CHAPTER 16

FIELD SANITATION

Section I. INTRODUCTION

16-1. General

a. This chapter provides information and instruction in the employment of established, practical measures designed to prevent disease and preserve the health of troops under field conditions.

b. Manpower is the Army's most valuable asset. Everything possible must be done to conserve this asset. In recent wars, more deaths resulted from disease than from enemy action. During the Civil War, a total of 199,720 soldiers died from disease compared to 138,154 battlefield deaths. Records of World War II, the Korean, Lebanese, and Vietman conflicts show 15,828,940 disease casualties as opposed to 640,254 combat casualties.

c. The control or prevention of disease is the responsibility of every soldier. By practicing proper personal hygiene, food and water sanitation, waste disposal, and insect and rodent control, the potential for disease can be kept to a minimum.

16-2. Command Emphasis

a. The commander of a military organization is responsible for the health of his command. In fulfilling this responsibility, he is assisted by a staff of medical personnel. Using the technical advice and guidance of these individuals, he issues orders and enforces measures that will most effectively maintain sanitation and protective practices conducive to the health and well-being of his troops. The maintenance of their health and, consequently, their fighting efficiency is one of his greatest responsibilities.

b. To provide a healthy field environment for the troops, the company, battery, or detachment commander appoints a field sanitation team and arranges for the team members' training that they need to accomplish their duties (AR 40-5). The duties include instructing, supervising, inspecting, and reporting, as applicable, to insure that field sanitation facilities are established and maintained, and effective hygiene and sanitation measures are practiced by troops.

16-3. Medical Specialist

The medical specialist may be, and in many situations is, the key medical advisor to the commander. You must know the basic elements of hygiene and sanitation to effectively advise the commander.

Section II. DRINKING WATER TREATMENT

16-4. General

a. Isolated units may not be able to obtain water from established water points. In this case, they must obtain and treat their own water.

b. The sources of water are public water supply systems, surface water (lakes, rivers, streams, and ponds), ground water (wells and springs), rain water collected from roofs or other catchment surfaces, ice or snow, and distilled sea water. The source that appears to be the cleanest should be selected. Water taken from any of these sources must be properly treated before use since these sources are presumed to be contaminated. There are four ways of disinfecting water in the field:

(1) Chlorination by calcium hypochlorite. This is supplied in 0.5 gram ampules along with chlorine residual testing vials and tablets (Chlorination Kit, Water Purification); or in bulk powder (Calcium Hypochlorite, 6-oz jar).

(2) Iodine tablets, supplied in bottles of 50.

(3) Commercial bleach (5 percent sodium hypochlorite).

(4) Boiling.

16-5. Disinfecting Water in a Water Purification (Lyster) Bag

a. Set up Lyster bag. (See Figure 16-1.)

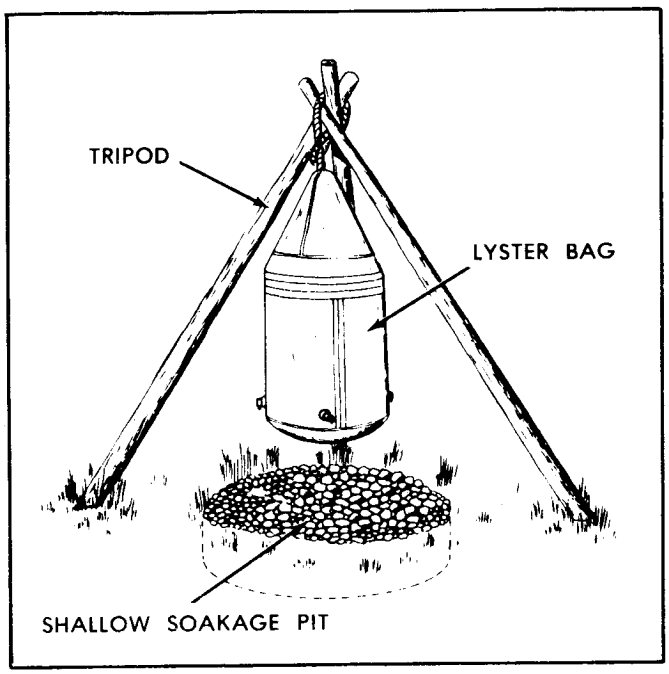

Figure 16-1. Lyster bag set up.

b. Fill the Lyster bag with water.

(1) Clean the Lyster bag thoroughly before filling it with water.

(2) Use settled or filtered clear water, if possible.

(3) Fill the bag to the 36-gal mark (approximately 4 inches from the top). BE CAREFUL—when full the bag weighs about 300 pounds.

c. Mix stock disinfecting solution.

(1) Add contents of three ampules of chlorine to a canteen cup half full of water.

(2) Stir with a clean implement to dissolve the calcium hypochlorite.

NOTES

1. Stock solution is a mixture of chlorine adequate to provide the initial treatment prescribed by the command surgeon. See the Job Performance Aid (JPA) packed with the Chlorination Kit, Water Purification, for procedures used in opening the ampules.

2. The command surgeon may prescribe other dosages, but the normal dosage is 5 mg/l chlorine residual (three ampules for the initial dose) (see Table 16-1). Chlorine residual is the amount of chlorine remaining after the disinfection demand has been satisfied.

Table 16-1. Chlorine Dosage Requirements

Dosage mg/l (ppm)	Required Ampules
1	1
5	3 or 4
10	5 or 6

d. Add the stock solution to the Lyster bag.

(1) Pour the stock solution from the canteen cup into the Lyster bag.

(2) Mix it well using a clean mixing device.

(3) Cover the Lyster bag and flush the faucets by running a small quantity of water through them.

CAUTION

The water is not safe to drink or use at this time.

(4) Allow the chlorine to react with the water contaminants for 10 minutes.

e. Test the water for chlorine residual.

(1) Select the testing vial (1 mg/1, 5 mg/1, or 10 mg/1) for required residual testing.

(2) Crush one chlorine test tablet (packed in the bottle inside the plastic testing tube) in the cap of the testing vial using the bottom of the test tablet bottle.

(3) Place the powder in the vial.

(4) Flush a faucet of the Lyster bag.

(5) Fill the testing vial to the lower edge of the color band with water from the Lyster bag.

(6) Place the cap on the testing vial and shake it until the crushed tablet is completely dissolved.

(7) Compare the color of the solution to the color band.

(8) If the color of the water is as dark as the color band, the chlorination is acceptable. Discard the water used for testing.

(9) If the desired residual has been satisfied, wait an additional 20 minutes to provide a total disinfection (contact) time of 30 minutes.

(10) If the color of the water is lighter than the color band, more chlorine is necessary. Repeat (1) through (7) above, using an additional chlorine ampule. *Wait an additional 10 minutes before retesting.* If the residual is the desired color, proceed to (9) above.

f. Recheck the chlorine residual.

(1) After the 30 minute contact time and before using the water for any purpose, recheck for chlorine residual by following the same procedure as (1) through (7) above.

(2) If the chlorination is now acceptable, the water may be used.

(3) If the chlorination is not acceptable, repeat the entire chlorination and testing procedure (steps *c* through *e* above) again beginning with the mixing of the stock disinfecting solution.

NOTES

1. Routinely recheck large containers of water for chlorine residual 2 or 3 times a day, since the chlorine residual decreases with time and increased temperature.

2. A 400-gallon trailer arriving from an approved supply point must be tested for chlorine residual in accordance with the procedure outlined in *e.* above. If the required chlorine residual is met, the water is safe. If there is no chlorine residual, dissolve 30 chlorine ampules in a canteen cupful of water or dissolve one mess kit spoonful of the bulk powder (Calcium Hypochlorite, 6-oz jar) in a canteen cup of water. Pour this stock solution into the water trailer. Stir the water with a clean stirring device. Wait 10 minutes, then test the chlorine residual.

3. If the desired residual has been reached, wait 20 minutes, then release the water for drinking. If the desired residual has not been reached, repeat the procedures above with 10 ampules or ⅓ mess kit spoonful of the bulk powder.

16-6. Disinfecting Water in a Canteen

When safe water is not available, each soldier must produce his own potable water by using his canteen and iodine purification tablets, calcium hypochlorite ampules, or commercial bleach (for example, Clorox).

a. Treat a canteen of water using iodine tablets.

(1) Fill the canteen with the cleanest, clearest water available.

(2) Take needed iodine tablets from the bottle. Check for good tablets not crumbled or stuck together. If the tablets are stuck together or crumbled, replace them.

(3) Add one iodine tablet to a 1-quart canteen of clear water (two tablets if the water is cloudy or very cold). Double these amounts for the 2-quart canteen.

(4) Place the cap on the canteen.

(5) Wait 5 minutes.

(6) Shake the canteen vigorously, loosen the cap, invert the canteen, and allow leakage to rinse the threads around the neck of the canteen.

(7) Tighten the canteen cap.

(8) Wait an additional 20 minutes before using the water for any purpose.

b. Treat a canteen of water using calcium hypochlorite ampules.

(1) Fill the canteen with the cleanest water available.

(2) Fill a canteen cup half full of water.

(3) Add the calcium hypochlorite from one ampule to the canteen cup filled half full of water.

(4) Stir with a clean device until the powder is dissolved.

(5) Fill the cap of a plastic canteen half full of the solution. Use a capful for the 2-quart canteen.

(6) Add this solution to the water in the canteen.

(7) Place the cap on the canteen and shake the canteen thoroughly.

(8) Loosen the cap slightly and invert the canteen, letting the water leak onto the threads around the neck of the canteen.

(9) Tighten the canteen cap again and wait 30 minutes before using the water for any purpose.

c. Treat a canteen of water using a commercial household bleach.

(1) Add two drops of bleach to a 1-quart canteen full of clear water (if the water is cloudy or very cold, add four drops of bleach to the canteen). Double these amounts for the 2-quart canteen.

(2) Place and tighten the cap on the canteen.

(3) Shake the canteen thoroughly.

(4) Loosen the cap slightly and invert the canteen, letting the treated water leak onto the threads around the neck of the canteen.

(5) Tighten the canteen cap.

(6) Wait 30 minutes before using the water for any purpose.

NOTE

Refer to FM 21-10 for additional information concerning field hygiene and sanitation.

d. Disinfect drinking water by boiling. Boil the water for at least 2 minutes. Allow the water to cool before drinking. In an emergency, boiling for 15 seconds will help reduce the harmful organisms. Protect the water; boiling will not prevent recontamination.

Section III. WASTE DISPOSAL

16-7. General

a. Waste includes all types of refuse resulting from the living activities of humans or animals, such as—

(1) Feces.

(2) Liquid (wash, bath, kitchen, and urine).

(3) Garbage (food).

(4) Rubbish (nonfood).

b. Waste must be disposed of properly to prevent the spread of disease (dysentery, cholera, and typhoid). The methods used for the disposal of wastes depend upon the military situation and the unit location.

16-8. Methods of Disposal and Types of Devices

a. Methods of disposal.

(1) Burial. Human wastes are usually disposed of by burial. If soil conditions (hard, frozen, or rocky) make digging difficult, a pail or burn-out latrine may be used.

(2) *Burning.* Solid garbage and combustible rubbish may be burned in temporary camps (longer than one week in duration). Garbage and rubbish must be buried when the tactical situation precludes burning.

(3) *Soakage.* Liquid wastes from bath and kitchen are drained into either a soakage pit or trench.

b. Types of waste disposal devices (Figure 16-2) are—

(1) Cat hole latrine.

(2) Straddle trench (short bivouac).

(3) Deep pit latrine.

(4) Pail latrine.

(5) Burn-out latrine.

(6) Trough urinal.

(7) Garbage pits.

(8) Soakage pit.

(9) Soakage trench.

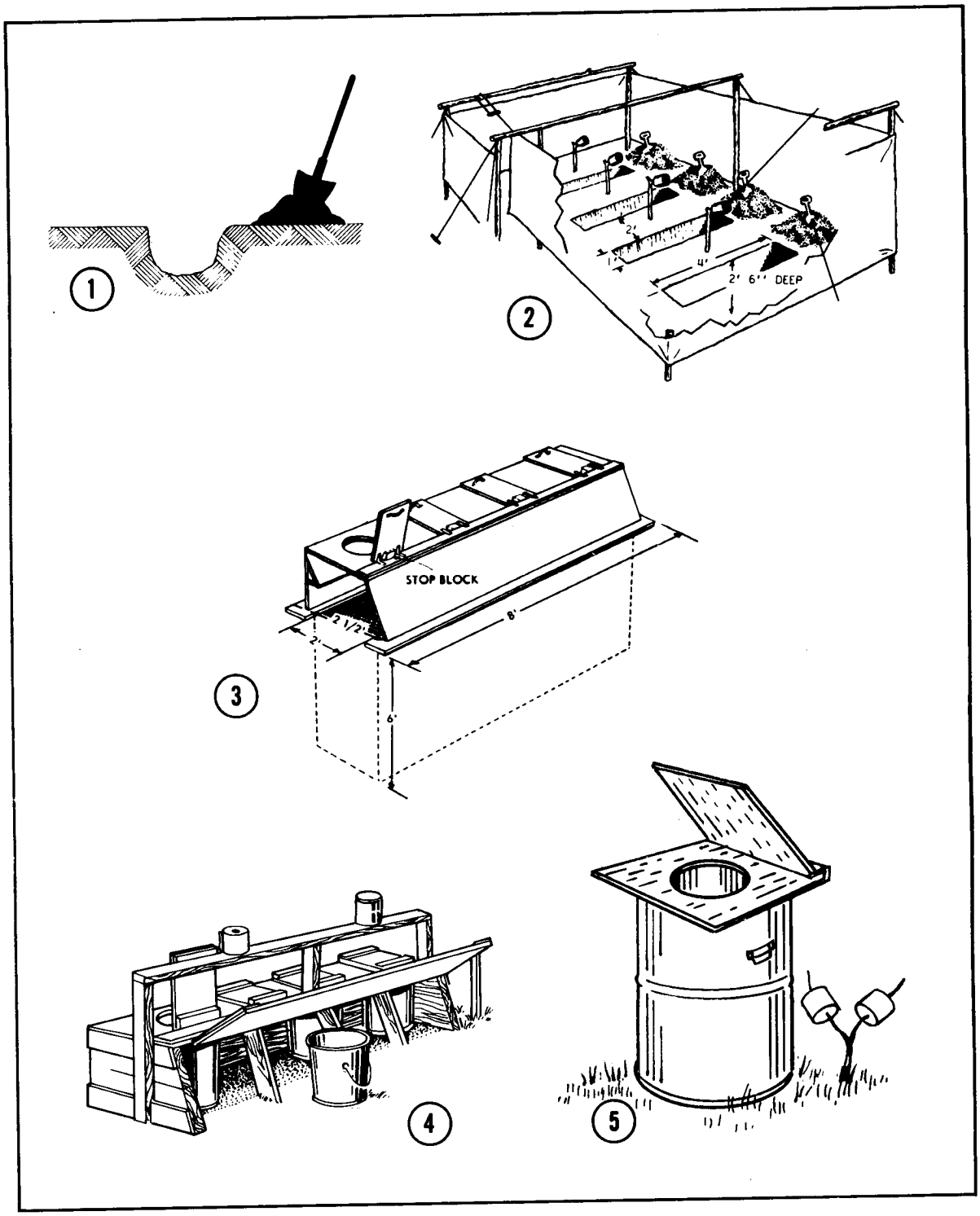

Figure 16-2. Types of waste disposal devices.

