



PASBA

Patient Administration Systems and Biostatistics Activity

**THE AMEDD LINK TO QUALITY
INFORMATION FOR EFFECTIVE MANAGEMENT**

Consolidation of Deployment Medical Documentation Guidance

4 January 2010



**PATIENT ADMINISTRATION SYSTEMS
AND
BIOSTATISTICS ACTIVITY**

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DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
1216 STANLEY ROAD, SUITE 25
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REPLY TO
ATTENTION OF

MCCHS-ISD

4 January 2010

MEMORANDUM FOR Deployed Patient Administration Divisions

SUBJECT: Consolidation of Deployment Medical Documentation Guidance

1. References:

- a. Army Regulation (AR) 40-66, Medical Record Administration and Healthcare Documentation, 17 June 2008, Rapid Action Revision (RAR) issue date, 4 January 2010.
- b. Army Regulation 40-400, Patient Administration, 6 February 2008.
- c. Army Regulation 190-8, Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees, 1 October 1997.
- d. Field Manual Interim (FMI) 4-02.46, Medical Support to Detainee Operations, November 2007.
- e. Army Regulation 25-400-2, The Army Records Information Management System (ARIMS), 21 October 2007.
- f. Memorandum, Office of The Assistant Secretary of Defense, Health Affairs, subject: Joint Theater Trauma Records, 14 December 2005.
- g. Memorandum, The Assistant Secretary of Defense, Health Affairs, subject: Joint Theater Trauma Records, 19 December 2005.
- h. Memorandum, HQ, US Army MEDCOM, DASG-ZH, subject: Interim Guidance on Detainee Medical Care, 24 May 2005.

2. Purpose: This document provides guidance on the management of medical documentation of military personnel, Federal civilian employees, and other persons eligible for care in treatment facilities during contingency operations. It is a consolidation of information and guidance regarding medical documentation and biostatistical reporting that is covered in AR 40-66, AR 40-400, FMI 4-02.46, AR 190-8, and AR 25-400-2.

3. Proponent: The proponent for this guidance is the Patient Administration Systems and Biostatistics Activity (PASBA).

MCHS-ISD

SUBJECT: Consolidation of Deployment Medical Documentation Guidance

4. Guidance:

- a. Required Documentation and Medical Records Management (See Enclosure 1).
- b. Service Treatment Records (STRs), Level-I, Level-II, Level-III and Final Disposition (See Enclosure 2).
- c. Inpatient Treatment Records and Final Disposition (See Enclosure 3).
- d. Detainee Inpatient and Outpatient Treatment Records and Final Disposition (See Enclosure 4).

5. Responsibilities:

a. Unit (Commander):

(1) Transports the Adult Preventive and Chronic Care Flowsheet (Department of Defense (DD) Form 2766) to the area of operation.

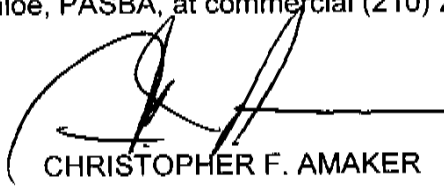
(2) Appoints a unit record custodian.

(3) Maintains the DD Form 2766 at the unit or the Level-II treatment facility if operationally feasible.

b. The Level-II and Level-III treatment facilities medical record custodian or patient administration personnel are to ensure all healthcare documentation and health information reporting requirements are completed and maintained during contingency operations.

6. Our point of contact is Ms. Carolyn Enloe, PASBA, at commercial (210) 221-1414.

4 Encls



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Required Documentation and Medical Records Management (Enclosure 1)

1. Medical record administration and healthcare document management in combat and contingency operations:

a. Army medical records are the property of the Government in accordance with (IAW) Army Regulation (AR) 40-66, Medical Record Administration and Healthcare Documentation, 17 June 2008, Rapid Action Revision (RAR) issue date, 4 January 2010, chapter 1, paragraph 1-6.a.

b. Service Treatment Records (STRs) or Civilian Employee Medical Records (CEMRs) of deployed individuals will **not** accompany them to combat areas IAW AR 40-66, Medical Record Administration and Healthcare Documentation, 17 June 2008, Rapid Action Revision (RAR) issue date, 4 January 2010, chapter 5, paragraph 5-33.a.

c. The Patient Administration Division (PAD) personnel are to ensure all healthcare documentation is completed and maintained during deployments.

d. The PAD Officer will be required to track and present accurate information to higher headquarters, the Patient Administration Systems and Biostatistics Activity (PASBA), MEDCOM and other Department of Defense (DoD) organizations on the status of all their facility's patients during combat or contingency operations.

2. Documentation maintained in medical records (minimum requirement):

a. All medical records will conform to AR 40-66.

b. Adult Preventive and Chronic Care Flowsheet (DD) Form 2766).

(1) The DD Form 2766 will be utilized in AHLTA or AHLTA-Theater (AHLTA-T). The AHLTA or AHLTA-T will be used for documentation and tracking of all immunizations when available.

(2) Minimum requirements:

(a) The DD Form 1380, US Field Medical Card—US Department of Defense form used primarily in the field to record basic patient identification data, describing the problem requiring medical attention and care provided.

(b) The DD Form 689, Individual Sick Slip – Issued to a patient who either requests or receives medical or dental treatment or evaluation at an Military Treatment Facility (MTF), as a means of communication to the individual's unit.

(c) The Standard Form (SF) 600, Chronological Record of Medical Care – The chronological record of outpatient treatment is the basic form of the health record.

(d) The SF 558, Emergency Care and Treatment (Patient and Doctor) – To record all care provided to patients in the emergency center or department.

(e) Diagnostic reports – laboratory, radiology, or electrocardiogram reports and other forms will be filed in the record as applicable.

3. Extended Ambulatory Record (EAR) will be prepared for each military or civilian patient who undergoes an extended ambulatory encounter. During contingency operations or war, EARs are typically provided by Forward Surgical Teams (or Other Service Equivalent) at Echelon of Healthcare Level:

a. The Alphabetical and Terminal Digit File for Treatment Record Department of the Army Form 3444-series jacket (DA Form 3444) will be prepared with a patient's name, family member prefix (FMP), and sponsor's Social Security number (SSN) IAW AR 40-66, Medical Record Administration and Healthcare Documentation, 17 June 2008, Rapid Action Revision (RAR) issue date, 4 January 2010, chapter 4, paragraph 4-4. "EAR" will be annotated on the front of the jacket.

b. Documentation for the EAR must meet the standards for a short-term stay and will be managed the same way as the inpatient records.

c. All forms used in the EAR, if applicable, will be filed on both sides of the folder IAW AR 40-66, Medical Record Administration and Healthcare Documentation, 17 June 2008, Rapid Action Revision (RAR) issue date, 4 January 2010, figure 10-1. The EAR forms and documents must be filed in an upright position and, at a minimum, must include the following:

(1) The DD Form 2770, Abbreviated Medical Record – Used for cases of a minor nature that require no more than 48 hours hospitalization. A copy will be placed in the DD Form 2766.

(2) The SF 516, Medical Record Operation Report – Reporting of all cases involving surgery, including operative or other invasive procedures in the operating room or ambulatory surgery unit when performed under local anesthesia. The SF 516 will include the preoperative and postoperative diagnosis, name of the operation, description of findings—both normal and abnormal—of all organs explored, a detailed account of the technique used and the tissue removed, the condition of the patient at the end of the operation, and the name of the primary surgeon and any assistants.

(3) The SF 509, Medical Record Progress Notes – Recorded by the person giving the treatment or making the observation, describing chronologically the clinical course of the patient, reflecting any change in condition, and the results of treatment.

(4) The DA Form 4256, Clinical Records Doctors Orders – The original white copy remains with the patient's record. No more than one order may be written on a single line. The prescriber will record the date and time, and sign each entry. The second copy (pink) is sent to the pharmacy and kept until the patient is discharged. The ward copy (yellow) may be used as a medication or treatment reminder and discarded when no longer needed.

(5) Original diagnostic report – Laboratory, radiology, or electrocardiogram reports will be filed in the record.

4. Documentation required for patient transfers and evacuations:

a. Forward Surgical Teams (Level-IIb) will follow the same procedures as Level-III treatment facilities when transferring patients to a higher level of care or returning to duty.

b. Copies of the complete inpatient record and EAR should accompany patients transferred to another Level-III or Level-IV treatment facility. The original record should remain with the originating Level-III treatment facility for final disposition.

c. If copying the entire inpatient record is not feasible, the minimum documentation required includes the trauma record (applicable to trauma patients), narrative summary, operative reports (all), and x-ray films.

d. If copying capability is not available, the original inpatient record will accompany the patient to the Level-IV treatment facility and will be

incorporated into the inpatient treatment record of the gaining treatment facility. The initiating Level-III treatment facility will create a memorandum for record documenting the missing register numbers for the corresponding records that are forwarded for accountability.

e. All original outpatient documentation will accompany patients transferred.

5. Patients discharged and returned to duty (RTD) required documentation:

a. Ensure the DD Form 2005, Privacy Act Statement - Health Care Records, is signed by the patient prior to disposition.

b. All patients should be provided a copy of the minimum documents upon discharge and RTD to be included in the DD Form 2766 (Military and DoD Civilians), narrative summary of care and operative reports.

c. If the PAD has coding capability and the appropriate coding manuals, the proper International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis and procedure codes should be entered on the DA Form 3647, Inpatient Treatment Record Cover Sheet.

d. Once records are completed (dispositioned and coded), make a copy of the DA Form 3647 and DD Form 2770. Place the copies in the patient's DD Form 2766 for continuity of care and to be integrated with the Health Care Record upon redeployment.

6. Patient death documentation requirements:

a. Death certificates must be completed on all deaths that occur at Level-I and Level-II treatment facilities. A copy of the death certificate will accompany the remains to the mortuary affairs unit (or appropriate local civilian authorities) and the original certificate will be maintained by the Level-I and Level-II treatment facilities.

b. Level-III treatment facilities: The original inpatient record, hospital report of death, death certificate, and all personal effects will accompany the remains of US Military, Federal employees, Federal contractors, and other appropriate categories of personnel whose remains would be dispositioned to CONUS for autopsy. Copies of the aforementioned documents will accompany all other patients who are not dispositioned to

the US for processing. Death documentation requirements are the same for detainees; however, the original death certificate will be turned over to Military Police to be forwarded to the Theater Detainee Reporting Center or the Bagram Theater Internment Facility.

c. If copying capability is limited or unavailable and if the original record has to be forwarded, the treatment facility should retain a treatment record DA Form 3444-series jacket or DA Form 8005-series jacket to include a memorandum for record with all pertinent patient information recorded (diagnosis, procedures, the MTF transferred to and the date the documentation was forwarded) to assist in future requests. A written copy of the hospital report of death and the death certificate should be retained in the record for patient recorded deaths.

7. Health information reporting requirements: Activated treatment facilities (Level-III and above) are responsible for submitting the monthly medical workload reports or standard inpatient data record directly to the Director, Patient Administration Systems and Biostatistics Activity, ATTN: MCHS-ISD, 1216 Stanley Road, Suite 25, Fort Sam Houston, Texas 78234-5053 (via post office mail or electronic mail). These are due by the 15th day of the month following the report period. Medical Communications for Combat Casualty Care (MC4) deploy and sustain theater patient information systems and applications. All Level-III treatment facilities have embedded MC4 administrators to provide onsite maintenance and support.

a. Theater Patient Information Systems/Applications.

(1) Ambulatory Data Capture - AHLTA-Theater (AHLTA-T): The AHLTA-T is used to capture ambulatory encounters, to include sexual assault victims who present for ambulatory care in theater. Ambulatory data are transmitted to PASBA on a daily basis.

(2) Inpatient Data Capture - Theater Medical Information Program Composite Health Care System Cache (TC2): The TC2 is used to capture patients admitted for medical treatment, to include sexual assault victims who present and require inpatient care in theater. Inpatient treatment data are transmitted to PASBA on a monthly basis from each TC2 server.

(3) Theater Medical Data Store (TMDS) – This web application is used to capture all inpatient and outpatient treatment provided in theater, to include sexual assault victims who present and require care in theater.

The TC2 and AHLTA-T electronically post medical treatment to TMDS, which enables enterprise-level reporting and tracking capability.

