Patient Administration Systems and Biostatistics Activity

Consolidation of Deployment Medical Documentation Guidance

15 December 2016

PATIENT ADMINISTRATION SYSTEMS AND BIOSTATISTICS ACTIVITY

2404 Stanley Road, Suite 25
Fort Sam Houston, TX 78234-5053
(210) 221-1102

Come visit us at our web site...
https://pasba.army.mil

TABLE OF CONTENTS

THIS PAGE IS INTENTIONALLY LEFT BLANK

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2748 WORTH ROAD, STE 3
FORT SAM HOUSTON, TEXAS 78234-6003

REPLY TO ATTENTION OF

MCHS-ISD 15 December 2016

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, 8 July 2014.

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, 8 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.

i. Memorandum, Task Force MED-A, subject: TF MED-A Policy Letter #17, Patient Registration and the Use of Non-US Patient Pseudo Social Security Numbers (PSSN), Pseudo Trauma Names (PTN), and Date of Birth.

j. Memorandum, HQ, US Army MEDCOM, subject: Interim Designation of Authority, 15 May 2009

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).

4. Guidance:

a. Required Documentation and Medical Records Management (See Enclosure 1).

b. Service Treatment Records (STRs), Role-I, Role-II, Role-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 Role-II treatment facility if operationally feasible.

b. The Role-II and Role-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 Mrs. Latonya M. Fletcher, PASBA, at commercial (210) 295-0324.

4 Encls

RACHELE M. SMITH
COL, MS
Director,
Patient Administration Systems
and Biostatistics Activity

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. DD Form 2766, Adult Preventive and Chronic Care Flowsheet.

(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 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 Department of the Army (DA) Form 344, Treatment Record series jacket 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 (Role-IIb) will follow the same procedures as Role-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 Role-III or Role-IV treatment facility. The original record should remain with the originating Role-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 Role-IV treatment facility and will be incorporated into the inpatient treatment record of the gaining treatment facility. The initiating Role-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 Role-I and Role-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 Role-I and Role-II treatment facilities.

b. Role-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. 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 Role-I through Role-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. Providers are responsible for documenting care provided to trauma patients at all levels of care (Role-I through Role-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 Role-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, Joint Theater Trauma Records; and memorandum, Office of the Assistant Secretary of Defense (Health Affairs), 19 December 2005, Joint Theater Trauma Records.

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

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

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

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

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

(6) SF 516, Medical Record Operation Report; SF 509, Medical Record Progress Notes; SF510, Medical Record Nursing Note; and SF 600, Medical Record Chronological Record of Medical Care.

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

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

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

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

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

a. Role-II treatment facilities:

(1) Behavioral health ambulatory care documentation generated at a Role-II treatment facility (Combat Stress Control) will be maintained at a Role-II treatment facility for continuity of care or transferred to a Role-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. Role-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 Role-IV through Role-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), Role-I, Role-II, Role-III and Final Disposition (Enclosure 2)

1. Role-I and Role-II treatment facilities and the STRs:

a. Patients treated at echelon of care Role-I – Role-II, the DD Form 2766, Adult Preventive and Chronic Care Flowsheet 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-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 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 DA Form 3444-series jacket or 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 MTF 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. Role-III treatment facilities and the DD Form 2766 or STRs:

a. If it is operationally feasible, the Role-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 Role-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, 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 (PSSN) or artificial nine-digit numbers for all Role-II and Role-III MTFs:

a. PSSNs, 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 PSSN will be constructed for all Role-II and Role-III MTFs using the designated PSSN for applicable patients IAW theater policy.

b. The MTF will assign a non-US patient a PSSN starting with the assigned prefix for their MTF, and will issue PSSNs in chronological order. To ensure that PSSNs 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 PSSNs. (Example: CJTH's pre-determined PSSN is 750-00-XXX, once CJTH has reached 750-00-9999; the next chronological number is 751-00-0000.

c. Listed are the templates for the assigned Role-II and Role-III MTFs pseudo-SSNs for the Afghanistan Theater of Operations.

(1) Afghanistan Role-II and III:

ROLE-II		
760-00-XXXX	CSH	SALERNO
770-00-XXXX	FST	JALALABAD (FENTY)
780-00-XXXX	FST	SHANKS
790-00-XXXX	FST	SHARANA
730-00-XXXX	FST	ORGUN-E
740-00-XXXX	FST	BOSTICK
820-00-XXXX	FST	GHAZNI
830-00-XXXX	FST	ASADABAD
835-00-XXXX	FST	WARRIOR
840-00-XXXX	FST	MAZAR E SHARIF
850-00-XXXX	FST	KHILAGAY
860-00-XXXX	FST	MEYMANEH
880-00-XXXX	FST	QALAT
900-00-XXXX	FST	TARIN KOWT
910-00-XXXX	FSE (CJSOTF)	TARIN KOWT
915-00-XXXX	FST	SPIN BOLDAK
920-00-XXXX	R2E	DWYER
930-00-XXXX	R3-US Personnel Only	BASTION
940-00-XXXX	FRSS USN	EDINBURGH
950-00-XXXX	FRSS USN	DELARAM
960-00-XXXX	R2E-US Personnel Only	HERAT
970-00-XXXX	FST	FARAH
980-00-XXXX	FSE	SHINDAND
990-00-XXXX	FST	BALA MURGHAB
DETAINEES		
890-00-XXXX	With Internment Serial Number (ISN)	
Facility Prefix-00-Last Four of	Without Internment Serial Number (ISN) EX: (920-00-XXXX)	

PSSN		
ROLE-III		
750-00-XXXX	CJTH	Craig Joint Theater Hospital
870-00-XXXX	MMU	KANDAHAR

d. Role-II and Role-III MTFs will clearly mark the full nine-digit PSSN on transfer paperwork. When a patient is transferred to another Role-III or Role-IV MTF, the PAD personnel at the receiving facility will admit the patient with the originating pseudo name, PSSN, and/or DOB. 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 PSSN 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 PSSNs in a logbook for future reference.