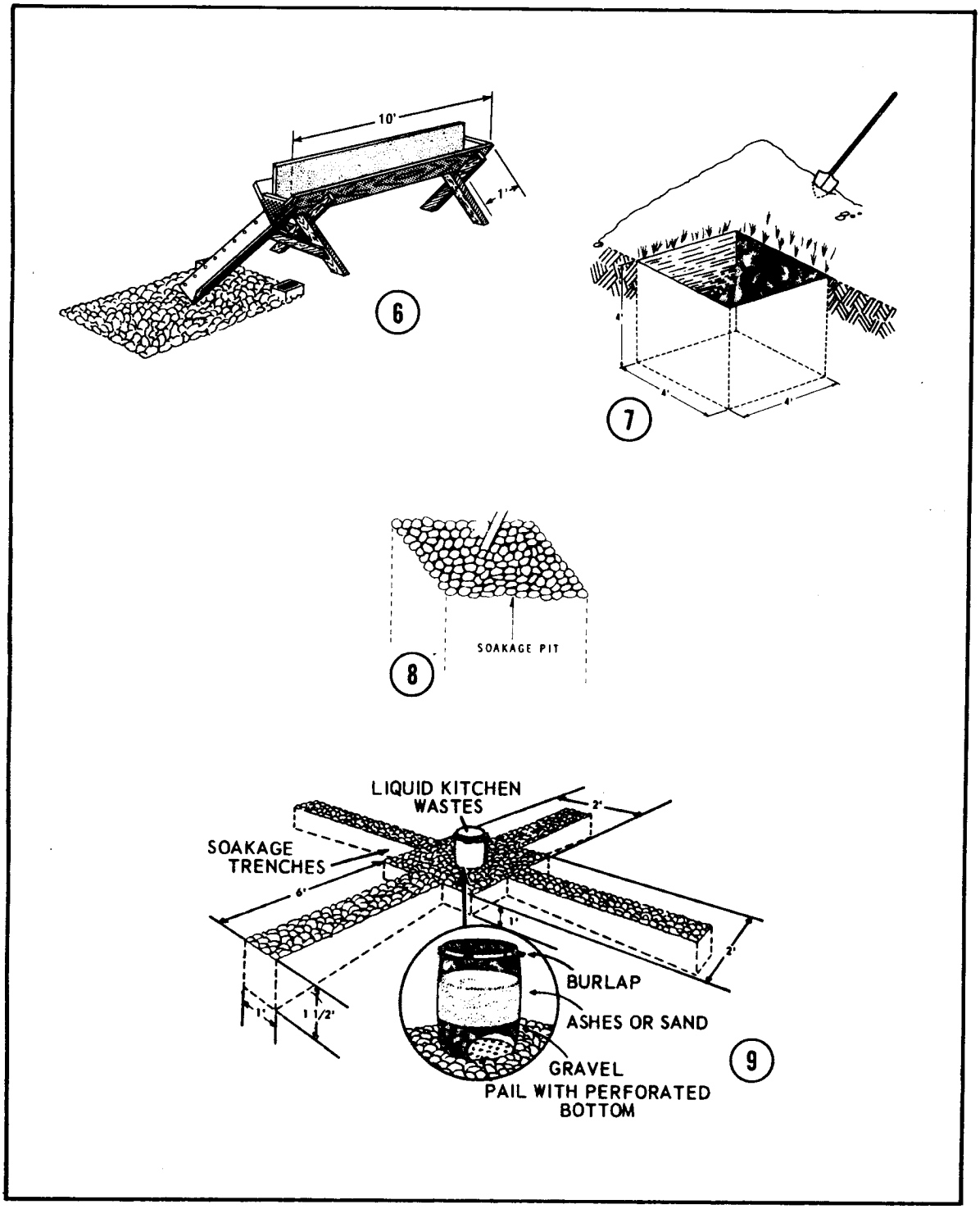

Figure 16-2. Types of Waste Disposals — continued

Section IV. FOOD SANITATION

16-9. General

Even the most appetizing food can cause illness if it has become contaminated with disease organisms through improper handling. Outbreaks of food poisoning, dysentery, infectious hepatitis, and typhoid fever can result from unsanitary practices in kitchens and dining areas. Persons who handle food must always maintain the highest standards of personal hygiene and sanitation.

16-10. Food Sanitation Measures

a. Cook hot foods sufficiently. For example, pork and pork products should be cooked throughout to a minimum internal temperature of 150°F in order to kill the trichinae (trichinosis).

b. Do not drink any liquids, eat food, or use ice from an unapproved civilian vendor.

c. Wash your hands before eating, whenever possible.

d. Keep hot foods hot until eaten. Hot food temperature should be at least 140°F.

CAUTION

Proteins, dairy products, and sauces spoil quickly. They must be kept hot (140°F) or cold (45°F or below).

e. Refrigerate or ice down cold food. Cold food temperature should be 45°F or below.

f. Inspect canned foods for damage and/or contamination. Do not use cans if damage is evident (rust, badly dented, top and/or bottom of can bulging).

g. Clean mess kit and utensils. Wash in warm soapy water. Rinse in clear boiling water. Disinfect by immersing in a second can of clear boiling water for 30 seconds.

NOTE

See FM 21-10 for additional information concerning food sanitation.

16-11. Insect Control

a. Keep food and garbage covered.

b. Use screens or nets to keep flies out of the food preparation area.

c. Spray outside infested areas. Read the label on the pesticide container before use. Apply the pesticide as instructed. Use care when spraying the food service facility. DO NOT spray the food storage and preparation area while preparing or serving food. Aerosol spray may be used in

the preparation area to keep the fly population down; however, care must be taken to keep the insecticide out of the food and off the food contact surfaces of the equipment and utensils.

16-12. Rodent Control

a. A rodent can be any one of several animals; however, this discussion will be limited to control of rats and mice.

b. Methods of rodent control:

(1) Store soft-packaged food in metal containers.

(2) Close cracks and openings in the food storage area.

(3) Bury or burn garbage/rubbish.

(4) Trap/poison rodents that get into the food storage area.

(5) Keep garbage/rubbish that is not burned in tightly closed containers.

Section V. PERSONAL HYGIENE

16-13. General

a. Personal Hygiene. Personal hygiene is often thought of as being the same as personal cleanliness; while cleanliness of the body is important, it is only one of the many essentials of healthful living. Personal hygiene is practiced by an individual to—

- Protect his own health.
- Protect the health of his unit and other units.
- Improve morale.

b. Personal Cleanliness. Before it was known how disease organisms were spread, civilized people gave attention to personal cleanliness because of a desire to please themselves as well as to be attractive to others. It is now known that there are also sound medical reasons for keeping the body clean. Dirt, filth, and invisible disease organisms are inseparable. Keeping the body and clothing clean are simple, effective means of reducing the number of disease organisms which can invade the body. Personal cleanliness is only one of the measures practiced in personal hygiene to prevent disease.

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16-14. Maintaining Personal Hygiene and Proper Foot Care

a. Practice personal hygiene.

(1) Cleanse your skin, hair, and teeth daily, or as often as possible.

(2) Change clothing daily or as often as possible. Avoid wearing unwashed clothing for long periods of time (this is an open invitation to lice and disease).

b. Take proper care of your feet.

(1) Wash your feet daily.

(2) Dry them thoroughly, especially between the toes.

(3) Apply foot powder lightly and evenly twice a day.

(4) Change socks at least daily.

c. Wear proper footwear.

(1) Use only issued footwear.

(2) Make sure footwear is properly fitted so that your feet will not slide forward or backward when walking.

(3) Avoid binding or pressure spots.

NOTE

See FM 21-10 for additional information on personal hygiene.

CHAPTER 17

MEDICAL INFORMATION AND RECORDS

Section I. CONFIDENTIALITY OF MEDICAL INFORMATION

17-1. General

This section discusses Department of the Army (DA) policies and procedures concerning the confidentiality of private medical information.

17-2. Explanation of Terms

a. Private Information. Information that belongs only to a patient and should not be open to public scrutiny. This information, if divulged, may cause personal embarrassment or harm.

b. Confidentiality. Guarding the privacy of medical information. Information gained through the examination or treatment of a patient is private and confidential. Medical confidentiality is NOT, however, a security classification of CONFIDENTIAL.

c. Privileged Communications. A communication made within a confidential relationship that as a matter of public policy is protected. Information disclosed by patients to Army Medical Department (AMEDD) health personnel is not privileged. See paragraph 151C(2), Manual for Courts-Martial, 1969 (Revised).

d. Medical Information. This is information that pertains to evaluations, findings, diagnosis, or treatment of a patient. The term also includes any other information given to AMEDD health personnel in the course of treatment or evaluation. Medical information is *confidential* and *private*. Paramedical documents such as immunization registers and dosimetry records are not considered medical information even though they are kept in the same file with medical records.

17-3. Responsibilities

a. The medical treatment facility (MTF) commander will issue local rules to enforce the policies and procedures stated in this section.

b. Persons and agencies within DA that use medical information for official purposes must protect the privacy and confidentiality of that information.

17-4. Protection of Confidentiality

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

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

b. At no time will personnel who are not involved in a patient's care or in medical research have access to the patient's records. Exceptions to this are allowed when access is required by law, regulation, or judicial proceeding; when needed for hospital accreditation; or when authorized by the patient.

(1) Medical information is seen by clerical and administrative personnel (such as secretaries, stenographers, and medical record administrators). This is needed for an MTF to properly process medical records; 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 when working with it.

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

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

17-5. 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. In his absence, requests will be handled by another chosen representative of the MTF commander. Medical information obtained from nonmilitary sources will be filed with, but not considered a part of, the patient's medical record. Such information is available for further diagnosis and treatment of the patient and other official DA uses. Any further redisclosure is prohibited. This information is the property of the nonmilitary facility and can be released only by that facility. The patient or other requester will be told that additional information is contained in the record and it may be requested from the originating facility. This does not apply to medical information on patients treated under supplemental or cooperative care. Such information may be released as a part of the patient's medical record.

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

(1) DA Form 4254-R (Request for Private Medical Information) (Figure 17-1) will be used for requests. This form will be locally reproduced. Submitted forms are filed under file number 901-02, AR 340-18-9, by the receiving MTF.

REQUEST FOR PRIVATE MEDICAL INFORMATION
For use of this form, see AR40-66; the proponent agency is the Office of The Surgeon General

DATE: 6 NOV 83

PATIENT'S NAME AND SOCIAL SECURITY NUMBER	MEDICAL TREATMENT FACILITY (Name and Location)
DOE, JOHN P 555-33-6666	5TH MASH NTC, CALIFORNIA

REASON FOR REQUEST

ASSAULT

PRIVATE MEDICAL INFORMATION SOUGHT *(Specify dates of hospitalization or clinic visits and diagnosis, if known)*

IN HOSP 7-26 OCT 83
INFORMATION NEEDED TO COMPLETE
LINE OF DUTY DETERMINATION.

REQUESTOR'S NAME, TITLE, ORGANIZATION AND SOCIAL SECURITY NUMBER

EDWARD J. RICHT, CPT, IN, CDR 2/6 INF, 888-88-9876

FOR USE OF MEDICAL TREATMENT FACILITY ONLY

Check applicable box

☐ APPROVED ☐ DISAPPROVED *(State reason for disapproval)*

SUMMARY OF PRIVATE MEDICAL INFORMATION RELEASED

SIGNATURE OF APPROVING OFFICIAL | DATE

DA FORM 4254-R, 1 Jul 74 *(Paper size 8 x 10½", image size 7 x 9-4/10".)*

Figure 17-1. DA Form 4254-R.

(2) MTF commanders or patient administrators will determine the legitimacy of the request. Advice of the local Staff Judge Advocate should be sought if there is any doubt about the need for information or about the credentials of the requester.

(3) In certain situations (cases of rape, assault, or death), the need for the information may be urgent. In these cases, both the request for information and permission for disclosing it may be given verbally. Immediately after giving permission, the MTF commander or his representative will prepare a memorandum on the release. The requesting agent will follow up his verbal request with a written one using DA Form 4254-R.

b. Official Request from Personnel Outside Department of the Army. See Chapter 3, AR 340-21.

c. Unofficial Requests. See Chapter 2, AR 40-66.

d. Requests from Patients. If a patient requests information from his medical record or copies of the documents in it, it will be given to him. Access to the information will be denied, however, if a physician or dentist judges that it could adversely affect the patient's physical or mental health. When such a decision has been made, the information may be released to another physician or dentist, one named by the patient. In such a case, the patient must be told that he may name the physician or dentist (paragraph 2-6*e*, AR 340-21). Such medical records will be identified with a conspicuous strip of tape (see paragraph 4-4*a*(10), AR 40-66). Direct access by a patient to his original record will be allowed only in the presence of the custodian or his designee.

e. Release of Medical Information to Members of the Public. See paragraph 2-9*a*, AR 340-17.

17-6. Alcohol and Drug Abuse Records

No information concerning the treatment, identity, prognosis, or diagnosis for alcohol or drug abuse patients will be released except in accordance with the provisions of AR 600-85.

Section II. MEDICAL RECORDS ENTRIES

17-7. General

a. Content. Entries will be made on medical record forms by the health care provider who observes, treats, or cares for the patient. Although AR 40-66 prescribes the amount of information that must be given for entries, health care providers must always remember that entries serve as a useful record for continued and future care. Therefore, all entries must be clinically pertinent and kept up-to-date.

b. Legibility. All entries must be legible; they are usually typed but may be handwritten. Handwritten entries will be made in permanent black or blue-black ink, except when pencil entries are either directed or necessary under field conditions. Rubber stamps may be used only for standardized entries, such as routine orders.

c. Signatures. All entries must be signed. The first entry made by a specific person will be signed; later entries on the same page by that person will be signed or initialed. Military members must add grade and corps. A rubber-stamped signature will not be used in place of written signatures or initialing. However, the use of rubber block stamps under written signatures is recommended because it establishes a method to identify the authors of entries. Block stamps for military members should contain printed name, grade, and corps.

d. Dating Entries. All entries must be dated. Dates will be written in the day-month-year sequence; month will be stated by name, not by number. For example, a correct entry is 17 Jun 84.

e. Corrections to Entries. To correct an entry, a single line is drawn through the incorrect information; this information must remain readable. The new information is then added, dated, and signed (with title) by the person making the correction.

17-8. Patient Identification

The "Patient's Identification" section will be completed when each record document is begun. Patient identification will be typed or handwritten in black or blue-black ink. Patient identification must include at least the patient's name, rank, grade, or status.

17-9. Facility Identification

The MTF providing care will be clearly named in all medical records and reports (such entries on SF 600 (Chronological Record of Medical Care) will be made by rubber stamp when possible). Since patients are often treated at several MTFs, the MTF that is custodian of the patient's records will be named also. For outpatient records and health records, this may be done using the patient recording card.

Section III. RECORDING DIAGNOSES AND PROCEDURES

17-10. General

a. Diagnostic nomenclature will be recorded in language accepted as good professional usage. Vague and general expressions will be avoided.

b. The affected body part will always be stated when relevant to the condition and when not given in the name of the condition. In addition, the body part will be described in as much detail as is needed (that is, skin of, tissue of, region of). Terms such as "right," "left," "bilateral," "posterior," and "anterior" will also be added when applicable. For dental diagnoses and procedures see TB MED 250.

c. Few abbreviations should be used in medical records. Only those listed in the appendix of AR 40-66 and the medical terminology section are authorized. The chief of the MTF clinical and professional services will insure that those listed are properly used. Abbreviations not listed in the appendix of AR 40-66 may be used in long narratives but only if defined in the text. For example: Nerve condition time (NCT) is changed by many factors. NCT varies with electrolytes or with temperature.