(4) The MC4 – Ambulatory Data Capture: Use the AHLTA-T application to capture ambulatory encounters to include sexual assault victims who present for ambulatory care in theater. The use of this application will enable the information to be transmitted to PASBA and included in Sexual Assault Response Program Tracking Application (SARPTA).

(5) The MC4 – Inpatient Data Capture: Use the Theater Medical Information Program Composite Health Care System Cache (TC2) application to capture admitted patients to include sexual assault victims who present and require inpatient care in theater. The use of this application will not enable the information to be transmitted to PASBA and included in SARPTA. The TC2 application that resides on the MC4 platform lacks the capability to generate and transmit the standard inpatient data record for processing at PASBA for inclusion in SARPTA.

(6) The TMDS – The application is used to capture all patients to include sexual assault victims who present and require care in theater.

b. The SARPTA Reporting Requirements.

(1) Deployed Units are required to report and track all victims or patients treated and evacuated for sexual and alleged sexual assault during contingency operations. All sexual assault victims who present for initial evaluation and treatment or for follow up care related to the sexual assault must be entered in the patient information system/application TC2 or AHLTA-T at the Level-III treatment facility within 24 hours of presentation.

(2) The treating facility is required to ensure the complete, accurate, and timely collection of relevant clinical information regarding the sexual assault and transmit this information to PASBA within 24 hours of presentation.

(3) All Level-II treatment facilities presented with a victim of sexual assault will transfer the patient to the nearest Level-III treatment facility (unless approved by the Theater Surgeon to conduct the Sexual Assault Forensic Examination (SAFE)) for initial evaluation, treatment and entry into the appropriate patient information system.

8. Joint theater trauma registry (JTTR) documentation requirements: The JTTR is designed to support the collection of combat casualty episodes of care, treatment, and outcome data by establishing a database to archive medical care data. The JTTR integrates pre-hospital and hospital delivery of care for analysis available from Level-I through Level-V treatment facilities. The JTTR creates a longitudinal record for the military casualty and provides de-identified data to the US Army Institute of Surgical Research database for research:

a. Provider(s) are responsible for documenting care provided to trauma patients at all levels of care (echelons/Level-I through Level-V) using the appropriate trauma documentation.

b. The appropriate trauma documentation should be completed at each level of care and follow the patient through the medical evacuation system.

c. The appropriate trauma documentation generated on inpatients that are RTD in the theater of operations should be maintained in the inpatient treatment record.

d. The appropriate trauma documentation will be scanned at the Level-III treatment facility and made available electronically for inclusion into the trauma registry. Normally, Trauma Nurse Coordinators are assigned to complete this task.

e. Trauma documentation completed on active duty outpatients who are RTD should be given to the individual to be placed in the DD Form 2766 for integration into the health record.

f. The source documentation used to populate the JTTR is provided below. The medical care captured on these documents should be completed IAW the standards listed in AR 40-66, Medical Record Administration and Healthcare Documentation, 17 June 2008, Rapid Action Revision (RAR) issue date, 4 January 2010; memorandum, Office of the Assistant Secretary of Defense (Health Affairs) 14 December 2005, subject: Joint Theater Trauma Records; and memorandum, Office of the Assistant Secretary of Defense (Health Affairs), 19 December 2005, subject: Joint Theater Trauma Records.

(1) Joint Theater Trauma Nursing Record – ASD (HA) September 2005.

(2) Physician Trauma Treatment Record (Forward Resuscitative Care) (Level 2B) – ASD (HA) September 2005.

(3) Physician Trauma Admitting Record (Theater Hospital Care) (Level 3) – ASD (HA) September 2005.

(4) Emergency Medical Treatment/Room Assessment, Medical Record Emergency Care and Treatment (SF 558), or the overprint (DA Form 4700).

(5) Medical Record Anesthesia Record (DA Form 7389).

(6) Medical Record Operation Report (SF 516), Medical Record Progress Notes (SF 509), Medical Record Nursing Note (SF 510), and Medical Record Chronological Record of Medical Care (SF 600).

(7) Medical Record Report (Optional Form (OF) 275) documents Physician Narrative Summary for Transfer/Discharge Note.

(8) Medical Record - Nursing Discharge Summary (DA Form 3888-3) for noncritical patients and nurse's notes summarizing medications, treatments and care on the Medical Record Nursing Notes (SF 510), or a Medical Record - Nursing History and Assessment (DA Form 3888) and Flowsheet for Vital Signs and Other Parameters (DA Form 3950).

(9) Deaths: Certificate of Death (Overseas) (DD Form 2064), and the Hospital Report of Death (DA Form 3894).

(10) Evacuation Summary: Patient Movement Record (Air Force (AF) Form 3899), Patient Movement Record Progress Note (AF Form 3899A), Patient Movement Physical Assessment (AF Form 3899C), Patient Movement Hemodynamic/Respiratory Flowsheet (AF Form 3899D), Patient Movement Intake/Output (AF Form 3899E), Patient Movement Neurological Assessment (AF Form 3899H), Patient Movement Medication Record (AF Form 3899I), Patient Movement/In-Flight Resuscitation Flow Sheet (AF Form 3899K), and all documentation transported with patient.

9. Behavioral health (BH) records (ambulatory care):

a. Level-II treatment facilities:

(1) Behavioral health ambulatory care documentation generated at a Level-II treatment facility (Combat Stress Control) will be maintained at a Level-II treatment facility for continuity of care or transferred to a Level-III treatment facility and above if patient is evacuated.

(2) Upon unit redeployment or when the treatment case is closed, the record/documentation should be forwarded to the fixed MTF responsible for the patients' behavioral healthcare.

(3) In the event the fixed MTF responsible for the soldier's behavioral healthcare cannot be determined, the treating unit in theater will properly secure and maintain the documentation.

(4) Documentation of clinical encounters by behavioral healthcare providers will be recorded in AHLTA/AHLTA-T and should have the AHLTA sensitive button checked. Behavioral health-specific medical care guidance for providers is available in AR 40-66, Medical Record Administration and Healthcare Documentation, 17 June 2008, Rapid Action Revision (RAR) issue date, 4 January 2010, chapter 6, paragraph 6-7h.

b. Level-III treatment facilities:

(1) Behavioral health ambulatory care documentation/records generated at all level treatment facilities will be maintained at the theater facility for continuity of care during the deployment or transferred to the Level-IV through Level-V facility if evacuation is necessary.

(2) Upon unit redeployment, or when the treatment case is closed, the record/documentation should be forwarded to the fixed MTF responsible for the soldier's behavioral healthcare, maintained for 5 years, and then destroyed after the end of the calendar year in which the case is closed.

(3) In the event the fixed MTF responsible for the soldier's behavioral healthcare cannot be determined, the treating unit in theater will properly secure and maintain the documentation.

(4) Documentation of clinical encounters by behavioral healthcare providers will be recorded in AHLTA/AHLTA-T and should have the AHLTA sensitive button checked.

Service Treatment Records (STRs), Level-I, Level-II, Level-III and Final Disposition (Enclosure 2)

1. Level-I and Level-II treatment facilities and the service treatment records (STRs):

a. Patients treated at echelon of care Level-I – Level-II, the Adult Preventive and Chronic Care Flowsheet (Department of Defense (DD) Form 2766) will be maintained by the organic treatment unit or the command-designated medical record custodian at the unit level. Ensure test results or other applicable documents created during a deployment for active duty members assigned to deployable units are included in DD Form 2766. The DD Form 2766 will be utilized in the AHLTA or AHLTA-Theater (AHLTA-T). The AHLTA or AHLTA-T will be used for documentation and tracking all immunizations when available.

b. Entries will be made in a record by the healthcare provider who observes, treats, or cares for the patient and in accordance with (IAW) the locally defined patient assessment policy. All entries must be legible, dated, timed, and signed by the physician responsible for the patient's care. No healthcare practitioner is permitted to complete the documentation for a medical record on a patient unfamiliar to him or her. In unusual or extenuating circumstances (Example: Death), local policy will ensure that all means have been exhausted to complete the record.

c. If you choose to use an STR, the patient identification section on the Alphabetical and Terminal Digit File for Treatment Record Department of the Army (DA) Form 3444-series jacket or Outpatient Medical Record (OMR) DA Form 8005-series jacket must include the patient's name, family member prefix (FMP), sponsor's Social Security number (SSN), his or her rank, grade or status, date of birth, and the code for the treatment facility that maintains records.

d. If the supporting treatment facility at this level is not capable of maintaining the DD Form 2766s of supported units, all patients receiving outpatient care will have the original documentation placed in the DD Form 2766 (or comparable civilian record jacket) after treatment to be returned to the unit medical record custodian (Example: S-1, unit medic or civilian designee).

e. If the DD Form 2766 and supporting documents are with a supporting unit and the patient's unit has redeployed, or the supporting treatment unit

is pending redeployment, the closest Military Treatment Facility (MTF) Patient Administration Division (PAD) personnel should package and forward the documentation to the appropriate installation responsible for maintaining the unit's permanent STRs. For example, if units were stationed at Fort Bragg, the PAD in theater would box up the loose elements and mail these to Womack Army Medical Center, Fort Bragg for final disposition into the soldier's records back at the home station.

2. Level-III treatment facilities and the DD Form 2766 or STRs:

a. If it is operationally feasible, the Level-III treatment facility will maintain the DD Form 2766 and the appropriate supplemental documentation for units that it provides direct outpatient medical support. The DD Form 2766 will be utilized in the AHLTA or AHLTA-T. The AHLTA or AHLTA-T will be used for documentation and tracking all immunizations when available.

b. The Level-III treatment facility must coordinate with the supported unit to return the DD Form 2766 of unit members prior to relocation or redeployment.

c. The PAD Officer/Non-Commissioned Officer in Charge can use resources such as the Division G-1 and the Medical Occupational Data System (MODS) to determine a soldier's specific unit of assignment in theater or permanent duty location to properly disposition loose outpatient documentation.

d. Upon redeployment ensure all DD Form 2766s and STRs or outpatient documentation be returned to the home or mobilization station MTF to be integrated with the health records.

e. If copying capability is limited or unavailable and if the original record has to be forwarded, the treatment facility should retain a treatment record DA Form 3444-series jacket to include a memorandum for record with all pertinent patient information recorded (diagnosis, procedures, the MTF transferred to and date the documentation was forwarded) to assist in future requests. A written copy of the hospital report of death and the death certificate should be retained in the patient record.

3. Assignment of pseudo-SSNs or artificial nine-digit numbers for all Level-II+ and Level-III MTFs:

a. Pseudo-SSNs, or artificial nine-digit numbers will be assigned to a patient who presents for care when their identity is unknown (John/Jane Doe), or if they are foreign citizens who do not possess a nine-digit identity number. The pseudo-, or artificial, SSN will be constructed for all Level-II+ and Level-III MTFs using the designated pseudo-SSNs for applicable patients IAW theater policy.

b. The MTF will assign a non-US patient a pseudo-SSN starting with the assigned prefix for their MTF, and will issue pseudo-SSNs in chronological order. To ensure that pseudo-SSNs do not match a US patient's SSN, MTFs will keep the fourth and fifth digits as 00 and change the third digit when the MTF goes over 9999 when constructing pseudo-SSNs. (Example: 970-00-0001, 970-00-0002, 970-00-0003, and 970-00-9999). Once the last four digits have reached 9999, then the third digit number of the SSN advances to the next subsequent number and the numbering starts over: 971-00-0001, 971-00-0002, etc. (Example: Having reached 971-00-9999, the next pseudo-SSN assignment will be 972-00-0001, 972-00-0002, etc).

c. Listed are the templates for the assigned Level-II+ and Level-III MTFs pseudo-SSNs for the Iraqi Theater of Operation.

