U.S. Department
of Transportation
**United States**
**Coast Guard**

# MEDICAL MANUAL

COMDTINST M6000.1B
Includes Change 16

U.S. Department of Transportation
United States Coast Guard

Commandant
U.S. Coast Guard

2100 2nd Street S.W.
Washington, DC 20593-0001
Staff Symbol: G-WKH-1
Phone: (202) 267-0767

COMDTINST M6000
27 June 2001

COMMANDANT NOTICE 6000

Subj: CH-16 TO MEDICAL MANUAL, COMDTINST M6000.1B

1. PURPOSE. This Notice publishes revisions to Medical Manual, COMDTINST M6000.1B. Intended user of this directive are all Coast Guard Units that maintain medical Manuals.

2. ACTION. Area and district commanders, commanders of maintenance and logistics commands, commanding officers of Headquarters units, Assistant Commandants for directorates, Chief Counsel and special staff offices at Headquarters shall ensure compliance with the provisions of this Notice.

3. DIRECTIVES AFFECTED. Medical Manual, COMDTINST M6000.1B.

4. SUMMARY. Newly revised material and editorial changes are denoted by a line on the outside of the page. Enclosure (1) summarizes the substantial changes throughout the Manual provided as enclosure (2).

5. PROCEDURES. No paper distribution will be made of this Manual. Official distribution will be via the Coast Guard Directives System CD-ROM and the Department of Transportation Website http://isddc.dot.gov/. An electronic version will also be made available via the Commandant (G-WK) Publications and Directives website (see # 6, below).

   a. Remove and insert the following pages

| Remove | Insert |
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| Chapter 1 CH-15 | Chapter 1 CH-16 |
| Chapter 2 CH-14 | Chapter 2 CH-16 |
| Chapter 3 CH-15 | Chapter 3 CH-16 |
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| Chapter 12 CH-15 | Chapter 12 CH-16 |

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NON-STANDARD DISTRIBUTION:

6. FORMS AVAILABILITY. All forms listed in this Manual with the exception noted in this paragraph are available from stock points listed in the Catalog of Forms, COMDTINST 5213.6. The stock number for DD Form 2766 (Rev 01-00), Adult Preventive and Chronic Care Flowsheet, Sponsor (Navy) is 2766-0102-LF-984-8400 (pkg 100). The DD-877, Request for Medical/Dental Records no longer has a stock number. Availability of this form is only by .pdf format, a web link is provided on the Pubs and Directives web page. Some forms referenced in this manual are also available on SWSIII Jet Form Filler. Web links to forms in .pdf format have been provided on the Pubs and Directives page; http://www.uscg.mil/hq/g-w/g-wk/g-wkh/g-wkh-1/Pubs/Pubs.Direct.htm.

JOYCE M. JOHNSON
Director of Health and Safety

Encl (1) Summary of substantial changes
(2) CH-16 to Medical Manual, COMDTINST M6000.1B

CH-16 TO MEDICAL MANUAL, COMDTINST M6000.1B

| | |
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| **Chapter 1** | |
| **Chapter 1-B-1.a.i:** | Specifies the patient will be notified of all abnormal test results. |
| **Chapter 1** | Chapter layout re-formatted for uniformity. |
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| **Chapter 2** | |
| **Chapter 2-A-6** | Provides guidelines for Elective Health Care. |
| **Chapter 2-A-7** | Provides guideline for Other Health Insurance (OHI). |
| **Chapter 2-F-3.a** | Provides new guidelines for Members of Foreign Military Services. |
| **Chapter 2-I-1-e:** | Provides definition for Super Sickbay |
| **Chapter 2** | Chapter layout re-formatted for uniformity. |
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| **Chapter 3** | |
| **Figure 3-A-1** | Revised Overseas Modified Screening to reflect DNA sample. |
| **Figure 3-B-2** | Revised to show current routing symbol. Re-added (5) to NOTES. |
| **Chapter 3-B-c.(3)** | Revised text to read: Upon completion of flight training and assignment to a Coast Guard unit, the NOMI approved physical will be considered valid until the last day of the member's next birth month. |
| **Chapter 3-C-19** | Item 18 (Dental) portion of the SF 88, Report of Medical Exam, updated to show current accession standards in 3-D. |
| **Chapter 3, Figure 3-C-2** | Dental Carious Teeth Standards removed from chapter. Reflects current standards in section 3-D. |
| **Chapter 3, Figure 3-C-3** | Reduced height standard for (Candidate for Flight Training) from 64 to 62 inches. |
| **Chapter 3-D** | Revised Section D to reflect DOD Directive 6130.4 dtd Dec 14,2000, P.E. Standards for Entrance into the Coast Guard. |
| **Chapter 3-F-5-** | Provides guidelines for Corneal Refractive Surgery. |
| **Chapter 3-F-7-b.(2)** | Provides new definition for Bronchial Asthma. |
| **Chapter 3-F-8-a.(5)** | Provides new definition for Myocarditis and degeneration of the myocardium. |
| **Chapter 3-F-8.b.(9)** | Revised text to read: Any condition requiring anti-thrombotic medication other than aspirin. |
| **Chapter 3-F-10-a.(8) & (13)** | Provides new definition for Crohn's Disease and Ulcerative Colitis. |
| **3-F-10.e** | Provides new definition for Diabetes Mellitus. |
| **3-F-15.e** | Provides new definition for Convulsive Disorders. |
| **3-F-18.e** | Provides new definition for Purpura and other bleeding diseases. |
| **3-F-22** | Revised definition for HIV to read identical to HIV ALCOAST #425/00 |
| **3-G-4.d** | Provides new height standards for Class 1 Aviators (62) inches. |
| **3-G-6.a.(1).(a)** | Provides new guidelines for anthropometric measurements for Candidates for Flight Training. |
| **Chapter 3** | Chapter layout re-formatted for uniformity |

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| **Chapter 4** | |
| **Chapter 4-A-5.a.(8)** | Provides definition for Custody of Health Records. |
| **Chapter 4-A-6** | Provides new guidance for Transfer of Health Records. |
| **Chapter 4-B-3** | Provides guidance and adds new form DD-2766 (Adult Preventive and Chronic Care Flowsheet) Note: Problem Summary List is now obsolete. |
| **Chapter 4-B-32** | Provides guidance and adds form DD-877 (Request for Medical/Dental Records or Information). |
| **Chapter 4-D-8** | Provides guidelines for the Transfer of Clinic Records. |
| **4-G** | Provides guidelines for Mental Health Records (a new section). |
| **Chapter 4** | Chapter layout re-formatted for uniformity. Most forms updated to show current form available as a word document.. |
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| **Chapter 5** | |
| **Chapter 5-C** | Provides new section C. Command directed Mental Health Evaluation of CG Members. |
| **Chapter 5** | Chapter layout re-formatted for uniformity. |
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| **Chapter 6** | |
| **Chapter 6-A-6** | Provides new guidance for Inpatient Hospitalization message to include ICD-9 code for diagnosis. |
| **Chapter 6-B-8** | Provides guidelines for the DD-2766 Adult Preventive and Chronic Care Flowsheet. |
| **Removed CG5534** | Removed CG 5534 Non Fed Med as per ALCOAST #129/01, cancellation of COMDTINST 6010.20. |
| **Chapter 6** | Chapter layout re-formatted for uniformity. |
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| **Chapter 9** | |
| **Chapter 9-A-4.a.(10)** | Provides guidelines for unit instruction or SOP in the event of family violence. |
| **Chapter 9-A-9.b.(2).(a)** | Provides guidelines for signs on interior surfaces of cutters. |
| **9.A.7.h.** | Removes the reference to Chapter 10 of the Coast Guard Rescue and Survival Systems Manual for guidance on inspection and maintenance of the Rescue EMT Set and requirements for documentation of those procedures in a Preventive Maintenance Schedule (PMS) log. |
| **9-A-8.b.(2)(f)** | Removes requirement to maintain a Preventive Maintenance Schedule (PMS) log. The requirement for this has been removed from the Coast Guard Rescue and Survival Systems Manual (COMDTINST M10470.10 (series). |
| **Chapter 9** | Chapter layout re-formatted for uniformity. |
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| **Chapter 12** | |
| **Chapter 12-A-2.c** | Provides guidelines for Enrollment Criteria. |
| **Chapter 12-A-3.a.(1)** | Provides guidance for using the most current OMSEP Physical Form (6-00). |
| **Chapter 12-A-3.b** | Provides guidance for the OMSEP database. |
| **Chapter 12-A-5** | Provides new guidance for Roles and Responsibilities. |
| **Chapter 12-A-5.a** | Provides new guidance for OMSEP Coordinators. |

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| **Chapter 12-A-5.e** | Provides new guidance for Medical Officer's responsibilities. |
| **Chapter 12-A-5.f** | Provides guidance for Medical Administrators. |
| **Chapter 12-A-g** | Provides guidelines for civilian OMSEP enrollees. |
| **Chapter 12-B-2.d.(1) & (2)** | Provides new section (1) and (2), End of Exposure guidelines. |
| **Chapter 12-B-2.e** | Provides guidance for time intervals between OMSEP examinations. |
| **Chapter 12 forms** | Table 12-C-1 to 12-C-12 were revised and updated to show current requirements. |
| **Chapter 12** | Chapter layout re-formatted for uniformity. |

U.S. Department of Transportation
**United States Coast Guard**

Commandant G-KRM-3
United States Coast Guard

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COMDTINST M6000.1B

**12 JAN 1990**

COMMANDANT INSTRUCTION M6000.1B

Subj: Medical Manual

1. PURPOSE. This instruction provides information relative to the administration of matters pertaining to health care provided by the U. S. Coast Guard.

2. DIRECTIVES AFFECTED. Commandant Instruction M6000.1A is cancelled. The reports "Submission of Duplicate Copies of Processed Health Care Bills" (RCS-G-KMA-13016) and "Health Care Equipment Inventory Change Sheet" (RCS-G-KMA-13003) are cancelled.

3. MISSION. The primary responsibility of the Coast Guard Health Services program is the provision of those services medically necessary to assure the member's fitness for duty in support of Coast Guard missions. Health care services for dependents and retirees are authorized, and when available, will be delivered as part of the health benefits program for these beneficiaries.

4. GOAL. The goal of the Coast Guard Health Services is the timely and cost effective delivery of care in strict conformance with the law and accepted medical ethics and with dignity, empathy, and respect.

5. CHANGES. The major changes are summarized as follows:

   a. Section 1-A-2b.(11) - Rewritten to reflect the move of the disability evaluation system from Commandant (G-KDE) to (G-PDE).

   b. Section 1-A-2b.(12) - Rewritten to reflect the move of the safety programs from Commandant (G-CSP) to (G-KSE).

   c. Section 1-A-2b.(15) - Added to establish the Alcohol Abuse Prevention Program as a duty and responsibility of the Office of Health and Safety; moved from the Office of Personnel and Training.

**DISTRIBUTION—SDL No.** 128

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**NON-STANDARD DISTRIBUTION:** See Page (6)

5. d. Section 1-A-3 - Rewritten to add the mission, functions, and responsibilities of the Health Services Division, Maintenance and Logistics Commands.

e. Sections 1-B-1a.(2) and 1-B-4a.(4) - Rewritten to require medical and dental officers to have unrestricted state licenses to practice while assigned with the Coast Guard.

f. Sections 1-B-2a, 1-B-5a, and 1-B-9a - Authorizes the unit commanding officer to designate the department head of the medical department.

g. Section 1-B-12 - Health Safety technicians, formerly Section 1-B-11. Rewritten to more accurately describe the duties and responsibilities of health services technicians and includes the duties and responsibilities for independent duty.

h. Section 1-B-12b(3) - Rewritten for clarity and to indicate that HS's assigned to units without a physician assigned shall not treat dependents and retirees.

i. Section 2-A-1c - Changed to indicate that prior approval is required from MLC before nonemergency health care can be obtained from civilian medical facilities. Also, requires recording all health care received at other than CG clinic in the health record.

j. Section 2-A-2a(2) - Rewritten to more accurately describe the criteria for providing emergency treatment.

k. Section 2-A-2c(2) - Changed to require notification of MLC (p) and (k) when a member of the CG is hospitalized, transferred to another facility, or discharged from IP status.

l. Section 2-A-6c - Changed to show MLC (k) as approving official for requests for nonfederal health care. This Section also authorizes MLCs to delegate limited authority to approve requests to qualified clinic administrators.

m. Section 2-B-3 - New section that requires preauthorization by MLC(k) for nonemergency care at other than CG or DoD Facilities.

n. Section 2-I - Rewritten to reflect new names for Coast Guard Medical Treatment Facilities (MTFs). All references to hospitals and Mobile Dental Detachments (MDDs) deleted as Coast Guard no longer has either type of facilities.

5. o. Section 3-A-7a - Rewritten to require the use of Military Entrance Processing Stations as the only physical examining facilities to be used for original enlistments. Also changes valid period for examinations to 18 months.

p. Section 3-A-7d(2) - Rewritten to require that an HIV antibody test be performed and documented within 6 months prior to overseas transfer or deployment.

q. Section 3-A-7d(5) - Requires G6PD level results be recorded if members being assigned to malaria endemic area.

r. Section 3-A-h thru j - Rewritten to incorporate the provisions of ALDISTS 040/89 and 044/89. Changes the age of beginning annual physical exams to 50. Also, changes requirements for biannual and quadrennial exams. Selected Reservists will continue with quadrennials until retired.

s. FIGURE 3-B-2 - Redone to describe the reviewing, routing, and final disposition of reports of physical examinations.

t. Section 3-C-19c - Rewritten to include certain assignments for which members with fixed orthodontic appliances are disqualified. Also, adds requirement for prior approval by Commandant (G-PE)/(G-PO) before obtaining orthodontic treatment.

u. Section 3-C-20b(4)(a) - Changes HIV-antibody testing requirements.

v. Section 3-C-20f - Changes PAP testing requirements, corrects item number.

w. Section 3-E-7a - Adds requirement for members of Coast Guard Reserves to have a current physical exam prior to appointment to warrant officer.

x. Section 3-G-1b - Changes the age for grouping aviation personnel.

y. Section 3-G-2d(2) - Rewritten to change the age for beginning annual aviation physical examinations to 50.

z. Section 3-G-2f(3)(b) - New section added to provide guidance pertaining to aviation personnel diagnosed with alcohol abuse or alcohol dependency.

aa. Section 3-G-2f(3)(c) - New section added to provide guidance pertaining to pregnant aviation personnel.

