SUMMARY of CHANGE

AR 40-68
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.
- Eliminates 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 8, section V, on maintenance of health records upon mobilization.
- Adds requirement for recording rubella titre results to SF 401 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 (chap 5 and 6).

- Adds copies of additional inpatient treatment record forms to be filed in health records and outpatient treatment records (chap 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 8-3).

- 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 8006-1 (Alphabetical and Terminal Digit File for Treatment Record (Orange)) (para 4-3).

  --DA Form 8006-2 (Alphabetical and Terminal Digit File for Treatment Record (Light Green)) (para 4-3).

  --DA Form 8006-3 (Alphabetical and Terminal Digit File for Treatment Record (Yellow)) (para 4-3).

  --DA Form 8006-4 (Alphabetical and Terminal Digit File for Treatment Record (Grey)) (para 4-3).

  --DA Form 8006-5 (Alphabetical and Terminal Digit File for Treatment Record (Tan)) (para 4-3).

  --DA Form 8006-6 (Alphabetical and Terminal Digit File for Treatment Record (Light Blue)) (para 4-3).

  --DA Form 8006-7 (Alphabetical and Terminal Digit File for Treatment Record (White)) (para 4-3).

  --DA Form 8006-8 (Alphabetical and Terminal Digit File for Treatment Record (Brown)) (para 4-3).

  --DA Form 8006-9 (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 (ADAPCF Outpatient Discharge Summary) (para 7-9).
--DA Form 7096 (ADAPCF Outpatient Aftercare Plan) (para 7-9).
--DA Form 7097 (ADAPCF Outpatient Problem List and Treatment Plan Review) (para 7-9).
--DA Form 7098 (ADAPCF Outpatient Treatment Plan and Review) (para 7-9).
--DA Form 7099 (ADAPCF Outpatient Biopsychosocial Evaluation) (para 7-9).
--DA Form 8000 (ADAPCF Triage Instrument (For Unscheduled Patients)) (para 7-9).
--DA Form 8001 (Limits of Confidentiality) (para 7-9).
--DA Form 8002 (ADAPCF Outpatient Administrative Summary) (para 7-9).
--DA Form 8003 (ADAPCF Enrollment) (para 7-9).
--DA Form 8004-R (ADAPCF outpatient Medical Records--Privacy Act Information) (para 7-9).
Medical Services

Military Record Administration

By Order of the Secretary of the Army

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

Official

METON 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 policy for preparing and using medical reports and records in accord with North Atlantic Treaty Organization standardization agreements (STANAGs) 2348 and 2132, and quadruplicate 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 published without prior approval from HQDA (SGIPS-PSA), 5109 Lonsburg Pike, Falls Church, VA 22041-3258.

Distribution. Distribution of this publication is made in accordance with the requirements of DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HqDA (SGIPS-PSA), 5109 Lonsburg Pike, Falls Church, VA 22041-3258.

Filing automated and computerized forms 3 2, page 8
Guidelines for local forms and oversizes 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

Section III
Releasing Diagnoses and Procedures, page 10
Nonessential use in releasing diagnoses 3 8, page 10
Special instructions for certain diseases 3 9, page 11
Special instructions for certain diagnoses 3 10, page 11

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


AR 40-66 • UPDATE

Unclassified
Chapter 4
Filing and Requesting Medical Records, page 15
Filing by social security number and family member pets • 4-1, page 15
Terminal digit filing system • 4-2, page 15
Use of DA Form 3443-series, DA Form 3446-series, and DA Form 8005-series folders • 4-3, page 15
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 charge system • 4-6, page 19
Record requests • 4-7, page 19

Chapter 5
Health Records, page 19
Section 1
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 2007-A, and DA Form 2007-D-R • 5-5, page 24
DA Form 5008 • 5-6, page 24
DA Form 5218:R • 5-7, page 24
DA Form 5669-R • 5-8, page 24
DA Form 5750 • 5-9, page 25
DA Form 5571:R • 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 371 • 5-17, page 25
SF 603 and SF 603A • 5-18, page 25
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 1
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 1
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 44

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 1
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

2 AR 40-66 UPDATE
Contents—Continued

Disposition of inpatient treatment records • 8-4, page 48

Section III
Preparation and Use of Inpatient Treatment Records, page 48
Inpatient treatment records contents • 5-9, page 48
Medical reports • 4-10, page 48
Countersignatures • 8-13, page 50

Section IV
DA Form 1567, page 50
General purpose • 8-12, page 50
Use • 8-13, page 50
Institution 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 559 • 8-17, page 51
Laboratory forms • 8-16, page 51
DA Forms 4256 • 8-19, page 52
Radiologic forms (SF 519, SF 519A, and SF 519-B) • 8-20, page 52
DA Form 5000-B • 8-21, page 53

Chapter 9
DD Form 1380, page 53
Use • 9-1, page 53
Preparation • 9-2, page 53
Supplementary DD Form 1380 • 9-3, page 54
Depository • 9-4, page 54
DA Form 4006 • 9-5, page 54

Chapter 10
Rule 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 4-1: File numbers, recordkeeping requirements, page 7
Table 4-1: Assignment of family member prefix, page 15
Table 4-2: Key to color foldage 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 patients 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 3441-series, page 18
Table 4-7: General instructions for preparing laboratory forms, page 52
Table 8-2: Specific instructions for preparing laboratory forms, page 52
Table 9-1: Instructions for preparing DD Form 1340, page 53
Table 17-1: Animal hospital rates, page 57

Figure List
Figure 2-1: Opinion from the DOD Privacy Board Legal Committee, 24 November 1980, page 7
Figure 3-1: Forms and documents of the BHRSC using DA Form 3441-series jackets, page 20
Figure 3-2: Forms and documents of the BHRSC using DA Form 3441-series jackets, page 22
Figure 5-3: Forms and documents of the BHRSC dental record, page 24
Figure 5-4: Sample message format for telex medical records, page 44
Figure 5-5: Sample message on SF 600, page 25
Figure 5-6: Sample message SF 600-Continued, page 29
Figure 6-1: Forms and documents of the OTR using DA Form 3441-series jackets, page 77
Figure 6-2: Forms and documents of the OTR using DA Form 3441-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 ADAACP-OMR, page 43
Figure 8-1: Forms and documents of the ITR, page 45
Figure A-1: Medical symbols, page 78

Glossary
Index

Reproducible Forms
Chapter 1

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, medical approval, support, and research and education. A medical record also provides a means of communicating 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 at hospital inpatients will be recorded in an inpatient treatment record (ITR). Outpatients care on a military member will be recorded in a health record (HERC) which 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 the alcohol and drug abuse prevention and control program (ADAPCP) will have an ADAPCP outpatient medical record (ADAPCP-OBR). Occupritional and intracorporal occupational 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. Abbreviation 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 230. The use of locally approved abbreviations and symbols is authorized if the conditions in paragraph 3-4 are met.

c. Definitions—(1) Adequate and timely ITR is prepared for each patient who may have one.

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

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

(4) Ensure that HREC personnel inspect medical and dental care in a timely process for each patient who may have one.

(5) Ensure that a duplicate paragraph is on file with the Central Geographic Storage Facility.

b. Unit Commanders. Unit Commanders will ensure that HERCs are always available in accordance with continuing care standards. HERC personnel will also ensure that information in HERCS is kept private and confidential. If a commander acquires HERCs or documents belonging in HERCS, he or she will ensure that they are treated confidentially (chaps 2 and 3) and be sent to the proper HREC custodian without delay. As an exception to (1) below, some commanders may act as the custodians of their unit's HERC's or appoint a competent person to do so if no HERC is on file in the hospital. The registrar will be sent to the ABRC in an envelope that is stamped or plainly marked "Health (or Dental) Records." In addition to the address, the envelope will be also 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 HERC 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.

C. Health-care providers. Health-care providers will promptly and accurately record all patient observations, treatments, and care in HERCS. Hospital chaplains are allowed access to medical records subject to standards outlined in the American Hospital Association guidelines and Chaplains' Notes in Medical Records. Visiting clergy will not have access to ITRs. Chaplains enrolled as surrogates in pastoral education courses will be

members should not be kept at the unit. Per paragraph 4-6, copies should be furnished to the family members. As the original records are recorded along with an explanatory letter to the military MTF that emits provided medical care to the family member.

c. U.S. Army medical records are maintained in the custody and dispense of Army National Guard (ARNG) HERCS. U.S. Army Reserve (USAR) unit commanders will initiate and dispose of HERCS of troop program unit members and the Commanding General, USAV Personal Center (USAR/PERCEN), will initiate and dispose of HERCS for individual Ready Reserve members.

d. Medical personnel officers. Medical personnel officers will—

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

(2) Ensure that personnel are changing stations carry their HERCS. When an HREC custodian feels a soldier should not hand-carry his or her record, the custodian will send it to the person's next station. (See para 5-24a(1))

(3) To HREC custodian of immediate unit or personal movement.

(4) Provide on a quarterly basis restates that identify personnel for whom MT and DTFI correspondents are medical record custodians.

(5) Keep secure any defense information in HERCS para 2-4. When members officers acquire HERCS or documents belonging in HERCS, they will be sure that the records are treated confidentially (chaps 2 and 3) and be sent to the proper HREC custodian without delay.

a. AMEDD officers. AMEDD officers will—

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

(2) Use HERCS for diagnoses and treatment. They will also use HERCS for record generation and documentation. In doing so, they will see that all needed information is promptly entered in theHERCS in their custody. If any such information is omitted, they will take the necessary 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 HERCS is not in his or her custody. These records will be sent to be sent to the envelope that is stamped or plainly marked "Health (or Dental) Records." In addition to the address, the envelope will be also 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 HERC 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.

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

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

(2) Records prepared and received from other MTF and DTFI are promptly reviewed and entered in ITRs.

a. Health-care providers. Health-care providers will promptly and accurately record all patient observations, treatments, and care in HERCS. Hospital chaplains are allowed access to medical records subject to standards outlined in the American Hospital Association guidelines and Chaplains' Notes in Medical Records. Visiting clergy will not have access to ITRs. Chaplains enrolled as surrogates in pastoral education courses will be
affiliated the same privilege 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 chaplains 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 ought want to include additional information that would be helpful for the total care and treatment of the patient. Such information would be considered observational.

2-4. 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 medical center MTSA at all times, except when being transferred directly from one military MTSA 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 confidentiality 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 2345, STANAG 2312, and quadripartite standardization agreement [QSPA]). As a team member in an RTF, he or she ought want to agree. 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 DoD policies and procedures on the confidentiality of medical information. It is a document to ensure that the confidentiality of medical quality assurance records are set forth in AR 40-68, paragraph 1-7.

2-2. Protection of confidentiality
DoD policy states that medical confidentiality for all patients will be protected as fully as possible.

a. Within DoD, 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 MTSA 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 that for which it was obtained, 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 authorized representative of the MTSA 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 DoD uses. Any further disclosure 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 transmission 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.

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

(1) DA Form 4254-R (Request for Private Medical Information) is used for requests. DA Form 4254-R is a standard printed form with a blue background and a red top margin. A copy for reproduction purposes is located at the back of this regulation. Submitted forms are filed under AR 25-490-2, file number 40 (general medical services correspondence files), by the receiving MTSA. (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) MTSA 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 requestor.

(3) In certain situations for example, cases of emergency care, rape, assault, or similar activity for 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 MTSA 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 meets requirements in this chapter and if appropriate measures are taken to ensure that the record is transmitted to the correct party.

d. Official requests from personnel outside DoD. See AR 340-21, chapter 2.

e. Unofficial requests.

(1) Other persons requesting medical information must include such authorization for release of information. DA Form 500-R (Medical Record—Authorization for Disclosure of Information) will be used wherever possible. (DA Form 500-R will be locally reproduced on 8 1/2 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. Information will be released only when the patient is applying 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.

(f) If a request is oral, information and authorization will be filed with the request in the patient's medical record. (Applications should be made on SF 544 (Clinical Record) - Statement of Patient's Treatment). The request must be in writing, and the request must be annotated to show the information released. Requests for release of 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 23-55, chap 6, for fees and charges for copying, certifying, and searching records).

(g) The request must be in writing, and information and authorization will be filed with the request in the patient's medical record. (Applications should be made on SF 544 (Clinical Record) - Statement of Patient's Treatment). The request must be in writing, and the request must be annotated to show the information released. Requests for release of 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 23-55, chap 6, for fees and charges for copying, certifying, and searching records).

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

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

(j) If a request is oral, information and authorization will be filed with the request in the patient's medical record. (Applications should be made on SF 544 (Clinical Record) - Statement of Patient's Treatment). The request must be in writing, and the request must be annotated to show the information released. Requests for release of 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 23-55, chap 6, for fees and charges for copying, certifying, and searching records).

(k) The request must be in writing, and information and authorization will be filed with the request in the patient's medical record. (Applications should be made on SF 544 (Clinical Record) - Statement of Patient's Treatment). The request must be in writing, and the request must be annotated to show the information released. Requests for release of 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 23-55, chap 6, for fees and charges for copying, certifying, and searching records).

(l) The law of the State in which the medical record of a teen-age family member is located governs the disclosure of information from that record. This information pertains to statutory or regulatory programs for:

(1) Drug and alcohol abuse.
(2) General disease control.
(3) BOP control.
(4) Abortion.

(2) For overseas installations, the opinion from the Department of Defense (DOD) Privacy Board Legal Committee (24 November 1995) will be used. See figure 2-1

2.5. Medical records of the teen-age family member.

(a) Disclosure of information:

(1) The law of the State in which the medical record of a teen-age family member is located governs the disclosure of information from that record. This information pertains to statutory or regulatory programs for:

(a) Drug and alcohol abuse.
(b) General disease control.
(c) BOP control.
(d) Abortion.

(2) For overseas installations, the opinion from the Department of Defense (DOD) Privacy Board Legal Committee (24 November 1995) will be used. See figure 2-1

For the purpose of parental access to the 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 refused to release it to a parent or guardian.

(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 1995

(b) Medical confidentiality. So that medical confidentiality will not be compromised, medical records in a file should be maintained as "Civilian Consulation Service Case Files." Because medical information in these records may be an important part of continued and follow-up care, SF 600 will note "Patient sent, refer to file number 40-2168" and will be filed in the patient's OTR. Department of these records will be per AR 25-400-2, file number 40-2168, civilian consultation service case. See table 2-1.

Table 2-1

<table>
<thead>
<tr>
<th>File number</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>General medical services (Response files)</td>
</tr>
<tr>
<td>40-104</td>
<td>Personnel/retirement files</td>
</tr>
<tr>
<td>40-460</td>
<td>Health records</td>
</tr>
<tr>
<td>40-465</td>
<td>Dental health records</td>
</tr>
<tr>
<td>40-466</td>
<td>Foreign national outpatient treatment records</td>
</tr>
<tr>
<td>40-467</td>
<td>Civilian outpatient treatment records</td>
</tr>
<tr>
<td>40-468</td>
<td>NATO personnel treatment records</td>
</tr>
<tr>
<td>40-469</td>
<td>Military outpatient records</td>
</tr>
<tr>
<td>40-470</td>
<td>Civilian outpatient records</td>
</tr>
<tr>
<td>40-475</td>
<td>Foreign national outpatient records</td>
</tr>
<tr>
<td>40-476</td>
<td>NATO personnel outpatient records</td>
</tr>
<tr>
<td>40-478</td>
<td>Troops and dependents clinical record cover sheets</td>
</tr>
</tbody>
</table>

AR 40-468• UPDATE 7
2-6. Research using medical records
Qualified people may have access to Army medical records and bi-
ostatistical information for research and study. Access may be
granted to records in MTFs and DTFs, Army record centers, and
furloughed without their permission, and photographs of a record
may be made if the record 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 ex-
cceptions.

a. Approval of requests.
(1) The Surgeon General will approve all requests for research.
An exception to this is given in (3) below.

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

b. Submission of requests. With the exception of those requests
falling under (1) above, all requests from outside and within DA
will be made through channels to HQDA (GPGS-PFA). 5109
Leesburg Pike, Falls Church, VA 22041–3258. Such requests will
be:

(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 reasons for granting 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:

(1) Information taken from Army medical records will be relat-
ted only to the ethos of the medical and dental profession.

(2) The identities of people mentioned in the records will not be
released without the permission of a person or
of any exterior portion of his or her body will not be released
without his or her consent.

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

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

(5) Any published material or features on the particular project
or study will contain the following statement: “The use of Army
medical records in the preparation of this material is consid-
ered, but it is not to be construed as implying official Depart-
ment of the Army approval of the conclusions presented.”

(6) Access authorization approved.

(7) 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 AX
600–63. See chapter 7.

2-8. Civilian employee medical records
Guidance in this chapter will be followed to protect the confiden-
tiality of medical information and usual disclosure procedures in
CL 63, LC. Supp 293–11, paragraph 56–4. In addi-
tion, Occupational Safety and Health Act rules (29 CFR 1910.2
and 29 CFR 1910.105) 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 physi-
ological effects. The employee or his or her designated representative
must be provided one copy of the data upon request without
charge to the employee or his or her representative within 15 work-
ing days.

Chapter 3
Preparation of Medical Records

Section 1
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 regulation
does not prohibit the use of other documents by attending physi-
cians and dentists for 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 electroen-
diagrams, coronary care unit, or intensive care unit vital sign-mon-
toring records, scans, anesthetists monitoring records, and
laboratory test results. They would be filed with the SFs, ID,
forms, and DA forms to which they most closely relate (for ex-
ample, electrocardiogram and cardiac monitoring with SF 520
(Clinical Record—Electrocardiographic Record), anesthesia moni-
toring with SF 517 (Clinical Record—Anesthesia), and laboratory
test results with SF 545 (Laboratory Report Display). Handwritten
reports, such as monitoring strips, should be mounted on DA
Form 4700 (Medical Record—Supplement Medical Data) over-
prints identified as display sheets, except for cardiac rhythm
strips, which may be mounted on the corresponding SF 510
(Clinical Record—Nursing Notes). Also see para 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 reports will be discarded.

c. Computerized or automated versions of recognized forms
should include reference to “Automated version of form num-
ber” 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
MEDGEN and MEDDAD or DENTAC commanders, using the
guidelines described in a through c below.

a. Local forms and overprints should be well thought out in
content and design; be well identified with a title, heading, and/or
3-5. Patient identification

The patient's identification section will be completed when each re¬
cord 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 pa¬
tient's name; his or her rank, grade, or status; his or her family member identification code or SNMP and sponsor's SSN (para 4-1); date of birth; code for MTF that maintains records; and his or her register num¬ber.

a. Patient's recording card. This card is used to enter identify¬
ing data on forms filed in the OTR and HREC; it is used with the ward or clinic identification plates (see below). The card must be used as an appointment card. An adhesive-backed paper ap¬
nouncement note may be attached to the back. The clinical receptionist or appointment clerk fills in the date, time, and clinic
name on the blank lines of the notice. The (or twice also has space for the name, location, and telephone number of the MTF.) This information is then available to the patient and to clinical person¬
nel 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 1171 (Uni¬
formed Services Identification and Privilege Card) or DD Form
2A(ACI) (Active Duty Military ID Card), DD Form 2A(RE) (Armed Forces of the United States Identification Card (Re¬
serve)), or DD Form 2(RE) (United States Uniformed Services
Identification Card (Reservist)) 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 re¬
cording 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 SNMP and SSN to make the filing of records easier. The suggested format for this card is described in
(a) through (c) below.

(a) I. Name—Space through 14—FMF 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).

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

(ii) 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—Spon¬
or's name if patient is a dependent; otherwise, blank.

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

(c) The patient's recording card is designed only to make the
printing of identification data on records easy. It is not used to do

terminate eligibility of care. Such determinations are made per AR
40-3.

b. Ward or clinic identification plate. This plate is used to iden¬
tify the MTF and the nursing unit or clinic. It will also be used to iden¬
tify 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:

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

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

(c) Inpatient identification plate. This plate is used to imprin¬
t the patient with information on all forms is 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) Line 1 and 2. All spaces—Blank.

(b) Line 3. Spaces 8 through 23—Patient's name (last, first, and
middle initial). Spaces 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 19—FMF and sponsor's SSN (para
4-1).

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

(e) When not in use, the patient's identifying 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.

(f) Patient bad card. This card will be prepared or a plate 3- to
5-inch card. The format for the information on the card is—

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

(ii) Rank, grade, or status.

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

(iv) 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 identifica¬
tion may be done using the patient recording card.

3-7. Destruction of unidentifiable medical documents

An unidentifiable document is one that contains either no identify¬
ing data or such a small amount that it is impossible to identify
the person on 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 com¬
mitee'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 may be described in such detail as is
necessary 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 appendices B, as well as locally
approved abbreviations and symbols, are authorized if the follow¬
ing conditions are met:

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

(ii) 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.

(iii) 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.