(1) Level-II+:

LEVEL-II+		
20X-00-XXXX	ASMC	TALLIL
64X-00-XXXX	EMEDS	BIAP
70X-00-XXXX	SURGICAL COMPANY	AL QAIM
71X-00-XXXX	SURGICAL COMPANY	KOREAN VILLAGE
72X-00-XXXX	SURGICAL COMPANY	AL ASAD
73X-00-XXXX	SURGICAL COMPANY	AL TAQQADAM
74X-00-XXXX	SURGICAL COMPANY	CAMP FALLUJAH
75X-00-XXXX	SURGICAL COMPANY	RAMADI
77X-00-XXXX	EMEDS	KIRKUK

(2) Level-III:

LEVEL-III		
00X-00-XXXX	EMDG	BALAD
10X-00-XXXX	CSH	BAGHDAD (Camp Sather)
30X-00-XXXX	CSH	TIKRIT
40X-00-XXXX	CSH	MOSUL
60X-00-XXXX	CSH	CROPPER
78X-00-XXXX	CSH	AL ASAD

d. Level-II+ and Level-III MTFs will clearly mark the full nine-digit pseudo-SSN on transfer paperwork. When a patient is transferred to another Level-III or Level-IV MTF, the PAD personnel at the receiving facility will admit the patient with the originating pseudo-SSN. The receiving facility will provide daily summaries while the patient is in their care, and properly disposition the patient when the patient's care is complete. The theater pseudo-SSN policy provides medical providers a means to easily track and get clinical updates on patients that are transferred from their MTF to a lateral or higher continuum of care.

e. Track all pseudo-SSNs in a logbook for future reference.

4. Assignment of patient identification numbers to Task Force Medical (TF MED) Operations:

a. All detained personnel are processed through the Camp Cropper detention facility and assigned a 13-digit Internment Serial Number (ISN) as soon as possible after coming under DoD control. The six-digit sequence numbers embedded in the 13-digit ISN will support the pseudo-Detainee Identification Number. Once assigned, detainees are referred to by an ISN only for all outpatient encounters and inpatient admissions.

b. Standards for issuing detention facilities pseudo-SSNs for non-US and non-detainee patients for inpatient and outpatient care.

(1) The MTF will assign non-US and non-detainee patients a pseudo-SSN starting with the following assigned prefix for their MTF when entering data into the medical data systems. For example, 600-00-1234.

60X-00-XXXX	CSH	CROPPER
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(2) Level-II+ and Level-III MTFs register non-US and non-detainee patients using the designated pseudo-SSNs for applicable patients IAW theater policy.

(3) Issue pseudo-SSNs in chronological order.

(4) The fourth and fifth digits remain as (00) to ensure that the pseudo-SSN does not match a US patient's SSN. The third digit number of the pseudo-SSN advances to the next subsequent number when the MTF uses (9999), as the last four-digits. (Example: Once 200-00-9999 is used the next number issued would be 201-00-0001).

(5) Track all pseudo-SSNs in a logbook for future reference.

c. Standards for issuing detainee identification numbers.

(1) Once a detainee has been issued an ISN, that number is the only number used to reference a detainee. In order to facilitate the use of a medical automation system that requires a nine-digit number, detainees are issued a pseudo-SSN with (900) as the first three-digits and then the six-digit sequence from the ISN.

(2) A detainee with an ISN of US91Z-123456CI becomes 900-12-3456 in medical automation systems. This number is the only number used by all MTF(s) to document care for that particular detainee. If the detainee is transferred to a different MTF, use the same ISN/pseudo-Detainee Identification Number.

(3) Do not assign patients a (900) prefix until they have been assigned an ISN from the detention MTF, even if they are a suspected insurgent/detainee.

(4) Detention MTF changes the pseudo-SSN assigned by the previous MTF to the (900) pseudo-SSN and links the old pseudo-SSN to the new ISN-driven pseudo, once the patient is classified as a detainee. Update all hard copy medical documentation with the new Detainee Identification Number.

(5) Detainees will be identified by the 900 prefixes, name and ISN. (Example: NAME = Detainee, ISN 311234 and PSSN = 900-31-1234).

5. If outpatient treatment records (OTRs) are used, prepare the treatment record DA Form 3444-series jacket or the DA Form 8005-series jacket with the following procedures:

a. Select the correct colored Alphabetical and Terminal Digit File for the Treatment Record DA Form 3444-series jacket that represents the last two-digits of the patient's SSN or pseudo-SSN. Select the series jacket color as described below.

00 – 09	ORANGE
10 – 19	LIGHT GREEN
20 – 29	YELLOW
30 – 39	GREY
40 – 49	TAN
50 – 59	LIGHT BLUE
60 – 69	WHITE
70 – 79	BROWN
80 – 89	PINK
90 – 99	RED

b. The front of the treatment record DA Form 3444-series jacket must contain the following information:

Register #, FMP, SSN

Name

Sex, Date of Birth (DOB)

Service, Pat Cat, Rank

Date of Admission

OUTPATIENT, MTF, MTF DMIS ID

0001234 20 234567890

Doe, John M.

M 29DEC52

Army Active Duty A11 E9

23AUG04

OUTPATIENT 31st CSH 1180

c. Mark the block labeled "Outpatient Treatment" on the front of the treatment record DA Form 3444-series jacket with black permanent marker or black ink.

d. Mark the last digit of the patient's SSN on the top and the right edge of the treatment record DA Form 3444-series jacket by using one-half inch of black tape over the number that is the same as the last digit. If black tape is not available use black ink to block it out.

e. Print the patient's last name, first name, and middle initial on the top left corner of the DA Form 3444-series jacket.

f. Enter the two-digit FMP of the patient in the two circles to the left of the hyphenated blocks on the top middle of the DA Form 3444-series jacket.

g. Enter the patient's SSN in the hyphenated blocks on the top of the DA Form 3444-series jacket.

h. Mark the block marked "S" with colored tape denoting the patient category status. If tape is not available use a colored permanent marker. See Table 2-1 for common patient category codes used.

Table 2-1			
BENEFICIARY CATEGORY DESCRIPTION	BEN CAT CODE	FMP	“S” TAPE COLOR
ACTIVE DUTY			
ARMY	A11	20	RED
NAVY	N11	20	RED
AIR FORCE	F11	20	RED
MARINES	M11	20	RED
COAST GUARD	C11	20	RED
RESERVE			
ARMY	A12	20	RED
NAVY	N12	20	RED
AIR FORCE	F12	20	RED
MARINES	M12	20	RED
COAST GUARD	C12	20	RED
NATIONAL GUARD			
ARMY	A15	20	RED
AIR FORCE	F15	20	RED
MISCELLANEOUS			
FOREIGN CIVILIAN (Host Nation)	K91	99	BLACK
FOREIGN CIVILIAN (Non-Host Nation)	K76	20	WHITE
IRAQ CIVILIAN	K91	99	BLACK
LOCAL NATIONAL	K91	99	BLACK
FOREIGN CIVILIAN DEPENDENT (Non-Host Nation)	K76	20	WHITE
IRAQ CIVILIAN DEPENDENT	K91	99	BLACK
LOCAL NATIONAL DEPENDENT	K91	99	BLACK
EPW PRISONER	K78	20	BLACK
CIVILIAN IN DETENTION	K78	20	BLACK
DoD EMPLOYEE	K53	20	BLACK
CONTRACT EMPLOYEE	K65	20	BLACK
NATO MILITARY	K72	20	WHITE
NON-NATO MILITARY	K74	20	BLACK

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j. Records must be checked for quality assurance (Example: Provider signatures and dates on all entries, proper forms used with patient diagnoses and assessments, etc.).

k. If OTRs are used, records will be assembled using the treatment record DA Form 3444-series jacket or the DA Form 8005-series jacket. All documents should be filed in an upright position on both sides of the folder. Order given is from top to bottom of the record. See Table 2-2, Outpatient Treatment Record Assembly Forms and Documents if using treatment record DA Form 3444-series jacket or Table 2-3, Outpatient Treatment Record Assembly Forms and Documents if using DA Form 8005-series jacket. If not operationally feasible during the deployment, the DD Form 2766 will serve as the outpatient record.

TABLE 2-2	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
LEFT SIDE — DA FORM 3444 SERIES JACKET	
FORM	DESCRIPTION
DD Form 2766	Adult Preventive and Chronic Care Flow Sheet
DD Form 2766C	Adult Preventive and Chronic Care Flow Sheet – Continuation Sheet
DA Form 3180	Personnel Screening and Evaluation Record
DA Form 4186	Medical Recommendation for Flying Duty
	Health Enrollment/Evaluation Assessment Review (HEAR) Primary Care Managers (PCM) Report
DD Form 2882	Pediatric and Adolescent Preventive and Chronic Care Flowsheet
DA Form 5571	Master Problem List. This form is obsolete; use for file purposes only if already in existence.
DD Form 2792-1	Exceptional Family Member Special Education/Early Intervention Summary
	Automated Exceptional Family Member Program Summary
	Civilian source pediatric growth charts
SF 601	Health Record – Immunization Record
	Automated laboratory report forms
SF 512	Clinical Record – Plotting Chart
SF 545	Laboratory Report Display

TABLE 2-2 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
LEFT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 557	Chemistry I – III, Hematology, Urinalysis, Serology, Parasitology, Microbiology I – II, Spinal Fluid; Miscellaneous
SF 556	Immunohematology
SF 507	Clinical Record – Report on or Continuation of SF
SF 519-B	Radiologic Consultation Request/Report
SF 519; SF 519A	Medical Record – Radiographic Report
OF 520	Clinical Record – Electrocardiographic Record
SF 560	Medical Record – Electroencephalogram Request and History
DA Form 2631	Medical Care – Third Party Liability Notification
DA Form 3647	Inpatient Treatment Record Cover Sheet or CHCS automated equivalent. File with it copies of SF 502 (if prepared), SF 515, SF 509, SF 516, and DD Form 2770 or SF 539
OF 275	Medical Record Report

TABLE 2-2 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
LEFT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
DD Form 2770	Abbreviated Medical Record (outpatient)
DA Form 4254	Request for Private Medical Information
DA Form 4876	Request and Release of Medical Information to Communications Media
DD Form 2870	Authorization for Disclosure of Medical or Dental Information
DA Form 5006	Medical Record – Authorization for Disclosure of Information
DA Form 5303R	Volunteer Agreement Affidavit
DA Form 3365	Authorization for Medical Warning Tag
DD Form 2569	Third Party Collection Program – Record of Other Health Insurance
	Administrative documents and other correspondence including advance directives
DA Form 4410-R	Disclosure Accounting Record
RIGHT SIDE — DA FORM 3444 SERIES JACKET	
FORM	DESCRIPTION
DA Form 4515	Personnel Reliability Program Record Identifier
	Interfile the following forms in reverse chronological order with the most recent on top.
SF 600	Medical Record Chronological Record of Medical Care

TABLE 2-2 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 558	Medical Record – Emergency Care and Treatment (Patient)
DA Form 5181	Screening Note of Acute Medical Care
SF 513	Medical Record – Consultation Sheet
DD Form 2161	Referral for Civilian Medical Care
DD Form 2341	Report of Animal Bite – Potential Rabies Exposure
	State Ambulance Forms
DA Form 5008	Telephone Medical Advice/Consultation Record
DA Form 3824	Urologic Examination
DD Form 2493-1	Asbestos Exposure Part I – Initial Medical Questionnaire
DD Form 2493-2	Asbestos Exposure Part II – Periodic Medical Questionnaire
DA Form 5568	Chronological Record of Well-Baby Care
DA Form 5694	Denver Developmental Screening Test
DA Form 3763	Community Health Nursing – Case Referral
	Home health care documentation
DA Form 5569	Isoniazid (INH) Clinic Flow Sheet

TABLE 2-2 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 602	Medical Record – Serology Record
DA Form 4700	Medical Record – Supplemental Medical Data
DA Form 5551-R	Spirometry Flow Sheet
DA Form 4970-E	Medical Screening Summary – Cardiovascular Risk Screening Program
DD Form 2808	Report of Medical Examination
SF 88	Report of Medical Examination
DD Form 2807-1	Report of Medical History
SF 93	Report of Medical History
DA Form 7389	Medical Record – Anesthesia
OF 522	Medical Record – Request for Administration of Anesthesia and Performance of Operations and Other Procedures
SF 559	Medical Record – Allergen Extract Prescription New and Refill
DD Form 2482	Venom Extract Prescription
DA Form 5007A; DA Form 5007B	Medical Record – Allergy Immunotherapy Record – Single and Double Extract
	Other SF 500-series forms

TABLE 2-2 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
DD Form 741	Eye Consultation
DD Form 771	Eyewear Prescription
DD Form 2215	Reference Audiogram
DD Form 2216	Hearing Conservation Data
DA Form 4465	Patient Intake/Screening Record (PIR)
DA Form 4466	Patient Progress Report (PPR)
SF 533	Medical Record – Prenatal and Pregnancy
DD Form 2005	Privacy Act Statement – Health Care Records. This form must be included in all OTRs.