5. bb. Section 3-G-10 - New section added for class 2 medical personnel.

cc. Section 3-G-11 - Changed to add requirement that technical observers required to undergo egress training have an aviation physical exam and meet certain standards.

dd. Section 4-C-1a - Changed to require that a new dental record be opened whenever the original record is lost or destroyed. Also corrects Headquarters element from which to request dental records for members recalled from retired list.

ee. Section 4-B-6c(43) - Requires recording of HIV antibody test dates on overseas physicals, PPD test dates and results, and G6PD.

ff. Section 6-A-1 - Rewritten to reflect the revised Health Services Statistical Report, CG 4142 (Rev 1-90) (RCN-6000-1); to incorporate the provisions of COMDTNOTE 6010 of 20 Jun 88.

gg. Section 6-A-2b - Form changed to authorize local reproduction of the form.

hh. Section 6-A-3, Health Care Equipment Inventory Change Sheet (CG-5318) (RCS-G-KMA-13003), and Figures 6-A-3 and 6-A-3A deleted. The provisions of this section will be incorporated into a forthcoming Commandant Instruction 6700.11(series).

ii. Section 6-B-7 - New section on use of Clinic Data Collection Form (CG-5460).

jj. Chapter 7: Sections 7-B (Sanitation Standards and Procedures); 7-E (Personnel Monitoring Program (Radiation Exposure); and, section 7-G (Pest Management Program) have been removed and placed in COMDTINST M5100.29 (series).

kk. Section 7-A-1 - Deletes references to general sanitation, insect and rodent vector control, occupational health and industrial hygiene, and safety, health education, and technical instruction to operators of sanitary facilities; all moved to COMDTINST M5100.29(series).

ll. Section 8-A - Rewritten to describe changes in resource management resulting from establishment of the MLC's and expansion of OG-57.

mm. Section 8-D-7 - New section regarding the wearing of the Coast Guard uniform by USPHS officers assigned to Coast Guard detail.

nn. Section 8-E-3a - Rewritten to require requests for non-standard eyewear to be submitted to MLC (k). Also allows an LES to be used as justification for requests. Deletes requirement for a visual acuity check at least every two years.

oo. Chapter 9 has been removed and inserted elsewhere in this manual or deleted, as follows:

pp. Sections 9-A, 9-C, 9-D, 9-E, and 9-F have been moved to chapter 1.

5. qq. Section 9-B - Mobile Dental Detachment (MDD) has been deleted, as the Coast Guard no longer has any operating mobile dental detachments.

rr. Section 10-A-2c - Rewritten for clarity, and to add that contract physicians may NOT countersign civilian prescriptions.

ss. Section 10-A-4 - Requires a signature file be kept in the pharmacy.

tt. Section 10-A-5g - Rewritten to allow prescription refills for oral contraceptives and estrogens for up to one year. Also requires verifying the original prescription and authorization for refills. Deletes reference to refill log.

uu. Section 10-A-5j - Rewritten to eliminate filling of nonemergency civilian prescriptions from the after-hours locker.

vv. Section 10-B-10b - Rewritten to provide guidelines for disposal of hypodermic syringes and needles.

ww. Section 11-A-2 - Rewritten eliminating the non-personal restriction on contracting and expands services to include dental hygiene, physical therapy, and occupational medicine.

xx. Section 11-A-4 - Rewritten to describe changes in information required for contract approval. Requires all requests to be submitted to MLC (k).

yy. Section 11-A-5 - Rewritten deleting all references to the automatic pickup system. Charges MLCs with all budgeting, reviewing, and paying for authorized nonfederal health care.

zz. Section 12-A-2 - Establishes new criteria for use to determine when a person is considered occupationally exposed for medical monitoring purposes.

aaa. Section 12-A-5b - Rewritten to assign review responsibility for OMMP reports and data to MLC (k).

bbb. Section 12-B-3a - Changes requirement for PERIODIC exam to annual.

5. ccc. Section 12-D-4a(1) - Adds requirements for a physical exam prior to assignment to a position involving potential exposure to asbestos.

ddd. Section 12-D-4b - Rewritten to require PERIODIC and termination exams annually.

eee. Section 12-E - New section added to provide guidance on Medical Surveillance Program for Benzene.

6. REQUIRED REPORTS. Chapters 6 and 7 contain detailed instructions and procedures for completing all required reports and outline forms availability.

7. ACTION. Area and district commanders, commanders of maintenance and logistics commands, unit commanding officers, and Commander, CG Activities Europe shall comply with the contents of this manual.

Michael Hudgins
MICHAEL HUDGINS
Chief, Office of Health and Safety

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U.S. Department of Transportation
United States Coast Guard

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COMDTNOTE 6000

24 AUG 2000

COMMANDANT NOTICE 6000

CANCELED: 23 AUG 2001

Subj: CH-15 TO MEDICAL MANUAL, COMDTINST M6000.1B

1. PURPOSE. This Notice publishes revisions to Medical Manual, COMDTINST M6000.1B. Intended users of this directive are all Coast Guard Units that maintain Medical Manuals.

2. ACTION. Area and district commanders, commanders of maintenance and logistics commands, commanding officers of headquarters units, assistant commandants for directorates, Chief Counsel, and special staff offices at Headquarters shall ensure compliance with the provisions of this Notice.

3. DIRECTIVES AFFECTED. Medical Manual, COMDTINST M6000.1B

4. SUMMARY. Newly revised material and editorial changes are denoted by a line in the right hand column of the page (numerous changes have been made to Chapters 1, 2, 3, 4, 5, 7, 8, 10, 11, and 12. Chapter 9 (Health Services Technicians Assigned to Independent Duty) has also been established. Significant changes to content are summarized below:

   a. Chapter 1-B-1.g: Specifies mailing procedures for DMOA review of IDT record entries.

   b. Chapter 1-B-6.c: Specifies general duties of Chief, Health Services Division as they relate to supporting clinic duties for units designated by the cognizant MLC in their area of responsibility (AOR).

   c. Chapter 1-B-14: Specifies that HSDs may be assigned to supplement HS duty sections, and that HSDs may not stand HS watches independently.

   d. Chapter 2-A-1.b: Specifies that members shall receive health care at the Uniformed Services Medical Treatment Facility (USMTF) which serves the organization to which the member is assigned.

DISTRIBUTION – SDL No. 138

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NON-STANDARD DISTRIBUTION: see page 4

e. Chapter 2-A-6(e): Revised to clarify MLC(k) responsibility to outline the appeals process in their denial transmittal for nonfederal medical care requests.

f. Chapter 3-A-7.l(5): Adds non-fitness for duty determination physical examinations under the miscellaneous physical examinations section.

g. Chapter 3-F-16.b. Changes policy regarding those members taking medication for anxiety, somatoform, or dissociative disorders regardless of the length of treatment by removing them from aviation duty.

h. Chapter 3-F-16.c: Prescribes guidance for health services practitioners on the administrative processing of members diagnosed with mood disorders, i.e. bipolar disorders, recurrent major depression, all other mood disorders associated with suicide attempt, untreated substance abuse, requiring hospitalization, or requiring treatment (including medication, counseling, psychological or psychiatric therapy) for more than 6 months, or requiring 36 months of prophylactic treatment (while asymptomatic) following initial therapy.

i. Chapter 3-F-22: Revised to allow members who are HIV-1 antibody positive, but are otherwise asymptomatic may now receive an assignment from CGPC to remain on active duty in a non-deployable billet.

j. Chapter 3-G-4: Add to read, "Routine crown and temporary dental work is not disqualifying for aviation missions. Recommends that temporary crowns be cemented with permanent cement like polycarboxylate or zinc oxyphosphate cement until the permanent crown is delivered. Recommend temporary grounding of 6-12 hours after procedures. Such work may be disqualifying for deployment."

k. Chapter 3-G-6: Extended audiometric table to include ranges 3000 and 4000 hz with accompanying decibels.

l. Chapter 4: Added figures omitted in Change 14.

m. Chapter 5-B-1: Discusses availability of world-wide assignment for personnel on therapy for conditions listed in DSM IV-R under Axis I or Axis II.

n. Chapter 5-B-11: Revises policy concerning Anxiety Disorders or Anxiety and Phobic Neuroses.

o. Chapter 5-B-18: Addresses management and treatment of diagnosed eating disorders in the Coast Guard.

p. Chapter 7 (Preventive Medicine) has been revised to reflect current reportable disease policies and procedures.

q. Chapter 8-A-2 (Fiscal and Supply Management): Revised to reflect changes in monetary limitations for purchasing health care equipment.

r. Chapter 8-B-1 and (2): Changes reference from cancelled reference COMDTINST M4400.13 to current policy manual Property Management Manual, COMDTINST M4500.5A.

s. Chapter 9: Establishes Health Services Technician Assigned to Independent Duty chapter in COMDTINST M6000.1B, Medical Manual.

t. Chapter 10: Revises prescription filling policy at Coast Guard clinics. Establishes policy prohibiting dispensing of "herbal supplements" or "dietary supplements'. Establishes policy for all clinics to procure controlled substances from DSCP prime vendor or directly through DSCP if items are available. Also establishes policy that all schedule II controlled substance prescriptions by physician assistants or nurse practitioners shall be countersigned quarterly by their supervising medical officer.

u. Chapter 11: Revised to reflect changes in health care procurement for all Coast Guard beneficiaries. Establishes MLC (k) responsibility for processing all federal and nonfederal health care claims in compliance with Federal Law and CG Regulations.

v. Chapter 12: Establishes the Occupational Medical Surveillance and Evaluation Program (OMSEP) in lieu of the Occupational Medical Monitoring Program (OMMP).

w. Chapter 13-L-4.c: Deletes written consent requirement for "Immunizations."

5. PROCEDURES. Remove and insert the following chapters or pages:

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| Chapter 8, Pg. 2, 3, 15 | Chapter 8, Pg. 2, 3, 15 CH-15 |
| Chapter 9, "to be developed" | Chapter 9 CH-15 |
| Chapter 10 CH-14 | Chapter 10 CH-15 |
| Chapter 11 | Chapter 11 CH-15 |
| Chapter 12 | Chapter 12 CH-15 |
| Chapter 13, Pg. 13-91, CH-14 | Chapter 13, Pg. 13-91 CH-15 |

6. FORMS AVAILABILITY: All forms listed in this Manual are available from stock points listed in the Catalog of Forms, COMDTINST 5213.6D. Some forms referenced in this manual are available on SYSIII Jet Form Filler.

JOYCE M. JOHNSON
Director of Health and Safety

Encl: (1) CH-15 to Medical Manual, COMDTINST M6000.1B

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# CHAPTER 1
# ORGANIZATION AND PERSONNEL

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# CHAPTER 1. ORGANIZATION AND PERSONNEL

## Section A - Organization.

1. Mission of the Coast Guard Health Services Program.

   a. The Health Services Program supports Coast Guard missions by providing quality health care to maintain a fit and healthy active duty corps, by meeting the health care needs of dependents and retirees to the maximum extent permitted by law and resources, and by providing authorized occupational health services to civilian employees.

2. Director of Health and Safety.

   b. Mission. The mission of the Director of Health and Safety is to:

      (1) serve as advisor to the Secretary of Transportation;

      (2) serve as advisor to the Commandant; and

      (3) develop and implement the Coast Guard's overall health care program.

   c. Duties and Responsibilities. Under the general direction and supervision of the Commandant, Vice Commandant, and the Chief of Staff, the Director of Health and Safety shall assume the following duties and responsibilities:

      (1) serve as Program Director (PD) for the Health Services Program (G-WKH), and the Safety and Environmental Health Program (G-WKS);

      (2) act as advisor to the Commandant in providing counsel and advice on:

         (a) health care issues affecting operational readiness and quality of life in the Coast Guard;

         (b) interdepartmental and interservice agreements for health care of Coast Guard personnel;

         (c) the significance of legislative matters affecting the Coast Guard Health Services and Safety and Environmental Health Programs; and

         (d) important developments in the Department of Defense and the Department of Health and Human Services which affect the Coast Guard Health Services and Safety and Environmental Health Programs;

      (3) serve as advisor to the Secretary in developing and implementing departmental national defense emergency medical, health, and sanitation policies and plans (except those involving civil aviation) and such other advisory services that may be required or requested;

(4) plan, develop, and administer a comprehensive, high quality health care program (quality is defined as the desired level of performance against established standards and criteria) for all authorized beneficiaries;

(5) plan, develop and administer a comprehensive program for the prevention of illness and injury of Coast Guard personnel and dependents, to reduce losses, and protect the environment in Coast Guard working facilities and living spaces/by establishing and maintaining adequate safety and environmental health standards for aircraft, vessel, shore facilities, and motor vehicle; providing information and encouragement to beneficiaries for personal wellness programs and providing healthy and pleasing meals at Coast Guard dining facilities;

(6) administer TRICARE Management Activity (TMA), including the appropriation of funds, on behalf of the Coast Guard as provided in the Dependents Medical Care Act and regulations pursuant thereto;

(7) monitor and protect the health of personnel attached to the Coast Guard through the Occupational Medical Surveillance and Evaluation Program (OMSEP);

(8) direct the administration of funds in those appropriations or allotment fund codes under the control of the Office of Health and Safety, including furnishing total budget estimates and apportionment or allotment recommendations to the Chief of Staff;

(9) advise responsible offices concerning establishing physical standards for military duty and special operational programs;

(10) procure and recommend assignments to the Commander, Coast Guard Personnel Command (CGPC), and review the performance of Public Health Service personnel detailed to the Coast Guard;

(11) provide professional health care guidance to all health services personnel;

(12) maintain liaison with the Public Health Service, the Department of Veterans Affairs, the Department of Defense, and other Federal agencies and serve on interservice boards and committees as appointed;

(13) set policy and guidelines for the subsistence program;

(14) provide technical advice to operating program managers;

(15) set policy and guidelines for health care quality assurance; and act as the Governing Body for Coast Guard health care;

(16) set policy and guidelines for the Alcohol Abuse Prevention program; and

(17) serve as a member of the Human Resources Coordinating Council.

(18) administer the Coast Guard Emergency Medical system.

(19) Public Health Service. The responsibility of the Public Health Service for providing physicians, dentists, and other allied health personnel support to the Coast Guard is set forth in 42 USC, 253. These personnel are provided on a reimbursable basis and are subject to Coast Guard regulations and the Uniform Code of Military Justice (UCMJ).

3. Health and Safety Division, Maintenance and Logistics Commands MLC (k).

a. Mission. The mission of MLC (k) is to:

(1) interpret and implement health care policies as set forth by the Commandant;

(2) develop and implement the Coast Guard's overall Health Services, and Safety and Environmental Health Programs for the Area; and

(3) serve as Health Care Advisor to Commander, Maintenance and Logistics Command.

b. Functions and Responsibilities. Under the direction and supervision of the Commander, Maintenance and Logistics Command (MLC), the Chief, Health and Safety Division shall:

(1) act as Medical Advisor to the Area commander in providing counsel and advice on:

(a) interagency and interservice agreements for health care of Coast Guard personnel;

(b) the significance of legislative matters affecting the Coast Guard health care program; and

(c) important developments in the Department of Defense which affect the Coast Guard health care program.

(2) serve as advisor to the Area commander in developing and implementing national defense emergency medical, health, and sanitation policies and plans;

(3) plan, develop, and administer a comprehensive health care program for all beneficiaries;

(4) develop health services mobilization requirements and support documents;

(5) review and act on requests for contract health care services;

(6) act as contract technical representative in reviewing health care contract proposals;

(7) administer the health care quality assurance program;

(8) administer the Safety and Environmental Health Programs;

(9) administer the Alcohol Abuse Prevention program;

(10) develop and implement pharmaceutical support services;

(11) be responsible for providing funding for direct health care expenditures;

(12) be responsible for the general oversight of health care budgets;

(13) be responsible for the oversight of general clinic policy to include setting standards for clinic operations and prioritizing of clinic functions;

(14) designate clinics as catchment area patient management sites;

(15) maintain liaison with U. S. Public Health Service, the Department of Veterans Affairs and the health departments of the Department of Defense and other Federal agencies within you area of responsibility; and

(16) be responsible for the general oversight of the subsistence program by providing assistance to Coast Guard units (ashore and afloat) to ensure the maintenance of high quality food service operations.

c. In addition, the MLC (k)s shall have the right, in coordination with unit commanding officers, to detail health services personnel (officer and enlisted, Coast Guard and Public Health Service) for special assignments including meeting short-term staffing needs.