4. Instructions for recording dental diagnosis and procedures, to include abbreviations and symbols, are provided in TF MED 250.

3-9. Special instructions for certain diseases

a. Infective and parasitic disease. Infective disease, the causative organism will be named unless it is specific in the diagnosis itself. For parasitic disease, 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 cases 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 reporting 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 nonbacterial 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 stated. In all cases, the suspected food or the organism or causative agent will be named.

d. Malaria. When malaria is recorded, the type of plasmodium 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 (Globe 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 presence of metastasis and the exact site (if possible) when the neoplasm is malignant. When the primary site is known and metastasis has occurred, add the phrase “with metastasis” any time the metastatic sites. If generalized metastasis has occurred, state so. If the primary site is not known, give the site of the clinical manifestation and state that it is secondary (for example, “Adenocarcinomas, 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 persons formerly diagnosed as cases of “simple drunkenness” who are patients not cared for because of alcoholism but who are now by a physician because of driving-while-intoxicated charges, allegations 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 patient 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 (see section 913 title 10, United States Code (10 U.S.C. 913)). When the diagnosis is added to the TFR, 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 date that it was given.

(3) The reasons for its being given.

(4) Any other pertinent facts.

b. Skin integrity and sensitization. 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 apply to those individuals whose tuberculin skin test is positive. The level of tuberculin skin test is positive at a level of 5 mm, from less than 10 mm in diameter to 15 mm or more in diameter, within 24 months.

f. Child abuse. When recording injury 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 psychiatomic conditions

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

4. Recording diagnosis.

a. The specific types of conditions are well enough defined to be used without the term for the broader disorder groups. In recording a psychiatric condition, the lowest subclassification of the disorder will be used.

b. 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 that 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, chronic symptoms may be added to the diagnosis, for example, “Acute anxiety, 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. Complimentary diagnostic evaluation. 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 had 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 complimentary diagnostic evaluation will be entered in the medical records. These conditions are transient situational disturbances, alcoholism, drug dependency, neurasthenia, physical disorders of presumably psychogenic origin, and psychosis. (Such complimentary evaluation will be made for personality disorders, sexual deviation, mental retardation, and psychiatric disorders due to structural changes in the brain.) The complimentary information for such case will be recorded at the MTF.
where the medical officer has the information to make the evalua-
tion. (When he or she does not have this information, the medical
office should enter "undetermined" in the record.) When making
these evaluations, medical officers must recognize that the tissue el-
ement is all important; the diagnosis on one day may (and in
many cases should) be changed on a later date. For example, a pa-
tient 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 re-
ported in the medical record are described in (1) through (5) be-
low.

(1) Extrapleural precipitating areas. The external stress precipitat-
ating the condition is to be evaluated for type, degree, and duration.
When describing type, refer to the environmental situation, mil-
itary or otherwise, that is the direct cause of the patient's reaction.
Unusual internal conflicts will not be considered external stresses.

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

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

(4) Stress will be classified as "severe," "moderate," or "mini-
mal." "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 symp-
toms and the psychiatric disability. "Minimal stress" is stress
by which the average person could be exonerated without developing
psychiatric symptoms.

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

(2) Personalized personality and predisposition. Predisposition will
be divided into two general categories, covering the patient's outstand-
ing 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 pa-
tient'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, ab-
normal personality traits, or defects of intelligence, but these con-
tinued 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) up-
sets, 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
history of overt emotional or mental illness or disorder.

(3) Degree of psychiatric impairment (to be used for military pa-
tients only) is defined in terms of the degree to which the patient'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 treat-
ment. It is the degree of impairment after treatment (residual im-
pairment) that the medical officer must evaluate and record. He or
she must also remember that psychiatric impairment is not neces-
sarily the same as general ineffectiveness. Effectiveness in a partic-
ular job is judged by more than the degree and type of psychiatric
impairment; it also depends on the person's emotional stability, in-
tellectual, physical condition, attitude, training, and so on. This di-
vision 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" re-
fers usually to ineffectiveness caused by psychiatric impairment; oth-
er factors are not to be considered.

(a) No impairment. This term is used when there are no med-
ical reasons for changing the assignment or for degrading the
person. Although a person may have certain Symptoms, there may be
no medical reason for his or her not performing full duty. For exam-
ple, 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 the symptoms.

(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 residu-
al impairment that totally prevents the patient from performing
his or her current duty. The impairment may be temporary or per-
manent.

(d) Marked impairment. This term is used to describe a residu-
al impairment that seriously interferes with the patient's
ability to perform his or her current duty.

3. Meaning of recording diagnoses. Diagnoses will continue
to be numbered consecutively (first diagnosis being the cause of
admission). However, the proper time number (1, 2, or 3) will be placed
in parentheses following the ordinal number. Axis I represents
clinical syndromes, conditions not attributable to a single disor-
der that are a focus of attention or treatment, and additional
categories. Axis II represents personality disorders and specific de-
velopmental 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 I: Psychotic illness, paranoid schizophrenia, ever present;
(b) axis II: Personal stress, severe, manifested by alienation
from duties of work, and inability to coexist with others;
d) axis III: Physical disorders, and conditions.

(2) Case of a soldier brought to return to duty for administrative
separation: (Axis II) Antisocial personality, severe, manifested by
history of repeated burglary and other delinquency, impairement
marked for military duty, note for social and industrial adaptability;

(3) Case of a family member: (Axis I) Fetal alcoholism, mild, man-
fested by sexual arousal associated with impotence; (Axis II) Psychiatric
complaint casualty. Psychiatric combat casualties consist of a unique group of military patients for whom the di-
agnosis has strong possibilities for adversely affecting recovery. The
term "battle fatigue" is ideal because it suggests a nearly normal
response, in relatively nonspecific, is allowing for labeling of the great variety of symptoms syndrome 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 combat stress reaction. The terms should be considered roughly equivalent and both terms will be coded under mixed disorders in reaction to stress. Technical terms that can be regarded as diagnoses should be avoided, for example, anxiety, conversion, or paranoia. Examinations are provided in (1) and (2) below.

(1) Case of an unwounded soldier with tension, tachycardia, sweating, paralysis of right arm, andslow amnesia 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.

(Axis II) General 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. Examinations are provided in (1) and (2) below.

(Axis I) Single drug dependency, heroin, with alcohol dependency (alcohol dependence, episodic; opiod dependence, chronic) manifested by injection of low "bags" of heroin daily and signs of tolerance and withdrawal, and by repeated loss of jobs due to interference.

(Axis II) Cirrhosis of liver, secondary to alcoholism.

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

3-12. Recurring injuries

(a) Details to be recorded.

(1) The soldier will be given the same items used when both battle and no battle 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 recording, 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: HSH-325, Fort Sam Houston, TX 78234-6795. Record on DA Form 3667 (Inpatient Treatment Record Cover Sheet) in item 33a 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 brain injury, traumatic acranial trauma, or traumatic convulsion. Describe the original injury. For example, record a contused wound resulting in burst 4" burns due to concussion.

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

(c) The external cause agent. In the case of asphyxia poisoning, name the poison.

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

(e) Whether the injury was self-inflicted. If the injury was deliberately self-inflicted, state whether it was an act of misconduct (to avoid duty) or an act of the mentally somnolent (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 state (for example, home or leave or in transit). While WTI.

(g) Date and time of the injury.

(2) Examples of properly recorded injuries are provided in (a) and (b) below:

(a) Fracture left thumb, upper third of shaft of upper arm, left, no nerve or artery involvement, bullet entering anterior upper portion of left thigh and lodging in femur. Caused by rifle bullet, accidentally incurred when patient's rifle discharged. While he was cleaning it in Barracks A, Fort Dix, NJ, 3 Jul 78.

(b) Brittle, acute, knew, right, due to concussion, anterior aspect. Accidentally incurred when patient toppled and fell, striking knee on floor while entering Barracks 28, 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 causality (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 ofquisite or other agent that caused the wound.

(c) The time that the wound occurred.

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

(2) The following example is a correctly recorded WIA case:

"WIA wound, penetrating, left leg, entrance, posterior lateral, proximal third, entering femoral artery without severe involvement. incurred during search and destroy mission while struck by enemy mortar shell fragments, 16 Dec 66 near Kek Found, Rep 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 time, and place where contamination took place.

(3) Estimate and record the time that layover 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 200") if not known, the dosage should be estimated (for example, "yet 1500")

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

(6) Occupational injury and illness. This term includes all injury or illness incurred as the result of performance of duty for military and civilian personnel, excluding those classified 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, unknown causes. 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 3467, 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 7a and 8 of DA Form 3894 (Hospital Report of Death). The immediate cause will be entered in item 7a, and the underlying cause will be entered in item 7b. Only one cause should be entered on each line of items 7a and 8; no entry is needed in 7b if the im-
mediate cause of death given in 7a describes completely the train of events. To record the example given in b above, cerebral hemorrhage would be entered in 7a as the condition directly leading to death; hypertension would be entered in 7b as the underlying cause or condition leading to the immediate cause; and myocardi-
itis would be entered in 8 as the condition contributing to death but not related to the case.

(2) The diagnosis given as the underlying cause of death on DA Form 3467 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 can be left blank; and if lines c and d 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 20782-8102.)

c. Recording neonatal deaths. When recording deaths of infants under 28 days of age, use the term "neonatal death," and state the infant's date at birth. For deaths in the first 24 hours of life, state the age in number of hours; for death 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, ob-
servation reveals no condition related to the symptom that would warrant recording and so need for any treatment. In such a case, the proper diagnosis entry is "Observe." 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 "Observe" 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 spe-
cific cardiac diagnosis is not made. While in the hospital, however, the patient is also treated for arthritis. In such a case, "Obser-
vation, suspected arthritis" is given 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 medica 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 immedi-
ate diagnosis is not possible, give the symptoms or the name of the suspected condition. Replace these terms with a more definitive di-
agnosis as soon as possible. When given a final or definitive diag-
nosis cannot be made, use the condition or manifestation causing admission.

c. Recording cause of separation. For a noninjury patient sepa-
rated or retired for physical disability, the cause must be recorded.

If there is more than one diagnosis, select the one that is the prin-
cipal 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 re-
corded, that is, the injury causing the residual disability. For ex-
ample, if a leg injury leads to amputation, the leg injury is stated as the underlying cause.

3-15. Recording surgical, diagnostic, and therapeuti c procedures

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

3-16. Recording therapeutic abortions

Section 1039, title 10, United States Code (10 USC 1093) states that funds available to DOD may not be used to perform abor-
tions except when the mother's life would be endangered if the fe-
tus were carried to term.

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

b. The same documentation will be placed in the medical re-
cord 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 command-
er must countersign the physician's statement before the proce-
dure 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-re-
cord-only (CRO) cases. For these cases, DA Form 3467 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 3467 is used, items 7, 10, 14, 24, 27, and 30 and the name of the admit-
ting 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 in a civilian facility.

These cases are CRO cases only if they were not previously re-
corded 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 command-
er of the installation must notify the MTF of the death.

(c) When the remains are disposed of outside military supervi-
sion (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 internes and prisoners of war under U.S. milita-
ry custody.
(b) Deaths of foreign military personnel attached to or serving with Armed Forces.

c) Deaths of any individual pronounced dead by physicians serving in an MTF located in preparing a State or country death certificate.

d) Repatriation or separation due to disability. This class includes—

(1) U.S. military personnel separated at retired for medical conditions under AR 635-40 or 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.

(2) U.S. military personnel separated from the Temporary Disability Retired List and returned to duty or placed on the Permanent Disability Retired List which is an outpatient status.

(3) Other.

(4) Any outpatient abortion procedures.

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

5-18. Absent-sick status

An Army patient admitted to a local military MTF is in an absent-sick status. (See AR 40-3, chap 5.)

b. 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.

c. DA Form 3647 and DA Form 2985 (Admission and Coding Instruction for absent-sick status) are required 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 is presented in chapter 15. Chapter 15 presents the requirements for absent-sick patients.

Chapter 4

Filing and Requesting Medical Records

4-1. Filing by social security number and family member proxy

An 11-digit number is used to identify and file the medical records under the pre-existing digital filing system. This number consists of the sponsor's SSN and an FMP. The first two digits of the file member are the FMP. These digits identify the patient, as shown in table 4-1.

Table 4-1

<table>
<thead>
<tr>
<th>Rule</th>
<th>FMP</th>
<th>Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>01</td>
<td>If the patient is—Sponsor’s eldest child.</td>
</tr>
<tr>
<td>2</td>
<td>02</td>
<td>If the patient is—Sponsor’s second eldest child.</td>
</tr>
<tr>
<td>3</td>
<td>03</td>
<td>If the patient is—Sponsor’s third eldest child.</td>
</tr>
<tr>
<td>4</td>
<td>04, 05, and 06 to 19</td>
<td>Ambiguity resolved through administrative procedures.</td>
</tr>
<tr>
<td>5</td>
<td>20</td>
<td>If the patient is—Sponsor’s fourth eldest child, fifth, and so on.</td>
</tr>
<tr>
<td>6</td>
<td>30 to 39 inclusive</td>
<td>If the patient is—Sponsor’s spouse.</td>
</tr>
<tr>
<td>7</td>
<td>40</td>
<td>If the patient is—Sponsor’s mother or stepmother.</td>
</tr>
<tr>
<td>8</td>
<td>45</td>
<td>If the patient is—Sponsor’s father or stepfather.</td>
</tr>
</tbody>
</table>

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 Emie Jones, SSN 390-22-7742, would be identified as 20 3902 37 34; his wife's number would be 40 3902 37 34; his oldest child's number would be 30 3902 37 34. As shown in the example the spouse's SSN will be used for beneficiaries. When both parents are active or children are in the same SSN as that used in the mother's records. When a newborn infant is born to a couple married and at 20 3902 37 34, for example, newborn infant is a descendant of a marriage record (in this case, Emie Jones). The newborn infant's FMP will be assigned to the father and the SSN will be that of the father. The mother.

The next 11 digits will be broken into groups of nine, as shown in table 4-1. These numbers will also be given to patients who do not have a SSN. In these numbers, the two-digit FMP will be either 99 or 98. The privacy or artificial SSN will be instructed according to the patient's state of birth. The following format will be employed: 30 + (6-9) + YY(MMD), where 80 is constant in every case and the third digit is used for sequencing of multiple birth certificates. For example, a birth certificate of 20 4046 09-1798 will have the patient's 30 + (6-9) + YY(MMD), 80, 90, and so on. Each digit is classified in the third digit, 80-99 or 20-29. (Civilian emergency numbers who have an SSN were described in rule 15 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 INRs, OTRs (including dental), ADAPC-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). 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 73 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 390-22-3753 is needed, the clerk looks first for the primary group "390" file. Within this group, the clerk looks for the secondary group "22" file. Within this group, the clerk looks for the folder numbered 3753. Thus, when filing records, read the SSN backwards rather than the normal way. Read the last two digits first (34 is the example above), then the next two digits (37), then the remaining digits (0922).

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 incidental x-ray films. Similarly, the DA Form 3444-series and DA Form 3445-series are the only folders authorized for filing ITRs, OTRs, HRECs, CEMRs, and nuclear medicine films. Only DA Form 3443-series folders will be used for dental records, ITRs, ADAPC-OMRs, and CEMRs. DA Form 8005-series will be used only for HRECs and OTRs. DA Form 8005-series folders will be used only when files 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 Negative Preserver), DA Form 3443X (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 (Light Green)), DA Form 3444-1 (Terminal Digit File for Treatment Record (Yellow)), DA Form 3444-3 (Terminal Digit File for Treatment Record (Green)), DA Form 3444-4 (Terminal Digit File for Treatment Record (Gray)), DA Form 3444-5 (Terminal Digit File for Treatment Record (Tan)), DA Form 3444-6 (Terminal Digit File for Treatment Record (Light Blue)), 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 requested 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 3443-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 3443-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 3443-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 the current system is used or the new folders are being used, the old folders have deteriorated or the MTF converts to the terminal digit filing system. Whether the current system is used or the new folders are being used, the old folders have deteriorated or the MTF converts to the terminal digit filing system.

4-4. Preparation of DA Form 3443-series and DA Form 8005-series folders

a. The DA Form 3443-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>
<thead>
<tr>
<th>Primary Group</th>
<th>Color</th>
<th>DA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>00-09</td>
<td>Orange</td>
<td>3444 or 8005</td>
</tr>
<tr>
<td>10-19</td>
<td>Light green</td>
<td>3444 or 8005-1</td>
</tr>
<tr>
<td>20-29</td>
<td>Yellow</td>
<td>3444 or 8005-2</td>
</tr>
<tr>
<td>30-39</td>
<td>Gray</td>
<td>3444 or 8005-3</td>
</tr>
<tr>
<td>40-49</td>
<td>Tan</td>
<td>3444 or 8005-4</td>
</tr>
<tr>
<td>50-59</td>
<td>Light blue</td>
<td>3444 or 8005-5</td>
</tr>
<tr>
<td>60-69</td>
<td>White</td>
<td>3444 or 8005-6</td>
</tr>
<tr>
<td>70-79</td>
<td>Brown</td>
<td>3444 or 8005-7</td>
</tr>
<tr>
<td>80-89</td>
<td>Pink</td>
<td>3444 or 8005-8</td>
</tr>
<tr>
<td>90-99</td>
<td>Red</td>
<td>3444 or 8005-9</td>
</tr>
</tbody>
</table>

(2) Put an identification label in the “Patient Identification” block. (See fig 4-1 below for instructions on preparing these labels.)

(3) Code the last digit of the patient’s SSN on the folder by putting 1/8 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 slant; 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 names. To make sure the numbers can be seen, enter them with a fiber-tipped pen or other marking device; do not use pencil or "rubber ner. The other numbers of the SSN and the FMP may also be entered on the follet. The other numbers of the SSN are put in the hyphenated blocks along the top of the folder; the FMP is put in the circle 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 1/4 inch of colored tape over the block marked "R" on the back also. If the retirement date changes (for example, a patient treated in 1948 is treated again in 1951), this block will be recorded. The color of tape to be used are shown in Table 4-3. HRQCs are never retired using these procedures. No disposition of HRQCs, see paragraphs 2-27. On HRQCs, the "R" block may be used at local discretion (for example, for appointment turnover). (See R2) 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

<table>
<thead>
<tr>
<th>Year records to be retired</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>1949</td>
<td>Blue</td>
</tr>
<tr>
<td>1990</td>
<td>Green</td>
</tr>
<tr>
<td>1991</td>
<td>Silver or white</td>
</tr>
<tr>
<td>1992</td>
<td>Black</td>
</tr>
<tr>
<td>1994</td>
<td>Orange</td>
</tr>
<tr>
<td>1995</td>
<td>Red</td>
</tr>
<tr>
<td>1996</td>
<td>Blue</td>
</tr>
<tr>
<td>1997</td>
<td>Green</td>
</tr>
<tr>
<td>1998</td>
<td>Yellow</td>
</tr>
<tr>
<td>1999</td>
<td>Silver or white</td>
</tr>
<tr>
<td>2000</td>
<td>Black</td>
</tr>
<tr>
<td>2001</td>
<td>Orange</td>
</tr>
<tr>
<td>2002</td>
<td>Red</td>
</tr>
</tbody>
</table>

(6) Show the status of the patient by putting 1/4 inch of colored tape over the block marked "S" on the right edge of the follet. Wrap the tape around the edge to cover the "S" in 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

<table>
<thead>
<tr>
<th>File number</th>
<th>General group</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-66a (HRQC)</td>
<td>active duty military HRQC (and den)</td>
<td>Red</td>
</tr>
<tr>
<td>40-66b (dental)</td>
<td>active duty dental personnel or active duty or active duty training for more than 30 days</td>
<td>Red</td>
</tr>
<tr>
<td>40-66f (military ITRs)</td>
<td>military personnel records (MIL)</td>
<td>Red</td>
</tr>
<tr>
<td>40-66g (military outpatient records)</td>
<td>military personnel</td>
<td>Red</td>
</tr>
<tr>
<td>45-66m (foreign national ITRs)</td>
<td>foreign nationals or refugees</td>
<td>Red</td>
</tr>
<tr>
<td>45-66n (foreign national outpatient records)</td>
<td>foreign nationals or refugees</td>
<td>Red</td>
</tr>
<tr>
<td>45-66q (NATO personnel)</td>
<td>NATO personnel</td>
<td>Red</td>
</tr>
<tr>
<td>45-66r (NATO personnel outpatient records)</td>
<td>NATO personnel outpatient</td>
<td>Red</td>
</tr>
<tr>
<td>45-66s (foreign national dental files)</td>
<td>foreign nationals or refugees</td>
<td>Red</td>
</tr>
<tr>
<td>45-66t (foreign national dental files)</td>
<td>foreign nationals or refugees</td>
<td>Red</td>
</tr>
</tbody>
</table>

(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 prescribed DD Form 365 (Privacy Act Statement—Health Care Records) on the inside of the follet. If the patient's DD Form 2025 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 2-3d 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 medicolegal insignia is applicable, prepare the identification label using the patient's recording card (para 3a). When it is 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 place (AR 40-400, table 2-5) 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 (dental ITRs), and 40-66h (NATO International Treaty Organization (NATO) personnel ITRs). (See table 2-1.)