TABLE 2-3	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART I — DA FORM 8005 SERIES JACKET	
DD Form 2766	Adult Preventive and Chronic Care Flow Sheet
DD Form 2766C	Adult Preventive and Chronic Care Flow Sheet – Continuation Sheet
DD Form 2882	Pediatric and Adolescent Preventive and Chronic Care Flowsheet
	Health Enrollment/Evaluation Assessment Review (HEAR) Primary Care Managers (PCM) Report
DA Form 5571	Master Problem List. This form is obsolete; use for file purposes only if already in existence.
DD Form 2792	Exceptional Family Member Medical Summary
DD Form 2792-1	Exceptional Family Member Special Education/Early Intervention Summary
	Automated Exceptional Family Member Program Summary
	Civilian source pediatric growth charts
DD Form 2493-1	Asbestos Exposure Part I – Initial Medical Questionnaire
DD Form 2493-2	Asbestos Exposure Part II – Periodic Medical Questionnaire
SF 601	Health Record – Immunization Record
	Automated laboratory report forms.
SF 512	Clinical Record – Plotting Chart

TABLE 2-3 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART I — DA FORM 8005 SERIES JACKET — CONTINUED	
SF 545	Laboratory Report Display
SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 557	Chemistry I – III, Hematology, Urinalysis, Serology, Parasitology, Microbiology I – II, Spinal Fluid; Miscellaneous.
SF 556	Immunohematology
SF 507	Clinical Record – Report on or Continuation of SF
SF 519-B	Radiologic Consultation Request/Report
SF 519; SF 519A	Medical Record – Radiographic Report
OF 520	Clinical Record – Electrocardiographic Record
SF 524	Medical Record – Radiographic Report
SF 525	Medical Record – Radiographic Report Summary
SF 526	Medical Record – Interstitial/Intercavitary Therapy

TABLE 2-3 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART I — DA FORM 8005 SERIES JACKET — CONTINUED	
SF 541	Medical Record – Gynecologic Cytology
SF 560	Medical Record – Electroencephalogram Request and History
DD Form 2482	Venom Extract Prescription
SF 559	Medical Record – Allergen Extract Prescription New and Refill
DA Form 5007A; DA Form 5007B	Medical Record – Allergy Immunotherapy Record – Single and Double Extract
DA Form 5551-R	Spirometry Flow Sheet
DA Form 4060	Report of Optometric Examination
DD Form 741	Eye Consultation
DD Form 771	Eyewear Prescription
DD Form 2215	Reference Audiogram
DD Form 2216	Hearing Conservation Data

TABLE 2-3 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART II — DA FORM 8005 SERIES JACKET	
DA Form 4515	Personnel Reliability Program Record Identifier
DA Form 3180	Personnel Screening and Evaluation Record
DA Form 4186	Medical Recommendation for Flying Duty
	Interfile the following forms in reverse chronological order with the most recent on top.
SF 600	Medical Record – Chronological Record of Medical Care
SF 558	Medical Record – Emergency Care and Treatment (Patient)
DA Form 5181	Screening Note of Acute Medical Care
SF 513	Medical Record – Consultation Sheet
DD Form 2161	Referral for Civilian Medical Care
DD Form 2341	Report of Animal Bite – Potential Rabies Exposure
	State Ambulance Forms
DA Form 5008	Telephone Medical Advice/Consultation Record
DA Form 3824	Urologic Examination
DA Form 5568	Chronological Record of Well-Baby Care
DA Form 5694	Denver Developmental Screening Test

TABLE 2-3 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART II — DA FORM 8005 SERIES JACKET — CONTINUED	
SF 602	Medical Record – Serology Record
DA Form 3763	Community Health Nursing – Case Referral
	Home health care documentation
DA Form 5569	Isoniazid (INH) Clinic Flow Sheet
	Other SF 500-series forms
SF 527	Group Muscle Strength, Joint R.O.M. Girth and Length Measurements
SF 528	Clinical Record – Muscle and/or Nerve Evaluation
SF 529	Medical Record – Muscle Function by Nerve Distribution
DA Form 4700	Medical Record – Supplemental Medical Data
DA Form 7389	Medical Record – Anesthesia
OF 522	Medical Record – Request for Administration of Anesthesia and Performance of Operations and Other Procedures
SF 518	Medical Record – Blood or Blood Component Transfusion
DD Form 2808	Report of Medical Examination
SF 88	Report of Medical Examination

TABLE 2-3 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART II — DA FORM 8005 SERIES JACKET — CONTINUED	
DD Form 2807-1	Report of Medical History
SF 93	Report of Medical History
DA Form 4970-E	Medical Screening Summary – Cardiovascular Risk Screening Program
DA Form 4465	Patient Intake/Screening Record (PIR)
DA Form 4466	Patient Progress Report (PPR)
PART III — DA FORM 8005 SERIES JACKET	
DA Form 2631	Medical Care – Third Party Liability Notification
DA Form 3365	Authorization for Medical Warning Tag
DD Form 2569	Third Party Collection Program – Record of Other Health Insurance
DA Form 4254	Request for Private Medical Information
DA Form 4876	Request and Release of Medical Information to Communications Media
DD Form 2870	Authorization for Disclosure of Medical or Dental Information
DA Form 5006	Medical Records – Authorization for Disclosure of Information
DA Form 5303-R	Volunteer Agreement Affidavit
	Administrative documents and other correspondence including advance directives
DA Form 4410-R	Disclosure Accounting Record

TABLE 2-3 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART IV — DA FORM 8005 SERIES JACKET	
	Group copies of the following forms by hospitalization episode with most recent on top
DA Form 3647	Inpatient Treatment Record Cover Sheet or CHCS automated equivalent. File with it copies of SF 502 (if prepared), SF 515, SF 509, SF 516, and DD Form 2770 or SF 539
OF 275	Medical Record Report
SF 502	Clinical Record – Narrative Summary (outpatient)
DD Form 2770	Abbreviated Medical Record (outpatient)
SF 509	Medical Record – Progress Notes SF 509 is the final discharge note.
SF 515	Medical Record – Tissue Examination (outpatient)
SF 516	Medical Record – Operation Report (outpatient)
SF 531	Clinical Record – Anatomical Figure
SF 533	Medical Record – Prenatal and Pregnancy
DD Form 2005	Privacy Act Statement – Health Care Records. This form must be included in all OTRs

Inpatient Treatment Record and Final Disposition (Enclosure 3)

1. Inpatient treatment records:

a. Create and maintain inpatient treatment records for every admission utilizing Theater Medical Information Program Composite Health Care System Cache (TC2) to include patients classified as Carded for Record Only (CRO) due to death in the emergency room/treatment section prior to admission and those who are dead on arrival (DOA).

b. All patients admitted will be assigned the appropriate register number for each admission to include CRO cases. The register numbers are to continue consecutively, will all be accounted for, and the series are not to be interrupted. Transfer of Authority units will continue with the next available register number from the previous unit.

c. Entries will be made in a record by the healthcare provider who observes, treats, or cares for the patient and in accordance with (IAW) the locally defined patient assessment policy. All entries in the inpatient record must be legible, dated, timed, and signed by the physician responsible for the patient's care, including signatures on the Inpatient Treatment Record Cover Sheet (DA Form 3647) and the Admission and Coding Information (DA Form 2985). No healthcare practitioner is permitted to complete the documentation for a medical record on a patient unfamiliar to him or her. In unusual or extenuating circumstances (Example: Death), local policy will ensure that all means have been exhausted to complete the record. Electronic notes used in the record are to be dated, timed, and signed by the healthcare provider responsible for the patient's care.

d. The inpatient treatment records must be accurate, complete, and current. The inpatient treatment record must reflect the patient's current status and treatment. After discharge of an inpatient, the practitioner will complete the final progress note on the Medical Record Progress Notes (SF 509), Clinical Record-Narrative Summary (SF 502), and DA Form 3647.

e. Record the nature of the injury to include the who, what, when, where, why, and how an injury occurred.

f. Clearly document the patient's name, Social Security number (SSN), family member prefix (FMP), register number and Military Treatment Facility (MTF) on all medical record documents.

g. Use designated forms for medical record documentation. If a designated form is not available and another form is used in its place for recording of additional entries, change the name of the form and form number to reflect the form it is replacing.

h. Refer to AR 40-66, Medical Record Administration and Healthcare Documentation, 2008, Rapid Action Revision (RAR) issue date, 4 January 2010, chapter 3, Preparation of Medical Records and chapter 9, Inpatient Treatment Records for more detailed information.

2. Disposition of inpatient treatment records: Upon disposition of the patient, the following procedures should be performed:

a. Select the correct colored Alphabetical and Terminal Digit File for Treatment Record DA Form 3444-series jacket that represents the last two-digits of the patient's SSN. Assignment of pseudo-SSNs or artificial nine-digit numbers will be given to patients who present for care and their identity is unknown (John/Jane Doe), or if they are foreign citizens who do not possess a nine-digit identity number. The pseudo-, or artificial SSN, will be constructed for detainees using the Internment Serial Number (ISN) as the last six-digits of the SSN or the designated pseudo-SSNs for applicable patients IAW theater policy. Select the series jacket color as described below.

00 – 09	ORANGE
10 – 19	LIGHT GREEN
20 – 29	YELLOW
30 – 39	GREY
40 – 49	TAN
50 – 59	LIGHT BLUE
60 – 69	WHITE
70 – 79	BROWN
80 – 89	PINK
90 – 99	RED

b. The front of the treatment record DA Form 3444-series jacket must contain the following information:

Register #, FMP, SSN	0001234 20 234567890
Name	Doe, John M.
Sex, Date of Birth (DOB)	M 29DEC52
Service, Pat Cat, Rank	Army Active Duty A11 E9
Date of Admission	23AUG04
INPATIENT, MTF, MTF DMIS ID	INPATIENT 31 st CSH 1180

c. Mark the block labeled “Inpatient (Clinical)” on the front of the treatment record DA Form 3444-series jacket with black permanent marker or black ink.

d. Mark the last digit of the patient’s SSN on the top and the right edge of the treatment record DA Form 3444-series jacket by using one-half inch of black tape over the number that is the same as the last digit. If black tape is not available use black ink to block it out.

e. Print the patient’s last name, first name, and middle initial on the top left corner of the DA Form 3444-series jacket.

f. Enter the two-digit FMP of the patient in the two circles to the left of the hyphenated blocks on the top middle of the DA Form 3444-series jacket.

g. Enter the patient's SSN in the hyphenated blocks on the top of the DA Form 3444-series jacket.

h. Mark the block marked “S” with colored tape denoting the patient category status. If tape is not available use a colored permanent marker. See Table 3-1 for common patient category codes used.

