

## CHAPTER 4

# MEDICAL RECORDS

### INTRODUCTION

Navy and Marine Corps personnel and DoD eligible beneficiaries utilize the *U.S. Navy Medical Outpatient and Dental Treatment Record* (NAVMED 6150/21-30) as the official record jacket for the chronological documentation of medical and dental evaluations, care, treatments and occupational health. The medical and dental history stored in these color coded jackets assists medical department personnel to provide care.

The health record has significant medico-legal value to the patient, the healthcare provider, the Medical Treatment Facility (MTF) and Dental Treatment Facility (DTF) and the U.S. Government. Also, various officials and boards (i.e., special duty boards and medical boards) refer to information furnished by the health record in determining physical fitness or physical disability. Accurate and complete record entries and proper record maintenance are of the utmost importance.

This chapter provides the fundamentals of effective records' management. Opening, filing, verifying, and closing active duty and reserve personnel medical and dental records, will be outlined including the use of appropriate forms. Guidelines for record management are in Chapter 16 of the *Manual of the Medical Department* (MANMED P-117).

### PRIMARY AND SECONDARY MEDICAL RECORDS

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#### LEARNING OBJECTIVE:

*Identify the types of primary and secondary records, and the usage of each type.*

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### PRIMARY MEDICAL RECORDS

The primary medical records are used for the documentation of outpatient medical and dental care. A secondary medical record is established by a patient's specialty healthcare provider and contains medical information needed by that provider for a specific need. Secondary medical records are maintained separate from the primary medical record.

The three major categories of primary medical records are:

- Health records (HRECs)
- Outpatient records (ORECs)
  - Dental records (DRECs) are part of HRECs (active duty) and ORECs (retirees and family members)
- Inpatient records (IRECs)

#### Health Record

The HREC is a file of continuous care given to *active duty members* and documents all outpatient care provided during a member's career. While the HREC primarily documents ambulatory (outpatient) care, copies of inpatient narrative summaries and operative reports are also placed in the HREC to provide continuity of healthcare documentation.

## **Dental Records**

The DREC is a file of continuous care given to active duty and reserve members and their families. It contains all documents of dental care provided during a member's career.

## **Outpatient Record**

The OREC is a file of continuous care that documents ambulatory treatment received by a *person other than an active duty person*, i.e. retiree and family members.

## **Inpatient Record**

The IREC is a medical file that documents care provided to a patient assigned to a designated inpatient bed at an MTF or ship. Summaries of inpatient care are placed into the HREC (Active Duty) or OREC (non-active duty personnel) to maintain continuity of care.

## **SECONDARY MEDICAL RECORDS**

Primary healthcare providers of active duty personnel must be aware of their personnel's medical status at all times. Thus, temporary and ancillary records will not be opened or maintained for active duty personnel. The exceptions to this policy are records for obstetrics/gynecology (OB/GYN), family advocacy, psychology and psychiatry clinical records.

Secondary medical records are separate from the primary medical record and must follow the guidelines established by the MANMED. These records are kept in a separate file and secured in a specialty clinic or department of MTFs.

Opening a secondary medical record requires the healthcare provider to write a note on the *DD Form 2766, Adult Preventive and Chronic Care Flow Sheet* in the primary treatment record. Information includes: nature of the secondary record; patient's diagnosis; and clinic or department name including address and telephone number. A note is written on the same form when the secondary record is closed.

Secondary medical records include:

- Convenience records
- Temporary records
- Ancillary records

## **Convenience Record**

A convenience record contains excerpts from a patient's primary record and is kept within the MTF by a treating clinic, service, department, or individual provider for increased access to the information. When the convenience record's purpose has been served, the establishing clinic, service, department, or provider purges the record from its file, compares it to the primary medical record, and adds any medical documents that are not already in the primary medical record.

## **Temporary Medical Record**

A temporary record is an original medical record established and retained in a specialty clinic, service, or department in addition to the patient's primary medical record. Its purpose is to document a current course of treatment. The temporary medical record becomes a part of the primary medical record when the course of treatment is concluded. This record is most commonly established in OB/GYN for a prenatal patient.

## **Temporary Dental Records**

Temporary records are required to ensure the timely availability of information that documents a current course of treatment for a patient being seen in the DTF. An example is a military member on temporary additional duty (TAD) without his or her dental record who requires emergency dental treatment.

The temporary dental record is maintained by the DTF providing the current course of treatment. When the treatment is complete or when the patient returns to the location of the permanent dental record, the patient may hand carry the record or the custodian of the temporary record must forward it to the custodian of the permanent record.

The temporary dental record must, at a minimum contain the following forms:

- Privacy Act Statement, DD 2005
- Dental Health Questionnaire, NAVMED 6600/3
- Dental Treatment Form, EZ603A

<b>NOTE</b>
If a patient is receiving dental treatment, and a dental record jacket is not used, care must be taken to securely fasten any radiographs to the forms comprising the temporary dental record.

### **Ancillary Record**

Ancillary records consist of original healthcare documentation withheld from a patient's primary HREC or OREC. In certain cases it may be advisable to not file original treatment information in the primary treatment record, but instead place this information into a secondary medical record, to which the patient, parent, or guardian has limited access. Examples of such instances include psychiatric treatment or instances of real or suspected child or spouse abuse, etc.

## **RECORDS MANAGEMENT**

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### **LEARNING OBJECTIVE:**

*Describe the fundamentals of effective records management.*

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All treatment records are the property of the U.S. Government and must be maintained by the responsible treatment facility (naval hospitals, health clinics, and medical/dental departments of ships, submarines, aviation squadrons, and

isolated duty locations). The Commanding Officer (CO) has ultimate responsibility for all medical records. Patients are not authorized to retain or maintain their original HREC, OREC, or dental record. In addition, the hand-carrying of medical records by unauthorized individuals (e.g., spouses or siblings of the patient) without written permission is prohibited.

## **OPENING HEALTH RECORDS**

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### **LEARNING OBJECTIVES:**

*Identify when a health record should be opened.*

*Identify appropriate record jacket and sequence of medical forms to be placed within a new record.*

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This section covers the opening of active duty records. Health and dental records are opened when an individual becomes a member of the Navy or Marine Corps, when a member on the retired list is returned to active duty, or when the original record has been lost or destroyed.

When establishing the four-part health record, the appropriate health record jacket and required forms must be current and assembled in accordance with current directives.

### **OPENING HEALTH RECORDS FOR ACTIVE DUTY OFFICERS**

Recruiting commands open HRECs for civilian applicants who are accepted for an officer appointment. The health record is then forwarded to the new officer's first duty station. Midshipmen and former enlisted members appointed to commissioned officer or warrant officer grade continue to use their existing HREC. The MTF having custody of the record at the time of acceptance of appointment will make necessary entries to indicate the new grade. The record custodian will prepare summary information entries on SF 600 and NAVMED 6150/4 to include date, place, and grade to which the member was appointed.

Health records of civilian candidates selected for appointment to the Naval Academy will be prepared at the Naval Academy at the time of appointment. Health records for civilian applicants selected for officer candidate programs should be opened upon enrollment in the program.

### OPENING HEALTH RECORDS FOR ACTIVE DUTY ENLISTED PERSONNEL

The HREC is opened by the activity executing the original enlistment contract in the Navy or Marine Corps. An exception to this rule involves service members who are enlisted or inducted and ordered to immediate active duty at a recruit training facility. In this instance, the HREC (Fig. 4-1) will be opened by either the Naval Training Center (NTC) or Marine Corps Recruit Depot, as appropriate. Copies of the service member's *DD 2807, Report of Medical History*, and *DD 2808, Report of Medical Examination* are sent to the appropriate NTC or recruit depot, and added to other applicable forms in the member's records.

### OPENING HEALTH RECORDS FOR RESERVISTS

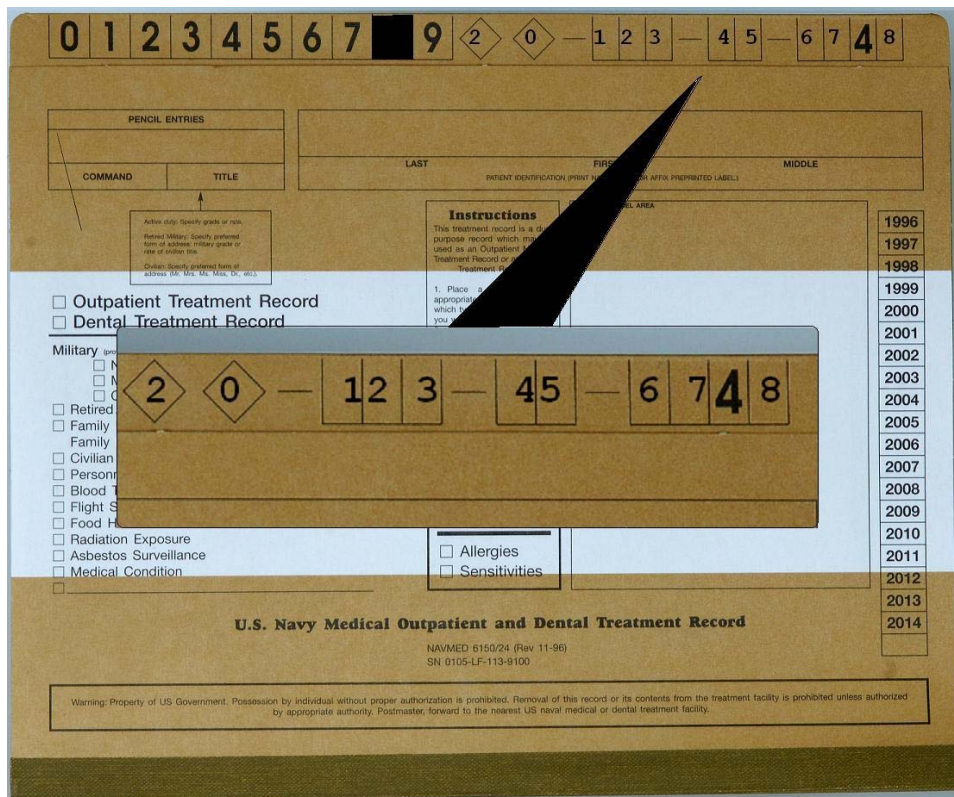
The Naval Reserve Personnel Center (NRPC), New Orleans, is the HREC custodian for inactive reserve personnel and is responsible for records' preparation and maintenance. When inactive reservists are called to active duty and their HRECs have not been received by their duty station, a request for their records should be initiated. Requests for Navy personnel are sent to NRPC. Marine Corps personnel requests are sent to the Marine Corps Reserve Support Center.