(1) Prepare and attach an identification label as described in (b) 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 OTP folder.

(12) The retirement date for OTRs will be 3 years after the end of the year in which the last medical treatment was given. For example, if a record is admitted in 1990, it is color-coded for inpatient reactivation on January 1, 1994 by placing a strip of yellow 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 inpatient retirement date of January 1, 1995; dental records (commissary) are retired 2 years after the end of the year in which the last treatment was given, therefore, dental records begin in 1990 are color-coded black for inactivate retirement in January 1993.

(13) A nominal card index will be kept for OTRs by the archival digital filing system. A nominal card index will be maintained on HRQC's when the facility receives and uses the active duty alphabetic index. 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 treatments records in the 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.

(14) To color code the DA Form 3444-series folder as a general 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 fit-
ness 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.

6. When the size of an individual's medical record requires the
creation of another DA Form 3443-series or DA Form 805-series
folders, 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 to-
gather 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 forms, dated 1 March 1975, are prepared in
the same manner of DA Form 3443-series folders. See para 4-4. The re-
vised DA Form 3443-series consists of one master folder, one re-
port folder, one subsfolder, and one loan folder. These folders will
begin to be used as existing supplies of old folders are exhausted.
In instances where old DA Form 3443-series are unevenly used, remaining folders will be
used by substituting new folders only for the ones that are ex-
hausted. (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 Form 3443-1 through 3443-5 will be replaced by the
two forms until the entire series is depleted.) Existing patient folders will be converted to the revised series only as each patient
returns for follow-up 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 circle, 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-
marginal margin of the master folder serve for color tagging the last four digits of
the SSN. The SSN code will be read from top to bottom in these spaces. Self-adhesive, numbered, and colored tape 1/8" by
1/4" will be used. Facilities maintaining 25,000 or fewer files will
identify only the last two SSN digits by tagging the lower two SSN boxes. Facilities maintaining more than 22,000 files will iden-
tify the last four SSN digits by tagging all four SSN boxes. The col-
ors used are shown in table 4-5.

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

(a) Subfolder identification.

(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, gas-
trointestinal, 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: "O" (orange) will be
used by all facilities for all subfolders transferred from another
facility, and "0" (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.

(d) Identification of subfolders contained in master folder.

Subfolders will be identified by code numbers in the boxes provid-
ed 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.


(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 con-
taining the reports will be identified with a "9" (red) tape.

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

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 ter-

(2) Alternate filing. When files are maintained in separate ser-

(a) Chargeout. All chargeouts or transfers of film will be re-

(b) Final-type photography. Reports and film will be filed in a master

(c) Subfolder. Subfolders will not be used in facilities without radiologists

18
AR 40-66-4 UPDATE
(1) If the requested records are available the custodian will—
(2) 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 address shown in item 19.

(c) Send a copy of DD Form 877 where the records were
to show that they were taken from the file. If records are not
sent from several files, place a check in each additional file.
On this sheet will be the following statement: “(Type of records)
pertaining to (name, SSN, or service number) were forwarded to
(sources) on (date) in compliance with DD Form 877 received
from (address).” These records covered treatment during (indicate
dates).” When the records return, destroy the duplicate copy of
DD Forms 877, and remove the slash 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, but 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
located the records to another office, they will send the request on
to that office first completing items 15 through 18.

(c) After using the records, the requesting MTF or DTF will
delete 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 ad-
ditional records on the patient, they will be returned promptly,
first completing items 15 through 11 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 enclosures.
(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

5-1. Purpose of the Health Record
(a) The HREC includes the dental record in 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 Reserves. The HREC is used for patient care, medical sup-
port, and research and education. The HREC helps medical of-
cers advise commanders on retaining and using their personnel.
It helps physical examination boards appraise the physical fitness of
Army members and eligibility for benefits. In the case of USAFR
and NAVPERS, it assists in the mobilization process. The HREC
serves other purposes, such as serving as a nucleus of claims and is
an important source of medical research information.
The dental portion can be used to assist in identifying de-
ceased persons.
5-2. Use of the heam record

c. General. Throughout the person's military career, each con-
tact with the AMEDD as a patient is recorded in the HREC. These contacts include periods of treatment as an inpatient and are described in copies of DA Form 3467 and SF 501 (Clinical Record). Any information from HREC possibly SF 515 (Medical Rec-
ord—Tissue Examination), SF 516 (Medical Record—Operation Report), or other inpatient documents that the physician or
dentist deems necessary for proper outpatient followup care. Dis-
traction and treatment quarters referrals, outpatient medical care, and death cases 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 de-
scription record is filled and sent to 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 out-
patient care, the HREC may be sent also. The referring or the con-
sulting practitioner makes this decision. If it is sent, the requesting
practitioner will receive 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 Records—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 8-10d.

(3) See paragraph 1(e)(3) for information on when a person re-
ports for outpatient treatment to the 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 per-
son is admitted for treatment. (See paras 5-31 through 5-34 for information on patients from the hospital areas.) When an inpatient receives an HREC, or a part of it, the patient administrator becomes the custodian and will ensure that it is accessible to AMEDD per-
sonnel. 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 physicians, surgeons, and other medical personnel in-
volved in the case. The patient administrator will ensure that a
copy of each of the forms required for the HREC prepared by the
MTF is put in the HREC (para. 5-3) and that the entries needed for inpatients on SF 600 are made. (See para 5-1a.)

(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 para-
graph 5-28b; the record will be sent to the proper custodian when the
patient is released from the MTF. Any other necessary inpa-
tient records will also be completed. Prolonged treatment for a
dental condition (for example, fracture) will not be recorded in de-
tail in the dental record; in most cases a brief summary of the di-
agnoses, treatment, and results is sufficient. Any extractions, extractions, or other oral or dental treatment re-
quired must be entered on SF 403 (Health Record—Dental) of the
permanent or temporary dental record.

(3) When a patient is released from the MTF, the patient ad-
ministrator will forward the HREC as described in (a) through (b) below.

b. 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 MEDICEN commandant for return to the person's assigned installation.

(2) Attending patients returned to duty. Send the HREC to the
medical duty officer of the patient's assigned unit. If the MTF is
locally reorganized, send the HREC to the custodian as in (a)
above.

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

(d) Decedent patients. Send the HREC to the office holding the
patient's personnel records.

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

(f) Other patients separated from service. Send the HREC to the

(g) RC patient not on active duty. Send the HREC to the cus-
todian of MPJ.

5-3. For whom prepared and maintained

HRECs will be prepared and maintained for all Army personnel. These personnel include active duty personnel, USAHR and ARNG personnel, and civilians of the U.S. Military Academy. ARNG and
USAHR HRECs will be prepared and maintained by the custodian of personnel records. (These HRECs will be prepared by 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 personnel will be kept as long as they are confined in U.S. military facilities.

5-4. Forms and documents of health records

c. 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 figure 5-1 through
5-3 are available through normal publications supply channels.

b. The folders of USAHR 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.

---

Limit the raw four-part froze to fully assimilate into the system (use 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 4166
Medical/Pathology Examination for Flying Duty. (See AR 45-501 and para 5-1B(6) of this regulation)

DA Form 3180-h
Personal History and Evaluation Record. (See AR 50-6, AR 50-6, and para 5-18b) of this regulation

DA Form 5871
Medical Problem List. (See para 5-10)

DD Form 2452-1
Venereal Disease History. (See para 5-12)

SF 681-14
Health Record—Immunization Record. (See paras 5-17 and 6-7)

DD Form 4141
Record of Occupational Exposure to Ionizing Radiation, and automated

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

20
AR 40-66•UPDATE
PART II
DA Form 4515
Personnel Reliability Program Record Identifier. (See AR 50-5 or AR 50-6, and para 5-19h(3) of this regulation)

DA Form 3180-8
Performance Screening and Reliability Record. (See AR 50-5, AR 50-6, and para 5-19h(3) of this regulation)

DA Form 4148
Medical Recommendation for Flying Duty. (See AR 40-601 and para 5-19h(8) of this regulation)

Documents and correspondence on flying status, that is, restrictions, removal of restrictions, suspensions, and termination of suspensions. Insert the following six forms in reverse chronological order—most recent visit on top.

SF 600-12
Health Record—Chronic Medical Condition of Medical Care. (See para 5-15.)

DA Form 5058
Telephone Medical Advice—Consultation Record. Attach to and file with SF 600 in chronological order. (See para 5-6 for completion instructions.)

SF 558
Emergency Care and Treatment. Interfile with SF 600 in chronological order. (See para 5-14.)

DA Form 3204
Urologic Examination.

DA Form 5181-1
Screening Note of Acute Medical Care. (See para 5-7.)

Stab wounds ambulance forms. (See para 5-19h(7)).

SF 513
Medical Record—Consultation Sheet. (See para 8-10.)

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

SF 602
Health Record—Supplement Record. (See parar 5-19h(10) and 5-24.)

DA Form 375
Community Health Nursing—Case Record. (See AR 40-407.)

DA Form 5569-R
Transit (NHN) Clinic Flow Sheet. (See para 5-8.)

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

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

SF 528

SF 529
Clinical Record—Muscle Function by Nerve Distribution: Trunk and Lower Extremity.

DA Form 4700
Medical Record—Supplemental Medical Data. When DA Form 4700 is used, it should be referenced on SF 550. Understand reports should be maintained on DA Form 4700 display wade and faded with reports to which they have closely relate. (See chap 4.)

SF 517
Clinical Record—Anesthesia. Output party only. (See para 8-10.)

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

SF 522
Medical Record—Report for Administration of Anesthesia and for Performance of Operations and Other Procedures. All other special cover documents. (See para 5-3.)

SF 516
Medical Record—Blood or Blood Component Transfusion

SF 81
Report of Medical Examination. (See AR 40-601 and para 5-5, 5-19, and 5-23 of this regulation)

SF 93
Report of Medical History (Form SF 86). Fill here any other medical history form. (See AR 40-601 and paras 5-19 and 5-23 of this regulation.)

DA Form 4070
Medical Screening Summary—Over-the-Physical Fitness Program. (See AR 40-407.)

DA Form 4071-R
Medical Screening Program—Cardiovascular Risk Screening Program. (See AR 40-501.)

DA Form 4485
Chief Intake Record. Also file here any other authorized alcohol and drug forms. (See AR 40-65 and paras 5-19h(4) and 7-9 of this regulation.)

PART III
DA Form 498
Physical Evaluation Board (PEB) Proceedings. (See AR 635-40 and para 5-19h(5) of this regulation)

DA Form 2173
Statement of Medical Examination and Duty Status. (See AR 850-8-1.)

DA Form 5531-R
Medical Case—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 5-19h(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 4216-R
Request for Private Medical Information. (See para 2-3.)

DA Form 4976-R
Request and Release of Medical Information to Communications Media. (See para 2-3.)

DA Form 5006-R
Medical Record—Authorization for Disclosure of Information. (See para 2-4.)

DA Form 5025-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 (attome directives)

DA Form 4410
Disability Accounting Record. DA Form 4410 is always the bottom form or it printed on the folder. It is a template, use for lifes purposes only.

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

AR 40-66 • UPDATE 23
PART IV
Grave copies of the following forms by hospitalization episode within 30 days:

DA Form 1847:
Inpatient Treatment Record Cover Sheet (formerly DA Form 8-275-
series and DD Form 4151-revised). See it with a copy of SF 402 if
prepared). SF 515, SF 509, and SF 516. Also see here AR Form 585,
NA/VED 6300-5, DD Form 1300 (formerly DA Form 4-37), or any
other relevant information from the VA, Pacific Region, San Francisco,
or other Government MTF. (See AR 40-200 and para 5-15(a), 5-15(b),
3-17a, 3-18b, 5-2a, 5-14a, 6-7, 6-19, 6-12, 8-13, 8-14, 8-15, 8-16,
and 5-20 of this regulation).

CF 275.14
Medical Record-Report. File in order of the number of the form.1
References. (See para 3-3.)

SF 563.12
Clinical Record—Narrative Summary. (See para 6-14.)

SF 529. Medical Record—Summary. (See para 6-17.)

SF 499. Medical Record—Results of Proctor Examinations. SF 499 is the
final discharge note. (See para 6-10.)

SF 516.12
Medical Record—Operation Report. (See para 6-10.)

SF 516.2
Medical Record—Postoperative Report. (See para 6-10.)

SF 516.3
Medical Record—Institutional Figure.

SF 523.12
Medical Record—Prenatal and Perinatal. File here any forms
delivered in MTF. (See para 6-7.)

Copies of civilian treatment facilities records?

DD Form 2050.1
Privacy Act Statement—Health Care Receive, DD Form 2050 is
always the bottom form of a printed on the envelope. (See AR 40-2 and
para 5-4 of this regulation.)

Notes:
1. This form may be included in all NRECs.
2. Instruction for completing this form are self-explanatory.
3. These forms usually will have copies of these forms except for SF 523
when patient is not admitted to the MTF for delivery.

Figure 5-2. Forms and documents of the NRECs using DA Form
4005-series Jackets—Continued

LEFT SIDE OF FOLDER

DA Form 5570.12
Health Questionnaire for Dental Treatment. DA Form 5570 is printed
on the radiograph storage envelope. Radiographs will be stored in the
envelope. (See para 5-4 and 5-25.)

Paragraph.1 The paragraph includes the radiograph too large to be
included in the DA Form 5570 envelope.

RIGHT SIDE OF FOLDER

DA Form 4515
Personal Retractability-Program Record Identifier. (See AR 60-5, AR
50-4, and lewa 5-13(a) and 5-23(c) of this regulation.)

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

SF 403.1
Health Record—Dental. Fills in reverse chronological order with
original SF 603 on the bottom. Also file here SF 563a (Health
Record—Dental Condition) when needed as a continuation of
section II (Attendance Record) SF 402. (See para 5-18 for
instructions for completing SF 603 and SF 603A. Also see para 6-7.)

DA Form 398
Dental Treatment Plan. (See Td MED 250.)

SF 515.12
Medical Record—Correlation Sheet. (See para 6-15.)

SF 519.1, SF 518.1
Medical Record—Radiographic Report. (See para 6-20.) SF 519 and
518A are obsolete; use for purposes only.

SF 519A.7
Radiographic Consultation Request Report. (See para 6-20.)

SF 527.12
Medical Record—Request for Administration of Anesthesia and for
Preparation of Operations and Other Procedures. (See para 5-2.)

DA Form 2-115
Regulate on Dental Protocols. This form is obsolete; use for
purposes only.

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

DA Form 441.1
Registration and Accounting Record. DA Form 441/4 is always the
bottom form or is printed on the envelope. It is obsolete; use for
purposes only.

DD Form 2050.1
Privacy Act Statement—Health Care Records. DD Form 2050 is
always the bottom form or is printed on the envelope. (See AR 40-2 and
para 5-4 of this regulation.)

Notes:
1. This form may be included in all dental records.
2. Instruction for completing this form are self-explanatory.

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

5-5. DA Form 5007-4-R and DA Form 5007-1-R
DA Form 5007A-R and DA Form 5007B-R will be used to
record hypopituitarism data as prescribed on SF 339
(Medical Record—Hypopituitarism Data). (See para 5-25.)

DA Form 5007—A-R is intended for patients on single injection
immunosuppressive therapy, while DA Form 5007—B-R is intended for
patients on two separate immunosuppressive treatments. (DA Form
5007A—R and DA Form 5007B—R will be locally reproduced on
8½- x 11-inch paper. Copies for reproduction purposes are
located at the back of this regulation.)

5-6. DA Form 5908
DA Form 5908 will be used to record medical advice or consulta-
tion given to a patient over the telephone. Self-explanatory in-
structions for completion are located on the back of DA Form 5908.

5-7. DA Form 5181-R
A Form 5181-R is used in conjunction with the Enlisted
Reenlist Review Process in enlistment status and non-armed forces.
(DA Form 5181B-R will be locally reproduced on 8½- x
11-inch paper. A copy for reproduction purposes is located at the
back of this regulation.)

5-8. DA Form 5596-R
DA Form 5596-R will be used to document INH clinic visits.
(DA Form 5596-R will be locally reproduced on 8½- x 11-inch
paper. A copy for reproduction purposes is located at the back of this publication.)

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 Prosthesis List) will be filed in each HRECG, OTR, and CEMR to provide a summary of significant post surgical procedures, past and current diagnosis or problems, and currently or recently used medications. (Also see para 5-24(2)(d)).

5-11. DD Form 1380
DD Form 1380 will be used as described in chapter 9 and paragraph 5-31 (see HREC document under section 7) for the preparation and supplementation of DD Form 1380 are provided in chapter 9.

5-12. DD Form 2482
DD Form 2482 will be used to order a venen extract prescription. One venen 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 HREC's, OTRs, and CEMRs to record cholesterinerase 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 case given in the dental record as the medical history questionnaire. For completeness see 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 TTR. Where 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 in each form. SF 559 is not designed for multiple prescription orders.

a. Use the pathway's recording tool to complete the patient's identification block in the lower left corner of SF 559 (parts 3-5a).

b. In all cases, give the patient's full name, sponsor's SSN, and appropriate FMF (table 4-1). Provide the patient's name, address, and phone number in the space provided on SF 559.

c. 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.

d. The front of SF 559 may be overprinted with the allergen extract most commonly prescribed for hyposensitization treatment (hyposensitization) to 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 the following order: town, streets, weeds, moon, earth, environments, insects, and miscellaneous. List complete antigenic components, and state the volume in milliliters (mL) of these components in the final mixture. The mixture must add up to a total volume of 10 mL including diluent. State the volume of diluent mL in the space provided. The volume of stock film will also be 10 mL. State the concentration of the allergenic components in parts nitrogen units/mL, weight/volume, or allergy units/mL. On the second line of the front page, state the strength of the described msw 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, associate the vital numbers of the most dilute most concentrated vius.

e. Complete the section on the lower front page for refill request 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.

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

g. SF 559 must be signed by the ordering physician. A signature cannot be on file in the U.S. Army Centralized Allergen Extract Laboratory for the prescribing physician.

5-16. SF 600
SF 600 will be used only in the HREC and OTRs. It is the chronological record of outpatient treatment and that 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 5-4c). (See fig 5-3 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 (11) below. These entries will be either typed or printed. If printed, permanent black or blue-black ink will be used.

(1) Patient's name.
(2) SSN.
(3) Year of birth.
(4) Complaint. (Do not include branch).
(5) Department.
(6) Ranks.
(7) Organization.
(8) SSN.
(9) Entries for justification case.
(10) Entries should be concise but complete, that is, medially and administratively adequate entries should—

(a) Describe the nature and severity 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 559 instead of SF 600. SF 559 will be the inpatient admission note filed in the patient's inpatient record. For emergency room admissions, see paragraphs 5-14h. 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 "sporadically for special procedures or therapy (for example, physical and occupational therapy, renal dialysis, or radiation), the therapy will be noted on SF 600, and entries
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 (k) 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 evaluation 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.
(i) If an injury is treated, the cause and circumstances ("how-when-where-leave status") will be entered.
(j) For persons taking part in research projects as test subjects, entries will include—
   (1) Drug or appropriate identifying code.
   (2) Investigative procedures performed.
   (3) Significant observations, including effects.
   (4) Physical and mental state of the subject.
   (5) Tests and laboratory procedures performed.
   (6) Outpatient care received at civilian facilities will also be re-
       corded 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) Extent of patient’s status.
           (d) Instructions to patient.
           (e) When the patient will be returned to duty.

   (f) Laboratory, x-ray, consultation, and similar reports.
   (g) Entries for physical examinations. "Physical Examination"
       and the date it will be entered on SF 600 for each complete physical
       examination made and recorded on SF 88 (Report of Medical Ex-
       amination). Entrance medical examinations will not be entered.
   (h) External hemorrhage, the term "orthopedic footwear"
       "authorized" will be entered on SF 600, as well as the prescription
       and date.