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

a. Detainees with assigned Internment Serial Numbers (ISN) are assigned the 890-000-PSSN prefix and the last four numbers contained in the ISN for their PSSN. For example, if a detainee is admitted and the ISN of USAF-0012345DP, then the PSSN assigned would be 890-00-2345. Once assigned, detainees are referred to by an ISN only for all outpatient encounters and inpatient admissions.

b. If a detainee is admitted directly from the field prior to being assigned an ISN, use the standard PSSN format. For example, the detainee is admitted to Dwyer use the chronological order format, 920-00-0001 (first patient), 920-00-0002 (second patient), etc.

(1) All PSSNs are tracked chronologically in a log book for historical data and future reference.

(2) For intra-theater transfer, the transferring facility is to ensure the appropriate PSSN is included on all transferred medical documentation.

c. TF MED-A Role II and III MTFs must assign pseudo names to trauma patient who are unable to give their name and/or have no valid photo identification documentation.

(1) Contractors or AC patients that are incoherent, unconscious, or do not have valid photo identification are admitted using a pseudo name also referred to as a pseudo trauma name. The purpose of a pseudo name is to provide an organized and uniform identification process across the Combined Joint Operations Area Afghanistan (CJOA-A), to ensure the ability to track historical patients and improve patient safety.

(2) Pseudo names are assigned at the originating MTF (initial MTF where the patient was evaluated) and follows the patient unless the patient's official name is identified.

(a) Pseudo names are assigned by using the following process:

1 Patients will be identified by the Facility Prefix and the Last Four of the assigned chronological PSSN as the Last Name.

2 The facility prefix and the last four numbers of the PSSN will be used for the patient's FIRST name.

(b) The following prefixes are used:

FACILITY NAME	PREFIX
CRAIG JOINT THEATER HOSPITAL (CJTH)	BAF
SALERNO CSH	SAL
JALALABAD (FENTY) FST	JBAD
SHANK FST	SHA
SHARANA FST	SHR
ORGUN-E FST	ORG
BOSTICK FST	BOS
GHAZNI FST	GHZ
ASADABAD FST	ABAD
WARRIOR FST	WRR
MAZAR E SHARIF FST	MES
KHILAGAY FST	KH I
MEYMANEH FST	MEY
KANDAHAR MMU (R3)	KAF
QALAT FST	QAL
TARIN KOWT FST	TK1
TARIN KOWT FSE (CJSOTF)	TK2
SPIN BOLDAK FST	SPK

FACILITY NAME (Continued)	PREFIX
DWYER R2E	DWY
BASTION R3	BSN (If Applicable)
EDINBURGH FRSS USN	EDI (If Applicable)
DELARAM FRSS USN	DEL (If Applicable)
HERAT R2E	HER
FARAH FST	FAR
SHINDAND FSE	SHI
BALA MURGHAB FST	BMG
DETAINEES	DET

(c) The first name will be derived from a list that is to be provided by the TFMED-A subordinate regional TF Medical Commanders quarterly. A request for information (RFI) will be sent from the TF MED-A battle captain to indicate suspense dates for the quarter.

(d) The first names created by the subordinate TF medical commands will not be offensive or disrespectful in nature. The names should not include animals, Disney cartoon characters or the like.

(e) The names listed below are approved examples of the first names used in the MTF naming convention:

Patient Status	Male	Female
1st Patient	Andy	Ana
2nd Patient	Bill	Beth
3rd Patient	Charlie	Charlotte
4th Patient	Dan	Delta

(f) Provided below is an example of the full naming convention:

Patient Status	Facility	LAST 4 PSSN	Chronological name on first name list	Complete Trauma Name
1st Patient	BAGRAM	0001	Ann	BAF0001, Ann
2nd Patient	BAGRAM	0002	Beth	BAF0002, Beth

(g) If a patient's identification is obtained at any time before or during admission to the originating facility, personnel conducting PAD

functions or PAD personnel are to correct the patient's information and use the patient's legal Name, SSN/patient identification number, and DOB.

(h) If a patient's identification is obtained after a patient transfer is completed, then the PSSN information will be the only information utilized. Using the PSSN information will alleviate the creation of duplicate patients in the TMDS, MC4, TC2 systems. Upon proper disposition, the receiving MTF is to correct the patient's identification in the TC2 system, identify the PSSN information as a duplicate patient's information and merge the two records.

(3) If a patient only has one name, the one name will be used as the patient's first name. The last name convention is the abbreviation of the facility and the last four of the next chronological PSSN.