Table 3-1			
BENEFICIARY CATEGORY DESCRIPTION	BEN CAT CODE	FMP	“S” TAPE COLOR
ACTIVE DUTY			
ARMY	A11	20	RED
NAVY	N11	20	RED
AIR FORCE	F11	20	RED
MARINES	M11	20	RED
COAST GUARD	C11	20	RED
RESERVE			
ARMY	A12	20	RED
NAVY	N12	20	RED
AIR FORCE	F12	20	RED
MARINES	M12	20	RED
COAST GUARD	C12	20	RED
NATIONAL GUARD			
ARMY	A15	20	RED
AIR FORCE	F15	20	RED
MISCELLANEOUS			
FOREIGN CIVILIAN (Host Nation)	K91	99	BLACK
FOREIGN CIVILIAN (Non-Host Nation)	K76	20	WHITE
IRAQ CIVILIAN	K91	99	BLACK
LOCAL NATIONAL	K91	99	BLACK
FOREIGN CIVILIAN DEPENDENT (Non-Host Nation)	K76	20	WHITE
IRAQ CIVILIAN DEPENDENT	K91	99	BLACK
LOCAL NATIONAL DEPENDENT	K91	99	BLACK
EPW PRISONER	K78	20	BLACK
CIVILIAN IN DETENTION	K78	20	BLACK
DoD EMPLOYEE	K53	20	BLACK
CONTRACT EMPLOYEE	K65	20	BLACK
NATO MILITARY	K72	20	WHITE
NON-NATO MILITARY	K74	20	BLACK

BLACK										BLANK RED									
DOE, John M.										0 1 2 3 4 5 6 7 8 9 R									
1 2 3 4 5 6 7 8 9 R										1 2 3 4 5 6 7 8 9 R									
ALPHABETICAL AND										0001234 20 01234567									
TERMINAL DIGIT FILE FOR										000, John M.									
TREATMENT RECORD										M 230EG52									
For use of this form, see AR 40-68: the proponent agency is OTRG										Army Active Duty A11 E9									
NOTE TO PHYSICIAN:										23AUG04									
<input type="checkbox"/> Medical Condition (<i>Medical Warning Tag</i>)										INPATIENT 31st CSH 1180									
<input type="checkbox"/> Personnel Reliability Program (<i>Screening</i>)										PATIENT IDENTIFICATION									
<input type="checkbox"/> Radiation Screening Program										0									
<input type="checkbox"/> Flight Status										1									
<input type="checkbox"/> Medical Registries										2									
<input type="checkbox"/> Blood Type										3									
TYPE OF RECORD:										4									
<input type="checkbox"/> Inpatient (<i>Clinical</i>)										5									
<input type="checkbox"/> Outpatient Treatment										6									
<input type="checkbox"/> Health										7									
<input type="checkbox"/> Health - Dental										8									
<input type="checkbox"/> Dental (<i>Non-Military</i>)										9									
<input type="checkbox"/> ADAOCP OMR										R									
<input type="checkbox"/> Civilian Employee Medical Record										0									
IF FOUND RETURN TO:										1									
ANY U.S. POST OFFICE										2									
POSTMASTER - FORWARD TO:										3									
Department of the Army										4									
Office of the Surgeon General										5									
Washington, D.C. 20310-3017										6									
EXAMPLE										7									
DA FORM 3444-6, MAY 91										8									
EDITION OF 1 JAN 79 WILL BE USED UNTIL EXHAUSTED										9									
0										R									
1										0									
2										1									
3										2									
4										3									
5										4									
6										5									
7										6									
8										7									
9										8									
R										9									
0										R									
1										0									
2										1									
3										2									
4										3									
5										4									
6										5									
7										6									
8										7									
9										8									
R										9									
0										R									
1										0									
2										1									
3										2									
4										3									
5										4									
6										5									
7										6									
8										7									
9										8									
R										9									
0										R									
1										0									

j. Records must be checked for quality assurance (Example: Provider signatures and dates on all entries, proper forms used, DA Form 2985 and DA Form 3647 completed with final patient diagnoses and procedures performed, etc).

k. Record assembly of the record must be accomplished upon discharge or transfer of a patient. All forms should be filed in an upright position on both sides of the treatment record DA Form 3444-series jacket and from top to bottom. Tape only the edges of the lab slips when attaching to lab form. For the commonly used forms and documents for the treatment record DA Form 3444-series jacket see Table 3-2. Reference AR 40-66, Medical Record Administration and Healthcare Documentation, 17 June 2008, Rapid Action Revision (RAR) issue date, 4 January 2010, figure 9-1 for additional inpatient treatment record forms and documents not found on listing below.

TABLE 3-2	
INPATIENT TREATMENT RECORD ASSEMBLY (COMMONLY USED FORMS AND DOCUMENTS)	
DA FORM 3444 SERIES JACKET	
LEFT SIDE — DA FORM 3444 SERIES JACKET	
FORM	DESCRIPTION
DA Form 5571	Master Problem List. This form is obsolete; use for file purposes only if already in existence.
DA Form 3947	Medical Evaluation Board
DA Form 3349	Physical Profile
DA Form 3894	Hospital Report of Death
DHS 159	Death Certificate
DA Form 2984	Very Seriously Ill
DD Form 689	Individual Sick Slip
RIGHT SIDE — DA FORM 3444 SERIES JACKET	
DA Form 3647	Inpatient Treatment Record Cover Sheet
SF 502	Clinical Record – Narrative Summary
DD Form 2770	Abbreviated Medical Record
SF 504	Clinical Record – History Part I
SF 505	Clinical Record – History Part II, III
SF 506	Clinical Record – Physical Examination

TABLE 3-2 — CONTINUED	
INPATIENT TREATMENT RECORD ASSEMBLY (COMMONLY USED FORMS AND DOCUMENTS)	
DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 509	Medical Record – Progress Notes
SF 558	Medical Record – Emergency Care and Treatment
SF 513	Medical Record – Consultation Sheet
DA Form 3888	Medical Record – Nursing History and Assessment
DA Form 3888-2	Medical Record – Nursing Care Plan
DA Form 3888-3	Medical Record – Nursing Discharge Summary
SF 510	Clinical Record – Nursing Notes
DA Form 5179	Medical Record – Preoperative/Postoperative Nursing Document
DA Form 5179-1	Medical Record – Intraoperative Document
DA Form 3950	Flowsheet for Vital Signs and Other Parameters
SF 511	Medical Record – Vital Signs Record
SF 512	Clinical Record – Plotting Chart
SF 545	Laboratory Report Display

TABLE 3-2 — CONTINUED	
INPATIENT TREATMENT RECORD ASSEMBLY (COMMONLY USED FORMS AND DOCUMENTS)	
DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 557	Chemistry I – III, Hematology, Urinalysis, Serology, Parasitology, Microbiology I – II, Spinal Fluid; Miscellaneous
SF 515	Medical Record – Tissue Examination
SF 516	Medical Record – Operation Report
DA Form 7389	Medical Record – Anesthesia
SF 518	Medical Record – Blood Component Transfusion
SF 519-B	Radiologic Consultation Request/Report
SF 520	Clinical Record – Electrocardiographic Record – report with tracings
OF 522	Medical Record – Request for Administration of Anesthesia and Performance of Operation
SF 527	Group Muscle Strength, Joint R.O.M Girth and Length Measurements
SF 528	Clinical Record – Muscle/Nerve Evaluation

TABLE 3-2 — CONTINUED	
INPATIENT TREATMENT RECORD ASSEMBLY (COMMONLY USED FORMS AND DOCUMENTS)	
DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 530	Medical Record – Neurological Examination
SF 560	Medical Record – Electroencephalogram Request and History
DA Form 3824	Urologic Examination
DA Form 4221	Diabetic Record
DA Form 4256	Doctor's Orders
DA Form 4677	Clinical Record – Therapeutic Documentation Care Plan (non-medication)
DA Form 4678	Clinical Record – Therapeutic Documentation Care Plan (medication)
DA Form 4700	Medical Record – Supplemental Medical Data
DD Form 602	Patient Evacuation Tag (staple to SF 502)
DA Form 4359	Authorization for Psychiatric Service Treatment
DA Form 2985	Admission and Coding Information

3. Retirement of inpatient treatment records:

a. Records are to be sorted and boxed individually by patient category with all active duty military first, detainee records second, and all others third. Do not mix the patient category records listed within a box. Records are to be filed in terminal digit order by each patient category within the box.

b. Forward an electronic list of all records in each box to Patient Administration Systems and Biostatistics Activity (PASBA). Place a paper inventory list in the front of each box. The electronic inventory list is to include column titles for DMISID/MTF, Box Number, Register Number, Patient Name, SSN, Patient Category, and Disease or Injury status. Each row is to contain patient information for each record in the box.

c. The original inpatient treatment records will be retired by PASBA IAW AR 25-400-2, The Army Records Information Management System (ARIMS) and the Medical Registry System.

d. Inpatient treatment records will be mailed to PASBA quarterly and will be mailed to the following address by traceable mail.

DIRECTOR PASBA ATTN MCHS ISD
1216 STANLEY RD STE 25 BLDG 126
FT SAM HOUSTON TX 78234-5053

e. The PASBA will be responsible for retirement and final disposition of inpatient treatment records.

(1) The inpatient treatment records will be forwarded to the appropriate retirement facility or appropriate theater record storage facility.

(2) Retirement of inpatient treatment medical records not identified as a detainee record will be retired by accessing the Medical Registry System, awaiting an accession number and shipping records to the following record holding facility.

NATIONAL PERSONNEL RECORD CENTER ANNEX
1411 BOULDER DRIVE
ROCK CITY INDUSTRIAL CENTER
VALMEYER IL 62295

Detainee Inpatient and Outpatient Treatment Records and Final Disposition (Enclosure 4)

1. Detainee inpatient treatment records:

a. Specific medical care guidance for providers is available in the HQ, US Army MEDCOM, DASG-ZH, subject: Interim Guidance on Detainee Medical Care, 24 May 2005.

b. Inpatient records will be created on all detainees admitted to Army MTFs, to include patients classified as Carded for Record Only (CRO) (due to death in the emergency room/treatment section prior to admission and those who are dead on arrival (DOA)).

c. The Level-III treatment facilities will follow the same procedures specified in AR 40-66, Medical Record Administration and Healthcare Documentation, regarding record storage, maintenance, and management.

d. Providers will document entries into detainee medical records with the same standard as US forces and maintained according to the provisions of AR 40-66 and AR 190-8, Enemy Prisoner of War, Retained Personnel, Civilian Internees and Other Detainees. A medical record in AHLTA or AHLTA-Theater (AHLTA-T) will be developed and used where it is available.

e. All patients admitted will be assigned the appropriate register number for each admission to include CRO cases. The register numbers are to continue consecutively, will all be accounted for, and the series are not to be interrupted.

f. Entries will be made in a record by the healthcare provider who observes, treats, or cares for the patient and IAW the locally defined patient assessment policy. All entries in the inpatient record must be legible, dated, timed, and signed by the physician responsible for the patient's care, including signatures on Inpatient Treatment Record Cover Sheet (DA Form 3647) and the Admission and Coding Information (DA 2985). No healthcare practitioner is permitted to complete the documentation for a medical record on a patient unfamiliar to him or her. In unusual or extenuating circumstances (Example: Death), local policy will ensure that all means have been exhausted to complete the record. Electronic notes used in the record are to be dated, timed, and signed by the healthcare provider responsible for the patient's care.

g. The inpatient treatment records must be accurate, complete, and current. The inpatient treatment record must reflect the patient's current status and treatment. After discharge of a patient, the practitioner will complete the final progress note on Medical Record-Progress Note, SF 509, Clinical Record-Narrative Summary, SF 502, and DA Form 3647.

h. Record the nature of the injury to include: Who, what, when, where, why, and how an injury occurred.

i. Clearly document the patient's name, SSN, FMP, register number, and MTF on all medical record documents.

j. Use designated forms for medical record documentation. If a designated form is not available and another form is used in its place for recording of additional entries, change the name of the form and form number to reflect the form it is replacing.

k. Refer to AR 40-66, Medical Record Administration and Healthcare Documentation, 17 June 2008, Rapid Action Revision (RAR) issue date, 4 January 2010, chapter 3, Preparation of Medical Records and chapter 9, Inpatient Treatment Records for more detailed information.

l. The original inpatient medical record remains the property of the US Government, but detainees are entitled to copies of their medical records upon release. Local theater policy will determine the specific procedures for records or documentation requests from released detainees.

m. Assignment of Patient Identification Numbers to Task Force Medical (TF MED) Operations:

(1) All detained personnel are processed through the Camp Cropper detention facility and assigned a 13-digit Internment Serial Number (ISN) as soon as possible after coming under DoD control. The six-digit sequence numbers embedded in the 13-digit ISN will support the pseudo-Detainee Identification Number. Once assigned, detainees are referred to by ISN only for all outpatient encounters and inpatient admissions.

(2) Standards for issuing detention facilities pseudo-SSNs for non-US and non-detainee patients for inpatient and outpatient care.

(3) The MTF will assign non-US and non-detainee patients a pseudo-SSN starting with the following assigned prefix for their MTF when entering data into medical data system. For example, 600-00-1234.

60X-00-XXXX	CSH	CROPPER
-------------	-----	---------

(4) Level-II + and Level-III MTFs register non-US and non-detainee patients using the designated pseudo-SSNs for applicable patients IAW theater policy.

(5) Issue pseudo-SSNs in chronological order.

(6) The fourth and fifth digits remain as (00) to ensure that the pseudo-SSN does not match a US patient's SSN. The third digit number of the pseudo-SSN advances to the next subsequent number when the MTF uses (9999), as the last four digits. (Example: Once 200-00-9999 is used the next number issued would be 201-00-0001.

