's findings and recommendations. Also see para 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 automated equivalent. SF 502 should be concise (rarely more than one typewritten, single-spaced sheet). Diagnostic and procedural terminology on SF 502 or progress note (SF 509) ((2) below) and DA Form 3647 will be the same. (See paras 5–2, 5–19, 6–7, 8–7, 8–9, 8–14, and 8–17 for more information on SF 502.)

(1) SF 502 (in narrative form) will include—

(a) The reason for hospitalization, including a brief clinical statement of the chief complaint and history of the present illness.

(b) All significant findings.

(c) All procedures performed and treatment given, including patient's response, complications, and consultations. (Any prosthetic device that is permanently implanted in the body will be identified, including nomenclature of prosthesis, manufacturer, and serial numbers as provided.)

(d) The condition of the patient on transfer or discharge.

(e) The discharge instructions given to the patient or his or her family (that is, physical activity permitted, medication, diet, and followup care).

(f) All relevant diagnoses (including complications) made by the time of discharge or transfer.

(2) A progress note (SF 509) summarizing the case may be substituted for the narrative summary (SF 502) when—

(a) A transfer or discharge occurs within 72 hours after admission. (See para 8–17*d*.)

(b) An obstetrical case has a normal, uncomplicated delivery.

(c) A patient's problem is minor. (See para 8–17.)

(3) All hospital death cases require a narrative summary.

f. SF 503. The pathologist's provisional anatomic diagnoses will be entered in the ITR within 72 hours; the complete protocol will be recorded on SF 503 within 60 days. 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.

8–11. 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:

(1) Histories and physical examinations performed by someone other than the senior resident, staff physician, qualified oral and maxillofacial surgeon, or certified midwife.

(2) Operation reports (SF 516) written or dictated by someone other than the surgeon.

(3) Narrative summaries (SF 502) written or dictated by someone other than the attending physician, dentist, podiatrist, or midwife in charge of the case.

(4) Doctors' verbal and telephone orders (DA Form 4256). (These orders will be countersigned by the prescribing physician.)

b. Progress notes (SFs 509) do not require the countersignature of the supervising physician or nurse.

c. When personnel in approved graduate medical education programs are involved in patient care, the care provided will be documented on SF 509 and SF 510, as appropriate. Sufficient evidence will be documented in the medical record to substantiate active participation in and supervision of the patient's care by the responsible program preceptor. Documentation of histories and physicals (SF 504, SF 505, and SF 506) and doctors' orders (DA Form 4256), when an integral part of the program, will be countersigned by the preceptor physician or, when appropriate, by a qualified oral and maxillofacial surgeon.

Section IV
DA Form 3647

8–12. General purpose

DA Form 3647 is a medical and administrative summary of each case and will be prepared for each case that requires an ITR. (For CRO cases, DA Form 3647 may be the entire ITR.) DA Form 3647 is also an essential document for HRECs and OTRs and serves as a source document for statistical information of major military and medical interest. In facilities using CHCS or AQCESS, an automated version of DA Form 3647 may be used. A worksheet copy may not be provided in AQCESS or CHCS.

8–13. Use

Paragraph 8–1*a* names the kinds of MTFs that use DA Form 3647. 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 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 is not needed; a note on the patient's medical record giving the date and name of the holding station is sufficient.

8–14. Initiation and disposition

DA Form 3647 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 and the worksheet copy of the DA Form 3647 will both be filed in the ITR, with the worksheet 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 and SF 502 (when prepared) will also be filed in HRECs and OTRs. Copies of DA Form 3647 and SF 502 on Public Health Service or Coast Guard commissioned corps officers should be forwarded to Medical Branch, 5600 Fishers Lane, Parklawn Building, Room 4–35, Rockville, MD 20857–0435.

8–15. Preparation

Instructions for completing DA Form 3647 are found in the IPDS Users' Manual, which may be obtained from PASBA (ATTN: HSHI–QZ), Fort Sam Houston, TX 78234–6070. Also see International Classification of Disease—Ninth Revision—Clinical Modification. This publication is on file in each Army MTF, and the three-volume set can be purchased from the Superintendent of Documents, WASH DC 20402–9325. Also see the Triservice Disease and Procedure ICD–9–CM. Diagnostic entries on the worksheet copy of DA Form 3647 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.

8–16. Corrections and corrected copies

Corrections to DA Form 3647 will be made when necessary. (See para 3–4*e*.)

Section V
Preparation and Use of Other Inpatient Treatment Record Forms

8–17. SF 539

a. SF 539 is used for cases of a minor nature that require no more than 72 hours' hospitalization. For example, it is used for lacerations, plaster casts, removal of superficial growths, and accident cases held for observation. SF 539 will not be used for death cases, admission by transfer, or probable medical-board cases.

b. SF 539 may 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, paragraph *d* below applies.

c. SF 539 may be used for cases in which general anesthesia was given only if—

(1) The patient is classified as American Society of Anesthesiologists Class I or II; that is, the patient has no organic, physiologic, biochemical, or psychiatric disturbance, or the systemic disturbance is well controlled, or the pathologic process to be operated on is localized and does not entail a systemic disturbance.

(2) The patient will be hospitalized no more than 72 hours. When SF 539 is used for these cases, the physical examination section must fully describe the cardiopulmonary findings. (Terms such as "normal," "wnl," and "negative" will not be used.) It must also describe any exceptions or other pertinent findings.

d. When SF 539 is used, SF 502 may be replaced by a final progress note (SF 509). However, when a short stay becomes a long one, SF 502 must be prepared. In such cases, SF 504, SF 505, and SF 506 need not be completed in addition to SF 539; 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 72 hours, SF 539 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.

8–18. Laboratory forms

a. Laboratory forms (SF 545, SF 546, SF 547, SF 548, SF 549, SF 550, SF 551, SF 552, SF 553, SF 554, SF 555, SF 556, and SF 557) and automated versions of them are used to request laboratory tests and to report the results of those tests. When a computerized or automated summary of all previous laboratory tests is provided, only the cumulative final report should be filed in the record. The forms are three-part sets (original and two copies). When a test is requested, the whole set is sent to the laboratory. After the results are recorded, the third copy is kept in the laboratory files. The original is routed for immediate filing in the ITR or OTR or outpatient HREC. The second copy is routed to the requesting practitioner for use and disposition.

b. Carbon copies of laboratory reports will not be filed in the medical record. The MTF commander will ensure that each patient's laboratory test reports are prepared correctly.

c. General instructions for preparing these forms are given in table 8–1. Instructions for each form are given in table 8–2.

Table 8–1
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.

Table 8–1
General instructions for preparing laboratory forms—Continued

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.
c. On SF 556, give specimen source information for obstetric patients.

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.

Block: Tests Requested.
Completed by: Clinic or ward.

Table 8–1
General instructions for preparing laboratory forms—Continued

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 8–2
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 on 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—antistreptolysis 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, malaria, and other blood parasites, and most feces tests.
Remarks: N/A

Table 8–2
Specific instructions for preparing laboratory forms—Continued

Form: SF 553
Use: To request most bacteriological isolations and sensitivities.
Remarks: See table 8–1 (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 8–1 (Specimen Source block) for information on preparing the Infection, Clinical Information, and Antibacterial Therapy blocks.

Form: SF 555
Use: To request spinal fluid tests.
Remarks: To request bacteriological studies on spinal fluid specimens, submit SF 553 or SF 554 also. Bacteriological cultures must grow at least 24 hours before the results can be observed. The extra request form allows complete identification of the specimen; it also allows the quick return of the cell count and chemistry results to the physician without a wait for the bacteriological results. When requesting electrophoresis measurements, also submit SF 557. These measurements take many hours to complete, and the report is a tracing by a densitometer on special paper. The extra request form allows complete identification of the specimen; it also allows the cell count and chemistry results to be returned quickly to the physician without a wait for the electrophoresis results to be completed.

Form: SF 556
Use: To request blood grouping, blood typing, and blood back tests.
Remarks: Do not use this form as a request for blood crossmatching; such requests are made on SF 518. Specimen source information is needed for obstetric patients.

Form: SF 557
Use: To request tests, such as electrophoresis and assays of coagulation factors, which are not ordered on other forms.
Remarks: N/A

8–19. 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 ballpoint pen using blue-black or black ink. 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 and time that each order is written. Each order must be accounted for separately; use of the entry "routine orders" (to imply a number of predetermined orders) is prohibited. However, a group of orders written at the same time for a patient needs only one signature. Standard orders overprinted on DA Form 4256 also must be signed by 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. 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.

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 (*d* above) and then noted on DA Form 4677 or DA Form 4678 by putting "DC (discontinued)/date/initials" and drawing a single line through the HR (hour) and Date Completed/Dispensed blocks beside the stopped order. Corresponding annotations in an automated system such as CHCS are acceptable.

f. Verbal orders. Verbal orders will be used only for emergency STAT orders. The registered nurse who accepts the order must write it on DA Form 4256 and enter after it "Verbal order (doctor's/nurse's name, grade, Army nurse corps or registered nurse)." The prescriber must countersign the order as soon as possible, but no later than 24 hours after the emergency.

g. Telephone orders. As few telephone orders as possible will be accepted and only by a registered nurse. The prescriber must countersign DA Form 4256 within 24 hours.

8–20. Radiologic forms (SF 519, SF 519A, and SF 519–B)

a. SF 519, SF 519A, and SF 519–B will be used to request radiologic examinations and to report the results. The forms are 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 2–1 of this regulation.) The original is routed for immediate filing in the ITR or OTR or outpatient HREC. The second copy is routed to the requesting practitioner for use and disposition. Carbon copies of radiologic reports will not be filed in the medical record.

b. Whether a typewritten, automated, handwritten, or verbal report, the results of all "wet" readings must be documented in the patient's medical record. This documentation can be found on either SF 519, SF 519A, SF 519–B, SF 600, or SF 558.

8–21. DA Form 5009–R

DA Form 5009–R (Medical Record—Release Against Medical Advice) will be used when the patient leaves the MTF against the advice of hospital authorities and attending practitioners. A parent or legal guardian will complete the "statement of representative" portion of the form if the patient is a minor or mentally incompetent. (DA Form 5009–R will be locally reproduced on 8½- by 11-inch paper. A copy for local reproduction is located at the back of this regulation.)

Chapter 9
DD Form 1380

9–1. Use

DD Form 1380 will be used to record basic patient identification data and to describe the problem requiring medical attention and the care provided. NATO STANAG 2132 and QSTAG 470 govern the use of DD Form 1380. DD Form 1380 is available through normal publications supply channels. Instructions for completing the form are provided in table 9–1. Combat medics, aid stations, treatment teams operating nonfixed troop clinics, and MTFs will use DD Form 1380 as outlined in *a* through *d* below.

a. The combat medic first 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).

b. Aid stations will record medical care provided on DD Form 1380 any time that the aid station is operational and does not have access to the patient's HREC or OTR.

c. Treatment teams providing Level–II medical care will use DD Form 1380 any time that care is provided and the patient's HREC is not readily available. If a patient is treated in a holding section or is expected to return for additional treatment or evaluation, an OTR may be initiated using standard medical record forms. The OTR need not be filed in a DA Form 3444-series record. When the patient is returned to duty or when treatment and evaluation are completed, the medical officer will summarize care provided on DD Form 1380, and DD Form 1380 will be disposed of in accordance with paragraph 9–4. 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.

d. MTFs where the primary mission is to provide Level–III or Level–IV medical care will use DD Form 1380 to record outpatient care provided when the patient's HREC is not readily available as stated in *a*, *b*, and *c* above.

9–2. 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 combat theater of operations, DD Form 1380 will be prepared for any patient treated at one of the MTFs listed in paragraph 9–1 and may also be used for CRO cases (para 3–17). 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 returns to duty. 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 Graves Registration 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 9–1. All abbreviations authorized for use on DA Form 3647 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.

Table 9–1
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.

Table 9–1
Instructions for preparing DD Form 1380—Continued

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 United Ministry Team. Check appropriate box of service provided. Write in signature of chaplain providing service.

9–3. 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.

9–4. Disposition

In a combat zone, if DD Form 1380 is generated but the patient is not admitted to a hospital, the form will be sent to the medical command and control headquarters or the command surgeon for statistical coding.

a. After coding, DD Form 1380 will be disposed of per AR 25–400–2 as described in (1) through (4) below.

(1) Military personnel.

(a) Active duty Army officers to Commander, U.S. Total Army Personnel Command, ATTN: TAPC–MSR, 200 Stovall Street, Alexandria, VA 22332–0400 for insertion in official military personnel file.

(b) Active duty Army enlisted to Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PC–RE–FT, Fort Benjamin Harrison, IN 46249–5301 for insertion in official military personnel file.

(c) Active duty Navy or Marine Corps personnel to The Surgeon General, Naval Medical Command, ATTN: Code 33, Department of the Navy, WASH DC 20372–5120.

(d) Active duty Air Force personnel to AFOMS/SGSB, Brooks Air Force Base, TX 78235–5000.

(e) All other U.S. uniformed personnel to HQDA (SGPS–PSA), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

(2) Civilian personnel to National Personnel Records Center (Civilian), 111 Winnebago Street, St. Louis, MO 63118–4199.

(3) Foreign nationals within the overseas area, forward to the appropriate authorities. Within Health Services Command, forward to HQDA (SGPS–PSA), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

(4) Prisoners of war to HQDA (DAPE–HRE), WASH DC 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 8–1.)

c. The original DD Form 1380 used to record outpatient treatment in peacetime operations or during training exercises will be forwarded to the custodian of the patient's HREC or OTR for inclusion in the record.

d. All carbon copies of DD Form 1380 will be disposed of per AR 25–400–2.

9–5. 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 so used, it must become a part of the ITR.

Chapter 10
Role of the Medical Department Activity or U.S. Army Medical Center Patient Administration Division in the Quality Assurance Program

10–1. General

The Quality Assurance Program will follow guidelines contained in AR 40–68. The patient administration division will conduct administrative record reviews, give administrative support to the MTF-wide Quality Assurance Program as prescribed by the local

written Quality Assurance plan, and assist MTF committees and departments and/or services in patient-care assessment studies as appropriate. The extent of assistance to individual departments and services will be contingent on availability of personnel resources. Trends and findings made during quality assurance reviews 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 to the Quality Assurance committee. However, trends in errors or deficiencies or large numbers of errors or deficiencies are a proper subject for committee discussion and action; the patient administration division will refer these and the necessary supporting records to the committee.

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, and HRECs to the appropriate review committee. This review will be done per paragraph 10–3 and instructions from the commander or chairman of the Quality Assurance committee. The patient administration division will also furnish any material requested by the Quality Assurance committee, for example, statistical presentation of trends and comparisons with data available in literature.

10–2. Internal Quality Assurance Program for medical record services

Medical record personnel will implement an internal Quality Assurance Program that will focus on the identification, resolution, and followup of existing or potential problems. This program will be written, and documentation will support an ongoing assessment of the major functional areas listed in *a* through *g* below by the use of objective criteria. Overall goals should be quality records and quality services.

a. Administration or management.
b. Record review and analysis.
c. Retrieving, filing, and controlling records.
d. Correspondence and release of medical information.
e. Coding and abstracting.
f. Medical statistics.
g. Medical transcription.

10–3. Patient care assessment

a. Documentation review of medical records for accuracy, timeliness, completeness, clinical pertinence, and adequacy as medicolegal documents. This review, in coordination with the medical staff, will be made on a sample of randomly selected OTRs, ITRs, and HRECs. (See also AR 40–68, para 3–3*a*(5).) (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, and HRECs, depending on the size and degree of specialization of the MTF concerned. However, over a reasonable period (quarterly), all three types of records will be included in the review. 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 (9) 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 followup care.

(2) The ITRs of current inpatients describe the progress and the current status and treatment of the patient so that the case can be fully understood at any time. HRECs and OTRs will be reviewed for clinical pertinence and completeness, that is, appropriate documentation of visit or episode, up-to-date problem list, and diagnostic test results filed.