For Navy and Marine Corps service members who were discharged before 31 January 1994, requests should be sent to the National Personnel Records Center (NPRC) for record retrieval. For service members who were discharged after 31 January 1994, requests for record retrieval are sent to the Department of Veterans Affairs (VA). Addresses of each of these activities are listed in Chapter 16 of the MANMED.

The form is titled "U.S. Navy Medical Outpatient and Dental Treatment Record" (NAVFORM 6150/26, Rev. 11-96). At the top, there is a patient identification area with the name "BIGGUMS TYRONE D'WAYNE" and a service number "0102456780". Below this, the patient's grade is listed as "HM2 / E-5". The form includes several sections: "PENCIL ENTRIES" with handwritten text "NM MPT&E HM2 / E-5"; "Instructions" detailing how to use the record; "Alert" section for allergies and sensitivities; and a "Military" section where "Navy" is selected. A vertical year selector on the right side of the form ranges from 1996 to 2014. A red circle highlights a stamp that says "CONSIDER ON SERVICE ONLY".

Figure 4-1.—Completed Front Cover of Medical Record

Photograph provided by HM2 Timothy Hanna of the Biomedical Photography Department of Navy Medicine Support Command, Bethesda, MD.



**Figure 4-2.—Record (SSN)**

*Photograph provided by Sean Brennan of the Biomedical Photography Department of Navy Medicine Support Command, Bethesda, MD.*

## PREPARING THE MEDICAL RECORD JACKETS: HREC, OREC, AND DREC

A new NAVMED 6150/21-30, *U. S. Navy Medical Outpatient and Dental Treatment Record*, will be prepared when a record is opened or when the existing jacket has been damaged or is deteriorating to the point of illegibility. The old jacket will be destroyed following replacement.

A felt-tip or permanent black-ink pen will be used to record all identifying data, except in the "Pencil Entries" block on the upper left of the outer front cover of these medical records. Information in this block should be written in pencil, so it can be updated or changed. Figure 4-1 illustrates the completed outside front cover and inside back cover of a military health record jacket.

Each health record jacket has the second to the last digit of the social security number (SSN) preprinted on it. The preprinted digit also matches the last digit of the form number (e.g., the preprinted digit on NAVMED 6150/26 is 6). The color of the treatment record jacket corresponds to the preprinted digit. In preparing a treatment record jacket, select a pre-numbered NAVMED 6150/21-30 jacket by matching the second to the last number of the member's SSN.

## Social Security Number

Enter the rest of the member's SSN on the top of the inside back cover (Part IV) as shown in Figure 4-2. For members who do not have an SSN (e.g., foreign military personnel) use NAVMED 6150/29 as the treatment record jacket.

A “substitute” SSN should be created for these members by assigning the numbers "9999" as the last four digits of the SSN and assigning the first five digits in number sequence (e.g., first SSN 000-01-9999, the second SSN 000-02-9999). Place a piece of black cellophane tape over the number that corresponds to the last digit of the SSN in each of the two number scales on the inside back cover of the HREC.

**Family Member Prefix**

Enter the member’s family member prefix (FMP) code in the two diamonds preceding the SSN on the top of Part IV. Enter the FMP code of 20 for all Navy and Marine Corps active duty members. Enter an FMP code of 00 for all foreign military personnel. See Table 4-1 for more FMP codes.

<b>Family Member</b>	<b>Code</b>
Sponsor	20
Children	01-19 (First Child 01, Second Child 02, etc.)
Spouse	30 (First Spouse 30, Second Spouse 31, etc.)
Mother, Stepmother	40-44
Father, Stepfather	45-49
Mother-in-law	50-54
Father-in-law	55-59
Other Authorized Dependents	60-69
Beneficiary Authorized by Statute	90-95
Civilian Emergencies	98
All Others	99

**Table 4-1.—Family Member Prefix**

**PREPARING THE OUTSIDE FRONT COVER**

**Patient Name**

Enter the member’s full name (last, first, middle initial, in that order) in the upper-right corner. Indicate no middle name by the abbreviation "NMN." If the member uses initials instead of first or middle names, show this by enclosing the initials in quotation marks (e.g., "J" "C"). Indicate titles, such as JR, SR, and III, at the end of the name. The name may be handwritten on the line provided or imprinted on a self-adhesive label and attached to the jacket in the patient identification box.

**Alert Box**

In the lower center area of the outside front cover; indicate in the alert box whether the member has drug sensitivities or allergies by entering an "X" in the appropriate box. If there are no allergies or sensitivities, leave it blank. If allergies and or sensitivities are listed ensure that all information is the same on the DREC and either the HREC (active duty) or OREC (non-active duty).

**Record Category**

Indicate the appropriate record category by entering an "X" in the appropriate box on the outside front cover, just below the "Pencil Entries" block. Indicate whether the record will be an Outpatient or Dental Treatment Record, attach ½-inch red cellophane tape to the record category block on the right edge of the inside back cover of the jacket; indicating an active duty record.

**Patient Service and Status**

Below the record category area is the patient service and status box. Mark an "X" in the appropriate service block.

## Special Categories of Records

Identify the records of personnel assigned to special duty or medical surveillance programs (e.g., Flight Status, Radiation Exposure, or the Asbestos Medical Surveillance Program) by marking an "X" at the appropriate special category entry listed below the record category type.

Identify flag officers and general officers by stamping or printing "FLAG OFFICER" or "GENERAL OFFICER," as appropriate, on the lower portion of the patient identification box. If a patient identification label is used, print or stamp the appropriate identification below the label.

## Pencil Entries

Following the instructions on the front cover, pencil in the appropriate title (i.e., grade or rate, if on active duty; preferred form of address, if retired or civilian), and include the current command if active duty.

## Retired Year Tape Box

Leave the retired year tape box on the inside back cover blank unless creating a record for a retired service member.

## Bar Code Label Area

Some Navy treatment facilities have bar coding capabilities. The bar code label indicates the patient's FMP, SSN, record type, and record volume number. Affix the label to the front of the record jacket in the box to the right of the alert box. If the bar code is part of the patient identification label (such as the patient identification label produced by the Composite Health Care System (CHCS) computers), place this label in the patient identification box.

## Labels

Use of a self-adhesive label with the name of the MTF, ship, or other units having custodial responsibility for the record is optional.

Ship or MTF logos are permitted as long as the necessary patient identifying information is not obscured.

## Preparing Part I (Inside Front Cover)

Enter the following information in pencil on the inside front cover (Fig. 4-3) of the record jacket. Recording the information in pencil allows changes and updating throughout a member's career.

- Date of arrival
- Projected rotation date
- Home address and telephone number
- Command UIC and telephone number

## Preparing Part II (Front of Center Page)

**IMPRINT OF DD 2005, PRIVACY ACT STATEMENT.**—The imprint of DD 2005, Privacy Act Statement form is preprinted and located in front of the center page in the record jacket. It must be signed and dated in black ink by the patient, the parent, or the guardian must sign if the patient is a minor (Fig. 4-4).

## Preparing Part III (Back of Center Page)

**DISCLOSURE ACCOUNTING RECORD.**—The Disclosure Accounting Record is preprinted and located on the back of the center page of the record jacket. It is self-explanatory and will be filled out as needed. Disclosure and release of information will be covered later in this chapter (Fig. 4-5).

## Preparing Part IV (Inside Back Cover)

The Forensic Examination form is preprinted and located on the inside back cover of the record jacket, and should be completed if the record is going to be used for dental care (Fig. 4-6).

- Part I: Summary of Care  
Record of Immunizations**
- Part II: Chronological documentation of care  
(including consults, inpatient care, etc.)**
- Part III: Overseas screening  
Boards  
Physical examinations  
Exposure forms (i.e., radiation, asbestos, etc.)**
- Part IV: Laboratory/Radiology/EKG, etc.  
Ancillary studies**

PENCIL ENTRIES ONLY!

ARRIVAL DATE		PROJECTED ROTATION DATE	
LOCAL HOME ADDRESS (OR MAILING ADDRESS)			LOCAL HOME TELEPHONE
COMMAND UIC (OPTIONAL)	WORK TELEPHONE	IF A FAMILY MEMBER, SPONSOR'S WORK TELEPHONE	

**Figure 4-3.—Part I - Inside Front Cover**

*Photograph provided by HM2 Timothy Hanna of the Biomedical Photography Department of Navy Medicine Support Command, Bethesda, MD.*



<b>PRIVACY ACT STATEMENT - HEALTH CARE RECORDS</b>		
<i>THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.</i>		
1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)		
Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.		
2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED		
This form provides you with the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.		
3. ROUTINE USES		
The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.		
4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION		
In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.		
This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.		
Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.		
SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE
<b>DD FORM 2005</b> PREVIOUS EDITION IS OBSOLETE <small>1 FEB 76</small>		

**Figure 4-4.—Part II – Front of Center Page**

*Photograph provided by HM2 Timothy Hanna of the Biomedical Photography Department of Navy Medicine Support Command, Bethesda, MD.*



**FORENSIC EXAMINATION**

Existing restoration, existing teeth, missing teeth, prosthetic appliances, and variation of normal conditions  
(nondisease) as of \_\_\_\_\_

**Remarks** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Occlusion**

Angle's Class \_\_\_\_\_  
 Overjet \_\_\_\_\_  
 Overbite \_\_\_\_\_  
 Crossbite \_\_\_\_\_  
 Remarks \_\_\_\_\_  
 \_\_\_\_\_

**Soft Tissue** \_\_\_\_\_  
 Leukoedema \_\_\_\_\_  
 Melanoplakia \_\_\_\_\_  
 Amalgam Tattoo \_\_\_\_\_  
 Other: \_\_\_\_\_

**Hard Tissue**

Intrinsic Staining (tetracycline ) \_\_\_\_\_  
 \_\_\_\_\_  
 Tori \_\_\_\_\_  
 Rotated Teeth \_\_\_\_\_  
 Malposed Teeth \_\_\_\_\_  
 Other: \_\_\_\_\_

Examining Dentist's Name Stamp \_\_\_\_\_  
 Examining Dentist's Signature \_\_\_\_\_

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

6

**Figure 4-6.—Part IV - Inside Back Cover**

*Photograph provided by HM2 Timothy Hanna of the Biomedical Photography Department of Navy Medicine Support Command, Bethesda, MD.*

## FILING HEALTH RECORDS

### LEARNING OBJECTIVE:

*Identify filing and tracking procedures for health, outpatient, and dental records.*

### RECORD FILING SYSTEM

The Navy Medical Department uses the Terminal Digit Filing System (TDFS) to file health records. Records are filed according to the terminal digits (last two numbers) of the service member's social security number (SSN), color coding of the record jacket, and use of a block filing system.