Patients only Name	Facility abbreviation	LAST PSSN	Complete Trauma Name
Mohammad	JBAD	1234	JBAD1234, Mohammad

(4) TF MED-A subordinate Role II and III MTFs must assign pseudo dates of birth to trauma patients who are unable to give their name and/or no valid photo identification is available.

(5) If a patient is incoherent, unconscious, or if a patient does not know their date of birth or age, the treating MTF care provider is to estimate the patient's age and enter the PSSN DOB into TMDS, ALTHA-T/TC2 systems.

(a) For example, a patient visited an MTF on 17 MAY 2011 and the treating provider estimates the patient to be approximately five years old. The provider will then populate TMDS, ALTHA-T or TC2 with a DOB of 05172006, which reflects the patient's pseudo age of five years old.

(b) In the notes section, the provider must annotate that the DOB and ages are an estimate.

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 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.

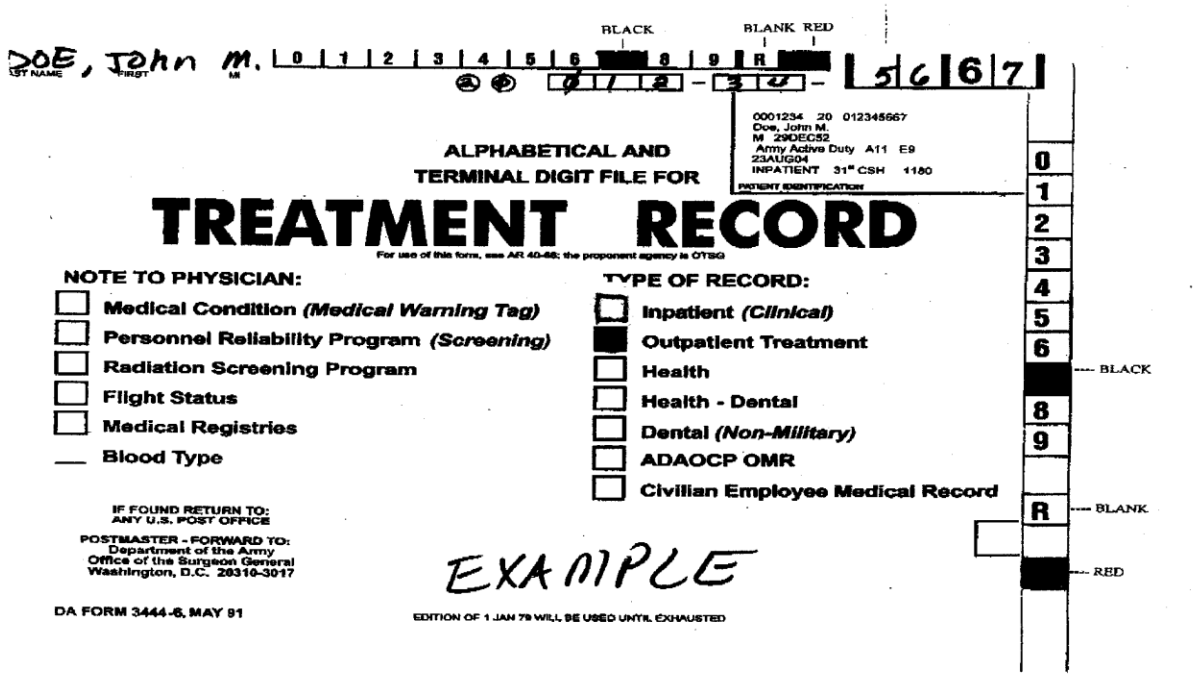
g. Enter the patient's SSN in the hyphenated blocks on the top of the DA Form 3444-series jacket.

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
BENEFICIARY CATEGORY DESCRIPTION	**BEN CAT CODE**	**FMP**	**“S” TAPE COLOR**
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	BLACK
AFGHAN/IRAQ CIVILIAN	K91	99	BLACK
LOCAL NATIONAL	K91	99	BLACK
FOREIGN CIV DEP (Non-Host Nation)	K76	20	BLACK
IRAQ CIVILIAN DEPENDENT	K91	99	BLACK
LOCAL NATIONAL DEPENDENT	K91	99	BLACK
EPW PRISONER	K78	20	BLACK
CIVILIAN IN DETENTION	K78	20	BLACK

Table 2-1 Continued			
BENEFICIARY CATEGORY DESCRIPTION	**BEN CAT CODE**	**FMP**	**"S" TAPE COLOR**
DoD EMPLOYEE	K53	20	BLACK
CONTRACT EMPLOYEE	K65	20	BLACK
NATO MILITARY	K72	20	WHITE
NON-NATO MILITARY	K74	20	BLACK

i. 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.



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
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

TABLE 2-2 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 3444 SERIES JACKET	
LEFT SIDE — DA FORM 3444 SERIES JACKET — CONTINUED	
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
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

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 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
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

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**
DA Form 5007A; DA Form 5007B	Medical Record – Allergy Immunotherapy Record – Single and Double Extract
	Other SF 500-series forms
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
SF 545	Laboratory Report Display

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 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
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

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	
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
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

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	
DA Form 5568	Chronological Record of Well-Baby Care
DA Form 5694	Denver Developmental Screening Test
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
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

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	
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 Medial 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 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 four-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 31st 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.