17-11. Special Instructions for Certain Diseases

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

17-12. 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 function. For other individuals whose use of alcohol has brought them to medical attention, the appropriate term is "nondependent abuse of alcohol." This term applies to people formerly diagnosed as "simple drunkenness" cases. It also applies to people not suffering from alcoholism but who are seen by a physician because of driving-while-intoxicated charges, an altercation involving alcohol, AWOLs, or absences from work due to overuse of alcohol.

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

c. Malingerer. This term is used for a person who claims to be ill or unduly exaggerates a disability. It is used only when the medical officer believes there is no actual illness or disability or only a slight one (see paragraph 194, Manual for Courts-Martial).

17-13. Recording Psychiatric Conditions

See paragraph 3-7, AR 40-66.

17-14. Recording Injuries

a. Details To Be Recorded.

(1) The same details will be given and the same terms used when recording both battle and nonbattle injuries. To be complete, the recording of an injury must include the details given below. On DA Form 3647 (Inpatient Treatment Record Cover Sheet) (ITRCS), the details listed in *(c)* through *(h)* below will be recorded in Item 33.

(a) The nature of the injury. The exact nature of the injury must be recorded as well as the condition caused by it. Conditions like traumatic bursitis, traumatic neuritis, traumatic myositis, or traumatic synovitis must be explained by describing the original injury. For example, a contused wound resulting in bursitis would be recorded as bursitis due to contusion.

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

(c) The external causative agent. In the case of acute poisoning for example, the poison must be named.

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

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

(f) The place where injured. If on-post, state the building or area (barracks, mess tent, motor pool); if off-post, state the place and person's status (home on leave, in transit while AWOL).

(g) The date of the injury.

(2) Examples of properly recorded diagnoses are as follows:

(a) "Fracture, open comminuted, upper third of shaft of femur, left, no nerve or artery involvement; bullet entering anterior upper portion of left thigh and lodging in femur. Caused by rifle bullet, accidentally incurred when patient's rifle discharged while he was cleaning it in Arms Room, Bldg 902, Ft Dix, NJ, 8 Jul 84."

(b) "Bursitis, acute, knee, right, due to contusion, anterior aspect. Accidentally incurred when patient tripped and fell, striking knee on floor while entering Barrack 1380, Ft Sam Houston, TX, 9 Jul 84."

b. Wound or Injury Incurred in Combat.

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

(a) The wound resulted from enemy action. The definition of wounded in action (battle casualty) is given in Appendix C, AR 40-400. The abbreviation WIA (wounded in action) will be used. However, this abbreviation by itself is not acceptable as a diagnosis.

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

(c) The time the wound occurred.

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

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

c. Injuries or Diseases Caused by Chemical or Bacteriological Agents by Ionizing Radiation.

(1) For the 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 (odor, color, physical state).

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

(3) Estimate and record the time that lapsed between contamination and self-decontamination or first aid (if any). The procedures will also be stated.

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

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

17-15. Recording Deaths

a. The following terms will be used to record a death 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 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. For additional information, see Section II, AR 40-66.

Section IV. OUTPATIENT TREATMENT RECORD

17-16. General

a. Treatment Record. DA Form 3444 (Outpatient Treatment Record) (OTR) will be prepared for all patients treated as outpatients other than active duty personnel.

b. Responsibilities. Medical and dental officers and other care providers will insure that information is promptly and accurately recorded on OTR medical and dental forms. They will also insure that records prepared and received from other MTFs are promptly reviewed and filed in the OTR.

c. Outpatient Treatment Record Forms and Documents.

(1) DA Form 3444 (see Figure 17-2) series folders will be used as OTR file folders. On these folders, the "Outpatient Treatment" box is checked if the folder is used as a medical record and the "Dental (Non-military)" box if used as a dental record. (For the preparation and filing of the DA Form 3444 series folder, see Chapter 4, AR 40-66.)

(2) The forms used in medical OTR are listed in Table 17-1. These forms will be filed from top to bottom in the order they are listed in the table. Copies of the same form will be grouped and filed in reverse chronological order; that is, the latest on top.

17-17. Initiating and Keeping Outpatient Treatment Records

The OTR will be kept at the MTF that provides primary medical care. Only one medical OTR and one dental OTR will be kept at the MTF for each patient. Keeping partial or multiple records is prohibited except in obstetrical cases (see paragraph 17-21*d*).

17-18. Transferring Outpatient Treatment Records

To insure a patient's record is complete, the MTF providing care should include all outpatient records prepared at other facilities. OTR should be transferred to the next MTF when patients are transferred.

a. Mailing Outpatient Treatment Records.

(1) When a patient moves, the OTR may be handcarried or mailed to the next MTF. However, the following OTR must be mailed and will be sent directly to the next MTF, ATTN: Patient Administration Division. They will not be sent to installations, organizations, or area commanders or to personnel officers.

- *Special category records.*
- *OTR of patients who will be ineligible for care at a military MTF after the move.*

(2) When mailing an OTR to the next MTF, the procedures below will be followed:

(a) The MTF will complete DD Form 2138 (Request for Transfer of Outpatient Records) and instruct the sponsor to present the card at the next MTF.

(b) When the losing MTF receives the DD Form 2138, it will mail the OTR to the requesting MTF. The losing MTF will file the DD Form 2138 alphabetically and keep the form until the retirement of that year's records.

(3) A patient whose OTR must be mailed ((1) above) may be given a copy of certain parts of the OTR or an extract. This may be done if the patient needs medical care en route to or upon arrival at another MTF. The extract or copies will be given to the patient or any other authorized person as described in b below. Documentation of the treatment en route should be included in the original OTR; the patient should be told to give this documentation to the next MTF.

b. Handcarrying Outpatient Treatment Records. If the patient (other than those described in *a*(1) above) requests it, he may handcarry the OTR to the next MTF. These procedures will be followed when OTR are handcarried:

(1) The patient will sign for the OTR on DA Form 3705 (Receipt for Outpatient Treatment/Dental Records). When preparing DA Form 3705, the "address" blocks must be completed. Once signed, DA Form 3705 will be filed like DD Form 2138.

(2) An adult's OTR will not be released to anyone other than the patient unless a signed authorization is presented to the MTF. Any statement approving release to another person will be acceptable if signed and dated by the patient. This statement will be attached to the DA Form 3705.

c. Troop-Unit Changes of Station. When troop units change station, the losing and gaining MTFs will coordinate to transfer the OTRs. If mailed, the losing MTF will securely package and seal all OTRs destined for the same MTF and send them by registered mail.

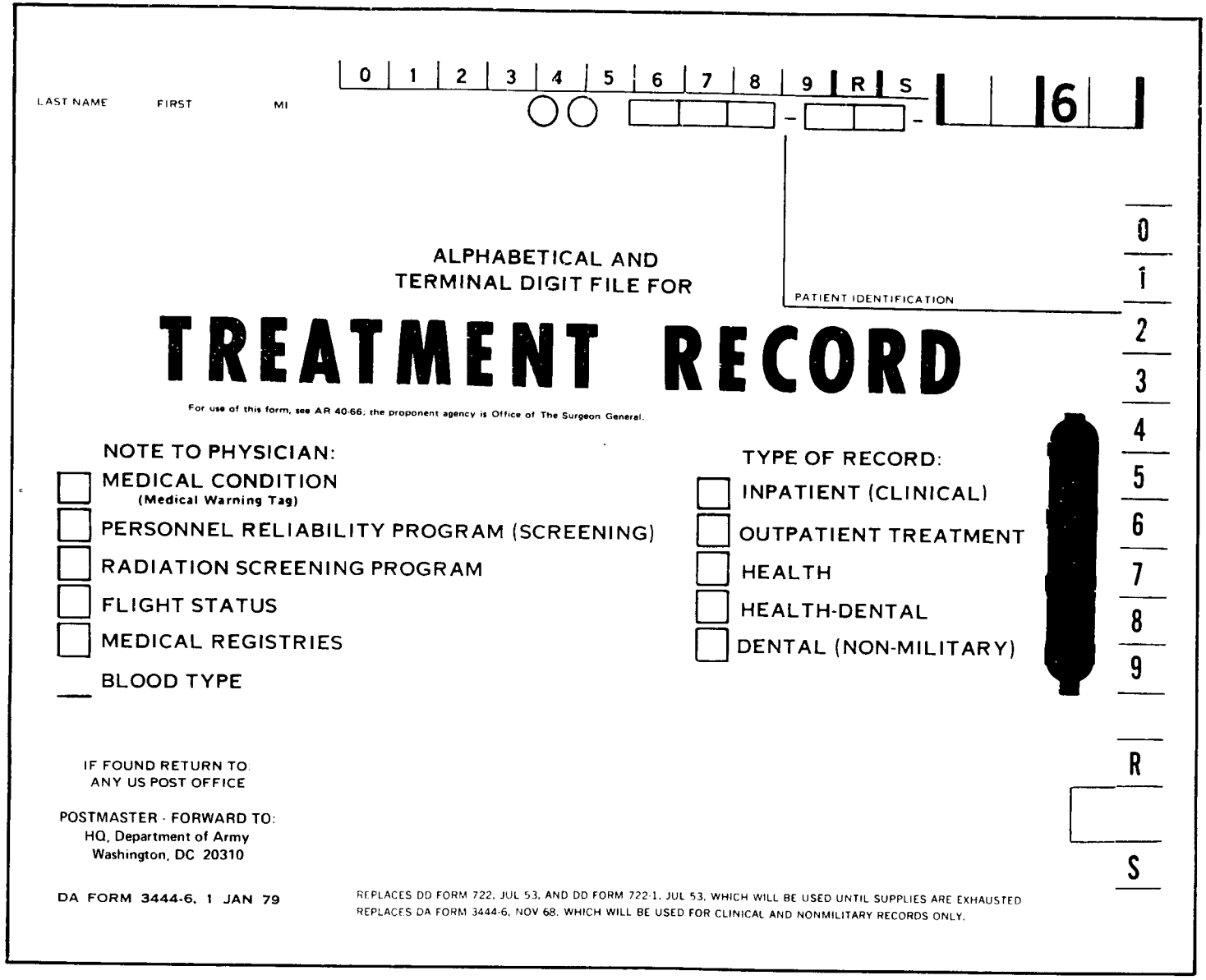


Figure 17-2. DA Form 3444.

Table 17-1. Forms and Documents of the Medical OTR

LEFT SIDE OF FOLDER	
Form No.	*Form Title and Notes*
DA Form 3180/3180A	Personnel Screening and Evaluation Record. (See AR 50-5 and Chapter 4, AR 380-380.)
*SF 601	Health Record—Immunization Record.
*SF 545	Laboratory Report Display. Filed with SFs 546 through 557 mounted.
*SF 519/519A	Medical Record—Radiographic Report.
SF 520	Clinical Record—Electrocardiograph Record. Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of this form or on another attached sheet of paper.
DA Form 3647	Inpatient Treatment Record Cover Sheet. (Formerly DA Forms 8-275 series and DD Form 481 series.) File with it a copy of SF 502 (if prepared). Also filed here is SG Form 84, AF Form 565, NAVMED 6300/5, or DD Form 1380 (formerly DA Form 8-27).
—	Authorization for release of medical information. File with this a synopsis of any information released and related correspondence. (The synopsis may be entered on SF 544, which would be filed here.)
—	Administrative documents and other correspondence.

Table 17-1. Forms and Documents of the Medical OTR—continued

RIGHT SIDE OF FOLDER	
DA Form 4515	Personnel Reliability Program Record Identifier. See AR 50-5.
*SF 600/SF 558	Health Record—Chronological Record of Medical Care. File here also any other basic chronological medical care records (for example, SF 558 (Medical Record— Emergency Care and Treatment) and AMOSIST Encounter Forms).
DA Form 3763	Community Health Nursing—Case Referral. See paragraph 4-2*b*, AR 40-407.
DA Form 4530	Electroencephalogram Request and History.
DA Form 4700	Medical Record—Supplemental Medical Data.
SF 513	Medical Record—Consultation Sheet.
SF 522	Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures.
—	Other SF 500 series forms in numerical sequence.
DD Form 771/771-1	Eyewear Prescription/Eyewear Prescription—Plastic Lenses.
—	Reports or certificates prepared by neuropsychiatric consultation services.
—	Correspondence on hearing aids.
—	Medical documents from civilian sources.
DA Form 3365	Authorization for Medical Warning Tag.
*DA Form 4410-R	Disclosure Accounting Record.
*DD Form 2005	Privacy Act Statement—Health Care Records.

*This form must be included in all OTRs.

17-19. Transfer Requests Other Than DD Form 2138

Although DD Form 2138 is the only form authorized for use as a request for transferring OTR in ordinary circumstances, this does not preclude prompt response to other types of requests such as DD Form 877 (Request for Medical/Dental Records or Information). Charge-out information for such requests will be filed and kept at the losing MTF as described in AR 40-66.

17-20. Disposition of Outpatient Treatment Records

Outpatient Treatment Records will be disposed in accordance with AR 340-18-9.

17-21. Preparation of Outpatient Treatment Records

Each contact with the AMEDD as an outpatient will be recorded in the OTR. Periods of treatment as an inpatient will be described on DA Form 3647 and SF 502 (Medical Record—Narrative Summary) and put into the OTR.

a. Preparation and Use of SF 600. SF 600 is the basic record form of the medical OTR. It is a chronological record of outpatient visits. For the preparation and use of SF 600, see paragraph 5-14*a*(1) and 5-14*a*(3) through (7) of AR 40-66. See Figure 17-3.

b. Preparation and Use of SF 601 and PHS Form 731.

(1) An SF 601 (Health Record—Immunization Record) will be prepared and permanently kept for each person who has an OTR. It will be put into the record when:

(a) The OTR is initiated.

(b) The patient next reports for immunizations or sensitivity tests.

(c) Reactions are noted.

(2) PHS Form 731 (International Certificates of Vaccination) will be prepared or posted when a patient reports to an MTF for immunizations. Only the following identification information is entered on the form:

(a) The patient's name on the "Traveler's Name" line.

(b) The patient's address on the address line.

(c) The county of the individual's address on its appropriate line.

(3) Individuals preparing SF 601 and PHS Form 731 will insure that all entries are recorded on both forms and that both forms are current with each other.

(4) In accordance with international rules, entries on PHS Form 731 for immunization against smallpox, yellow fever, and cholera will be authenticated. Each entry must show the DOD immunization stamp and the signature of the medical officer or his chosen representative. (See AR 40-562.) For other entries on PHS Form 731 and all entries on SF 601, the signature block may be stamped or typewritten and initialed by the medical officer.

c. Preparation of the Outpatient Treatment Record Folder for Patients Allergic to Medications. On the outside front cover of the DA Form 3444 series folder, the "Medical Condition" block will be marked and a DA Label 162 (Emergency Medical Identification Symbol) affixed. This will be done when SF 601, PHS Form 731, or DA Form 3365 (Authorization for Medical Warning Tag) is prepared. (See AR 40-15 and AR 40-562.)

d. Obstetrical Cases. A pregnancy diagnosis will be entered on SF 600. After the pregnancy, all forms related to it will be filed in the Inpatient Treatment Record (ITR). When the records are filed, the following will be entered on SF 600: "Prenatal care records filed in ITR of (patient's name, FMP, and SSN), (location of MTF), and (date)."