To understand the TDFS filing system, the SSN must be regarded in a specific manner. The nine digits of the SSN are divided into three number groups, reducing the chance of transposing numbers. In the TDFS system the SSN 123-45-6789 is visually grouped and read from right to left (instead of left to right), as follows:

<u>Primary Number</u>	<u>Secondary Number</u>	<u>Third Number</u>
89	67	123-45

On the record jacket, the family member prefix (FMP) is added to the patient's social security number showing a beneficiary's relationship to the sponsor. For example, the FMP for active duty personnel is 20, while the FMP for a spouse is 30.

Under the Terminal Digit Filing System, the central files are divided into 100 approximately equal sections. Each section is identified by a maximum of 100 file guides bearing the 100 primary numbers, 00 consecutively through 99. Each of these 100 sections contains records whose last two digits correspond to the section's primary number. For example, every record with the SSN ending in 56 is filed in section 56.

Within each of these 100 sections, records are filed in numerical sequence according to their secondary numbers. The secondary number is the pair of digits immediately left of the primary number.

To make filing of records easier, they are color-coded. The second to the last digit of the SSN is preprinted on the record jacket. The color of the record jacket corresponds to the preprinted digit as shown in Table 4-2.

Record Color Stock Number	Form Number
Orange 0105-LF-113-9700	NAVMED 6150/20
Green 0105-LF-113-8700	NAVMED 6150/21
Yellow 0105-LF-113-8800	NAVMED 6150/22
Grey 0105-LF-113-9000	NAVMED 6150/23
Tan 0105-LF-113-9100	NAVMED 6150/24
Blue 0105-LF-113-9200	NAVMED 6150/25
White 0105-LF-113-9300	NAVMED 6150/26
Almond 0105-LF-113-9400	NAVMED 6150/27
Pink 0105-LF-113-9500	NAVMED 6150/28
Red 0105-LF-113-9600	NAVMED 6150/29

**Table 4-2.—Record Color-Coding**

Centralized files having records based upon more than 200 SSNs, or a file of more than 200 records, may need to use the TERTIARY (third) NUMBER in filing. In a properly maintained terminal-digit, color-coded and block-filing system, it is almost impossible to misfile a record. A record misfiled with respect to the left digit of its primary number (for example, a 45 that has been inserted among the 55s) will attract attention because of its color difference. A record jacket misfiled in respect to the right primary number (for example, a 45 that has been inserted among the 42s) causes a break in the diagonal pattern formed by the blocking within a color group.

## Internal Charge out Control

A problem that a facility can encounter is misfiled, lost, and missing treatment records. It is the responsibility of all medical and dental personnel to ensure records are accounted for and returned to the records custodian or department. Personnel responsible for maintenance and upkeep of the records can reduce this incident from occurring by filing the records in the correct order and using a charge out form/charge out guide or a computerized system for record tracking.

Charge out Form NAVMED 6150/7, Health Record Receipt also known as the pink card (Fig. 4-7), will be used for charge out control of medical records. Many commands have implemented an electronic record charge out system that will not be covered in the chapter. When a computerized system is not employed, a receipt is prepared for each record established and will be filed in the record. The following will be recorded on each health record receipt when the treatment record is received:

- Patient's name (last, first, middle)
- Sponsor's grade or rate
- Patient's FMP code and sponsor's SSN
- Ship or station to which sponsor is assigned

Use home address for retired personnel and their family members and for those family members of active duty personnel when the sponsor is assigned duty out of the area. For a patient to check a record out, specific information is required on the pink card. This information includes the date the record is checked out, location that the record will be going and the patient's signature. The completed charge out form should be retained in the terminal digit file until the record is returned. Records charged out from the file should be returned as soon as possible after the patient's visit, but not more than 5 working days. Commands shall develop local procedures for the recovery of delinquent treatment records.

HEALTH RECORD RECEIPT FILE CHARGE-OUT AND DISPOSITION RECORD NAVMED 6150/7 (2-74)	
NAME (Last)	(First) (Middle)
GRADE/RATE	SSN
SHIP/STATION	
RECEIVED FROM	DATE
TRANSFERRED TO	DATE
REMARKS:	
<b>INSTRUCTIONS</b>	
This form is designed for use as a permanent record of receipt and disposition of the HEALTH RECORD.	
(A) For each HEALTH RECORD received, complete lines 1 through 4 and file in the HEALTH RECORD.	
(B) Upon transfer complete line 5 and retain form in permanent files.	
(C) Whenever HEALTH RECORD is temporarily removed from files enter information provided for below and retain form in HEALTH RECORD files.	
<b>FILE CHARGE-OUT</b>	
DATE	RECEIVED BY AND/OR LOCATION
S/N 0105-LF-209-5071 U.S. Government Printing Office: 1995 - 704-002/42121	

Figure 4-7.—Charge Out Form

## Charge out Guide

When open-shelf filing is used for records, a charge out guide may be used in conjunction with the charge out form. A charge out guide is a plastic folder with a pocket. The charge out form should be placed in the pocket and the charge out guide placed in the file in place of the patient's record until the record is returned. The charge out guide also allows for loose forms to be placed in the guide where the record will be returned, reducing the risk of lost or misfiled record forms.

**Part I (Inside front cover): Record of Preventive Medicine and Occupational Health**

- NAVMED 6150, Summary of care form (always top form)
- SF 601, Immunization Record
- NAVMED 6000/2, Chronological record of HIV Testing
- DD 771, Eyewear Prescription
- NAVMED 6490/1, Visual Record
- NAVMED 6470/10, Record of Occupational Exposure to Ionizing Radiation
- NAVMED 6470/11, Record of Exposure to Ionizing Radiation from Internally Deposited Radionuclide
- DD 2215, Reference Audiogram
- DD 2216, Hearing Conversation Data
- NAVMED 6224/1, TB Contact converter followup
- NAVMED 6260/5, Asbestos Medical Surveillance Program
- DD 2493-1, Asbestos Exposure – Part I, Initial Medical Questionnaire
- DD 2493-1, Asbestos Exposure – Part II, Periodic Medical Questionnaire
- OPNAV 5100/15, Medical Surveillance Questionnaire

**Part II: Section A (Front of Center Page)**

- NAVPERS 5510/1, Record Identifier for Personnel Reliability Program (PRP)
- SF 558, Medical Record- Emergency Care and Treatment record of Ambulance Care
- SF 600, HREC – Chronological Record of Medical Care
- SF 513, Medical Record Consultation Sheet
- DD 2161, Referral for Civilian Medical Care

**Part II: Top Forms After a Patient is Deceased**

- Attestation sheet
- DD 2604, Certificate of Death
- SF 503, Autopsy Protocol
- SF 523, Authorization for Autopsy
- SF 523A, Disposition of Body
- SF 523B, Authorization for Tissue Donation

**Part II: Section B: Inpatient Care, Ambulatory Surgeries, etc.**

- NAVMED 6300/5, Inpatient Admission Disposition Record
- SF 502, Narrative Summary
- SF 539, Abbreviated Medical Record
- SF 509, Progress Notes
- SF 516, Operation Report
- SF 600, Chronological Record of Medical Care
- SF 517, Anesthesia
- SF 522, Request for Administration of Anesthesia
- SF 233, Prenatal and Pregnancy Civilian Medical Care Notes
- DD 602, Patient Evaluation Tag

### **Part III (Back of Center Page)**

- NAVMED 1300/1, Medical and Dental Overseas Screening Review for Active Duty and Dependents
- NAVPERS 1300/16, Report of Suitability for Overseas Assignment
- NAVMED 6100/1, Medical Board Report Cover Sheet
- NAVMED 6100/2, Medical Board Statement of Patient
- NAVMED 6100/3, Medical Board Certificate
- NAVMED 6100/5, Abbreviated Temporary Limited Duty
- SF 2824C, Physician Statement for Employee Disability Retirement
- SF 47, Physical Fitness Inquiry for Motor Vehicle Operators
- SF 78, Certificate of Medical Examination
- DD 2807, Report of Medical History
- DD 2808, Report of Medical Examination
- NAVMED 6120/2, Officer Physical Examination Special Questionnaire
- NAVMED 6120/3, Annual Certificate Physical Condition
- NAVMED 6150/4, Abstract of Service and Medical History
- NAVJAG 5800/10, Injury Report
- NAVJAG Report
- NAVPERS 1754/1, Exceptional Family Member Program Application
- DD 2569, Third Party Collection Program
- Living Will or Medical Power of Attorney
- OPNAV 5211/9, Record of Disclosure, Privacy Act 1974
- DD 877, Request for Medical/Dental Records
- DD 2005, Privacy Act Statement

- Deoxyribonucleic Acid (DNA) Analysis Sample Pouch

### **Part IV (Inside of Back Cover)**

- SF 217, Epilepsy Medical Report
- SF 515, Tissue Examination
- SF 519A, Radiographic Report
- SF 519B, Radiologic Consultation Request/Report
- SF 519, Medical Record-Radiographic Reports
- SF 518, Blood or Blood Component Transfusion
- SF 520, Electrocardiogram Request
- SF 524, Radiation Therapy
- SF 525, Radiation Therapy Summary
- SF 526, Interstitial/Intercavity Therapy
- SF 527, Group Muscle Strength, Joint ROM, Girth and Length Measurements
- SF 528, Muscle Function by Nerve Distribution: Face, neck, and Upper Extremity
- SF 529, Muscle Function by Nerve Distribution: Trunk and Lower Extremity
- SF 53, Neurological Examination
- SF 531, Anatomical Figure
- SF 541, Gynecologic Cytology
- SF 545, Laboratory Report Display
- SF 546-557, Laboratory Reports
- SF 559, Allergen Extract Prescription- New and Refill
- SF 560, Electroencephalogram Request and History
- SF 511, Vital Signs Record
- SF 512, Plotting Chart
- SF 512A, Blood Pressure Plotting Chart

## **VERIFICATION OF ACTIVE DUTY HEALTH AND DENTAL RECORDS**

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### **LEARNING OBJECTIVES:**

*Describe the requirements for record verification.*

*Describe the requirements for the documentation of record verification.*

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All records are verified annually by medical and dental personnel having custody of them. Health records will be reviewed when service members report and detach from their commands, and at the time of any physical examinations.