(3) Each medical record includes all completed forms and reports needed by the nature of the case and the treatment given.

(4) Final diagnoses are fully recorded; symbols and abbreviations have not been used.

(5) All entries are current, clinically pertinent, and legible; entries do not contain provider accusations or derogatory (ventilated) comments.

(6) All entries are dated and signed.

(7) Discharge instructions, including restrictions, medications, and followup 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) 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 MCJA of potential liability, in-service education, and preparation of reports to the Quality Assurance committee. For corrections to medical records see paragraph 3–4*e*.

c. Record delinquencies. On a quarterly basis, the following medical record delinquencies will be reported to the Quality Assurance committee:

(1) History and physical not done within 24 hours after admission.

(2) Operative report not dictated within 24 hours of the completion of surgery.

(3) Narrative summary not dictated within 4 working days of patient discharge.

(4) DA Form 3647 (worksheet) not completed within 4 working days of patient discharge.

(5) ITRs not completed within 30 days of patient discharge.

(6) Percent of medical records not available at time of clinic visit.

10–4. 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 directly to the patient or his or her authorized representative. The MCJA or claims judge advocate (CJA) or U.S. Army Claims Service (USARCS), as appropriate, will release copies of the records. (This restriction does not apply to cases in which the claim is being filed with an individual or agency outside the U.S. Government.) Original records will not be released unless requested by a Government attorney defending the United States in a malpractice lawsuit. Any such request for medical or dental records must be in writing, specifying the dates of treatment and the names of the MTFs or DTFs involved. The records will be released, if at all, per AR 340–21 and AR 27–20. Release of medical or dental records is limited to records defined in figures 5–1, 5–2, 5–3, 6–1, 6–2, 6–3, 7–1, and 8–1. Records kept by various departments, services, and clinics in an MTF or DTF (for example, x rays, wet tissue, paraffin blocks, microscopic slides, surgical and autopsy specimens, tumor death reports, and fetal monitoring strips) will not be released unless requested by the Litigation Division, Office of The Judge Advocate General (OTJAG), or USARCS. Original x rays, paraffin blocks, and slides will not be released. When medical or dental records are needed for treatment purposes elsewhere, copies or appropriate extracts will be furnished. Before the disposition of these records to the National Personnel Records Center (NPRC), consult USARCS or the Litigation Division, OTJAG, ATTN: JALS–LT, 901 West Stewart Street, Arlington, VA 22203–1837.

b. Special attention will be given to the handling of medical or dental records involved in litigation or adjudication to ensure accuracy and correlation of evidential documentation. The practices described in (1) through (6) below will be followed.

(1) Before any action (for example, photocopy; release to local CJA; transmittal to Litigation Division, OTJAG; or response to subpoena), the original medical or dental record will be reviewed for completion by the patient administration division or the DENTAC and will be assembled in the appropriate order prescribed in this regulation. All undersized reports (x-ray reports, laboratory reports, electrocardiographic tracings, or special tracings) will be attached to their respective display or mounting sheets. Medical or dental records involved in litigation or adjudication require special safeguarding in the patient administration division and will be maintained separately in locked filing cabinets or safes. Complete records filed separately will be accounted for in the central file area with a chargeout guide. 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 2–5.)

(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.

(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 within 48 hours of the request or as soon as the priority system will allow.

Chapter 11
Monthly and Annual Statistics

11–1. Terms to be used

The terms listed in *a* through *d* below are often used in chart analysis, audits of patient care, and the compilation of medical statistics. Some of the terms listed below also include examples of specific conditions and instructions on how to use them in reviews and analyses.

a. Natality terms.

(1) *Hospital live birth.* After a pregnancy of any length, the complete expulsion or extraction of a product of conception from its mother in a hospital. After separation, the product breathes or shows some other sign of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles; these signs are evident whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

(2) *Hospital fetal death.* Death of a product of conception before its complete expulsion or extraction from its mother in a hospital. The product had a gestation of 20 weeks or more or its fetal weight is 500 grams or more. (If accurate information on gestation is not available, fetal weight will be used.)

b. Mortality terms.

(1) *Hospital death.* Death after admission to a hospital or after birth in a hospital. (Fetal death is not included.)

(2) *Types of hospital deaths.* The categories described in *(a)* through *(e)* below are not always mutually exclusive. A "maternal death," for instance, may also be an "anesthetic death." In such cases, the death is counted only once when a total death rate is computed for the hospital; however, the death should be included in each category when counts or rates for the categories are made. Such counts will be footnoted to show that a case is included more than once.

(a) Operative death. Death resulting from surgical procedure, for example, death from hemorrhage, shock, embolism, and infection. This term includes deaths occurring in the postoperative, convalescent period (usually 10 days) if they cannot be ascribed to conditions clearly unrelated to the surgical procedure. Anesthetic deaths are not included.

(b) Anesthetic death. Death caused by anesthetic agents.

(c) Maternal death. Death due to causes related to pregnancy, its termination (including abortion), or the puerperium.

(d) Neonatal death. Death of an infant within 28 days after birth. For analysis, neonatal deaths are often grouped according to the time between birth and death; deaths in the first week are grouped according to completed days of life.

(e) Other hospital death.

c. Morbidity terms.

(1) *Hospital complication.* A disturbance occurring during the treatment of a condition. The disturbance is related to, but not part of, the normal expected course of the condition when treated, or the disturbance is caused by the treatment itself. The term is not to be used for complicating illness of a secondary diagnosis present on admission. In analysis, infections are classified separately.

(a) Postoperative complication. Complications after surgical procedures, including embolism, thrombosis, postoperative hemorrhage, disruption of operative wound, postoperative hyperpyrexia (exclude expected febrile reactions to tissue injury), phlebitis, and so forth.

(b) Anesthetic complication. Complications caused by anesthetic agents and equipment. Expected mild headaches after spinal anesthetic should not be included.

(c) Obstetric complication. Complications caused by pregnancy or its termination. (Do not include obstetrical infections.) In audits, cases in which there was blood loss of 1,000 cubic centimeters or more will be reviewed; however, all cases for which transfusion is recorded will be reviewed. Cases with lacerations not healing primarily and causing fistulae will be reviewed.

(d) Newborn complication. Complications arising within 28 days after birth. The term does not include infections or mild and expected (or inevitable) conditions, such as minor conjunctival reactions to silver nitrate, mild cephalhematomas, or transient forceps marks.

(e) Reaction to whole blood or blood components. (This term does not include minor reactions that are easily and quickly ended, for example, antihistamine therapy.)

(f) Reaction to drugs, including biologicals. Drug toxicity and interactions. (This term does not include minor reactions that are easily and quickly ended, for example, antihistamine therapy.)

(g) Accidental injury to patient. Any injury sustained by a patient while in the hospital, including injuries in wards, treatment rooms, corridors, indoor recreation areas, and any other area under the control of the hospital commander.

(h) Other complications. All complications not named elsewhere.

(2) *Hospital infection.* Any infection known or suspected to have been communicated in the hospital. All cases that might be so classed will be reviewed. The Infection Control Committee will determine whether a case should be classified as a hospital infection. The committee will also classify each case as "postoperative," "obstetrical," and so on, and will identify the service in which it occurred.

(a) Postoperative infection. An infection introduced into a wound or body cavity during surgery or during postoperative care. The term applies only if the type of infection did not previously exist in the case. If no previous infection was present in the operative area, stitch abscesses will be classified as postoperative infections. Infections following any procedure on the wards or elsewhere will also be classified as postoperative infections but only if the procedure involves puncture of the skin and can be properly classified as a surgical procedure. A wound incurred outside the hospital is presumed to have been contaminated when it occurred. Infections of such wounds will not be classified as postoperative infections although a primary closure or closure with drainage was made. However, such infections will be classified as postoperative if the time that symptoms began or other evidence strongly suggests introduction of the infection in the hospital.

(b) Obstetrical infection. Any infection related to pregnancy, its termination, or the puerperium. All cases in which temperatures of 100.4°F or above were recorded on any 2 days in the first 10 days postpartum (excluding the first 24 hours) will be classified as obstetrical infections.

(c) Newborn infection. Any infection in an infant newborn in the hospital within 28 days after birth. This term does not include infections in infants who have been readmitted to the hospital after an earlier discharge. However, if information strongly suggests that the infection was communicated in the hospital, it will be classified as a newborn infection.

(d) Common respiratory disease—hospital infection. Common colds and nonspecific acute upper respiratory diseases in which symptoms were first noted on or after the fifth day following admission.

(e) Infective or parasitic disease—hospital infection. Any case in which the time between admission and the onset of symptoms suggests that the disease was contracted in the hospital.

(f) Other hospital infection. Infections not named above, arising during hospitalization, including infections after "nonsurgical" procedures performed on the wards or elsewhere if punctures of the skin are involved (for example, hypodermic injections).

d. Miscellaneous terms.

(1) *Surgical procedure.* Any systematic manipulation on or in the body to restore disunited or deficient parts, to remove diseased or injured tissues, to remove foreign matter, to aid in obstetrical delivery, or to aid in diagnosis. The procedure is normally performed by a physician, dentist, or other licensed practitioner; it may be performed with or without instruments. Procedures normally performed by nurses or technicians (for example, hypodermic injections) will not be classified as surgical procedures. (The number of surgical procedures in a given period may exceed the number of patients undergoing surgery because more than one procedure may be performed during a single period of anesthesia. For example, a cholecystectomy and appendectomy may be performed at the same time; two procedures would then be counted for the one patient undergoing surgery.)

(2) *Single unit transfusion.* Giving only one unit of blood or blood products to a patient during a period of hospitalization. Two or more units given during the same period of hospitalization should be considered as multiple-unit transfusions; this term applies even if the units were given on different days.

11–2. Monthly analysis of hospital services

a. The monthly analysis will include review of inpatient disposition data in the diagnosis index and in the operations index, required by the Joint Commission on Accreditation of Healthcare Organizations. These indices are available ad hoc in AQCESS.

b. Additional monthly reports available ad hoc include the death index and the tumor registry report.

c. Monthly hospital reports will be provided by Patient Administration Systems and Biostatistics Activity (PASBA) upon request on number of dispositions, bed days, average length of stay, and average daily patient load by clinical service and patient category.

d. Monthly hospital reports containing diagnosis related group (DRG) information will also be provided by PASBA upon request. These reports will include DRGs by number of dispositions, bed days, average length of stay, and outliers; DRGs by clinical service; relative weighted products by DRG and clinical service; patient category and peer group; and inpatient data for records with a length of stay greater than the DRG trim point.

e. In addition, the Retrospective Case Mix Analysis System can provide either focused reports or custom tables (ad hoc reports). These reports and tables include—

(1) Utilizational analysis with reports on days of care, discharge rates, and length of stay presented by DRG, patient category, or age group and compared with civilian or military norms.

(2) Targeted analysis with reports on Resource Intensive Procedures based on principal procedure, Surgical Procedures for Appropriateness Review based on principal procedure, Diagnosis Not Normally Hospitalized based on principal diagnosis and length of stay less than 5 days, Potential Ambulatory Surgery based on principal procedure and length of stay less than 3 days, and Outlier Analysis based on both short- and long-stay outliers per DRG. Each report can be presented by specific report item, clinical service, patient category, rank, or age group.

(3) Comparative DRG data with reports on civilian norms (charge norms, length of stay norms, discharge rates, and per diem costs) and military norms (length of stay norms and discharge rates).

(4) Custom table design that enables the hospital to develop reports that suit its needs.

(5) Subpopulation creation that enables the hospital to print information from a particular group of records.

f. Other specific requirements, as determined by the hospital and medical staff, may be requested from PASBA as either recurring or one-time reports.

11–3. Annual analysis of hospital services

The annual analysis will—

a. Review the annual IPDS disposition data reports.

b. Compare the current report with the reports of the previous 5 years.

c. Compute hospital rates. The hospital rates that must be computed annually are explained in table 11–1 or contained in automated reports.

Table 11–1
Annual hospital rates

Mortality (death) rates
Rate to be computed: Gross death rate **Explanation:** Percentage ratio of deaths to the total number of dispositions during the year. Include newborn deaths in total number of deaths; do not include fetal deaths. Include all deaths in the total number of dispositions.
Rate to be computed: Maternal death rate **Explanation:** Percentage ratio of maternal deaths to the total number of dispositions from obstetrical service during the year. Include deaths in the total number of dispositions.
Rate to be computed: Neonatal death rate **Explanation:** Percentage ratio of neonatal deaths to the total number of hospital live births during the year.

Table 11-1
Annual hospital rates—Continued

Rate to be computed: Postoperative death rate
Explanation: Percentage ratio of postoperative deaths to the number of patients undergoing surgery during the year.
Rate to be computed: Anesthetic death rate
Explanation: Percentage ratio of anesthetic deaths to the number of anesthetics given during the year.
Rate to be computed: Gross death rate for each clinical service
Explanation: Percentage ratio of deaths occurring on a service to the total number of dispositions from that service during the year. Include deaths in the total number of dispositions.

Necropsy (autopsy) rates

Rate to be computed: Hospital necropsy (autopsy) rate
Explanation: Percentage ratio of the number of necropsies (autopsies) performed to the number of deaths during the year.
Rate to be computed: Necropsy (autopsy) rate for each clinical service
Explanation: Percentage ratio of necropsies (autopsies) performed on death cases of a service to the total number of deaths occurring on that service during the year.

Morbidity (Infection) rates

Rate to be computed: Gross hospital infection rate
Explanation: Percentage ratio of the number of hospital infections to the number of dispositions during the year.
Rate to be computed: Common respiratory disease—hospital infection rate
Explanation: Percentage ratio of the number of such infections to the number of dispositions during the year. (The review committee should not study each case; it should analyze increases in the rate of incidence of these conditions among patients.)
Rate to be computed: Postoperative infection rate
Explanation: Percentage ratio of the number of such infections to the number of patients undergoing surgery during the year.
Rate to be computed: Newborn infection rate
Explanation: Percentage ratio of the number of such infections to the number of newborn infant dispositions (including deaths) during the year.
Rate to be computed: Infection rate for each clinical service
Explanation: Percentage ratio of hospital infections occurring on a service to the total number of dispositions (including deaths) from that service during the year.

Cesarean section rate

Rate to be computed: Cesarean section rate
Explanation: Percentage ratio of cesarean sections to the total number of deliveries during the year.

11-4. Presentation of statistics

Clinical statistics make it possible to evaluate the operation of the hospital and the quality of patient care. Analysis must be meaningful for the local situation to be accurately described.

a. Instead of considering periods separately, present and analyze trends.

b. When feasible, the presentation of statistics should be graphic as well as tabular and narrative. In addition, the format of reports must be clear.

c. In presentations, any pertinent data published in current periodic literature, which often provide information benchmarks, may be used. In addition, comparisons with other MTFs may be of interest; hospital commanders should informally exchange clinical statistics. No hospital commander will send to higher headquarters or otherwise release any data furnished informally by another hospital commander. Similarly, comparison with objective factors for evaluating professional care, as set forth in literature on hospital administration, may also be of interest. However, these factors are based on minimum acceptable standards, not on the high standards applicable to Army hospitals.

Appendix A
References

Section I
Required Publications

DOD directives, regulations, instructions, and manuals can be obtained from the Naval Publications and Forms Center, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120-5099 using DD Form 1425 (Specifications and Standards Requisition). Unless otherwise noted, all other publications are available through normal publications supply channels.

AR 25–55
The Department of the Army Freedom of Information Act Program. (Cited in paras 1–5 and 2–3.)

AR 25–400–2
The Modern Army Recordkeeping System (MARKS). (Cited in paras 2–3, 2–5, 4–4, 5–20, 5–26, 6–1, 6–4, 6–6, 6–7, 7–5, 7–6, 7–8, 8–1, 8–2, 8–5, 8–8, 8–10, 8–20, and 9–4 and table 2–1.)

