REVIEW OF SERVICE TREATMENT RECORDS

AND

POST SERVICE TREATMENT RECORDS

TRAINEE HANDOUT

Basic Organization of STRs

Generally, the newer type of STRs used by the services starting in the late 1970s or early 1980s are separated into four parts. If the STRs are still in their original jackets, these parts can be opened like a book. The left inside is page 1, the left side of the middle page is page 2 (to the right of page 1), the right side of the middle page is page 3 (to the left of page 4) and the right inside page is page 4.

Each service uses a slightly different format for filing down evidence and forms and this format has also changed somewhat over time. Information found in STRs is generally in chronological order, new information is filed on top during the veteran's active service. Records from the 1960s and early 1970s only have two sides, page 1 and 2.

STRs in their original jackets are organized as follows:

Two-sided STRs

Page 1 (two-sided STRs): These records may or may not have a back-filed treatment summary. Often physical exams will be filed on this side as well as some specialty tests and physical profile reports.
Page 2 (two-sided STRs): Radiology reports, laboratory reports and some other specialty tests are filed on the bottom and treatment notes are filed chronologically on the top. Sometimes the entrance examination and other physical exam reports are on the bottom or inter-filed among the treatment reports.

Four-sided STRs

Page 1 (four-sided STRs): Back-filed on this page, or in the newer type of STRs included as a cardboard attachment, is a treatment summary (often titled Preventative and Chronic Care Flow Sheet). These forms may have different names but are generally completed by the treatment provider and give a good history of surgeries, chronic conditions, allergies and other information that treatment providers want to highlight. Below this summary, physical profile reports,

audiology reports and other specialized types of reports that depending on the veteran's occupation will be found.

Page 2 (four-sided STRs): This is where treatment notes are found. Treatment notes are records of clinic visits and emergency room visits. Referrals to specialty providers (often titled Requests for Consultation) and abbreviated mental health notes will be found here. Most military mental health clinics keep separate mental health files but cross reference visits in the STRs; these cross-referenced entries often do not show the diagnosis or reason for visit to the Mental Health Clinic.

Page 3: This is where you will find entrance and separation physicals, periodic physicals and associated tests.

Page 4: Here you will find radiology reports (x-ray reports), laboratory test results/reports, and biopsy results.

Please keep in mind that the basic organization of records may vary by military service and time.

Additionally, if the STRs are removed from their original jackets, you should maintain a similar order in the STRs envelopes. **Do not damage, mark up, date-stamp, write on, or hole-punch the original service treatment records!** (M21-1MR.III.iii.2.A.2.b)

How to Identify the Entrance and Separation Physical Exams

To identify the entrance and separation physical exams in the STRs, you will need to know the dates the veteran entered and separated from service.

When reviewing the STRs, the entrance and separation physical exams can be noted by the status of the veteran. Often the status of the veteran or type of exam is noted as "Civilian" on the entrance examination or "Separation Exam" for a separation physical exam.

You may find it helpful to tab these two records for future reference.

SOAP Format

The SOAP format found in treatment records came into use by the military in the late 1970's and early 1980's. Generally, you would only look at the **S** and the **A** parts and not read the full note. You will also notice that many treatment records will use different abbreviations to signify each section. Some of these variations are included below:

S or H	Subjective summary or history of the patient's reason for seeking medical advice/help or symptoms experienced
O	Objective finding by the treatment provider during the examination
A, I(Imp) or Dx	Assessment (the diagnosis, or in some cases the provisional diagnosis pending further tests)
P	Plan for treatment or medication prescribed

See below for an example of a treatment record in SOAP format.

Sample Treatment Report
Gorgas Army Hospital

Wilber C. Fuegot

S: Past hx R knee injury in 1995. Arthroscopic surgery showed torn medical meniscus. Pt underwent medial meniscectomy, physical therapy, then limited duty. Sx continued. MEB completed 9/95. That exam showed marked lateral laxity, some tenderness at medial aspect, no edema, no locking. Pt discharged from service w/disability severance pay. Today, C/O R knee buckling, pain w/standing, sitting, stair climbing.

O: Flexion to 110, extension to 5. + tenderness to patellar compression. + varus/valgus stress test. Marked lateral laxity. Negative drawer sign. No edema.
X-ray: slight joint space narrowing, early arthritic changes.

Dx: s/p R medial meniscectomy w/residual laxity, DJD.

P: MRI, orthopedics consult.

General Information Found in STRs

The following is a basic list of information found in the STRs:

Entrance and Separation Physical Exams: Each document consists of two parts: a self-report by the veteran regarding medical history and problems experienced and a body system review part completed by the physician.

Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB): These reports are generally very comprehensive and provide a lot of background information.

Preventative and Chronic Care Flow Sheets (or equivalents): These are found on page 1 of the STRs in the original jackets. They often provide excellent summaries of chronic medical conditions, surgeries, and injuries.

Hearing Conservation Data (DD Form 2216E or equivalent): These are periodic audiological examinations.

Physical Therapy and X-ray Reports: They provide information regarding orthopedic conditions and injuries.

Emergency treatment reports (SF 558 or equivalent): These provide information regarding injuries and acute conditions. They list assessment/diagnosis on the middle of the left side of the page.

General Information Found in PSTRs

Generally, post service treatment records utilize the SOAP format. Limit your review and tabbing to finding one instance where the claimed condition was noted.

How to Efficiently Review Records

In order to review Service Treatment Records and Private Medical Records efficiently you should:

- Limit your review as much as possible.
- Locate and tab the entrance and separation physical exams in the STRs.
- Review the body of the STRs only if the claimed condition(s) are not listed on the separation examination or one or more are listed on the entrance examination.
- Tab where a claimed condition is located if it is not mentioned on the separation physical exam.
- Take brief notes on the development checklist.
- Tab post service records only to show the claimed condition exists.

Components and Variations of SOAP

Please fill out the components of SOAP as discussed in classroom. Also, list their variations usually found in service treatment records (STRs):

S: _____

O: _____

A: _____

P: _____

What is the main difference between "Subjective" and "Objective" portions of a treatment report?

_____

Review Practical Exercise

This exercise will give VSRs the opportunity to apply knowledge to claims cases by identifying various components of SOAP format within service treatment records.
(See answer key for suggestion).

Instructions: In the following scenarios, please provide the correct SOAP component for each.

1. "Diagnosis: Left knee strain"

_____

2. "Patient complains of sore throat. Patient says that redness and swelling of throat causes painful swallowing. Took 2 Aleve in past 1 hour."

_____

3. "Patient should continue back exercises to alleviate lower back pain. Patient should alternate ice & heat when pain occurs at nighttime. 800mg Motrin prescribed up to 3 x day."

_____

4. "S/P ACL reconstruction. Dry & intact. No mottling of lower leg. Toes warm to touch, no discoloration of nail beds. Full mobility of toes."

_____

5. "Patient says he cannot lift left arm above shoulder. Prognosis is: left shoulder rotator cuff syndrome."

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