Each record will be carefully reviewed and any errors or discrepancies corrected. Items to be reviewed during any verification include: form placement, order of forms (chronological), and completeness and accuracy of patient identification data on the record jacket and on each piece of medical documentation. In addition, verify that the Privacy Act Statement has been signed, the DD 2766 (covered later in this chapter) is updated as necessary, operational and occupational requirements updated, and currency of immunizations and accuracy of allergy documentation are complete.

Upon completion of an annual medical record verification, the HM will make an entry on the SF 600 for medical records and black-out the corresponding year block on the front leaf of the jacket with a black felt-tip pen. With this procedure, records that have not been verified during the calendar year can be identified and the annual verification accomplished. The annual verification section is located on the right-hand side of the front cover of the record jacket as a series of blocks numbered with the years 1996 thru 2014. The year of verification will be blackened out for health records once it has been verified.

For dental records, document verification on the EZ603A and as they are verified at the time of the annual exam there is no requirement to blacken the verification year. The information on the inside of the jacket front cover should be updated in pencil only for both records. This information will be entered at the time of record check-in (receipt) and will be kept current at all times by erasing previous, outdated entries.

### **PERMANENT CHANGE OF STATION (PCS)**

At the time of a member's PCS from a command, the medical and dental facilities that are responsible for the release of records will ensure the following steps are completed. Guidance for PCS is found in MANMED, Chapter 16.

1. Verify medical and dental records.
2. If no health, outpatient, and or dental record exist, construct a new record following the instructions in this chapter and MANMED. When re-constructing dental records have a dentist perform a T-2 dental examination.
3. Ensure member has been processed for transfer.
4. Complete record charge-out card.
5. Allow active duty members to hand carry their records, unless the facility or member's command determines it is not in the Navy's or member's interest to do so. If the medical and dental records are not to be hand carried, forward them via certified mail along with a DD Form 877, Request for Medical/Dental Records Information, or place medical and dental records in the custody of authorized personnel.



## CLOSING HEALTH RECORDS

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### LEARNING OBJECTIVE:

*Explain closing procedures for health records.*

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### HEALTH RECORD CLOSURE

A member's health records may be closed due the following circumstances:

- Death or declared death
- Discharge
- Resignation
- Release from active duty
- Retirement
- Transfer to the Fleet Reserve or release to inactive duty
- Missing or missing in action (MIA; when officially declared as such)
- Desertion (when officially declared as such)
- Disenrollment as an officer candidate or midshipman

When closing a HREC, ensure the record is in order, there are no loose papers, and all identification data is consistent. Ensure all tests (lab, x-ray, etc.) and their reports have been printed out and placed in chronological order within the record. Record the closing entry on the NAVMED 6150/4, Abstract of Service and Medical History (Fig. 4-8). Include the date of separation, title of servicing activity, and any explanatory circumstances.

Upon final discharge or death, send the complete and verified health and dental records to the command maintaining the member's service record (no later than the day following separation) for inclusion in and transmittal with the member's service record. Make sure the original of the separation physical examination documents are included in the HREC before delivery to the command maintaining the member's service record, such as the PSD, PSA, etc. In case of death, send a copy of the death certificate along with the transmitted records.

A copy of the HREC is provided free of charge to members requesting one upon their release, discharge, or retirement.

### Missing or Missing-in-Action Members

Whenever a member disappears and the available information is insufficient to warrant an administrative determination of death, enter a summary of the relevant circumstances on the SF 600. Include circumstances about the presumed disappearance of the individual, status (missing or missing in action), and supporting documentation. Close the record as would be done for members being discharged from the service.

### Desertion

When a member is officially declared a deserter, document the event fact on the SF 600, EZ603A and the NAVMED 6150/4. Deliver HREC and DREC to the member's CO for inclusion in and transmittal with the service record for both Navy and Marine Corps personnel.

When a deserter is apprehended or surrenders, the CO of the activity having jurisdiction is required to submit a request for the member's records to Bureau of Naval Personnel (BUPERS) or Commandant of the Marine Corps (CMC).

### Retirement

When a member of the naval service is placed on the retired list or Fleet Reserve List, close the HREC. Upon request of the retiring member, a new medical record (OREC) is established. A **copy** of the retiring member's active duty HREC may be incorporated into a new NAVMED 6150/21-30 folder. Make an entry on an SF 600 in the HREC and in the new OREC, stating the date the HREC was closed. Dental records should be verified and retired at the same time, and forwarded to the National Personnel Records Center, Military Personnel Records, St. Louis, Missouri.



Members separating from the service and eligible for veteran's benefits will be provided a copy of their HREC on request. Members should be counseled to request a copy in the event they may make a claim for veteran's benefits in the future. Always offer to send a copy of their HREC to the regional VA office for them.

## **HEALTH / OUTPATIENT RECORD FORMS**

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### **LEARNING OBJECTIVE:**

*Describe the purpose and completion procedures for the health / outpatient record forms.*

---

There are many medical forms placed in the health or outpatient records. Computerized medical documentation (e.g., laboratory test results, emergency room reports, etc.) has become a common place through various computerized healthcare systems (i.e., CHCS, AHLTA); however, the Navy Medical Department continues to use many government printed forms (e.g., NAVMED, DD, and SF). This section covers selected medical forms, their purpose, and procedures for completing them.

Healthcare providers will enter their signature and identification data in the HREC in black or blue-black ink. Type, print, or stamp the provider's name, grade or rating, and social security number below their signature. Stamped facsimile signatures are NOT to be used on any medical form in the HREC. The signing individual assumes responsibility for the correctness of the entry for which they sign.

It is imperative that all forms documenting patient care contain adequate data to identify the patient and permit filing of the forms in the record. All forms documenting patient care and filed in records will, at a minimum, contain the following data in the identification block:

- Patient's FMP and sponsor's SSN
- Patient's name (last, first, middle initial)

- Sponsor's branch of service (e.g., Army, Navy, or Air Force) and patient's status (e.g., family member or retired)

Complete and accurate documentation of patient identification data is critical to ensure the documents are placed in the correct patient's record. Three methods are currently used to place patient identification on medical documents:

- Embossed medical card
- Automated forms
- Handwritten entries

Embossed medical cards are used to imprint patient identification data on medical forms. Printouts of automated (computerized) forms should provide the same information as required on any medical form. Handwritten patient identification data should be entered in spaces at the bottom of the form.

## **DEALING WITH LOST, DESTROYED, OR ILLEGIBLE RECORDS AND FORMS**

### **Lost or Destroyed**

When a HREC or OREC is lost or destroyed, the custodian will open a replacement record. The designation "REPLACEMENT" will be prominently entered on the front of the jacket and all forms replaced. A brief explanation of the circumstances requiring the replacement and the date accomplished should be entered on SF 600, *Chronological Record of Medical Care*. If the missing record is recovered, the information or entries in the replacement record will be inserted in the original record.

The HREC/OREC or any part of it should be duplicated whenever it becomes illegible or deteriorates to the point that it may endanger its future use or value as a permanent record. The duplicate record or duplicate portion must reproduce as closely to the original as possible. When duplicating an entire health record, place the designation "DUPLICATE RECORD" prominently on the front of the jacket above the wording OUTPATIENT MEDICAL RECORD.

When duplicating only part of the record, identify the individual forms by printing "DUPLICATE" at the bottom of each form. Enter the circumstances necessitating the duplication and the date accomplished on an SF 600. If possible, microfiche all forms replaced for protection and preservation, and make the envelope a permanent part of the medical record. On front of the envelope, record the member's full name, FMP (family member prefix) and SSN, date of birth, and list the original forms contained in the envelope.

If microfilming is not available, place the original health forms (except forms contaminated with mold or mildew) inside a plain envelope for preservation and make them part of the permanent record. On the front of the envelope, record the member's identifying data (same as microfiche envelope) and list the contents of the envelope. Mark the envelope "ORIGINAL MEDICAL RECORDS PERMANENT" and file as the bottommost item in part 2 of the 4-part record jacket.

### **Loose Forms**

When loose treatment forms are discovered, every effort should be made to determine the present location of the record. If reasonable search efforts do not locate the record, retain loose forms for a period of 1 year. Upon expiration of the retention period, destroy the forms locally according to paragraph six of the standard identification code 6150 contained in **SECNAVINST 5212.5 series, Navy and Marine Corps Records Disposition Manual.**

### **Health/Outpatient Record Forms**

When assembling a medical record, arrange the forms of the same type in chronological order by date. The most current document should be placed on top, and the least current documents below it. The HREC/OREC contains dividers that partition the record into four parts. A sequential listing of medical forms to be filed in each section is provided in Table 4-3. The titles for each part of the HREC/OREC are as follows:

- Part 1 - Record of Preventive Medicine and Occupational Health
- Part 2 - Record of Medical Care and Treatment
- Part 3 - Physical Qualifications
- Part 4 - Record of Ancillary Studies, Inpatient Care, and miscellaneous forms

### **ADULT PREVENTIVE AND CHRONIC CARE FLOW SHEET (DD 2766)**

The Adult Preventive and Chronic Care Flow Sheet (Fig. 4-9) contains a summation of relevant problems and medications that significantly affect the patient's health status. Properly maintained, the DD Form 2766 form aids healthcare providers by allowing them quick access to pertinent medical factors that may affect how they manage a patient's medical care. This form is a permanent part of the HREC or OREC. This form should be reviewed and revised during the patient's visit. The DD Form 2766 should also be reviewed during annual verification and before HREC or OREC transfers.

The DD Form 2766 is divided into 4 pages: significant health problems, hospitalization/surgery, medical alert, medications, and health maintenance (immunizations, deployment readiness, etc.).

Significant health problems section: Enter only significant medical conditions in this section. Significant medical conditions include chronic diseases (such as hypertension, diabetes, arthritis, etc.) and acute recurrent illnesses (such as recurrent urinary tract infections, recurrent otitis media, recurrent bronchitis, etc.)