AR 27–20
Claims. (Cited in para 10–4.)

AR 40–2
Army Medical Treatment Facilities: General Administration. (Cited in para 8–10 and figs 5–1, 5–2, 5–3, 6–1, 6–2, 6–3, and 8–1.)

AR 40–3
Medical, Dental, and Veterinary Care. (Cited in paras 3–5, 3–18, and 5–19 and figs 5–1, 5–2, and 8–1.)

AR 40–5
Preventive Medicine. (Cited in para 5–19 and figs 5–1, 5–2, 6–1, and 6–2.)

AR 40–14
Control and Recording Procedures for Exposure to Ionizing Radiation and Radioactive Materials. (Cited in para 5–19 and fig 5–1.)

AR 40–15
Medical Warning Tag and Emergency Medical Identification Symbol. (Cited in paras 5–24 and 6–7 and figs 5–2, 6–1, and 6–2.)

AR 40–16
Special Notification—Injury Cases. (Cited in figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

AR 40–31
Armed Forces Institute of Pathology and Armed Forces Histopathology Centers. (Cited in para 8–8.)

AR 40–38
Clinical Investigation Program. (Cited in para 6–2 and figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

AR 40–40
Documentation Accompanying Patients Aboard Military Common Carriers. (Cited in figs 5–1, 5–2, and 8–1.)

AR 40–63
Ophthalmic Services. (Cited in figs 5–1, 5–2, and 6–2.)

AR 40–68
Quality Assurance Administration. (Cited in paras 2–1, 10–1, and 10–3.)

AR 40–400
Patient Administration. (Cited in paras 3–12, 4–4, 8–2, and 8–4 and figs 5–1, 5–2, 6–1, and 8–1.)

AR 40–407
Nursing Records and Reports. (Cited in para 8–10 and figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

AR 40–501
Standards of Medical Fitness. (Cited in para 5–19 and figs 5–1, 5–2, 6–2, and 8–1.)

AR 40–562
Immunizations and Chemoprophylaxis. (Cited in paras 5–17 and 6–7.)

AR 50–5
Nuclear and Chemical Weapons and Materiel—Nuclear Surety. (Cited in paras 5–19, 5–21, and 5–28 and figs 5–1, 5–2, 6–1, 6–2, 7–1, and 8–1.)

AR 50–6
Nuclear and Chemical Weapons and Materiel—Chemical Surety. (Cited in paras 5–19, 5–21, and 5–28 and figs 5–1, 5–2, 6–1, 6–2, 7–1, and 8–1.)

AR 340–21
The Army Privacy Program. (Cited in paras 2–3, 3–4, 4–4, 5–21, and 10–4.)

AR 380–5
Department of the Army Information Security Program. (Cited in para 2–4.)

AR 600–8–1
Army Casualty and Memorial Affairs and Line of Duty Investigations. (Cited in para 8–2 and figs 5–1 and 5–2.)

AR 600–85
Alcohol and Drug Abuse Prevention and Control Program. (Cited in paras 2–7, 5–19, 5–24, 7–2, 7–3, 7–6, and 7–9 and figs 5–1, 5–2, 5–3, 6–1, 6–2, and 7–1.)

AR 635–40
Physical Evaluation for Retention, Retirement or Separation. (Cited in paras 3–17 and 5–2 and figs 5–1 and 5–2.)

NGR 40–501
Standards of Medical Fitness. (Cited in fig 5–1.)

NGR 600–200
Enlisted Personnel Management. (Cited in para 5–27.)

NGR 640–100
Officers and Warrant Officers Military Personnel Records Jacket. (Cited in para 5–27.)

Individual Patient Data System User's Manual. (Cited in paras 3–18 and 8–15.)

TB MED 230
Treatment and Management of Venereal Disease. (Cited in para 5–19.)

TB MED 250
Recording Dental Examinations, Diagnoses, and Treatments; and Appointment Control. (Cited in paras 1–3, 3–8, 5–18, and 5–25, fig 5–3, and app B.)

TB MED 509
Spirometry in Occupational Health Surveillance. (Cited in figs 5–1, 5–2, and 6–2.)

ICD–9–CM
International Classification of Diseases (ICD)—Ninth Revision—Clinical Modification. (Cited in para 8–17.)

ICD–9–CM
Triservice Disease and Procedure, ICD–9–CM. (Cited in paras 3–12, 3–15, and 8–17.)

Section II
Related Publications

A related publication is merely a source of additional information. The user does not have to read it to understand this publication.

American Hospital Association Guidelines—Recording Chaplains' Notes in Medical Records

AR 20–1
Inspector General Activities and Procedures

AR 600–75
Exceptional Family Member Program

AR 600–105
Aviation Service of Rated Army Officers

AR 635–100
Officer Personnel

AR 635–200
Enlisted Personnel

AR 640–10
Individual Military Personnel Records

FPM Supp 293–31
Basic Personnel Records and Files System

Physicians Handbook on Medical Certification: Death, Fetal Death, and Birth

QSTAG 470
Documentation Relative to Medical Evacuation, Treatment, and Cause of Death Patients

STANAG 2132
Documentation Relative to Medical Evacuation, Treatment, and Cause of Death Patients

STANAG 2348
Basic Military Hospital (Clinic) Records

TM 39–25–1
Department of Defense Nuclear Weapons Technical Inspection System

29 CFR 1910.2
Occupational Safety and Health Standards

29 CFR 1913.10d
Rules of Agency Practice and Procedure Concerning OSHA Access to Employee Medical Records

10 USC 915
Manual for Courts Martial, "Malingering," United States 1984

10 USC 1093
Restriction on Use of Funds for Abortions

Section III
Prescribed Forms

DA Form 3443
Terminal Digit—X-Ray Film Preserver. (Prescribed in para 4–3.)

DA Form 3443X
Terminal Digit—X-Ray Film Negative Preserver (Loan). (Prescribed in para 4–3.)

DA Form 3443Y
Terminal Digit—X-Ray Film Negative Preserver (Insert). (Prescribed in para 4–3.)

DA Form 3443Z
Terminal Digit—X-Ray Film Negative Preserver (Report Insert). (Prescribed in para 4–3.)

DA Form 3444
Terminal Digit File for Treatment Record (Orange). (Prescribed in para 4–3 and table 4–2.)

DA Form 3444–1
Terminal Digit File for Treatment Record (Light Green). (Prescribed in para 4–3 and table 4–2.)

DA Form 3444–2
Terminal Digit File for Treatment Record (Yellow). (Prescribed in para 4–3 and table 4–2.)

DA Form 3444–3
Terminal Digit File for Treatment Record (Gray). (Prescribed in para 4–3 and table 4–2.)

DA Form 3444–4
Terminal Digit File for Treatment Record (Tan). (Prescribed in para 4–3 and table 4–2.)

DA Form 3444–5
Terminal Digit File for Treatment Record (Light Blue). (Prescribed in para 4–3 and table 4–2.)

DA Form 3444–6
Terminal Digit File for Treatment Record (White). (Prescribed in para 4–3 and table 4–2.)

DA Form 3444–7
Terminal Digit File for Treatment Record (Brown). (Prescribed in para 4–3 and table 4–2.)

DA Form 3444–8
Terminal Digit File for Treatment Record (Pink). (Prescribed in para 4–3 and table 4–2.)

DA Form 3444–9
Terminal Digit File for Treatment Records (Red). (Prescribed in para 4–3 and table 4–2.)

DA Form 3824
Urologic Examination. (Prescribed in figs 5–2, 6–2, and 8–1.)

DA Form 4006
Field Medical Record Jacket. (Prescribed in para 9–5.)

DA Form 4221
Diabetic Record. (Prescribed in fig 8–1.)

DA Form 4254–R
Request for Private Medical Information. (Prescribed in para 2–3 and figs 5–2 and 6–2.)

DA Form 4256
Doctors Orders. (Prescribed in para 8–19 and fig 8–1.)

DA Form 4700
Medical Record—Supplemental Medical Data. (Prescribed in chap 3 and figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

DA Form 4876–R
Request and Release of Medical Information to Communications Media. (Prescribed in para 2–3 and figs 5–2, 6–2, and 8–1.)

DA Form 5006–R
Medical Record—Authorization for Disclosure of Information. (Prescribed in para 2–3 and figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

DA Form 5007–A–R
Medical Record—Allergy Immunotherapy Record—Single Extract. (Prescribed in para 5–5 and figs 5–1, 5–2, 6–1, and 6–2.)

DA Form 5007–B–R
Medical Record—Allergy Immunotherapy Record—Double Extract. (Prescribed in para 5–5 and figs 5–1, 5–2, 6–1, and 6–2.)

DA Form 5008
Telephone Medical Advice/Consultation Record. (Prescribed in para 5–6 and figs 5–1, 6–1, and 6–2.)

DA Form 5009–R
Medical Record—Release Against Medical Advice. (Prescribed in para 8–21 and fig 8–1.)

DA Form 5128
Clinical Record—Visual Field Examination. (Prescribed in fig 8–1.)

DA Form 5181–R
Screening Note of Acute Medical Care. (Prescribed in para 5–7 and figs 5–1, 5–2, and 6–2.)

DA Form 5568–R
Chronological Record of Well-Baby Care. (Prescribed in para 6–2 and figs 6–1 and 6–2.)

DA Form 5569–R
Isoniazid (INH) Clinic Flow Sheet. (Prescribed in para 5–8 and figs 5–1, 5–2, 6–1, and 6–2.)

DA Form 5570
Health Questionnaire for Dental Treatment. (Prescribed in para 5–9 and figs 5–3 and 6–3.)

DA Form 5571
Master Problem List. (Prescribed in para 5–10 and figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

DA Form 5694
Denver Developmental Screening Test. (Prescribed in para 6–2 and figs 6–1, 6–2, and 8–1.)

DA Form 7095
ADAPCP Outpatient Discharge Summary. (Prescribed in para 7–9 and fig 7–1.)

DA Form 7096
ADAPCP Outpatient Aftercare Plan. (Prescribed in para 7–9 and fig 7–1.)

DA Form 7097
ADAPCP Outpatient Problem List and Treatment Plan Review. (Prescribed in para 7–9 and fig 7–1.)

DA Form 7098
ADAPCP Outpatient Treatment Plan and Review. (Prescribed in para 7–9 and fig 7–1.)

DA Form 7099
ADAPCP Outpatient Biopsychosocial Evaluation. (Prescribed in para 7–9 and fig 7–1.)

DA Form 8000
ADAPCP Triage Instrument (for Unscheduled Patients). (Prescribed in para 7–9 and fig 7–1.)

DA Form 8001
Limits of Confidentiality. (Prescribed in para 7–9 and fig 7–1.)

DA Form 8002
ADAPCP Outpatient Administrative Summary. (Prescribed in para 7–9 and fig 7–1.)

DA Form 8003
Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) Enrollment. (Prescribed in para 7–9 and fig 7–1.)

DA Form 8004–R
Alcohol and Drug Abuse Prevention and Alcohol Program (ADAPCP) Outpatient Medical Records—Privacy Act Information. (Prescribed in para 7–9 and fig 7–1.)

DA Form 8005
Alphabetical and Terminal Digit File for Treatment Record (Orange). (Prescribed in para 4–3.)

DA Form 8005–1
Alphabetical and Terminal Digit File for Treatment Record (Light Green). (Prescribed in para 4–3.)

DA Form 8005–2
Alphabetical and Terminal Digit File for Treatment Record (Yellow). (Prescribed in para 4–3.)

DA Form 8005–3
Alphabetical and Terminal Digit File for Treatment Record (Gray). (Prescribed in para 4–3.)

DA Form 8005–4
Alphabetical and Terminal Digit File for Treatment Record (Tan). (Prescribed in para 4–3.)

DA Form 8005–5
Alphabetical and Terminal Digit File for Treatment Record (Light Blue). (Prescribed in para 4–3.)

DA Form 8005–6
Alphabetical and Terminal Digit File for Treatment Record (White). (Prescribed in para 4–3.)

DA Form 8005–7
Alphabetical and Terminal Digit File for Treatment Record (Brown). (Prescribed in para 4–3.)

DA Form 8005–8
Alphabetical and Terminal Digit File for Treatment Record (Pink). (Prescribed in para 4–3.)

DA Form 8005–9
Alphabetical and Terminal Digit File for Treatment Record (Red). (Prescribed in para 4–3.)

DA Form 8006
Pediatric Dentistry Diagnostic Form. (Prescribed in para 6–7 and fig 6–3.)

DA Form 8007
Individual Medical History (IMH). (Prescribed in para 5–30.)

DD Form 741
Eye Consultation. (Prescribed in figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

DD Form 1380
U.S. Field Medical Card. (Prescribed in chap 9 and fig 8–1.)

DD Form 2138
Request for Transfer of Outpatient Records. (Prescribed in para 6–4.)

DD Form 2215
Reference Audiogram. (Prescribed in figs 5–1, 5–2, 6–1, and 6–2.)

DD Form 2482
Venom Extract Prescription. (Prescribed in para 5–12 and figs 5–1, 5–2, and 6–2.)

OF 275
Medical Record Report. (Prescribed in para 3–3 and figs 5–2 and 6–2.)

SF 502
Clinical Record—Narrative Summary. (Prescribed in para 8–10 and figs 5–2, 6–2, and 8–1.)

SF 503
Clinical Record—Autopsy Protocol. (Prescribed in para 8–10 and fig 8–1.)

SF 504
Clinical Record—History—Part I. (Prescribed in para 8–10 and fig 8–1.)

SF 505
Clinical Record—History—Parts II and III. (Prescribed in para 8–10 and fig 8–1.)

SF 506
Clinical Record—Physical Examination. (Prescribed in para 8–10 and fig 8–1.)

SF 507
Clinical Record—Report on or Continuation of SF. (Prescribed in para 8–10 and fig 8–1.)

SF 509
Medical Record—Doctor's Progress Notes. (Prescribed in para 8–10 and figs 5–1, 5–2, 6–2, and 8–1.)

SF 511
Medical Record—Vital Signs Record. (Prescribed in fig 8–1.)

SF 512
Clinical Record—Plotting Chart. (Prescribed in para 5–13 and figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

SF 513
Medical Record—Consultation Sheet. (Prescribed in para 8–10 and figs 5–1, 5–2, 5–3, 6–1, 6–2, 6–3, 7–1, and 8–1.)

SF 515
Medical Record—Tissue Examination. (Prescribed in figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

SF 516
Medical Record—Operation Report. (Prescribed in para 8–10 and figs 5–2, 6–2, and 8–1.)

SF 517
Clinical Record—Anesthesia. (Prescribed in para 8–10 and figs 5–2, 6–2, and 8–1.)

SF 518
Medical Record—Blood or Blood Component Transfusion. (Prescribed in figs 5–2, 6–2, 8–1, and 8–3.)

SF 519–B
Radiologic Consultation Request/Report. (Prescribed in para 8–20 and figs 5–1, 5–2, 5–3, 6–1, 6–2, 6–3, 7–1, and 8–1.)

SF 520
Clinical Record—Electrocardiographic Record. (Prescribed in figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

SF 522
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures. (Prescribed in para 3–3 and figs 5–1, 5–2, 5–3, 6–1, 6–2, 6–3, and 8–1.)

SF 523
Clinical Record—Authorization for Autopsy. (Prescribed in fig 8–1.)

SF 523A
Medical Record—Disposition of Body. (Prescribed in fig 8–1.)

SF 523B
Medical Record—Authorization for Tissue Donation. (Prescribed in fig 8–1.)

SF 524
Medical Record—Radiation Therapy. (Prescribed in figs 5–2, 6–2, and 8–1.)

SF 525
Medical Record—Radiation Therapy Summary. (Prescribed in figs 5–2, 6–2, and 8–1.)