17-22. Use of Outpatient Treatment Records

The OTR will be given to physicians, dentists, and other medical personnel attending an outpatient or inpatient. When an outpatient is to be treated over a short period of time in a clinic, the OTR may be kept in that clinic; however, it will be made available to other medical personnel when required during this retention period. Further, the OTR should accompany a patient admitted to a military MTF and be constantly available for use by the attending physician. A strict audit trail will be kept for any OTR temporarily out of the file.

Section V. HEALTH RECORDS

17-23. General

The primary purpose of the health record (HREC) is to insure that AMEDD personnel have a concise but complete medical history of everyone on active duty or active duty for training. It will help medical officers advise commanders on retaining and using their personnel. Similarly, the record will help physical evaluation boards appraise the physical fitness of Army members and their eligibility for benefits.

17-24. Responsibilities

a. Unit Commanders. Unit commanders will insure that HRECs are always available to AMEDD personnel. They will also insure that information in the HREC is kept private and confidential. If a commander acquires the HREC or records belonging in HREC, he will insure that they are treated confidentially and sent to the proper HREC custodian without delay. In some instances, some commanders may act as the custodians of their units' HRECs or appoint a competent person to do so. They may act as custodians only if no AMEDD personnel are locally available.

b. AMEDD Officers.

(1) AMEDD officers will serve as custodians of the HRECs. In their charge are the HRECs for members of the units to which they supply primary medical care. Also in their charge are the HRECs of other individuals they are currently treating. AMEDD officers will use the HRECs for diagnosis and treatment. They will also use them for conservation and improvement of health. In doing so, they will see that all needed information is promptly entered into the HREC in their custody. If any such information is omitted, they will take the needed action to have it included.

(2) When an AMEDD officer examines or treats a person whose HREC is not in his custody (that is, "casuals"), he will send copies of the proper records to the person's HREC custodian. These records will be sent sealed in an envelope stamped or plainly marked "Health Records." In addition to the address, the envelope also will be plainly marked "Health Record of (person's name, grade, and SSN)." The person's unit of assignment will also be shown. (If the HREC custodian is not known, the document will be sent to the MEDDAC (Medical Department Activity) or MEDCEN (Medical Center) commander of the person's assigned installation.)

17-25. For Whom Prepared and Kept

HRECs will be prepared and kept for all Army personnel. These include active duty personnel, Reserve Component personnel, and cadets of the US Military Academy. When transferred to Army custody, HRECs for members of the Navy and Air Force will also be kept.

17-26. Forms and Documents of the Health Record

The medical forms authorized for use in the HREC are listed in Table 17-2. To make access to information easier in these folders, the forms will be filed from top to bottom in the order they are listed in the tables. Copies of the same form will be grouped and filed in reverse chronological order; that is, the latest on top.

Table 17-2. Forms and Documents of the Health Record

LEFT SIDE OF FOLDER	
Form No.	Form Title and Notes
DA 4186	Medical Recommendation For Flying Duty. See AR 40-501.
DA Form 3180/3180A	Personnel Screening and Evaluation Record. See AR 50-5.
*SF 601	Health Record—Immunization Record.
DD Form 1141	Record of Occupational Exposure to Ionizing Radiation. Also automated dosimetry records, DD Form 1952 (Dosimeter Application and Record of Occupational Radiation Exposure), results of investigation of alleged or actual overexposure, and any other record of personnel dosimetry. See AR 40-14.
*SF 545	Laboratory Report Display. (Formerly SF 514.) Filed with SFs 546 through 557 mounted.
*SF 519/519A	Medical Record—Radiographic Report.
SF 520	Clinical Record—Electrocardiograph Record. Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of this form or on another attached sheet of paper.
DA Form 3647	Inpatient Treatment Record Cover Sheet. (Formerly DA Forms 8-275 series and DD Forms 481 series.) File with it a copy of SF 502 (Medical Record—Narrative Summary), if prepared. File here also SG Form 84, AF Form 565, NAVMED 6300/5, DD Form 1380 (formerly DA Form 8-27 (Emergency Medical Tag)), or any other narrative summaries from the Veterans Administration, Public Health Service, or other Government MTF.
DA Form 3365	Authorization for Medical Warning Tag.

Table 17-2. Forms and Documents of the Health Record—continued

RIGHT SIDE OF FOLDER	
DA Form 4515	Personnel Reliability Program Record Identifier. See AR 50-5.
*SF 600/SF 558	Health Record—Chronological Record of Medical Care. File here also any other basic chronological medical care records (for example, SF 558 (Medical Record— Emergency Care and Treatment) and AMOSIST Encounter Forms).
SF 602	Health Record—Syphilis Record. (Formerly DA Form 8-114.)
—	Civilian or foreign military treatment records.
DA Form 199	Physical Evaluation Board Proceedings.
*DA Form 1811	Physical Data and Aptitude Test Scores upon Release from Active Duty. See AR 601-210. For personnel separated to continue on active duty in the same or another status, file this form directly in front of the last SF 88 in the HREC continued in use. For personnel reentering service after the HREC has been retired, file this form as the last document in the temporary HREC; when the permanent HREC is received, file the form directly in front of SF 88.
DA Form 2173	Statement of Medical Examination and Duty Status.
DA Form 3349	Medical Condition—Physical Profile Record. (Formerly DA Form 8-274.) File here also any correspondence on a revision of physical profile serials.
DA Form 3947	Medical Board Proceedings. (Formerly DA Form 8-118.)
DA Form 4060	Record of Optometric Examination. (This form became obsolete after 1 October 1974.)
DA Form 4530	Electroencephalogram Request and History.
DA Form 4700	Medical Record—Supplemental Medical Data.
*SF 88	Report of Medical Examination.
*SF 93	Report of Medical History. (Formerly SF 89.) File here any other medical history form.

Table 17-2. Forms and Documents of the Health Record—continued

SF 513	Medical Record—Consultation Sheet.
SF 522	Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures.
—	Other SF 500 series forms in numerical sequence.
DD Form 771/771-1	Eyewear Prescription/Eyeware Prescription—Plastic Lenses.
DD Form 2215	Reference Audiogram.
DD Form 2216	Hearing Conservation Data.
—	Reports or certificates prepared by neuropsychiatric consultation services or psychiatrists.
—	Correspondence on hearing aids.
—	Documents and correspondence on flying status. That is, restrictions, removal of restrictions, suspensions, and termination of suspensions. See AR 600-107.
—	Other medical documents important enough to keep on file. This includes correspondence on release of medical information, statements instead of physical examinations for the promotion of officers and warrant officers, and so forth.
DA Form 4465	ADAPCP Military Client Intake and Follow-up Record. File here also any other authorized alcohol and drug forms.
*DA Form 4410-R	Disclosure Accounting Record. To be included if DD Form 722 is used as the folder instead of the DA Form 3444 series.
*DD Form 2005	Privacy Act Statement--Health Care Records. To be included if DD Form 722 is used as the folder instead of the DA Form 3444 series. See paragraph 1-6*c*, AR 40-1

**This form must be included in all health records.*

17-27. Access to Health Records

All personnel having access to HRECs will protect the privacy of medical information. The extent of access allowed certain personnel is described below.

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

b. Service Members. If a service member requests information from his HREC or copies of the documents in it, they will be given to him. For special category records, see paragraph 2-6*e*, AR 340-31.

c. Inspectors. Personnel inspecting an MTF are allowed direct access to the HRECs. This includes personnel conducting Technical Proficiency Inspections under AR 20-1; it also includes Technical Standardization Inspections conducted by the Defense Nuclear Agency. Inspectors may have access to the HRECs to evaluate the compliance of AMEDD personnel with regulations. All inspectors must respect the confidentiality of the HRECs they inspect.

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

e. Other Nonmedical AMEDD Personnel. Nonmedical personnel may need information from a person's HREC for official reasons. Such personnel include unit commanders, inspectors general, officers of the Judge Advocate General's Corps, military personnel officers, and members of the US 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 commander or patient administrator.

17-28. Cross-Servicing of Health Records

AR 40-66 and similar regulations in the other services allow and direct cross-servicing of the HREC. Procedures for maintaining and transferring Navy and Air Force HRECs are similar to those described for Army HRECs.

a. When members of other services are attached to Army MTFs for primary care, custody will be assumed for their HREC. These will be maintained as discussed in this regulation.

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

c. When cross-servicing HRECs, Army personnel are not required or allowed to check or complete records for any periods before the HREC came under Army custody.

17-29. DA Form 3444 Series Folder

For preparation of this folder, see Chapter 4, AR 40-66 (Figure 17-2). For health records, check the "Health" box under "Type of Record"; for dental records, check the "Dental (military)" box. Handwritten entries will be made in dark ink and boldly printed. (The member's current organization; for example, "Company A, 163d Infantry," will be handwritten but must be done in soft pencil.)

17-30. SF 600

One copy of SF 600 will be put in the health record. (See Figure 17-3.) The following parts of the form are completed:

a. Person's name.

b. Sex.

c. Year of birth.

d. Component. (Do not include branch.)

e. Department.

f. Grade.

g. Organization.

h. SSN.

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

PATIENT'S NAME (Last, First, Middle initial): DOE JOHN P.

SEX: M

YEAR OF BIRTH: 1958

RELATIONSHIP TO SPONSOR:

COMPONENT/STATUS: AD

DEPART/SERVICE: ARMY

SPONSOR'S NAME:

RANK/GRADE: SP4

SSAN OR IDENTIFICATION NO.: 555-33-6666

ORGANIZATION: 2/6 INF DIV

CHRONOLOGICAL RECORD OF MEDICAL CARE

Standard Form 600
600-106-01

Figure 17-3. SF 600 (Patient Data).

17-31. SF 601 and PHS Form 731

a. One copy of SF 601 will be put in the health record. The identification parts of this form will be completed as described for SF 600 in Figure 17-3. At reception stations, procedures will be set up to insure that immunization information is entered on the copy of SF 601. For persons allergic to medication, the "Medical Condition" block on the front of the HREC folder will be checked. Also, DA Label 162 will be put on the front of the folder.

b. A copy of PHS Form 731 will be sent with the health record for later entries of immunization data. This form should be clipped or fastened to SF 601 and it will not be punched. The name and SSN of the person will be typed or written in ink on the front of the form. The address put on the form for officers and warrant officers is HQDA (DAPC-PSR-R), Alexandria, VA 22332. The address for enlisted personnel is Commander, US Army Enlisted Records Center, Fort Benjamin Harrison, IN 46249. 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 reaches his first training or duty station.

17-32. SF 88 and SF 93

The original copies of SF 88 (Report of Medical Examination) and SF 93 (Report of Medical History) will be put in the health record.

17-33. CDC 9.2936A

If a CDC 9.2936A (Venereal Disease Epidemiologic Report) has been received with a person's records, it will be stapled to a blank letter-sized sheet of paper. It will then be fastened in the health record under SF 601.

17-34. Transferring Health Records

a. Sending Health Records. Both parts (health and dental) of a person's HREC are transferred when his Military Personnel Records Jacket (MPRJ) is transferred (AR 740-10). When a person is to be transferred to another unit or station, the military personnel officer of the losing unit will get both parts of the HREC from their respective custodians. The HREC will be sent with the MPRJ except when:

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

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

(3) The HREC custodian sends the records directly to the gaining custodian. If the HREC custodian feels a person should not hand carry his HREC, he will send it directly to the commander of the person's next MTF. The servicing military personnel officer will be promptly informed that the HREC will be sent and not carried. If the custodian does not know the address of the person's next MTF, he will send the HREC to the servicing military personnel officer; it will be sent to the person's next HREC custodian.

b. AMEDD Personnel.

(1) The officer in charge must insure that any health problems of a newly arrived individual are treated. Thus, he must insure that the person's HREC is reviewed when received. This review may be made by the medical officer, a physicians' assistant (MOS 911A), or other qualified individuals. (The HRECs of all personnel working with nuclear weapons or nuclear reactors will be reviewed by medical officers or designated physicians' assistants in accordance with the Personnel Reliability Program (AR 50-5).) Each MTF commander will establish qualifications for people who are not physicians to review the HRECs. Each MTF will also perform audit reviews to insure the HRECs are referred to medical officers when needed. The responsible medical personnel will develop written quidelines for the review of the HRECs by nonmedical officers. These guidelines will insure that reviews check for pending actions, health care problems, and record inadequacies. When writing guidelines, the medical officer must insure that reviews include the actions listed below. These may be modified or expanded to fit the local situation:

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

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

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

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

(e) Recurrent problems such as repeated bouts of pneumonia, urinary tract infections, cardiac arrhythmias, emotional problems, and drug and alcohol abuse will be noted.

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

(g) The HREC folder will be checked to insure that the person's blood type is entered. Also, it will be checked to insure that any allergic reaction to medication was entered and DA Label 162 affixed (AR 40-15).

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

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

(4) If a CDC 9.2936A is in the individual's record, the medical officer will immediately have the person examined and start an SF 602 (Health Record—Syphilis Report), if needed. If the CDC 9.2936A is not for syphilis, comments on the examination and any treatment given will be made on SF 600. When no longer useful in the case, the CDC 9.2936A will be removed from the HREC and destroyed.

c. Health Records Not Received. The military personnel officer will request information on the missing records from the individual's last known unit. If neither he nor the last unit can find an officer's or warrant officer's HREC, the military personnel officer will send a request for the missing HREC to HQDA (DAPC-PSR-R), Alexandria, VA 22332. If an enlisted member's HREC cannot be found, a request will be sent to Commander, US Army Enlisted Records Center, Fort Benjamin Harrison, IN 46249. A copy of this request will be kept in the member's MPRJ until a reply has been received. If the individual is transferred before the reply arrives, the copy of the request will be indorsed to his next unit. When the request reaches the individual's next unit, it will be put in his "temporary" HREC. (A notation of a reply to the request will be made on SF 600 and the reply inserted in the HREC.)

d. Movements of Units with the Medical Treatment Facility. When a unit and its attached MTF move, the unit's HRECs will be retained and moved by the MTF. This will be done only if the MTF continues to give primary medical and dental service to the unit during and after the move. If another MTF will give primary service to the unit during or after the move, the HRECs will be sent to the record custodian of the MTF that provides care during the move.

17-35. "Temporary" and "New" Health Records

a. "Temporary" Health Record. When receipt of a health record is delayed, a temporary one will be prepared if the individual needs any medical attention. This will also be done if any documents meant to be included in a health record arrive before it. A manila folder rather than the DA Form 3444 series folder will be used. The date the temporary record was begun will be printed on the folder. Documents concerning the member's medical care will be added to the temporary health record as they are used; they will not be prepared until needed. For example, SF 601 would not be prepared for a temporary health record until an immunization was given. When a delayed HREC is received, the forms in the temporary record will be filed in it.

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

(1) When a new health record is prepared, an SF 601 will be added if necessary.

(2) Should a lost health or dental record be found after a new record has been prepared, the new record forms will be filed in the original record. The custodian will note on SF 600 or SF 603 (Health Record—Dental) that the original health or dental record was received.

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

17-36. Filing the Health Record

a. Health Record Files. Health records will be filed at the MTF that provides primary medical care. The records may be filed alphabetically or in terminal digit sequence. A charge-out system will be used when the HREC is temporarily removed from the record room.

b. Keeping Health Record Files Current. The following procedures will be followed to keep HREC files current:

(1) The MTF and division surgeon will give the military personnel office (MILPO) a list of the MTFs and the units they serve.

(2) The MILPO will give the MTF quarterly personnel rosters of the units they serve.