   (i) Exits for board proceedings. When copies of Physical Evalu-
       ation 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.
   (j) Entries for drug abuse treatment. When a person has been
determined by clinical evaluation to be an alcoholic or other drug
abuser, care will be made on the SF 600, which will be filed in the
HREC. (See also AR 600-65, para 3-11.)
   (k) Entries for a pregnancy diagnosis. After a pregnancy, all
forms relating to it will be filed in the ITR. When the record is
 filed, the following information will be entered on SF 600: "Fema-
tal care not filed in ITR due to (patient’s name, EFP, and SSN),
(l) Location of MTF, (date)." If the pregnancy is not confirmed 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 Re-
cord—Immunization Record) will be prepared and kept for each
person who needs an HREC. PHS Form 731 (International Certif-
icates of Vaccination) is a personal record of immunizations re-
cieved; it is normally needed for international travel. Usually,
active duty and USAFR personnel have custody of their PHS
Forms 731; they will ensure their safekeeping. PHS Forms 731 for
RC personnel will usually be 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
   (1) Identification parts of this form will be completed as described
   for SF 600 in paragraph 5-14. As reception stations, procedures will
   be established to ensure that immunization information is entered
   on the copy of SF 601. For persons allergic to medications, the
   "Medical Condition" block on the front of the HREC folder will be
   checked. In addition, DA Label 160 (Emergency Medical Iden-
   tification Symbol) will be placed on the front of the folder. SF 601
   is available through normal publications supply channels.Instruc-
tions for completing the forms 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 pasted
   like permanent documents in the record. The name and SSN of
   the person will be typed or written in list on the front of the form.
   The address put on the form for officers and warrant officers is the
   Commander, PERSCOM, ATTN: TAPF-POR-R, Alexandria,
   VA 22332-0002. The address for enlisted personnel is Command-
er, U.S. Army Enlisted Records and Evaluation Center, ATTN:  
FCRE-R, Fort Benjamin Harrison, IN 46439-3301. 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 at-
tached 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 as due.

   (2) The unit personnel officer, acting on behalf of the com-
mander, will notify members that immunizations are needed ac-
cording 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
prepare immunization records and reports.

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

   e. Entries.

   (1) Immunizations and sensitivity tests will be recorded on SF
601. Rabies titr results must be recorded on SF 601. Rabies im-
munizations must be recorded on both SF 601 and PHS Form 731.

   (2) Remarks and recommendations regarding the immunization
status on SF 601 may be added at the MTF. The reasons for waiting any immuni-
ization will be recorded in enough detail for later medical evalu-
ation. Any attacks of diseases for which immunizing agents were
used must be noted; the year and place of attack must also be giv-
ing. 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.

8. Disposition on separation from service. When released from active duty or from active service, a service member may 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 DENT and MTF. SF 603 (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 panoramic radiograph of the teeth and surrounding tissues taken. The radiograph will be taken during processing. If a panoramic film is not available, 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. (Disqualifying of disqualifying dental defects will be made by a dental officer.) Except as instructed in (d) below, charts 4 and 5 in section 1 of SF 603 will no longer be used to record any dental defects that are found. Chart 16 in section III will be used.

b. Personnel reporting military service. A new SF 603 will be completed for personnel reporting active service.

(2) 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 has been given a complete dental examination on (date) and all dental services and treatment indicated by the examiner have been rendered. (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. USAAR, ARNG, and those 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 USAAR AMEDD officers) or those individuals without a panoramic x-ray (initial entry service was prior to this policy) will have a dental record initiated. The dental records portion of the SF 603 will be completed. 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.

a. 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 TM 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.

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 described in TM MED 250, when initial dental processing is performed and there is no panoramic radiograph capability. A paragraph 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 name of the person doing the examination will be recorded. Therefore, this chart may have to be used for forensic identification purposes. Restoration drawn in this section must accurately portray the restoration in the mouth.

(3) SF 603, section II
(a) Personal history. 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 M or F is entered, race and skin color can be added. (If item 7 is left blank, the blank is to be filled in and initialed.) Educated C for Caucasian, BI for black, Och for a member of any other race, and UK for unknown. Compares or Branch (item 9). Enter the applicable code. See TM 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. Parent's Name and Date of Birth (items 12 and 13), Self-sponsor. Identification No. (item 14), Enter the SSN or military personnel (active and retired). For family members, enter the PMP 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 TM 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 the SF 603 and SF 603A is an examination chart. It is used to record those defects which are discovered at the time of initial processing. The defects will be noted in pencil on the chart and initialed. When the defects are noted in pencil and individual entries are made as such 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 sequences 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 multiple visits. Extensive fillings will be entered across the entire page when necessary. Date column—Enter the current year on the first line. Subsequent dates on the following line 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 columns. Treatment should be included to indicate clearly what is being 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 speed record audits. See TM 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 excess movement examinations, etc., and is recoded in the "Class" column of block 17 of SF 603 and SF 603A. Fitness classifications apply to active dutyolders 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 side 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, above the "0" 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 403A.

(a) All entries made on SF 403A and SF 403A 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 403A, become confusing. Entries are made on SF 403A in the same manner as on SF 403A. For convenience, any remaining entries in block 16 on the original SF 403A may be carried over to SF 403A. When a new SF 403A 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 403A with transcription entries will be added to a record before the previous SF 403A or SF 403A has been filled. In this instance, the empty portion of block 17 on the old form must be rendered unsuitable 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 entry of oral or dental care provided by personnel who did not have access to the permanent HREC and dental records (for example, dental field operations, from civilian or foreign sources, from other DTF or NTF, and so on) will be transferred to SF 403A or SF 403A as 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 available and will be performed by the record custodian or dental providers authorized such entry 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 02.
(3) If the physician deems necessary for proper outpatient follow-up care, SF 515, SF 509, SF 516, and other physician-designated forms.

(b) DA Form 199 (AR 635-40).
(c) DA Form 3947 (Medical Evaluation Board Proceedings) (AR 40-3).

(d) Copies of other HREC forms will be filed and prepared as described in paragraph (a) through (f) below.

(1) SF 9F and SF 93. The original of each of these forms will be filed (AR 40-501).
(2) DA Form 771. Each time DA Form 771 is prepared, a copy will be filed permanently in the HREC.
(3) DA Form 3349. When a patient's profile serial is revised (AR 40-501), a copy of DD Form 3349 will be put in the HREC.

(d) DA Form 4652. DA Form 4652 will be prepared, kept, and used per AR 40-055.

(e) DA Form 1141. DA Form 1141 or a summarized dosimetry record of personnel dosimetry must be kept in the HREC per AR 45-14. 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 radia tion 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 40-14, personnel dosimetry files, and table 2-1 of this regulation.)

(d) When dosimetry records are temporarily withdrawn from the HREC, file OF 21 in their place. Under the Identification of Record column of OF 21, 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 those records will be kept. Enter the date the record is removed in the Date Charged Out column.

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

(f) DA Form 4186. Per figure 5-1, file the most recent DA Form 4186 on top left. If the patient is granted clearance to fly, then file the most recent DA Form 4186, if any, that shows a medical restriction for 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. For any additional DA Forms 4186 that the flight surgeon determines to be required as a permanent record next. (Enter "Permanen Record in" in marks section.) Destroy other DA Forms 4186.

(g) State ambulances forms. By their design and content, State ambulances familiarize 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 ambulances 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 ambulances forms in the OTR is also encouraged.

(h) DA Form 3180-R (Personnel Screening and Evaluation Record) and DA Form 4315 (Personal Reliability Program Record Identifier). DA Form 3180-R and DA Form 4315 will be used to identify the medical records of individuals qualified for the Nuclear or Chemical Personnel Reliability Program per AR 50-5 and AR 50-6. The records manager will insert DA Form 4315 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.

(i) DA Form 2493-1 and DD Form 2493-2. DA Form 2493-1 and DD Form 2493-2 are required by AR 40-50. 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 asbestos surveillance program.

(j) DA Form 602. The medical officer who diagnoses syphilis will prepare SF 602 (original only) on the infested person. Examinations and laboratory procedures used to make the diagnosis will be noted on SF 602 when the case is given outpatient treatment; SF 602 will be completed after the diagnosis is made and antibiotic 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.

(k) The medical officer treating or observing the case will report each periodic followup in section V of SF 602. The period or followup examinations required before the record may be closed is provided in TB MED 320. 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.

(l) 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.

(m) A syphilis record will be reopened for re-treatment (The record filed in the HREC will be used for needed information; entries
about the case will be continued on SF 602.) or reclassification. (If reclassification occurs before the record is closed, the current record will be continued. In addition, thefollowing will be extended for an additional period of observation. Upon completion of the record it will remain in the SF 602 file and will be kept in all pertinent information and state a new diagnosis. They will also cite the clinical and laboratory data that prove the new diagnosis. If reclassification occurs after the record is closed, a new diagnosis will be prepared.)

(b) If the patient and his or her HREC are transferred before the record is closed, the medical officer of the laboratory command will put a statement in the HREC that the person desires for more followup studies. This statement will be formalized 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: "Postion seen, refer to file number 40-216" (military consultation service case files). (See AR 25-400-3 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. AHMED 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 patient 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 in a special category record, see AR 340-21, paragraph 2-5.

c. Inspector. Personnel inspecting MTF, DENTAC, or USAR records are allowed direct access to HRECs. These personnel include Inspector General personnel conducting Nuclear Safety Program and Chemical Safety Program inspections per AR 59-5 and AR 50-6 (AR 20-1). It also includes Defense Nuclear Agency inspection conducting Defense Nuclear Safety Inspection per TM 39-35-1 and AR 50-5. Inspectors may have access to HRECs to evaluate the compliance of AMDP personnel with regulations. All inspections must be done in a manner that will not violate the confidentiality of the HRECs they inspect.

d. Labor negotiation personnel. Grievance registration personnel are allowed direct access to the HREC 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 be allowed access to HRECs 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 United States 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 2-5-1.) 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-sectioning of health records
This regulation and similar ones in the other Services allow and direct cross-sectioning of HRECs. Procedures for maintaining and transferring Navy and Air Force HRECs are similar to those described for Army HRECs.

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

b. HRECs will not vest with Navy and Air Force patient will be requested when needed for treatment. Similarly, Army HRECs will be vested with Navy or Air Force HREC custodians when Army Personnel are given care by MTFs or DTFs of those Services.

Section II
Initiating, Keeping, and Displaying of Health Records
5-23. Initiating health records
a. HRECs for personal or personnel acting 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 custodians of Military Personnel Record Jourses, U.S. Army (MPRJ).

b. HRECs for personnel entering service. For personnel entering service, HRECs will be prepared as described in a above and d below. Any past HREC will be acquired; the documents are the temporary HREC (parts 5-25) will be put into the past one once. 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 Commanders, USAR/AFRJAC, ATTN: DARP-P-AS, 9700 Page Boulevard, St. Louis, MO 63122-5200. For ARNG, the HRECs for a person entering 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. HRECs for Army civilians. Any person entering military service will be kept in the MPJ. 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 he or her arrival at the station, the custodian of the MPJ will retain custody of the HREC; however, they will send it immediately to a medical or dental officer who requisitions or it to person the person. (In the ARNG and USAR, the custodian of the MPJ 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 344-series or DA Form 800-series folders. For preparation of these folders, see paragraphs 4-4. For HRECs, check the "Health" box and not "Type of Record", for dental records, using only DA Form 344-series folders, check the "Health (Dental)" box. Contents of any remaining DD Form 722-1 (old record jacket) will be transferred to DA Form 344-series folders or DA Form 800-series folders. Handwritten entries will be made in blank blue and black ink. (The members current organization for example, "C0 A 163 Inf") will be handwritten in pencil.

(2) SP 600. See paragraphs 5-14.

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

(4) SD 601 and SD 601A. See paragraphs 5-18 and 6-7.

(5) SF 88 and SF 9. The original copies of SF 88 and SF 9 will be put in the HREC.

(6) CDC Form 5.29564 (Veneral Disease Epidemiologic Report). If a CDC 5.29564 has been received with a person's
b. "Temporary" dental records. Temporary dental records will be prepared by dental personnel as described in a above. D4 Form 5570 and SF 603A will be placed in the temporary record. A dental examination to complete section 1 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 HIROC. If a delayed HIROC is not received within 60 days after a temporary record is prepared, a new HIROC will be prepared. This new HIROC will also be prepared when information or records after initial contact is received that a record has been destroyed.

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

(2) New permanent dental records replacing lost records are prepared in accordance with guidance in TM 250. A new document of a ray will be taken in duplicate, the original is for the new record, and the duplicate is sent to the Central Paragraph 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 command. When personnel who have been missing, missing in action, interned, or captured are returned to military control, their original HIROC will be acquired and continued in use.

5-26. Filing health records

a. HIROC files. HIROC files 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 personnel) or with the KC records custodian that provides military medical and dental care. If the soldier is assigned to an isolated unit without a serving military MTF or AMEED personnel, the HIROC will be filed at the unit under the custodianship of the commander. (See para 1-4b.) The records may be filed alphabetically or in terminal digit sequence. (See chap 4.) A clergiate system is used and when the HIROC is temporarily removed from the record room. (See para 4-6.)

b. Keeping HIROC files current. The procedure described in (a) through (l) below will be followed to keep HIROC files current.

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

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

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

c. Handling identifiable HIROC and medical forms. A record or form is an identifiable form if it contains enough information to identify it as belonging to a specific person. To keep files current, identifiable HIROC 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 HIROC. The member may hand carry the HIROC to the gaining MTF or DTF, or it can be sent with the MPK to the new custodian in accordance with paragraph 5-24a. When the HIROC 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 the record or form as the new custodian, 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 will be in the patient's mail or the member's assigned unit.

(2) When no proper custodians can be determined, the MTF or DTF will do its best, if possible, to defend in Defense Enrollment Eligibility Reporting System (DERS) MDRTS to obtain the current record or records. Otherwise, the MTF or DTF will ask the record custodians 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 service within its organization to comprise the required action on the list. (Some installations have In/Out Processing Sections where installations rosters and cleaner files can be checked; at other installations, these functions are handled in the consolidating of military personnel activities.) After the MILPO has searched its files, the list should be forwarded to the post locators or to the installation activity that maintains the worldwide locater files. The MILPO or post locator response will be kept by the MTF or DTF in a file (the number 40 (general medical services correspondence files) for 1 year. (See AR 25-400-2 for information on maintain those files.)

(3) If the MILPO or post locator cannot find the address of the proper custodians, the MTF or DTF will follow the steps outlined in (1) through (l) 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 off, and enlisted personnel) based on a check of outprocessing and separation files, the local Standard Installation/Division Personnel System/Security (DEERS, and the worldwide locater microfilm) and if the MIPO provides a forwarding address, active duty record, then send them to the forwarding address. If the soldier retired or was discharged or separated to an inactive US Army status then send them to Commandmaster, USAFRICEN, ATTN: DARP-HGD, 9900 Page Boulevard, St. Louis, MO 63132-5200. If an address from orders and OD Form 214 (Certificate of Release or Discharge from Active Duty) assigns the soldier to a US Army troop program unit or releases the US Army soldier from active duty for training or initial active duty or training then send them to the soldier's US Army unit. If an orders and OD Form 214 or the ARNG or National Guard 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 received his or her actual separation data then send them to the servicing separation transfer point. If no loga- ration and records are available the request for location service to the Commandmaster, U.S. Army Enlisted Records Center, ATTN: PC-KE-RF, Fort Benjamin Harrison, IN 46221-5301, 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 Systems, ATTN: NMC-OG-2, Navy Worldwide Locater Service, WASH DC 20370-5000.

(c) Rule 3. If the records or forms have a complete name and SSN on them and are AF or Corps records or forms, then send them to Commandant, the Marine Corps, HQ, U.S. Marine Corps, WASH DC 20380-0001.
Rule 4 If the records or forms have a complete name and
SSN on them and see Air Force records or forms, then send them to
HQ U.S. Air Force, ATTN: AFNIP/FDMDR, Randolph Air
Force Base, TX 71150-6001.

Rule 5 If the records or forms have a complete name and
SSN on them and see Public Health Service or Coast Guard com-
misioned corps records or forms, then send them to Medical
Branch, 5604 Fishers Lane, Parklawn Building, Rooms 4–15,
Rockville, MD 20857-6435.

Rule 6 If the records or forms have a complete state and
SSN on them and see National Oceanic and Atmospheric Admin-
istrative District of any of the Commissioned Person-
nel Center, NOAA (ATTN: CPI), 11400 Rockville Pike, Room 104, Rockville, MD 20855-0000.

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 be-
longs is impossible. Before destroying these records, the patient
administrator will send a report to the MTF or DOD attorney
that audits medical and dental records, listing the type of record
(laboratory forms, x-ray reports, SF 600, and so on) and the
number of each type to be destroyed. This report and the commit-
tee’s action on it will be entered in the committee minutes. Fol-
lowing the committee’s approval, the patient administrator or his
or her designee will destroy these records and forms.

Disposing of health records

Upon discharge, release from active duty, retirement, death, or
transfer from USAR to ARNG, the member’s HERC will be dis-
posed of per AR 465-10, paragraphs 2–8 and 2–10. ARNG HREC
will be disposed of as are MPRs (For officers and war-
nant 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

Screening Personnel Reliability Program records

a. Per AR 50-3 or AR 50-4, paragraph 1-15, each Personnel
Reliability Program candidate must be medically evaluated as part
of the screening process. For a review of the individual’s medical
records. HREC 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 as-
sistant, 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) spe-
nificantly to the supporting U.S. military
MTM commander to screen medical records and complete part
II, DA Form 1180-R.

b. Personnel Reliability Program HREC or CEMRs will be
screened per AR 50-3 or AR 50-4 by the losing organization’s
supporting medical activity before the individual departs on orders
for reassignment to a nuclear or chemical duty position and
by the gaining organization’s supporting medical activity before
being assigned to a nuclear or chemical duty position. The screen-
ing individual will annotate SF 600 with the following or similar
statement: “Proceeding entity screened under provisions of AR
50-3 or AR 50-4” 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.

Maintaining Personnel Reliability Program records

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

b. Personnel Reliability Program HREC or CEMRs must ensure that the chain of custody in the handling of Personnel Reliability Program medical records is not broken. Personnel Reliability Program records must be retained in 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 re-
cord 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 Name DA Form 3180-R and DA Form 4515 as de-
scribed in paragraph 5–199. The Personnel Reliability Program block or record folder will be marked to indicate participation in the program.

Section IV

Maintenance of Health Records Upon Mobilization

Health records of deployed soldiers

a. HREC of deployed soldiers. HREC of deployed soldiers
will not accompany them to combat areas. When processing
soldiers for deployment, the MTF and DITF will audit each sol-
dier’s HREC and record essential health- and dental-care informa-
tion on DA Form 800. DA Form 800 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 800
should be initiated and/or updated during record screening (para
5–194(2)). DA Form 800 is intended for use until an electron-
ic device that stores medical or dental, personnel, and fluandes
is fielded. The preparation and use of DA Form 800 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 800 during train-
ing exercises. (See also para 5–24.)

b. If an HREC is not available, DA Form 800 will be com-
pletes based on soldier records and any locally available data.
An HREC may be not available for most Individual Ready
Reserve, Individual Mobilization Augment, and retired per-
nel because these HREC may remain on File at the USARPERCEN.

2. The Officers and DA Form 800 will be provided to the sol-
dier’s command, or to the soldier if an individual replacement,
and then handed off to the MTF in the area of operation responsi-
ble for providing primary medical care. The MTF will maintain
DA Form 800 in an outpatients file field for reference as needed.
The field file will consist of, in part, DA Form 800 and possibly
SF 600, SF 538, SF 603, or DD Form 1380.

3. The soldier’s field file may be managed as a “drop” file
(items not attached).

4. MTFs and DTFs at the mobilization site(s) will follow the
procedure in AR 465-10 for incorporating the HREC into the
MPR.

5. Forwarded deployed force. If time permits, follow guidance
in at 1 and 2 above. If not, consolidate HREC in-country, and pro-
cade when time permits.

6. Limited consideration operations. Review the HREC at the
MTF and DTF providing primary care. If the servicing primary
facility is unable to forward the HREC to the MTF or DTF indi-
cated by the servicing MEDDAC and DENTAC. If full mobiliza-
tion occurs, follow guidance in at 1 and 2 above.

7. Units 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.

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 home base 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 stations or mobilization stations. Field files will be forwarded to USARPERCEN for those soldiers whose HREC is maintained at USARPERCEN.