SF 526
Medical Record—Interstitial/Intercavitary Therapy. (Prescribed in figs 5–2, 6–2, and 8–1.)

SF 527
Group Muscle Strength, Joint R.O.M. Girth and Length Measurements. (Prescribed in figs 5–2, 6–2, and 8–1.)

SF 528
Clinical Record—Muscle and/or Nerve Evaluation—Manual and Electrical: Upper Extremity. (Prescribed in figs 5–2, 6–2, and 8–1.)

SF 529
Medical Record—Muscle Function by Nerve Distribution: Trunk and Lower Extremity. (Prescribed in figs 5–2, 6–2, and 8–1.)

SF 530
Clinical Record—Neurological Examination. (Prescribed in fig 8–1.)

SF 531
Medical Record—Anatomical Figure. (Prescribed in figs 5–2, 6–2, and 8–1.)

SF 533
Medical Record—Prenatal and Pregnancy. (Prescribed in figs 5–2, 6–2, and 8–1.)

SF 534
Medical Record—Labor. (Prescribed in fig 8–1.)

SF 535
Clinical Record—Newborn. (Prescribed in figs 6–1, 6–2, and 8–1.)

SF 536
Clinical Record—Pediatric Nursing Notes. (Prescribed in fig 8–1.)

SF 537
Medical Record—Pediatric Graphic Chart. (Prescribed in fig 8–1.)

SF 538
Clinical Record—Pediatric. (Prescribed in fig 8–1.)

SF 539
Medical Record—Abbreviated Medical Record. (Prescribed in para 8–17 and figs 5–2, 6–2, and 8–1.)

SF 541
Medical Record—Gynecologic Cytology. (Prescribed in figs 5–2, 6–2, and 8–1.)

SF 545
Laboratory Report Display. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–1, 6–2, 7–1, 8–1, and 8–3.)

SF 546
Chemistry I. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, and 8–3.)

SF 547
Chemistry II. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, and 8–3.)

SF 548
Chemistry III (Urine). (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, 8–2, and 8–3.)

SF 549
Hematology. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, and 8–3.)

SF 550
Urinalysis. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, and 8–3.)

SF 551
Serology. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, and 8–3.

SF 552
Parasitology. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, and 8–3.)

SF 553
Microbiology I. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, 8–2, and 8–3.)

SF 554
Microbiology II. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, 8–2, and 8–3.)

SF 555
Spinal Fluid. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, and 8–3.)

SF 556
Immunohematology. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, 8–2, and 8–3.)

SF 557
Miscellaneous. (Prescribed in para 8–18 and figs 5–1, 5–2, 6–2, 7–1, 8–1, and 8–3.)

SF 558
Emergency Care and Treatment. (Prescribed in para 5–14 and figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

SF 559
Medical Record—Allergen Extract Prescription, New and Refill. (Prescribed in para 5–15 and figs 6–1 and 6–2.)

SF 560
Medical Record—Electroencephalogram Request and History. (Prescribed in figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

SF 600
Health Record—Chronological Record of Medical Care. (Prescribed in para 5–16 and figs 5–1, 5–2, 6–1, 6–2, and 7–1.)

SF 601
Health Record—Immunization Record. (Prescribed in paras 5–17 and 6–7 and figs 5–1, 5–2, 6–1, and 6–2.)

SF 603
Health Record—Dental. (Prescribed in paras 5–18 and 6–7 and figs 5–3 and 6–3.)

SF 603A
Health Record—Dental Continuation. (Prescribed in paras 5–18 and 6–7 and figs 5–3 and 6–3.)

Section IV
Referenced Forms

AF Form 565
Record of Inpatient Treatment

CDC Form 9.2936A
Venereal Disease Epidemiologic Report

DA Form 2
Personnel Qualification Record—Part I (For Army Reserve Use Only)

DA Form 2–1
Personnel Qualification Record—Part II

DA Form 199
Physical Evaluation Board (PEB) Proceedings

DA Form 2173
Statement of Medical Examination and Duty Status

DA Form 2631–R
Medical Care—Third Party Liability Notification

DA Form 2984
Very Seriously Ill/Seriously Ill/Special Category Patient Report

DA Form 2985
Admission and Coding Information

DA Form 3180–R
Personnel Screening and Evaluation Record

DA Form 3349
Physical Profile

DA Form 3365
Authorization for Medical Warning Tag

DA Form 3647
Inpatient Treatment Record Cover Sheet

DA Form 3647–1
Inpatient Treatment Record Cover Sheet (For Plate Imprinting)

DA Form 3705
Receipt for Outpatient Treatment/Dental Records

DA Form 3763
Community Health Nursing—Case Referral

DA Form 3888
Nursing Assessment and Care Plan

DA Form 3888–2
Medical Record—Nursing Care Plan

DA Form 3888–3
Medical Record—Nursing Discharge Summary

DA Form 3894
Hospital Report of Death

DA Form 3947
Medical Evaluation Board Proceedings

DA Form 3950
Flowsheet for Vital Signs and Other Parameters

DA Form 3984
Dental Treatment Plan

DA Form 4186
Medical Recommendation for Flying Duty

DA Form 4359–R
Authorization for Psychiatric Service Treatment

DA Form 4465
Client Intake Record

DA Form 4466
Client Progress Report

DA Form 4497–R
Interim Medical Examination—Flying Personnel

DA Form 4515
Personnel Reliability Program Record Identifier

DA Form 4677
Therapeutic Documentation Care Plan (Non-Medications)

DA Form 4678
Therapeutic Documentation Care Plan (Medication)

DA Form 4970
Medical Screening Summary—Over-40 Physical Fitness Program

DA Form 4970–E
Medical Screening Summary—Cardiovascular Risk Screening Program

DA Form 5018–R
ADAPCP Client's Consent Statement for Release of Treatment Information

DA Form 5179
Medical Record—Preoperative/Postoperative Nursing Document

DA Form 5179–1
Medical Record—Intraoperative Document

DA Form 5288
Exceptional Family Member Program Needs Booklet

DA Form 5291–R
Army Exceptional Family Member Program Educational Questionnaire

DA Form 5303–R
Volunteer Agreement Affidavit

DA Form 5551–R
Spirometry Flow Sheet

DA Form 5862–R
Army Exceptional Family Member Program Functional Medical Summary

DA Label 162
Emergency Medical Identification Symbol

DD Form 2A(ACT)
Active Duty Military ID Card

DD Form 2A(RES)
Armed Forces of the United States Identification Card (Reserve)

DD Form 2(RET)
United States Uniformed Services Identification Card (Retired)

DD Form 214
Certificate of Release or Discharge from Active Duty

DD Form 602
Patient Evacuation Tag

DD Form 771
Eyewear Prescription

DD Form 877
Request for Medical/Dental Records or Information

DD Form 1141
Record of Occupational Exposure to Ionizing Radiation

DD Form 1173
Uniformed Services Identification and Privilege Card

DD Form 1425
Specifications and Standards Requisition

DD Form 2005
Privacy Act Statement—Health Care Records

DD Form 2161
Referral for Civilian Medical Care

DD Form 2216
Hearing Conservation Data

DD Form 2493–1
Asbestos Exposure Part I—Initial Medical Questionnaire

DD Form 2493–2
Asbestos Exposure Part II—Periodic Medical Questionnaire

FAA Form 8500–8
Medical Certificate—Class and Student Pilot Certificate (Photocopy)

NAVMED 6300–5
Admission/Disposition Record, Inpatient

OF 23
Charge-Out Record

PHS Form 731
International Certificates of Vaccination

SF 88
Report of Medical Examination

SF 93
Report of Medical History

SF 510
Clinical Record—Nursing Notes

SF 544
Clinical Record—Statement of Patient's Treatment

SF 602
Health Record—Syphilis Record

Appendix B
Authorized Medical Records Abbreviations and Symbols

B–1. Medical abbreviations

A list of medical abbreviations authorized to be used in medical records is shown below. (For abbreviations used in dental records, see TB MED 250.)

AA
Alcoholics Anonymous

ab
abortion

ABE
acute bacterial endocarditis

ABG
arterial blood gases

abnl
abnormal

A/B ratio
acid/base ratio

ac
before meals

ACTH
adrenocorticotropic hormone

ACVD
acute cardiovascular disease

AD
right ear

A&D
admission and discharge

ADAPCP
Alcohol and Drug Abuse Prevention and Control Program

ADCO
alcohol and drug control officer

ADH
antidiuretic hormone (vasopressin)

ADL
activities of daily living

ad lib
as desired

adm
admission; admit; admitted

A/E
air evacuation

AFB
acid-fast bacilli

afeb
afebrile; without fever

AFib/AFlut
atrial fibrillation/atrial flutter

AFIP
Armed Forces Institute of Pathology

AGA
appropriate for gestational age

A/G ratio
albumin/globin ratio

AHD
atherosclerotic heart disease

AIDS
acquired immune deficiency syndrome

AK
above knee

AKA
above-the-knee amputation

ALL
acute lymphoblastic or lymphocytic leukemia

ALS
amyotrophic lateral sclerosis

AMA
against medical advice

amb
ambulatory

AMI
acute myocardial infarction

AMIC
Acute Minor Illness Clinic

AML
acute myelocytic/myeloblastic leukemia

AMNIO
amniocentesis

Amox
amoxicillin

amt
amount

anesth; anes
anesthesia

ant
anterior

ante
before

AP
anterior-posterior

A&P
anscultation and percussion

AP&Lat
anteroposterior and lateral

approx
approximate

ASA
acetylsalicylic acid (aspirin)

ASA Grades I–IV
American Society of Anesthesiology surgical risk classification

ASAP
as soon as possible

ASD
atrial septal defect

ASHD
arteriosclerotic heart disease

assoc
associate; associated; association

AU
both ears

Audio
audiology

Ausc
auscultation

AV, A–V
arteriovenous; atrioventricular

av
average

BAC
blood alcohol concentration

bact
bacterium (-ia) (-ial) (-iology)

B. asthma
bronchial asthma

BAT
blood alcohol test

BBB
bundle branch block

BCG
Bacillus Calmette-Guerin (vaccine)

BCP
birth control pills

BE
barium enema

bicarb
bicarbonate

bid
twice a day

bil or bilat
bilateral

bili
bilirubin

BKA
below-knee amputation

bl
blood

bl; bld
blood; bleeding

BM
bowel movement

BMR
basal metabolic rate

BP
blood pressure

BPH
benign prostatic hypertrophy

BR
bed rest

BSO
bilateral salpingo-oophorectomy

BSR
blood sedimentation rate

BTL
bilateral tubal ligation

BUN
blood urea nitrogen

bw
birth weight

Bx
biopsy

C
celsius or centigrade

C1 to C7
cervical nerves or vertebrae 1 to 7

c
with

Ca
calcium; cancer; carcinoma

CABG
coronary artery bypass graft

CAD
coronary artery disease

card
cardiac; cardiology

CAT
computerized axial tomography

cath
catheter

cau
caucasian

CBC
complete blood count

CG
chief or current complaint

cc
cubic centimeter

CCU
coronary care unit

CDC
Centers for Disease Control

cerv
cervical

CF
cystic fibrosis

ChE
cholinesterase

CHF
congestive heart failure

Chol
cholesterol

chr
chronic

circ
circulation; circumcision; circumferences

Cl
chlorine

cm
centimeter

CNS
central nervous system

CO_2
carbon dioxide

Co
cobalt

c/o
complains of

conv
convalescent; convalescence

COPD
chronic obstructive pulmonary disease

CPD
cephalopelvic disproportion

CPK
creatine phosphokinase

CPR
cardiopulmonary resuscitation

CRF
chronic renal failure

CRNA
certified registered nurse anesthetist

C/S
cesarean section

C&S
culture and sensitivity

C-section
cesarean section

CT
computerized tomography

ct
count

cu ft
cubic foot

cu in
cubic inch

cu m
cubic meter

cu mm
cubic millimeter

CVA
cerebrovascular accident

CVD
cardiovascular disease

CVP
central venous pressure

cx
cervix

CXR
chest x-ray

cysto
cystogram; cystoscope; cyctoscopy

dB
decibel

dbl
double

D/C
discharge or discontinue

D&C
dilatation and curettage or curettement

DDS
Doctor of Dental Surgery

D&E
dilatation and evacuation

def
deficiency

Dept
department

Derm
dermatology

DES
diethylstilbestrol

dev
deviation

dil
dilute; diluted

dis
disease

disp
disposition

DJD
degenerative joint disease

DM
diabetes mellitus

DNR
do not resuscitate

DO
Doctor of Osteopathy

DOA
dead on arrival

DOB
date of birth

DOE
dyspnea on exertion

DPT
diphteria toxoid, pertussis vaccine, tetanus toxoid

DSM-III-R
Diagnostic and Statistical Manual III–Revised

dtd
dated

DTR
deep tendon reflexes

DTs
delirium tremens

DTT
diphtheria tetanus toxoid

DUB
dysfunctional uterine bleeding

DUI
driving under the influence

DVT
deep vein thrombosis

DWI
driving while intoxicated

Dx
diagnosis

EBL
estimated blood loss

EBV
Epstein-Barr virus

ECG; EKG
electrocardiogram

E. coli
Escherichia coli

ECT
electroconvulsive therapy

EDC
estimated date of confinement

EEG
electroencephalogram

EGA
estimated gestational age

EGD
esophagogastroduodenoscopy

EKG; ECG
electrocardiogram

ELISA
enzyme-linked immunosuppressant assay

EMG
electromyogram

EMS
emergency medical service

E-mycin
erythromycin

Endo
endocrinology

ENT
ear, nose, and throat

EOM
extraocular movement

eos
eosinophil

epis
episiotomy

epith
epithelium or epithelial

eq; equiv
equivalent

ER
emergency room

esp
especially

ESR
erythrocyte sedimentation rate

ESRD
end-stage renal disease

EST
electroshock therapy

est
estimated

ESWL
extracorporeal shock wave lithotripsy

ET
endotracheal tube

etc.
et cetera

etiol
etiology

ETOH
ethyl alcohol

eval
evaluate; evaluation

exam
examine

exp
expired

expir
expiration; expiratory

ext
external

F
Fahrenheit

FACMT
Family Advocacy Case Management Team

FB
foreign body

FBS
fasting blood sugar

FDA
Food and Drug Administration

Fe
iron

FFP
fresh frozen plasma

FHR
fetal heart rate

FHT
fetal heart tone

F Hx
family history

fib
fibrillation

Fl; fl
fluid

FP
family practice

freq
frequent; frequency

FS
frozen section

FSH
follicle-stimulating hormone

FT
full term

ft
foot; feet

F/U
followup

FUO
fever of unknown or undetermined origin

Fx
fracture

g
gram(s)

garg
gargle

GB
gallbladder

GC
gonococcus; gonococcal

Gen
general

Gest
gestation

GI
gastrointestinal

glu
glucose

gm
gram

GOT
glutamic-oxalacetic transaminase

GP
general practitioner

gr
grain

gr; grav
pregnant

Grav I, Grav II
one pregnancy, two pregnancies, and so on

GS
general surgery

GSW
gunshot wound

gt; gtt
drop; drops

GTT
glucose tolerance test

GU
genitourinary

GYN; Gyn
gynecology

H
hydrogen

H_2O
water

HA or H/A
headache

HAA
hepatitis-associated antigen

Hb; hgb
hemoglobin

HBP
high blood pressure

HBV
hepatitis B virus

HC
head circumference

HCl
hydrochloric acid

Hct
hematocrit

hd
at bedtime

HDL
high-density lipoprotein

HEENT
head, eyes, ears, nose, and throat

HEM
hematology

Hgb; Hb
hemoglobin

HIV
human immunodeficiency virus

HMO
Health Maintenance Organization

HNP
herniated nucleus pulposus

H/O
history of

Hosp
hospitalization

H&P
history and physical

HPI
history of present illness

hr
hour

HR
heart rate

hs
at bedtime

ht
height

HTLV
human T-cell leukemia/lymphoma virus

HTN
hypertension

Hx
history

hypo
hypodermic

I^{131}
radioactive iodine

IAW
in accordance with

ICU
intensive care unit

I&D
incision and drainage

ID
identification

IIDM
insulin-independent diabetes mellitus

IM
intramuscular (injection)

in
inch

incis.
incision

Ind
individual

inf
inferior

Inf Dis
infectious disease

info
information

Ing
inguinal

INH
insonicotinic acid hydrazide; isoniazid; isonicotinoylhydrazide

inj
injury; injured

int
internal

I&O
intake and output

IOP
intraocular pressure

IPPB
intermittent positive pressure breathing

IQ
intelligence quotient

IU
international unit

IUCD; IUD
intrauterine contraceptive device

IUP
interuterine pregnancy

IV
intravenous (injection)