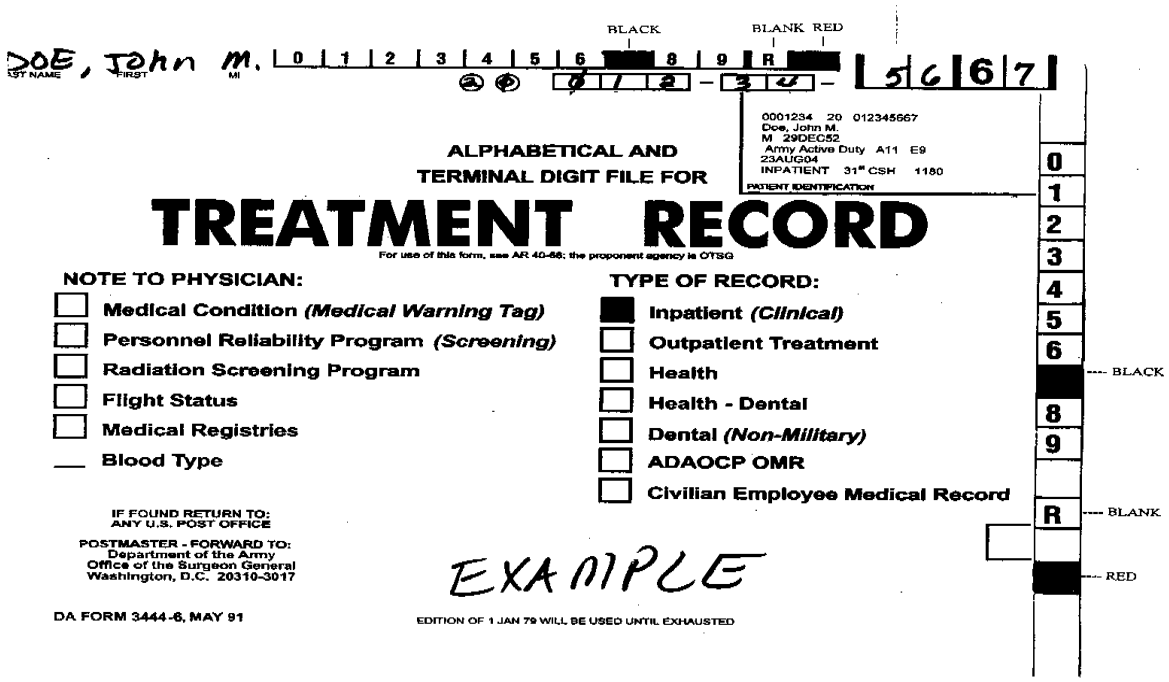
f. Enter the two-digit FMP of the patient in the two circles to the left of the hyphenated blocks on the top middle of the DA Form 3444-series jacket.

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	BLACK
AFGHAN/IRAQ CIVILIAN	K91	99	BLACK
LOCAL NATIONAL	K91	99	BLACK
FOREIGN CIVILIAN DEPENDENT (Non-Host Nation)	K76	20	BLACK
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

i. 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.



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
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

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**
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
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

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 527	Group Muscle Strength, Joint R.O.M Girth and Length Measurements
SF 528	Clinical Record – Muscle/Nerve Evaluation
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.

DEPARTMENT OF THE ARMY
DIRECTOR PASBA
ATTN MCHS ISD
2404 STANLEY RD, SUITE 25
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
ROCK CITY INDUSTRIAL CENTER
1411 BOULDER DRIVE
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, 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 Role-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 DA Form 3647, Inpatient Treatment Record Cover Sheet and DA Form 2985, Admission and Coding Information. 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 SF 509, Medical Record-Progress Note; SF 502, Clinical Record-Narrative Summary; 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 detention facility and are assigned an Internment Serial Number (ISN) as soon as possible after coming under DoD control. The ISN will support the Pseudo Social Security Number (PSSN).

DETAINEES	
890-00-XXXX	With Internment Serial Number (ISN)
Facility Prefix-00- Last four of PSSN	Without Internment Serial Number (ISN) Ex: 920-00-XXXX

(2) Once assigned, detainees are referred to by ISN only for all outpatient encounters and inpatient admissions.

(3) Detainees with assigned ISNs are assigned the 890-00-PSSN prefix and the last four numbers contained in the ISN for their PSSN. For example, if a detainee is admitted and has an ISN of USAF-0012345DP, then the PSSN assigned would be 890-00-2345.

(4) If a detainee is admitted directly from the field prior to being assigned an ISN, use the standard PSSN format. For example, the detainee is admitted to Dwyer use the chronological order format, 920-00-0001 (first patient), 920-00-0002 (second patient), etc.

(5) All PSSNs are tracked chronologically in a log book for historical data and future reference.

(6) For intra-theater transfer, the transferring facility is to ensure the appropriate PSSN is included on all transferred medical documentation.

(7) Patients that are incoherent, unconscious, or do not have valid photo identification are admitted using a pseudo name also referred to as a pseudo trauma name. The purpose of a pseudo name is to provide an organized and uniform identification process across the Combined Joint Operations Area Afghanistan (CJOA-A), to ensure the ability to track historical patients and improve patient safety.