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

TO CHIEF RECORDS LOCATOR 3VC//FT BEN HARRISON IN//DREO-O//

UNCLAS:

SUBJECT: MEDICAL/DENTAL RECORD LOCATOR SERVICE

ADDED INSTRUCTIONS:

1. LMF - MUST BE CT.
2. CIC - MUST BE D3ER.
3. ORIG/MSG IDENT - MUST BE SENDER’S ROUTING INDICATOR (CODE ORIC).
4. COMMUNICATIONS CENTER MUST ROUTE MSG TO REC: 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/777869999

UNCLAS:

SIGNED

SPECIAL INSTRUCTIONS

DOCUMENT NAME: NAME TITLE ADDRESS PHONE

SIGNATURE CLASSIFICATION DATE THE CAMP

DD 2404 1732 (DCR)

Figure 9-4. Sample message format for stray medical records

AR 46-66+ UPDATE
Pt: Ft with history of pain in L shoulder x 1 week. Progressively worse with radiation of pain to arm and forearm. No hx of trauma or stress.
4 Feb 73
No previous hx of shoulder or joint pain.
Exam: Limited motion of L shoulder, especially to active abduction and rotation. Point tenderness over antecubital fossa. No evidence of nerve involvement in arm, forearm or hand.
Lab: X-ray demonstrated calcification in bursa.
Pt: Leric acid, RF.
1) Refer to Phys Therapy for evaluation and approp. treatment.
Goal: Relief of pain and normal range of motion.
2) Profile: Temp 93, Coda 0, 30 days.
4) If no improvement in 1 month, return for re-evaluation.
L. E. Smith, MAJ, MC

Pt Splendid, TX
Pt with L shoulder pain was evaluated and found to have limitation of L shoulder motion and pain on act. abd. beyond 60°. Active ROM L shoulder.
4 Feb 73
100°: Abd. 65°; Flex. 95°; Int. rec. 65°; Ext tot. 65°. Rx of ice massage to glenohumeral joint followed by ROM exercises L shoulder initiated. Daily x 5.
Mary Thomas, LIT, ARINC

Pt Splendid, TX
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 exercises and gaged to return in two weeks. Pt returned this date with L shoulder asymptomatic and ROM within normal limits. Treatment discontinued.
Mary Thomas, LIT, ARINC

PATIENT IDENTIFICATION (Use the Space for This Information)

PATIENT'S NAME (Last, First, Middle initial)
Walker, Paul O.

YEAR OF BIRTH
1944

RELATIONSHIP TO SPOUSE
Ad

SPOUSE'S NAME
Army

SBS

XO 218102 99 93

ORGANIZATION
Mo, Ft Splendid, TX

CHRONOLOGICAL RECORD OF MEDICAL CARE

Figure 9-5. Sample entries on SF 600

AR 40-66 UPDATE 35
DATE  SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Rep 11 for stn pg)

TOOP HEALTH  CLINIC 6
FT Splendid  TX
20 March 73
0800

Pt: 27 year old MN with pain low back following lifting of footlocker at home (3200 R. Jones St., Arlington, Va) at 0800 hours 19 March 73.

Immediate pain at L-S area but gradual resolution last evening. Awakes this AM with severe pain. Unable to get out of chair without pain. No neurological symptoms. No sciatic 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.

Rx: Prob. acute low back strain

Pt: 1) Diazepam 5 mg QID (warn about driving, etc.)

2) Bed board

3) Quarters 24 hours

4) Return in AM

R. O. Jones, MAJ, MC

---

TOOP HEALTH  CLINIC 6
FT Splendid  TX
31 March 73
0915

Pt: Back pain much better, minimal discomfort.

PE: Slight tenderness but full ROM.

Rx: Duty (clerical job, no Profile Change required)

R. J. Jones, MAJ, MC

---

Figure 6-5. Sample entries on SF 600—Continued
RIGHT SIDE OF FOLDER
DA Form 4155
Personal Reliability Program Record Identifier. (See AR 50-5 or AR 50-6, and para 5-1(6)(6) and 5-29c of this regulation.)
SF 600-1-2; SF 558-1-2 Health Records—Chronological Record of Medical Care; Emergency Care and Treatment. Also file here any other basic chronological medical care records, for example, AR 40-6 and MAOS/IST local encounter forms. (See para 5-16 and 5-16.)
State ambulance forms (fied behind covering SF 558.) (See para 5-10(7)).
DD Form 2493-1
Abacavir Exposure Part I—Initial Medical Questionnaire. (See AR 40-5 and para 5-15b (9) of this regulation.)
DD Form 2493-2
Abacavir Exposure Part II—Periodic Medical Questionnaire. (See AR 40-5 and para 5-15b (9) of this regulation.)
DA Form 566-87-1
Chronicologic Record of Wart-Baby Care. (See para 6-21.)
DA Form 3783
Community Health Nursing—Case Referral (See AR 40-407, para 4-2b.)
DA Form 559-R1
Iron/Lead (HM) Clinic Flow Sheet. (See para 5-8.)
DA Form 4530
Electrocardiogram Report and History. (See SF 569.) DA Form 4530 is obsolete; use for file purposes only.
DD Form 4700-1
Medical Record—Supplemental Medical Data. (See chap 3.)
DA Form 5059
Telephone Medical Advice/Consultation Record. Attach to and file with SF 600. (See para 5-6 for completion instructions.)
SF 512
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 222
Medical Records—Request for Administration of Anesthesia and Performance of Operations and Other Procedures.
SF 5061
Medical records—Allergen Extract Prescription, New and Refill. (See para 5-15.)
DD Form 2482
Venom Extract Prescription. (See para 5-12.)
DA Form 5007-A-R1; DA Form 5007-B-R1
Medical Record—Allergy Immuno/therapy Record—Single Extract Medical Record—Allergy Immunotherapy Record— dilute Extract. (See para 5-6.)
Other SF 500-series forms.
File in numerical sequence.
DA Form 741
Eye Consultation.
DD Form 771-1
Eye Wear Prescription/Eyewear Prescription— Plastic Lenses. DD Form 771-1 is obsolete; use for file purposes only.
DD Form 2215
Reference Audiogram.
DD Form 2216
Hearing Conservation Data. (See para 40-5.)

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

Reports or certification prepared by neuropsychiatric consultation services.
Correspondence on hearing aids.
Medical documents from civilian sources.
DA Form 4465
Audit Intake Record. Also file here any other authorized alcohol and drug forms. (See AR 60-85 and para 5-1065 and 7-2-9 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 OTR.

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

PART I
DA Form 5571-1
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 60-75 and para 5-2g of this regulation.)
DA Form 5931-R
Army Exceptional Family Member Program Educational Questionnaire. (See AR 60-75 and para 5-2g of this regulation.)
DA Form 5288
Exceptional Family Members Program Summary Report. When available, DA Form 5288 replaces either DA Form 5862-R and DA Form 5291-R, or both. (See AR 60-75 and para 5-2g of this regulation.)
Civilian source pediatric growth charts. (See para 5-2d.)
DA Form 5692
Denom Developmental Screening Form. (See para 5-2e of this regulation.)
DD Form 1141
Record of Occupational Exposure to Ionizing Radiation or Automated Dosimetry Record. (See AR 50-14 and para 5-19k(5) of this regulation.)
DD Form 2493
Abacavir Exposure Part I—Initial Medical Questionnaire. (See AR 40-5 and para 5-15(9) of this regulation.)
DD Form 2493-2
Abacavir Exposure Part II—Periodic Medical Questionnaire. (See AR 40-5 and para 5-15(9) of this regulation.)
SF 401-1
Health Record—Immuno/therapy Record. (See para 5-17 and 6-7.)
SF 401-2
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

AR 40-66* UPDATE 38
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 clinic) 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 statutory cases (para. 6-3b) or consultation service cases (para. C-2). When receipt of an OTR is delayed, a temporary one will be prepared according to paragraph 5-25a.

6-4. Transferring outpatient treatment records

To ensure that a patient’s outpatient records are complete, the MTF providing the care will include in the OTR all outpatient records prepared at other facilities. To this end, OTRs should be transferred to the next MTF when patients change residences. OTRs of patients who may be lost to the AMEDD system (that is, patients are being released from military service in conjunction with the move or are being assigned to a remote location not served by an Army MTF) will be retained by the losing MTF per AR 25-403.2. 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 paragraph 6-3a.)

(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 station, the sponsor will report to the MTF that provides care to his or her dependents as a part of out-processing. He or she will give the MTF the information needed to identify the records that are required.

(b) The MTF or DTF will complete DD Form 2138 and instruct the sponsor to present the card at the next MTF or DTF. (See paragraph 6-3a2.)

(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's administrative 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 (i) above may be given a copy of certain parts of his or her OTR or an extract from his or her OTR. The record will be on the location of the patient during the period on 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 on route should be indicated 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 (either those described in a(i) 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. (While preparing DA Form 3705, complete the "address" blocks.) Once signed, DA Form 3705 will be filed as DD Form 2138 (G/36) above.)

AR 40-46 • UPDATE 41
(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 3795.

c. "Measles units" case of status. When a Measles unit arises, the following actions will be taken: (1) The patient will be isolated on single room and until he is declared free of the disease (see paragraph 2-5C)(2).

4-6. Requests other than DD Form 2138

Although DD Form 2138 is the only form authorized for use as a request for transferring other than MTIs, any other types of requests will be treated in the same manner. The form will be sent to the OTR, who will forward it to the appropriate authority. The form will be treated in the same manner as any other form.

5. Disposition

a. OTRs will be disposed of as per AR 25-400-2 (see paragraphs 3-7 for information on destroying other forms).

b. If a patient requests a change in diagnosis, the patient's medical record must be updated to reflect the change. If the patient requests a change in treatment, the patient's medical record must be updated to reflect the change.

c. The patient's medical record will be updated to reflect any changes in diagnosis or treatment.

6. Preparation and Use of Outpatient Treatment Records

4-7. Preparation

Each entry in the AIMEED as an outpatient will be recorded in the OTR. The requirements for treatment as an inpatient will be described on DA Form 3647 and DA Form 3795 and will be put into the OTR. Initial data (treatment) will be recorded on DA Form 600 and DA Form 601 in the OTR. The patient's medical record will be updated to reflect any changes in diagnosis or treatment.

4-8. Use

The OTR will be open 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 by the patient; however, it will be made available to any medical or dental personnel when required during this period. Furthermore, the OTR will accompany a patient assisted to a military hospital and will be immediately available for use by the attending physician.

4. Chargeback system. A select audit trail will be kept for OTRs temporarily out of the file. (See paragraph 4-6.)

b. Protection of medical information. See chapter 2.
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 7090 is completed.

h. DA Form 8023 will be used to briefly summarize rehabilitation efforts from date of patient enrollment to current date or termination of ADAFCP 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 is used to make an ADAFCP 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 consulted by the ADAFCP 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 ADAFCP-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 is the ADAFCP or when a medical evaluation is needed. (See AR 600–5 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 365-day intervals (following enrollment) upon inpatient enrollment and/or discharge, to change the diagnosis or basis for enrollment, patient PCS, or patient assignment, or to discharge the patient from the program. (See AR 600–5 for instructions on completing the form.)

Chapter 8
Inpatient Treatment Records

Section I
General

P-1. For whom prepared

a. An ITR will be prepared for—

(1) Every bed patient (military or civilian) in a fixed or field hospital, level health clinic, or convalescent center.

(2) Each inborn infant delivered in one of these MTFs.

(3) CRO cases (para 3–7).

(4) Nato patients (para 4–4).

b. An ITR will not be prepared for—

(1) Stillbirths. (There will be no separate record made for the stillbirth. Forms and information pertinent to the stillbirth will be included in the mother's ITR.)

(2) MTFs supporting combat operations if the surgeon consents their use impractical and if DD Form 1380 has been approved for such use.

c. For nonmilitary MTFs using ITRs, instructions for preparation will be provided by the MEDIAC or MDCEN in whose geographic area the nonfixed facility is operating. Disposition will be per AR 25-400-2.

P-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 344-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

---

The text seems to be a part of a military document discussing various forms and procedures for managing patient information within the ADAFCP framework. It provides instructions on how to handle patient data, including the types of forms used, their purpose, and when they are to be completed. The document also outlines procedures for setting up an inpatient treatment record and details what information should be included in these records. The text is quite detailed and seems to be part of a larger set of instructions for military medical personnel.
LEFT SIDE OF FOLDER
DA Form 5571-1
Master Problem List. Filing x ITR It optional. (See para 8-10.)

DA Form 3947
Medical Evaluation Board Proceedings. (See AR 40-3 and para 5-18(b) of this regulation.)

DA Form 3349
Physical Profile. See AR 40-501 and para 5-18(b) 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
Request and Release of Medical Information to Communications Media. (See para 2-2.)

DA Form 5006-R
Medical Record—Authorization for Disclosure of Information. File here any other authorizations for release of medical information related to care. (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 or release of medical information. (See AR 40-2.)

DA Form 5009-R
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 5302-R
Volunteer Agreement Affidavit. (See AR 40-38 and para 8-2 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 40-3 and para 5-18(b) of this regulation)

DA Form 3647
Inpatient Treatment Record Cover Sheet. All versions. (See AR 40-600 and para 5-12(a)(1), 5-12(b), 5-17(a), 5-17(b), 5-2(a), 5-19(a), 5-7, 8-78, 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
Clinic Record—Narrative Summary. (See para 8-10.)

SF 503
Clinical Record—Autopsy Protocol. Used as a summary for detailed autopsy reports. (See para 8-12.)

SF 509
Medical Record—Abbreviated Medical Record. (See para 8-17.)

SF 504
Clinical Record—History—Part I. (See para 8-10.)

SF 505
Clinical Record—History—Parts II and III. (See para 8-10.)

SF 506
Clinical Record—Physical Examination. (See para 8-10.)

SF 535
Clinical Record—Newborn. Civilian source pediatric growth charts. (See para 8-20.)

DA Form 5694
Deny Developmental Screening Test. (See para 8-2e of this regulation.)

SF 507
Clinical Record—Report on or Continuation of SF. (See para 8-10.)

SF 509
SF 558
Medical Record—Doctor’s Progress Notes; Medical Record—Emergency Care Treatment. (See paras 5-14 and 8-10.)

DA Form 3808
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 614 and DA Form 4335). (See AR 40-407 and para 3-2-3, 8-10, and 8-11 of this regulation.)

DA Form 5179
Medical Record—Preoperative/Postoperative Nursing Document. (See AR 40-407.)

DA Form 5179-R
Medical Record—Preoperative Document. (See AR 40-407.)

DA Form 3950
Flowsheet for Vital Signs and Other Parameters. (See AR 40-407.)

SF 511
Medical Record—Vital Signs Record (formerly Temperature-Pulse-Respiration (Fahrenheit))

SF 512
Clinical Record—Pretreatment Chart. (See para 5-13.)

SF 513
DD Form 2416
Medical Record—Contribution Sheet; Referral for Civilian Medical Care. (See para 8-10.)

SF 545
Laboratory Report Display. File with SF 545, SF 546, SF 547, SF 548, SF 549, SF 550, SF 551, SF 552, SF 553, SF 554, SF 555, SF 558, and SF 557 mounted. (See para 8-18.) Instructions for completing these forms are provided in tables 8-1 and 8-2.

SF 515
Medical Record—Tissue Examination. (See para 5-22 and 5-19.)

Army Forensic Institute of Pathology Consultation Report on Contributor Manual

SF 515
Medical Record—Operation Report. (See para 8-10.)

SF 517
Clinical Record—Anesthesia. (See para 8-10.)

Figure 8-1. Forms and documents of the ITR—Continued

AR 40-600 UPDATE 45
Figure 8-1. Forms and documents of the ITR—Continued

DA Form 4577
Therapeutic Documentation Care Plan (Non-Medications). (See AR 40-407 and para 8-16 of this regulation.)

DA Form 4578
Therapeutic Documentation Care Plan (Medications). (See AR 40-407 and para 8-19 of this regulation.)

DA Form 4530
Electroencephalograph Report and History. (See SF 5810.) DA Form 4530 is obsolete; use for file purposes only.

DA Form 4700
Clinical Record—Visual Field Examination (formerly DD Form 742).

DD Form 602
Patient Evaluation Tag, Stuide to SF 502. (See AR 40-40 and para 8-4 of this regulation.)

DD Form 761
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 Records—Head Injury. DD Form 749 is obsolete; use for file purposes only.

DD Form 1380
U.S. Field Medical Card. (See chap 7 for completion instructions.)

DA Form 4359-R
Authorization for Psychiatric Supervision Treatment. (See AR 40-3.)

Medical reports (for example, autopsy report and fetal death certificate) are not available. File in the mother’s ITR.

DA Form 2885
Adopting information. (See AR 40-400 and para 3-11 of this regulation.)

EA Form 6410
Disclosure Accounting Record. Include when imprinted DA Form 3443-series forms are not used. DA Form 4410 is obsolete; use for file purposes only.

DD Form 3905
Privacy Act Statement—Health Care records. To be included when imprinted DA Form 3443-series forms are not used. (See AR 40-2 and para 4-4 of this regulation.)

Notes:
1. Instructions for completing each form are self-explanatory.

Figure 8-1. Forms and documents of the ITR—Continued
(2) When a patient executes a living will (also known as ad
vance directive), 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 re-
sponsibility to ensure that copies of the living will are given to
MTF personnel at each admission and/or creation of a new outpa-
tient record. Living wills should be filed with administrative doc-
ments 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 pre-
bared by authorized AMEED personnel will be filed in the ITR.
However, this restriction does not prohibit the use of other docu-
ments by attending physicians and does not prohibit the filing of
other documents in the ITR as summaries or pertinent brief ex-
tracts. If filed, their source and the physician under whom they
were prepared must be identified.

d. Identification procedures for fetal monitoring strips are pro-
vided in (1) through (5) below.
(1) Identify and file the fetal monitoring strips in envelopes that
are kept in the file box on the sideboard tables that are
used to retire records. (For example, two rows of 65 by 9-inch
envelopes can be placed in these boxes.) Keep the strips on the ob-
steatrical 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 imprinted to the left margin.
(a) Name and record number of infant. If the infant has not
been named, record "baby boy" or "baby girl" with the last name.
(b) Spouse'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 reviewed.
(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 provid-
ed in (1) through (4) below.
(1) The inpatient records section will maintain the fetal moni-
toring strips as a separate file; strips will be filed in register num-
ber sequence.
(2) The locator card received from admissions and dispositions
with the monitoring strips will be stapled on the outside of the en-
velope or kept in a separate alphabetical file until the strips are re-
tired.
(3) Medical records personnel will write the register number of
the infant at the top of each envelope where it will be clearly vis-
ible 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 copies 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 forward-
ed 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 pre-
natal 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 alphabet-
ically 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 se-
quence (except as described in (5) 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

B-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 estab-
lished procedures.

B-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, in-
cluding x-rays, will accompany a NATO member who is trans-
ferred 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 40-405,
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 stan-
dard for all forces. All items normally recorded for U.S. person-
nel will be recorded for NATO personnel. In addition, the marital sta-
tus of the NATO member will be recorded.

B-5. Inpatient treatment records of absent-without-leave
patients

The ITR of a patient who has been AWO for 10 consecutive
days will be closed and disposed of per file numbers 43-66 (mili-
tary ITRs) and 40-66 (NATO personnel ITRs). (See AR
40-405-2 and table 2-1 of this regulation.)

B-6. Five-year inpatient treatment record maintenance

Medical centers will keep ITR files for 5 years. These centers are:

- Brooke Army Medical Center, Fort Sam Houston TX
78234-8200.
- Fitzsimons Army Medical Center, Aurora, CO 80045-5590.
- Madigan Army Medical Center, Tacoma, WA 98431-5055.
- Tripler Army Medical Center, HI 96859-5000.
- William Beaumont Army Medical Center, El Paso, TX
79925-5001.
- Walter Reed Army Medical Center, Washington, DC
20307-5000.
- Dwight David Eisenhower Medical Center, Fort Gordon,
GA 30905-5650.
- Womack Army Medical Center, Fort Bragg, NC
28057-5000.

AR 40-66 • UPDATE 47
Access must be given to ITRs in file or to cases having report numbers. In addition, a record audit trail must be kept. The two indices described in a and b below will be kept for these purposes.

When an automated database (for example, Automated Questionnaire Evaluation Support System (AQESS) and CHCS) is used to consolidate the admission and disposition history of individual in-patients, a mailing inertial nominal index is no longer necessary.

a. Nominal index. The nominal index will include a code 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 AQESS, CHCS, or other automated patient data systems.

b. Register number index. MEDDACs will maintain a register number index for 5 years. MEDCECs do not need to maintain this index because the ITRs are maintained at the MEDDAC for 5 years. The register number index will include a copy of DA Form 3467 for each patient assigned a register number. A copy of SF 502 (when prepared) may be attached to DA Form 3467. This index will be kept in register number sequence. For transfer cases, a copy of the transmittal form will be attached to DA Form 3467.

8-4. Disposition of Inpatient treatment records

8-4a. Inpatient transfer. When a patient is transferred to a U.S. Army MTF, the original ITR will be sent along with and will become a part of the receiving MTF's ITR (para 8-2B(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 a civilian facility, a transfer certificate, a copy of the ITR, or a copy of the ITR will be sent; the original ITR will be kept by the Army MTF and disposed of per AR 25-402, file folders 40-466 (military ITRs), 46-46 (civilian ITRs), and 44-66 (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. The slides will be sent when the histopathological findings have direct bearing on diagnosis and treatment. (See AR 40-3J, para 4A). 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 physician administrator will enter "Microscope slide (or number of microscope slides) forwarded with ITR" and then send the slides with the patient's records if the patient is a "transient" (that is, to route to another hospital), the physician administrator will send the slides with the ITR when the patient departs.

c. Normal separation procedures. For these disposition instructions, see AR 25-402-2, file numbers 40-466 (Foreign national), 46-46 (ITRs), 46-46 (military ITRs), 46-46 (civilian ITRs), and 44-66 (NATO personnel ITRs). (See Table 2-1.)