IVP
intravenous pyelogram

jct
junction

jej
jejunum

jt
joint

K
potassium

kg
kilogram

KJ
knee jerk

kL
kiloliter

km
kilometer

KUB
kidney, ureter, and bladder

L
liter

lab
laboratory

lac
laceration

lap
laparotomy

laser; LASER
light amplification by stimulated emission of radiation

lat
lateral

lb
pound

L/B
live birth

LBBB
left bundle branch block

LBP
low back pain

LBW
low birth weight

L&D
labor and delivery

LDL
low-density lipoprotein

LE
lupus erythematosus

lig
ligament

LLE
left lower extremity

LLL
left lower lobe (of lung)

LLQ
left lower quadrant

LMP
left mentoposterior (position of fetus); last menstrual period

LOC
loss of consciousness

LOD
line of duty

LOM
limitation of motion

LOS
length of stay

LP
lumbar puncture

LPN
licensed practical nurse

LQ
lower quadrant

L–S
lumbosacral

LSH
lutein-stimulating hormone

lt
left

LUL
left upper lobe (of lung)

LUQ
left upper quadrant

LV
left ventricular

LVN
licensed vocational nurse

lymphs
lymphocytes

m
meter

max
maximum

mc; mCi
millicurie

mcg
microgram

MCHC
mean corpuscular hemoglobin concentration or count

MEB
medical evaluation board

med
medicine or medication

mEq
milliequivalent

MG
myasthenia gravis

mg
milligram

MI
myocardial infarction

MIA
missing in action

MICU
medical intensive care unit

min
minute

mL
milliliter

mm
millimeter

MMPI
Minnesota Multiphasic Personality Inventory

mod
moderate

Mono
mononucleosis

monos
monocytes

mos
months

MS
multiple sclerosis

msec
millisecond

NA
nursing assistant

Na +
sodium

N/A
not applicable

NAD
no acute distress

NaPent
sodium pentothal

NB
newborn

N/C
no complaint

NCHS
National Center for Health Statistics

neg
negative

Neph
nephrology

Neuro
neurological, neurology

NICU
Neonatal Intensive Care Unit

NIDDM
non-insulin-dependent diabetes mellitus

NKA
no known allergies

NKDA
no known drug allergies

nl; norm
normal limits

NLT
not later than

NPH insulin
neutral protamine Hagedorn insulin

npo
nothing by mouth

NS
nervous system

nsg
nursing

NTG
nitroglycerin

nurs
nursery

O_2
oxygen; both eyes

OB
obstetrics

OB–GYN
obstetrics and gynecology

obj
objective

OBS
organic brain syndrome

OD
overdose; right eye

OS
left eye

Onc
oncology

OOB
out of bed

op
operation

OPC
outpatient clinic

OPD
outpatient department

ophth
ophthalmology

OPV
oral poliomyelitis vaccine

OR
operating room

Ortho
orthopedics

os, per os
mouth; by mouth

OT
occupational therapy

OTC
over the counter (drugs)

OU
each eye

oz
ounce

PA
physician's assistant

P&A
percussion and auscultation

PAC
premature atrial contractions

Pap test
Papanicolaou's test

path
pathology

pc
after meals

PDR
Physician's Desk Reference

PE
physical examination

PEB
Physical Evaluation Board

Ped
pediatrics

PERRLA
pupils equal, round, and react to light and accommodation

PE tubes
pressure-equalizing tubes

PH
past history

phar; pharm
pharmacy; pharmaceutical; pharmacopeia

PI
present illness

PID
pelvic inflammatory disease

Pit
Pitocin

pkg
package

PKU
phenolketonuria

PMH
past medical history

PO
postoperative

po
by mouth; orally

POD
postoperative day

Pod
podiatry

pos
positive

postop
postoperative

POW
prisoner of war

PP
post partum

PPB
positive pressure breathing

preg
pregnancy

Pre med
premedication

pre-op
preoperative

prep
preparation; prepare (for surgery)

prn
according as circumstances may require

prog
prognosis

Psych
psychiatry

PT
physical therapy

pt
patient

PTCA
percutaneous transluminal coronary angioplasty

PUD
peptic ulcer disease

PULHES
physical profile factors: P—physical capacity or stamina; U—upper extremities; L—lower extremities; H—hearing and ears; E—eyes; S—psychiatric

pulm
pulmonary

PVC
premature ventricular contractions

q
every

qd
every day

qh
every hour

q2h, q3h, and so on
every 2 hours, every 3 hours, and so on

qid
four times a day

qn
every night

r
roentgen

RA
rheumatoid arthritis

Ra
radium

RBC
red blood cells or corpuscles

R.D.
registered dietician

RDS
respiratory distress syndrome

Rec Rm
recovery room

reg
regular

rehab
rehabilitation

req
requirement

resp
respiratory

Rh factor
Rhesus blood factor

RLL
right lower lobe (of lung)

RLQ
right lower quadrant

RML
right middle lobe (of lung)

RN
registered nurse

R/O
rule out

ROM
range of motion

ROS
review of systems

RR
recovery room

rt
right

RTC
return to clinic

RUL
right upper lobe (of lung)

RUQ
right upper quadrant

Rx
prescription; treatment; take

S
left

S–A; SA node
sino-atrial node

SB
stillborn

SBE
subacute bacterial endocarditis

SC
subcutaneous

sec
second; secondary

sed
sedentary

Sed rate
erythrocyte sedimentation rate

SGA
small for gestational age

SGOT
serum glutamin-oxaloacetic transaminase

SGPT
serum glutamic-pyruvic transaminase

SI
seriously ill

SICU
surgical intensive care unit

SIDS
sudden infant death syndrome

signif
significant

sm
small

SOAP
progress note format
S—subject
O—objective
A—assessment
P—plans

SOB
shortness of breath

S/P
status post

SQ
subcutaneous

staph
staphylococcus

STAT
immediately and once only

STD
sexually transmitted disease

strep
streptococcus

STS
serologic test for syphilis

Surg
surgery

Svc
Service

SWS
Social Work Service

sx
signs; symptoms

sys
system

T
temperature

T&A
tonsillectomy and adenoidectomy

tab
tablet

TAH
total abdominal hysterectomy

TB
tuberculosis

tbs; tbsp
tablespoon

temp
temperature

TIA
transient ischemic attacks

tid
three times a day

TMJ
temporomandibular joint

tng
training

TPR
temperature, pulse, and respiration

trf
transfer

TSH
thyroid-stimulating hormone

tsp
teaspoon

TURP
transurethral resection, prostate

TVH
total vaginal hysterectomy

UA
urinalysis

UGI
upper gastrointestinal

unk
unknown

UQ
upper quadrant

URI
upper respiratory infection

urol
urology; urological

URQ
upper right quadrant

US
ultrasound

USPHS
U.S. Public Health Service

UTI
urinary tract infection

VA
Veterans Administration

vag
vaginal

VD
venereal disease

VDRL
venereal disease research laboratory test

vit
vitamin

VS
vital sign

vs
against

VSI
very seriously ill

WBC
white blood cell

wd
ward

WD/WN/BF
well-developed, well-nourished, black female

WD/WN/BM
well-developed, well-nourished, black male

WD/WN/WF
well-developed, well-nourished, white female

WD/WN/WM
well-developed, well-nourished, white male

WIA
wounded in action

WISC
Weschler Intelligence Scale for children (test)

wk
week

WNL
within normal limits

wt
weight

W/U
workup

X
times

y/o
year old

yr
year

B–2. Medical symbols
Medical symbols authorized to be used in medical records are shown in figure B–1.

female

♀

male

♂

increased; elevated

↑

decreased; depressed; lowered

↓

descended bilaterally

↓↓

causes; transfer to

→

is due to

←

less than

<

more than

>

systolic blood pressure

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

$1^{\bullet}$

changes

Δ

secondary; second degree

$2^{\bullet}$

amounts; dosages

i ii iii iv v vi

Angstrom unit

Å

of each

āā

before

ā

with

c̄

murmur

ⓜ

after; following

p̄

without

s̄

one-half

s̄s̄

dram; drachm

ʒ

ounce

℥

fluid dram; fluid ounce

fʒ; f℥

Figure B–1. Medical symbols

Glossary

Section I
Abbreviations

ADAPCP
alcohol and drug abuse prevention and control program

ADAPCP–OMR
alcohol and drug abuse prevention and control program outpatient medical record

AMEDD
Army Medical Department

AMOSIST
Automated Military Outpatient System

AQCESS
Automated Quality of Care Evaluation Support System

ARNG
Army National Guard

AWOL
absent without leave

CCC
Community Counseling Center

CEMR
civilian employee medical record

CHCS
Composite Health-Care System

CJA
claims judge advocate

CRO
carded-for-record-only

DA
Department of the Army

DEERS
Defense Enrollment Eligibility Reporting System

DENTAC
dental activity

DOD
Department of Defense

DRG
diagnosis related group

DTF
dental treatment facility

EPTS
existed prior to service

FMP
family member prefix

HQDA
Headquarters, Department of the Army

HREC
health record (both the outpatient treatment and dental records)

IMH
Individual Medical History

IPDS
Individual Patient Data System

ITR
inpatient treatment record

LOD
line of duty

MCJA
medical claims judge advocate

MDRTS
Medical and Dental Record Tracking System

MEDCEN
U.S. Army Medical Center

MEDDAC
medical department activity

MILPO
military personnel offices

MPRJ
Military Personnel Records Jacket, U.S. Army

MTF
medical treatment facility

NATO
North Atlantic Treaty Organization

NPRC
National Personnel Records Center

OP
overprint

OSHA
Occupational Safety and Health Act

OTJAG
Office of The Judge Advocate General

OTR
outpatient treatment record

OTSG
Office of The Surgeon General

PASBA
Patient Administration Systems and Biostatistics Activity

PCS
permanent change of station

PRIMUS
primary care for the uniformed services

QSTAG
quadripartite standardization agreement

RC
Reserve Components

RTF
residential treatment facility

SSN
social security number

STANAG
standardization agreement

USAR
U.S. Army Reserve

USARCS
U.S. Army Claims Service

USARPERCEN
U.S. Army Reserve Personnel Center

VA
Department of Veterans Affairs

WIA
wounded in action

Section II
Terms

Alcohol and drug abuse prevention and control program outpatient medical record (ADAPCP–OMR)
The outpatient medical record used for both military and nonmilitary persons enrolled in an alcohol and drug abuse prevention and control program.

Civilian employee medical record (CEMR)
The medical record used for the documentation of occupational and nonoccupational health information for civilian employees.

Confidentiality
Guarding the privacy of medical information. Information gained through the examination or treatment of a patient is private and confidential. Medical confidentiality is not, however, a security classification of confidential.

Field medical card
A medical record used by aid stations, clearing stations, and nonfixed troop or health clinics operating overseas, on maneuvers, or attached to commands moving between stations.

Fixed medical treatment facility (MTF)
A medical treatment facility designed to operate for an extended period of time at a specific site.

Health record (HREC)
The OTR and the dental record of a military member. The term refers to both parts.

Inpatient treatment record (ITR)
The record used at an MTF that has authorized beds for inpatient medical or dental care. It is begun on admission to the MTF and completed at the end of hospitalization. This record applies to all beneficiaries.

Medical information
All information that pertains to evaluations, findings, diagnosis, or treatment of a patient. The terms also includes any other information given to AMEDD health personnel in the course of treatment or evaluation. Medical information is confidential and private. Paramedical documents, such as immunization registers and dosimetry records, are not considered medical information even though they are kept in the same file with medical records.

Medical record
Any military or civilian document that gives information on the evaluation, findings, diagnosis, and treatment of a patient. Included as medical records are the OTRs, HRECs, dental records, ITRs, CEMRs, ADAPCP–OMRs, and x rays. Paramedical documents, such as immunization registers and dosimetry records, are not considered medical records although they are kept in the same file with other medical records.

Nonfixed medical treatment facility (MTF)
An MTF designed to be moved from place to place, including MTFs afloat.

Outpatient treatment record (OTR)
The OTR and the dental record of the beneficiary for whom an HREC is not kept.

Private information
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 as a matter of public policy is protected. Information disclosed by patients to AMEDD health personnel is not privileged.

Special category record
A record that is individually identified (para 4–4a(10)) and specially handled to reduce the risk of harming or embarrassing the patient and ensuring its medicolegal integrity.

Section III
Special Abbreviations and Terms

This section contains no entries.

Index

This index is organized alphabetically by topic and subtopic within a topic. Topics and subtopics are identified by paragraph number.

Abbreviations and terms, 1–3
Abbreviations used on DD Form 1380 (U.S. Field Medical Card), 9–2
Authorized medical records abbreviations and symbols, App. B
Local abbreviations and symbols, 3–8

Abortion, disclosure of information regarding, 2–5

Abortion, recording therapeutics, 3–16

Absent-sick status, 3–18

Absent-without-leave patients, inpatient treatment record, 8–5

Access to inpatient treatment records, 8–7

Accidental injury to patient, 11–1

Active Army personnel, absent-sick status, 3–18

Adjudication, review of medical records involved in, 10–3

Age of majority, medical confidentiality and, 2–5

Alcohol abuse. *See* **Drug and alcohol abuse**

Alcohol and Drug Abuse Prevention and Control Program medical record (ADAPCP–OMR)
Access, 7–2
Audit trail, 7–10
DA Form 3444-series folders used for, 4–3, 7–4
Description of, 1–1
Disclosure of information, 7–3
Disposition, 7–8
File folders for, 7–4
Forms and documents, 7–4
Initiating and maintaining, 7–5
Persons for whom prepared, 7–1
Preparation, 7–9
Requests other than DD Form 2138, 7–7
Terminal digit filing system for, 4–2
Transfer of, 7–6
Use, 7–10

Alcohol-related psychiatric diagnoses, 3–11

AMEDD officers, responsibilities, 1–4

AMEDD personnel
Access to health records, 5–21
Transfer of health records, 5–24

Amendment of medical records, 3–4

American Hospital Association Guidelines, documentation by chaplains according to, 1–4

Anesthesia monitoring records, filing of, 3–2

Anesthetic complication, 11–1

Anesthetic death, 11–1

Annual analysis of hospital services, 11–3

Annual Statistics. *See* **Monthly and Annual Statistics**

Appointment card, patient's recording card as, 3–5

Army Reserve National Guard (ARNG) personnel, absent-sick status, 3–18

Audit trail
Alcohol and drug abuse prevention and control program medical records, 7–10
Inpatient treatment records (ITR), 8–7

Authorized forms, 3–1

Bacteriological agent as cause of injury or disease, recording procedures, 3–12

Birth control, disclosure of information regarding, 2–5

Brain syndrome, 3–11

Carded-for-record-only (CRO) cases, 3–17

CDC 9.2936A (Venereal Disease Epidemiologic Report), 5–23

Central Panographic Storage Facility, duplicate panograph on file with, 1–4

Certificate of Death, 3–13

Chaplains, responsibilities, 1–4

Chemical agent as cause of injury or disease, recording procedures, 3–12

Chief, patient administration division, responsibilities, 1–4

Child abuse, 3–10

Civilian Consultation Service Case Files, 2–5
Outpatient treatment record (OTR), 6–7