(8) Pseudo names are assigned at the originating MTF (initial MTF where the patient was evaluated) and follows the patient unless the patient's official name is identified.

(a) Pseudo names are assigned using the following process:

1 Patients will be identified by the Facility Prefix and the Last Four of the assigned chronological PSSN as the Last Name.

2 The facility prefix and the last four numbers of the PSSN will be used for the patient's FIRST name.

(b) The following prefixes are used:

FACILITY NAME	PREFIX
CRAIG JOINT THEATER HOSPITAL (CJTH)	BAF
SALERNO CSH	SAL
JALALABAD (FENTY) FST	JBAD

FACILITY NAME	PREFIX
SHANK FST	SHA
SHARANA FST	SHR
ORGUN-E FST	ORG
BOSTICK FST	BOS
GHAZNI FST	GHZ
ASADABAD FST	ABAD
WARRIOR FST	WRR
MAZAR E SHARIF FST	MES
KHILAGAY FST	KH I
MEYMANEH FST	MEY
KANDAHAR MMU (R3)	KAF
QALAT FST	QAL
TARIN KOWT FST	TK1
TARIN KOWT FSE (CJSOTF)	TK2
SPIN BOLDAK FST	SPK
DWYER R2E	DWY
BASTION R3	BSN (If Applicable)
EDINBURGH FRSS USN	EDI (If Applicable)
DELARAM FRSS USN	DEL (If Applicable)
HERAT R2E	HER
FARAH FST	FAR
SHINDAND FSE	SHI
BALA MURGHAB FST	BMG
DETAINEES	DET

(c) The first name will be derived from a list that is to be provided by the TFMED-A subordinate regional TF Medical Commanders quarterly. A request for information (RFI) will be sent from the TF MED-A battle captain to indicate suspense dates for the quarter.

(d) The first names created by the subordinate TF medical commands will not be offensive or disrespectful in nature. The names should not include animals, Disney cartoon characters or the like.

(e) The names listed below are approved examples of the first names used in the MTF naming convention:

Patient Status	Male	Female
1st Patient	Andy	Ana
2nd Patient	Bill	Beth
3rd Patient	Charlie	Charlotte
4th Patient	Dan	Delta

(f) Provided below is an example of the full naming convention:

Patient Status	Facility	LAST 4 PSSN	Chronological name of the first name list	Complete Trauma Name
1st Patient	BAGRAM	0001	Ann	BAF0001, Ann
2nd Patient	BAGRAM	0002	Beth	BAF0002, Beth

(g) If a patient's identification is obtained at any time before or during admission to the originating facility, personnel conducting PAD functions or PAD personnel are to correct the patient's information and use the patient's legal Name, SSN/patient identification number, and DOB.

(h) If a patient's identification is obtained after a patient transfer is completed, then the PSSN information will be the only information utilized. Using the PSSN information will alleviate the creation of duplicate patients in the TMDS, MC4, TC2 systems. Upon proper disposition, the receiving MTF is to correct the patient's identification in the TC2 system, identify the PSSN information as a duplicate patient's information and merge the two records.

(9) If a patient only has one name, the one name will be used as the patient's first name. The last name convention is the abbreviation of the facility and the last four of the next chronological PSSN.

Patients only Name	Facility abbreviation	LAST PSSN	Complete Trauma Name
Mohammad	JBAD	1234	JBAD1234, Mohammad

(10) TF MED-A subordinate Role II and III MTFs must assign pseudo dates of birth to trauma patients who are unable to give their name and/or no valid photo identification is available.

(a) If a patient is incoherent, unconscious, or if a patient does not know their date of birth or age, the treating MTF care provider is to estimate the patient's age and enter the PSSN DOB into TMDS, ALTHA-T/TC2 systems.

(b) For example, a patient visited an MTF on 17 MAY 2011 and the treating provider estimates the patient to be approximately five years old. The provider will then populate TMDS, ALTHA-T or TC2 with a DOB of 05172006, which reflects the patient's pseudo age of five years old.

(c) In the notes section, the provider must annotate that the DOB and age are an estimate.

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 (890) as the first three digits, 00 for the fourth and fifth digits, and then the four digit sequence from the ISN.

(2) 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.

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	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
INPATIENT, MTF, MTF DMIS ID	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.