(7) Track all pseudo-SSNs in a log book for future reference.

n. Standards for issuing detainees identification numbers.

(1) Once a detainee has been issued an ISN, that number is the only number used to reference a detainee. In order to facilitate the use of the medical automation system that requires a nine-digit number, detainees are issued a pseudo-SSN with (900) as the first three digits and then the six digit sequence from the ISN.

(2) A detainee with an ISN of US91Z-123456CI becomes 900-12-3456 in the medical automation systems. This number is the only number used by all MTF(s) to document care for that particular detainee. If the detainee is transferred to a different MTF, use the same ISN/pseudo-Detainee Identification Number.

(3) Do not assign patients a (900) prefix until they have been assigned an ISN, from the detention MTF, even if they are a suspected insurgent/detainee.

(4) Detention MTF changes the pseudo-SSN assigned by the previous MTF to the (900) pseudo-SSN and links the old pseudo-SSN to the new ISN-driven pseudo, once the patient is classified as a detainee.

Update all hard copy medical documentation with the new Detainee Identification Number.

(5) Detainees will be identified by the 900 prefixes, name and ISN. (Example: NAME = Detainee, ISN 311234 and PSSN = 900-31-1234).

(6) Track all pseudo-SSNs in a logbook for future reference.

2. Disposition detainee inpatient treatment records:

a. Upon disposition of the detainee, the following procedures should be performed:

(1) Select the correct colored Alphabetical and Terminal Digit File for Treatment Record DA Form 3444-series jacket that represents the last two-digits of the patient's SSN or pseudo-SSN. Select the series jacket color as described below.

00 – 09	ORANGE
10 – 19	LIGHT GREEN
20 – 29	YELLOW
30 – 39	GREY
40 – 49	TAN
50 – 59	LIGHT BLUE
60 – 69	WHITE
70 – 79	BROWN
80 – 89	PINK
90 – 99	RED

(2) The front of the treatment record DA Form 3444-series jacket must contain the following information:

Register #, FMP, SSN

Name

Sex, date of birth

Service, Pat Cat, Rank

Date of Admission

INPATIENT, MTF, MTF DMIS ID

0001234 20 234567890

Doe, John M.

M 29DEC52

Army Active Duty A11 E9

23AUG04

INPATIENT 31st CSH 1180

(3) Mark the block labeled “Inpatient (Clinical)” on the front of the treatment record DA Form 3444-series jacket with black permanent marker or black ink.

(4) Mark the last digit of the patient’s SSN on the top and the right edge of the treatment record DA Form 3444-series jacket by using one-half inch of black tape over the number that is the same as the last digit. If black tape is not available use black ink to block it out.

(5) Print the patient’s last name, first name, and middle initial on the top left corner of the DA Form 3444-series jacket.

(6) Enter the two-digit FMP of the patient in the two circles to the left of the hyphenated blocks on the top middle of the DA Form 3444-series jacket.

(7) Enter the patient's SSN in the hyphenated blocks on the top of the DA Form 3444-series jacket.

(8) Mark the block marked “S” with colored tape denoting the patient category status. If tape is not available use a colored permanent marker. See Table 4-1 for common patient category codes used.

Table 4-1			
BENEFICIARY CATEGORY DESCRIPTION	BEN CAT CODE	FMP	“S” TAPE COLOR
ACTIVE DUTY			
ARMY	A11	20	RED
NAVY	N11	20	RED
AIR FORCE	F11	20	RED
MARINES	M11	20	RED
COAST GUARD	C11	20	RED
RESERVE			
ARMY	A12	20	RED
NAVY	N12	20	RED
AIR FORCE	F12	20	RED
MARINES	M12	20	RED
COAST GUARD	C12	20	RED
NATIONAL GUARD			
ARMY	A15	20	RED
AIR FORCE	F15	20	RED
MISCELLANEOUS			
FOREIGN CIVILIAN (Host Nation Civilian)	K91	99	BLACK
FOREIGN CIVILIAN (Non-Host Nation)	K76	20	WHITE
IRAQ CIVILIAN	K91	99	BLACK
LOCAL NATIONAL	K91	99	BLACK
FOREIGN CIVILIAN DEPENDENT (Non-Host Nation)	K76	20	WHITE
IRAQ CIVILIAN DEPENDENT	K91	99	BLACK
LOCAL NATIONAL DEPENDENT	K91	99	BLACK
EPW PRISONER	K78	20	BLACK
CIVILIAN IN DETENTION	K78	20	BLACK
DoD EMPLOYEE	K53	20	BLACK
CONTRACT EMPLOYEE	K65	20	BLACK
NATO MILITARY	K72	20	WHITE
NON-NATO MILITARY	K74	20	BLACK

(9) Retirement year tape of record is no longer required IAW AR 40-66. See example of prepared inpatient treatment record DA Form 3444-series jacket below.

DOE, John M. 0 1 2 3 4 5 6 7 8 9 R 5 6 6 7

ALPHABETICAL AND
TERMINAL DIGIT FILE FOR

TREATMENT RECORD

For use of this form, see AR 40-66; the proponent agency is OTSC.

NOTE TO PHYSICIAN:

☐ Medical Condition (Medical Warning Tag)

☐ Personnel Reliability Program (Screening)

☐ Radiation Screening Program

☐ Flight Status

☐ Medical Registries

☐ Blood Type

TYPE OF RECORD:

☒ Inpatient (Clinical)

☐ Outpatient Treatment

☐ Health

☐ Health - Dental

☐ Dental (Non-Military)

☐ ADAOCP OMR

☐ Civilian Employee Medical Record

0001234 20 012345667
Doe, John M.
M 29DEC52
Army Active Duty A11 E9
23AUG04
INPATIENT 31st CSH 4480

PATIENT IDENTIFICATION

0
1
2
3
4
5
6
7
8
9
R
Blank
Red

IF FOUND RETURN TO:
ANY U.S. POST OFFICE

POSTMASTER - FORWARD TO:
Department of the Army
Office of the Surgeon General
Washington, D.C. 20310-3017

EXAMPLE

DA FORM 3444-6, MAY 91

EDITION OF 1 JAN 79 WILL BE USED UNTIL EXHAUSTED

(10) Inpatient treatment records must be checked for quality assurance (Example: Provider signatures and dates on all entries, proper forms used, Inpatient Treatment Record Cover Sheet (DA Form 3647) and the Admission and Coding Information (DA Form 2985) completed with final patient diagnoses and procedures performed, etc).

(11) Record assembly of the inpatient treatment record must be accomplished upon discharge or transfer of a patient. All forms should be filed in an upright position on both sides of the treatment record DA Form 3444-series jacket and from top to bottom. Tape only the edges of the lab slips when attaching to lab forms. For the commonly used forms and documents for the treatment record DA Form 3444-series jacket see Table 4-2. Reference AR 40-66, Medical Record Administration and Healthcare Documentation, 17 June 2008, Rapid Action Revision (RAR) issue date, 4 January 2010, figure 9-1 for additional inpatient treatment records forms and documents not found on listing below.

TABLE 4-2	
INPATIENT TREATMENT RECORD ASSEMBLY (COMMONLY USED FORMS AND DOCUMENTS)	
DA FORM 3444 SERIES JACKET	
LEFT SIDE — DA FORM 3444 SERIES JACKET	
FORM	DESCRIPTION
DA Form 5571	Master Problem List. This form is obsolete; use for file purposes only if already in existence.
DA Form 3947	Medical Evaluation Board
DA Form 3349	Physical Profile
DA Form 3894	Hospital Report of Death
DHS 159	Death Certificate
DA Form 2984	Very Seriously Ill
DD Form 689	Individual Sick Slip
RIGHT SIDE — DA FORM 3444 SERIES JACKET	
DA Form 3647	Inpatient Treatment Record Cover Sheet
SF 502	Clinical Record – Narrative Summary
DD Form 2770	Abbreviated Medical Record
SF 504	Clinical Record – History Part I
SF 505	Clinical Record – History Part II, III
SF 506	Clinical Record – Physical Examination

TABLE 4-2 — CONTINUED	
INPATIENT TREATMENT RECORD ASSEMBLY (COMMONLY USED FORMS AND DOCUMENTS)	
DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 509	Medical Record – Progress Notes
SF 558	Medical Record – Emergency Care and Treatment
SF 513	Medical Record – Consultation Sheet
DA Form 3888	Medical Record – Nursing History and Assessment
DA Form 3888-2	Medical Record – Nursing Care Plan
DA Form 3888-3	Medical Record – Nursing Discharge Summary
SF 510	Clinical Record – Nursing Notes
DA Form 5179	Medical Record – Preoperative/Postoperative Nursing Document
DA Form 5179-1	Medical Record – Intraoperative Document
DA Form 3950	Flowsheet for Vital Signs and other Parameters
SF 511	Medical Record – Vital Signs Record
SF 512	Clinical Record – Plotting Chart
SF 545	Laboratory Report Display

TABLE 4-2 — CONTINUED	
INPATIENT TREATMENT RECORD ASSEMBLY (COMMONLY USED FORMS AND DOCUMENTS)	
DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 557	Chemistry I – III, Hematology, Urinalysis, Serology, Parasitology, Microbiology I – II, Spinal Fluid; Miscellaneous
SF 515	Medical Record – Tissue Examination
SF 516	Medical Record – Operation Report
DA Form 7389	Medical Record – Anesthesia
SF 518	Medical Record – Blood Component Transfusion
SF 519-B	Radiologic Consultation Request/Report
SF 520	Clinical Record – Electrocardiographic Record – report with tracings
OF 522	Medical Record – Request for Administration of Anesthesia and Performance of Operation
SF 527	Group Muscle Strength, Joint R.O.M Girth and Length Measurements
SF 528	Clinical Record – Muscle/Nerve Evaluation

TABLE 4-2 — CONTINUED	
INPATIENT TREATMENT RECORD ASSEMBLY (COMMONLY USED FORMS AND DOCUMENTS)	
DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 530	Medical Record – Neurological Examination
SF 560	Medical Record – Electroencephalogram Request and History
DA Form 3824	Urologic Examination
DA Form 4221	Diabetic Record
DA Form 4256	Doctor's Orders
DA Form 4677	Clinical Record – Therapeutic Documentation Care Plan (non-medication)
DA Form 4678	Clinical Record – Therapeutic Documentation Care Plan (medication)
DA Form 4700	Medical Record – Supplemental Medical Data
DD Form 602	Patient Evacuation Tag (staple to SF 502)
DA Form 4359	Authorization for Psychiatric Service Treatment
DA Form 2985	Admission and Coding Information

3. Inpatient treatment records generated at detainee treatment facilities will be mailed to the Patient Administration Systems and Biostatistics Activity (PASBA) every 6 months by traceable mail.

a. Records are to be sorted and boxed individually by patient category with all active duty military first, detainee records second, and all others third. Do not mix the patient category records listed within a box. Records are to be filed in terminal digit order by each patient category within the box.

b. Forward an electronic list of all records in each box to PASBA. Place a paper inventory list in the front of each box. The electronic inventory list is to include column titles for DMISID/MTF, Box Number, Register Number, Patient Name, SSN, Patient Category, and Disease or Injury status. Each row is to contain patient information for each record in the box.

c. The original inpatient treatment records will be retired by PASBA IAW AR 25-400-2, The Army Records Information Management System (ARIMS) and the Medical Registry System.

d. Detainee inpatient treatment records will be mailed to PASBA every six months and will be mailed to the following address by traceable mail.

DIRECTOR PASBA ATTN MCHS ISD
1216 STANLEY RD STE 25 BLDG 126
FT SAM HOUSTON TX 78234-5053

e. The PASBA will be responsible for retirement and final disposition of detainee inpatient medical records to the following holding facility below:

DEPARTMENT OF THE ARMY
ATTN SUSAN SCHAECHER
1 ROCK ISLAND ARSENAL
ROCK ISLAND, ILLINOIS 61299-5000

f. In the event a released detainee is recaptured and returned to a Theater Internment Facility (TIF), the servicing treatment facility should request return of the detainee's record from the in theater storage facility (IAW ST 4-02.46, Medical Support to Detainee Operations, November 2007, paragraph 3-74).

g. All retired detainee records will be retained in theater after they have been processed IAW ST 4-02.46, Medical Support to Detainee Operations, November 2007, paragraph 3-74 until an end of conflict is declared. At that time the records will be forwarded to the Office of the Provost Marshal General, National Detainee Reporting Center, ATTN: DAPM-MPD-ND, 2800 Army Pentagon, Washington, DC 20310-2800. Final disposition of the consolidated detainee records will occur when the National Detainee Reporting Center archives the records with the National Archives and Records Administration IAW AR 25-400-2. The records will be forwarded to the appropriate retirement facility or appropriate theater record storage facility.

h. The PASBA is responsible for retirement of inpatient treatment medical records not identified as a detainee record by accessing the Medical Registry System, awaiting an accession number and shipping records to the following record holding facility.