- Hospitalization/surgery section:
  - Enter significant surgical conditions
  - Include all procedures requiring general or regional anesthesia and any procedures likely to have long-term effects on the patient's health status

<b>ADULT PREVENTION AND CHRONIC CARE FLOWSHEET</b>				
<i>(This form is subject to the Privacy Act of 1974 – Use DD form 2005)</i>				
<b>1. ALLERGIES</b>				
a. MEDICATION ALLERGIES		b. OTHER ALLERGIES		
<b>2. CHRONIC ILLNESS</b>		<b>3. MEDICATIONS</b>		
<b>4. HOSPITALIZATIONS/SURGERIES</b>				
<b>5. COUNSELING</b>				
F	FITNESS	a. DATE		
D	DENTAL	b. AGE		
I	INJURY PREVENTION	c. TOPIC		
N	NUTRITION/FOLATE			
C	CANCER PREVENTION			
S	SAFE SEX	d. DATE		
FP	FAMILY PLANNING	e. AGE		
RX	PRESENT MEDICATIONS	f. TOPIC		
MH	MENTAL HEALTH/STRESS/SUICIDE/ OCCUPATIONAL STRESS			
H	HORMONE/CALCIUM REPLACEMENT	g. DATE		
To	TOBACCO	h. AGE		
A	ALCOHOL/SUBSTANCE ABUSE	i. TOPIC		
t	TRAVEL			
o	OCCUPATIONAL EXPOSURE (HEARING THRESHOLD CHANGES/ CUMULATIVE TRAUMA DISORDER)	j. DATE		
		k. AGE		
		l. TOPIC		
<b>ADVANCE DIRECTIVES: DATE FILED</b>				
PATIENT'S IDENTIFICATION (Use this space for mechanical imprint)		RECORDS MAINTAINED AT:		
<p><i>SUPPLIED (Navy)</i> 2766-0102-LF-984-8400, pkg-100</p>		PATIENT'S NAME		
		LAST	FIRST M.I. SEX	
		RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
		SPONSOR'S NAME (Last, First, Middle Initial)		DEPT/SERVICE
		ORGANIZATION	SSN/ID NUMBER	DATE OF BIRTH

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**Figure 4-9A.—DD Form 2766**

- Medical alert section:
  - Allergies: Note any allergies (food, drug, latex, etc.) and significant reactions to same in the medical alert section
  - Chronic Illness: Record alcohol and tobacco use in this section along with chronic illnesses
- Medication section: Record all chronic and recently used medications
- Medical maintenance section:
  - This section of the DD Form 2766 contains a variety of medical information including health maintenance functions, such as mammograms, chest X-rays, EKGs, and pap smears
  - Enter the prospective due date of the health maintenance functions in pencil, so it can be updated
  - Include in this section occupational health surveillance activities, such as involvement in the Asbestos Program, the Hearing Conservation Program, or exposure to lead
  - Include the following laboratory tests: blood type, G6PD, and sickle cell trait

ADULT PREVENTION AND CHRONIC CARE FLOWSHEET							
<b>6. FAMILY HISTORY</b> <i>M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather</i>							
a. CANCER (Specify)							
b. CARDIOVASCULAR DISEASE (Specify)							
c. DIABETES (Specify)							
d. MENTAL ILLNESS/CHEMICAL DEPENDENCY (Specify)							
<b>7. SCREENING EXAMS</b> (* = Actual Result, ** = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused, NA = Not Indicated) (● = Next Due)							
a. TEST	b. FREQUENCY	c. YEAR					
		d. AGE					
(1) CLINICAL DISEASE PREV EVAL/PHA (HEAR)	ANNUAL		e. DATES				
* (2) WEIGHT	ANNUAL FOR ACTIVE DUTY						
* (3) HEIGHT	ANNUAL FOR ACTIVE DUTY						
* (4) BLOOD PRESSURE	ONCE q 2 YRS FOR BP < 130/85, ANNUAL IF GREATER						
* (5) CHOLESTEROL **	*q 5 YRS FOR AGE ≥ 18 q YR IF PREV ABN						
(6) HEARING	CLINICAL DISCRETION						
(7) SKIN EXAM (Cancer)	ANNUAL IF AT RISK						
(8) ORAL/DENTAL **	ANNUAL						
(9) EYE/VISION **	ROUTINE ACUITY WITH PERIODIC ASSESSMENT DIABETES ANNUAL GLAUCOMA CHECK. Blacks q 3-5 yrs age 20-29 All q 2-4 years age 40-64						
(10) BREAST EXAM	ANNUAL: ≥ 40 YRS						
(11) MAMMOGRAM **	BASELINE @ 40, q 2 YRS 40-50, ANNUALLY > 50						
(12) PAP **(Digital Rectal Exam)	BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY AFTER 3 NL ANNUAL EXAMS, PERFORM q 1-3 years.						
(13) FECAL OCCULT BLOOD	ANNUAL ≥ 50 yrs						
(14) SIGMOID	EVERY 3-5 YRS: ≥ 50 YRS						
(15) COLONOSCOPY	HIGH RISK q 5 YRS ≥ 40 YRS						
(16) TESTICULAR	HIGH RISK ANNUAL 13-39 YRS						
(17) PROSTATE ** **(DIGITAL RECTAL EXAM)	WITH P.E. ≥ 40 YRS (Presently recommended annually)						
(18) RUBELLA SCREEN (Females)	ONCE BETWEEN AGES 12-18 YRS (Unless prev vaccinated)						
(19) OCCUPATIONAL SCREENING EXAMS	APPROPRIATE TO EXPOSURES						
(20)							
(21)							
(22)							

Figure 4-9B.—DD Form 2766

ADULT PREVENTION AND CHRONIC CARE FLOWSHEET											
<b>8. OCCUPATIONAL HISTORY/RISK</b>											
a. PRP		YES		NO							
b. FLYING STATUS		YES		NO							
<b>9. IMMUNIZATIONS (Enter numeric class in sub block)</b>											
(1) IMMUNIZATION	(2) DATE (ddmmmyyyy)	(1) IMMUNIZATION	(2) DATE (ddmmmyyyy)	(1) IMMUNIZATION	(2) DATE (ddmmmyyyy)	(1) IMMUNIZATION	(2) DATE (ddmmmyyyy)				
a. HEP A #1		f. MMR #1		j. TD (q 10 YRS) (Last)							
b. HEP A #2		g. MMR #2		k. TD (DUE)							
c. HEP B #1		h. PNEUMOCOCCUS		l. YELLOW FEVER (LAST)							
d. HEP B #2		i. POLIO OPV=0 IPV=1		m. YELLOW FEVER							
n. TYPHOID (Enter numeric class in sub block) Oral=0, TYPHUM Vi=1, TYPHOID USP=2		(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
o. ANTHRAX		(1) INITIAL DATE	(2) 2 WEEK DATE	(3) 4 WEEK DATE	(4) 6 MONTH DATE	(5) 12 MONTH DATE	(6) 18 MONTH DATE				
p. PPD (Enter mm and date)		(1)(a) mm	(2)(a) mm	(3)(a) mm	(4)(a) mm	(5)(a) mm	(6)(a) mm	(7)(a) mm			
		(b) DATE	(b) DATE	(b) DATE	(b) DATE	(b) DATE	(b) DATE	(b) DATE			
q. INFLUENZA		(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE	(7) DATE			
r. VARICELLA		(1) DATE	(2) DATE	u. JAPANESE ENCEPHALITIS	(1) DATE	(2) DATE	(3) DATE	(4) DATE			
s. MENINGO		(1) DATE	(2) DATE	v. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE				
t. ADENO		(1) DATE	(2) DATE	w. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE				
<b>10. READINESS (Glucose-6-phosphate dehydrogenase)</b>											
a. DNA	DATE:	b. BLOOD TYPE	DATE:	RESULT:	c. G-PD	DATE:	RESULT:	d. SICKLE CELL	DATE:	RESULT:	
e. PERMANENT PROFILE CHANGE		(1) DATE	(2) P:	(3) U:	(4) L:	(5) H:	(6) E:	(7) S:			
f. GLASSES/GAS/MASK Rx:		(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
g. DENTAL EXAM (Enter numeric class in sub block)		(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
h. HIV TESTING		(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
i. FITNESS (in sub block enter P=Pass, F=Fail, W=Waiver)		(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
		(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
		(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE				
<b>11. PRE/POST DEPLOYMENT HISTORY</b>											
<b>a. LOCATION</b>											
(1) PREDEPLOYMENT		(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE				
(2) POSTDEPLOYMENT		(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE				
<b>b. LOCATION</b>											
(1) PREDEPLOYMENT		(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE				
(2) POSTDEPLOYMENT		(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE				
<b>c. CHART AUDIT</b>											

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Figure 4-9C.—DD Form 2766





## **CHRONOLOGICAL RECORD OF MEDICAL CARE (SF 600)**

The *Chronological Record of Medical Care*, SF 600, provides a continuous comprehensive record of a patient's medical history (Fig. 4-10). Use the SF 600 for all outpatient care and file in the HREC or OREC. Record all visits, including those that result in referrals to other MTFs. Each person making an entry on the SF 600 will sign the entry and include identification information (full name, grade or rate, profession [e.g., MC, NC, etc.], and SSN), either hand printed, typed, or stamped.

The SF 600 facilitates the evaluation of a patient's condition and reduces correspondence necessary to obtain medical records. Appropriate use of the form eliminates unnecessary repetition of expensive diagnostic procedures and serves as a permanent record of medical evaluations and treatments.

### **Completing the SF 600**

- Entries made on the SF 600 can be typewritten when practical. However, entries normally are handwritten with black or blue-black ink pens. When initiating an SF 600, patient identification data will be completed. Type or stamp the date (DD/MM/YY) and the name and address of the activity responsible for the entry.
- Use both sides of each SF 600. Preparation of a new SF 600 is not necessary each time the person is seen in a different MTF. If only a few entries are recorded on the SF 600 at the time of a PCS, stamp the designation and location of the receiving MTF below the last entry and use the rest of the page to record subsequent visits. If the back of the SF 600 is not going to be used, the back needs to be crossed out and the words "No further entries" printed in the middle of the form.

- SF 600s include the following information: complaints, duration of illness or injury, physical findings, clinical course, results of laboratory or other special examinations, treatment (including operations), physical fitness at the time of disposition, and disposition. The subjective complaint, observation, assessment, and plan (SOAP) format may be used for entries as long as the required information is included.

Record each visit and the complaint described, even if a member is returned to duty without treatment. Document if a patient leaves before being seen.