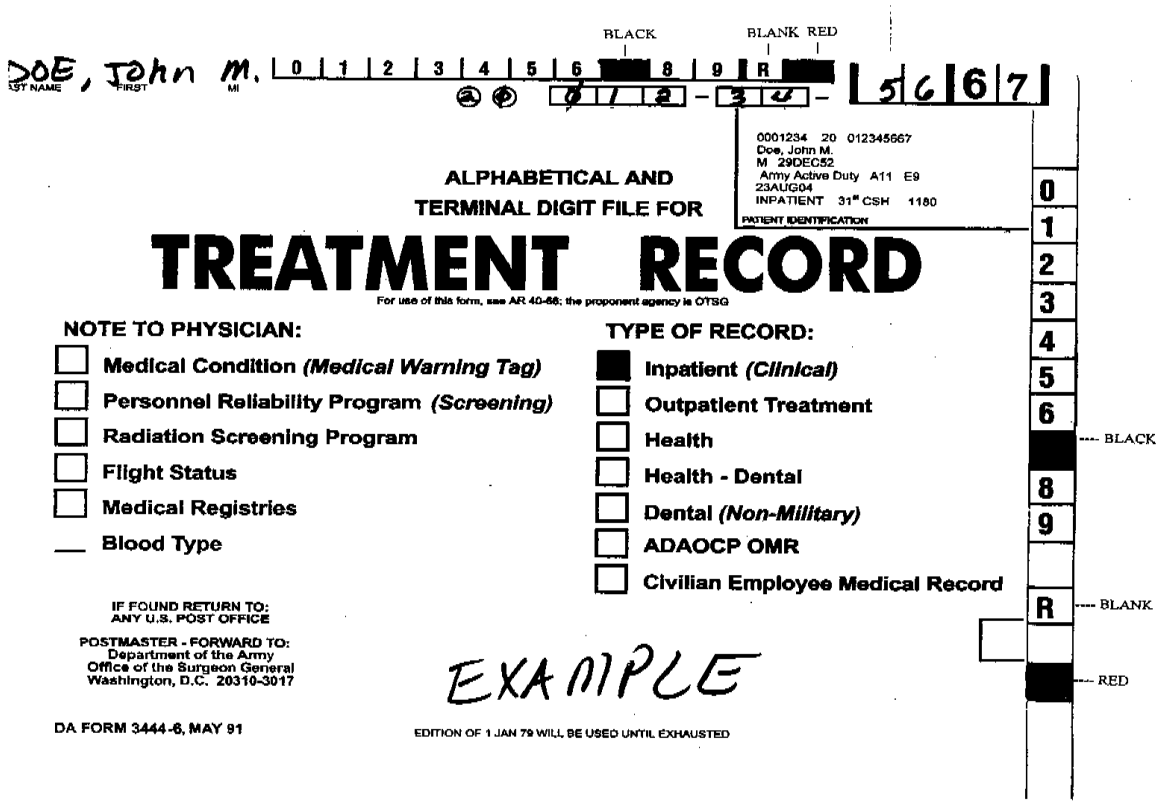
(6) Enter the two-digit FMP of the patient in the two circles to the left of the hyphenated blocks on the top middle of the DA Form 3444-series jacket.

(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	BLACK
IRAQ CIVILIAN	K91	99	BLACK
LOCAL NATIONAL	K91	99	BLACK
FOREIGN CIVILIAN DEPENDENT (Non-Host Nation)	K76	20	BLACK
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.



(10) Inpatient treatment records must be checked for quality assurance (Example: Provider signatures and dates on all entries, proper forms used, DA Form 3647, Inpatient Treatment Record Cover Sheet and DA Form 2985, Admission and Coding Information 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 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
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

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**
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
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

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 527	Group Muscle Strength, Joint R.O.M Girth and Length Measurements
SF 528	Clinical Record – Muscle/Nerve Evaluation
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.

DEPARTMENT OF THE ARMY
DIRECTOR PASBA
ATTN MCHS ISD
2404 STANLEY RD, SUITE 25
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:

IRAQ (OIF):
DEFENSE LOGISTICS AGENCY DOCUMENT SRVS
BUILDING 809, SUITE A
290 SRAGUE AVE
PENSACOLA FL 32509-5112

AFGHANISTAN (OEF):
DEFENSE LOGISTICS AGENCY DOCUMENT SRVS
BUILDING 2011
1144 USS HENRY CLAY BLVD
NAVAL SUBMARINE BASE KINGS BAY GA 31547-1547

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
ROCK CITY INDUSTRIAL CENTER
1411 BOULDER DR
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, Interim Guidance on Detainee Medical Care, 24 May 2005.

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

c. The Role-II and Role-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 Role-III treatment facility must be documented and the original documentation forwarded to the detention facility's medical officer (or Role-II treatment facility).

e. At the time of transition of the Role-II or Role-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 Role-III detention facilities will ensure that all detainee outpatient treatment documentation is maintained in a 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 detention facility and are assigned an Internment Serial Number (ISN) as soon as possible after coming under DoD control. The ISN will support the Pseudo Social Security Number (PSSN).

DETAINEES	
890-00-XXXX	With Internment Serial Number (ISN)
Facility Prefix-00-last four of PSSN	Without Internment Serial Number (ISN) Ex: 920-00-XXXX

(2) Once assigned, detainees are referred to by ISN only for all outpatient encounters and inpatient admissions.

(3) Detainees with assigned ISNs are assigned the 890-00 PSSN

prefix and the last four numbers contained in the ISN for their PSSN. For example, if a detainee is admitted and has an ISN of USAF-0012345DP, then the PSSN assigned would be 890-00-2345.

(4) If a detainee is admitted directly from the field prior to being assigned an ISN, use the standard PSSN format. For example, the detainee is admitted using the chronological order format, 890-00-0001 (first patient), 890-00-0002 (second patient), etc.

(5) All PSSNs are tracked chronologically in a log book for historical data and future reference.

(6) For intra-theater transfer, the transferring facility is to ensure the appropriate PSSN is included on all transferred medical documentation.