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

c. Handling Identifiable Health Records and Medical Forms. When a record or form contains enough information that it can be identified as belonging to a specific person, it is an identifiable form. To keep files current, identifiable HRECs and forms will be handled as follows:

(1) When a member outprocesses at an MTF, the MTF will give the serving MILPO his HREC. This is done so that it can be sent with the MPRJ to the new custodian. When the HREC is sent to the MILPO, the MTF will record identification of the new custodian so that any late-arriving medical records, such as laboratory slips or SF 600s can be forwarded to him.

(2) When the MTF cannot find the member's health or dental record, a suspense card will be prepared. This card will contain the member's name, rank, SSN, the complete address of his new unit, the MEDDAC that serves his new unit, and the date the card is put in suspense. The suspense card will be kept in a charge-out folder; the folder kept in the files where the member's records should have been. These suspense cards will be kept until the record is found and sent to the new custodian or until the files have been given two semiannual reviews, whichever comes first. They will then be destroyed.

d. Handling Stray Records and Forms. Stray records and forms found during the semiannual files review will be handled as follows:

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

(2) When the proper custodians cannot be determined, the MTF will make a list of the members to whom the records belong. This list will give each member's full name and SSN. The list will be sent to the MILPO. With it will be sent a cover letter requesting that the names be checked against installation rosters, clearance files, and with the Standard Installations/ Division Personnel System (SIDPERS) Interface Branch that keeps a

worldwide locator file. It will request that the member's unit of assignment be named, if possible. The MILPO response will be kept by the MTF in a reference paper file (File Number 901-07) for 1 year. (See AR 340-18-9 for information on reference paper files.)

(3) If the MILPO cannot find the address of the proper custodian before the files are given two semiannual reviews, the MTF will draft a letter stating that the serving MILPO has done the proper screening and cannot find the correct custodian. With this letter, the identifiable records and forms will be disposed of as outlined in Table 17-3.

Table 17-3. Disposition of Stray Records and Forms

RULE	A If the records or forms belong to	B then send them to (see Note)
1	An Army officer or warrant officer	HQDA (DAPC-PSR-R) Alexandria, VA 22332
2	Army enlisted personnel	Commander US Army Enlisted Records and Evaluation Center Fort Benjamin Harrison, IN 46249
3	Army retired personnel	Commander US Army Reserve Components Personnel and Administrative Center 9700 Page Boulevard St. Louis, MO 63132
4	Navy/Marine personnel	Chief, Bureau of Medicine and Surgery ATTN: Code 7424 Navy Department Washington, DC 20372
5	Air Force personnel	Headquarters, US Air Force ATTN: AFMPC/DPMDR Randolph Air Force Base, TX 78148

Note: HRECs that contain only blank forms will not be sent to the agencies listed above. Reusable folders and forms will be returned to stock; folders and forms that cannot be reused will be destroyed.

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

17-37. Disposition of Health Records

Upon discharge, release from active duty, retirement, death, or transfer from US Army Reserves (USAR) to Army National Guard (ARNG), HRECs will be disposed of in accordance with Appendix E, AR 635-10. ARNG HRECs will be disposed of like an MPRJ. (For officers and warrant officers, see NGR 640-100; for enlisted personnel, see NGR 600-200.)

17-38. Preparation of the Health Record

Throughout the soldier's military career, each contact with the AMEDD as a patient is recorded in the HREC. Periods of treatment as an inpatient, described on DA Form 3647 and SF 502, are put in the health record. Quarters referrals are reported as to duration and treatment. Outpatient medical care is recorded each time the person is seen. Medical care at MTFs that do not keep the HREC is recorded and sent to the HREC custodian.

17-39. Use of the Health Record

a. Use Within Medical Treatment Facilities. Precise procedures for using the HREC within MTFs are not set by this publication. Such procedures should be set locally to insure the most efficient handling of the HRECs. The procedures set by MTF commanders will insure that:

(1) HRECs are readily available to AMEDD personnel who are treating patients.

(2) Access to information in the HREC is controlled.

b. Use in Primary (Outpatient) Medical Care.

(1) Normally a person's health record will be kept by the MTF that gives his unit primary medical care. Each time the person is treated, the health record will be removed from the file and used by the physician. Each time a physician uses a record, he will comment on the case on the SF 600. When an MTF refers a patient elsewhere for outpatient care, the health record may be sent also. This is decided by either the referring or consulting physician. If it is sent, the consulting physician will comment in the record on his findings and treatment. If it is not sent, the consulting physician will enter his findings on SF 513 (Medical Record—Consultation Sheet) or any other medical forms (including SF 600) he deems proper. These consultation and treatment records will be filed in the person's HREC.

(2) A person may report for outpatient treatment to an MTF that does not keep his health record. In this case, the findings and treatment will be recorded on an SF 600 and any other medical forms that are needed. After treatment, the SF 600 and other records will be sent to the custodian of the person's health record.

c. Use in Inpatient Care.

(1) Normally, the HREC will be sent to the MTF when a person is admitted for treatment. When an MTF receives the HREC (or a portion of it), the patient administrator becomes the custodian. He will insure it is accessible to authorized personnel. When received, the HREC will be sent to the patient's ward. It will be kept there during his stay for use by his attending physician and other medical personnel involved in his case. The patient administrator will insure that a copy of each of the forms required for the HREC prepared by the MTF is put in the HREC. He will also insure that the entries needed for inpatients on SF 600 are made.

(2) When a patient is released from the MTF, the patient administrator will forward the HREC as follows:

(a) For attached patients returned to duty. Send the HREC to the record custodian of the MTF that provides the person with primary outpatient care. If the primary MTF is unknown, send the HREC to the hospital commander at the person's assigned installation.

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

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

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

(e) For patients AWOL in excess of ten days. Send the HREC to the custodian of the MPRJ.

17-40. Preparation and Use of SF 600

SF 600 is a chronological record of each treatment in a person's military health history. 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. (See Figure 17-4 for examples of entries of SF 600.)

Standard Form 600
General Services Administration and
Interagency Committee on Medical Records
FPMR [illegible] Exception Approved by NARS
October 1975 1 Aug 79

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 APR 1984	HX: 101° FEVER
TMC #1	IMP: URI
BERLIN BDE APO NY 09742	DISPOSITION: ADMIT TO WARD 4B.
0400 HRS.	Mark L. Moore Cpt. M.C.

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

PATIENT'S NAME (Last, First, Middle initial)			SEX
DOE JOHN P.			M
YEAR OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS	DEPART/SERVICE
1958		A D	ARMY
SPONSOR'S NAME			RANK/GRADE
			SP4
SSAN OR IDENTIFICATION NO.		ORGANIZATION	
555-33-6666		2/6 INF DIV	

CHRONOLOGICAL RECORD OF MEDICAL CARE
Standard Form 600
600-106-01

Figure 17-4. SF 600 (Medical Care).

a. Entries for Outpatient Care.

(1) Entries should be concise but complete; that is, medically and adjudicatively adequate. They should include:

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

(b) Findings of any examination or test.

(c) Diagnoses and impressions (if made).

(d) Treatment, disposition, and any instructions given to the patient for follow-up care. All prescribed drugs will be recorded. These entries may be recorded in a "subjective, objective, assessment plan" format. SF 558 (Emergency Care and Treatment) will be used for emergency cases.

(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 will also be stated.

(3) When admission as an inpatient is imminent, the entries discussed in (1) above may be made on SF 509 (Medical Record-Doctor's Progress Notes) instead of SF 600. This will then be the inpatient admission note filed in the patient's inpatient record. 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) With patients seen repeatedly for special procedures or therapy (for example, physical and occupational therapy, renal dialysis, or radiation), the therapy will be noted on SF 600 and interim progress statements will be recorded. Also, a final summary will be given when the special procedures or therapy are ended. This summary will include:

- Results of evaluative procedures.
- Treatment given.
- Reaction to treatment.
- Progress noted.
- Condition on discharge.
- Any other pertinent observations.

Initial notes, interim progress notes, and any summaries may be recorded on any authorized form but must be referenced on SF 600.

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

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

- The drugs given or appropriate identifying code.
- Investigative procedures performed.
- Significant observations, including effects.
- The physical and mental state of the subject.
- Tests and laboratory procedures performed.

(8) Outpatient care received at civilian facilities will also be recorded on SF 600. If available, copies of records concerning this 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 then send this information to the person's HREC custodian.

b. Entries for Periods of Medical Excuse from Duty. Except during 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:

- The time and date of admission.
- The name and location of the MTF.
- The cause of admission.

(2) In the case of referral to quarters, detailed comments will be made regarding:

- Care given.
- Estimated duration.
- Extensions of quarters status.
- When the patient will be returned to duty.

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

d. Entries for Orthopedic Footwear. When a person is authorized the issue of orthopedic footwear, the term "orthopedic footwear authorized" will be entered on SF 600. Also entered will be the prescription and date.

e. Entries for Syphilis Treatment. The preparation of an SF 602 and the date it was done will be noted on SF 600. Later information recorded on the SF 602 will not be noted on SF 600.

f. Entries for Drug Abuse Treatment. When a person has been judged by a clinical evaluation to be an alcohol or other drug abuser, entries will be made on the SF 600. (See paragraph 6-3*a*(6), AR 600-85.)

17-41. Preparation and Use of SF 601 and PHS Form 731

An immunization record on SF 601 will be prepared and kept for each person who needs an HREC. The PHS Form 731 is a personal record of immunizations received; it is normally needed for international travel. Usually, active duty personnel have custody of their PHS Forms 731; they will insure their safekeeping. PHS Forms 731 for Reserve Components personnel will be filed with their personnel records. The form will usually be issued to the person only upon mobilization, activation, or when traveling internationally.

a. Responsibilities.

(1) The unit commander will insure that each assigned or attached member receives the immunizations required by AR 40-562. To do this, he will periodically check the immunization status of each unit member. He will then consult with the local medical officer to insure that immunizations are given when due.

(2) When personnel report for immunization, the medical officer will check the accuracy of the entries on SF 601 and PHS Form 731. He will insure that immunizations given are recorded on both forms and that the entries are properly authenticated.

b. Authentication of Entries. In accordance with international rules, entries on PHS Form 731 for immunizations against smallpox, yellow fever, and cholera will be authenticated. Each entry must show the DOD immunization stamp and the signature of the medical officer or his chosen representative (AR 40-562). For other entries on PHS Form 731 and all entries on SF 601, the signature block may be stamped or typewritten and authenticated by initialing.

c. Entries.

(1) Immunizations and sensitivity tests will be recorded on SF 601.

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

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

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

17-42. Preparation and Use of SF 602

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

b. The medical officer treating or observing the case will record each periodic follow-up in Section V of the form. The period of time follow-up examinations must be made before the record may be closed is given in TB MED 230. The medical officer who treats and follows up syphilis cases will keep suspense files or appointment records needed to insure that current cases are observed long enough.

c. The medical officer treating the patient closes the record by signing Section VI of the form. After closing, it will be kept as a permanent part of the HREC. The record will be closed for any one of the following reasons:

(1) The treatment and follow-up are completed with satisfactory results.

(2) The patient is separated from active service.

(3) The patient deserts or is otherwise lost to military control.

(4) The patient dies.

d. A syphilis record will be reopened for the following reasons:

(1) *Relapse.* The patient record files in the HREC will be used for needed information. On that form, entries about the case will be continued.

(2) *Reinfection.* If reinfection occurs before the record is closed, the current record will be continued. Also, the follow-up will be extended for an additional period of observation. Interim progress notes will be entered; they will give all pertinent information and state a new diagnosis. They will also cite the clinical and laboratory data that prove the new diagnosis. If reinfection occurs after the record is closed, a new syphilis record will be prepared.

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

17-43. Other Forms Filed in the Health Record

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

(1) DA Form 3647.

(2) SF 502.

(3) DA Form 199 (Physical Examination Board Proceedings, prepared in accordance with AR 635-40).

(4) DA Form 3947 (Medical Board Proceedings, prepared in accordance with AR 40-3).

b. Copies of the other HREC forms will be filed as follows:

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

(2) *DD Forms 771 (Eyewear Prescription) and 771-1 (Eyewear Prescription—Plastic Lenses).* Each time one of these forms is prepared, a copy will be filed permanently in the HREC.

(3) *DA Form 3349 (Medical Condition—Physical Profile Record).* When a person's physical profile serial is revised in accordance with AR 40-501, a copy of this form will be put in the HREC.

(4) *DA Form 4465 (ADAPCP Military Client Intake and Follow-up Record).* This form will be prepared, kept, and used in accordance with AR 600-85.

(5) *Dosimetry records.* DD Form 1141 (Record of Occupational Exposure to Ionizing Radiation), automated dosimetry records, DD Form 1952 (Dosimeter Application and Record of Occupational Radiation Exposure), and earlier records of personnel dosimetry must be kept in the HREC. When a person changes station or leaves the service, these records will be moved with his HREC. The dosimetry records of personnel whose work exposes them to ionizing radiation may be removed from their HREC and filed separately. This is done when the medical officer who keeps and uses the records does not have easy access to the HREC of these personnel. In these cases, the separate file of dosimetry records will be kept as described in AR 40-14.

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

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

17-44. Maintenance of Health Records Under Combat Conditions

a. Theater commanders are authorized to name units or areas covered by the provisions of this paragraph and to change them as needed in current military circumstances. Under combat conditions, military personnel officers will keep the HRECs of US military personnel. They will file both parts of the HREC with the MPRJ. They will also file in the HREC the documents they receive from the MTF and send the HREC with the MPRJ when a person's MPRJ moves. Normally HRECs will not be sent to or kept at an MTF; this will be done only when the HREC is needed and requested by a fixed hospital for treatment of a patient. Evaluations or releases of medical information contained in the HREC will be sent to the closest MTF.

b. Identification entries on SF 600 and DD Form 1380 (Field Medical Card) (FMC) for outpatient treatment will include at least the patient's name, grade, and SSN; other data will be entered as time permits. These forms will be kept at the MTF only until treatment is completed (and statistical or other reports prepared). They are then sent to the military personnel officer keeping the HREC.

(1) *DD Form 1380.* Instructions for preparing the FMC are given in paragraph 17-63. When the FMC is put into the HREC, it will be mounted on an SF 600. To mount it, staple along the top margin only so that no entries on the SF 600 are hidden and both sides of the FMC can be read.

(2) *SF 600.* SF 600 is prepared the same under combat conditions as under normal ones (paragraph 17-30).

Section VI. INPATIENT (CLINICAL) TREATMENT RECORDS, AR 40-66

17-45. General

a. An ITR will be prepared for:

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

(2) Each liveborn infant delivered in one of those MTFs.

(3) Carded for record only (CRO) cases (paragraph 3-12, AR 40-66).

(4) NATO patients.

b. An ITR will not be prepared for:

(1) Stillbirths.

(2) MTFs supporting combat operations if the surgeon considers their use impractical and FMCs are used (Section 4, FMC).

c. For nonfixed MTF using ITR, instructions for preparation will be provided by MEDDAC/MEDCEN in whose geographical area the nonfixed facility is operating. Disposition will be in accordance with AR 340-18-9.

17-46. Responsibilities

a. Each MTF commander will insure that an adequate and timely ITR is prepared for each patient who must have one.

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

17-47. Forms and Documents

a. All ITR forms will be fastened into the proper DA Form 3444 series folder. During treatment, the forms will be arranged in the order prescribed by the MTF commander. When the patient is discharged or transferred, the forms will be arranged in the order they are listed in Table 17-2. The same numbered forms will be grouped chronologically (an exception to this is laboratory and radiology orders).

b. All ITRs transferred with a patient are to be kept as a part of his current ITR. However, forms from transferred records will not be interfiled.

c. Although administrative documents are not a part of the ITR itself, they should be filed in the ITR folder.