Other SF 600 entries include the following:

- Imminent hospitalization
- Special procedures and therapy
- Sick call visit
- Injuries or poisonings
- Line-of-duty inquiries
- Binnacle list and sick list
- Reservist check-in and check-out statements

### **IMMINENT HOSPITALIZATION—**

When a patient's admission is imminent, admission notes can be made on an SF 600. However, the use of the SF 509, *Medical Record-Progress Report*, is preferred. The SF 509 form is routinely used for inpatient admission notes and is filed in the patient's IREC. Record referred or postponed inpatient admissions on the SF 600.



**SICK CALL VISITS**— Whenever a member is evaluated at sick call, an entry will be made on a SF 600 reflecting the complaints or conditions presented, pertinent history, treatment rendered, and disposition.

**INJURY OR POISONING**— In the event of injury or poisoning, record the duty status of the member at the time of occurrence and the circumstances of occurrence per the guidelines in **BUMEDINST 6300.3 series, *Inpatient Data System***.

**LINE-OF-DUTY INQUIRIES**— When a member of the naval service incurs an injury that might result in permanent disability or results in a physical inability to perform duty for a period exceeding 24 hours, an entry will be made concerning line-of-duty misconduct. Entries include the time of injury, date, place, names of persons involved, and the circumstances surrounding the injury.

A line-of-duty inquiry is conducted to establish whether the injuries sustained by the patient are the result of misconduct on the part of the member or others. Guidance on line-of-duty inquiries is located in the *Manual of the Judge Advocate General (JAGMAN)*.

**SERIOUSLY ILL/VERY SERIOUSLY ILL (SI/VSI) LIST**—Place personnel whose illness or injuries are severe on the SI/VSI List (as defined in MILPERSMAN 421-0100), make appropriate notification, and document on the SF 600.

**SPECIAL-HYPERSENSITIVITY SF 600**— Indicate any Hypersensitivity to drugs or chemicals on a separate SF 600. The SF 600 will be marked “SPECIAL-HYPERSENSITIVITY” at the bottom of the page. Appropriate entries regarding the hypersensitivity should be made on the SF 601 (Immunization Record), EZ603 (Dental Examination Report), EZ603A (Dental Treatment Report), NAVMED 6150/10-19 (HREC, OREC & DREC jackets), and the DD Form 2766 (Adult Preventive and Chronic Care Flow Sheet).

## Immunization Entries

The name of the medical officer or Senior Medical Department Representative (SMDR) administering the immunization, test, or determining the nature of the sensitivity reaction should be typed or written on the DD Form 2766. Signatures are not required; however, when signatures are used, make sure they are legible.

The medical officer or SMDR administering the immunization is responsible for completing entries in the appropriate sections of DD Form 2766. For smallpox, cholera, yellow fever and anthrax immunizations, record the manufacturer's name and batch or lot number.

### NOTE

The specific protocol for recording anthrax immunizations is outlined in **SECNAVINST 6230.4 series, *Department of the Navy (DoN) Anthrax Vaccination Implementation Program (AVIP)***.

Type any hypersensitivity to drugs or chemicals under “Remarks and Recommendations” in capital letters (e.g., HYPERSENSITIVITY TO ASPIRIN, HYPERSENSITIVE TO LIDOCAINE). This entry is in addition to a similar entry required on the EZ603 or EZ603A, current treatment form, the SF 600 Special-Hypersensitivity form, and the NAVMED 6150/20 retained permanently in the HREC or OREC.

For DREC's annotate the sensitivity information on the front of the record in the free space located within the bar code label area. Additionally, document it in Box 3 of the current dental teeth assessment form and the NAVMED 6600/3 form under allergies.

When recording positive results (10 mm or more induration) of the tuberculin skin test (TST), refer to **BUMEDINST 6224.8 series *Tuberculosis Control Program***, for guidance.

**INTERNATIONAL CERTIFICATES OF VACCINATION (PHS-731)**

All personnel performing international travel will be immunized in accordance with NAVMEDCOMINST 6230.15, *Immunizations and Chemoprophylaxis*, and **Control of Communicable Diseases of Man, FM 8-33 / NAVMED P-5038**. Service members should have a properly completed and authenticated PHS-731 form (International Certificates of Vaccination) in their possession. The form is issued to service members for independent international travel. This form, kept by the individual, is a personal record of immunizations.

The PHS-731 is not to be filed in the HREC at any time. Any immunizations recorded on the PHS-731 should be transcribed onto the DD Form 2766. According to international rules, entries on the PHS-731 require authentication for immunizations against smallpox (if administered), yellow fever, cholera, and anthrax.

Authentication (proof the immunization has been given) is accomplished by stamping each entry with the Department of Defense (DoD) immunization stamp and by the healthcare provider’s signature. The signature block may be stamped or typewritten and authenticated with the healthcare provider’s signature.

**ABSTRACT OF SERVICE AND MEDICAL HISTORY (NAVMED 6150/4)**

This form provides a chronological history of the duty stations to which a member has been assigned for duty and treatment, and an abstract of medical history for each admission to the Sick List.

A NAVMED 6150/4 (Fig. 4-11) is prepared upon opening the health record and remains with the health record regardless of changes in the member’s status. Continuation sheets are incorporated whenever an abstract is completely filled.

**Figure 4-11.—NAVMED 6150/4**

**RECORD OF OCCUPATIONAL EXPOSURE TO IONIZING RADIATION (DD FORM 1141)**

This form is initiated when military personnel are first exposed to ionizing radiation (with the exception of patients incurring such radiation while undergoing diagnostic treatment). This form becomes a permanent part of the member’s health record.

Instructions for preparing DD Form 1141 are on the back of the form. Additional guidance concerning the applicability and use of the form are contained in the, Radiation Health Protection Manual, NAVMED P-5055.

## ADJUNCT HEALTH RECORD FORMS AND REPORTS

This section provides instruction for using certain forms in the health record instead of transcribing their data to the *Chronological Record of Medical Care*, SF 600.

### Narrative Summary (SF 502)

The SF 502 (Fig. 4-12) is used to summarize clinical data relative to treatment received during periods of hospitalization. The narrative summary will include all procedures and diagnoses, and must match with information listed on the *Inpatient Admission/Disposition Report* (NAVMED 6300/5) and any information listed in the operation report.

The SF 539 may be used as a substitute for the narrative summary for those admissions of a minor nature that require less than 48 hours of hospitalization. A copy of SF 539 will be filed in the HREC. If a SF 502 or SF 539 is used, if the inpatient stay resulted from dental procedures a copy of the form used will be placed in the DREC as well.

Figure 4-12.—SF 502

### Consultation Sheet (SF 513)

The SF 513 (Fig. 4-13) is used for outpatients who need to be referred to other healthcare providers or specialists, such as gynecologists, internists, optometrists, etc. The primary assessment and results of examinations and tests will be entered onto the form. The patient remains the responsibility of the referring provider until the specialist takes over the care. In some cases, the specialist will perform an examination or procedure and refer the patient back to the original provider for continued care. The original consultation form stays in the HREC.

Figure 4-13.—SF 513

### Medical Board Report (NAVMED 6100/1)

Whenever a member of the naval service is reported on by a medical board, place a legible copy of the report in the health record instead of transcribing the clinical data to the SF 600. Make a notation on the current SF 600 to indicate the clinical data is contained in the copy

of the Medical Board Report incorporated in the health record. When the Medical Board Report is forwarded to the Navy Department for review and appropriate disposition, enter a report of the departmental action on the current SF 600.

**Eyewear Prescription (DD Form 771)**

The DD form 771, *Eyewear Prescription* (Fig. 4-14) is used to order corrective prescription eyewear. Depending on its edition date (any of which are authorized), the DD Form 771 may consist of a 3- carbon copy form (for use with pen), a 2-part carbonless form (printed on a tractor-feed printer), or a computer-generated form using virtual copies. The original of the form will be sent to the optical laboratory and a copy of the form will be placed in the patient’s HREC. The DD Form 771 is frequently submitted via computer modem or fax.

Three major areas covered by the DD Form 771 are patient information, prescription information, and miscellaneous information.

- Patient Information: This information is required to establish eligibility and provide the requesting activity with an address for the patient upon receipt of the completed eyeglasses
- Prescription Information:
  - The spectacle prescription is the technical portion of the order form; ensure the prescription is transferred in its entirety
  - The essential elements of the prescription are interpupillary distance, frame size, temple length, plus and minus designators for both sphere and cylinder powers, segment powers and heights, prism, and prism base
    - It is **not** necessary to calculate decentration in the single vision or multi-focal portions of the order
    - It is also unnecessary to try to transpose any prescription into plus or minus cylinder form

- Leave the prescription as is, copy it onto the DD Form 771, and note in the remarks section that the prescription has been copied and is in the HREC
- Miscellaneous Information: This area is reserved for any information the HM feels the Navy Optical Laboratory may need
  - Information the laboratory may need includes special fabrication requirements such as multi-focal lenses and proof of eligibility for specialized eyewear such as aviator sunglasses
  - Standard issue items can be determined from **NAVMEDCOMINST 6810.1 series, Ophthalmic Services**

EYEWEAR PRESCRIPTION												DATE	ACCOUNT NUMBER	ORDER NUMBER									
TO: (Lab)						FROM:																	
NAME (Last, First)						SSN			GRADE														
ADDRESS/UNIT						PHONE																	
ADDRESS CONTINUED						SHIP TO:						<input type="checkbox"/> CLINIC <input type="checkbox"/> PATIENT											
CITY, STATE, ZIP																							
AD		RES		NO		RET		OTHER*		A		N		AF		MC		CG		PHS		OTHER*	
FRAME		EYE		BRIDGE		TEMPLE		COLOR															
PD		DIST		NEAR		LENS		TINT		MATERIAL		PAIR		CASE									
		SPHERE		CYLINDER		AXIS		DECENTER		H PRISM		H BASE		V PRISM		V BASE							
R																							
L																							
		NEAR ADD		SEG HT		TOTAL DECENTER																	
R																							
L																							
SPECIAL COMMENTS/JUSTIFICATION (Use this space to specify blocks marked "Other")																							
PRESCRIBING OFFICER/AUTHORITY												SIGNATURE											
DISTRIBUTION: ORIGINAL - Retained by Lab. COPY 1 - Returned with eyewear. COPY 2 - Entered in health record. DD FORM 771, JUL 96 (EG) PREVIOUS EDITION IS Designated using Perform Pro, WMSOICR, Aug 95																							

**Figure 4-14.—DD Form 771**

The DD Form 771 should be typewritten or computer printed whenever possible. This practice eliminates any errors by misreading an individual's handwriting. Omission of any information or entering erroneous information will result in a delay at the fabricating facility or patients receiving an incorrect pair of eyeglasses, or both.