(7) Patients that are incoherent, unconscious, or do not have valid photo identification are admitted using a pseudo name also referred to as a pseudo trauma name. The purpose of a pseudo name is to provide an organized and uniform identification process across the Combined Joint Operations Area Afghanistan (CJOA-A), to ensure the ability to track historical patients and improve patient safety.

(8) Pseudo names are assigned at the originating MTF (initial MTF where the patient was evaluated) and follows the patient unless the patient's official name is identified.

(a) Pseudo names are assigned using the following process:

1 Patient will be identified by the Facility Prefix and the Last Four of the assigned chronological PSSN as the Last Name.

2 The facility prefix and the last four numbers of the PSSN will be used for the patient's First Name.

(b) The following prefixes are used:

FACILITY NAME	PREFIX
CRAIG JOINT THEATER HOSPITAL (CJTH)	BAF
SALERNO CSH	SAL
JALALABAD (FENTY) FST	JBAD
SHANK FST	SHA
SHARANA FST	SHR
ORGUN-E FST	ORG
BOSTICK FST	BOS
GHAZNI FST	GHZ
ASADABAD FST	ABAD
WARRIOR FST	WRR
MAZAR E SHARIF FST	MES
KHILAGAY FST	KH I
MEYMANEH FST	MEY
KANDAHAR MMU (R3)	KAF
QALAT FST	QAL
TARIN KOWT FST	TK1
TARIN KOWT FSE (CJSOTF)	TK2
SPIN BOLDAK FST	SPK
DWYER R2E	DWY
BASTION R3	BSN (If Applicable)
EDINBURGH FRSS USN	EDI (If Applicable)
DELARAM FRSS USN	DEL (If Applicable)
HERAT R2E	HER
FARAH FST	FAR
SHINDAND FSE	SHI
BALA MURGHAB FST	BMG
DETAINEES	DET

(c) The first name will be derived from a list that is to be provided by the TFMED-A subordinate regional TF Medical Commanders quarterly. A request for information (RFI) will be sent from the TF MED-A battle captain to indicate suspense dates for the quarter.

(d) The first names created by the subordinate TF medical commands will not be offensive or disrespectful in nature. The names should not include animals, Disney cartoon characters or the like.

(e) The names listed below are approved examples of the first names used in the MTF naming convention:

Patient Status	Male	Female
1st Patient	Andy	Ana
2nd Patient	Bill	Beth
2nd Patient	Charlie	Charlotte
3rd Patient	Dan	Delta

(f) Provided below is an example of the full naming convention:

Patient Status	Facility	LAST 4 PSSN	Chronological name of the first name list	Complete Trauma Name
1st Patient	BAGRAM	0001	Ann	BAF0001, Ann
2nd Patient	BAGRAM	0002	Beth	BAF0002, Beth

(g) If a patient's identification is obtained at any time before or during admission to the originating facility, personnel conducting PAD functions or PAD personnel are to correct the patient's information and use the patient's legal Name, SSN/patient identification number, and DOB.

(h) If a patient's identification is obtained after a patient transfer is completed, then the PSSN information will be the only information utilized. Using the PSSN information will alleviate the creation of duplicate patients in the TMDS, MC4, TC2 systems. Upon proper disposition, the receiving MTF is to correct the patient's identification in the TC2 system, identify the PSSN information as a duplicate patient's information and merge the two records.

(9) If a patient only has one name, the one name will be used as the patient's first name. The last name convention is the abbreviation of the facility and the last four of the next chronological PSSN.

Patients only Name	Facility abbreviation	LAST PSSN	Complete Trauma Name
Mohammad	JBAD	1234	JBAD1234, Mohammad

(10) TF MED-A subordinate Role II and III MTFs must assign pseudo dates of birth to trauma patients who are unable to give their name and/or no valid photo identification is available.

(a) If a patient is incoherent, unconscious, or if a patient does not know their date of birth or age, the treating MTF care provider is to estimate the patient's age and enter the PSSN DOB into TMDS, ALTHA-T/TC2 systems.

(b) For example, a patient visited an MTF on 17 MAY 2011 and the treating provider estimates the patient to be approximately five years old. The provider will then populate TMDS, ALTHA-T or TC2 with a DOB of 05172006, which reflects the patient's pseudo age of five years old.

(c) In the notes section, the provider must annotate that the DOB and age are an estimate.

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 the medical automation system that requires a nine-digit number, detainees are issued a pseudo-SSN with (890) as the first three digits, 00 for the fourth and fifth digits, and then the four digit sequence from the ISN.

(2) 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) 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 PSSN. 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 31st 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.