Section III

Preparation and Use of Inpatient Treatment Records

8-5. 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 3467 within 4 working days. If a test result is pending, 7 working days will be allowed. If the transcription or other data is not entered to the ITR, the practitioner will be held to 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 Health Care Organizations for a completed ITR. Records will be completed using available fillings; delayed reports will be filed in the ITR when received and, if needed, a corrected DA Form 3467 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) After consultation with, or other reports are completed, they will be added to the ITR along with any progress notes (SF 509) (para 8-10B) and other notes made by health-care providers.

c. When the patient is discharged, the attending physician will prepare SF 502 (para 8-10C) complete the DA Form 3467 work sheet (section IV), and sent the completed ITR through channels to the patient administration. The ITRs prepared by the transferring MTF will be sent with the completed ITR to the patient administration division and filed in the DA Form 3444-series folder (para 8-2B(2)). OTRs and HRECs will be returned to the proper records custodian.

d. In exceptional 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 8-10F)

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 each form.

a. History and Physical. An admission workup will be prepared on SF 504 (Clinical Record—History—Part 1), SF 505 (Clinical Record—History—Part 2 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 cardiovascular system findings will be fully recorded, terms such as "normal," "well," and "negative" will be used. These records are not needed, however, in emergencies for emergency surgery, the physician will report only vital signs, pertinent physical findings, and any abnormal (if known). (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 receiving MTE. (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 5-11A(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 records will describe any pertinent changes. However, these interval reports are allowed only if the ITR with the original history and physical is also sent with 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 tibial and 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 attest when counter signing 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 the treatment. SF 509 will be recorded by the person giving the treatment or making the observations.

(1) Progress notes by doctors. In addition to the information described in b. above, doctors notes, documents 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 record will briefly describe the patient's clinical circumstances that brought the patient to the hospital. It will list the proposed diagnostic workup and it 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 5-14-1.) The 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 anesthesia preoperative 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 in- duction, and the removal of sutures and dressings. Progress notes (SF 509) will also record examinations of chest and legs until the patient is ambulatory and ambulatory, 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, final diagnosis, and postdischarge care, including activity permitted, diet, medications, stresses, and the date and clinic for follow up care.

(f) In hospitalization the work sheet on 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 to the patient. (See AR 40-407.)

(4) Dietetic progress notes. See AR 40-2, paragraph 9-16a.

(5) Physical and occupational therapy notes. Treatment given in patients 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) Medi-social 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 (the number 40-216b, social work individual cases).) (See AR 25-400-2 and table 2-1 of this regulation.)

(7) Psychology notes. Psychology officers (area of concentration 068) 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 40-216b, clinical psychology individual cases). (See AR 25-400-2 and tables 2-1 of this regulation.)

i. SF 516. Reports for all cases involving surgery is the operating room or ambulatory surgery unit, even when performed under local anesthesia, will be dictated immediately after surgery and transcribed on SF 516, OP 275, or automated equivalents. (See para 3-3 for information on OP 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 abnor-
mal, of all organs explored.
(4) A detailed account of the technique used and the tissue re-
moved.
(5) The condition of the patient at the end of the operation.
(6) Care of recipient.—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 cre-
dentials 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 5–24(d).

f. SF 502. The narrative summary will be dictated promptly at transfer-out or discharge of the patient and transcribed onto SF 502 (Fig 1), 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 para 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 pro-
thetic device that is permanently implanted in the body will be identified, including nomenclature of prosthesis, manufacturer, and serial numbers as provided.)

d. The condition of the patient on transfer or discharge.

e. The discharge instructions given to the patient or his or her

family (that is, physical activity permitted, medication, diet, and follow-up care).

f. All relevant diagnoses (including complications) made by the time of discharge or transfer.

(2) A progress note (SF 509) summarizing the case may be sub-
mittted for the narrative summary (SF 502) when—

a. A transfer or discharge occurs within 72 hours after admis-
sion. (See para 5–17.)

b. An obstetrical case has a normal, uncomplicated delivery.

c. A patient’s problem is minor. (See para 5–17.)

(3) All hospital death cases require a narrative summary.

(4) SF 502. The patient’s progress notes 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 histopathological analyses.

(2) Prognosis of postoperative/progress notes.

(3) Final diagnoses based on the definitive microscopic findings and histopathological analyses.

8–11. Counter signatures

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 attending surgeon.

(3) Narrative summaries (SF 502) written or dictated by some-

one other than the attending physician, dentist, podiatrist, or mid-

wife 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 case provided will be documented on SF 509 and SF 510, as appropriate. Sufficient evi-
dence will be documented in the medical record to substantiate ac-
tive participation in and supervision of the patient’s care by the responsible program preceptor. Documentation of histories and physicals (SF 504, SF 503, and SF 506) and doctors’ orders (DA Form 4256), when an integral part of the program, will be coun-
tersigned 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 that will be prepared for use in any 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 HREC and OTRs and serves as a source document for statistical information of major military and medical interest. In facilities using CHCS or AQCRESS, an automated version of DA Form 3647 may be used. A worksheet copy may not be provided in AQCRESS or CHCS.

8–13. Use

Paragraph 8–12 names the kinds of MTFs that use DA Form 3647. In addition, DA Form 3647 may be used in overseas com-
mands by clearing stations chosen and staffed to be run as outpa-

tient hospitals. The theater surgeon will determine if those holding

stations will use DA Form 3647 by the mission and function of the holder unit. When such a mission holds a field hospital

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 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 ma-

chine copied. For Allied and neutral military personnel, an addi-
tional copy is filed with the ITR. A copy of the DA Form 3647

and SF 502 (when prepared) will also be filed in HREC and OTRs. Copies of DA Form 3647 and SF 502 on Public Health Service stations will be countersigned and annotated as appro-

priate.

8–15. Preparation

Instructions for completing DA Form 3647 are found in the IPDS

Users’ Manual, which may be obtained from PASBA (ATTN: HSHL-Q2), Fort Sam Houston, TX 78234-6070. Also see Inter-
national 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 20402-0335. Also see the Tricare Paga-

dance Procedure ICD–9–CM. Diagnostic entries on the work-

sheet 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 those people will sign the worksheet copy.

8–16. Corrections and corrected copies

Corrections to DA Form 3647 will be made when necessary. (See para 3–4c.)
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 hospitaliza-
tion in the civilian sector, for example, measles or upper respira-
tory infections. 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 Anesthesi-
    ologists Class I or II; that is, the patient has no organic, physiologi-
    cal, biochemical, or psychiatric disturbance, or the systemic distur-
    bance 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 sec-
    tion must fully describe the cardiopulmonary findings. (Terms such
    as "normal," "well," and "negative" will not be used.) It must also
describe any exceptions or other pertinent findings.

d. When SF 539 is used, SF 503 may be replaced by a final pro-
gress note (SF 509). However, when a short stay becomes a long
one, SF 503 must be prepared. In such cases, SF 504, SF 505, and
SF 506 need not be completed in addition to SF 539; the reason
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 ad-
dition to the already completed SF 506, SF 503, and SF 506, and
the case may be summarized in the progress notes (SF 509) in-
stead of in SF 503.

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 555, and SF
557) and automated versions of them are used to request labora-
tory tests and to report the results of those tests. When a computer-
ized or automated summary of all previous laboratory tests is
provided, only the cumulative final report should be filed in the rec-
cord. 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 labora-
tory files. The original is routed for immediate filing in the ITR or
OTR or outpatient HREC. The second copy is routed to the re-
questing practitioner for use and disposition.

b. Carrying or distributing laboratory reports will not be filed in
the medical record. The MTF commander will ensure that each pa-
tient'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

<table>
<thead>
<tr>
<th>Block</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block: Patient Identification.</td>
<td>Completed by: Clinic or ward.</td>
</tr>
<tr>
<td>Instructions: Enter patient's name, date of birth, and sex.</td>
<td></td>
</tr>
<tr>
<td>Block: Follow-up.</td>
<td>Completed by: Clinic or ward.</td>
</tr>
<tr>
<td>Instructions: Enter the patient's name, date of birth, and sex.</td>
<td></td>
</tr>
<tr>
<td>Block: Specimen Taken.</td>
<td>Completed by: Laboratory.</td>
</tr>
<tr>
<td>Instructions: Enter the date and time the specimen was taken.</td>
<td></td>
</tr>
</tbody>
</table>

Table 8–2
Table 8–1—Continued

<table>
<thead>
<tr>
<th>Block</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block: Urgency.</td>
<td>Completed by: Clinic or ward.</td>
</tr>
<tr>
<td>Instructions: Check the proper box.</td>
<td></td>
</tr>
<tr>
<td>Completed by: Laboratory.</td>
<td></td>
</tr>
<tr>
<td>Instructions: Enter the specimen or laboratory report number.</td>
<td></td>
</tr>
<tr>
<td>Block: Patient Status.</td>
<td>Completed by: Clinic or ward.</td>
</tr>
<tr>
<td>Instructions: Check the proper box.</td>
<td></td>
</tr>
<tr>
<td>Block: Specimen Source.</td>
<td>Completed by: Clinic or ward.</td>
</tr>
<tr>
<td>Instructions: Check the proper box or write in the needed</td>
<td></td>
</tr>
<tr>
<td>information.</td>
<td></td>
</tr>
<tr>
<td>Remarks:</td>
<td>Forms some forms request other specimen information:</td>
</tr>
<tr>
<td>a. On SF 548, give specimen interval information.</td>
<td></td>
</tr>
<tr>
<td>b. On SF 550 and SF 554, give infection information. Extra</td>
<td></td>
</tr>
<tr>
<td>information is needed on these forms to identify sensitivities and</td>
<td></td>
</tr>
<tr>
<td>infecting organisms. Enter this information in the Clinical</td>
<td></td>
</tr>
<tr>
<td>Information and Antibiotic Therapy blocks.</td>
<td></td>
</tr>
<tr>
<td>c. On SF 550, give specimen source information for obstetric</td>
<td></td>
</tr>
<tr>
<td>patients.</td>
<td></td>
</tr>
<tr>
<td>Block: Requesting Physician's Signature.</td>
<td>Completed by: Clinic or ward.</td>
</tr>
<tr>
<td>Instructions: Enter the name of the practitioner ordering the</td>
<td></td>
</tr>
<tr>
<td>test. If he or she is a military member, enter grade and corps.</td>
<td></td>
</tr>
<tr>
<td>Remarks: The signature is not needed.</td>
<td></td>
</tr>
<tr>
<td>Block: Report by.</td>
<td>Completed by: Laboratory.</td>
</tr>
<tr>
<td>Instructions: Enter the name of the laboratory.</td>
<td></td>
</tr>
<tr>
<td>Remarks: The laboratory ensures that test results are</td>
<td></td>
</tr>
<tr>
<td>accurate.</td>
<td></td>
</tr>
<tr>
<td>Block: Data.</td>
<td>Completed by: Laboratory.</td>
</tr>
<tr>
<td>Instructions: Enter date that the report is completed by the</td>
<td></td>
</tr>
<tr>
<td>laboratory.</td>
<td></td>
</tr>
<tr>
<td>Remarks: N/A.</td>
<td></td>
</tr>
<tr>
<td>Block: Lab ID No.</td>
<td>Completed by: Laboratory.</td>
</tr>
<tr>
<td>Instructions: Enter laboratory identification number.</td>
<td></td>
</tr>
<tr>
<td>Remarks: This field may be used to identify and monitor the request form.</td>
<td></td>
</tr>
<tr>
<td>Block: Remarks.</td>
<td>Completed by: Laboratory.</td>
</tr>
<tr>
<td>Instructions: Enter any special information for the practitioner or</td>
<td></td>
</tr>
<tr>
<td>the patient's records.</td>
<td></td>
</tr>
<tr>
<td>Remarks: N/A.</td>
<td></td>
</tr>
<tr>
<td>Block: Specimen Taken.</td>
<td>Completed by: Laboratory.</td>
</tr>
<tr>
<td>Instructions: Enter the date and time the specimen is taken.</td>
<td></td>
</tr>
<tr>
<td>Remarks: This block is completed by whoever takes the specimen,</td>
<td></td>
</tr>
<tr>
<td>either laboratory or ward or clinic personnel.</td>
<td></td>
</tr>
<tr>
<td>Block: Tests Requested.</td>
<td>Completed by: Clinic or ward.</td>
</tr>
</tbody>
</table>

AR 40–664 UPDATE

51
### 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.

**Block:** Results or Report.

**Completed by:** Laboratory.

**Instructions:** Write or stamp the review of each test performed.

**Remarks:** N/A

### Table 8-2
**Specific instructions for preparing laboratory forms**

<table>
<thead>
<tr>
<th>Form</th>
<th>SF 545</th>
<th>Use:</th>
<th>To mount laboratory forms.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Remarks:</strong></td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Form:</strong></td>
<td>SF 545</td>
<td>Use:</td>
<td>To request blood chemistry tests.</td>
</tr>
<tr>
<td><strong>Remarks:</strong></td>
<td>Instructions: At the bottom of the list of tests, there is a block requesting a battery or profile of tests. When requesting the battery, enter the name of the profile.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Form:</strong></td>
<td>SF 547</td>
<td>Use:</td>
<td>To request blood gas measurements, T3, T4, serum iron, iron-binding capacity, glucose tolerance, and other chemistry tests.</td>
</tr>
<tr>
<td><strong>Remarks:</strong></td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Form:</strong></td>
<td>SF 548</td>
<td>Use:</td>
<td>To request chemistry test on urines specimens.</td>
</tr>
<tr>
<td><strong>Remarks:</strong></td>
<td>Explain a check in the &quot;Other&quot; box under &quot;Specimen Interval.&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Form:</strong></td>
<td>SF 549</td>
<td>Use:</td>
<td>To request routine hematology (including differential morphology), coagulation measurements, and other hematology tests.</td>
</tr>
<tr>
<td><strong>Remarks:</strong></td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Form:</strong></td>
<td>SF 550</td>
<td>Use:</td>
<td>To request urinalysis tests, both routine and microscopic.</td>
</tr>
<tr>
<td><strong>Remarks:</strong></td>
<td>Use: &quot;HCG&quot; to request and report measurements of human chorionic gonadotropin. Use &quot;PSP&quot; to request and report phenolsulphonphthalein measurements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Form:</strong></td>
<td>SF 551</td>
<td>Use:</td>
<td>To request tests that measure serum antibodies, including tests for syphilis.</td>
</tr>
<tr>
<td><strong>Remarks:</strong></td>
<td>Definitions for the serology test abbreviations are as follows: RPR—rapid plasma reagin card test for syphilis. COLO AG—cold agglutination. ASO—antistreptolysin O titer. CBP—C reactive protein. CTA-ABS—fluorescent treponemal antibody-absorption test. FBNHLE AGS—fluorescent treponemal test. COMP FIX—complement fixation. HAI—hemagglutination-inhibition. TPHA—treponema pallidum hemagglutination.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Form:</strong></td>
<td>SF 552</td>
<td>Use:</td>
<td>To request tests for intestinal parasites, malaria, and other blood parasites, and most major tests.</td>
</tr>
</tbody>
</table>

### 8-19. DA Form 4256

| 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 have a copy of all orders to ensure appropriate surveillance of drug-drug and laboratory-drug interactions.) The third 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 8 through 9 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, addendum plates should be used. (See pages 3–4 to 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 initialed for separately; use of the entry "routine order" (to imply a from 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 Ordered and Sign" column. The
clerk or nurse who notes two or more orders may endorse the or-
ders 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 ac-
tion has been taken or the order, as written, has been transcribed on DA Form 4677 or DA Form 4678.

4. 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 (if 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 DR (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 (doc-
tor’s name, date, Army nurse corps or registered nurse.)" The prescriber must counterorder the time as soon as pos-
sible, but no later than 24 hours after the emergency.

7. Telephone orders. As few telephone orders as possible will be accepted and only by a registered nurse. The prescriber must counterorder DA Form 4256 within 24 hours.

8-20. Radiologic forms (SF 510, SF 519A, and SF 519-B) a. SF 510, SF 519A, and SF 519-B will be used to request radi-
ologic examinations and to report the results. The forms are three-
part sets (original and two copies). When an examination is re-
quested, the whole set is sent to the radiology department. After 
the results are recorded, the third copy is kept in the radiology de-
partment 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 TR or OTR or patient HERCS. The second copy is rout-
ed 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 report and all "wax" notes 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 358.

8-21. DA Form 5009-R DA Form 5009-R (Medical Record—Referral) Against Medical Advice will be used when the patient leaves the MTF against the advice of hospital authorities and attending practitioners. A par-
et or legal guardian will complete the "statement of representa-
tive or minor mentally incompetent". (DA Form 5009-R will be locally reproduced on 8-1/2 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 procedures requiring medical attention and the care provided. NATO STANAG 2322 and QSTAG 470 govern 
the use of DD Form 1380. DD Form 1380 is available through non-purchase supply channels. Instructions for 
completing the form are provided in table 9-1. Combat medics, ord-
stations, treatment teams operating nonduty troop clinics, and 
MTFs will use DD Form 1380 as outlined in a through b below.

a. The combat medic first attending battle casualties will initi-
ate DD Form 1380 by completing blocks 1, 3, 4, 7, and 9 and by

enturing as much information in the remaining blocks as time per-
miss. He or she will enter his or her initials in the first line to the 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 HERCS or OTR.

c. Treatment teams providing Level-I medical care will use 
DD Form 1380 any time that care is provided and the patient’s 
HERCS is not readily available. If a patient is treated in a holding 
section or is expected to return for additional treatment or evalua-
tion, an OTR may be initiated using standard medical record 
forms. The OTR need not be filed in a DA Form 3444-series re-
cord. 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 evacuat-
ed, treatment will be summarized on DD Form 1380. DD Form 1380 
and all forms and records initiated will accompany the pa-
tient during evacuation.

d. MTFs where the primary mission is to provide Level-II or 
Level-IV medical care will use DD Form 1380 to record outpa-
tient care provided when the patient’s HERCS is not readily availa-
ble 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 com-
batt 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 para-
graph 9-5 and may also be used for CRQ cases (para 3-17). For 
transfer cases, DD Form 1380 will be attached to the patient’s 
medical record 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 interment, when it will be removed. If 
the body cannot be identified, the registration number gives the 
name of the patient. The remains will be identified by the Graves 
Registration Service will be noted on DD Form 1380.

c. Under conditions of extreme stress, DD Form 1380 for pa-
tients being transferred may be only partially completed. Other-
wise, all entries will be completed as fully as possible. Details 
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, howev-
er, abbreviations may not be used for diagnostic terminology.

1. Abbreviation
2. Cont.—Continued wound.
3. Fr.—Fracture (compound) open.
4. Fr.—Fracture (closed) compound.
5. Sim.—Simple fracture (compound).
7. MW—Multiple wounds.
8. Pen.—Penetrating 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.

AR 40-68-UPDATE 53
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: AT = Army, AF/NA = Air Force, N/V = Navy, and MC/N/M = Marine.

Block 3
Instructions: Use figures to show location of injury or injuries. Check appropriate boxes to describe patient injury or injuries.

Block 4
Instructions: Check appropriate box.

Block 5
Instructions: Write in the pulse rate and the time that the pulse was measured.

Block 6
Instructions: Check yes or no box. Write in date and time that treatment was applied.

Block 7
Instructions: Check yes or no box. Write in date 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 initial of combat medic 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 treatment and time administered. Record type and time 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 States Department of Defense. 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 this block to obtain 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 Commanders, U.S. Total Army Personnel Command, ATTN: TAPC-MDR, 200 Stovall Street, Alexandria, VA 22332-0400 for insertion in official military personnel file.
   (b) Active duty Army enlisted to Commanders, U.S. Army Enlisted Records and Evaluation Center, ATTN: PC-RE-FT, Fort Benjamin Harrison, IN 46449-5301 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/SGBR, Brooks Air Force Base, TX 7313-5000.
   (e) All other U.S. uniformed personnel to HQDA (SOPS-PSA), 5109 Leesburg Pike, Falls Church, VA 22041-2585.
   (f) Civilian personnel to National Personnel Records Center (Civilian), 111 Winnebag Street, St. Louis, MO 63114-4199.
   (g) Foreign nationals within the overseas area, forward to the appropriate authorities. Within Health Services Command, forward to HQDA (SOPS-PSA), 5109 Leesburg Pike, Falls Church, VA 22041-2585.
   (h) Prisoners of war to HQDA (DAPE-HRE), WASH DC 20314-2300.
   b. When a transferred patient arrives at a hospital, his or her DD Form 1380 will be used to prepare the TTR. DD Form 1380 will then become part of the TTR. (See fig. 9-1.)
   c. The original DD Form 1380 used to record outpatient treatment in peacetime operations or during training exercises will be forwarded to the custodian of the patient’s HRES 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 TTR.