17-48. Preparation and Use of Inpatient Treatment Records

ITRs must be accurate, complete, and current. The ITR must reflect the patient's current status and treatment. An ITR cover sheet "worksheet" is prepared in the admitting office. This cover sheet and all available medical records will be given to the attending physician without delay.

17-49. Inpatient Treatment Records of AWOL Patients

The ITR of a patient who has been AWOL for 10 consecutive days will be closed and disposed of in accordance with AR 340-18-9.

17-50. Use of SF 539

a. SF 539 (Abbreviated Medical Record) (Figures 17-5A and 17-5B) may be used for cases of a minor nature that require no more than 72 hours hospitalization. For example, it may be used for lacerations, plaster casts, removal of superficial growths, and accident cases held for observation.

b. SF 539 may be used by military members who are hospitalized for uncomplicated conditions not requiring hospitalization in the civilian sector (for example, measles and upper respiratory infection).

c. For further information, see paragraph 7-20, AR 40-66.

17-51. Use and Preparation of DA Form 4256

a. Use of DA Form 4256 (Clinical Record—Doctor's Orders) (Paragraph 7-22, AR 40-66). DA Form 4256 (Figure 17-6) is a three-copy, carbonless form. The original copy (white) remains with the patient's permanent record. The second copy (pink) is sent to the pharmacy, where it is kept until the patient is discharged. The pharmacy must receive a copy of all orders to insure appropriate surveillance of food-drug and laboratory-drug interactions. The ward copy (yellow) is used to give orders to the nursing staff. It may be used as a medication or treatment reminder and will be discarded when no longer needed.

b. Preparation. All entries will be made with ballpoint pen using blue-black or black ink. Entries must be legible on all three copies. In each "Patient Identification" section, addressograph plates should be used. If not, print patient name (last, first, middle initial), rank, grade or status, SSN, sex, and age of patient. More than one order may be written in each section, but no more than one may be written on a single line. The prescriber will record the date and time each order is written. Each order must be accounted for separately; use of the entry "ROUTINE ORDERS" is prohibited. However, a group of orders written at the same time for a patient needs only one signature.

c. Method of Discontinuing Orders. To discontinue a medication or treatment, the prescriber must write and sign a stop order. Automatic stop orders (for example, for antibiotics or controlled drugs) will be governed by written local policy. When an order is stopped, it must be accounted for and then noted on DA Form 4677 (Therapeutic Documentation Care Plan (Non-Medication)) or DA Form 4678 (Therapeutic Documentation Care Plan (Medicated)). This is done by putting "DC/DATE/INITIALS" and drawing a single line through the "HR" and "Date Completed/Dispensed" blocks beside stopped order.

d. Verbal Orders. Verbal orders will be used only for emergency "STAT" orders. The nurse accepting the order must write it on the form and enter after it "VERBAL ORDER (doctor's name/nurse's name, grade, ANC)". The prescriber must countersign as soon as possible after the emergency.

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

PHYSICAL EXAMINATION

PROGRESS *(Enter date of discharge and final diagnosis)*

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION (For typed or written entries give Name last, first, middle, grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.
JONES, JIMMY L. SFC 972-39-6217 M 43 A Co., 1/508 INF		2A

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 101-11.806-8
OCTOBER 1975 539-105

Figure 17-5A. SF 539, Abbreviated Medical Record.

DOCTOR'S ORDERS (*Date and sign all orders*)

TEMPERATURE–PULSE–RESPIRATION						NURSE'S NOTES
DATE AND TIME	T	P	R	STOOLS	WEIGHT	MEDICATION AND NURSE'S NOTES

GPO : 1982 O - 387-355

Figure 17-5B. SF 539, Abbreviated Medical Record (continued).

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: MARTIN, TOBY N. 596-35-8212 MSG M 39 5TH MASH

NURSING UNIT: 2A | ROOM NO.: 15 | BED NO.:

DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
16 JULY 1984 0600 HOURS	
ADMIT TO 2A	0610/B
REGULAR DIET	0610/B
CBC	0610/B
U/A	0610/B
CXR	0610/B
ROUTINE VITAL SIGNS	0610/B
Allen Brown MAJ/MC	
16 JULY 1984 1800 HOURS	
NPO P 2400 HRS	1805/HF
SHAVE PREP LLQ & PUBIS	1805/HF
NO PRE-OP MEDS	1805/HF
START DEEP BREATHING EXERCISES q2°	1805/HF
THANK YOU!	1805/HF
Lowery L Bragg LTC/MC	

PATIENT IDENTIFICATION: MARTIN, TOBY N. 596-35-8212 MSG M 39 5TH MASH

NURSING UNIT: 2A | ROOM NO.: 15 | BED NO.:

DATE OF ORDER / TIME OF ORDER	
17 JULY 1984 1300 HOURS	
NPO UNTIL 1800 HRS THEN SIPS P.O.	1330/B
(30cc P.O./HR ONLY)	1330/B
NG TO LOW GOMCO SUCTION - MAY	1330/B
D/C AT 2400 HRS IF P.O.'s TOLERATED	1330/B
VITAL SIGNS q 4 HRS	1330/B
COUGH & DEEP BREATHE q 2°	1330/B
D5½NS @ 125cc/HR Allen Brown MAJ/MC	1330/B

PATIENT IDENTIFICATION: MARTIN, TOBY N 596-35-8212 MSG M 39 5TH MASH

NURSING UNIT: 2A | ROOM NO.: 15 | BED NO.:

DATE OF ORDER / TIME OF ORDER	
18 JULY 1984 0700 HOURS	
D/C NG TUBE	0700/BP
CLEAR LIQUID DIET	0700/BP
ENCOURAGE AMBULATION	0700/BP
D5½NS TO RUN AT 100cc/HR	0700/BP
TYLENOL #3 I-II TABS PO q 4° PRN PAIN	0700/BP
Allen Brown MAJ MC	

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

Figure 17-6. DA Form 4256, Clinical Record—Doctor's Orders.

17-52. Use of DA Form 5009-R

DA Form 5009-R (Medical Record-Release Against Medical Advice) (Figure 17-7) will be used when the patient leaves the MTF at his own insistence and against advice of the attending physician(s). DA Forms 5009-R will be reproduced locally.

Section VII. PREPARATION AND USE OF LABORATORY FORMS

17-53. General

a. Laboratory forms are used to request laboratory tests and to report the results of those tests. The forms are three-part sets (original and two copies). When requesting a test, the whole set is sent to the laboratory. After the results are recorded, the third copy is kept in the laboratory files. For disposition instructions, see AR 340-18-9. The original is routed for immediate filing in the ITR, OTR, or HREC. The second copy is routed to the requesting practitioner for use and disposition.

b. Carbon copies of laboratory reports will not be filed in the Medical Record. The MTF commander will insure that each patient's laboratory test reports are prepared correctly.

17-54. Instructions for Filling Out Forms

General instructions for preparing these forms are given in Table 17-4. Instructions for each form are given in Table 17-5.

MEDICAL RECORD	RELEASE AGAINST MEDICAL ADVICE For use of this form, see AR 40-66; proponent agency is the Office of The Surgeon General.

STATEMENT OF PATIENT RELEASING HOSPITAL FROM LIABILITY
UPON LEAVING HOSPITAL AGAINST MEDICAL ADVICE

1. This is to CERTIFY that I am leaving _____ (Name of Med Treatment Facility) at my own insistence and against the advice of the hospital authorities and my attending physician(s).

2. I have been advised of the dangers involved in leaving the hospital at this time.

3. I hereby release the hospital, its staff and the Federal Government of all responsibility for any ill effects brought about by my failure to remain in the hospital.

_____ (Signature of Patient)

_____ (Signature of Witness)

_____ (Date and Time)

STATEMENT OF REPRESENTATIVE OF PATIENT RELEASING HOSPITAL FROM LIABILITY
UPON LEAVING HOSPITAL AGAINST MEDICAL ADVICE

1. This is to CERTIFY that I _____ (Name), _____ (Relationship to Patient) of _____ (Name of Patient) insist that he/she be discharged from _____ (Name of Med Treatment Facility) without the authorization of the patient's attending physician(s).

2. I have been informed of the dangers to the patient in his/her leaving the hospital at this time, including the possibility that it may worsen or aggravate the patient's condition.

3. I hereby release the hospital, its staff and the Federal Government of all responsibility for any ill effects brought about by _____(Name of Patient) leaving the hospital against medical advice.

_____ (Signature of Representative)

_____ (Signature of Witness)

_____ (Date and Time)

PATIENT IDENTIFICATION	REGISTER NUMBER	WARD NUMBER
JONES, JOHNNY 011-55-3661 M E-7 46 YRS. C 1/351 INF		

DA FORM 5009-R, OCT 81

Figure 17-7. DA Form 5009-R, Medical Record—Release against Medical Advice.

Table 17-4. General Instructions for Preparing Laboratory Forms

Block	Laboratory	Completed by Clinic/Ward	Instructions	Remarks
Patient Identification		X	Enter patient's name, register number and FMP/SSN of inpatients (only FMP/SSN of outpatients), treating MTF, ward or clinic, date test is requested.	Enter this information correctly. If possible, enter it by mechanical imprinting, using the ward plate or patient's recording card. If not, use ballpoint pen or typewriter.
Urgency Specimen Lab. Report No.	X	X	Check the proper box. Enter the specimen or laboratory report number.	This block is not on SF 553 or 554. This entry may be used to identify and monitor the request form in the laboratory.
Patient Status		X	Check the proper box.	"NP" and "DOM" are not used by the Army.
Specimen Source		X	Check the proper box or write in the needed information.	Some forms request other specimen information: *a.* On the SF 548, give specimen interval information. *b.* On SF 553 and 554, give infection information. Extra information is needed on these forms to identify sensitivities and the infecting organisms. Enter this information in the "Clinical Information" and "Antibacterial Therapy" blocks. *c.* On SF 556, give specimen source information for obstetric patients.
Requesting Physician's Signature		X	Enter clearly the name of the practitioner ordering the test. If a military member, enter also grade and corps.	The signature is not needed.
Reported by	X		The technologist signs here after the test results have been verified as correct.	The chief of the laboratory will insure that test results are accurate.
Date	X		Enter date the report is completed by the laboratory.	
Lab ID No.	X		Enter laboratory identification number.	Like the Specimen/Lab. Rpt. No., this entry may be used to identify and monitor the request form.
Remarks	X		Enter any special information for the practitioner or the patient's records.	
Specimen Taken	X	X	Enter date and time the specimen is taken.	This block is completed by whoever takes the specimen, either the laboratory or ward/clinic personnel.
Tests Requested		X	Put an "X" beside the test that is needed. For tests not listed, write their names at the bottom of the list.	On most forms the correct box is marked (X).
Results	X		Write or stamp the results for each test performed.	

Table 17-5. Specific Instructions for Preparing Laboratory Forms

Form	Use	Remarks
SF 545	A display form for mounting laboratory forms.	Instructions for mounting laboratory forms are printed on the bottom of this form. 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 (for example, 1, 3, 5, 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 what forms are displayed.
SF 546	Requesting blood chemistry tests.	At the bottom of the list of tests, there is a block for requesting a battery or profile of tests. When requesting this, write in the name of the profile.
SF 547	Requesting blood gas measurements, T3, T4, serum iron, iron binding capacity, glucose tolerance, and other chemistry tests.	
SF 548	Requesting chemistry tests on urine specimens.	Remember that a check in the "Other" box under "Specimen Interval" must be explained.
SF 549	Requesting routine hematology (including differential morphology), coagulation measurements, and other hematology tests.	
SF 550	Requesting urinalysis tests (both routine and microscopic).	Use "HCG" for requesting and reporting measurements of human chorionic gonadotropin. Use "PSP" for requesting and reporting phenolsulfonephthalein measurements.
SF 551	Requesting tests that measure serum antibodies (including tests for syphilis).	Definitions for the serology test abbreviations are as follows: RPR—Rapid Plasma Reagin card test for syphilis. COLD AGG—Cold Agglutinins. ASO—Antistreptolysis O titers. CPR—C—Reactive Protein. FTA—ABS—Fluorescent Treponemal Antibody—Absorption Test. Febrile AGG—Febrile Agglutinins. COMP FIX—Complement Fixation. HAI—Hemagglutination-Inhibition TPHA—Treponema Pallidum Hemagglutination Write the name of the specific antibody determination in the COMP FIX or HAI block.

Table 17-5. Specific Instructions for Preparing Laboratory Forms — continued

Form	Use	Remarks
SF 552	Requesting tests for intestinal parasites, malaria, other blood parasites, and most feces tests.	
SF 553	Requesting most bacteriological isolations and sensitivities	Complete section marked "Antibacterial Therapy" with the antibiotic medications the patient is receiving; "Clinical Information" includes fever, site of infection, or culture; and "Infection would include tentative diagnosis which could assist in identifying infecting organism. SF 553 and SF 554 may take as long as 72 hours to be completed by the laboratory.
SF 554	Requesting tests for fungi, acidfast bacteria (tuberculosis), and viruses.	Same as above.
SF 555	Requesting spinal fluid tests	When requesting bacteriological studies on spinal fluid specimens, submit an SF 553 or 554 also. Bacteriological cultures must grow at least 24 hours before the results can be observed. The extra request form allows complete identification of the specimen. It also allows the quick return of the cell count and chemistry results to the physician without his having to wait for the bacteriological results. When requesting electrophoresis measurements, submit also an SF 557. These measurements take many hours to complete and the report is a tracing by densitometer on special paper. The extra request form allows complete identification of the specimen; it also allows the cell count and chemistry results to be returned quickly to the physician without waiting for the electrophoresis results to be completed.
SF 556	Requesting blood grouping, blood typing, and blood	Do not use this form as a request for blood crossing
SF 557	Requesting tests, such as electrophoresis and assays of coagulation factors, which are not ordered on other forms.	
DD Form 1892 (Drug Screening Urinalysis Record)	Requesting Drug Screening Urinalysis Tests.	

Section VIII. NURSING RECORDS AND REPORTS (PERMANENT CLINICAL FORMS)

17-55. General

Initiation of permanent clinical records is an essential part of the inpatient admission procedure (AR 40-407). A permanent outpatient treatment record is maintained on each outpatient seen in an Army MTF. Authorized clinical record forms which nursing personnel are responsible for or use frequently are described in this section.

17-56. Recording Data

All entries will be made with a pen, using reproducible black or blue-black ink, except when specifically stated otherwise.

17-57. Correcting Errors

Erasures are prohibited. A line will be drawn through an incorrect entry, and the initials of the person making the entry will be placed above the lined-out portion. The correct information or statement will be recorded following the lined-out entry.

17-58. DA Form 4256

For additional information concerning DA Form 4256, see AR 40-407 or AR 40-66.