If the Corpsman cannot read what has been written on an eyewear prescription, contact the optometrist for clarification. In the case where the optometrist cannot be contacted, send a photostatic copy of the prescription to the optical laboratory rather than transcribing information which is unclear. Make sure the copy of the prescription is accompanied by a completed DD Form 771.

## DENTAL RECORD FORMS

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### LEARNING OBJECTIVE:

*Describe the types and locations of dental record forms.*

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### ARRANGEMENT OF FORMS

#### Front of Dental Record Jacket Center Page

Forms will be filed in the front of the dental record jacket center page as covered in the following paragraphs:

(NAVMED 6600/3)—Dental officers, civilian dentists, and auxiliary personnel providing direct patient care will ensure that each patient has a completed, current Dental Health Questionnaire (HQR), in the dental treatment record before performing an examination or providing dental treatment. The NAVMED 6600/3 (Fig. 4-15) will be filled out and signed by each patient. This will be reviewed, dated, and signed by the first dentist conducting the examination or dental treatment. For minors, i.e., under the age of consent or majority in the applicable jurisdiction, the parent or guardian must fill out the form and sign in the patient's signature block of the form, using his or her name and not the child's name.

Each dental care provider must indicate, in the dental treatment section of the EZ603A that the questionnaire has been reviewed and updated by the patient. Dentist must also annotate on the EZ603A in the "O" objective block, sections marked "HQ dated," "Reviewed," and "HQR Finding."

During annual dental exams, patients need only to review, date, and sign the current questionnaire if health status has not changed. Whenever a significant change in medical history or health status occurs, a new questionnaire must be filled out, dated, and signed.

The initial and subsequent Dental HQRs are permanently maintained in the Dental Treatment Record. For conditions that require medical clarification, use the SF 513 (Consultation Sheet). Document the consultation on the EZ603-Dental Exam Form and in the Summary of Pertinent Findings section of the NAVMED 6600/3. **BUMED Instruction 6600.12 series** provides guidance for the Dental HQR.

#### Part I (Inside Front Cover)

Forms will be filed in the inside front cover of the dental record jacket as follows:

- Un-mounted radiographs in envelopes - Front
- Sequential bitewing radiograph - Middle
- Panographic or full-mouth radiograph - Back

#### Part II (Front of Center Page)

Place the NAVMED 6600/3, Dental Health Questionnaire (HQR) here.

DENTAL HEALTH QUESTIONNAIRE				Personal Data - Privacy Act of 1974				BUMEDINST 6600.12			
My Chief Complaint or Reason for this Examination is: _____											
HAVE YOU EVER HAD OR HAVE YOU NOW: (Please check at the Right of each item)											
(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW
Epilepsy or Seizures				Menstruata				Ulcers			
Fainting or Dizziness				Bruise or Bleed easily				Kidney problems			
Nervousness				Heart problems or Angina				Veneral disease			
Stroke				Hypertension				Diabetes			
Glaucoma				Rheumatic fever				Thyroid disease			
Cold sores (Herpes)				Heart murmur				HIV +			
Persistent cough				Mitral valve prolapse				Arthritis			
Emphysema				Congenital heart lesion				Painful joints (incl. jaw)			
Tuberculosis/PPD positive				Heart surgery				Prosthetic joints(s)			
Asthma				Parvovir. heart valve(s)				Hives			
Hay fever				Patemaker				Steroid medication(s)			
Sinus problems				Blood transfusion(s)				Drug addiction			
Anemia				Liver disease				Alcoholism			
Sickle cell disease				Yellow jaundice				Unexplained weight change			
G-6PD deficiency				Hepatitis type:				Cancer/radiation			
1. Have you ever been told that you should not donate blood? _____ 2. Have you ever been told that you need antibiotics before dental treatment? _____ 3. Females: Are you taking birth control pills (BCPs)? _____ Are you or might you be pregnant? (Estimated delivery) _____ Are you breast feeding at the present time? _____ 4. Do you have a disease, condition, or problem not listed above? _____ If Yes, Please Describe: _____											
<b>INSTRUCTIONS:</b> Please answer the following questions by circling, and if applicable by entering the appropriate response. If yes, describe - If no, please write "no/none"											
1. Are You In: Flight Status? . . Yes No / Personnel Reliability Program? YES NO 2. Are You Presently Ill Or Under The Care Of A Physician YES NO If Yes, Please Describe: _____											
History Of Hospitalizations: _____ (Including Cancer Treatment) _____ 3. Any Allergies? (Including Rubber) _____ 4. Medications Presently Taking: _____ (including aspirin, etc.) _____											
<b>Any Family History Of: (Circle)</b> Heart Disease    Cancer Diabetes        Seizures				<b>Your Social History:</b> ● Type and frequency of: ● Tobacco use: (age started) _____ ● Alcohol consumption: _____				<b>Occupation/Job:</b> _____			
Patient's Signature _____						Date _____					
Patient's Signature _____						Date _____					
Patient's Signature _____						Date _____					
Patient's Signature _____						Date _____					
SUMMARY OF PERTINENT FINDINGS/RECOMMENDED TREATMENT MODIFICATIONS: (Dentist's use only)											
<b>PATIENT'S IDENTIFICATION</b> (Use Space for Mechanical Imprints)				Patient's Name (Last, First, Middle initial)						SEX	
				DATE OF BIRTH		RELATIONSHIP TO SPONSOR		COMPONENT/STATUS		DEPART/SERVICE	
				SPONSOR'S NAME						Rank/Grade	
				SSN OR IDENTIFICATION NO.				ORGANIZATION			

Figure 4-15.—NAVMED 6600/3



**Part III (Back of Center Page)**

Place all Dental Exam Forms, EZ603s (Fig. 4-16) (Plan “P” side up) in reverse chronological order, i.e. newest date on top, in this area.

**DENTAL EXAM**  
 S: Reason for Examination: Initial / Periodic / Separation / DD2808 / Other  
 Chief Complaint: None / Use INK!  
 O: Type of Exam: T-1 T-2 Blood Pressure: / HQ dated: Reviewed  
 HDR: WNL / Radiographs Ordered: BWs  Pano  PAF  
 Findings: (except caries) Caries, defective restorations & fractured teeth. (radiographic & clinical) None / Noted as follows:  
 OCS/Soft Tissue: WNL / Incip: Max 


 Mand 


  
 Endo: WNL / TMD: WNL / Pain (Dys)FNCL Occlusion: WNL / Oral Surgery: WNL/Impacted # Partial Impacted (Comm) # Symptomatic #  
 Other findings:  
 A: Assessment of Chief Complaint: Perio: Healthy / Gvls (Local/Gen) / Pals (Mild/Med/Severe) / Other Oral Surgery: Endo: Tobacco use: None / Other:  
 P: Treatment Plan  
 Department: Sequence: Urgent: Routine: DATA ENTRY: Urgent | Routine  
 HYGIENE: Regular: 1 2 3 | 1 2 3 Priority: 4 5 6 | 4 5 6 P-1 High: 5 6 7 8 | 5 6 7 8 Priority:  
 ORAL SURG: Urgent: 1 16 17 32 | 1 16 17 32 4 5 6 | 4 5 6 Complete: 1 2 3 | 1 2 3  
 PERIO: Load: 1 2 3 4 | 1 2 3 4 4 5 6 | 4 5 6 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50  
 ENDO: Urg: 1 2 3 4 | 1 2 3 4 4 5 6 | 4 5 6 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50  
 PROS: Urg: 1 2 3 4 | 1 2 3 4 4 5 6 | 4 5 6 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50  
 ORAL DIAG: Urg: 1 2 3 4 | 1 2 3 4 4 5 6 | 4 5 6 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50  
 SEALANTS: Urg: 1 2 3 4 | 1 2 3 4 4 5 6 | 4 5 6 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50  
 ADDITIONAL REMARKS (See reverse)  
 Patient (or parent/guardian) has read and understands the health hazards associated with tobacco use and agrees to seek cessation assistance.  
 Patient has been advised of the findings of this examination and treatment plan.  
 Examiner's Signature: Date: RECALL INTERVAL: 12 Months DENTAL CLASS: 1 2 3 4  
 Name Stamp: Date: Patient's Last Name: First Name: MI: FBP / SSN:

**Figure 4-16.—EZ603**

**Part IV (Inside Back Cover)**

Place all dental forms listed below in the order given. Numbered forms must be grouped together with the most recent form placed on top of each previous form.

- Record Identifier for Personnel Reliability Program, NAVPERS 5510/1 (if applicable)
- Current Status Form
- Reserve Dental Assessment and Certification Form, NAVMED 6600/12 (if applicable)
- Most current Dental Treatment Form, EZ603A
- Previous Dental Treatment Forms (EZ603As, Old SF603s and 603As)

- Narrative Summary, SF 502, Figure 4-12 (when related to dental treatment)
- Consultation Sheet, SF 513, Figure 4-13 (when related to dental treatment)
- Doctor’s Progress Notes, SF 509, (when related to dental treatment)
- Tissue Examination, SF 515 (Fig. 4-17) (if required)
- Request for the Administration of Anesthesia and for Performance of Operations and Other Procedures, SF 522 (Fig. 4-18) (if required)

515-117  
 MEDICAL RECORD TISSUE EXAMINATION  
 SPECIMEN SUBMITTED BY: DATE OBTAINED:  
 SPECIMEN:  
 BRIEF CLINICAL HISTORY (Include duration of lesion and regularity of growth, if a complaint):  
 PREOPERATIVE DIAGNOSIS:  
 OPERATIVE FINDINGS:  
 POSTOPERATIVE DIAGNOSIS: SIGNATURE AND TITLE:  
 NAME OF LABORATORY: PATHOLOGICAL REPORT: ACCESSION NO.:  
 (Specify description, histologic examination and diagnosis)  
 SIGNATURE OF PATHOLOGIST: (Continue on reverse side) DATE:  
 AGE: SEX: RACE: REGISTER NO.: BOARD NO.: IDENTIFICATION NO.:  
 PATIENT'S IDENTIFICATION (For typed or written entries give: Name, sex, race, middle, grade, date, date, height or medical history)  
 TISSUE EXAMINATION Medical Record  
 (FORMED FORM 1-15, REV. 1-82) Printed by GSA/AMR, FORM 14 (12/79) 2014-8-200-1

**Figure 4-17.—SF 515**

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA  
AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE \_\_\_\_\_

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be \_\_\_\_\_  
*(Description of operation or procedure in layman's language)*

which is to be performed by or under the direction of Dr. \_\_\_\_\_

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: \_\_\_\_\_  
*(If "none", so state)*

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

- a. The name of the patient and his/her family is not used to identify said pictures.
- b. Said pictures be used only for purposes of medical/dental study or research.