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 40-48. The patient administration division will coordinate 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 statistics; and referring ITRs, OTRs, and HERCS 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 requested data requested by the Quality Assurance committee.

c. Record deficiencies. Deficiencies of all missing, untimely, inaccurate, incomplete, conflicting, or altered records should be identified and referred by the reviewing physician to the appropriate medical officer or the quality assurance manager for action. The record deficiencies will be reported by the quality assurance manager to the quality assurance committee and the contractor. The contractor will report the deficiencies to the quality assurance committee in writing. The contractor will also report to the patient administration division.

10-3. Patient care assessment

a. Documentation review of medical records for accuracy, timeliness, completeness, clinical pertinence, and adequacy as to medical use. This review, in coordination with the medical staff, will be made on a sample of randomly selected OTRs, ITRs, and HERCS. See also AR 40-68, para 3-5(d)(3). (Random selection must be based on those characteristics of the record, such as sex, certain digits 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 HERCS, depending on the size and degree of specialization of the MTF concerned. However, over a reasonable period of time, all 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 medical record clearly identifies the patient, the treating AMEDD facility, and the treating personnel. In addition, enough information is given to support the diagnoses, to justify the treatment, and to provide for follow-up care.

(1) The medical record clearly identifies the patient, the treating AMEDD facility, and the treating personnel. In addition, enough information is given to support the diagnoses, to justify the treatment, and to provide for follow-up care.

(2) The ITRs of current inpatients describe the program and the current status and treatment of the patient so that the case can be fully understood at any time. HERCS and OTRs will be reviewed for clinical pertinence and completeness, that is, appropriateness of documentation of visit or episode, up-to-date problem list, and diagnostic test results filed.

(3) Each medical record includes all completed forms and reports needed by the nature of the case and the treatment given.

(4) Final diagnoses are fully recorded; symbols and abbreviations have not been used.

(5) All entries are current, clinically pertinent, and legible; entries do not contain provider accusations or derogatory (ventilated) comments.

(6) All entries are dated and signed.

(7) Discharge instructions, including restrictions, medications, and follow-up provisions, are adequate.

(8) Documentation of all deaths clearly shows the condition of the patient on admission and the events leading to the patient's death. The record will be reviewed for completeness, including any ordered laboratory tests or studies.

(9) The record complies with all other provisions of this regulation.

b. Entry deficiencies. Deficiencies of all missing, untimely, inappropriate, conflicting, or altered records should be identified and referred to the appropriate medical officer or the quality assurance manager for action. The record deficiencies will be reported by the quality assurance manager to the quality assurance committee and the contractor. The contractor will report the deficiencies to the quality assurance committee in writing. The contractor will also report to the patient administration division.

c. Record deficiencies. On a quarterly basis, the following medical record deficiencies 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 3447 (worksheet) not completed within 4 working days of patient discharge

(5) ITRs not completed within 30 days of patient discharge.

(6) Presence of medical records not available at time of clinical 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 MCIAs or claim judgment 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 tape, paraphlin 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, paraphlin 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 re the Litigation Division, OTJAG, ATTN: JALS-LT, 901 West Stewart Street, Arlington, VA 22203-1837.
Special attention will be given to the handling of medical or dental records involved in litigation or adjudication to ensure accuracy and continuity of medical documentation. The practices described in (1) through (6) below will be followed:

(1) Before any record (for example, photography; release to local GJ, transtential to Longdon Drs, OTOGA, or response to subpoenas) the original medical or dental record will be reviewed for completion by the patient administration division or the DENTAC and will be appended in the appropriate record prescribed in this regulation. All underlined 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. Completed records filed separately will be accounted for in the central filing 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)

(2) Reproduction must be legible (that is, the print will not be blurred to too tiny 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 assure legible reproduction of laboratory reports measured 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 wherein an original authenticated photocopy of a medical record may be made for purposes child as above.

(4) If medical or dental records are released to GJ or USAFRC, the patient administration division will append a list to the record identifying the signature and initial appearing in the record. (Signature and initial verification will be maintained for practices involved in medical or dental record documentation.)

(5) Copies of 400 and will be filed in the patient's medical or dental record.

(6) Copies of all correspondence concerning the case will be apped to the record. Copies of correspondence will also be maintained by the CJA.

(7) The original medical or dental record, will be initiated by the NPO, the CJA or USAFRC, the DEPLAC. MDGEN, or DENTAC, will notify NPO not to release the record to the patient, his or her representative. They will also request any records needed from NPO.

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 paragraph below are often used in chart analysis, audit, studies of patient care, and the compilation of medical statistics. Some of these terms listed below also include examples of specific circumstances and instructions to see them in reviews and analyses.

a. Nuptial terms:

(1) Hospital live birth. After a pregnancy of any length, the complete expulsion or extraction of a product of conception from another in a hospital. After separation, the product branches or shows some sign of life, such as breathing of the feebles, pulsation of the umbilical cord, or definite movement of voluntary mus-

b. Mortality terms:

(1) Hospital death. Death after admission to a hospital or after birth in a hospital. (Death shall not be included.)

(2) Types of hospital deaths. The categories described in (a) through (d) below are not mutually exclusive. A "maternal death," for example, 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 deaths should be included in each category when counts or rates for the categories are made. Such deaths will be footnoted to show that a case is included more than once.

(3) Operative death. Death resulting from surgical procedure, for example death from hemorrhage, shock, embolism, and infec-


(5) Maternal death. Death due to causes related to pregnancy, its terms of pregnancy, abortion, or the confinement.

(6) Delayed death. Death of an infant within 1 week 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.

(7) Other hospital deaths.

b. Maternal deaths:

(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 situation when created, or as the disturbance is caused by the treatment. The term is a general term for any complication that is a secondary diagnosis present on admission. In analysis, infections are classified separately.

(2) Obstetric complications. Complications after surgical pro-
c.

(3) Obstetric complications. Complications caused by anesthetic agents and equipment. Expected mid hazard head when obstet-

(4) Ophthalmic complications. Complications caused by pregnancy or its termination. (Do not include obstetric infections.) In as-
d.

(5) Ophthalmic complications. Complications caused by pregnancy or its termination. (Do not include obstetric infections.) In as-

(6) Newborn complications. Complications arising within 28 days after birth. The term does not include infections or mild and expected (or inevitable) conditions, such as minor congenital re-

(7) Newborn complications. Complications arising within 28 days after birth. The term does not include infections or mild and expected (or inevitable) conditions, such as minor congenital re-

(8) Reaction to whole blood or blood components. This term covers the various reactions to whole blood or its components or transfusions, which cause tissue damage and result in a clinical condition.
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 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 impatient 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) Utilization analysis with reports on days of care, discharge rates, and length of stay presented by DRG, patient category, 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 5 days, and Outlier Analysis based on both short- and long-stay outliers per DRG.
- (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 specific needs.

(5) Subpopulations creation that enables the hospital to print information from a particular group of records.

(6) 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 FPDS disposition data reports.
- b. Compare the current report with the reports of the previous 5 years.
- c. Compute hospital rates. The hospital rates that may be computed annually are explained in table 11-1 or contained in automated reports.

<table>
<thead>
<tr>
<th>Table 11-1</th>
<th>Annual hospital rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate to be computed</td>
<td>Mortality (death) rates</td>
</tr>
<tr>
<td>Rate to be computed</td>
<td>Maternal death rate</td>
</tr>
<tr>
<td>Rate to be computed</td>
<td>Neonatal death rate</td>
</tr>
</tbody>
</table>

Explanations:

- Percentage ratio of deaths to the total number of dispositions during the year. Include newborn deaths in total number of deaths; do not include homemaker deaths in the total number of dispositions.

- 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.

- Percentage ratio of neonatal deaths to the total number of hospital live births during the year.

AR 40-66 • UPDATE
Table 11-1
Annual hospital rates—cont’d

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 by each clinical service
Explanation: Percentage ratio of deaths occurring on a service to the total number of discharges from that service during the year. Includes deaths in the total number of discharges.

Necropsy (autopsy) rates

Rate to be computed: Hospital necropsy (autopsy) rate
Explanation: Percentage ratio of the number of necropsy (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 necropsy (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: General hospital infection rate
Explanation: Percentage ratio of the number of hospital infections to the number of discharges 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 discharges 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 discharges (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 discharges (including deaths) from that service during the year.

Cesarean section rates

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. Where feasible, the presentation of statistics should be graphic as well as tabular and narrative. In addition, the format of reports must be useful.

c. In presentations, any pertinent data published in current periodic literature, which often provide information beneficially, 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, comparisons with objective factors for evaluating professional care, or not forth in literature on hospital administration, may also be of interest.
Section I
Required Publications

DOD directives, regulations, instructions, and manuals can be obtained from
the Naval Publications and Forms Center, Code 2015, 5801 Tabor Avenue,
Philadelphia, Pennsylvania, or through orders using DOD Form 1405 (Specifications
and Standards Requests). 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, 3–5, 4–4, 5–20, 5–26, 6–1, 6–4, 6–6, 6–7, 7–5, 7–4, 7–3, 8–1, 8–2, 8–5, 8–8, 8–10, 8–20, and 9–4 and table 5–1.)

AR 27–20
Claims. (Cited in para 10–4.)

AR 40–2
Army Medical Treatment Facilities: General Administration. (Cited in
paras 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 paras 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 paras 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
6–7.)

AR 40–16
Special Notice—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 8–4.)

AR 40–38
Clinical Investigation Program. (Cited in paras 6–2 and figs 5–1, 5–2, 6–1, 6–2, and 8–1.)

AR 40–40
Documentation Accompanying Patients Abroad Military
Common Carriers. (Cited in figs 5–1, 5–2, and 8–1.)

AR 40–43
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.)
TB MED 509
Splenectomy in Occupational Health Surveillance. (Cited in figs 5-1, 5-2, and 5-2.)

ICD-9-CM
International Classification of Diseases (ICD)—Ninth Revision—Clinical Modification (Cited in para 9.17.)

ICD-9-CM
Three digits and Procedure, ICD-9-CM. (Cited in paras 1-12, 1-15, and 4-17.)

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 30-1
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

AS 640-10
Individual Military Personnel Records

FPM Supp 293-31
Basic Personnel Records and Film 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 1913.100
Rules of Agency Practice and Procedure Concerning OSHA Access to Employee Medical Records

10 USC 915

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 (Linear). (Prescribed in para 4-3.)

DA Form 3443Y
Terminal Digit—X-Ray Film Negative Preserver (Insert). (Prescribed in para 4-3.)

DA Form 3442
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 3444-2
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 6006
Fidel Medical Records Jacket. (Prescribed in para 9-5.)

DA Form 6221
Diabetic Record. (Prescribed in fig 8-1.)
DA Form 4254-R
Request for Private Medical Information. (Prescribed in para 3-3 and fgs 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 fgs 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 fgs 5-2, 6-2, and 8-1.)

DA Form 5006-B
Medical Record—Authorization for Disclosure of Information. (Prescribed in para 2-3 and fgs 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 5-3 and fgs 5-1, 5-2, 6-1, and 6-2.)

DA Form 5007-B-R
Medical Record—Allergy Immunotherapy Record—Double Extract. (Prescribed in para 5-3 and fgs 5-1, 5-2, 6-1, and 6-2.)

DA Form 5008
Telephone Medical Advice/Consultation Record. (Prescribed in para 5-6 and fgs 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 8128
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 fgs 5-1, 5-2, and 6-2.)

DA Form 5568-B
Chromatographic Record of Wound-Infant Care. (Prescribed in para 6-2 and fgs 6-1 and 6-2.)

DA Form 5569-B
Formatted (NHS) Clinic Flow Sheet. (Prescribed in para 5-8 and fgs 5-1, 5-2, 6-1, and 6-2.)

DA Form 5570
Health Questionnaire for Dental Treatment. (Prescribed in para 5-9 and fgs 5-3 and 6-3.)

DA Form 5571
Master Problem List. (Prescribed in para 5-10 and fgs 5-1, 5-2, 6-1, 6-2, and 8-1.)

DA Form 5694
Denver Developmental Screening Test. (Prescribed in para 6-2 and fgs 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 7098-R
ADAPCP Outpatient Psychosocial 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
Limit 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 (RD). (Prescribed in para 4-0.)

DA Form 8006
Pediatric Dental Diagnostic Form. (Prescribed in para 6-7 and fig 6-3.)

DA Form 8007
Individual Medical History (IMH). (Prescribed in para 5-36.)

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 2128
Request for Transfer of Outpatient Records. (Prescribed in para 6-4.)

DD Form 2215
Reference Articulogram. (Prescribed in figs 5-1, 5-2, 6-1, and 6-2.)

DD Form 2482
Venous Extract Prescriptions. (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.)

SP 612
Clinical Record—Narrative Summary. (Prescribed in para 8-10 and figs 5-2, 6-2, and 8-1.)

SP 503
Clinical Record—Anoxia Protocol. (Prescribed in para 8-10 and fig 8-1.)

SP 504
Clinical Record—History—Part I. (Prescribed in para 8-10 and fig 8-1.)

SP 505
Clinical Record—History—Parts II and III. (Prescribed in para 8-10 and fig 8-1.)

SP 506
Clinical Record—Physical Examination. (Prescribed in para 8-10 and fig 8-1.)

SP 507
Clinical Record—Report on or Continuation of SF. (Prescribed in para 8-10 and fig 8-1.)

SP 509
Medical Record—Doctor's Progress Notes. (Prescribed in para 8-10 and figs 5-1, 5-2, 6-2, and 8-1.)

SP 511
Medical Record—Vital Signs Record. (Prescribed in fig 8-1.)

SP 512
Clinical Record—Flooding Chart. (Prescribed in para 5-13 and figs 5-1, 5-2, 6-1, 6-2, and 8-1.)

SF 513
Medical Record—Constitution Sheet. (Prescribed in para 8-10 and figs 5-1, 5-2, 5-3, 6-1, 6-2, 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—Wound or Blood Component Transfusion. (Prescribed in fig 8-1, 8-2, 8-1, and 8-3.)

SF 519-A
Radiologic Consultation Report/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—Anesthesia Request for Administration of Anesthesia and for Performance of 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—Anti—immunization for Anesthesia. (Prescribed in fig 8-1.)

SF 524
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—Intervenial/Intercavity Therapy. (Prescribed in figs 5-2, 6-2, and 8-1.)

SF 527
Group Muscle Strength, Joint ROM, Girth and Length Measurements. (Prescribed in figs 5-2, 6-2, and 8-1.)

SF 628
Clinical Record—Musculoskeletal 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.)
A/B ratio
acid/base ratio
ac
before meals
ACTH
adrenocorticotropic hormone
ACVD
acute cardiovascular disease
AD
right ear
A&D
admission and discharge
ADAPCF
Alcohol and Drug Abuse Prevention and Control Program
ADCO
alcohol and drug control officer
ADH
antidiuretic hormone (vasopressin)
ADHL
activities of daily living
ad lib
as desired
adn
admission; admit; admitted
A/E
air evacuation
AFB
acid-fast bacilli
Af sb
afebrile; without fever
Afib/AFls
atrial fibrillation/atrial flutter
AFIP
Armed Forces Institute of Pathology
AGA
appropriateness for gestational age
A/G ratio
albumin/globulin ratio
AHD
atherosclerotic heart disease
AIDS
acquired immune deficiency syndrome
AK
above knee
AKA
above-the-knee amputation
ALL
acute lymphoblastic or lymphocytic leukemia
ESR  
blood sedimentation rate

BTL  
bilateral talal lipnosis

BUN  
blood urea nitrogen

bw  
birth weight

Bs  
body surf

C  
celsius or centigrade

Cl 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  
intravenous catheter

caucasian

CBC  
complete blood count

CG  
chief or current complaint

cubic centimeter

CCU  
coronary care unit

CDC  
Centers for Disease Control

cervical

CF  
cystic fibrosis

ChE  
cholinesterase

CHF  
congestive heart failure

Chol  
cholesterol

ehr  
chronic

circ  
circulation; circumflex; circumferential

Cl  
chlorine

cm  
centimeter

CNS  
central nervous system

CO 2  
carbon dioxide

Co  
cobalt

c/o  
complaints of

conv  
convalescent; convalescence

COPD  
chronic obstructive pulmonary disease

CPD  
cephalic pelvic disproportion

CPL  
creatine phosphokinase

CPR  
cardiopulmonary resuscitation

CRF  
chronic renal failure

CRNA  
ocerified registered nurse anesthetist

C/S  
cesarean section

C&S  
culture and sensitivity

c-section  
cesarean section

CT  
computed tomography

c/t  
count

cu ft  
cubic foot

cu in  
cubic inch

cu m  
cubic meter
CVA: cerebrovascular accident
CVD: cardiovascular disease
CVP: central venous pressure
CS: cervix
CXR: chest x-ray
cysto: cystoscopy; cystoscopic cystoscopy
dil: dilate
D/C: discharge or discontinue
D&C: dilation and curettage or curettament
DDS: Doctor of Dental Surgery
D&E: dilatation and evacuation
def: deficiency
Dept: department
Derm: dermatology
DES: diethylstilbestrol
dev: deviation
dil: dilate; dilauded
dis: disease
disp: disposition
DJD: degenerative joint disease
DMS: diabetes mellitus
DNR: do not resuscitate
DO: Doctor of Osteopathy
DOA: dead on arrival
DOB: date of birth
DOE: diagnosis
DPT: diphtheria, tetanus, 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
DU: driving under the influence
DVT: deep vein thrombosis
DWI: driving while intoxicated
Ivx: 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
ELISA
enzyme-linked immunosorbent assay
EMG
electromyogram
EMS
emergency medical service
E. coli
erythromycin
Endo
endocrinology
ENG
ear, nose, and throat
EOM
extraocular movement
eos
eosinophil
ep
epididymis
epithelium or epithelial
equiv
equivalent
ER
emergency room
eup
especially
ESR
erythrocyte sedimentation rate
ESRD
end-stage renal disease
EST
electroshock therapy
est
estimated
ESWL
extracorporeal shock wave lithotripsy
ET
eadreastheal tube
etc.
et cetera
etn
econti
ETOH
ethyl alcohol
eval
evaluate; evaluation
exam
examine
exp
expired
expir
expiration; respiratory
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
FHx
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
F/UO
fever of unknown origin
HAA  hepatitis-associated antigen
Hb  hemoglobin
HRP  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
HIM  hematology
Hgb, Hb  hemoglobin
HIV  human immunodeficiency virus
JMO  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
ht  at bedtime
ht  height
KTLV  human T-cell leukemia/lymphoma virus
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LBW</td>
<td>low birth weight</td>
</tr>
<tr>
<td>L&amp;D</td>
<td>labor and delivery</td>
</tr>
<tr>
<td>LDL</td>
<td>low-density lipoprotein</td>
</tr>
<tr>
<td>LE</td>
<td>lupus erythematosus</td>
</tr>
<tr>
<td>Lig</td>
<td>ligament</td>
</tr>
<tr>
<td>LLE</td>
<td>left lower extremity</td>
</tr>
<tr>
<td>LLL</td>
<td>left lower lobe (of lung)</td>
</tr>
<tr>
<td>LLQ</td>
<td>left lower quadrant</td>
</tr>
<tr>
<td>LMP</td>
<td>left meposterior (position of fetus), last menstrual period</td>
</tr>
<tr>
<td>LOC</td>
<td>loss of consciousness</td>
</tr>
<tr>
<td>LOD</td>
<td>line of duty</td>
</tr>
<tr>
<td>LOM</td>
<td>limitation of motion</td>
</tr>
<tr>
<td>LOS</td>
<td>length of stay</td>
</tr>
<tr>
<td>LP</td>
<td>lumbar puncture</td>
</tr>
<tr>
<td>LPN</td>
<td>licensed practical nurse</td>
</tr>
<tr>
<td>LQ</td>
<td>lower quadrant</td>
</tr>
<tr>
<td>L-S</td>
<td>lumboacral</td>
</tr>
<tr>
<td>LSH</td>
<td>lutein-stimulating hormone</td>
</tr>
<tr>
<td>Lt</td>
<td>left</td>
</tr>
<tr>
<td>LUL</td>
<td>left upper lobe (of lung)</td>
</tr>
<tr>
<td>LUQ</td>
<td>left upper quadrant</td>
</tr>
<tr>
<td>LV</td>
<td>left ventricular</td>
</tr>
<tr>
<td>LVN</td>
<td>licensed vocational nurse</td>
</tr>
<tr>
<td>Lymph</td>
<td>lymphocytes</td>
</tr>
<tr>
<td>M</td>
<td>meter</td>
</tr>
<tr>
<td>Max</td>
<td>maximum</td>
</tr>
<tr>
<td>Mcc, mCl</td>
<td>milliCurie</td>
</tr>
<tr>
<td>Meg</td>
<td>microgram</td>
</tr>
<tr>
<td>MCHC</td>
<td>mean corpuscular hemoglobin concentration or count</td>
</tr>
<tr>
<td>MED</td>
<td>medical evaluation board</td>
</tr>
<tr>
<td>Med</td>
<td>medicine or medication</td>
</tr>
<tr>
<td>MEq</td>
<td>milliequivalent</td>
</tr>
<tr>
<td>MG</td>
<td>myasthenia gravis</td>
</tr>
<tr>
<td>Mg</td>
<td>milligram</td>
</tr>
<tr>
<td>MI</td>
<td>myocardial infarction</td>
</tr>
<tr>
<td>MIA</td>
<td>missing in action</td>
</tr>
<tr>
<td>MICU</td>
<td>medical intensive care unit</td>
</tr>
<tr>
<td>Min</td>
<td>minute</td>
</tr>
<tr>
<td>mL</td>
<td>milliliter</td>
</tr>
<tr>
<td>Mm</td>
<td>millimeter</td>
</tr>
<tr>
<td>MMPI</td>
<td>Minnesota Multiphasic Personality Inventory</td>
</tr>
<tr>
<td>Mod</td>
<td>moderate</td>
</tr>
<tr>
<td>Mono, monocytes</td>
<td></td>
</tr>
<tr>
<td>Monos</td>
<td>monocytes</td>
</tr>
<tr>
<td>Mns</td>
<td>months</td>
</tr>
<tr>
<td>MS</td>
<td>multiple sclerosis</td>
</tr>
<tr>
<td>Msec</td>
<td>millisecond</td>
</tr>
<tr>
<td>NA</td>
<td>nursing assistant</td>
</tr>
</tbody>
</table>
Na +
sodium