17-59. SF 510

a. General. SF 510 (Clinical Record—Nursing Notes) is a single sheet, identical on both sides, which is maintained in the patient's chart. Nursing notes will be written by the person whose name and grade appear on the notes (Figures 17-8 and 17-9).

b. Preparation. Enter all patient identification, including SSN and other data as indicated in spaces at the bottom of the form.

c. Admission and Discharge Notes. Initial entry will include date, time, manner of admission, reported known allergies, and a brief, clear description of symptoms and pertinent observations. In the absence of a discharge planning form, note the date, time, manner of discharge, and concise summary of discharge plan. This will include documentation of health teaching appropriate to the disease and desired behavior outcome.

d. Content. Nursing Notes will contain objective observations of the patient's condition, to include physical and mental status, symptoms, response to diagnostic or therapeutic procedures, or any changes noted. The Nursing Notes must reflect the patient response/status to all nursing care measures documented on the Medical Record Nursing Assessment and Care Plan (DA Form 3888 and DA Form 3888-1). Since Nursing Notes aid in diagnosis, furnish reference material for research and teaching, and provide important evidence in the event of litigation; it is essential that all entries contain significant and pertinent data relative to nursing care. At the minimum, entries are required on SF 510 once every shift for intensive nursing care and moderate nursing care patients; every 24 hours for minimal nursing care patients; and once a week for self-care patients.

e. Medications. Accomplishment of orders for Narcotic and PRN or STAT medication will be entered on SF 510. Each entry will include time, medication, and indication for administration. Assessment of effectiveness of action of medication will be noted following administration. If, for any reason, scheduled medication or treatment is not given, enter this fact and reason for its omission.

f. Special Procedures. Diagnostic, therapeutic and special nursing procedures, and usual occurrences will be described in SF 510. Notation will include time, name of procedure, by whom performed, brief description of what was done, patient's condition before and during the procedure, and the patient's reaction after the procedure.

NOTE

Nursing Notes may also be written in the "signs and symptoms, observations, assessment, and plan" (SOAP) format as shown below.

17-60. SF 511

a. Preparation of SF 511 (Clinical Record—Temperature - Pulse-Respiration). Enter patient's identification data and social security number in the space at bottom of the form. This form will be maintained in the patient's chart (Figure 17-10).

b. Recording Data. Number the "Hospital Day" line of blocks with day of admission as 1, and continue consecutively. The day of surgery or other event is the operative day. The day following surgery is noted as the first post-operative day. The day and hour blocks will be properly labeled. Represent temperature by dots (.) placed between the columns and rows of dots and joined by straight lines. If route of determination is other than oral, it should be indicated by (R) for rectal and (A) for axillary. Show pulse determination by use of (o) connected by straight lines. Enter respiration and blood pressure on the indicated rows below the graphic portion. Record frequent blood pressure readings on the form's graphic portion by entering an "X" between the columns and row of dots at points equivalent to systolic and diastolic levels. Connect the two with a vertical solid line. Use blank lines at bottom of the sheet to record special data such as 24-hour total of patient's intake and output.

(1) When the diastolic blood pressure falls below the recorded pulse symbol (o), and the straight line connection is drawn between the blood pressure symbol (x), the connecting line will be drawn to the edge of the blood pressure symbol on each side, top and bottom to form the connecting link but never completely through the pulse symbol or the temperature symbol.

(2) If the systolic blood pressure and the pulse are to be recorded on the same line, the pulse will be recorded with its normal symbol and the systolic pressure symbol will be recorded around it with an imaginary (x). In Figure 17-10, the straight connecting line (o) will be drawn as described above and the same basics will be used in the application of recording a temperature and blood pressure. Symbols for vital signs will never be drawn completely through each other when recorded on the temperature, pulse, and respiration (TPR) graphic sheet.

CLINICAL RECORD — **NURSING NOTES** (*Sign all notes*)

DATE	HOUR AM	HOUR PM	OBSERVATIONS (Include medication and treatment when indicated)
9 JUN 84		1300	49 YO WHITE MALE ADMITTED TO WARD 2A VIA GURNEY FROM SURGICAL/UROLOGY CLINIC C DIAGNOSIS OF (R) RENAL CALCULUS. VS: T-99.8 P-102 R-24 BP-148/92. PT COMPLAINS OF SEVERE (R) FLANK PAIN. PT IS DIAPHORETIC, PALE, & HOLDING (R) SIDE. ADMISSION CXR, CBC, U/A, & URINE CULTURE COMPLETED IN CLINIC. DENIES ALLERGIES. IV OF D5 1/2 NS STARTED IN (L) FOREARM C 18 ABBO-CATH TO INFUSE AT 150cc/HR. PT INSTRUCTED TO STRAIN ALL URINE. John James LT/ANC
		1340	DEMEROL 75mgm AND VISTARIL 50mgm IM (L) GLUTEUS FOR RELIEF OF (R) FLANK PAIN. Alice Anderson CPT/ANC
		1415	RESTING COMFORTABLY. PT STATES PAIN HAS BEEN RELIEVED "QUITE A BIT." Alice Anderson CPT/ANC

Continue on reverse side

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility*)

STONE, GREGORY P.
772-33-1234
LTC M 49
USA MEDDAC

REGISTER NO

WARD NO. 2A

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

Figure 17-8. SF 510, Clinical Record—Nursing Notes.

CLINICAL RECORD — **NURSING NOTES** (Sign all notes)

DATE	HOUR AM	HOUR PM	OBSERVATIONS (Include medication and treatment when indicated)
18 SEP 83		1300	**S:** I have severe Rt lower back pain and am sick to my stomach. Denies any allergies.
			O: 32 YO black male admitted via w/c from urology clinic c diagnosis of Rt Renal Calculi. T 97.6 P 102 R 24 BP 140/88. Diaphoretic appears in severe pain. Extremely restless. Unable to stand in upright position. Lab-work and X-Rays done on way to ward.
			A: Severe Rt. flank pain and nausea secondary to Rt. Renal Calculi.
			P: Continuous monitoring of Rts voidings and effectiveness of analgesic. Instruct pt. to strain urine. Elbert Humphery CPT, ANC.
18 SEP 83		1320	**I:** Demeral 75 mg and Phenergan 25 mg given Im in Lt gluteus. Elbert Humphery CPT, ANC.
			E: Resting comfortably. Pt states pain is now bearable.

Continue on reverse side

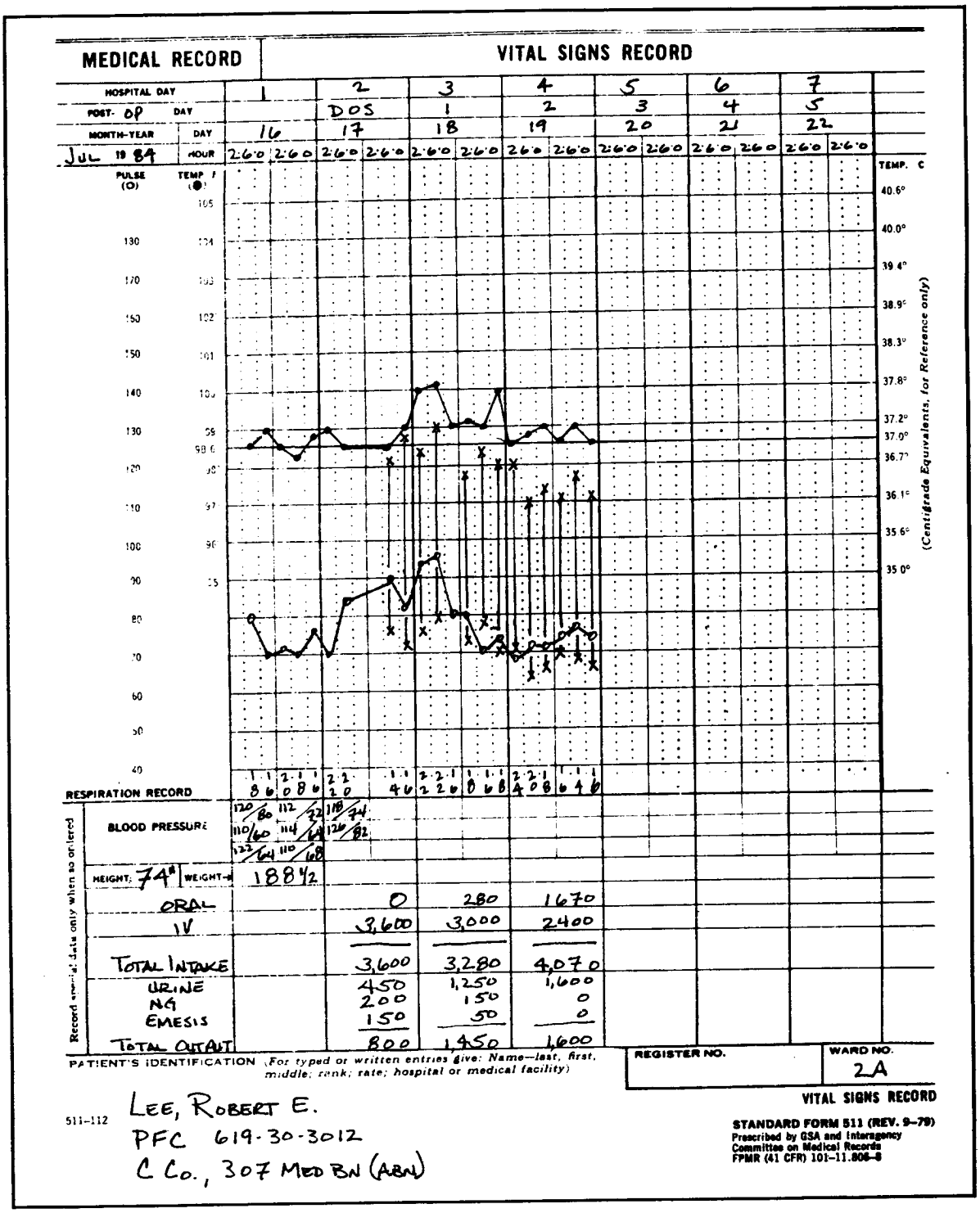
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

ELBERT, HUBERT A. SFC
666-66-5420
M-32 1ST DIV CLR CO.

REGISTER NO 06215 | WARD NO. 6A

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

Figure 17-9. SF 510, Clinical Record—Nursing Notes in SOAP format.



MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		1		2		3		4		5		6		7	
POST- OP DAY				DOS		1		2		3		4		5	
MONTH-YEAR	DAY	16		17		18		19		20		21		22	
JUL 19 84	HOUR	2:60	2:60	2:60	2:60	2:60	2:60	2:60	2:60	2:60	2:60	2:60	2:60	2:60	2:60

PULSE (O) / TEMP. F (●): 180 104 170 103 160 102 150 101 140 100 130 99 98.6 120 98 110 97 100 96 90 95 80 70 60 50 40

TEMP. C: 40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18 20 18 20 22 20 16 22 20 18 18 20 22 18 16 16

BLOOD PRESSURE	120/80	112/72	118/74			
	110/60	114/64	126/82			
	122/64	110/68				
HEIGHT: 74" WEIGHT: #	188½					
ORAL			0	280	1670	
IV			3,600	3,000	2400	
TOTAL INTAKE			3,600	3,280	4,070	
URINE			450	1,250	1,600	
NG			200	150	0	
EMESIS			150	50	0	
TOTAL OUTPUT			800	1,450	1,600	

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; rank; rate; hospital or medical facility)

LEE, ROBERT E.
PFC 619-30-3012
C Co., 307 MED BN (ABN)

REGISTER NO.

WARD NO. 2A

511-112

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8

Figure 17-10. SF 511, Medical Record—Vital Signs Record.

17-61. Temporary Nursing Records

The following DA forms are part of the Temporary Nursing Record, and information on these forms can be found in Chapter 3, AR 40-407.

a. DA Form 3872—Nursing Service Personnel Time Schedule.

b. DA Form 3889—Nursing Unit 24-Hour Report.

c. DA Form 3889-1—Nursing Unit 24-Hour Report-Continuation Sheet.

d. DA Form 3950—Temperature, Pulse, and Respiration Record Worksheet.

e. DA Form 3951—Nursing Service—Assignment Roster.

f. DD Form 792—24-Hour Patient Intake and Output Worksheet.

g. DA Form 1924—Surgical Checklist.

h. DA Form 4028—Prescribed Medication.

Section IX. USE OF THE US FIELD MEDICAL CARD

17-62. General

a. The US Field Medical Card (DD Form 1380)(AR 40-66) is used to record data similar to that recorded on the ITRCS. The FMC will be used by aid stations, clearing stations, and nonfixed troop or health clinics working overseas, on maneuvers, or attached to commands moving between stations. It may also be used to record an outpatient visit when the HREC is not readily available at an MTF. The FMC is used in the theater of operations during time of hostilities. It also may be used to record CRO cases.

b. The FMC is made so that it can be attached to the casualty. The cards are issued as a pad, with each pad consisting of an original card, a sheet of carbon paper, a carbon protective sheet, and a duplicate.

c. Use of the FMC is covered by NATO STANAG 2132.

17-63. NATO STANAG 2348 Requirements

The ITRs of NATO personnel treated by Army MTFs are prepared the same as ITRs for other patients. This applies to DA Form 1380 (Record of Individual Performance of Reserve Duty Training), DD Form 1380, and DD Form 602. In addition, the following policies cover NATO personnel:

a. If a service member is transferred to hospitals of other nations, his ITR will go with him. When he is discharged from an Army MTF, his record will be sent to his national military medical authority. (See Table 2-4, AR 40-400 for a list of these authorities.) Sometimes DD Form 1380 or DD Form 602 (STANAG 2132) will be prepared as well as an ITR. If so, these forms will go with the ITR.

b. The amount of information put in an ITR should be STANDARD for all forces. All items normally recorded for US personnel will be recorded for NATO personnel. In addition, the marital status of the NATO member will be recorded.

17-64. Preparation of Field Medical Cards

a. An MTF officer will complete the FMC or supervise its completion. However, the company aidman first attending the casualty may initiate an FMC. To do this, he will record the name, SSN, and grade of the patient (Figure 17-11). He will also briefly describe the medical care of treatment given and enter as much information as time permits (Figure 17-11). After doing this, he will put his initials in the far right side of the signature block (Item 29, Figure 17-11). The supervising AMEDD officer will then complete, review, and sign the FMC.

b. An FMC will be prepared for any patient treated at an MTF. For transfer cases, the FMC will be attached to the patient's clothing. It will remain with him until his arrival at a hospital, his death and interment (burial), or his return to duty. If a patient dies, the FMC will remain attached to the body until interment when it will be removed. If the body cannot be identified when it is to be interred, the registration number given the remains by the Graves Registration Service will be noted on the FMC.

c. Under combat conditions, the aidman may only partially complete the FMC for patients being treated. Otherwise, all entries will be completed as fully as possible. The blocks that must be complete are 1, 2, 4, 13, 14, 20, 21 (if a tourniquet is applied), 22, and 29. This also applies to the battalion aid station when patients are being transferred to another MTF during a combat situation. Instructions for completing items on the ITR cover sheet apply to similar items on the FMC; all abbreviations authorized for use on the cover sheet may also be used on the FMC. Except for those listed below, however, abbreviations may not be used for diagnostic terminology.

Abr W—Abraded wound

Cont W—Contused wound

FC—Fracture (compound) open

FCC—Fracture (compound) open comminuted

FS—Fracture simple (closed)

LW—Lacerated wound

MW—Multiple wounds

Pen W—Penetrating wound

Perf W—Perforating wound

SV—Severe

SL—Slight

d. FMC may also be used for "CARDED FOR RECORD ONLY" cases. Certain cases not admitted to MTF will be CRO. For CRO cases, DA Form 3647 or DD Form 1380 will be prepared; and a registrar number assigned. When DA Form 3647 is used, Items 7, 10, 14, 24, 27, 30, and the name of the admitting officer need not be completed. When the FMC is used, Item 11 need not be completed.