Civilian employee medical record (CEMR)
Confidentiality of medical information, 2–8
DA Form 3444-series folders used for, 4–3
Description of, 1–1
Terminal digit filing system for, 4–2

Civilian personnel, disposition of DD Form 1380 (U.S. Field Medical Card), 9–4

Civilian source pediatric growth chart, 6–2

Classified defense information, medical records containing, 2–4

Clinical statistics, 11–4

Clinic identification plate, 3–5

Combat, recording of injuries or wounds incurred in, 3–12

Commanding Genral, USAR Personnel Center (USARPERCEN), responsibilities for health records (HREC), 1–4

Common respiratory disease—hospital infection, 11–1

Community health nurse files, release of information from, 2–3

Confidentiality of medical information
Civilian employee medical records (CEMR), 2–8
Classified defense information, 2–4
Disclosure procedures, 2–3
Drug and alcohol abuse records, 2–7
Generally, 2–1
Protection of, 2–2
Research using medical records, 2–6
Teenage family member medical records, 2–5

Content of medical record entries, 3–4

Correction of medical record entries, 3–4

Cross-servicing of health records, 5–22

DA Form 2 (Personnel Qualification Record—Part I), 5–23

DA Form 2–1 (Personnel Qualification Record—Part II), 5–23

DA Form 8–115 (Register of Dental Patients), 5–4, 6–2

DA Form 199 (Physical Evaluation Board (PEB) Proceedings), 5–4, 5–19

DA Form 2173 (Statement of Medical Examination and Duty Status), 5–4

DA Form 2631–R (Medical Care—Third Party Liability Notification), 5–4, 6–2, 8–2

DA Form 2984 (Very Seriously Ill/ Seriously Ill/Special Category Patient Report), 8–2

DA Form 2985 (Admission and Coding Information), 3–18, 8–2

DA Form 3180–R (Personnel Screening and Evaluation Record), 5–4, 5–19, 6–2, 7–4

DA Form 3349 (Physical Profile), 5–4, 5–19, 8–2

DA Form 3365 (Authorization for Medical Warning Tag), 5–4, 6–2

DA Form 3443-series folders, 4–3
Preparation of, 4–5

DA Form 3443X (Terminal Digit—X-Ray Film Negative Preserver (Loan)), 4–3

DA Form 3443Y (Terminal Digit—X-Ray Film Negative Preserver (Insert)), 4–3

DA Form 3443Z (Terminal Digit—X-Ray Film Negative Preserver (Report Insert)), 4–3

DA Form 3444 (Terminal Digit File for Treatment Record (Orange)), 4–3

DA Form 3444–1 (Terminal Digit File for Treatment Record (Light Green)), 4–3

DA Form 3444–2 (Terminal Digit File for Treatment Record (Yellow)), 4–3

DA Form 3444–3 (Terminal Digit File for Treatment Record (Gray)), 4–3

DA Form 3444-4 (Terminal Digit File for Treatment Record (Tan)), 4-3

DA Form 3444-5 (Terminal Digit File for Treatment Record (Light Blue)), 4-3

DA Form 3444-6 (Terminal Digit File for Treatment Record (White)), 4-3

DA Form 3444-7 (Terminal Digit File for Treatment Record (Brown)), 4-3

DA Form 3444-8 (Terminal Digit File for Treatment Record (Pink)), 4-3

DA Form 3444-9 (Terminal Digit File for Treatment Record (Red)), 4-3

DA Form 3444-series folders, 4-3, 5-23, 7-4, 8-2
Outpatient treatment record (OTR), 6-2
Preparation of, 4-4

DA Form 3647 (Inpatient Treatment Record Cover Sheet), 3-12, 3-13, 3-18, 5-19, 8-10
Corrections, 8-16
Generally, 8-12
Health record form, 5-4
Initiation and disposition, 8-14
Inpatient Treatment Record form, 8-2
Outpatient Treatment Record form, 6-2
Preparation, 8-15
Use, 8-13

DA Form 3647-1 (Inpatient Treatment Record Cover Sheet (For Plate Imprinting)), 8-2

DA Form 3763 (Community Health Nursing—Case Referral), 5-4, 6-2

DA Form 3824 (Urologic Examination), 5-4, 6-2, 8-2

DA Form 3888 (Nursing Assessment and Care Plan), 8-2

DA Form 3888-2 (Medical Record—Nursing Care Plan), 8-2

DA Form 3888-3 (Medical Record—Nursing Discharge Summary), 8-2

DA Form 3894 (Hospital Report of Death), 3-13, 8-2

DA Form 3947 (Medical Evaluation Proceedings), 5-4, 5-19, 8-2

DA Form 3950 (Flowsheet for Vital Signs and Other Parameters), 8-2

DA Form 3984 (Dental Treatment Plan), 5-4, 6-2

DA Form 4006 (Field Medical Record Jacket), 9-5

DA Form 4060 (Record of Optometric Examination), 5-4, 6-2

DA Form 4186 (Medical Recommendation for Flying Duty), 5-4, 5-19, 6-2

DA Form 4221 (Diabetic Record), 8-2

DA Form 4254-R (Request for Private Medical Information), 2-3, 6-2

DA Form 4256 (Doctors Orders), 8-2, 8-10, 8-19

DA Form 4359-R (Authorization for Psychiatric Service Treatment), 8-2

DA Form 4410 (Disclosure Accounting Record), 5-4, 6-2, 8-2

DA Form 4465 (Client Intake Record), 5-19, 7-9
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7-4
Health record form, 5-4
Outpatient Treatment Record form, 6-2

DA Form 4466 (Patient Progress Report), 7-4, 7-9

DA Form 4497-R (Interim Medical Examination—Flying Personnel), 5-4

DA Form 4515 (Personnel Reliability Program Record Identifier), 5-4, 6-2, 7-4, 8-2

DA Form 4530 (Electroencephalogram Request and History), 5-4, 6-2, 8-2

DA Form 4677 (Therapeutic Documentation Care Plan (Non-Medications)), 8-2

DA Form 4678 (Therapeutic Documentation Care Plan (Medication)), 8-2

DA Form 4700 (Medical Record—Supplemental Medical Data), 5-4, 6-2, 8-2
Mounting of undersigned reports on, 3-2

DA Form 4876-R (Request and Release of Medical Information to Communications Media), 2-3, 6-2, 8-2

DA Form 4970 (Medical Screening Summary—Over-40 Physical Fitness Program), 5-4, 6-2

DA Form 4970-E (Medical Screening Program—Cardiovascular Risk Screening Program), 5-4, 6-2

DA Form 5006-R (Medical Record—Authorization for Disclosure of Information), 2-3, 5-4, 6-2, 8-2

DA Form 5007-A-R (Medical Record—Allergy Immunotherapy Record—Single Extract), 5-4, 5-5, 6-2

DA Form 5007-B-R (Medical Record—Allergy Immunotherapy Record—Double Extract), 5-4, 5-5, 6-2

DA Form 5008 (Telephone Medical Advice/Consultation Record), 5-4, 5-6, 6-2

DA Form 5009-R (Medical Record—Release Against Medical Advice), 8-2, 8-21

DA Form 5128 (Clinical Record—Visual Field Examination), 8-2

DA Form 5179 (Medical Record—Preoperative/Postoperative Nursing Document), 8-2

DA Form 5179-1 (Medical Record—Intraoperative Document), 8-2

DA Form 5181-R (Screening Note of Acute Medical Care), 5-4, 5-7, 6-2

DA Form 5288 (Army Exceptional Family Member Program Summary Report), 6-2

DA Form 5291-R (Army Exceptional Family Member Program Educational Questionnaire), 6-2

DA Form 5303-R (Volunteer Agreement Affidavit), 5-4, 6-2, 8-2

DA Form 5551-R (Spirometry Flow Sheet), 5-4, 6-2

DA Form 5568-R (Chronological Record of Well-Baby Care), 6-2

DA Form 5569-R (Isoniazid (INH) Clinic Flow Sheet), 5-4, 5-8, 6-2

DA Form 5570 (Health Questionnaire for Dental Treatment), 5-4, 5-9, 6-2

DA Form 5571 (Master Problem List), 5-10, 5-24
Health record form, 5-4
Outpatient Treatment Record form, 6-2, 8-2

DA Form 5694 (Denver Developmental Screening Test), 6-2, 8-2

DA Form 5862-R (Army Exceptional Family Member Program Functional Medical Summary), 6-2

DA Form 7095 (ADAPCP Outpatient Discharge Summary), 7-4, 7-9

DA Form 7096 (ADAPCP Outpatient Aftercare Plan), 7-4, 7-9

DA Form 7097 (ADAPCP Outpatient Problem List and Treatment Plan Review), 7-4, 7-9

DA Form 7098 (ADAPCP Outpatient Treatment Plan and Review), 7-4, 7-9

DA Form 7099 (ADAPCP Outpatient Biopsychosocial Evaluation), 7-4, 7-9

DA Form 8000 (ADAPCP Triage Instrument (For Unscheduled Patients)), 7-4, 7-9

DA Form 8001 (Limits of Confidentiality), 7-4, 7-9

DA Form 8002 (ADAPCP Outpatient Administrative Summary), 7-4, 7-9

DA Form 8003 (ADAPCP Enrollment), 7-4, 7-9

DA Form 8004-R (ADAPCP-OMR-Privacy Act Information), 7-4, 7-9

DA Form 8005 (Alphabetical and Terminal Digit File for Treatment Record (Orange)), 4-3

DA Form 8005–1 (Alphabetical and Terminal Digit File for Treatment Record (Light Green)), 4–3

DA Form 8005–2 (Alphabetical and Terminal Digit File for Treatment Record (Yellow)), 4–3

DA Form 8005–3 (Alphabetical and Terminal Digit File for Treatment Record (Grey)), 4–3

DA Form 8005–4 (Alphabetical and Terminal Digit File for Treatment Record (Tan)), 4–3

DA Form 8005–5 (Alphabetical and Terminal Digit File for Treatment Record (Light Blue)), 4–3

DA Form 8005–6 (Alphabetical and Terminal Digit File for Treatment Record (White)), 4–3

DA Form 8005–7 (Alphabetical and Terminal Digit File for Treatment Record (Brown)), 4–3

DA Form 8005–8 (Alphabetical and Terminal Digit File for Treatment Record (Pink)), 4–3

DA Form 8005–9 (Alphabetical and Terminal Digit File for Treatment Record (Red)), 4–3

DA Form 8005-series folders, 4–3, 5–23
Preparation of, 4–4

DA Form 8006 (Pediatric Dentistry Diagnostic Form), 6–2

DA Form 8007 (Individual Medical History (IMH)), 5–24
Deployed soldiers, 5–30

Dating of medical record entries, 3–4

DD Form 602 (Patient Evacuation Tag), 8–2

DD Form 741 (Eye Consultation), 5–4, 6–2, 8–2

DD Form 742 (Clinical Record—Visual Field Examination), 8–2

DD Form 749 (Clinical Record—Head Injury), 8–2

DD Form 771 (Eyewear Prescription), 5–4, 5–19, 6–2

DD Form 877 (Request for Medical/Dental Records or Information), 4–7

DD Form 1141 (Record of Occupational Exposure to Ionizing Radiation), 5–4, 5–19, 6–2

DD Form 1380 (U.S. Field Medical Card), 5–11, 5–31, 8–2
DD Form 4006 as field jacket for, 9–5
Disposition, 9–4
Preparation, 9–2
Supplemental, 9–3
Use, 9–1

DD Form 2005 (Privacy Act Statement—Health Care Records), 4–4, 5–4, 6–2, 8–2

DD Form 2161 (Referral for Civilian Medical Care), 5–4, 6–2, 7–4, 8–2

DD Form 2215 (Reference Audiogram), 5–4, 6–2

DD Form 2216 (Hearing Conservation Data), 5–4, 6–2

DD Form 2482 (Venom Extract Prescription), 5–4, 5–12, 6–2

DD Form 2493–1 (Asbestos Exposure Part I—Initial Medical Questionnaire), 5–4, 5–19, 6–2

DD Form 2493–2 (Asbestos Exposure Part II—Periodic Medical Questionnaire), 5–4, 5–19, 6–2

Deaths, recording, 3–13
Carded-for-record-only (CRO) cases, 3–17

Dental activity (DENTAC) commander, approval of research projects, 2–6

Dental diagnosis and procedures, recording, 3–8

Dental officers, responsibilities, 1–4

Dental records, DA Form 3444-series folders used for, 4–2

Dental treatment facility (DTF)
Record request by, 4–7
Responsibilities, 1–4

Department of the Army (DA)
Confidentiality of medical information, 2–2
Requests for medical information, 2–3

Department of the Army (DA) agencies, responsibilities of persons within, 1–4

Deployed soldiers, health records of, 5–30

Destruction of unidentifiable medical documents, 3–7

Diagnoses and procedures, recording of
Alcoholism, 3–10
Child abuse, 3–10
Deaths, 3–13
Diagnostic nomenclature, 3–8
Diagnostic procedures, 3–15
Food poisoning/infection, 3–9
Infective and parasitic diseases, 3–9
Injuries, 3–12
Malaria, 3–9
Malingerer, 3–10
Neoplasms, 3–9
Nondependent abuse of alcohol, 3–10
Nondependent abuse of drugs, 3–10
Observation without need for further medical care, 3–14
Occupational diseases, 3–9
Psychiatric conditions, 3–11
Reactions to prophylactic procedures, 3–10
Separation, cause, 3–14
Skin immunity and sensitization tests, 3–10
Surgical procedures, 3–15
Therapeutic abortions, 3–16
Therapeutic procedures, 3–15
Undiagnosed (undetermined diagnosis), 3–14

Diagnostic nomenclature, 3–8

Diagnostic procedures, recording, 3–15

Disclosure procedures for medical information, 2–3

Disposal of health records, 5–27

Disposition
Alcohol and drug abuse prevention and control program medical records, 7–8
DD Form 1380 (U.S. Field Medical Card), 9–4
Inpatient treatment records (ITR), 8–8
Outpatient treatment records, 6–6

Documentation review of medical records, 10–3

Drug and alcohol abuse
Disclosure of information regarding, 2–5, 2–7
Nondependent use, 3–10

Drug- and alcohol-related psychiatric diagnoses, 3–11

Electrocardiograms, filing of, 3–2

Entries, medical records
Destruction of unidentifiable medical documents, 3–7
Facility identification, 3–6
Generally, 3–4
Patient identification, 3–5

FAA Form 8500–8 (Medical Certificate—Class and Student Pilot Certificate), 5–4

Facility identification, 3–6

Facsimile, 2–3

Family member prefix (FMP), filing medical records by, 4–1

Fetal monitoring strips, 8–2

Field files, use of, 5–32

Filing health records, 5–26

Filing medical records
Folders, DA Form 3443-series, DA Form 3444-series, and DA Form 8005-series, 4–3
Preparation of DA Form 3443-series folders, 4–5
Preparation of DA Form 3444-series folders, 4–4
Preparation of DA Form 8005-series folders, 4–4
Record chargeout system, 4–6
Record requests, 4–7
Social security number (SSN) and family member prefix (FMP), 4–1
Terminal digit filing system, 4–2

Food poisoning/infection, 3–9

Foreign nationals within overseas area, disposition of DD Form 1380 (U.S. Field Medical Card), 9–4

Forms and documents
Authorized, 3–1
Automated and/or computerized forms, 3–2
Guidelines for local forms and overprints, 3–3