4. Responsibilities of Commands with Health Care Facilities. Unit commanding officers shall be responsible for:

a. oversight of clinic procurements;

b. ensuring adherence to policies, military regulations and general administrative procedures,

c. funding for administrative and non-health care expenditures for clinics;

d. maintenance, repair and general support of clinic facilities;

e. ensuring compliance with action items required by quality assurance site surveys; and

f. working with the appropriate MLC in fostering quality, productivity, and operating efficiencies.

Section B.- Personnel.

1. General Duties of Medical Officers. The principal duty of medical officers is to understand and support the operational missions of the Coast Guard. Medical Officers include Physicians, Physician Assistants (PA/PYA), and Nurse Practitioners (NP) who are members of the Coast Guard or Public Health Service detailed to the Coast Guard. Medical officers are required to have appropriate certification or licensure while assigned to the Coast Guard. Physicians must have an unrestricted state license to practice medicine. See 1-B-11 for nurse practitioner and physician assistant credential requirements. Civilian medical practitioners (under contract to the Coast Guard or GS employees) assigned to a medical treatment facility are considered medical officers to the limits defined by the language of their contract and/or job description. Civilian medical practitioners who have a contract with the Coast Guard to see patients in their private offices are not considered medical officers for the purpose of this instruction.

   a. General Responsibilities.

      (1) Medical officers must keep informed in all fields of general and military medicine and shall:

         (a) ensure the fitness for unrestricted worldwide duty of active duty personnel;

         (b) provide health care for all eligible beneficiaries as authorized by applicable laws and regulations;

         (c) make appropriate referrals of eligible beneficiaries following existing policy and regulation;

         (d) treat sick and injured personnel;

         (e) prevent and control disease;

         (f) promote health;

         (g) give advice on such matters as hygiene, sanitation, and safety;

         (h) recommend duty status of active duty personnel and Coast Guard civil service employees;

         (i) ensure that each patient is notified of results of all PAP smears, mammograms, biopsies, pregnancy tests, and all tests that are abnormal or whose results indicate a need to initiate or change treatment.

         (j) thoroughly understand all operational missions of the unit, units within the local area, and the human factors involved in performing them;

(k) ensure that personnel are physically and psychologically fit for duty and attempt to learn of any unusual circumstances which might adversely affect their proficiency;

(l) maintain an active interest and participate in the local unit's safety program, assist the safety officers in planning, implementing, and coordinating the unit safety program, and advise the command on safety issues;

(m) be thoroughly familiar with the types of personal protective and survival equipment carried at the unit. Assist the engineering officer in maintaining and issuing the equipment, and be familiar with the Rescue and Survival System Manual, COMDTINST M10470.10 (series);

(n) actively participate in the unit physiology training program to ensure that personnel are capable of coping with the hazards of mission performance by presenting lectures and demonstrations which include, but are not limited to:

1 fatigue

2 emergency medicine,

3 survival,

4 disorientation,

5 night vision,

6 stress, and

7 drug and alcohol use and abuse.

(o) ensure that HSs who participate in EMT operations maintain their certification, knowledge and Health Services skills in EMT operations, physiology;

(p) provide Health Services refresher training on emergency procedures; and

(q) participate in a program of continuing education in operational medicine including familiarity with information published for other branches of the Armed Forces.

(2) Medical officers act as medical members in physical disability evaluation cases.

(3) Medical officers are responsible for advising commanding officers on: health status of personnel; nutritional adequacy, food handling and preparation;

heating, ventilation, and air conditioning; housing; insect, pest, and rodent control; water supply and waste disposal; safety; items sold in exchanges, commissaries, and other CGES facilities; the physical fitness of personnel; and immunization standards.

b. Physical Examinations. Medical officers shall conduct physical examinations in accordance with Section 3-C of this Manual and in cases involving disability evaluation be guided by the Physical Disability Evaluation System, COMDTINST M1850.2 (series), and the Department of Veterans Affairs Publication, Physician's Guide for Disability Evaluation Examinations.

c. Reports to Command. Report injuries to, or deaths of, personnel; damage, destruction, or loss of health services department property; and any other important occurrence, to the officer of the day or other command official for entry into appropriate log. Report any suspected child/spouse abuse to the commanding officer, family advocacy representative, and local law enforcement/child protective agency in accordance with Family Advocacy Program, COMDTINST 1750.7 (series), and other local, state, or Federal law. Report patients in serious or critical condition to the commanding officer or officer of the day, together with the information needed to notify the next of kin. Death imminent procedures are contained in the Physical Disability Evaluation System, COMDTINST M1850.2 (series).

d. Educational Measures. Conduct health education programs, including disseminating information about preventing disease and other subjects pertaining to hygiene and sanitation.

(1) Sexually Transmitted Diseases. Conduct or supervise the instruction of personnel regarding sexually transmitted diseases and advise them of the associated dangers.

(2) First Aid Instruction. Conduct or supervise a program which will ensure knowledge and ability in first aid.

(3) Occupational Medical Surveillance and Evaluation Program (OMSEP). Conduct or supervise a program to indoctrinate personnel in the various aspects of occupational health and the OMMP.

(4) Human Immunodeficiency Virus (HIV). Conduct or supervise the instruction of personnel regarding (HIV) and advise them of the associated dangers.

(5) Wellness. Conduct or supervise a program to emphasize the importance of life-styles in maintaining health.

(6) Human Services. Conduct or supervise the instruction of Health Services personnel to ensure they are aware of all the services available to maintain a state of well being for personnel.

e. Cooperation With Other Agencies. Cooperate with Federal, state, and local agencies for preventing disease, reporting communicable diseases, and collecting vital statistics.

f. Designated Supervising Medical Officer (DSMO). Medical officers assigned as "designated supervising medical officer" (DSMO) will assume clinical responsibility for the treatment provided by each health services technician in their clinic for whom they are responsible. Assignments shall be made in writing and signed by the DSMO's commanding officer. Clinical supervision and accountability is defined as follows:

(1) during normal clinic hours, HS consultation with the DSMO as determined by that medical officer, review 20 percent of each day's new patient encounters seen only by the HS, and review 100 percent of all patient encounters seen only by the HS who return with no improvements. (Ideally these reviews would include the patient's presentation to the medical officer.) The DSMO shall countersign all records reviewed.

(2) outside normal clinic hours, direct or telephone consultations as determined by the DSMO or duty MO; and, the following working day, a review of 100 percent of all visits seen only by the HS. The DSMO or duty MO shall countersign all records reviewed.

g. Designated Medical Officer Advisor (DMOA). Health Services Technicians on independent duty (IDTs) shall have a "designated medical officer advisor" (DMOA) identified. The DMOA shall provide professional advice and consultation to the IDT. The cognizant MLC (k) shall apportion units with IDTs to units with medical officers attached. The cognizant MLC (k) shall make changes as necessary and forward such information to the affected units and Commandant (G-WKH). At the unit level, assignments shall be made in writing (addressed to the DMOA) and signed by the DMOA's commanding officer, with copies to the IDT unit and the cognizant MLC (k). Assignment letters shall be addressed to the specific individuals involved, and new letters shall be issued following a change of DMOA or IDT. Professional advice and consultation, in this instance, is defined as follows:

(1) Telephone or radio consultation regarding specific cases as necessary between the HS and the DMOA. This does not preclude consultation between the HS and another Coast Guard medical officer, a medical officer of the Army, Navy, Air Force, or USPHS, or a physician under contract to the Coast Guard whose contract provides for such consultations; and

(2) Treatment record review: At the end of each quarter, the commanding officer of the independent duty HS or his designee (cannot be the HS) shall select at random 15 health records which have at least one entry made by the HS during the previous quarter. For each of these records, copies shall be made of all SF 600 entries during the quarter. Copies of the SF-600's shall be sealed in an envelope and marked for the **DMOA's Eyes Only**. The copies are then forwarded to the DMOA for review. The DMOA shall review these record

entries according to established criteria for record review at his/her facility. Each record entry (copy) shall be annotated "reviewed," dated, and stamped with the DMOA's name and pertinent comments concerning the record entry. One copy of the reviewed record entries shall then be returned to the HS via the unit's commanding officer. A second copy of the reviewed entries shall be retained by the DMOA. Both the HS and DMOA copies shall be retained at the respective commands for a period of three years, for MLC review during QA site surveys. The record review shall be discussed with the HS in the quarterly phone contact between the DMOA and the HS. The DMOA is encouraged to provide input to the unit CO or XO regarding the professional performance of the independent duty HS.

(3) Review of MLC quality assurance site survey reports for the independent duty site: The DMOA and HS shall review the MLC quality assurance site reports for the site. They shall collaborate on the required written plan of corrective actions which must be submitted to the MLC following the site survey. The DMOA should also consult with the unit commanding officer regarding the findings of the survey report.

2. Duties of Senior Medical Officers. The senior medical officer attached to a unit is responsible to the commanding officer of the unit for the provision of health services. In addition to the general duties of a medical officer, the senior medical officer is responsible for:

a. performing those duties as prescribed in Coast Guard Regulations, COMDTINST M5000.3 (series) if designated by Commander, Coast Guard Personnel Command (CGPC) as division chief;

b. advising the commanding officer of any deleterious environmental health factors;

c. supervising any assigned PYA/PAs and NPs including, on a monthly basis, random review of approximately five percent of the PYA/PA/NP's charts for adequacy and appropriateness of treatment rendered;

d. in the absence of a pharmacy officer, maintaining antidotes for narcotics and poisons and ensuring only properly trained personnel are assigned to the pharmacy;

e. acting as the commanding officer's representative on local emergency planning boards, and, during emergencies or disasters, furnishing advice to the commanding officer, formulating plans, and helping civilian authorities meet health care needs;

f. managing the quality of health care services provided;

g. maintaining liaison with the hospital commander or senior medical officer of nearby (75 miles) USMTF's;

h. acting as quality assurance technical supervisor for all contracted health services;

i. ensuring efficient and effective use of all assigned medical officers and civilian consultants;

j. preparing, through training and experience, health services technicians for independent duty assignments;

k. recommending to the command a designated supervising medical officer (DSMO) for each HS who provides medical treatment to patients; and

l. convening medical boards as appropriate in accordance with Chapter 3, Physical Disability Evaluation System, COMDTINST M1850.2 (series)

m. ensuring that all ancillary service areas (e.g., laboratory, radiology, etc.) maintain adequate policy and procedures manuals;

n. in conjunction with the MLC, providing professional oversight and establishing qualifications standards and privileging for assigned personnel, including contract, reserve and student providers;

o. assigning personnel and ensuring position and billet descriptions are accurate and that credentials and privileging requirements are met;

p. within general Coast Guard and unit guidelines, determining the priority and range of services for each beneficiary group;

q. maintaining liaison with counterparts in MTF, USTF, VA and private sector facilities;

r. preparing performance appraisals for assigned staff;

s. reviewing and ensuring accuracy of Clinic Automated Management System (CLAMS) and other statistical and informational reports;

t. ensuring that appropriate training is conducted on a regularly scheduled basis;

u. ensuring active participation and compliance with the Quality Assurance Program;

v. ensuring strict adherence to current infection control procedures and standards;

w. keeping the division chief informed;

x. other duties assigned by the Chief, Health Services Division.

3. Duties of Flight Surgeons. In addition to fulfilling the general duties of medical officers, flight surgeons must:

a. thoroughly understand all operational missions of the aviation unit and participate as a flight crew member as required on MEDEVACS and to meet the requirements as

set forth in the Coast Guard Air Operations Manual, COMDTINST M3710.1 (series);

b. be familiar with the operational missions of other Coast Guard units in the local area;

c. obtain a general understanding of the flight characteristics of the aircraft assigned to the unit and be thoroughly familiar with the human factors involved in pilot and crew member interaction with the aircraft;

d. be familiar with the Air Operations Manual, COMDTINST M3710.1 (series), with specific emphasis on Chapter 6, Rescue and Survival Equipment; Chapter 7, Flight Safety; and the sections of Chapter 3 (Flight Rules) dealing with protective clothing and flotation equipment;

e. ensure that aviation personnel are physically and psychologically fit for flight duty and attempt to learn of any unusual circumstances which might adversely affect their flight proficiency, this includes getting acquainted with each pilot and crew member;

f. make recommendations to the commanding officer concerning the health status of aviation personnel, and in particular, only a flight surgeon or aviation medical officer (AMO) shall issue "up" chits, except as noted in Section 3-G-2;

g. maintain an active interest and participate in the air station flight safety program and assist the flight safety officer in planning, implementing, and coordinating the station flight safety program, and advising the command on the aeromedical aspects of flight safety;

h. participate as the medical member of Aircraft Mishap Analysis Boards and, when so assigned, be responsible for completing the Medical Officer's Report in accordance with Chapter 2 of Safety and Environmental Health Manual, COMDTINST M5100.47 (series);

i. be thoroughly familiar with the types and uses of personal pro-protective and survival equipment carried on aircraft at the unit [The flight surgeon shall assist in inspecting the equipment, shall advise the engineering officer and aviation survival members in maintaining and issuing the equipment, and shall be familiar with Rescue and Survival Systems Manual, COMDTINST M10470.10 (series)];

j. actively participate in the unit aviation physiology training program to ensure that aviation personnel are capable of coping with the hazards of flight by presenting lectures and demonstrations which include, but are not limited to:

   (1) fatigue,

   (2) emergency medicine,

   (3) survival,

   (4) disorientation,

(5) night vision,

(6) reduced barometric pressure,

(7) crash injury avoidance,

(8) stress, and

(9) drug and alcohol use and abuse.

k. advise the command on MEDVAC operations:

l. ensure that HSs who participate in aviation operations maintain their knowledge and skills in aeromedical physiology, and provide refresher training lectures and demonstrations to emergency medical technicians (EMTs) and health services technicians on emergency medical procedures; and

m. participate in a program of continuing education in aviation medicine including familiarity with information published for flight surgeons by other branches of the Armed Forces.

4. General Duties of Dental Officers. The principal duty of dental officers is to support the Coast Guard operational mission by determining each member's fitness for unrestricted duty on a worldwide basis. Coast Guard dental officers are assigned to perform duties as general dental officers. Exceptions will be authorized in writing by Commander, Coast Guard Personnel Command (CGPC).

a. General Responsibilities.