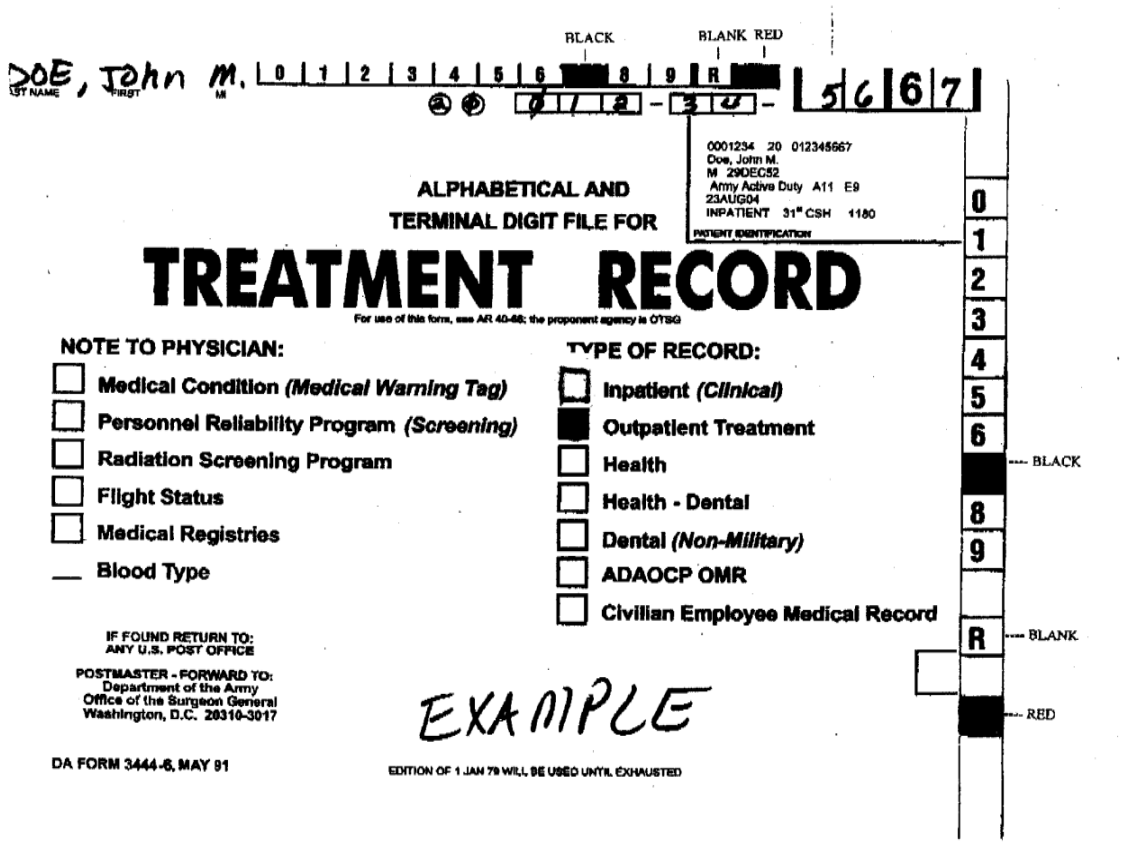
(7) Enter the patient's SSN in the hyphenated blocks on the top of the DA Form 3444-series jacket.

(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	BLACK
IRAQ CIVILIAN	K91	99	BLACK
LOCAL NATIONAL	K91	99	BLACK
FOREIGN CIVILIAN DEPENDENT (Non-Host Nation)	K76	20	BLACK
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

Table 4-3 (Continued)			
BENEFICIARY CATEGORY DESCRIPTION	BEN CAT CODE	FMP	"S" TAPE COLOR
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.



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

c. Outpatient treatment records will be assembled using the 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 below is from top to bottom of the record. See Table 4-4, Outpatient Treatment Record Assembly Forms and Documents if using the

DA Form 3444-series jacket or Table 4-5, Outpatient Treatment Record Assembly Forms and Documents if using the DA Form 8005-series jacket.

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 SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 557	Laboratory Report Display Chemistry I – III, Hematology, Urinalysis, Serology, Parasitology, Microbiology I – II, Spinal Fluid; Miscellaneous

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 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
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

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**
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

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 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
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	
PART I — DA FORM 8005 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
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
SF 545	Laboratory Report Display

TABLE 4-5 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
PART I — DA FORM 8005 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 524	Medical Record – Radiographic Report
SF 525	Medical Record – Radiographic Report Summary
SF 526	Medical Record – Interstitial/Intercavitary Therapy
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

TABLE 4-5 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
PART I — DA FORM 8005 SERIES JACKET — CONTINUED	
FORM	**DESCRIPTION**
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
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
PART II — DA FORM 8005 SERIES JACKET	
FORM	**DESCRIPTION**
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

TABLE 4-5 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
PART II — DA FORM 8005 SERIES JACKET	
FORM	**DESCRIPTION**
DA Form 5568	Chronological Record of Well-Baby Care
DA Form 5694	Denver Developmental Screening Test
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
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)

TABLE 4-5 — CONTINUED	
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
PART III — DA FORM 8005 SERIES JACKET	
FORM	**DESCRIPTION**
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
OUTPATIENT TREATMENT RECORD ASSEMBLY FORMS AND DOCUMENTS — DA FORM 8005 SERIES JACKET	
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)

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	
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.

IRAQ (OIF):
DEFENSE LOGISTICS AGENCY DOCUMENT SRVS
BUILDING 809, SUITE A
290 SRAGUE AVE
PENSACOLA FL 32509-5112

AFGHANISTAN (OEF):
DEFENSE LOGISTICS AGENCY DOCUMENT SRVS
BUILDING 2011
1144 USS HENRY CLAY BLVD
NAVAL SUBMARINE BASE KINGS BAY GA 31547-1547

NOTE: 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 Defense Logistics Agency Document Services, Building 809, Suite A, 290 Sragues Ave, Pensacola, FL 32509-5112. 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.)