Graves registration personnel, access to health records, 5–21

Health care providers, responsibilities, 1–4

Health record (HREC)
Access to, 5–21
Cross-servicing of, 5–22
Custody of, 5–23
DA Form 8005-series folders used for, 4–3
Deployed soldier, 5–30
Description of, 1–1
Disposal of, 5–27
Filing, 5–26
Forms and documents of, 5–4
Initiating, 5–23
Maintenance in isolated units, 1–4
New, 5–25
Patient's recording card, 3–5
Persons for whom prepared and maintained, 5–3
Purpose of, 5–1
Responsibility regarding, 1–4
Review of, 10–3
"Temporary," 5–25
Terminal digit filing system for, 4–2
Transfer of, 5–24
Use of, 5–2

Hospital complication, 11–1

Hospital death, 11–1

Hospital fetal death, 11–1

Hospital infection, 11–1

Hospital live birth, 11–1

Hospital services
Annual analysis of, 11–3
Monthly analysis of, 11–2

Individual Mobilization Augmentee (IMA), health record (HREC) for, 5–30

Individual Patient Data System (IPDS) User's Manual, 3–18

Individual Ready Reserve (IRR), health record (HREC) for, 5–30

Infective and parasitic disease, 3–9
Hospital infection, 11–1

Initiation
Alcohol and drug abuse prevention and control program medical records, 7–5
Health records, 5–23
Inpatient treatment record (ITR), 8–3
Outpatient treatment records, 6–3

Injuries, recording of, 3–12

Inpatient care, use of health record (HREC), 5–2

Inpatient identification plate, 3–5

Inpatient treatment record (ITR)
Absent-without-leave patients, 8–5
Access, 8–7
Audit trail, 8–7
DA Form 3444-series folders used for, 4–3
DA Form 3444-series folder used for, 8–2
Description of, 1–1
Disposition of, 8–8
Five-year maintenance, 8–6
Forms and documents, 8–2
Initiation, 8–3
Mechanical imprinting on identification label of folder, 4–4
Nominal card index for, 8–7
North Atlantic Treaty Organization Standardization Agreement 2348 requirements, 8–4
Patient transfer, 8–8
Persons for whom prepared, 8–1
Preparation and use, 8–9—8–11
Quality Assurance Program, 10–1
Register number index for, 8–7
Review of, 10–3
Terminal digit filing system for, 4–2
Timely preparation of, 1–4

Inspector, access to health records, 5–21

Internal Quality Assurance Program for medical record services, 10–2

International standardization agreements, 1–6

Ionizing radiation as cause of injury or disease, recording procedures, 3–12

Laboratory forms, 8–18

Laboratory test results, filing of, 3–2

Legibility of medical record entries, 3–4

Litigation, review of medical records involved in, 10–3

Living wills, 8–2

Local forms and overprints, guidelines for, 3–3

Maintenance of inpatient treatment records, 8–6

Malaria, 3–9

Malingerer, 3–10

Maternal death, 11–1

Medical officers, responsibilities, 1–4

Medical record, purpose of, 1–1

Medical record entries. *See* **Entries, medical records**

Medical record services, Internal Quality Assurance Program, 10–2

Medical treatment facility (MTF)
Army medical records custody of, 1–5
Local abbreviations and symbols, 3–8
Record request by, 4–7

Medical treatment facility (MTF) commanders
Approval of research projects, 2–6
Responsibilities, 1–4

Military consultation service case files, 5–20, 6–2

Military personnel, disposition of DD Form 1380 (U.S. Field Medical Card), 9–4

Military personnel officers, responsibilities, 1–4

Military stress, diagnosis of, 3–11

Minor, disclosure of medical records of, 2–5

Mobilization
Field files, 5–32
Maintenance of health records upon, 5–30
Operation after hostilities cease, 5–33
Preparation of health record forms, 5–31

Monthly analysis of hospital services, 11–2

Monthly and Annual Statistics
Annual analysis of hospital services, 11–3
Monthly analysis of hospital services, 11–2
Presentation of statistics, 11–4
Terms, 11–1

Morbidity terms, use of, 11–1

Mortality terms, use of, 11–1

Natality terms, 11–1

Neonatal death, 11–1
Recording of, 3–13

Neoplastic diseases, 3–9

Newborn complication, 11–1

Newborn infection, 11–1

New health record, 5–25

Nondependent substance abuse, 3–10

Nonmedical personnel, access to health records, 5–21

North Atlantic Treaty Organization Standardization Agreement 2348 requirements, 8–4

Nuclear medicine files
DA Form 8005-series and 3444-series folders used for, 4–3
Folders conspicuously stamped to avoid confusion with other files, 4–3

Observation without need for further medical care, recording of, 3–14

Obstetrical infection, 11–1

Obstetric complication, 11–1

Occupational diseases, 3–9

Occupational injury and illness, recording of, 3–12

OF 23, 5–19

OF 275 (Medical Record Report), 5–4, 6–2, 8–10

Operative death, 11–1

Outpatient care, use of health record (HREC), 5–2

Outpatient treatment record (OTR)
DA Form 3444-series folders used for, 6–2
DA Form 8005-series folders used for, 4–3
Description of, 1–1
Disposition, 6–6
Forms and documents, 6–2
Identification label of folder, 4–4
Initiating and keeping, 6–3
Mailing, 6–4
Nominal card index for, 4–4
Patient's recording card, 3–5
Persons for whom prepared, 6–1
Preparation of, 6–7
Requests other than DD Form 2138, 6–5
Review of, 10–3
Terminal digit filing system for, 4–2
Transfer of, 6–4
Use, 6–8

Overprints
Guidelines for, 3–3
Use of rubber stamps, 3–4

Patient, request for information from medical record, 2–3

Patient bed card, 3–5

Patient care assessment, 10–3

Patient's recording card, 3–5

Personnel reentering service, health record (HREC) for, 5–23

Personnel Reliability Program records
Maintenance of, 5–29
Screening, 5–28

PHS Form 731 (International Certificates of Vaccination), 5–17, 6–7

Postoperative complication, 11–1

Postoperative infection, 11–1

Pregnancy, preparation of Outpatient treatment record (OTR), 6–7

Preparation
Alcohol and drug abuse prevention and control program medical records, 7–9
Outpatient treatment records, 6–7

Preprinted instructions to patient, inclusion in local forms and overprints, 3–3

Prisoners of war, disposition of DD Form 1380 (U.S. Field Medical Card), 9–4

Prophylactic procedures, reactions to, 3–10

Psychiatric combat casualties, 3–11

Psychiatric conditions, recording of, 3–11

Public, release of medical information to, 2–3

Publications, App A

Purpose of regulation, 1–1

Quality Assurance Program
Generally, 10–1
Internal Quality Assurance Program for medical record services, 10–2
Patient care assessment, 10–3

Radiology images and reports, DA Form 3443-series folders used for, 4–5

Reaction
Drugs, 11–1
Whole blood or components, 11–1

Record chargeout system, 4–6, 6–8

Record ownership, 1–5

Record requests, 4–7

Release of medical records, 10–3

Research personnel, responsibilities, 1–4

Research using medical records, confidentiality of medical information, 2–6

Reserve commanders (RC), responsibilities, 1–4

Responsibilities, 1–4

Rubber stamp entries, 3–4

Scans, filing of, 3–2

Separation, recording cause of, 3–14

Service member, access to health records, 5–21

SF 88 (Report of Medical Examination), 5–4, 5–19, 5–23, 6–2

SF 93 (Report of Medical History), 5–4, 5–19, 5–23, 6–2

SF 502 (Clinical Record—Narrative Summary), 5–19, 8–10
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 503 (Clinical Record—Autopsy Protocol), 8–2

SF 504 (Clinical Record—History—Part I), 8–2, 8–10

SF 505 (Clinical Record—History—Parts II and III), 8–2, 8–10

SF 506 (Clinical Record—Physical Examination), 8–2, 8–10

SF 507 (Clinical Record—Report on or Continuation of SF), 8–2, 8–10

SF 509 (Medical Record—Doctors Progress Report), 5–19, 8–9, 8–10
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 510 (Clinical Record—Nursing Notes), 8–2, 8–10

SF 511 (Medical Record—Vital Signs Record), 8–2

SF 512 (Clinical Record—Plotting Chart), 5–4, 5–13, 6–2, 8–2

SF 513 (Medical Record—Consultation Sheet), 5–2, 8–10
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 515 (Medical Record—Tissue Examination), 5–2, 5–4, 5–19, 6–2, 8–2

SF 516 (Medical Record—Operation Report), 5–19, 8–10
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 517 (Clinical Record—Anesthesia), 6–2, 8–2, 8–10
Filing of anesthesia monitoring with, 3–2

SF 518 (Medical Record—Blood or Blood Component Transfusion), 5–4, 6–2, 8–2

SF 519 (Medical Record—Radiological Report), 5–4, 6–2, 8–2, 8–20

SF 519A (Medical Record—Radiological Report), 5–4, 6–2, 8–2, 8–20

SF 519B (Radiologic Consultation Request/Report), 5–4, 6–2, 7–4, 8–2, 8–20

SF 520 (Clinical Record—Electrocardiographic Record), 5–4, 6–2, 8–2
Filing of electrocardiogram and cardiac monitoring with, 3–2

SF 521 (Clinical Record—Dental), 5–4, 6–2

SF 522 (Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures), 5–4, 6–2, 8–2
Abortion, 3–3
Sterilization, 3–3

SF 523 (Clinical Record—Authorization for Autopsy), 8–2

SF 523A (Medical Record—Disposition of Body), 8–2

SF 523B (Medical Record—Authorization for Tissue Donation), 8–2

SF 524 (Medical Record—Radiation Therapy), 5–4, 6–2, 8–2

SF 525 (Medical Record—Radiation Therapy Summary), 5–4, 6–2, 8–2

SF 526 (Medical Record—Interstitial/Intercavitary Therapy), 5–4, 6–2, 8–2

SF 527 (Group Muscle Strength), 5–4, 6–2, 8–2

SF 528 (Clinical Record—Muscle and/or Nerve Evaluation—Manual and Electrical: Upper Extremity), 5–4, 8–2

SF 529 (Medical Record—Muscle Function by Nerve Distribution—Manual and Electrical: Trunk and Lower Extremity), 5–4, 6–2, 8–2

SF 530 (Clinical Record—Neurological Examination), 8–2

SF 531 (Medical Record—Anatomical Figure), 5–4, 6–2, 8–2

SF 533 (Medical Record—Prenatal and Pregnancy), 5–4, 6–2, 6–7, 8–2

SF 534 (Medical Record—Labor), 8–2

SF 535 (Clinical Record—Newborn), 6–2, 8–2

SF 536 (Clinical Record—Pediatric Nursing Notes), 8–2

SF 537 (Medical Record—Pediatric Graphic Chart), 8–2

SF 538 (Clinical Record—Pediatric), 8–2

SF 539 (Medical Record—Abbreviated Medical Record), 5–4, 6–2, 8–2, 8–17

SF 541 (Medical Record—Gynecologic Cytology), 5–4, 6–2, 8–2

SF 544 (Clinical Record—Statement of Patient's Treatment), 2–3, 8–2

SF 545 (Laboratory Report Display), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Filing of laboratory results with, 3–2
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 546 (Chemistry I), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 547 (Chemistry II), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 548 (Chemistry III (Urine)), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 549 (Hematology), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 550 (Urinalysis), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 551 (Serology), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 552 (Parasitology), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 553 (Microbiology I), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 554 (Microbiology II), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 555 (Spinal Fluid), 5–4, 6–2, 8–2, 8–18

SF 556 (Immunohematology), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 557 (Miscellaneous), 8–18
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 558 (Medical Record—Emergency Care Treatment), 5–14, 8–10
Health record form, 5–4
Inpatient Treatment Record form, 8–2
Outpatient Treatment Record form, 6–2

SF 559 (Medical Record—Allergen Extract Prescription, New and Refill), 5–4, 5–15, 6–2

SF 560 (Medical Record—Electroencephalogram Request and History), 5–4, 6–2, 8–2

SF 600 (Health Record—Chronological Record of Medical Care), 2–4, 5–16, 5–20, 5–23, 6–7
Alcohol and Drug Abuse Prevention and Control Program Outpatient Medical Record form, 7–4
Combat conditions, 5–31
Health record form, 5–4
Outpatient Treatment Record form, 6–2

SF 601 (Health Record—Immunization Record), 5–17, 5–23, 6–7
Health record form, 5–4
Outpatient Treatment Record form, 6–2

SF 602 (Health Record—Syphilis Record, 5–4, 5–19, 6–2

SF 603 (Health Record—Dental), 5–18, 5–23, 6–7
Health record form, 5–4
Outpatient Treatment Record form, 6–2

SF 603A (Health Record—Dental Continuation), 5–18, 5–23, 6–7
Operational setting, 5–31

Signatures on medical record entries, 3–4

Single unit transfusion, 11–1

Skin immunity and sensitization tests, 3–10

Social security number (SSN), filing medical records by, 4–1

State adjutants general, responsibilities for health records (HREC), 1–4

State ambulance forms, 5–19

Stillborn infant, medical reports on, 8–2

Stress, diagnosis of, 3–11

Sudden death, recording, 3–13

Supplemental DD Form 1380 (U.S. Field Medical Card), 9–3

Surgical procedures, 11–1
Recording, 3–15

Teenage family members, confidentiality of medical record information, 2–5

"Temporary" health record, 5–25

Terminal digit filing system, 4–2

Therapeutic procedures, recording, 3–15

Transfer of alcohol and drug abuse prevention and control program medical records, 7–6

Transfer of health records, 5–24

Transfer of outpatient treatment records, 6–4

Triservice Disease and Procedure ICD–9–CM Coding Guidelines, 3–12

Unauthorized disclosure of medical information, 2–2

Undersized reports, mounting on DA Form 4700 (Medical Record—Supplemental Medical Data), 3–2

Undiagnosed (undetermined diagnosis), recording of, 3–14

Unidentifiable medical documents, destruction of, 3–7

Unit commanders, responsibilities, 1–4

U.S. Army Reserve (USAR), absent-sick status, 3–18

U.S. Army Reserve (USAR) unit commanders, responsibilities for health records (HREC), 1–4

U.S. Military Academy cadets
Absent-sick status, 3–18
Health record (HREC) for, 5–23

Venereal disease control, disclosure of information regarding, 2–5

Vital-sign-monitoring records, filing of, 3–2

Ward identification plate, 3–5

X rays, transfer of, 5–24

RESERVED

REQUEST FOR PRIVATE MEDICAL INFORMATION

For use of this form, see AR 40-66; the proponent agency is the OTSG

1. Date.

2. Patient's Name and SSN.

3. Medical Treatment Facility *(Name and Location)*

4. Reason for Request.

5. Private Medical Information Sought *(Specify dates of hospitalization or clinic visits and diagnosis, if known)*

6. Requestor's Name, Title, Organization and SSN.

FOR USE OF MEDICAL TREATMENT FACILITY ONLY

7. Check applicable box.

☐ Approved ☐ Disapproved *(State reason for disapproval)*

8. Summary of Private Medical Information Released.

9. Signature of Approving Official.

10. Date.

TAB TAB TAB TAB

REQUEST AND RELEASE OF MEDICAL INFORMATION TO COMMUNICATIONS MEDIA

For use of this form, see AR 40-66: the proponent agency is the Office of The Surgeon General.

THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974

1. AUTHORITY: Section 3012, title 10, United States Code.

2. PRINCIPAL PURPOSE(S): This form provides for patient/parent/guardian consent to release requested personal medical information to news publication or broadcast.

3. ROUTINE USES: The requested information will be released on this form to the communications media. It will be used for news publication or broadcast.

4. MANDATORY OR VOLUNTARY DISCLOSURE: The release of this information is voluntary. There is no effect on the individual not providing the requested information.

SECTION I – PATIENT IDENTIFICATION

NAME *(Last, First, Middle)* ADDRESS

AGE SSN STATUS NAME OF MEDICAL TREATMENT FACILITY

SECTION II – TO BE COMPLETED BY REQUESTOR

I certify that I represent _____
(Name and Address of Communications Media)
_____ and that medical information on the above identified patient is requested for news publication or broadcast.