(1) Coast Guard dental officers must stay informed in all fields of general and military dentistry and be responsible for:

(a) ensuring the fitness for unrestricted duty of active duty personnel on a worldwide basis;

(b) providing dental care for all eligible beneficiaries as authorized be applicable laws and regulations (ensure non-enrollment in United Concordia or Delta Dental before providing covered services);

(c) preventing and controlling dental disease (this includes performing dental prophylaxis);

(d) promoting dental health;

(e) referring eligible beneficiaries for dental treatment per MLC (k) SOP;

(f) prioritizing the delivery of dental care to meet Coast Guard unit operational readiness requirements;

(g) ensuring that patients with gingivitis or periodontal disease have the opportunity to receive follow up care;

(h) ensuring that results of all biopsies are received and reviewed by a dentist to ensure that the appropriate action is taken;

(i) ensuring that when dental externs are assigned to the clinic, that a protocol is developed detailing lodging and subsistence arrangements, types of procedures allowed, available population to be treated and supervising dental officer responsibilities. The protocol must be signed by the Commanding Officer and provided to all participating dental schools;

(j) ensuring that procedures for handling medical emergencies within the dental clinic are clearly written and emergency drills are practiced periodically; and

b. Dental examinations. Dental officers shall conduct the dental examination portion of physical examinations in accordance with Chapter 3 of this Manual. Dental examinations shall be conducted as soon as practical on personnel who report for duty so as to determine the need for dental treatment and to verify their dental records. Annual Type 2 dental examinations shall be conducted on all active duty personnel collocated with dental examiners (i.e., Coast Guard DOs, DOD DOs, or civilian contract dentists).

c. Care of Mass Casualties. Dental officers shall be qualified to perform first aid procedures in order to treat or assist in treating mass casualties.

d. State Licensure. While assigned with the Coast Guard, dental officers are required to have an unrestricted state license to practice dentistry.

e. Continuing Education. Participate in a program of continuing training in operational medicine/dentistry including familiarity with information published for other branches of the Armed Forces.

5. General Duties of Senior Dental Officers. The senior dental officer is responsible for:

a. performing duties outlined in Coast Guard Regulations, COMDTINST M5000.3 (series) if designated by Commander, Military Personnel Command as division chief;

b. conducting an organized preventive dentistry and dental health education program for all eligible beneficiaries;

c. preparing, through training and experience, health services technicians for independent duty assignments;

d. overseeing the preparation of reports, updating the dental clinic policy and procedures manual, and maintaining records connected with assigned duties;

e. overseeing the overall working condition, cleanliness and infection control of the dental clinic, which includes sterilization procedures, dental supply, equipment, publications maintenance, and the establishment of a preventive maintenance program for dental equipment and supplies;

f. maintaining custody, security, and records of the dispensing of dental stores including all controlled substances and poisons under the cognizance of the dental branch, and maintaining antidotes for narcotics and poisons;

g. issuing prescriptions for, and supervising the dispensing of controlled substances used in the dental branch;

h. maintaining custody, security, and records of precious metals dispensed and ensuring that precious metals are reclaimed as required and necessary forms are filed with the Department of Treasury;

i. managing the quality of dental care services provided;

j. in conjunction with the MLC (k), providing professional oversight and establishing qualifications standards and privileging for assigned personnel, including contract, reserve and student providers;

k. assigning personnel and ensuring position and billet descriptions are accurate and that credentials and privileging requirements are met;

l. within general Coast Guard and unit guidelines, determining the priority and range of services for each beneficiary group;

m. maintaining liaison with counterparts in MTF, USTF, VA and private sector facilities;

n. preparing performance appraisals for assigned staff;

o. and reviewing and ensuring accuracy of CLAMS and other statistical informational reports;

p. ensuring that appropriate training is conducted on a regularly scheduled basis;

q. ensuring active participation and compliance with the Quality Assurance Program.

r. ensuring strict adherence to current infection control procedures and standards;

s. keeping the division chief informed;

t. other duties assigned by the Chief, Health Services Division.

6. General Duties of Chief, Health Services Division. The Chief, Health Services Division will:

   a. act as an advisor to the commanding officer regarding all health related matters;

   b. under the unit executive officer, carry out the plan of the day as it pertains to the Health Services Division;

   c. ensure that clinic performs Supporting Clinic duties for units designated by the cognizant MLC in their area of responsibility (AOR) IAW this instruction, cognizant MLC Instructions and SOP, and other pertinent directives. These duties include but are not limited to the following:

      (1) Ensure the medical/dental readiness of all active duty personnel within their area of responsibility. This includes the review of health records and correction of deficiencies issues such as:

         (a) Immunizations

         (b) physical examinations

         (c) annual dental exams

         (d) HIV testing

         (e) DNA specimen submission

         (f) tuberculosis testing

      (2) Provide pharmacy oversight to designated units via collateral duty Pharmacy Officer.

      (3) Provide prime vendor pharmaceutical services to designated units via collateral duty Pharmacy Officers.

      (4) Provide prime vendor medical/surgery services to designated units.

      (5) Ensure that a Designated Medical Officer Advisor program is in place for designated units. This should include CPR/Lifesaver training to designated individuals.

      (6) Provide physical examination review (approval/disapproval) to designated units.

      (7) Ensure that health care delivery is provided in a timely manner to units for which a clinic is designated as their primary management site.

      (8) Provide health benefits advice to designated units.

(9) Assist with nonfederal medical and nonfederal dental preauthorization processing for designated units.

(10) Assist with nonfederal invoice processing for designated units.

(11) Assist with the timely completion of Medical Boards.

d. ensure the medical/dental readiness of all active duty personnel within their area of responsibility;

e. review the division AFC-30 and AFC-57 budget submittals;

f. be responsible for the allocation of resources (personnel, funds, space, and equipment) within the division;

g. when directed by the command, represent the division at staff meetings and ensure timely dissemination of the information to division personnel;

h. prepare performance appraisals as appropriate and ensure that performance evaluations for all health services personnel are prepared and submitted in accordance with current directives;

i. review all division reports;

j. be responsible for the division training program, including rotation of personnel assignments for training and familiarization, in the health care delivery system;

k. oversee clinic policies, procedures and protocols for compliance with this Manual, COMDTINST M6000.1B, MLC Instructions and S.O.P, and other pertinent directives;

l. provide oversight with regard to applicable Federal, state, and local statutes and regulations;

m. seek opportunities for cost reduction and enhancement of patient care through billet conversions, resource sharing, contracting, etc.;

n. designate a clinic Quality Assurance Coordinator and ensure that the QA program is carried out;

o. proctor student extern programs;

p. proactively support and promote the command wellness program;

q. participate in health care initiatives with local/regional DOD delivery systems, under Headquarters and MLC guidance;

r. oversee and promote work-life issues pertaining to health care;

s. ensure strict compliance to current infection control procedures and standards;

t. serve as chair of the Patient Advisory Committee;

u. oversee DSMO and DMOA programs;

v. in coordination with their respective MLC (k), establish their clinic as a Patient Management Site for units within their area of responsibility;

w. And perform other duties as directed by the Commanding Officer.

7. General Duties of Pharmacy Officers. While assigned with the Coast Guard, pharmacy officers are required to have an unrestricted state license to practice pharmacy. Pharmacy officers shall ensure that medications are acquired, stored, compounded, and dispensed according to applicable Federal laws in their primary and collateral duty clinics. This includes the direct supervision and management of the following:

a. dispensing and labeling of all drugs, chemicals, and pharmaceutical products;

b. maintaining signature files for all health care providers;

c. providing patient-oriented pharmaceutical services including monitoring for appropriate drug therapy, allergies, therapeutic duplication, and medication interactions. Significant patient interactions should be documented on the SF-600;

d. providing verbal and written patient medication counseling when appropriate;

e. maintaining routinely stocked items at levels consistent with anticipated usage between regularly scheduled procurements of pharmacy supplies and determining the most effective expenditure of funds;

f. ensuring that security measures are instituted to prevent unauthorized entrance into the pharmacy or misappropriation of pharmacy stock;

g. receiving, safeguarding, and issuing all controlled substances as the command-designated custodian of controlled substances;

h. ensuring adequate quality control of all pharmaceuticals locally compounded;

i. maintaining current drug information files and a reference library of pertinent textbooks and professional journals;

j. implementing the decisions of the Pharmacy and Therapeutics Committee and serve as secretary of that committee;

k. inspecting monthly all clinic stocks of drugs and biologicals;

l. developing and maintaining a formulary for local use by medical and dental officers;

m. informing the clinical staff of new drug information, policy changes, or other pertinent data on drugs;

n. participate in a program of continuing education in pharmacy or related fields;

o. maintaining, updating, and documenting monthly inspections of poison antidote and emergency drug supplies;

p. providing technical advice to the unit concerning drug testing, substance abuse, and other pharmaceutical matters;

q. providing guidance and advice to the medical staff on current immunization requirements,

r. serving as a resource for designated therapeutic categories of medications as they relate to the Coast Guard Health Services Allowance Lists, Core formulary, HS Drug Formulary and other drug lists, and.

s. participate in a program of continuing training in operational medicine/pharmacy including familiarity with information published for other branches of the Armed Forces.

8. Maintenance and Logistics Command Pharmacy Officers. Under the general direction and supervision of the Chief, Quality Assurance Branch, MLC, the MLC pharmacy officer shall:

a. plan, develop and implement, within the resources available, an MLC-wide pharmacy quality assurance program to:

(1) eview and evaluate the delivery of pharmaceutical services in support of mission operations, implement established policies pertaining to pharmaceutical services, and recommend appropriate changes, and

(2) monitor pharmacy operations, via quality assurance site visits, financial monitoring, and other workload indicators to ensure optimum utilization of personnel and financial resources.

b. plan and administer the acquisition and distribution of pharmaceuticals:

(1) review, analyze, and recommend the most efficient and cost effective means for providing pharmaceutical services throughout the Area, including the financial resources to be allocated to each operating facility under MLC oversight;

(2) monitor the procurement of controlled substances by Coast Guard units within the Area;

(3) provide to MLC (kqa) a system for the random monitoring of drugs procured from nonfederal sources.

c. serve as pharmaceutical consultant on pharmacology, pharmacy, and drug utilization and provide technical pharmacy expertise, assistance, and advice to the MLC Commander and command elements within the Area;

d. provide guidance and advice regarding the evaluation, training, and justification for pharmacy personnel to meet operational needs of units within the Area;

e. provide liaison or representation to regional Federal and professional pharmacy groups and committees; and

f. administer and monitor the collateral duty assignments of pharmacy officers in their respective Area.

9. Environmental Health Officers.

a. Duties: Environmental health officers are responsible for recognition, evaluation, and control of biological, chemical, physical, and ergonomic factors or stresses arising from the environment which may cause sickness, impaired health and well-being, or significant discomfort and inefficiency, property damage, or which could adversely affect the Coast Guard's industrial hygiene, pest management, radiological health, and sanitation. Specific responsibilities can include:

(1) planning, budgeting, implementing and directing an environmental health program to support commands within their geographic area of jurisdiction.

(2) conducting environmental health audits of Coast Guard facilities and operations in order to detect health hazards and noncompliance with applicable safety and environmental health laws, regulations, standards, and procedures. Facilities and operations include:

(a) work environments;

(b) storage, handling, treatment, and disposal of hazardous materials and hazardous waste;

(c) storage, handling, treatment, and disposal of infectious medical waste;

(d) food preparation, service and storage operations;

(e) solid wastes storage, handling, treatment, and disposal;

(f) pest management operations;

(g) potable water treatment, storage and distribution systems;

(h) waste water collection, treatment, and disposal system;

(i) housing facilities;

(j) ionizing radiation sources;

(k) non-ionizing radiation sources;

(l) recreational facilities;

(m) health care facilities;

(n) child care facilities;

(o) laundry and dry-cleaning operations; and

(p) barber shop operations

(3) providing technical assistance to units to abate deficiencies identified by the environmental health officer during the audit.

(4) monitoring ongoing hazard abatement actions to ensure that identified hazards are being eliminated promptly.

(5) providing environmental health training to commands within their jurisdiction.

(6) providing technical assistance to units on request to identify and abate health risks.

(7) reviewing engineering plans and specifications for new facilities and modifications to existing facilities to ensure conformance with environmental health standards and practices.

(8) serving as technical advisor to commands within their jurisdiction.

(9) initiating and conducting special health risk assessment studies.

(10) maintaining liaison with Federal, state, and local government agencies concerning environmental health for commands within their jurisdiction.

(11) advising commands when medical monitoring data indicates the possibility of occupationally-induced or aggravated disease and investigating possible causes so that corrective measures can be initiated.

(12) providing consultation, advice, and training on the occupational medical monitoring program to Coast Guard commands within their area of jurisdiction.

(13) enrolling personnel in the OMSEP when they meet the criteria of occupational exposure as defined in paragraph 12-A-2.

(14) disenrolling personnel from the OMSEP when they do not meet the criteria of occupational exposure as defined in paragraph 12-B-4.

b. Reports. Environmental health officers shall submit reports to the appropriate MLC (k) about environmental health conditions observed during their surveys.

c. Duty Limitations. Environmental health officers shall carry out all management functions required to operate the safety and environmental health program within their AOR. They may be required to perform only those technical duties for which they are trained. They may represent health services at various staff meetings in matters relating to the management and budgetary aspects of their assignment. They will be primarily responsible for special studies as in the case of monitoring chemical spill response and enforcement personnel. They will be responsible to the Commander, MLC (k) for proper implementation of the safety and environmental health program.

10. Clinic Administrators. Officers, Chief Warrant Officers (experience indicator 19), or senior enlisted personnel assigned to manage and administer health care facilities.

a. Under the direction of the Chief, Health Services Division, manage the administrative functions required to operate the health care facility. The Clinic Administrator will not be required, nor attempt, to perform clinical duties for which he/she is not trained.

b. General Responsibilities. The Clinic Administrator will:

(1) plan, supervise, and coordinate general administration of the health services facility;

(2) prepare, submit, manage, and exercise fiduciary control and accountability over the health services division AFC-30 and AFC-57 funds;

(3) provide fiscal oversight over the acquisition of equipment and supplies;

(4) maintain a planned program of equipment maintenance and replacement;

(5) provide physical security of health services division supplies and pharmaceuticals;

(6) maintain liaison with other local agencies (military and civilian) in all health care related matters;

(7) provide resources to assist medical and dental officers in emergency care of the sick and injured when necessary;

(8) prepare the disaster preparedness plan as it relates to the health services division;

(9) prepare the heavy weather bill as it relates to the health services division;

(10) seek opportunities for cost reduction and enhancement to patient care through billet conversions, resource sharing, contracting, etc.;

(11) serve as an advisor to the chief, health services division on all administrative matters;

(12) oversee the supervision of enlisted personnel assigned to the health services division;

(13) ensure that correspondence, reports, and records comply with appropriate instructions (i.e. Paperwork Management Manual, Coast Guard Correspondence Manual, etc.);

(14) maintain an adequate health services division reference library;

(15) train subordinates, conduct classes, instruct enlisted personnel in their duties, and supervise their study of regulatory and professional publications and courses for advancement in rating;

(16) participate in a program of continuing education in Health Care Administration;

(17) assist beneficiaries with health benefits information;

(18) enforce standards of appearance and conduct of health services division personnel;

(19) ensure that accurate, appropriate data is submitted to the CLAMS information system, CHCS system, etc.;

(20) oversee clinic rotation assignments of Health Services Technicians;

(21) implement clinic policies, procedures, and protocols, for compliance with Coast Guard regulations, the Medical Manual, MLC INST/SOP, and other pertinent directives;

(22) ensure compliance with all applicable Federal, state, and local statutes, together with the medical, dental and pharmacy officers;

(23) oversee and promote work-life issues pertaining to health care

(24) serve as assistant chair for the Patient Advisory Committee;

(25) ensure that enlisted personnel evaluations for members assigned to the health services department are prepared and submitted in accordance with the Coast Guard Personnel Manual;

(26) provide administrative oversight in the areas of NONFED health care, contracts, and BPAs;

(27) ensure that health care invoices are processed in accordance with MLC INST/SOP;

(28) ensure that physical examinations comply with current standards;

(29) promote and administer the unit's environmental sanitation program (in the absence of an environmental health officer); and

(30) oversee the unit's Occupational Medical Surveillance and Evaluation Program (OMSEP), in the absence of an environmental health officer.