N/A
not applicable

NAD
no acute distress

NaPust
sodium pentathal

NB
newborn

N/C
no complaint

NCHS
National Center for Health Statistics

neg
negative

Neph
nephrology

Nurs
neurological, neurology

NICU
Neonatal Intensive Care Unit

NIDDM
non-insulin-dependent diabetes mellitus

NKA
no known allergies

NKA-DA
no known drug allergies

a1 norm
normal limits

NLT
not later than

NPH insulin
neutral protamine Hagedorn insulin

go
nothing by mouth

NS
nasogastric system

ng
nursing

NTG
nitroglycerin

nurs
nursery

O 2
oxygen; both eyes

OB
obstetrics

OB-GYN
obstetrics and gynecology

obj
objective

OBS
organic brain syndrome

OD
overview; right eye

OU
left eye

Onc
oncology

OOG
out of bed

op
operation

OPC
outpatient clinic

OPD
outpatient department

Ophth
ophthalmology

OPV
oral poliovirus vaccine

OR
operating room

Ortho
orthopedics

os, per os
mouth by mouth

OT
occupational therapy

OTC
over the counter (drugs)

OUI
each eye

oz
ounce

PA
physician's assistant

P&A
percussion and auscultation

PAC
premature atrial contractions

Pap test
Papanicolaou's test

Path
pathology

AR-40-66 • UPDATE: 73
pc
after meals

PDR
Physician’s Desk Reference

PE
physical examination

PEB
Physical Evaluation Board

Pd
pediatrics

PEMPRA
pupils equal, round, and react to light and accommodation

PE tubes
pressure-equalizing tubes

PH
past history

pharm
pharmacy; pharmaceutical; pharmacopeia

PI
present illness

PID
pelvic inflammatory disease

Pit
Pitocin

pkg
package

PKU
phenylketonuria

PMH
past medical history

PO
postoperative

po
by mouth; orally

POD
postoperative day

Pd
pediatric

pos
positive

postap
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)

dnr
according as circumstances may require

prognosis

Psych
psychiatry

PT
physical therapy

pt
patient

PTCA
percutaneous transluminal coronary angioplasty

PUD
peptic ulcer disease

PULSES
physical profile factors: P—physical capacity or stamina; U—upper extremities; L—lower extremities; H—hearing and ears; E—eye; S—psychiatric

pulm
pulmonary

PVC
premature ventricular contractions

every

q 6h
every day

q6h
every hour

q2h, q3h, and so on
every 2 hours, every 3 hours, and so on

q4d
four times day

every night

r
routine

rheumatoid arthritis

radium
RBC
red blood cells or corpuscles
RD.
registered dietician
RDS
respiratory distress syndrome
Rec Room
recovery room
reg
regular
rehab
rehabilitation
req
requirement
resp
respiratory
Rh factor
Rheneus 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
Ser rate
erythrocyte sedimentation rate
SGA
small for gestational age
SGOT
serum glutamic-oxaloacetic transaminase
SGPT
serum glutamic-pyruvic transaminase
SI
seriously ill
SICU
surgical intensive care unit
SIDS
sudden infant death syndrome
sigh
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
stag
staphylococcus
STAT
immediately and once only
STD
sexually transmitted disease
strep
streptococcus
STS
serologic test for syphilis

AR 46-66 UPDATE
75
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

negative; absent

secondary; second degree

male

positive; present

amounts; changes

increased; elevated

start of operation (anesthesia record only)

angstrom unit

decreased; depressed; lowered

end of operation (anesthesia record only)

of each

descended bilaterally

upright; vertical body position; body supported by lower stilts; mules; tons; upright

before

caucese; transfer to

lying down; horizontal body position

with

is due to

leaning; body trunk raised less than 90 degrees from primary supporting surface and supported by self or object

after; following

less than

sitting; weight of body resting on lower part of trunk, back raised greater than or equal to 90 degrees

without

more than

leaving over; dangling, any portion of body extended beyond the lower part of the trunk

one-half

diastolic blood pressure

systolic blood pressure

leaving over; dangling

dram; drachm

diastolic blood pressure

kneeling; supporting the body on the knees or legs

ounce

absent; none

primary first degree

fluid dram; fluid ounce

changes

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
AEMED Army Medical Department
AMOSIST Automated Military Outpatient System
AQCSSA Accredited Quality of Care Evaluation Support System
ARMG Army National Guard
AWOL absent without leave
CCG Community Counseling Center
CEMR civilian employee medical record
CHCS Composite Health-Care System
CIA chief judge advocate
CNG 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
DIF dental treatment facility
TIPS existed prior to service
PMP 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 input-at treatment record
LDI 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
MLPO military personnel offices
MPRJ Military Personnel Records Jacket, U.S. Army
MTF medical treatment facility
NATO North Atlantic Treaty Organization
NPIC 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
PAPOA Patient Administration Systems and Biostatistics Activity
PCS permanent change of station
PRIMS primary care for the uniformed services
QTAG quasitarget standardization agreement
RC Reserve Components
RTP residential treatment facility
SSN social security number
STANAG standardization agreement
USAR U.S. Army Reserve
USARCS U.S. Army Reserve Centers
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 in private and confidential. Medical confidentiality is not, however, a security classification or confidential.
Field medical card
A medical record used by aid stations, clearing stations, and nonfixed troop and health clinics operating overseas on manuevers, 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 dentistry 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, ADA/P/OMDs, and x rays. Paramedical documents, such as immunization registers and dentistry records, are not considered medical records although they are kept in the same file with other medical records.

Nonmed medical treatment facility (MTF)
An MTF designed to be moved from place to place, including MTFs abroad.

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 medical/legal integrity.

Section III
Special Abbreviations and Terms
This section contains no entries.
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 at, 3-5
Army Reserve National Guard (ARNG) personnel, absent-duty status, 3-18
Audit trail
Alcohol and drug abuse prevention and control program medical records, 7-10
Inpatient treatment records (ITR), 6-7

Authorized forms, 3-1
Bacteriological agent as cause of injury or disease, recording procedures, 3-12
Birth control, disclosure of information regarding, 3-5
Brain syndrome, 3-11
Carded-for-record-only (CRO) cases, 3-17
CDC 52036A (Venereal Disease Epidemiologic Reports, 5-23
Central Panoramic Storage Facility, duplicate paragraph on file with, 1-4
Certificate of Death, 3-13
Chaplains, responsibilities, 1-4
Chemical input 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, 3-5
Outpatient treatment record (OTR), 6-7
Civilian employee medical record (CEMR) Confidentiality of medical information, 2-8
DA Form 344-series folders used for, 4-2
Descriptive of, 1-1
Disclosure of information, 7-3
Disposition, 7-8
File folders for, 7-6
Forms and documents, 7-4
Initiating and maintaining, 7-5
Person 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

Amendments of medical records, 3-4
American Hospital Association Guidelines, documentation by chaplains according to, 1-4

Anesthesia monitoring records, filing of, 3-2

Community health aware 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
Enrollment 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 II), 5-22
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-B (Medical Care—Third Party Liability Notification), 5-4, 5-2
DA Form 3964 (Very Seriously Ill/Severely Ill/Special Category Patient Report), 5-2
DA Form 3968 (Admission and Coding Information), 5-18, 5-2
DA Form 3180-B (Personnel Screening and Evaluation Record), 5-4, 5-19, 6-2, 6-3
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 344-series folders, 4-3
Preparation of, 4-5
DA Form 344X (Terminal Digit—X-Ray Film Negative Preserver (Coil)), 4-3
DA Form 344Y (Terminal Digit—X-Ray Film Negative Preserver (Insert)), 4-3
DA Form 344Z (Terminal Digit—X-Ray Film Negative Provider (Report Insert)), 4-3
DA Form 3444 (Terminal Digit File for Treatment Record (Orange)), 4-3
DA Form 3444-I (Terminal Digit File for Treatment Record (Light Green)), 4-4
DA Form 3444-II (Terminal Digit File for Treatment Record (Yellow)), 4-3
DA Form 3444-3 (Terminal Digit File for Treatment Record (Gray)), 4-3

AR 40-60 UPDATE 81
Food poisoning/infection, 3-9
Foreign national within overseas area, disposition of ED Form 1380 (U.S. Field Medical Card), 5-4
Forms and documents
Authorized, 3-1
Automated and/or computerized forms, 3-2
Guidelines for local forms and overprints, 3-3
Gravés registration personnel, access to health records, 5-21
Health care providers, responsibilities, 1-4
Health record (HREC)
Access to, 5-21
Cross-service of, 5-22
 Custody of, 5-23
 DA Form 805-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, 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, 3-19
 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, 2-23
 Inpatient treatment record (ITR), 8-3
 Outpatient treatment records, 6-7
 Injury, recording of, 3-12
 Inpatient care, use of health record (HREC), 5-2
 Inpatient identification plate, 3-5
 Inpatient treatment record (ITR)
 Absent-without-leaves 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, 8-2
 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
 Registrar-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
 Malingerers, 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 ED 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
 Naitality terms, 11-1
 Neonatal death, 11-1
 Recording of, 3-13
 Neonatal diseases, 3-9
 Newborn complication, 11-4
 Newborn infection, 11-4
 New health record, 5-25
 Nondependent substance abuse, 3-10
 Nonmilitary personnel, access to health records, 5-21
 North Atlantic Treaty Organization Standardization Agreement 2348 requirements, 8-4
 Nuclear medicine files
 DA Form 805-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
 Osteoblastic infection, 11-8
 Obstetric complication, 11-1
 Occupational diseases, 3-9
 Occupational injury and illness, recording of, 3-12

84
AR 40-88• UPDATE
Publication, App A
Purpose of agitation, l-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 3445-series folders used for, 4-5
Reaction
Drugs, 11-1
Whole blood or components, 11-1
Record chargeout system, 4-4, 4-8
Record ownership, 1-5
Record requests, 4-7
Release of medical records, 10-3
Research personal, 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, 5-2
SF 38 (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, 6-10
Health record form, 5-4
Inpatient Treatment Record form, 6-2
Outpatient Treatment Record form, 6-2
SF 503 (Clinical Record—Antidote Protocol), 6-2
SF 504 (Clinical Record—History—Part II, 5-2, 8-10
SF 505 (Clinical Record—Health—Parts II and III), 5-2, 8-10
SF 506 (Clinical Record—Physical Examination), 8-2, 8-10
SF 507 (Clinical Record—Report or Continuation of SF), 8-2, 8-10
SF 509 (Medical Record—Doctors Program Report), 5-19, 8-2, 8-10
Health record form, 2-4
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 Records), 8-2
SF 512 (Medical Record—Plotting Chart), 5-4, 5-13, 6-2, 8-2
SF 513 (Medical Record—Counseling sheet), 8-2, 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, 3-2
SF 518 (Medical Record—Blood or Blood Component Transfusion), 5-4, 8-1, 8-2
SF 519 (Medical Record—Radiologic Report), 5-4, 6-2, 8-2, 8-20
SF 519A (Medical Record—Radiologic 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—Dentist), 5-4, 5-2
SF 522 (Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures), 5-4, 6-2, 8-2
Administration, 5-2
Stabilization, 3-1
SF 523 (Clinical Record—Anesthesia for Antispy), 8-2
SF 524 (Clinical Record—Disposition of Body), 8-2
SF 525 (Medical Record—Authorization for Tissue Donation), 8-2
SF 534 (Medical Record—Radiation Therapy), 5-4, 6-2, 8-2
SF 526 (Medical Record—Radiation Therapy Summary), 5-4, 6-2, 8-7
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, 6-2
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, 3-5
Vital-signs-monitoring records, filing of, 3-2
Ward identification plate, 3-5
X-rays, transfer of, 5-24
REQUEST FOR PRIVATE MEDICAL INFORMATION

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

DA FORM 4254-R, NOV 81

DA FORM 4254-R, JUN 74 IS OBSOLETE
REQUEST AND RELEASE OF MEDICAL INFORMATION TO COMMUNICATIONS MEDIA

For use of this form, see AR 40-68: the concerned agency is the Office of The Surgeon General.

THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974

1. AUTHORITY: Section 3013, title 10, United States Code.

2. PRINCIPAL PURPOSE: This form provides for patient/parent/guardian consent to release requested personal medical information to news publication or broadcast.

3. ROUTINE USE: 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 _______ SEX _______ STATUS ____________________________

NAME OF MEDICAL TREATMENT FACILITY ____________________________

SECTION II — TO BE COMPLETED BY REQUESTER

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:

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 the medical treatment facility, to the above mentioned communications media. I hereby agree to hold the hospital, its physician, 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 ____________________________

DA FORM 4878-3, 1 Apr 80
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.

Reverse of DA Form 4876-8, 1 Apr 80
MEDICAL RECORD

This form will not be used for authorization to disclose alcohol or drug abuse patient information from
medical records of the VA. See 38 CFR 1794.3(c) for other provisions of law that apply to disclosure of this
information.

PHYSICIAN OR MEDICAL TREATMENT FACILITY AUTHORIZED
TO RELEASE INFORMATION

It is understood that the authority may be revoked at any time, by notice in writing or
aforesaid, as the health professional may determine.

PATIENT DATA

NAME (Last, First, M.I.)

DATE OF BIRTH

SOCIAL SECURITY/IDENTIFICATION
NUMBER

PERIOD OF TREATMENT (Month, Day, Year)

TYPE OF TREATMENT

□ OUTPATIENT □ INPATIENT □ BOTH

REASONS FOR INFORMATION RELEASED

□ UH/CHS MEDICAL CARE □ INSURANCE CLAIMED □ ATTORNEY □ DISABILITY DETERMINATION

□ OTHER (Specify)

INFORMATION REQUESTED

□ INDIVIDUAL OR ORGANIZATION TO WHOM INFORMATION SHOULD BE RELEASED (Name and Address)

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION AT THIS INCINIENT IS PROHIBITED EXCEPT WHEN IMPICIT IN THE
REASONS FOR THE 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 (referred).

WORKER ID OF AUTHORIZED INDIVID/Organization

RELATIONSHIP TO PATIENT

IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE

DA FORM 5008-R, OCT 81
<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>VAL #</th>
<th>STRENGTH</th>
<th>SCHEDULE</th>
<th>ON BETA BLOCKERS?</th>
<th>REACTIONS OR SPECIAL INSTRUCTIONS</th>
<th>TECH INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PATIENT IDENTIFICATION**

(Fill typed or written entries give name, rank, first, middle, SSHID, OCS, treating facility)

**NURSING PER DIEM, INITIALS**

<table>
<thead>
<tr>
<th>NAME</th>
<th>INITIALS</th>
<th>NAME</th>
<th>INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DA FORM 5007A-R, NOV 91  REPLACES DA FORM 5007A, OCT 81 WHICH IS OBSOLETE.
<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>ARM</th>
<th>DOSE</th>
<th>REACTIONS OR</th>
<th>YEAR</th>
<th>SPACE</th>
<th>DATE</th>
<th>TIME</th>
<th>ARM</th>
<th>DOSE</th>
<th>REACTIONS OR</th>
<th>SPACE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PATIENT'S IDENTIFICATION**
For typed or written entries give Name: last, first, middle; SSN: (DD/MM/yyyy treating facility)

**NURSING PERSONNEL, INITIALS**
NAME: INITIALS, NAME: INITIALS.
STATEMENT OF PATIENT RELEASING HOSPITAL FROM LIABILITY UPON LEAVING HOSPITAL AGAINST MEDICAL ADVICE

1. This is to CERTIFY that I am leaving _______ (Name of Patient) 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 _______ (Name), _______ (Relationship to Patient) of _______ (Name of Patient) in ___________ (Name of 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

BADGE NUMBER

DA FORM 5009-R, OCT 81
## CHRONOLOGICAL RECORD OF WELL-BABY CARE

For use of this form, see AF 40-600, the probate agent or the Office of the Surgeon General.

<table>
<thead>
<tr>
<th>SIGNIFICANT NEONATAL KINF</th>
<th>DOB</th>
<th>WEIGHT</th>
<th>HEIGHT</th>
<th>PULS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SUBJECTIVE HISTORY

1. Feeding
2. Formula/Breast
3. Solids
4. Vitamin/Fluoride

### PHYSICAL EXAM

- Nutrition
- Head/Fontanelle
- Ears
- Neck/Cervicals
- Heart
- Abdomen
- Genital/Aura
- Limp/Skin
- Neurological

### PLANS AND COUNSELING

- Safety
- Feeding
- Growth and Development
- Immunization
- Next Visit

**EXAMINED BY**: 

**EXAMINED BY**: 

### PATIENT IDENTIFICATION (Name, last, first, middle, sex, date, hospital or medical facility)
<table>
<thead>
<tr>
<th>SIGNIFICANT NEONATAL HISTORY</th>
<th>DOB</th>
<th>WEIGHT</th>
<th>HEIGHT</th>
<th>FRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAS Congenital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SUBJECTIVE HISTORY

1. FEEDING
2. FORMULA/BREAST
   - SUGAR
   - VITAMIN/FLOURIDE
3. ELIMINATION
4. GROWTH AND DEVELOPMENT

OBJECTIVE

PHYSICAL EXAM

- Head/Fontanel
- Neck
- Clavicles
- Lungs
- Heart
- Abdomen
- Genitalia
- Nails
- Extremities
- Skin
- Neurological

ASSESSMENT

PLANS AND COUNSELING

- Safety
- Feeding
- Growth and Development
- Immunization
- Next Visit

EXAMINED BY

PATIENT IDENTIFICATION (Name, last, first, middle, sex, age, race, hospital or medical facility)

REMARKS

Reserve of DA FORM 5598-R
**ISONIAZID (INH) CLINIC FLOW SHEET**

For use of this form, see AR 40-86; the prepayment agency is the Office of The Surgeon General

<table>
<thead>
<tr>
<th>Date started INH</th>
<th>CODES</th>
<th>O = No</th>
<th>I = Yes</th>
<th>CO = Comment Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tinic's name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tinic's date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tinic's age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. months of INH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUBJECTIVE**

- Fatigue
- Nausea
- Loss of appetite
- Dark urine
- Light stools
- Joint pain
- Loss of weight
- Visual change
- Elevated temperature
- Tingling hands/feet

**OBJECTIVE**

- Rash
- Intox
- Other

**ASSESSMENT**

- Patient taking medications
- Side effects noted
- PLAN/EXECUTION

- Rifampin (RFP) no. 30
- Ethambutol (EMB) no. 30
- Patient education provided
- Initials for function here
- Observations (int)
- Refer to MD
- Referral to next duty day
- Next appointment (time)
- Interviewer's initials

**COMMENT SECTION**

(Continue on reverse)

**PATIENT'S IDENTIFICATION** (be mechanical imprints if readily available. For read or written names give: Name, Sex, Age, Unit, loc. B n. Hospital and duty phase.)

**INTERVIEWER'S IDENTIFICATION DATA**

[Signature and Title]

[Initials]
1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN).** Title V, Public Law 92-129; section 415, 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 as amended by 86 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 the 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 86 Stat 131 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 audit 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

DA FORM 8004-R, NOV 91