NATIONAL PERSONNEL RECORD CENTER ANNEX
1411 BOULDER DRIVE
ROCK CITY INDUSTRIAL CENTER
VALMEYER IL 62295

4. Detainee outpatient treatment records:

a. Specific medical care guidance for providers is available in the HQ, US Army Medical Command (MEDCOM), DASG-ZH, subject: Interim Guidance on Detainee Medical Care, 24 May 2005.

b. Detainees transferred from Level-I and Level-II treatment facilities must have all original medical documentation.

c. The Level-II and Level-III treatment facilities providing outpatient services to detainees will establish and document entries into detainee medical records to the same standard as US forces.

d. Detention facilities with organic outpatient treatment capability will maintain outpatient records on every patient treated. Specialty consultation support provided by a Level-III treatment facility must be documented and the original documentation forwarded to the detention facility's medical officer (or Level-II treatment facility).

e. At the time of transition of the Level-II or Level-III treatment facilities providing direct healthcare support at the detention facility, the original outpatient records and Extended Ambulatory Record must be transferred to the replacing unit for continued care of detainees remaining in detention.

f. Entries will be made in the inpatient treatment record by the healthcare provider who observes, treats or cares for the patient and IAW the locally defined patient assessment policy. All entries must be legible, dated, timed, and signed by the physician responsible for the patient's care. No healthcare practitioner is permitted to complete the documentation for a medical record on a patient unfamiliar to him or her. In unusual or extenuating circumstances (Example: Death), local policy will ensure that all means have been exhausted to complete the record.

g. The patient identification section on the Alphabetical and Terminal Digit File for Treatment Record DA Form 3444-series jacket or Outpatient Medical Record (OMR) DA Form 8005-series jackets must include the patient's name, family member prefix (FMP), sponsor's Social Security number (SSN), patient category, date of birth (DOB), and DMIS ID code for Medical Treatment Facility (MTF) that maintains records.

h. All Level-III detention facilities will ensure that all detainee outpatient treatment documentation is maintained in a treatment record DA Form 3444-series jacket or DA Form 8005-series jacket. On these series jackets check the "Outpatient Treatment" box.

i. Assignment of Patient Identification Numbers to Task Force Medical (TF MED) Operations:

(1) All detained personnel are processed through the Camp Cropper detention facility and assigned a 13-digit Internment Serial Number (ISN) as soon as possible after coming under DoD control. The six-digit sequence numbers embedded in the 13-digit ISN will support the pseudo-Detainee Identification Number. Once assigned, detainees are referred to by an ISN only for all outpatient encounters and inpatient admissions.

(2) Standards for issuing detention facilities pseudo-SSNs for non-US and non-detainee patients for inpatient and outpatient care.

(3) The MTF will assign non-US and non-detainee patients a pseudo-SSN starting with the following assigned prefix for their MTF when entering data into the medical data systems. For example, 600-00-1234.

60X-00-XXXX	CSH	(CROPPER)
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(4) Level-II+ and Level-III MTFs register non-US and non-detainee patients using the designated pseudo-SSNs for applicable patients IAW theater policy.

(5) Issue pseudo-SSNs in chronological order.

(6) The fourth and fifth digits remain as (00) to ensure that the pseudo-SSN does not match a US patient's SSN. The third digit number of the pseudo-SSN advances to the next subsequent number when the MTF uses (9999), as the last four digits. (Example: Once 200-00-9999 is used the next number issued would be 201-00-0001).

(7) Track all pseudo-SSNs in a logbook for future reference.

j. Standards for issuing detainees identification numbers.

(1) Once a detainee has been issued an ISN, that number is the only number used to reference a detainee. In order to facilitate the use of a medical automation system that requires a nine-digit number, detainees are issued a pseudo-SSN with (900) as the first three-digits and then the six-digit sequence from the ISN.

(2) A detainee with an ISN of US91Z-123456CI becomes 900-12-3456 in medical automation systems. This number is the only number used by all MTF(s) to document care for that particular detainee. If the detainee is transferred to a different MTF, use the same ISN/pseudo-Detainee Identification Number.

(3) Do not assign patients a (900) prefix until they have been assigned an ISN from the detention MTF, even if they are a suspected insurgent/detainee.

(4) Detention MTF changes the pseudo-SSN assigned by the previous MTF to the (900) pseudo-SSN and links the old pseudo-SSN to the new ISN-driven pseudo, once the patient is classified as a detainee.

Update all hard copy medical documentation with the new Detainee Identification Number.

(5) Detainees will be identified by the 900 prefixes, name and ISN. (Example: NAME = Detainee, ISN 311234 and PSSN = 900-31-1234).

(6) Track all pseudo-SSNs in a logbook for future reference.

5. Disposition of detainee outpatient treatment records (OTRs) or Documentation:

a. Upon release from detention, a copy of the outpatient record should be provided to the detainee upon request. Local theater policy will govern the mechanism in which copies are provided to detainees released.

b. If OTRs are used prepare the DA Form 3444-series jacket or the DA Form 8005-series jacket with the following procedures.

(1) Select the correct colored Alphabetical and Terminal Digit File for Treatment Record DA Form 3444-series jacket that represents the last two digits of the patient's SSN or pseudo-SSN. Select the series jacket color as described below.

00 – 09	ORANGE
10 – 19	LIGHT GREEN
20 – 29	YELLOW
30 – 39	GREY
40 – 49	TAN
50 – 59	LIGHT BLUE
60 – 69	WHITE
70 – 79	BROWN
80 – 89	PINK
90 – 99	RED

(2) The front of the DA Form 3444-series jacket must contain the following information:

Register #, FMP, SSN	0001234 20 234567890
Name	Doe, John M.
Sex, Date of Birth	M 29DEC52
Service, Pat Cat, Rank	Army Active Duty A11 E9
Date of Admission	23AUG04
OUTPATIENT, MTF, MTF DMIS ID	OUTPATIENT 31 st CSH 1180

(3) Mark the block labeled “Outpatient Treatment” on the front of the DA Form 3444-series jacket with black permanent marker or black ink.

(4) Mark the last digit of the patient’s SSN on the top and the right edge of the treatment record DA Form 3444-series jacket by using one-half inch of black tape over the number that is the same as the last digit. If black tape is not available use black ink to block it out.

(5) Print the patient’s last name, first name, and middle initial on the top left corner of the DA Form 3444-series jacket.

(6) Enter the two-digit FMP of the patient in the two circles to the left of the hyphenated blocks on the top middle of the DA Form 3444-series jacket.

(7) Enter the patient's SSN in the hyphenated blocks on the top of the DA Form 3444-series jacket.

(8) Mark the block marked “S” with colored tape denoting the patient category status. If tape is not available use a colored permanent marker. See Table 4-3 for common patient category codes used.

Table 4-3			
BENEFICIARY CATEGORY DESCRIPTION	BEN CAT CODE	FMP	“S” TAPE COLOR
ACTIVE DUTY			
ARMY	A11	20	RED
NAVY	N11	20	RED
AIR FORCE	F11	20	RED
MARINES	M11	20	RED
COAST GUARD	C11	20	RED
RESERVE			
ARMY	A12	20	RED
NAVY	N12	20	RED
AIR FORCE	F12	20	RED
MARINES	M12	20	RED
COAST GUARD	C12	20	RED
NATIONAL GUARD			
ARMY	A15	20	RED
AIR FORCE	F15	20	RED
MISCELLANEOUS			
FOREIGN CIVILIAN (Host Nation)	K91	99	BLACK
FOREIGN CIVILIAN (Non-Host Nation)	K76	20	WHITE
IRAQ CIVILIAN	K91	99	BLACK
LOCAL NATIONAL	K91	99	BLACK
FOREIGN CIVILIAN DEPENDENT (Non-Host Nation)	K76	20	WHITE
IRAQ CIVILIAN DEPENDENT	K91	99	BLACK
LOCAL NATIONAL DEPENDENT	K91	99	BLACK
EPW PRISONER	K78	20	BLACK
CIVILIAN IN DETENTION	K78	20	BLACK
DoD EMPLOYEE	K53	20	BLACK
CONTRACT EMPLOYEE	K65	20	BLACK
NATO MILITARY	K72	20	WHITE
NON-NATO MILITARY	K74	20	BLACK

(9) Retirement year tape of record is no longer required IAW AR 40-66. See example of prepared inpatient treatment record DA Form 3444-series jacket below.

DOE, John M.		0	1	2	3	4	5	6	7	8	9	R	0001234 20 01234567 Doe, John M. M 23DEC52 Army Active Duty A11 E9 23AUG04 INPATIENT 31 st CSH 1180	
ALPHABETICAL AND TERMINAL DIGIT FILE FOR												0		
TREATMENT RECORD												1		
NOTE TO PHYSICIAN:												2		
<input type="checkbox"/>	Medical Condition (Medical Warning Tag)											3		
<input type="checkbox"/>	Personnel Reliability Program (Screening)											4		
<input type="checkbox"/>	Radiation Screening Program											5		
<input type="checkbox"/>	Flight Status											6		
<input type="checkbox"/>	Medical Registries											7		
—	Blood Type											8		
TYPE OF RECORD:												9		
<input type="checkbox"/>	Inpatient (Clinical)											R		
<input checked="" type="checkbox"/>	Outpatient Treatment											0		
<input type="checkbox"/>	Health											1		
<input type="checkbox"/>	Health - Dental											2		
<input type="checkbox"/>	Dental (Non-Military)											3		
<input type="checkbox"/>	ADAOCP OMR											4		
<input type="checkbox"/>	Civilian Employee Medical Record											5		
IF FOUND RETURN TO: ANY U.S. POST OFFICE												6		
POSTMASTER - FORWARD TO: Department of the Army Office of the Surgeon General Washington, D.C. 20316-3017												7		
EXAMPLE												8		
DA FORM 3444-6, MAY 91												9		
EDITION OF 1 JAN 79 WILL BE USED UNTIL EXHAUSTED												R		
												0		
												1		
												2		
												3		
												4		
												5		
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TABLE 4-4	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
LEFT SIDE — DA FORM 3444 SERIES JACKET	
FORM	DESCRIPTION
DD Form 2766	Adult Preventive and Chronic Care Flow Sheet
DD Form 2766C	Adult Preventive and Chronic Care Flow Sheet – Continuation Sheet
DA Form 3180	Personnel Screening and Evaluation Record
DA Form 4186	Medical Recommendation for Flying Duty
	Health Enrollment/Evaluation Assessment Review (HEAR) Primary Care Managers (PCM) Report
DD Form 2882	Pediatric and Adolescent Preventive and Chronic Care Flowsheet
DA Form 5571	Master Problem List. This form is obsolete; use for file purposes only if already in existence.
DD Form 2792-1	Exceptional Family Member Special Education/Early Intervention Summary
	Automated Exceptional Family Member Program Summary
	Civilian source pediatric growth charts
SF 601	Health Record – Immunization Record
	Automated laboratory report forms
SF 512	Clinical Record – Plotting Chart
SF 545	Laboratory Report Display

TABLE 4-4— CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
LEFT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 557	Chemistry I – III, Hematology, Urinalysis, Serology, Parasitology, Microbiology I – II, Spinal Fluid; Miscellaneous
SF 556	Immunohematology
SF 507	Clinical Record – Report on or Continuation of SF
SF 519-B	Radiologic Consultation Request/Report
SF 519; SF 519A	Medical Record – Radiographic Report
OF 520	Clinical Record – Electrocardiographic Record
SF 560	Medical Record – Electroencephalogram Request and History
DA Form 2631	Medical Care – Third Party Liability Notification
DA Form 3647	Inpatient Treatment Record Cover Sheet or CHCS automated equivalent. File with it copies of SF 502 (if prepared), SF 515, SF 509, SF 516, and DD Form 2770 or SF 539
OF 275	Medical Record Report