11. Physician Assistants (PA/PYA(s)) and Nurse Practitioners (NP).

a. General Responsibilities. PA/PYA(s) and NP(s) responsibilities are defined in Section 1-B-1. Under the supervision of the senior medical officer they are subject to the duty limitations listed below.

b. Duty Limitations.

(1) Senior Medical Officers (SMO) of units with mid-level providers (physician assistants or nurse practitioners) assigned shall assign clinical duties and responsibilities to each provider and shall be accountable for the actions of those providers.

(a) To determine the extent of oversight required, SMOs shall be guided by this section, the provider's clinical training and previous experience, by personal observation, and Chapter 13-C, Clinical Privileges.

(b) The SMO may delegate supervisory responsibility to another staff physician or certified mid-level provider (mentor). A copy of this delegation shall be filed in the non-certified provider's Professional Credentials File (PCF).

(c) Physicians responsible for supervising mid-level providers shall perform and document reviews of at least five percent of the mid-level provider's charts each calendar month for accuracy of diagnosis and appropriateness of treatment rendered.

(2) Physician assistants who are not certified by the National Commission on Certification of Physician Assistants (NCCPA), recent graduates who have not taken or passed the NCCPA examination, and nurse practitioners who have not taken or passed a specialty board examination offered by the pertinent nurse practitioner certifying organization, shall practice in Coast Guard facilities only under the following conditions:

(a) all health record entries shall be co-signed by a licensed or certified provider by the end of the next working day;

(b) all prescriptions, except for those on the Coast Guard HS formulary, shall be co-signed by a licensed or certified provider by the end of the next working day;

(c) when a supervisory provider is not present at the unit, noncertified mid-level providers shall be restricted to providing medical care, except for emergencies, to active duty members only;

(d) noncertified mid-level providers may stand clinic watches providing a standby licensed or certified provider is available via telephone to discuss any questions or concerns; and,

(e) with the exception of operational emergencies, noncertified mid-level providers are not eligible for independent TAD assignments at locations where a supervisory provider is not present.

c. Nothing in this section limits PA/PYA's or NP's access to any available source of information or advice during an emergency.

12. TRICARE Management Acitivity-Aurora (TMA) Liaison Officer.

a. Responsibilities. The Coast Guard TMA liaison officer maintains liaison between TRICARE and Commandant (G-W) on matters of policy, operations, and program administration. This function will not involve the responsibility for formulating department policies. Departmental policies will continue to be developed by members of the liaison group for the Uniformed Services Health Benefits Program.

b. Duties.

(1) Specific Duties. Specific duties include, but are not limited to the following:

(a) coordinate and assist, as necessary, in preparing and submitting uniform workload data for use in budgetary programming at departmental level;

(b) ensure timely notification to Commandant (G-W) concerning changes in TRICARE operational or administrative procedures;

(c) identify gaps in the TRICARE information program and recommend solutions;

(d) represent Coast Guard viewpoints on matters relating to TRICARE operational and administrative procedures;

(e) assist in developing future TRICARE information programs;

(f) keep the Coast Guard informed of problem areas relating to service beneficiaries and service health care facilities, where appropriate, and recommend changes which will benefit the TRICARE operation; and

(g) monitor purchases of high-cost equipment for use by TRICARE beneficiaries and make recommendations concerning future purchases as opposed to rental.

(2) Duties within TMA Liaison Division.

(a) Investigate and respond to Presidential, Congressional, and beneficiary inquiries and complaints. Investigate and respond to inquiries concerning eligibility.

(b) Make public presentations concerning program benefits to various groups.

(c) Prepare special studies relating to program activities.

(d) Serve as liaison representative for USPHS, DVA, and NOAA.

(3) Other Duties. Participate in contract performance appraisal visits to the fiscal administrators. This function involves a comprehensive review and evaluation of the operations of the civilian agencies which, under contract, administer the program within each region.

13. Health Services Technicians.

a. Rating Structure. The rating structure for health services technicians is contained in Group VIII, Enlisted Qualifications Manual, COMDTINST M1414.8 (series).

b. General Duties of Health Services Technicians.

(1) The primary purpose of a health services technician is to provide supportive services to medical and dental officers and primary health care in the absence of such officers. In accordance with Paragraph 7-5-4, Coast Guard Regulations, COMDTINST M5000.3 (series), health services technicians shall not be detailed to perform combatant duties.

(2) In particular, health services technicians are responsible for all administrative aspects of health care and health record maintenance for both their command and subordinate commands without health services personnel attached. Geographically separate subordinate commands will retain responsibility for security (i.e. physical custody) of health records. In addition to the military duties common to all enlisted personnel, health services technicians perform health services department functions, such as:

(a) respond to calls for emergency medical assistance or evacuations (MEDEVACS);

(b) maintain appointments and appointment records;

(c) perform occupational medical monitoring duties;

(d) render first aid;

(e) perform tentative diagnosis and emergency treatment (In doing so, appropriate drugs, oral or injectable, may be administered as required in emergency situations to prevent or treat shock or extreme pain. In all

other incidents where injection of controlled substances is required, permission must be obtained from a physician prior to administration. In either case, the commanding officer shall be notified immediately and entries shall be made in the patient's health record.);

(f) provide nursing care where trained;

(g) provide definitive treatment;

(h) provide prophylactic treatments;

(i) instruct crew members in first aid and oral hygiene;

(j) prepare materials (including sterile instruments) and medications for use;

(k) maintain military readiness of the health services division by complying with the appropriate Health Services Allowance List;

(l) perform administrative procedures in health care matters, maintain health and dental records current in all aspects;

(m) adhere to regulations, instructions, and control of precious metals, controlled substances, and poisons;

(n) exercise responsibility for all equipment and stores placed in their charge, and exercise personal supervision over their condition, safekeeping, and economic expenditure;

(o) maintain cleanliness of all health services spaces;

(p) provide services as a health benefits advisor; and

(q) assist in the processing of nonfederal health care requests and invoices.

(3) Each HS who provides medical treatment to patients at a Coast Guard clinic staffed by one or more medical officers shall have a medical officer from that facility assigned in writing as his/her designated supervising medical officer (DSMO). The DSMO shall assume responsibility for all clinical treatment provided by the HS. Each independent duty HS, and HSs assigned to clinics without a medical officer, shall have a medical officer assigned in writing as his/her "Designated Medical Officer Advisor" (DMOA), to provide professional advice and consultation when needed. Refer to 1-B-1.f. and 1-B-1.g. for further details concerning DSMO/DMOA. Health services technicians assigned to units without a medical officer shall provide only "first response" emergency care to non-active duty personnel.

(4) Care shall be taken during medical examinations which involve chest, genital, and rectal areas to afford maximum privacy and minimum exposure of the

patient. An attendant of the same gender as the patient may be requested by the patient during examination or treatment. Health services technicians are authorized to conduct examinations to include: auscultation, palpation, percussion, and visual inspection as indicated by the medical complaint. Exceptions to the above are:

(a) health services technicians shall not perform:

1 routine digital examinations of the prostate;

2 routine examinations through instrumentation of the urethra; or

3 routine gynecological examinations.

(b) such routine examinations shall be referred to a medical officer. In situations where no medical officer is readily available and such examination is necessary to provide emergency care, the health services technician is authorized to do so. If the HS and patient are of different gender, an attendant of same gender as the patient shall accompany the patient during the examination or treatment.

(5) Participate in a course of continuing education, either clinical or administrative, through correspondence courses, resident courses, etc.

14. Health Services Technicians - Dental (HSDs).

a. The primary responsibility of HSDs is to provide chairside assistance to dental officers.

b. Additional duties include:

(1) Cleansing, sterilization, maintenance, and preparation of dental instruments;

(2) Cleansing, disinfecting, and maintenance of dental equipment and dental operatories;

(3) Preparing of dental materials;

(4) Assessing, referral, and treatment (under direct supervision of a dental officer) of common dental conditions;

(5) Charting dental conditions;

(6) Maintaining dental records;

(7) Exposure and development of dental radiographs;

(8) Providing oral hygiene instruction;

(9) Taking impressions and fabricating study models; and

(10) Performance of emergency intervention as necessary.

c. HSDs may be assigned to supplement HS duty sections, HSDs may not stand watch independently.

15. Independent Duty Health Services Technicians.

a. Duties.

(1) General Duties.

(a) Health services technicians on independent duty perform the administrative duties and, to the extent for which qualified, the clinical duties prescribed for medical officers of vessels and stations. (See Coast Guard Regulations, COMDTINST M5000.3 (series) and Section 1-B of this Manual.) They shall not attempt nor be required to provide health care for which they are not professionally qualified. They shall provide care only for active duty personnel, however they may provide care to non-active duty patients on an emergency basis. The filling of prescriptions for other than active duty personnel shall be strictly limited to emergency situations and to authorized stock on hand under the allowance list for the unit. They may, under the guidance set forth in Paragraph 10-A-6-h. of this Manual, establish non-prescription medication handout programs for eligible beneficiaries.

(b) Health services technicians shall not be detailed to perform combatant duties in accordance with Paragraph

(c) 7-5-4, Coast Guard Regulations, COMDTINST M5000.3 (series).

(d) In accordance with the Personnel Manual, COMDTINST M1000.6 (series), commanding officers are authorized to use health services technicians for general duties except noted below:

1 Health services technicians shall not be used for duties that require bearing arms (except for the limited purposes allowed by the Geneva Convention for their own defense or protection of the wounded and sick in their charge) even though the bearing of arms may be purely ceremonial.

2 Health services technicians shall not be used for combat duties that are unrelated to health care or administration.

(2) Specific Duties.

(a) Sanitation of the Command. Make daily inspections to ensure that appropriate sanitation practices are maintained.

(b) Health of Personnel. Establish and maintain a system for determining those who need immunizations, tuberculin tests, X-rays, dental services,

and routine physical examinations. The system shall include all return appointments requested by physicians or dentists from outside referrals requested by the command.

(c) Care of Sick and Injured. Hold daily sick call. Diagnose and treat patients within capabilities. When indicated, refer cases to facilities where medical or dental officers are available or, if this is not practical, obtain help and advice by radio or other expeditious means.

(d) Procurement, Storage, and Custody of Property. All parts of the Health Services Allowance List (HSAL) Afloat, COMDTINST M6700.6(series), and Health Service Allowance List Ashore, COMDTINST M6700.5 (series) contain information needed for ordering and procuring supplies. The HSAL also contains procedures for storage and custody of property.

(e) Reports. Prepare and submit reports required by Chapter 6 of this Manual and other directives.

(f) Health Records. Maintain health records as required by Chapter 4 of this Manual. Ensure that all treatment records and/or consults from outside referrals are obtained and placed in the health record. In addition, ensure that each patient is notified of all physical exams, consultations, and diagnostic tests (i.e., pap smears, mammograms, biopsies, x-rays, etc.) performed at any facility prior to filing in the health record.

(g) Training. Prepare and carry out a program for training non-medical personnel in first and self-aid, personal hygiene, sexually transmitted disease prevention, medical aspects of CBR warfare, cardiopulmonary resuscitation, etc., as part of the unit's regular training program.

(h) Other Duties. As assigned by the commanding officer.

b. Reporting Procedures.

(1) Policy. Upon reporting for independent duty, the health services technician shall consult with the commanding officer and executive officer to determine their policies regarding health care and the administration of the health services department.

(2) Inventory. Obtain the unit Health Services Allowance List and inspect the inventory of all health services department equipment, supplies, and publications. Initiate action for repair, survey, or replenishment of equipment, supplies, and publications. Verify inventory records and check logs of controlled substances. Report any discrepancies to the commanding officer without delay. Amplification of requirements and procedures is contained in Chapters 8 and 10 of this Manual.

(3) Health Records. Check health records against the personnel roster. Any missing records should be accounted for or requested from previous duty stations. If records cannot be accounted for within one month's time, open a new health record. Check health records for completeness, and if not current, obtain and enter all missing information to the fullest extent possible. (See Chapter 4 of this Manual for instructions pertaining to health records.)

(4) Operational Readiness. Ascertain the state of operational readiness of the health services department and advise the commanding officer. Operational readiness refers to the immediate ability to meet all health care demands within the unit's capabilities.

c. Responsibilities. The commanding officer is responsible for the health and readiness of the command. The health services department is charged with advising the commanding officer of conditions existing that may be detrimental to the health of personnel and for making appropriate recommendations for correcting such conditions. Meticulous attention to all details and aspects of preventing disease must be a continuing program. It is imperative that shipboard and station sanitation and preventive health practices be reviewed constantly in order that any disease promoting situation may be discovered immediately and promptly eradicated.

d. Routines.

(1) Daily Routines.

(a) Sickcall. Hold sickcall daily at a time prescribed by the commanding officer.

(b) Binnacle List. Prepare the unit Binnacle List and submit it to the commanding officer. (See section 6-B of this Manual for instructions pertaining to the Binnacle List.)

(c) Inspections. The following shall be inspected daily:

1 coffee messes;

2 living spaces;

3 heads and washrooms;

4 fresh provisions received (particularly milk and ice cream);

5 scullery in operation;

6 drinking fountains;

7 garbage disposals;

8 sewage disposals;

9 water supplies;

10 and industrial activities. (See Chapter 7 of this Manual and the Food Service Sanitation Manual, COMDTINST 6240.4(series)).

(d) Testing of Water. Perform water tests for chlorine/bromine content daily outside of CONUS and at all units that make or chlorinate/brominate their own water and record the results in the Health Services Log. Consult the Water Supply and Wastewater Disposal Manual, COMDTINST M6240.5 (series).

(e) Cleaning. Health services department spaces shall be cleaned daily and all used instruments cleaned and stored until sterilization can be accomplished.

(2) Weekly Routines.

(a) Health Services Logs. A health services log shall be kept by all activities and shall be submitted to the commanding officer for review, approval, and signature. Section 6-B of this Manual contains the information needed for maintaining the log.

(b) Inspections. Conduct sanitation inspection of the ship or station with emphasis on food service, living spaces, and sanitary spaces, specifically including food handlers, refrigerators and chill boxes, and galley spaces and pantries. Submit a written report to the commanding officer and make an appropriate entry in the health services log.