*(Cross out any parts above which are not appropriate)*

C. SIGNATURES

*(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

\_\_\_\_\_  
*(Signature of Counseling Physician/Dentist)*

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

\_\_\_\_\_  
*(Signature of Witness, excluding members of operating team)*

\_\_\_\_\_  
*(Signature of Patient)*

\_\_\_\_\_  
*(Date and Time)*

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, \_\_\_\_\_ sponsor/guardian of \_\_\_\_\_ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

\_\_\_\_\_  
*(Signature of Witness, excluding members of operating team)*

\_\_\_\_\_  
*(Signature of Sponsor/Legal Guardian)*

\_\_\_\_\_  
*(Date and Time)*

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

REGISTER NO.

WARD NO.

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR  
PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

STANDARD FORM 522 (REV. 7-81)  
Prescribed by GSA/ICMR, FIRM (41 CFR)

USAPPC V2.00

Figure 4-18.—SF 522

## **ADDITIONAL DENTAL FORMS**

Under the following conditions, additional dental treatment forms are approved for inclusion in the dental record.

Other health care treatment forms (e.g., Veterans Affairs, Office of Personnel Management, Compensation Act, Standard Forms, optional forms, and civilian practitioner forms) may be incorporated in the dental record when considered necessary to document care and treatment. When feasible, attach the form to the appropriate approved form (e.g., attach summaries of reports from civilian practitioners to validate the EZ603, EZ603A or old SF 603) in the proper sequential order. Those not attached to approved forms will be filed inside the back cover of the dental record jacket behind the last authorized form listed above (e.g., SF 522).

## **SECURITY AND SAFEKEEPING OF MEDICAL RECORDS**

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### **LEARNING OBJECTIVE:**

*Identify security and safekeeping procedures for medical records.*

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Each treatment facility develops policies to ensure that records are secure and patient's privacy is protected. Security and safekeeping are major concerns and responsibilities of staff handling medical records. The medical record contains information that is personal, treated as privileged information, and protected by the Privacy Act of 1974. The Privacy Act permits only the patients and their legal representatives to obtain this information. Additional protection is afforded under the HIPAA Privacy Rule. As this is a federal law, there are fines and or imprisonment consequences depending upon the breach, utilization of the breached information, and the number of breaches for the person or the organization.

Treatment facilities will take precautions to avoid compromise of medical and dental information during the movement and storage of medical records. This includes correspondence concerning the medical records when protected health information (PHI) is a part of the message contents. Medical records will be handled by only authorized medical service personnel. Records must be stored in a locked area, room, or file to ensure safekeeping, unless there is a 24-hour watch in the record's room. Refer to the MANMED Chapter 16 for detailed guidance.

## **RECORD CUSTODY**

Records are retained in the custody of the medical officer and or dental officer on the ship, submarine, or aviation squadron to which the member is assigned. For those platforms that do not have medical/dental officers, the health record may be placed in the custody of the SMDR at the discretion of the CO. Examples of SMDRs are Independent Duty Corpsman or Squadron Corpsman. When Medical Department personnel are not assigned, the CO may assign custody of the health records to the local representatives of the Medical and Dental Departments who generally furnish medical and dental support. The custody of the record by an individual is never permitted.

Records are subject to inspection at any time by the CO, superiors in the chain of command, the fleet medical officer, or other authorized inspectors. Records are for official use only and adequate security and custodial care are required.

There are many methods of providing adequate security and custodial control of records. In general, records will be stored in a manner making them inaccessible to the crew or general public. No records or record pages should be left unattended. This precaution helps to prevent loss or misplacement of records, and ensures that a command is compliant with federal and military regulations.

Medical Department personnel will maintain a NAVMED 6150/7, *Health Records Receipt, File Charge-out, and Disposition Record* for each health, outpatient, and dental record in their custody. The completed charge out form must be retained in the file until the record is returned. Medical and dental officers or SMDRs are responsible for the completeness of required health record entries while the record remains in their custody.

### **DISPOSING OF HEALTH RECORDS DURING HOSPITALIZATION**

When a patient is transferred to a treatment facility, the HREC should accompany the patient. If members are admitted to a military hospital while away from their command, their HRECs should be forwarded as soon as possible to the hospital. If a discharged member is directed to proceed home and await final action on the recommended findings of a physical evaluation board, an entry to this effect will be recorded in the HREC.

If a member is admitted to a civilian hospital for treatment involving brief periods of hospitalization, the HREC should be retained by the activity until disposition is completed. The HREC will then be forwarded to the cognizant office of medical affairs or to the activity designated by the Commandant of the Marine Corps (CMC) for Marine Corps members. In instances where the parent activity retains the HREC, a summary of the hospitalization will be entered on an SF 600 when the member returns to duty.

When a member is hospitalized at a medical facility of a foreign nation, an entry of this fact should be made in the HREC. The HREC should be retained on board and continued until the patient either returns to duty or is transferred to a U.S. military activity. Upon departure of the medical facility, the HREC will be delivered to the CO for inclusion in the member's service record for forwarding to the nearest U.S. embassy or consulate.

### **CROSS-SERVICING HEALTH RECORDS**

The HREC of a Navy or Marine Corps member is normally serviced by personnel of the Medical Department of the Navy. However, if a Navy or Marine Corps member is performing an assignment with the Army or the Air Force, the health record may be serviced by Army or Air Force Medical Department personnel. This management of the health record may be done if the attendant service interposes no objection and considers the procedure feasible. Reciprocal procedures for servicing the health records of Army or Air Force personnel by personnel of the Medical Department of the Navy will be maintained whenever feasible, and if requested by authorized representatives of those services.

### **RELEASING MEDICAL INFORMATION**

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#### **LEARNING OBJECTIVE:**

*Identify guidelines for releasing medical information.*

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#### **AUTHORITY**

The Surgeon General of the Navy is the official responsible for administering and supervising the execution of **SECNAVINST 5211.5 series, *Department of the Navy Privacy Act Program (PAP)***, as it pertains to the Health Care Treatment Record System. Additionally, the Office of the Surgeon General authorizes requests for access and amendment to a naval member's treatment records.

COs of Navy treatment facilities are designated as local systems managers for treatment records maintained and serviced within their activities. Local systems managers are authorized to release information from records located within the command if proper credentials have been established. The requesting office or individual will be advised that such information is private and must be treated with confidentiality.

In all cases where information is disclosed, an entry will be made on OPNAV Form 5211/9, *Record of Disclosure-Privacy Act* of 1974 to include the date, nature and purpose of the disclosure, and the name and address of the person or agency receiving the information. Maintain a copy of any such disclosure requests. Additionally, documentation of information released must also be noted in any required electronic databases.

## **GUIDELINES FOR RELEASING MEDICAL INFORMATION**

This section will cover the policy for release of record transcripts. The appropriate rule for the release implemented depends upon the intended recipient of the record transcript.

### **Release to the Public**

Information contained in treatment records of individuals having undergone medical or dental examination or treatment is personal and considered private and privileged in nature. Consequently, disclosure of such information to the public would constitute an unwarranted invasion of personal privacy. Such information is exempt from release under the Freedom of Information Act.

However, MTF Commanding Officers may release some information to the public or the press without the patient or patient's next of kin's (NOK) consent. This information is the patient's name; grade or rate; date of admission or disposition; age; sex; component, base, station, or organization; and general condition.

### **Release to the Individual Concerned**

Release of healthcare information to the individual concerned (patient) falls within the purview of the Privacy Act and not the Freedom of Information Act. When individuals request information from their medical record, it will be released to them unless, in the opinion of the releasing authority, it might prove injurious to their physical or mental health. In such an event, the releasing authority will request authorization from the patients to send their medical information to their personal physician.

### **Release to Representatives of the Individual Concerned**

Upon the written request from patients, healthcare information will be released to their authorized representatives. If an individual is mentally incompetent, insane, or deceased, the NOK or legal representative must authorize the release in writing. NOK or legal representatives must submit adequate proof that the member or former member has been declared mentally incompetent or insane, or furnish adequate proof of death if such information is not on file. Legal representatives must also provide proof of appointment, such as a certified copy of a court order.

## Releasing Medical Information to Federal and State Agencies

In honoring proper requests, the releasing authority should disclose only information relative to the request as listed in the "Routine Uses" section of the Medical Treatment Records System, which is annually set forth in **SECNAV NOTE 5211, *Systems of Personal Records Authorized for Maintenance Under the Privacy Act of 1974*, 5 U.S.C. 552a (PL 93-579)**.

In the following three instances agencies may have a legitimate need for the information:

- Health care information is required to process a governmental action involving an individual. The Veterans Administration and the Bureau of Employees' Compensation process claims in which the claimant's medical or dental history is relevant. If an agency requests health care information solely for employment purposes, a written authorization is required from the individual concerned.
- Health care information is required to treat an individual in the department's custody. (Federal and state hospitals and prisons may need the medical or dental history of their patients and inmates.)
- Release to federal or state courts or other administrative bodies. The preceding limitations are not intended to prevent compliance with lawful court orders for health records in connection with civil litigation or criminal proceedings, or to prevent release of information from health records when required by law. If there are doubts about the validity of record requests, ask the Judge Advocate General (JAG) for guidance.

## Releasing Medical Information for Research

COs of treatment facilities are authorized to release information from treatment records located within the command to members of their staff who are conducting research projects. When possible, the names of parties involved should be deleted. Other requests from research groups should be forwarded to Bureau of Medicine and Surgery (BUMED) for guidance.

### SUMMARY

The HM will be responsible for managing medical and dental records. These records are vital tools in the healthcare delivery process. It is of the utmost importance that the HM learns and follows the guidelines for establishing, handling, maintaining, and closing medical and dental records. Well maintained treatment records furnish healthcare providers with current medical and dental data, enabling the provider to give each patient timely and comprehensive care. Confidential treatment of the patient's PHI honors the patient's privacy and is in keeping with legal regulations.