17-65. Supplemental Field Medical Cards

When more space is needed, another FMC will be attached to the original. This second one will be labeled in the upper RIGHT corner "FMC #2" and will show the patient's name, grade, SSN, and nation. See Figure 17-12.

1. NAME (Last - First-Middle initial) / NOM, PRENOMS: DOE, JOHN P.
2. SERVICE NUMBER / NUMERO MATRICULE: 555-33-6666
3. GRADE / GRADE: SGT
4. NATION / NATION (e.g. Etats Unis): USA
5. FORCE / ARMEE
6. BRANCH AND TRADE / ARMEE (e.g. Infanterie)
7. UNIT / UNITE
8. SERVICE (Yrs) / DUREE DES SERVICES (e.g. 2 6/12)
9. AGE / AGE
10. RACE / RACE
11. RELIGION / RELIGION
12. FACILITY WHERE TAGGED / LIEU D'ETABLISSEMENT DE LA FICHE
13. DATE AND HOUR TAGGED / DATE ET HEURE D'ETABLISSEMENT DE LA FICHE: 1530 6 NOV 83
14. DIAGNOSIS (Including cause) / DIAGNOSTIC (Cause comprise): GUNSHOT WOUND TO RIGHT THIGH
15. LINE OF DUTY / EN RELATION AVEC LE SERVICE
NATURE OF CASUALTY OR ILLNESS / NATURE DE LA BLESSURE OU MALADIE
DISABILITY / INCAPACITE — ENEMY ACTION / DU FAIT DE L'ENNEMI
16. INJURY / BLESSURE — ☐ YES / OUI ☐ NO / NON
17. SICK / MALADIE — ☐ YES / OUI ☐ NO / NON
18. DATE & HOUR INJURED / DATE ET HEURE DE LA BLESSURE
19. WHAT WAS HE DOING WHEN INJURED / QUE FAISAIT-IL LORSQU'IL FUT BLESSE
20. TREATMENT GIVEN (For antibiotics specify which, and give dose, hour, and date) / TRAITEMENT EFFECTUE (Si des antibiotiques ont été donnés, précisez leur nature, la dose, l'heure et la date): PRESSURE BANDAGE
TREATMENT / TRAITEMENT EFFECTUE — a. DOSE / DOSE — b. HOUR AND DATE / HEURE - DATE
22. MORPHINE - 1st MORPHINE - 1ere — 15 [illegible] — 1550 6 NOV 83
23. MORPHINE - 2nd / MORPHINE - 2eme
24. MORPHINE - 3rd - / MORPHINE - 3eme
25. TETANUS TOXOID / VACCIN ANTITETANIQUE
26. A. T. SERUM / SERUM ANTITETANIQUE
21. TOURNIQUET (Yes or No. Time & date applied) / MISE EN PLACE D'UN GARROT (Oui ou Non - heure et date): YES 6 NOV 83 1545
27. DISPOSITION - DISPOSAL / DESTINATION DONNEE AU BLESSE
28. HOUR AND DATE / HEURE ET DATE
29. MEDICAL OFFICER (Signature & Grade) / SIGNATURE ET GRADE DU MEDECIN: JKS

DD FORM 1380. 1 JUN 82. U. S. FIELD MEDICAL CARD / FICHE MEDICALE DE L'AVANT ETATS-UNIS

Figure 17-11. DD Form 1380, US Field Medical Card.

FMC#2

1. NAME (Last - First-Middle initial) / NOM, PRENOMS
2. SERVICE NUMBER / NUMERO MATRICULE
3. GRADE / GRADE
4. NATION / NATION (e.g. Etats Unis)
5. FORCE / ARMEE
6. BRANCH AND TRADE / ARMEE (e.g. Infanterie)
7. UNIT / UNITE
8. SERVICE (Yrs) / DUREE DES SERVICES (e.g. 2 6/12)
9. AGE / AGE
10. RACE / RACE
11. RELIGION / RELIGION
12. FACILITY WHERE TAGGED / LIEU D'ETABLISSEMENT DE LA FICHE
13. DATE AND HOUR TAGGED / DATE ET HEURE D'ETABLISSEMENT DE LA FICHE

Figure 17-12. "FMC #2".

17-66. Disposition of Field Medical Cards

a. For Patients Admitted and Discharged and CRO Cases. The original FMC of CRO case or of an admission with a disposition other than to a hospital will be sent to higher headquarters within the command for coding. After coding, the FMC will be disposed of in accordance with AR 340-18-9.

b. For Transfer Patients. When a patient arrives at a hospital, his FMC will be used to prepare his ITR. This FMC will then become part of his ITR (see Table 7-1, AR 40-66).

c. For Outpatients. The original of an FMC used to record outpatient treatment will be filed in the patient's HREC or OTR.

d. Carbon Copies. All carbon copies of FMC will be destroyed locally after 3 months.

17-67. DA Form 4006

DA Form 4006 (Field Medical Record Jacket) may be used as an envelope for the FMC. To keep the jacket from being opened while the patient is in transit, pertinent personnel and medical data on the patient may be recorded on the outside. The movement of the patient may also be recorded. When the jacket has been so used, it must become a part of the ITR.

17-68. Instructions for Completing DD Form 1380

a. Item 1 (Name).

b. Item 2 (Service Number). Enter SSN for US military personnel. Enter service number for foreign military personnel (including prisoners of war). Leave blank for all others.

c. Item 3 (Grade). Enter patient's grade. Use abbreviations listed in Table 17-6.

d. Item 4 (Nation). Enter country of whose armed forces the patient is a member (for example, enter "USA" for US Armed Forces).

e. Item 5 (Force). Enter specific armed service of patient.

f. Item 6 (Branch and Trade). Enter branch or corps for US officers. Enter Special Skill Identifier (SSI) or brief description of occupation (for example, "rifleman;" for foreign military enter similar information).

g. Item 7 (Unit). Enter military unit. For civilian, enter enough information to identify patient (for example, "wife, Army SGT").

h. Item 8 (Service). Enter length of service for military personnel. Include all active duty during previous tours or enlistment even if interrupted. Show length of service less than 1 month in days (for example, "23/365") service less than 2 years in completed months (for example, "13/24") and service of more than 2 years in completed years (for example, "3 YRS" for 3 years and 9 months).

i. Item 9 (Age). Enter patient's age.

j. Item 10 (Race). Enter "Cau" for Caucasian; "Neg" for Negroid; "Oth" for other races; "Unk" for unknown.

k. Item 11 (Religion). Enter patient's religious preference. If none, enter "None."

l. Item 12 (Facility Where Tagged). Enter MTF and location. Describe location in broad geographic terms (for example, "Near Cu Chi, RVN").

m. Item 13 (Date and Hour Tagged). Enter date and time initial treatment was started. Enter time using the 24 hour system.

n. Item 14 (Diagnosis). Enter disease or injury requiring treatment.

(1) *Punctured, penetrating, or missile wounds.* Give point of entry and name organs, arteries, or nerves involved, if known.

(2) *Injuries not incurred in combat.* State the nature of the injury; the causative agent; the body parts affected; the circumstances causing the injury; if accidentally incurred, deliberately self-inflicted, or deliberately inflicted by another; and the place and date.

(3) *Injuries incurred in combat.* Add to the details described in (2) above that the injury was the result of enemy action. Also include causative agent and general geographical location (for example, "Near Seoul, Korea").

(4) *Injuries or diseases caused by chemical or bacteriological agents or by ionizing radiation.* Add to the details described in (2) above, the name of the agent or type of ionizing radiation. (If the name is not known, provide information that is known about the physical, chemical, or physiological properties of the agent (odor, color, physical state)). Also state date, time, and place of contamination; time between contamination and treatment; and nature of treatment. For those affected by ionizing radiation, also report the approximate distance from the source; if exposure was to gamma rays, the actual or estimated dosage (for example, "est 150 rad" or "measured 200 rad") and if exposed via airburst, ground burst, water surface burst, or underwater burst.

o. Item 15 (Line of Duty). Enter "Yes" or "No."

p. Item 16 (Injury). If injury, check Item 16 and indicate whether injury was caused by enemy action or not caused by enemy action; that is, if enemy action check "Yes."

q. Item 17 (Sick). If disease (sick), check Item 17 and indicate whether disease was caused by enemy action or not caused by enemy action.

r. Item 18 (Date and Hour of Injury). Self-explanatory. If injury occurred prior to treatment, estimate as accurately as possible the date and time of injury.

s. Item 19 (What Patient Was Doing When Injured). Enter circumstances leading to injury.

t. Item 20 (Treatment Given). Enter any antibiotics, drugs, blood plasma, and other treatment given. Enter name of antibiotic and/or drugs, and each dose, hour, and date it was given. If more space is needed, use Item 32 on reverse side of the FMC.

u. Item 21 (Tourniquet). Enter "Yes" or"No." If yes, enter date and time applied.

v. Item 22 through 26. Enter the dose, time, and date if any of the drugs in Items 22 through 26 were given.

w. Item 27 (Disposition). Enter one of the following:

(1) *"Transfer."* When transferred to another MTF. When MTF is not known, enter general destination and means of transportation.

(2) *"Duty."* Inpatient return to duty.

(3) *"Died."* Died after admission.

(4) *"CRO."* For military patients carded for record only and returned to duty, enter "CRO—Duty." For deaths carded for record only, enter "CRO—Death." (Death on Arrival (DOA).)

x. Item 28 (Hour and Date of Disposition). Self-explanatory.

y. Item 29 (Medical Officer). Enter signature, grade, and organization of MTF commander, medical officer, or selected enlisted members authorized to sign the FMC.

z. Item 30 (Religious Information). Completed by chaplain.

aa. Item 31 (Diet). Check appropriate box.

bb. Item 32 (Remarks). Use this item to continue or expand any information given on the front of the form, cross-reference the item being continued. Use this item also to give any additional information that might be needed for a patient being evacuated through the MTF. For transfer cases, enter the date and hour of transfer. When additional treatment is given en route, state the nature of the treatment, where it was given, and the date and hour it was given. For deaths en route, state the date, hour, cause, and approximate place of death as well as any other pertinent information. For patients returned to duty when they arrive at the MTF, enter that they were returned, the date, the MTF, and the hour returned. For these cases, no ITRCS is needed but IPDS (Individual Patient Data System) coding is required.

Table 17-6. Officer and Enlisted Grade Structure.

ARMY	MARINES	NAVY/ COAST GUARD	AIR FORCE	DATA CODES
GENERAL OF THE ARMY (GA)	--	FLEET ADMIRAL (FADM)	GENERAL OF THE AIR FORCE (GenAF)	G5
GENERAL(GEN)	GENERAL (GEN)	ADMIRAL (ADM)	GENERAL (GEN)	G3
LIEUTENANT GENERAL (LTG)	LIEUTENANT GENERAL (LtGen)	VICE ADMIRAL (VADM)	LIEUTENANT GENERAL (LtGen)	G3
MAJOR GENERAL (MG)	MAJOR GENERAL (Maj Gen)	REAR ADMIRAL (RADM)	MAJOR GENERAL (Maj Gen)	G2
BRIGADIER GENERAL (BG)	BRIGADIER GENERAL (BrigGen)	COMMODORE (Commodore)	BRIGADIER GENERAL (BGen)	G1
COLONEL (COL)	COLONEL (Col)	CAPTAIN (CAPT)	COLONEL (Col)	06
LIEUTENANT COLONEL (LTC)	LIEUTENANT COLONEL (LtCol)	COMMANDER (CDR)	LIEUTENANT COLONEL (LtCol)	05
MAJOR (MAJ)	MAJOR (Maj)	LIEUTENANT COMMANDER (LCDR)	MAJOR (MAJ)	04
CAPTAIN (CPT)	CAPTAIN (Capt)	LIEUTENANT (LT)	CAPTAIN (Capt)	03
FIRST (LIEUTEANT (1LT)	FIRST LIEUTENANT (1st Lt)	LIEUTENANT, JUNIOR GRADE (LTJG)	FIRST LIEUTENANT (1stLt)	02
SECOND LIEUTENANT (2LT)	SECOND LIEUTENANT (2dLt)	ENSIGN (ENS)	SECOND LIEUTENANT (2dLt)	01
CHIEF WARRANT OFFICER (CW4)	CHIEF WARRANT OFFICER (CWO4)	CHIEF WARRANT OFFICER (CWO-4)	CHIEF WARRANT OFFICER (CWO-4)	W4
CHIEF WARRANT OFFICER (CW3)	CHIEF WARRANT OFFICER (CWO3)	CHIEF WARRANT OFFICER (CWO-3)	CHIEF WARRANT OFFICER (CWO-3)	W3
CHIEF WARRANT OFFICER (CW2)	CHIEF WARRANT OFFICER (CWO2	CHIEF WARRANT OFFICER (CWO-2)	CHIEF WARRANT OFFICER (CWO-2)	W2
WARRANT OFFICER (WO1)	WARRANT OFFICER (WO)	WARRANT OFFICER (WO-1)	WARRANT OFFICER (WO)	W1
SERGEANT MAJOR OF THE ARMY (SMA)	SERGEANT MAJOR OF THE MARINE CORPS (SgtMaj)	MASTER CHIEF PETTY OFFICER OF THE NAVY (MCPON)	CHIEF MASTER SERGEANT OF THE AIR FORCE (MSAF)	E9

Table 17-6. Officer and Enlisted Grade Structure—continued.

ARMY	MARINES	NAVY/ COAST GUARD	AIR FORCE	DATA CODES
COMMAND SERGEANT MAJOR (CMS)	SERGEANT MAJOR (Sgt Maj)	MASTER CHIEF PETTY OFFICER (MCPO)	CHIEF MASTER SERGEANT (MSgt)	E9
STAFF SERGEANT MAJOR (SSM)	MASTER GUNNERY SERGEANT (MGySgt)	--	--	E9
FIRST SERGEANT (1SG)	FIRST SERGEANT (1st Sgt)	SENIOR CHIEF PETTY OFFICER (SCPO)	SENIOR MASTER SERGEANT (SMSgt)	E8
MASTER SERGEANT (MSG)	MASTER SERGEANT (MSgt)	--	--	E8
PLATOON SERGEANT PSG) or SERGEANT FIRST CLASS (SFC)	GUNNERY SERGEANT (GySgt)	CHIEF PETTY OFFICER (CPO)	MASTER SERGEANT (Msgt)	E7
SPECIALIST 7 (SP7)	--	--	--	E7
STAFF SERGEANT (SSG)	STAFF SERGEANT (SSgt)	PETTY OFFICER FIRST CLASS (PO1)	TECHNICAL SERGEANT (TSgt)	E6
SPECIALIST 6 (SP6)	--	--	--	E6
SERGEANT (SGT) (SGT)	SERGEANT (Sgt)	PETTY OFFICER (PO2)	STAFF SERGEANT (SSgt)	E5
SPECIALIST 5 (SP5)	--	--	--	E5
CORPORAL (CPL)	CORPORAL (Cpl)	PETTY OFFICER THIRD CLASS (PO3)	SERGEANT (Sgt)	E4
SPECIALIST 4 (SP4)	--	--	--	E4
PRIVATE FIRST CLASS (PFC)	LANCE CORPORAL (LCpl)	SEAMAN (Seaman)	AIRMAN FIRST CLASS (ALC)	E3
PRIVATE (PVT)	PRIVATE FIRST CLASS (PFC)	SEAMAN APPRENTICE (SA)	AIRMAN (Amn)	E2
PRIVATE (PVT)	PRIVATE (Pvt)	SEAMAN RECRUIT (SR)	AIRMAN BASIC (AB)	E1