(c) Training. Conduct training in some aspect of health care or treatment unless required more frequently by the commanding officer or other directive.

(d) Hold field day.

(e) Resuscitators. Inspect and test resuscitators to ensure proper functioning. Record results in the health services log.

(3) Monthly Routines.

(a) Reports. Submit all required health services monthly reports, outlined by Chapter 6 of this Manual and other appropriate directives.

(b) Inspection of Battle Dressing Station Supplies. Monthly, inspect battle dressing station supplies to ensure adequate and full inventory. Check sterile supplies and re-sterilize every six months (refer to Health Services Allowance List Afloat, COMDTINST M6700.6 (series). Replace

expired or deteriorated supplies and materials. Enter an appropriate entry in the health services log indicating that the inspection was conducted and the action taken.

(c) First Aid Kits. Inspect hinges and hasps to ensure that they are free from rust, corrosion, or excessive paint.

(4) Quarterly Routines.

(a) Inventory of Controlled Substances. The Controlled Substances Inventory Board shall conduct an inventory, as required by Chapter 10 of this Manual, and submit a written report of the findings to the commanding officer.

(b) Reports. Submit all required health services reports as outlined in Chapter 6 of this Manual and other appropriate directives.

(c) Inventory. Conduct a sight inventory of all health services consumable supplies/equipment as required by Chapter 8 of this Manual and the Health Services Allowance List.

(d) First Aid Kits. Inspect the contents to ensure adequate and full inventory. Replace expired and deteriorated supplies and materials. Make an appropriate entry in the health services log.

16. Coast Guard Beneficiary Representatives at Uniformed Services Medical Treatment Facilities (USMTF).

a. Duties. Health Services Technicians may be detailed to duty as representatives at USMTF's where the Coast Guard patient workload warrants. The purpose of these assignments is to ensure, for active duty personnel:

(1) that Coast Guard authorities are provided prompt and current information concerning the status of Coast Guard personnel being treated;

(2) that Coast Guard personnel being treated receive necessary command administrative support;

(3) that the USMTF use the patient's Coast Guard health record and that entries are made in it or on forms that are filed in it; and

(4) that necessary health records and forms either accompany the patient or are forwarded to the command having custody of the health record.

b. Responsibilities. The representative is responsible for the following:

(1) Notification of Patient Status. It is essential that the representative keep cognizant command levels advised of the status of Coast Guard patients admitted for inpatient treatment. The following procedures shall be used:

(a) notify commands, by the most expedient means possible, within 24 hours of admission or discharge of members of their command.

(2) Health Record Entries. The representative is responsible for ensuring that all information concerning inpatient hospitalization, (e.g., admissions, operative summaries, discharge summaries) which is required to be entered in the health record, is furnished to the command which maintains the patient's health record. The representative shall also make the USMTF aware that all entries or forms associated with outpatient medical and dental activity must be entered in the patient's Coast Guard health record.

(3) Copies of Forms. The USMTF is responsible for completing and furnishing at least one copy of the following forms to the representative. The representative is responsible for preparing any additional copies needed.

(a) Inpatient hospitalizations:

1 SF-502, Narrative Summary (or other discharge summary form), and

2 Operative summary if surgery was done.

(b) Physical examinations:

1 SF-88, Report of Medical Examination.

2 SF-93, Report of Medical History.

3 ANY specialty reports obtained pursuant to the physical examination.

(c) Initial and Disposition Medical Boards:

1 NAVMED 6100/1, Medical Board Report Cover Sheet;

2 SF-88, Report of Medical Examination;

3 SF-93, Report of Medical History;

4 SF-502, Narrative Summary;

5 ANY specialty reports obtained pursuant to the physical examination;

6 CG-4920, Patient's Statement Regarding the Findings of the Medical Board, signed by the patient;

7 The command endorsement, Line of Duty/Misconduct Statement (if any), and members rebuttal (if any) should normally be done at/by the command.

(4) Liaison and Assistance. The representative shall:

(a) Maintain liaison between the Coast Guard units in the area and the USMTF as follows:

1 Clinical services to obtain timely appointments for Coast Guard personnel;

2 Pharmacy to facilitate drug exchange with Coast Guard units; and

3 Biomedical repair to help originate and maintain agreements for repair and maintenance of local Coast Guard medical equipment.

(b) Whenever possible, personally meet with each hospitalized Coast Guard active duty member and meet or phone the immediate family of the member, offering them assistance.

(c) In appropriate cases, channel other Coast Guard and DOD resources such as Mutual Assistance, Family Programs, Red Cross, etc. to assist hospitalized members and their dependents.

(5) Assignment and Duties. Health Services technicians assigned to a USMTF as Coast Guard Beneficiary Representatives are attached to MLC (k) which will exercise military control over them. The representative is expected to comply with the rules and orders of the USMTF to which assigned, and is subject to the orders of the hospital commander. However, it is expected that any duties assigned will be consistent with the purpose noted in subparagraph 13a. above.

17. Coast Guard Representative at the Department of Defense Medical Examination Review Board (DODMERB).

a. General. DODMERB is located at the USAF Academy, CO and is a joint agency of the military departments responsible for scheduling, reviewing, and certifying service academy and ROTC scholarship applicant medical examinations, and other programs assigned by the Office of the Assistant Secretary of Defense, Health Affairs.

b. Responsibilities.

(1) As a member of DODMERB, the Coast Guard:

(a) establishes entrance standards for the Coast Guard Academy; and

(b) makes its health care facilities available for completing entrance physical examinations for all service academies.

(2) As a member of DODMERB, the Coast Guard liaison:

(a) is assigned as an examination evaluator/administrator; and

(b) participates in implementing plans and organizational procedures for board actions.

c. Duties.

(1) Maintain a current list of examining centers which includes dates and examination quotas.

(2) Schedule examinations for the applicants.

(3) Notify applicants and program managers of scheduled examinations.

(4) Review and apply medical standards.

(5) Notify applicants and program managers of the status and qualifications of applicants.

(6) Provide copies of medical examinations and medical information to the various programs on applicants until they are no longer eligible.

(7) Provide copies of medical examinations and medical information to eligible applicants as requested.

18. Health Benefits Advisors (HBA).

a. Responsibilities. Individuals designated as Health Benefits Advisors (HBAs) at CGMTFs are responsible for advising and assisting beneficiaries concerning their health benefits. This individual shall:

(1) keep current on the TRICARE Program, Uniformed Services Family Health Benefits Program (USFHBP) and on all other health benefits programs available for members, former members, and their eligible dependents;

(2) advise all beneficiaries on matters pertaining to healthcare benefits, including;

(a) obtaining Nonavailability Statements,

(b) using the local appeal system for Nonavailability Statements, and

(c) conducting a local information program on healthcare benefits;

(3) advise TRICARE beneficiaries on the relationship between TRICARE, DVA programs, Social Security, Medicare, insurance provided through employment, and the effect of employment and private insurance on benefits available under TRICARE:

(a) stress availability of TRICARE and explain financial implications of using non-participating providers,

(b) explain provider participation in TRICARE and explain financial implications of using non-participating providers,

(c) provide beneficiaries the names and addresses of participating providers of the specific services the beneficiary requires, and

(d) caution beneficiaries to verify that the provider participates in TRICARE at the time the services are provided;

(4) coordinates TRICARE problem cases with MLC HBAs, TRICARE contractors and the Coast Guard liaison officer at TMA-Aurora when required;

(5) assist beneficiaries in properly completing TRICARE claim forms;

(6) serve as a single point of contact for all health benefits programs available to active duty and retired members and their dependents;

(7) provide information and assistance based upon personal, written, or telephone inquiries concerning healthcare benefits;

(8) keep beneficiaries informed of changes within the various programs, e.g., legislative changes affecting benefits available or other policy/procedures impacting upon the usage of civilian medical care. Provides for an ongoing program of lecture services, informational seminars, and group counseling to various beneficiary groups, service clubs, retirement briefings, etc.;

(9) maintains liaison with local providers and encourages them to increase their acceptance of the TRICARE program, and;

(10) maintains liaison with cognizant MLC HBA, and unit collateral duty HBAs in local area.

b. Training.

(1) Individuals designated as HBAs must be trained in TRICARE benefits, exclusions, claims preparation, processing, cost sharing formulas, eligibility criteria, and alternatives to TRICARE.

(2) Training Schedule.

(a) Requests for attendance at the TRICARE course should be submitted via the Chain of Command to the CG TRICARE Liaison Officer at TMA-Aurora.

(b) TRICARE course registration form is available at http://www.TRICARE.osd. mil. This form may be submitted electronically or by mail.

(3) TMA-Aurora Liaison Staff Seminars. The Liaison Office at TMA-Aurora provides seminars for large beneficiary groups, e.g., recruiter, career counselor, etc. Arrangements for seminars should be made directly with CG Liaison.

(4) Funding. Training requests for the TRICARE course will be funded by the cognizant unit, MLC, or Headquarters component.

c. Sources of Reference Materials. HBAs shall acquire and become familiar with specific reference materials on Federal and nonfederal health programs. Specifically, as TRICARE policies change, the HBA shall maintain an updated reference library through distribution channels as outlined below:

(1) TRICARE Information.

(2) Contact: Coast Guard Liaison Officer
Commercial: (303) 676-3538
Website: http://www.TRICARE.OSD.MIL

Coast Guard Headquarters Distribution.
Stock Point: Commandant (G-WKH-3)
Via: Rapidraft Letter
Tel: (COMM) (202) 267-0846

TRICARE Standard Handbook 6010.46-H

(3) TRICARE Claim Forms (DD-2642, OCT93)
Now available at Website: http://www.TRICARE.OSD.MIL or by contacting:

Stock Point: Navy Publications and Forms Center
5801 Tabor Avenue
Philadelphia, PA 19120
U/I: PD

(4) Referral for Civilian Medical Care (DD-2161).

May be printed locally by accessing CG Standard Workstation III, Jetform Filler Database or by contacting:

Stock Point: Navy Publications and Forms Center
5801 Tabor Avenue
Philadelphia, PA 19120
U/I: PD

(5) Fiscal Intermediary Distribution by Region. Fiscal Intermediary Newsletter

(6) Local Community. Local Publication - Social Services Directory

19. Dental Hygienists. Dental hygienists are licensed graduates of American Dental Association accredited schools of dental hygiene. Whether contract or active duty providers, they are authorized to treat beneficiaries in Coast Guard dental clinics under the oversight of a dental officer. Restrictions on the degree of required oversight and the scope of services vary from state to state.

a. In the interests of standardization, quality assurance, and risk management, dental hygienists in Coast Guard health care facilities shall, in most circumstances, treat patients only when a dental officer is present for duty at the command. At the

discretion of the SDO, and in the interest of expediency, this guideline may be overridden if each of the following conditions is met on each patient:

(1) Only active duty members are treated;

(2) A medical officer is present in the building;

(3) Patients' Periodontal Screening and Recording (PSR) scores are 10 or less; and

(4) The licenses of the SDO and dental hygienist are not jeopardized by this action.

b. In every case, patients must receive a Type 2 examination by a dental officer no more than six months prior to treatment by a dental hygienist.

c. The Senior Dental Officer (SDO), or a staff dental officer designated by the SDO, shall review no fewer than 5% of the dental hygienist's patients for completeness of plaque/deposit removal and damage to hard/soft tissues. The responsible dental officer shall document these reviews in the patients' dental records.

d. The scope of the dental hygienist's services shall be governed by either the state in which the license is held or the state in which the clinic is located, whichever is more restrictive, and shall be itemized in the clinic's Standard Operating Procedures (SOP).

e. In some cases the state license may contain an addendum certificate which "privileges" the dental hygienist to administer injections of local anesthesia under the direct oversight of a licensed dentist. If the state in which the clinic is located also allows this, then the dental hygienist may deliver local anesthesia under the direct oversight of the dental officer. In all cases, the dental hygienist must possess specific credentials from the state of licensure allowing him/her to administer local anesthesia. "Direct oversight" shall mean that the dental officer personally has authorized the dental hygienist to administer local anesthesia to the specific patient being treated at the specific time (i.e., "blanket approvals" are not authorized). The dental officer shall be physically present in the clinic while local anesthesia is administered by the dental hygienist. While direct oversight does not require the dental officer to be physically present in the dental hygienist's operatory, the dental officer must be in the clinic and be capable of responding to an emergency immediately.

20. Red Cross Volunteers. Red Cross Volunteers are persons who have completed a formal training program offered by a Red Cross Chapter and have a certificate of successful completion. Red Cross training is a screening and educational tool that enables individuals with an interest in helping others to function as supervised medical assistants in the clinic.

a. Responsibilities. Red Cross Volunteers are responsible for scheduling their time in the clinic with clinic staff, accepting supervision, and carrying out activities mutually agreed upon by themselves and the clinic. These duties must fall within the scope of duties for which Red Cross training has prepared the volunteer. Duties may include:

patient transport via gurney or wheelchair within the clinic; assessing and properly recording temperature, respiratory rate, heart rate, and blood pressure; acting as a chaperone during exams or treatment; assisting in specialty areas, i.e., laboratory (with appropriate additional training and supervision); answering telephones, filing and other clerical duties; cleaning and wrapping instruments.

b. Supervision. Supervision of Red Cross volunteers is the responsibility of the Clinic Administrator and may be delegated.

c. Orientation. Each volunteer must have an initial orientation to the clinic documented. Orientation shall include at least the following topics:

(1) Fire Safety,

(2) Emergency procedures (bomb threats, mass casualty, power outages, hurricanes/tornadoes),

(3) Universal precautions and infection control,

(4) Proper handling of telephone emergency calls,

(5) Phone etiquette, paging, proper message taking,

(6) Patient Bill of Rights and Responsibilities, to include confidentiality, and chaperone duties in accordance with Chapter 2-J-3-b of this Manual.

# CHAPTER 2.

# HEALTH CARE AND FACILITIES

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CHAPTER 2. HEALTH CARE AND FACILITIES

Section A - Health Care for Active Duty Personnel.

1. Care at Uniformed Services Medical Treatment Facilities.

a. Authority for Health Care. Title 10 USC, 1074(a) provides that under joint regulations to be prescribed by the Secretary of Defense and the Secretary of Transportation, a member of a uniformed service who is on active duty is entitled to health care in any facility of any uniformed service. Members of the reserve components who are on active duty (including active duty for training) are entitled to the same health care in any facility of the uniformed services as that provided for active duty members of the regular services.

b. Use of Own Service Medical Treatment Facilities. Under ordinary circumstances, members shall receive health care at the Uniformed Services Medical Treatment Facility (USMTF) which serves the organization to which the member is assigned. However, Commanding Officers may request assignment to another USMTF through the cognizant MLC. Members away from their duty station or on duty where there is no USMTF of their own service may receive care at the nearest USMTF.

c. Use of Other Services Medical Treatment Facilities and/or Civilian Facilities. The closest USMTF having the appropriate capabilities shall be used for non-emergency health care. Health care in civilian medical facilities for non-emergent conditions is not authorized without prior approval of MLC (k). All health care received at other than a CG Clinic shall be recorded in the Coast Guard health record.

d. Definitions.

(1) Uniformed Services are the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the Public Health Service, and the Commissioned Corps of the National Oceanic and Atmospheric Administration.