List specific information requested below:

DATE SIGNATURE OF PUBLIC AFFAIRS OFFICER SIGNATURE OF MEDIA REPRESENTATIVE

SECTION III – TO BE COMPLETED BY PATIENT/PARENT/GUARDIAN

I, _____ ,hereby request and authorize the release of the requested information concerning my illness or injury and hospital treatment (complete when other than patient gives consent — the illness or injury and hospital treatment of_____) while a patient in this medical treatment facility, to the above mentioned communications media. I hereby agree to hold the hospital, its physicians, and its staff free and harmless from any, and all liabilities or ill effects which might arise from the publication or broadcast of such information.

DATE SIGNATURE OF WITNESS SIGNATURE OF PATIENT/PARENT/GUARDIAN

M TAB

SECTION IV – TO BE COMPLETED BY ATTENDING PHYSICIAN

Information as requested and authorized is hereby furnished:

DATE SIGNATURE OF ATTENDING PHYSICIAN

SECTION V – TO BE COMPLETED BY PATIENT ADMINISTRATION DIVISION

Sections I through IV have been reviewed and is ( ) approved ( ) disapproved for release.

DATE SIGNATURE OF CHIEF, PATIENT ADMINISTRATION DIVISION (or designated representative)

Upon completion of this form, a copy will be placed in the patient's medical record and a copy will be returned to the Public Affairs Officer for release of the requested information to the media representative.

MEDICAL RECORD	AUTHORIZATION FOR DISCLOSURE OF INFORMATION For use of this form, see AR 40-66; the proponent agency is Office of The Surgeon General

This form will not be used for authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. For authorization to disclose alcohol or drug abuse patient information, see 42 CFR 2 and AR 600-85.

(Pursuant to the Privacy Act of 1974, Public Law 93-579)

PHYSICIAN OR MEDICAL TREATMENT FACILITY AUTHORIZED TO RELEASE INFORMATION	It is understood that this authorization may be revoked at any time, if requested in writing, except to the extent that action will have already been taken.

PATIENT DATA

NAME *(Last, First, MI)*	DATE OF BIRTH	SOCIAL SECURITY/IDENTIFICATION NUMBER
PERIOD OF TREATMENT *(Month, Day, Year)*	TYPE OF TREATMENT ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

RESTRICTIONS ON INFORMATION *(Specify)*

USE OF MEDICAL INFORMATION

☐ FURTHER MEDICAL CARE ☐ INSURANCE CLAIM(S) ☐ ATTORNEY ☐ DISABILITY DETERMINATION
☐ OTHER *(Specify)*

INFORMATION DESTINATION

INDIVIDUAL OR ORGANIZATION TO WHOM INFORMATION SHOULD BE RELEASED *(Name and Address)*

(ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE)

RELEASE AUTHORIZATION

I hereby request and authorize the named physician/medical treatment facility to release the medical information described above to the named individual/organization indicated.	DATE
SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP TO PATIENT

IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE

MEDICAL RECORD	ALLERGY IMMUNOTHERAPY RECORD For use of this form, see AR 40-66; the proponent agency is the OTSG	SINGLE EXTRACT

START ALLERGY SHOT DATE

RE-EVALUATION DUE

PRESCRIPTION NUMBER

EXTRACT CONTENT

HISTORY OF SYSTEMIC SHOT REACTIONS? YES

ON BETA BLOCKERS? YES NO

DATE	TIME	VIAL #	STRENGTH (pnu/ml,wt/vol,AU/ml)	SCHEDULE A,B,C,D,E,F	DOSE (ml)	ARM	REACTIONS OR SPECIAL INSTRUCTIONS	TECH INITIALS

PATIENT'S IDENTIFICATION

(For typed or written entries give Name--last, first, middle, SSN;DOB;sex;treating facility)

NURSING PERSONNEL INITIALS			
NAME	INITIALS	NAME	INITIALS

DA FORM 5007A-R, NOV 91

REPLACES DA FORM 5007-R, OCT 81 WHICH IS OBSOLETE.

MEDICAL RECORD	ALLERGY IMMUNOTHERAPY RECORD For use of this form, see AR 40-66; the proponent agency is the OTSG	DOUBLE EXTRACT

RE-EVALUATION DUE

PRESCRIPTION NUMBER

EXTRACT CONTENT

HISTORY OF SYSTEMIC SHOT REACTIONS? YES

DATE	TIME	ARM/ DOSE	REACTIONS OR SPECIAL	TECH INITIALS

RE-EVALUATION DUE

PRESCRIPTION NUMBER

EXTRACT CONTENT

ON BETA BLOCKERS? YES NO

DATE	TIME	ARM/ DOSE	REACTIONS OR SPECIAL INSTRUCTIONS	TECH INITIALS

PATIENT'S IDENTIFICATION *(For typed or written entries give Name--last, first, middle, SSN;DOB;sex;treating facility)*

NURSING PERSONNEL INITIALS

NAME	INITIALS	NAME	INITIALS

MEDICAL RECORD	RELEASE AGAINST MEDICAL ADVICE For use of this form, see AR 40-66; proponent agency is the Office of The Surgeon General.

STATEMENT OF PATIENT RELEASING HOSPITAL FROM LIABILITY UPON LEAVING HOSPITAL AGAINST MEDICAL ADVICE

1. This is to CERTIFY that I am leaving _____ (Name of Med Treatment Facility) at my own insistence and against the advice of the hospital authorities and my attending physician(s).

2. I have been advised of the dangers involved in leaving the hospital at this time.

3. I hereby release the hospital, its staff and the Federal Government of all responsibility for any ill effects brought about by my failure to remain in the hospital.

_____ (Signature of Patient)

_____ (Signature of Witness)

_____ (Date and Time)

STATEMENT OF REPRESENTATIVE OF PATIENT RELEASING HOSPITAL FROM LIABILITY UPON LEAVING HOSPITAL AGAINST MEDICAL ADVICE

1. This is to CERTIFY that I _____ (Name), _____ (Relationship to Patient) of _____ (Name of Patient) insist that he/she be discharged from _____ (Name of Med Treatment Facility) without the authorization of the patient's attending physician(s).

2. I have been informed of the dangers to the patient in his/her leaving the hospital at this time, including the possibility that it may worsen or aggravate the patient's condition.

3. I hereby release the hospital, its staff and the Federal Government of all responsibility for any ill effects brought about by _____(Name of Patient) leaving the hospital against medical advice.

_____ (Signature of Representative)

_____ (Signature of Witness)

_____ (Date and Time)

PATIENT IDENTIFICATION	REGISTER NUMBER	WARD NUMBER

M TAB TAB TAB

SCREENING NOTE OF ACUTE MEDICAL CARE

For use of this form, see AR 40-66; the proponent agency is the TSG

TIME PATIENT DEPARTS UNIT *(From DD Form 689)*	SCREENER LOCATION		
	TIME PATIENT ARRIVES	TIME ENCOUNTER BEGINS	TIME PATIENT LEAVES
DATE	SCREENER LOCATION	CHIEF COMPLAINT	DURATION

PATIENT RESIDENCE
( ) BARRACKS ( ) POST HOUSING
( ) OFF POST ( ) TRANSIENT

VITAL SIGNS
TEMPERATURE _____ ALLERGIES _____
PULSE _____ BP _____ RESP _____

FIRST VISIT FOR THIS COMPLAINT ( ) YES ( ) NO. IF NO, WAS RETURN SCHEDULED/REQUESTED BY CARE PROVIDER?
( ) YES ( ) NO

ALGORITHM/CODE	ALGORITHM/CODE
ALGORITHM SUMMARY	ALGORITHM SUMMARY

COMMENTS *(Reasons for referral, method of referral, hospital appointments, self-care protocols, and patient instructions/precautions)*

PATIENT'S IDENTIFICATION *(Use mechanical imprint if available; for typed or written entries give: Name, SSN, Unit, Sex, Birthdate and Duty Phone)*

FINAL DISPOSITION
( ) I—PHYSICIAN STAT ( ) IV—SELF CARE PROTOCOL
( ) II—PA STAT ( ) V—HOSP CLINIC REFERRAL
( ) III—PA

AIDMAN'S SIGNATURE AND CODE	AUDITOR'S INITIALS AND DATE

M TAB TAB TAB TAB TAB TAB

RECORD OF ACUTE MEDICAL CARE

(Entries on this record should be restricted to further evaluation and treatment of complaint(s) screened)

DATE	2ND CARE LOCATION	TIME PATIENT ARRIVES	TIME ENCOUNTER BEGINS	TIME PATIENT LEAVES

SIGNATURE OF HEALTH CARE PROVIDER	SIGNATURE OF MEDICAL SUPERVISOR	AUDITOR'S INITIALS AND DATE

SPECIAL INSTRUCTIONS

This form will be utilized in lieu of SF 600 *(Health Record-Chronological Record of Medical Care)* at the BAS level and above when care is initiated by an ADTMC screener. The record of acute medical care will accompany the patient to the next level of care or remain in the BAS depending on disposition reached. This form will be filed in the HREC when evaluation and audit are completed.

CHRONOLOGICAL RECORD OF WELL-BABY CARE

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

SIGNIFICANT NEONATAL HX	DOB	WEIGHT	HEIGHT	PKU

DATE OF VISIT		
AGE		
WEIGHT		
HEIGHT		
HEAD CIRCUMFERENCE		
SUBJECTIVE (HISTORY)		
1. FEEDING		
2. FORMULA/BREAST		
SOLIDS		
VITAMINS/FLOURIDE		
2. ELIMINATION		
3. GROWTH AND DEVELOPMENT		
4. PARENTAL CONCERNS		
OBJECTIVE PHYSICAL EXAM		
NUTRITION		
HEAD/FONTANEL		
EENT		
NECK/CLAVICLES		
LUNGS		
HEART		
ABDOMEN		
GENITALIA/HERNIA		
HIPS/SPINE		
EXTREMITIES		
SKIN		
NEUROLOGICAL		
ASSESSMENT		
PLANS AND COUNSELING		
SAFETY		
FEEDING		
GROWTH AND DEVELOPMENT		
IMMUNIZATION		
NEXT VISIT		
	EXAMINED BY	EXAMINED BY

PATIENT's IDENTIFICATION (Name, last, first, middle, grade, date, hospital or medical facility)	REMARKS

DA FORM 5568-R, OCT 86

SIGNIFICANT NEONATAL HX	DOB	WEIGHT	HEIGHT	PKU

DATE OF VISIT		
AGE		
WEIGHT		
HEIGHT		
HEAD CIRCUMFERENCE		
SUBJECTIVE (HISTORY)		
1. FEEDING		
2. FORMULA/BREAST		
SOLIDS		
VITAMINS/FLOURIDE		
2. ELIMINATION		
3. GROWTH AND DEVELOPMENT		
4. PARENTAL CONCERNS		
OBJECTIVE PHYSICAL EXAM		
NUTRITION		
HEAD/FONTANEL		
EENT		
NECK/CLAVICLES		
LUNGS		
HEART		
ABDOMEN		
GENITALIA/HERNIA		
HIPS/SPINE		
EXTREMITIES		
SKIN		
NEUROLOGICAL		
ASSESSMENT		
PLANS AND COUNSELING		
SAFETY		
FEEDING		
GROWTH AND DEVELOPMENT		
IMMUNIZATION		
NEXT VISIT		
	EXAMINED BY	EXAMINED BY

PATIENT's IDENTIFICATION (Name, last, first, middle, grade, date, hospital or medical facility)	REMARKS

Reverse of DA FORM 5568-R

ISONIAZID (INH) CLINIC FLOW SHEET

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

DATE STARTED INH			CODES O = *No* √ = *Yes* CS = *Comment Section*									
Today's date												
Time												
No. months of INH												
SUBJECTIVE												
Fatigue												
Nausea												
Loss of appetite												
Dark urine												
Light stools												
Joint pain												
Loss of weight												
Visual changes												
Elevated temperature												
Tingling hands/feet												
OBJECTIVE												
Rash												
Icterus												
Other												
ASSESSMENT												
Patient taking medication												
Side effects noted												
PLAN/ACTION												
Refill INH no. 30												
Start/refill B6 no. 30												
Patient guidance provided												
Repeat liver function tests												
Discontinue INH												
Refer to MD												
Referral to next duty sta												
Next appointment *(Date)*												
Interviewer's initials												

COMMENT SECTION

(Continue on reverse)

PATIENT'S IDENTIFICATION *(Use mechanical imprint if available. For typed or written entries give: Name, SSN, Unit, Sex, Birthdate and Duty Phone.)*

INTERVIEWER'S IDENTIFICATION DATA	
SIGNATURE AND TITLE	INITIALS

ALCOHOL & DRUG ABUSE PREVENTION & CONTROL PROGRAM (ADAPCP) OUTPATIENT MEDICAL RECORDS - PRIVACY ACT INFORMATION

For use of this form, see AR 40-66; the proponent agency is the OTSG

This form is not a consent form to release or use health care information about you.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN). Title V, Public Law 92-129; section 413, Public Law 92-255.

2. PRINCIPAL PURPOSES OF OUTPATIENT MEDICAL RECORDS.

a. To provide necessary information to evaluate the existence of and, if appropriate, the nature and extent of the patient's alcohol and other drug problem.

b. To provide baseline information for monitoring the patient's progress during rehabilitation in the ADAPCP.

c. To ensure continuity of care of patient enrolled in ADAPCP rehabilitation.

d. As part of the Active Army soldier's medical record, to provide information to military physicians in diagnosing other medical problems and in prescribing medication.

e. To provide statistical information for program evaluation.

3. ROUTINE USES.

a. Active Army Soldiers. Release of any information from this record is subject to the restrictions of 21 USC 1175 as amended by 88 Stat 137; 42 USC 4582 amended by 88 Stat 131 chapter 1, title 42, Code of Federal Regulations. Under these statutes and regulations, disclosure of information that would identify the patient as an abuser of alcohol or other drugs is authorized within the Armed Forces or to those components of the Veterans Administration, furnishing health care to veterans. AR 600-85 further limits disclosure within the Armed Forces to those individuals having an official need to know (for example, the physician or the patient's unit commander). All other disclosures require the written consent of the patient except disclosures (1) to medical personnel outside the Armed Forces to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial competent jurisdiction.

b. Civilian employees and other personnel. Release of any information from this record is subject to the restrictions of 21 USC 1175 as amended by 88 Stat 137-42 USC 4582 as amended by 88 Stat 131 and chapter 1, title 42, Code of Federal Regulations. All disclosures require the written consent of the patient except disclosures (1) to medical personnel to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial audits or program evaluation or (3) upon the order of a court of competent jurisdiction.

4. MANDATORY / VOLUNTARY DISCLOSURE AND EFFECT ON AN INDIVIDUAL NOT PROVIDING INFORMATION.

a. Disclosure is mandatory for Active Army soldiers. Failure to obey order from competent authority to provide required information may be subject to appropriate disciplinary action under the UCMJ.

b. Disclosure is voluntary for civilian employees and other personnel. The failure to disclose the information will result in a reduced capability of the program to provide treatment and services.

5. Signature of Patient or Sponsor	6. SSN of Member or Sponsor.	7. Date.

Army Regulation 40-66
Medical Record Administration

Chapter 1
Introduction

Chapter 2
Confidentiality of Medical Information

Chapter 3
Preparation of Medical Records

Chapter 4
Filing and Requesting Medical Records

Chapter 5
Health Records

Chapter 6
Outpatient Treatment Records

Chapter 7
Alcohol and Drug Abuse Prevention and Control
Outpatient Medical Record

Chapter 8
Inpatient Treatment Records

Chapter 9
DD Form 1380

Chapter 10
Role of the Medical Department Activity or U.S. Army
Medical Center Patient Administration Division in the
Quality Assurance Program

Chapter 11
Monthly and Annual Statistics

Appendixes
A. and B.

Glossary

Index

Reproducible Forms

Unclassified

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