TABLE 4-4 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
LEFT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
DD Form 2770	Abbreviated Medical Record (outpatient)
DA Form 4254	Request for Private Medical Information
DA Form 4876	Request and Release of Medical Information to Communications Media
DD Form 2870	Authorization for Disclosure of Medical or Dental Information
DA Form 5006	Medical Record – Authorization for Disclosure of Information
DA Form 5303R	Volunteer Agreement Affidavit
DA Form 3365	Authorization for Medical Warning Tag
DD Form 2569	Third Party Collection Program – Record of Other Health Insurance
	Administrative documents and other correspondence including advance directives
DA Form 4410-R	Disclosure Accounting Record
RIGHT SIDE — DA FORM 3444 SERIES JACKET	
FORM	DESCRIPTION
DA Form 4515	Personnel Reliability Program Record Identifier
	Interfile the following forms in reverse chronological order with the most recent on top.
SF 600	Medical Record Chronological Record of Medical Care

TABLE 4-4 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 558	Medical Record – Emergency Care and Treatment (Patient)
DA Form 5181	Screening Note of Acute Medical Care
SF 513	Medical Record – Consultation Sheet
DD Form 2161	Referral for Civilian Medical Care
DD Form 2341	Report of Animal Bite – Potential Rabies Exposure
	State Ambulance Forms
DA Form 5008	Telephone Medical Advice/Consultation Record
DA Form 3824	Urologic Examination
DD Form 2493-1	Asbestos Exposure Part I – Initial Medical Questionnaire
DD Form 2493-2	Asbestos Exposure Part II – Periodic Medical Questionnaire
DA Form 5568	Chronological Record of Well-Baby Care
DA Form 5694	Denver Developmental Screening Test
DA Form 3763	Community Health Nursing – Case Referral
	Home health care documentation
DA Form 5569	Isoniazid (INH) Clinic Flow Sheet

TABLE 4-4 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
SF 602	Medical Record – Serology Record
DA Form 4700	Medical Record – Supplemental Medical Data
DA Form 5551-R	Spirometry Flow Sheet
DA Form 4970-E	Medical Screening Summary – Cardiovascular Risk Screening Program
DD Form 2808	Report of Medical Examination
SF 88	Report of Medical Examination
DD Form 2807-1	Report of Medical History
SF 93	Report of Medical History
DA Form 7389	Medical Record – Anesthesia
OF 522	Medical Record – Request for Administration of Anesthesia and Performance of Operations and Other Procedures
SF 559	Medical Record – Allergen Extract Prescription New and Refill
DD Form 2482	Venom Extract Prescription
DA Form 5007A; DA Form 5007B	Medical Record – Allergy Immunotherapy Record – Single and Double Extract
	Other SF 500-series forms

TABLE 4-4 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
RIGHT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
FORM	DESCRIPTION
DD Form 741	Eye Consultation
DD Form 771	Eyewear Prescription
DD Form 2215	Reference Audiogram
DD Form 2216	Hearing Conservation Data
DA Form 4465	Patient Intake/Screening Record (PIR)
DA Form 4466	Patient Progress Report (PPR)
SF 533	Medical Record – Prenatal and Pregnancy
DD Form 2005	Privacy Act Statement – Health Care Records. This form must be included in all OTRs.

TABLE 4-5	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART I — DA FORM 8005 SERIES JACKET	
DD Form 2766	Adult Preventive and Chronic Care Flow Sheet
DD Form 2766C	Adult Preventive and Chronic Care Flow Sheet – Continuation Sheet
DD Form 2882	Pediatric and Adolescent Preventive and Chronic Care Flowsheet
	Health Enrollment/Evaluation Assessment Review (HEAR) Primary Care Managers (PCM) Report
DA Form 5571	Master Problem List. This form is obsolete; use for file purposes only if already in existence.
DD Form 2792	Exceptional Family Member Medical Summary
DD Form 2792-1	Exceptional Family Member Special Education/Early Intervention Summary
	Automated Exceptional Family Member Program Summary
	Civilian source pediatric growth charts
DD Form 2493-1	Asbestos Exposure Part I – Initial Medical Questionnaire
DD Form 2493-2	Asbestos Exposure Part II – Periodic Medical Questionnaire
SF 601	Health Record – Immunization Record
	Automated laboratory report forms.
SF 512	Clinical Record – Plotting Chart

TABLE 4-5 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART I — DA FORM 8005 SERIES JACKET — CONTINUED	
SF 545	Laboratory Report Display
SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 557	Chemistry I – III, Hematology, Urinalysis, Serology, Parasitology, Microbiology I – II, Spinal Fluid; Miscellaneous.
SF 556	Immunohematology
SF 507	Clinical Record – Report on or Continuation of SF
SF 519-B	Radiologic Consultation Request/Report
SF 519; SF 519A	Medical Record – Radiographic Report
OF 520	Clinical Record – Electrocardiographic Record
SF 524	Medical Record – Radiographic Report
SF 525	Medical Record – Radiographic Report Summary
SF 526	Medical Record – Interstitial/Intercavitary Therapy

TABLE 4-5 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART I — DA FORM 8005 SERIES JACKET — CONTINUED	
SF 541	Medical Record – Gynecologic Cytology
SF 560	Medical Record – Electroencephalogram Request and History
DD Form 2482	Venom Extract Prescription
SF 559	Medical Record – Allergen Extract Prescription New and Refill
DA Form 5007A; DA Form 5007B	Medical Record – Allergy Immunotherapy Record – Single and Double Extract
DA Form 5551-R	Spirometry Flow Sheet
DA Form 4060	Report of Optometric Examination
DD Form 741	Eye Consultation
DD Form 771	Eyewear Prescription
DD Form 2215	Reference Audiogram
DD Form 2216	Hearing Conservation Data

TABLE 4-5 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART II — DA FORM 8005 SERIES JACKET	
DA Form 4515	Personnel Reliability Program Record Identifier
DA Form 3180	Personnel Screening and Evaluation Record
DA Form 4186	Medical Recommendation for Flying Duty
	Interfile the following forms in reverse chronological order with the most recent on top.
SF 600	Medical Record – Chronological Record of Medical Care
SF 558	Medical Record – Emergency Care and Treatment (Patient)
DA Form 5181	Screening Note of Acute Medical Care
SF 513	Medical Record – Consultation Sheet
DD Form 2161	Referral for Civilian Medical Care
DD Form 2341	Report of Animal Bite – Potential Rabies Exposure
	State Ambulance Forms
DA Form 5008	Telephone Medical Advice/Consultation Record
DA Form 3824	Urologic Examination
DA Form 5568	Chronological Record of Well-Baby Care
DA Form 5694	Denver Developmental Screening Test

TABLE 4-5 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART II — DA FORM 8005 SERIES JACKET — CONTINUED	
SF 602	Medical Record – Serology Record
DA Form 3763	Community Health Nursing – Case Referral
	Home health care documentation
DA Form 5569	Isoniazid (INH) Clinic Flow Sheet
	Other SF 500-series forms
SF 527	Group Muscle Strength, Joint R.O.M. Girth and Length Measurements
SF 528	Clinical Record – Muscle and/or Nerve Evaluation
SF 529	Medical Record – Muscle Function by Nerve Distribution
DA Form 4700	Medical Record – Supplemental Medical Data
DA Form 7389	Medical Record – Anesthesia
OF 522	Medical Record – Request for Administration of Anesthesia and Performance of Operations and Other Procedures
SF 518	Medical Record – Blood or Blood Component Transfusion
DD Form 2808	Report of Medical Examination
SF 88	Report of Medical Examination

TABLE 4-5 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART II — DA FORM 8005 SERIES JACKET — CONTINUED	
DD Form 2807-1	Report of Medical History
SF 93	Report of Medical History
DA Form 4970-E	Medical Screening Summary – Cardiovascular Risk Screening Program
DA Form 4465	Patient Intake/Screening Record (PIR)
DA Form 4466	Patient Progress Report (PPR)
PART III — DA FORM 8005 SERIES JACKET	
DA Form 2631	Medical Care – Third Party Liability Notification
DA Form 3365	Authorization for Medical Warning Tag
DD Form 2569	Third Party Collection Program – Record of Other Health Insurance
DA Form 4254	Request for Private Medical Information
DA Form 4876	Request and Release of Medical Information to Communications Media
DD Form 2870	Authorization for Disclosure of Medical or Dental Information
DA Form 5006	Medical Records – Authorization for Disclosure of Information
DA Form 5303-R	Volunteer Agreement Affidavit
	Administrative documents and other correspondence including advance directives
DA Form 4410-R	Disclosure Accounting Record

TABLE 4-5 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
FORM	DESCRIPTION
PART IV — DA FORM 8005 SERIES JACKET	
	Group copies of the following forms by hospitalization episode with most recent on top
DA Form 3647	Inpatient Treatment Record Cover Sheet or CHCS automated equivalent. File with it copies of SF 502 (if prepared), SF 515, SF 509, SF 516, and DD Form 2770 or SF 539
OF 275	Medical Record Report
SF 502	Clinical Record – Narrative Summary (outpatient)
DD Form 2770	Abbreviated Medical Record (outpatient)
SF 509	Medical Record – Progress Notes SF 509 is the final discharge note.
SF 515	Medical Record – Tissue Examination (outpatient)
SF 516	Medical Record – Operation Report (outpatient)
SF 531	Clinical Record – Anatomical Figure
SF 533	Medical Record – Prenatal and Pregnancy
DD Form 2005	Privacy Act Statement – Health Care Records. This form must be included in all OTRs

d. Outpatient records will be dispositioned upon release of detainee or final disposition of the detainee from detention and retired to the following record storage facility below.

DEPARTMENT OF THE ARMY
ATTN SUSAN SCHAECHER
1 ROCK ISLAND ARSENAL
ROCK ISLAND, ILLINOIS 61299-5000

Detainee outpatient records are not to be sent to the Patient Administration Systems and Biostatistics Activity (PASBA).

e. In the event a released detainee is recaptured and returned to a Theater Internment Facility (TIF), the servicing treatment facility should request return of the detainee's record from the in theater storage facility IAW Field Manual Interim (FMI) 4-02.46, Medical Support to Detainee Operations, paragraph 3-74, November 2007.

f. All retired detainee records will be retained in theater after they have been processed IAW Field Manual Interim (FMI) 4-02.46, Medical Support to Detainee Operations, paragraph 3-74, November 2007, until an end of conflict is declared. At that time the records will be forwarded to the Office of the Provost Marshal General, National Detainee Reporting Center (NDRC), ATTN: DAPM-MPD-ND, 2800 Army Pentagon, Washington, DC 20310-2800. Final disposition of the consolidated detainee records will occur when the NDRC archives the records with the National Archives and Records Administration IAW AR 25-400-2, The Army Records Information Management System (ARIMS).

6. Release of medical information of detainees:

a. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not apply to the medical records of detainees.

b. Given that the Geneva Conventions require the military provide the same standard of care to detainees as US service members; detainee medical records should be initiated and maintained at the same standard. The procedures outlined in AR 40-66, Medical Record Administration and Healthcare Documentation, 17 June 2008, Rapid Action Revision (RAR) issue date, 4 January 2010, chapter 2, Confidentiality of PHI (Personal Health Information) regarding the release of medical information for official purposes should be followed for detainee medical records.

c. Due to responsibilities of the detention facility chain of command regarding the care and treatment of detainees, they are entitled to some medical information. For example, patients suspected of having infectious diseases such as tuberculosis should be separated from other detainees. Guards and other personnel who come into contact with such patients should be informed about their health risks and how to mitigate those risks. Releasable medical information on detainees includes that which is necessary to supervise the general state of health, nutrition and cleanliness of detainees, and to detect contagious diseases. The information released should be used to provide health care, to ensure the health and safety of detainees, ensure the health and safety of the officers, employees or others at the facility, ensure law enforcement on the premises, ensure the administration and maintenance of the safety, security, and good order of the facility. (Note: Under this provision, a healthcare provider can confirm that a detainee is healthy enough to work or perform camp duties.)