(2) Active Duty means full-time duty in a Uniformed Service of the United States. It includes: duty on the active list; full-time training duty; annual training duty; and attendance, while in the service, at a school designated as a service school by law or by the Secretary of the Uniformed Service concerned.

(3) Health Care means outpatient and inpatient professional care and treatment, nursing care, diagnostic tests and procedures, physical examinations, immunizations, prophylactic treatment, medicines, biologicals, other similar medical services, and ambulance service. Prostheses, hearing aids, spectacles, orthopedic footwear, and similar adjuncts to health care may be furnished only where such adjuncts are medically indicated.

e. Application for Care. Members of the Coast Guard on active duty may be provided health care at a USMTF when requested by appropriate Coast Guard authority, a

Public Health Service medical officer detailed to the Coast Guard, or by application of the member by presenting an Armed Forces Identification Card (DD-2-CG).

f. Subsistence Charges. All active duty members of the uniformed services are required to pay subsistence in a USMTF at a rate prescribed by the Department of Defense.

g. Loss of Entitlement. A member of the Coast Guard who is separated from active duty, for any reason other than retirement, is not eligible for health care at a USMTF by reason of that previous service unless otherwise noted on the Certificate of Release or Discharge from Active Duty form DD-214.

2. Emergency Care at Other Than CG or DOD Facilities.

a. Definition of Emergency Condition.

(1) An emergency medical condition exists when the patient's condition is such that, in a medical officer's opinion, failure to provide treatment or hospitalization would result in undue suffering or endanger life or limb.

(2) In an emergency, the patient's safety and welfare, as well as that of the personnel around the patient, must be protected. When a USMTF cannot render immediate care, other local medical facilities, Federal or civilian, may be used. The decision to admit the patient to any of these facilities shall be made by the command with regard for only the health and welfare of the patient and the other personnel of the command.

b. Eligibility for Emergency Treatment. The following members of the Coast Guard are eligible for emergency medical treatment:

(1) active duty personnel of the regular Coast Guard;

(2) reserve personnel on extended active duty or temporary active duty (ASWAC); and

(3) reserve personnel who become ill, injured, or contract a disease in line of duty while on active duty for training or inactive duty for training, including authorized travel to or from such duty. [see Reserve Policy Manual, COMDTINST M1001.28 (series)]

c. Responsibilities.

(1) Patient.

(a) The patient is responsible for notifying the civilian physician or dentist that he or she is in the:

1 Regular Coast Guard;

2 Coast Guard Reserve on active duty or active duty for training; or

3 Coast Guard Reserve in an inactive duty training drill or appropriate duty status.

(b) It is also the responsibility of the patient or someone acting in the patient's behalf to request that the physician or dentist notify the member's command or the closest Coast Guard organization that he or she is undergoing emergency treatment at a civilian medical facility.

(c) The patient shall provide to appropriate authority all information needed to verify the course of treatment received and authorize release of all records associated with the episode of care.

(2) Commanding Officer. When notified that a member of the Coast Guard is hospitalized, transferred to another facility, or discharged from inpatient status, the commanding officer shall notify MLC (p) and (k) via message in accordance with MLC directives.

(3) Commander, Maintenance and Logistics Command. When notified that a member of the Coast Guard is hospitalized, MLC (k) shall:

(a) Be responsible for authorizing additional inpatient care at a civilian medical facility prior to transferring the patient to a USMTF. It is imperative, in the interest of good management, that the patient be transferred as soon as medically feasible. However, nothing in the above should be construed as precluding the necessary care for the patient concerned. MLC (k) shall notify the member's unit of any authorization action.

(b) Assist in ascertaining all necessary background information about the case, when the patient can be moved, and the location of the nearest CGMTF or USMTF which can accept the case. Patients shall be transferred in accordance with the provisions of Medical Regulating to and Within the Continental United States, COMDTINST M6320.8 (series).

(4) Commanding Officers of Reserve Units.

(a) A Reservist needing emergency treatment while performing inactive duty training shall be taken to a USMTF. If the nature of the case is so emergent as to preclude such transportation, a civilian medical facility may be used. If outpatient follow-up treatment is required, (i.e., office visits, tests, etc.) such treatment must be preauthorized by MLC (k) after issuance of a Notice of Eligibility by Commander, Integrated Support Command (FOT).

(b) The commanding officer of the reserve unit shall comply with Chapter 11 of the Reserve Policy Manual, COMDTINST M1001.28 (series) in notifying the commander, MLC and ISC (FOT) when a Reservist

engaged in inactive duty training is admitted to a civilian hospital or USMTF, and subsequent follow-up.

(5) Government Responsibility. Non-adherence to these notification directives cannot limit the Government's liability to pay bills for emergency medical and dental treatment provided to authorized Coast Guard beneficiaries. However, if prior approval is not obtained for NON-EMERGENT treatment in nonfederal facilities, the member receiving the care will be liable for payment.

d. Elective Surgery or Medical Treatment. Elective surgery or medical treatment is only authorized in USMTFs.

e. Emergency Care Outside the Continental United States. Coast Guard active duty personnel outside the continental limits of the United States are entitled to health care at USMTFs, where available. If such facilities are not available, emergency health care may be obtained at Coast Guard expense, without prior authorization.

f. Absentees or Deserters. Charges incurred by Coast Guard personnel for civilian health care when absent without authority or in desertion are the sole responsibility of the individual. However, charges for civilian health care after actual or constructive return of the individual to Coast Guard or military control may be paid from Coast Guard funds. Refer questions on payment of health care in regards to constructive return to MLC (k).

3. Dental Care and Treatment.

a. Extent of Dental Services.

(1) Active duty Coast Guard personnel are entitled to emergency, routine, and accessory dental treatment at all USMTFs. Dental care from contract dentists is authorized only as prescribed in Chapter 11 of this Manual.

(2) Reserve Coast Guard personnel ordered to active duty with their consent for less than thirty days are eligible for emergency dental treatment only, and are also subject to the following modifications;

(a) Reserve personnel are responsible for all dental diseases and conditions in existence prior to the initiation of or call to active duty. They must be in a class 1 or 2 dental status. (see section 4-C-3.c.)

(b) Reserve personnel shall not be eligible for routine or accessory dental treatment which cannot be completed prior to termination of or release from active duty status.

(c) Reserve personnel are responsible for maintaining their dental fitness for duty while on inactive status or during periods of active duty less than 30 days.

(3) Coast Guard Reserve personnel ordered to active duty for 30 days or more, are eligible for emergency, routine, and accessory dental treatment at all USMTFs, and are also subject to the modifications listed above. Reservists with active duty orders for 30 days or more are encouraged to obtain a dental exam as part of their check-in process at their newly assigned unit.

b. Definitions of Types of Dental Treatment.

(1) Emergency Dental Treatment. Emergency dental treatment includes those procedures directed toward the immediate relief of pain, the removal of oral infection which endangers the health of the patient, and repair of prosthetic appliances where the lack of such repair would cause the patient physical suffering.

(2) Routine Dental Treatment. Routine dental treatment includes the following: examinations, radiographs, diagnosis and treatment planning, amalgam fillings, synthetic fillings, prophylaxis, extraction, treatment of root canals, treatment for allaying pain, treatment of oral pathological conditions, periodontal conditions, other infections and related conditions detrimental to the patient's health, and repairs and adjustment of dentures and prosthetic appliances.

(3) Accessory Dental Treatment. Accessory dental treatment includes prosthetic replacement of missing teeth in cases where insufficient occlusal surfaces prevent proper mastication and where missing anterior teeth prevent correct phonation.

(4) Implants.

(a) Implant placement by Coast Guard dental officers (DOs) shall be performed only by:

1 those DOs specifically privileged to do so by DOD facilities, or

2 those DOs who have received implant training as part of a formal specialty program.

(b) Implant maintenance is the responsibility of all DOs. Each DO shall be familiar with the techniques and armamentarium of implant maintenance, as well as diagnosis of successful and unsuccessful implants.

(c) Requests for implants from nonfederal providers for active duty members shall be approved or denied on a case-by-case basis by the cognizant MLC. Factors to be considered include:

1 oral hygiene;

2 treatment alternatives;

3 feasibility and expectations for long-term success;

4 length of service and anticipated rotation; and

5 qualifications of the provider(s).

c. Dental Care of Recruits. Only emergency dental treatment should be provided those recruits who are to be separated from the Service prior to completing recruit training. It is important that recruits in this category do not have teeth extracted in preparation for prosthetic treatment and then be separated from the Service prior to the time prosthetic appliances are provided.

d. Emergency Dental Treatment in Nonfederal and Non-contract Facilities.

(1) If a contract dentist is not available, emergency dental treatment required for the immediate relief of pain or infection may be obtained by active duty Coast Guard personnel from any available dentist. Once the emergency has been alleviated, all follow-up treatment must be from a USMTF or contract dentist unless preauthorized by MLC (k).

(2) Process all bills in accordance with Chapter 11 of this Manual.

e. Criteria To Be Followed When Requesting Orthodontic/Orthognathic Surgical Care.

(1) Orthodontic/orthognathic surgical treatment can affect release from active duty, rotation dates, and fitness for duty. Therefore, written authorization to commence all orthodontic/orthognathic surgical treatment (whether elective or not, and whether provided by Federal or nonfederal practitioners) must be requested from Commander (CGPC-epm) for enlisted and (CGPC-opm) for officers via the cognizant MLC (k) prior to its initiation. Command endorsement must include a copy of Administrative Remarks CG-3307 documentation described in article 2-A-3.e.(3)(b) below. Request nonfederal care from appropriate MLC (k) following established guidelines. If authorized by MLC (k), the request will be forwarded to Commander (CGPC-epm or opm).

(2) Preexisting conditions are the member's responsibility.

(3) Treatment not required to maintain the member's fitness for duty is elective in nature and is not authorized for payment by the Coast Guard. If the member's condition does not impair job function, the treatment shall be considered elective.

(4) Elective care may be obtained, if available, from USMTFs. If obtained from nonfederal providers, payment is the member's responsibility. In addition, the member is financially responsible for any care arising from complications that require additional treatment, even if it is non-elective. Because complications could lead to subsequent action by the Physical Disability Evaluation System (PDES), and to protect the interests of both the service member and the Coast Guard, the member's command is responsible for Service Record Administrative Remarks CG-3307 documentation detailing:

(5) The personnel action to be taken by the command regarding the granting of absence.

(6) That the service member was instructed regarding the provisions contained herein and other applicable directives; and

(7) That the service member must obtain copies of all treatment records from the provider for inclusion into the Coast Guard dental record, including (for example) initial evaluation, treatment plan, progress notes, and follow-up care.

(8) If elective treatment is approved, PDES processing shall be suspended pending the outcome of the elective treatment. Aviation personnel and divers are required to have a waiver request approved by CGPC - opm or epm. In addition, members whose duties preclude regular visits to an orthodontist (e.g., icebreakers crews, isolated LORAN duty etc.) fall under this category.

(9) If the condition is service-related, the Coast Guard shall be responsible to acquire care sufficient to return the member to fit for full duty status (e.g., that which existed at the time of the member's entry to the service), but not necessarily to ideal conditions not impacting on performance of duties. If treatment is not available at a local MTF, use of a nonfederal provider may be authorized.

(10) If pain is the only symptom causing the member to be not fit for full duty, then it must be treated. Treatment may include, but is not limited to physical therapy, bite plates to improve occlusion, stress management, and medications. Since orthodontic treatment is of long duration, it is not an appropriate method to relieve acute pain.

(11) All treatment must be completed, inactivated, or terminated prior to transfer or release from active duty. Personnel who are being transferred or released from active duty, and who request inactivation of orthodontic appliances, shall sign an entry in the SF-603/603-A stating their intention to seek orthodontic therapy at their own expense.

4. Consent to and Refusal of Treatment.

a. Regulatory Restrictions. Coast Guard Regulations, COMDTINST M5000.3 (series), state in Section 8-2-1 that:

(1) "Persons in the Coast Guard shall not refuse to submit to necessary and proper medical or dental treatment to render themselves fit for duty, or refuse to submit to a necessary and proper operation not endangering life."

(2) "Persons in the Coast Guard shall permit such action to be taken to immunize them against disease as is prescribed by competent authority."

b. Policy Concerning Refusal of Treatment.

(1) Policy.

(a) It is the Commandant's policy that compulsion is not permissible at any time to require Coast Guard personnel to submit to various types of medical or dental treatment, diagnostic procedures, or examinations.

(b) Surgery will not be performed on persons over their protest if they are mentally competent.

(c) Individuals who refuse to submit to measures considered by competent medical or dental officers to be necessary to render them fit for duty, may be processed for separation from the Coast Guard in accordance with applicable regulations. Individuals may be subjected to disciplinary action for refusal of necessary treatment or surgery if the refusal is determined to be unreasonable. Refusal of medical care by vegetative or comatose individuals in accordance with a **Living Will** shall not be considered unreasonable.

(2) Non-Emergent Operations on Minors. A minor who enlists or otherwise enters active duty with parental or guardian consent is considered emancipated during the term of enlistment. There is, therefore, no legal requirement that the consent of any person, other than the minor, be obtained prior to instituting surgical procedures.

(3) Refusal of Emergency or Lifesaving Treatment or Emergency Diagnostic Procedures. The refusal of recommended emergency or lifesaving treatment or emergency diagnostic procedure required to prevent increased level of impairment or threat to life is ordinarily determined to be unreasonable. However, refusal of medical care by vegetative or comatose patients under the authorization of a **Living Will** is not considered unreasonable. A medical board shall be convened in accordance with the Physical Disability Evaluation System, COMDTINST M1850.2 (series) for unreasonable refusal of emergency or lifesaving treatment or emergency diagnostic procedures.

(4) Refusal of Non-Emergent Treatment. If a member of the Coast Guard refuses non-emergent medical, surgical, dental, or diagnostic procedures that are required to maintain a fit for full duty status, a determination of reasonable basis for this refusal is required. A medical board shall be convened in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).

c. Advance Directives (**Living Wills**).

(1) Federal law enacted in 1993 requires hospitals to ask about advance directives at the time of admission and provide patients with information to create advance directives. Advance directives, commonly known as **living wills**, express a person's wishes regarding certain aspects of treatment and care, including but not restricted to CPR, mechanical life support measures, etc., which may arise in the course of hospitalization.

(2) Coast Guard health care facilities are not required to provide such information under the law. Clinics may elect to provide standardized information to patients on request. Information given out shall conform to the implementing laws of the state in which the clinic is located. Clinics providing such information shall notify patients of its availability either by posted notice or via patient handout materials.

(3) Clinic staff members usually do not have the required training and experience to advise patients on the legal issues concerning creation of advance directives. Patients shall be referred to the appropriate source of legal support, e.g., command or district legal officers.

(4) Clinic staff members, where allowed by state law, may serve as witnesses to advance directive signatures.

(5) Advance directive documents shall be held by the member and/or the member's next of kin. Advance directive documents shall not be filed in the member's health record since health records are not universally available 24 hours a day, seven days a week, for reference by a treating hospital.

5. Elective Surgery for Pre-Existing Defects.

a. General. In many medical/dental procedures undertaken to correct defects that existed prior to entrance (EPTE) into the Service, the likelihood of return to full duty is questionable. In addition, such cases have often resulted in long periods of convalescence with subsequent periods of limited duty, outpatient care, and observation which render the Government liable for benefits by reason of aggravation of these defects.

b. Criteria. The following conditions must be met before attempting surgical correction of an EPTE defect.

(1) It interferes with the member's ability to perform duty.

(2) The procedure being considered is an accepted one, carries a minimal risk to life, and is not likely to result in complications.

(3) There should be a 90 percent chance that the procedure will correct the defect and restore the member to full duty within a reasonable time (three months) without residual disability. If the defect does not meet the above conditions and the member is, in fact, unfit to perform the duties of grade or rate, action shall be taken to separate the member from the Service.

c. Discussion. Whether elective medical/dental care should be undertaken in any particular case is a command decision which should be decided using the above guidelines. In questionable cases, the member may be referred to a medical board for final decision prior to undertaking elective treatment for an EPTE defect.

6. Elective Health Care.

a. Medical/Dental treatment not required to maintain the member's fitness for duty is elective in nature and is not authorized for payment by the Coast Guard. If the member's condition does not interfere with their ability to perform duty, the treatment shall be considered elective.

(1) Elective care may be obtained, if available, from USMTF's.

(2) If obtained from nonfederal providers, payment is the member's responsibility. In addition, the member is financially responsible for any care arising from complications that require additional treatment, even if it is non-elective.

(3) Because complications could lead to subsequent action by the Physical Disability Evaluation System (PDES), and to protect the interests of both the service member and the Coast Guard, the member's health record must contain a SF-600 entry detailing:

(a) the personnel action to be taken by the command regarding the granting of absence;

(b) that the service member was counseled regarding the provisions contained herein and other applicable directives. Counseling will be provided at the local Coast Guard primary care facility, or if there is no near by Coast Guard primary care facility, then the cognizant MLC (k) via phone. SF-600 will be faxed to the cognizant MLC (k) for appropriate entries, then faxed or mailed back to the unit for incorporation into the member's health record.

(c) that the service member must obtain copies of all treatment records from the provider for inclusion into the Coast Guard health record, including initial evaluation, treatment plan, progress notes, and follow-up care.

(4) If elective treatment is provided, it shall not affect the member's present or future fitness for duty. For example, radial keratotomy is disqualifying for divers and aviators.

7. Other Health Insurance (OHI)

a. General. In some situations a member may desire to utilize their spouses' health insurance (OHI) to obtain health care outside of the Military Health Care System. Whether elective health care or all other areas of health care, this decision has an impact on the command and possibly on a member's access to the Physical Disability Evaluation System (PDES).

b. Criteria. The following conditions must be met before utilizing a spouse's health insurance or OHI,

(1) **ALL** payment is the member's responsibility. In addition, the member is financially responsible for any care arising from complications that require additional treatment, even if it is non-elective.

(2) Because complications could lead to a loss of access to the Physical Disability Evaluation System (PDES), and to protect the interests of both the service member and the Coast Guard, the member's Coast Guard health record must contain a SF-600 entry detailing:

(a) the personnel action to be taken by the command regarding the granting of absence;

(b) that the service member was instructed regarding the provisions contained herein and other applicable directives. Counseling will be provided at the local Coast Guard primary care facility, or if there is no near by Coast Guard primary care facility, then the cognizant MLC (k) via phone. SF-600 will be faxed to the cognizant MLC (k) for appropriate entries, then faxed or mailed back to the unit for incorporation into the member's health record.

(c) that the service member must obtain copies of all treatment records from the provider for inclusion into the Coast Guard health record, including initial evaluation, treatment plan, progress notes, and follow-up care.

8. Procedures for Obtaining Non-Emergent Health Care from Nonfederal Sources. (Guidance reflecting current TRICARE procedures for obtaining Non-Emergent Health Care will be promulgated in future changes to this Manual).

a. Nonfederal sources for active duty care are intended to supplement and not substitute for care that is available through the federal system. USMTF's or DVA facilities, if located within a 40 mile radius of the member's unit (except a 30 mile radius for maternity care), shall be used first for non-emergent, non-elective health care before nonfederal sources are used. Each case must be evaluated for:

(1) appropriateness of care;

(2) urgency of treatment;

(3) time and cost factors associated with obtaining such care from a USMTF;

(4) the member's anticipated length of stay at the given station; and,

(5) operational need of the unit for the member.

b. Before active duty personnel are treated in a nonfederal medical facility for non-emergent conditions, prior approval must be obtained. Non-elective conditions are those which, without repair or treatment, would render the member unfit for duty.

c. MLC (k) may approve requests for nonfederal health care (both medical and dental) and may delegate, in writing, limited authority to qualified clinic administrators.

d. Requests for nonfederal health care beyond a clinic administrator's authority will be submitted by following the cognizant MLC(k) policy. Telephone authorization will not be provided without a hard copy of the request. As a minimum, the following information must be provided, as applicable:

(1) name, grade/rate, social security number;

(2) anticipated rotation date and expiration of enlistment;

(3) whether care will be completed before transfer or separation;

(4) diagnosis reported by International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code number and a brief explanation;

(5) history of patient's condition;

(6) total amount of local/MLC approved nonfederal expenditures to date for this condition;

(7) the necessity of treatment to maintain fitness to perform duty;

(8) treatment plan: length, type of therapy/treatment, and estimated cost (Cost estimates must include total scope of care not just primary provider or hospital costs.);

(9) name of facility where treatment will be done;

(10) attending physician's or dentist's prognosis with and without treatment, including likelihood of medical board action;

(11) treatment plan and justification, radiographs and copy of dental records for all dental requests (Study models will be submitted for all cases requiring crown and bridge work and partial dentures;

(12) name of nearest USMTF capable of providing care:

(a) distance to facility (miles);

(b) earliest appointment available (not available is unacceptable);

(c) travel/per diem cost;

(d) estimated total lost time; and

(e) other factors for consideration, i.e., travel time, road conditions, operational impact, etc; and

(13) indicate date of original submission and reason for resubmission, if previous requests were submitted for this procedure.

e. If approval is granted, MLC (k) will provide the requester with an authorization number. This authorization number must be noted on all bills submitted. Bills will be submitted to MLC (k). If approval is denied, MLC(k) will outline the appropriate appeals process to follow in their denial transmittal.

f. When personnel are transferred prior to completing the approved care, the request is canceled. Personnel are required to submit another request after reporting for their new assignment.

g. Amounts authorized shall not be exceeded without further authorization from MLC (k) which requires additional justification.

h. Inpatient hospitalization in nonfederal facilities shall be monitored closely by the MLC (k) responsible for the geographical area in which the facility is located. Normally, an inpatient stay will not exceed seven days duration without consideration of movement to a USMTF. Cases suspected to extend past the seven-day limit shall not be placed in a civilian facility, but shall be initially referred to a USMTF.

i. If prior approval is not obtained for non-emergent treatment in nonfederal facilities, the member receiving the care will be liable for payment.

j. EMERGENCY health care does not require prior approval.

9. Obtaining Vasectomies and Tubal Ligations from Nonfederal Providers.

a. Preauthorization is required. Submit all request for vasectomies and tubal ligations by nonfederal providers to cognizant MLC(kma) following the guidelines for requesting above. Request must show the provider of care decided on the procedure based upon applicable local and state guidelines.

b. Request must contain evidence that the patient has been counseled by a physician and has given informed consent to the procedure.

c. The request must contain evidence that the patient has completed a SF-600 entry acknowledging that the Coast Guard will not pay for reversal of this procedure in a non-federal facility.

d. The request must contain current information concerning the availability of the requested procedure from federal sources.

e. Request for tubal ligation to be performed at the time of delivery should be submitted with the request for nonfederal maternity care.

f. Sick leave may be granted for this procedure.

10. Care at Department of Veterans Affairs (DVA) Medical Facilities.

a. From time-to-time, acute medical, surgical, or psychiatric facilities are required for Coast Guard personnel where transportation to the nearest USMTF will place the individual's health or welfare in jeopardy. To preclude this and other similar situations and to provide the best possible medical care for all active duty members, a

support agreement between the Coast Guard and the Department of Veterans Affairs was completed in 1979 and remains in effect. FIGURE 2-1 is a copy of the medical service agreement.

b. DVA care must be requested by the member's commanding officer. The agreement is limited to active duty Coast Guard personnel and does not include dependents.

c. MLC commanders and commanding officers should establish local contact with DVA facilities to determine mission and facility capabilities and patient admission procedures.

d. Forward all bills received from DVA facilities to the service member's unit for certification prior to forwarding to MLC (k) for payment.

e. When a USMTF and a DVA facility are collocated, the USMTF shall be used unless it cannot provide the required services.

IGA V101(134A)S-79039

MEDICAL SERVICE AGREEMENT
BETWEEN THE
U. S. COAST GUARD
DEPARTMENT OF TRANSPORTATION
AND THE
VETERANS ADMINISTRATION

This agreement provides for medical services to be furnished the U.S. Coast Guard, Department of Transportation (hereinafter referred to as "CG") by the Veterans Administration (hereinafter referred to as "VA") and establishes the terms and conditions under which the services are to be furnished to active duty personnel.

I. BACKGROUND.

In February 1973, arrangements were established whereby CG active duty personnel utilized the VA hospital facilities for medical services. This agreement provides for the continuation of these services.

II. MEDICAL SERVICES TO BE FURNISHED BY THE VA.

A. Hospital care, medical services and emergency dental treatment may be provided to the extent that such care, services, or treatment are available at the VA medical facility from which requested.

B. To preclude the possibility of denying or delaying the care and treatment of an eligible veteran, VA medical services will be furnished only to the extent that there will be no reduction in the service to the veteran.

III. REFERRAL PROCEDURES.

VA medical services will be provided CG active duty personnel upon receipt of an authorization document from the responsible official at the CG facility. The authorization document will include the billing address for services to be rendered. Telephone authorizations will be accepted in emergencies pending receipt of a written authorization.

IV. REIMBURSEMENT.

A. The CG will reimburse the VA for the services performed at the current appropriate rates periodically approved by the Office of Management and Budget (OMB), except that if a CG beneficiary requires transfer to a non-VA facility, reimbursement shall be at the actual rates charged.

B. The VA medical center providing the medical services will prepare Standard Form 1081, Voucher and Schedule of Withdrawals and Credits, covering the services. The executed form will be submitted to the CG at the address shown on the authorization request.

V. TRANSPORTATION.

The CG will provide all necessary transportation and medical attendants, when applicable, for personnel scheduled for VA medical treatment. Travel costs to and from the VA medical facility will not be paid by the VA.

VI. LIABILITY.

Protection of the individuals furnishing services covered by this agreement will be that which is provided under 28 USC 1346(b), and by 38 USC 4116.

VII. GENERAL PROVISIONS.

A. Amendments or Cancellations:

This agreement or any of its specific provisions may be revised or amended only by the signature approval of the parties signatory to the agreement or by their respective official successors. Cancellation may be made upon 30 days written notice of either party, or their successors, to the other.

B. Effective Date:

This agreement, amendments to or cancellation thereof, shall become effective upon the date when the Chief, Office of Health Services, CG, and the Director, Supply Service, Department of Medicine and Surgery, VA, both have signed acceptance thereof.

C. Authority:

Authority for this agreement is the Economy Act of June 30, 1932, as amended (31 USC 686).

D. Previous Agreements:

This agreement supersedes previous medical service support arrangements.

ACCEPTED:

VETERANS ADMINISTRATION

By: Clyde C. Cook
CLYDE C. COOK
Director, Supply Service

Date: Sept 24, 1979

ACCEPTED:

DEPARTMENT OF TRANSPORTATION
U.S. COAST GUARD

By: Harry Allen
HARRY ALLEN
Rear Admiral, U. S. Public Health Service
Chief, Office of Health Services
U. S. Coast Guard

Date: _____

Section B - Health Care for Reserve Personnel.

1. Care at Uniformed Services Medical Treatment Facilities.

a. Authority for Reserve Personnel. Section 2-A of this Manual contains the authority for medical care. Information concerning entitlement to various benefits is contained in Chapter 11 of the Reserve Policy Manual, COMDTINST M1001.28(series). Information concerning eligibility for benefits from the Department of Veterans Affairs is included therein.

b. Application for Care. A member of the Coast Guard Reserve may be admitted to USMTFs upon written authorization from an appropriate Coast Guard authority (e.g., Commanding Officer's letter, Notice of Eligibility, or appropriately endorsed orders).

c. Definitions. The following definitions apply throughout this section:

(1) Active duty means full-time duty in a Uniformed Service of the United States. It includes duty on the active list, full-time training duty, annual training duty and attendance, while in the service, at a school designated as a service school by law or by the Secretary of the Uniformed Service concerned.

(2) Active Duty for Training is defined as full-time duty in a uniformed service of the United States for training purposes.

(3) Inactive Duty Training.

(a) Duty prescribed for reservists by the Secretary concerned under 37 USC 206 or any other provision of law.

(b) Special additional duties authorized for reservists by an authority designated by the Secretary concerned and performed by them on voluntary basis in connection with the prescribed training or maintenance activities of the units to which they are assigned.

(4) Disability. A temporary or permanent physical impairment resulting in an inability to perform full military duties or normal civilian pursuits.

(5) Employed. Reservists are employed on duty during the actual performance of duty, while engaged in authorized travel to or from active duty for training, and while on authorized leave or liberty.

(6) Line of Duty. An injury, illness, or disease shall be deemed to have been incurred in line of duty, if a reservist at the time of debilitating incident is performing active duty or active duty for training, or is on authorized leave or liberty, provided the disability is not the result of misconduct.

d. Injury Incurred in Line of Duty. A member of the Coast Guard Reserve who is ordered to active duty or to active duty for training, or to perform inactive duty training, for any period of time, and is disabled in line of duty from injury while so

employed is entitled to the same hospital benefits as provided by law or required in the case of a member of the regular Coast Guard. For the purpose of these benefits, a member who is not in a pay status is treated as though receiving the pay and allowances to which entitled if serving on active duty.

e. Disease Incurred in Line of Duty While on Active Duty. A member of the Coast Guard Reserve who is ordered to active duty for training for a period of more than 30 days, and is disabled while so employed, is entitled to the hospital benefits as are provided by law or regulation in the case of a member of the regular Coast Guard. An exception is that a member of the Coast Guard Reserve ordered to perform involuntary active duty for training under the provision of 10 USC 270 is only eligible for the limited medical benefits described below, following termination of the training duty period.

f. Illness or Disease Contracted in Line of Duty in Peacetime. A member of the Coast Guard Reserve who, in time of peace, becomes ill or contracts a disease in line of duty while on active duty for training or performing inactive duty training is entitled to receive medical, hospital, and other treatment appropriate for that illness or disease. The treatment shall be continued until the disability resulting from the illness or disease cannot be materially improved by further treatment. Such a member is also entitled to necessary transportation and subsistence incident to treatment and return home upon discharge from treatment. The treatment may not extend beyond ten weeks after the member is released from active duty, except:

(1) upon an approved recommendation of a medical board or

(2) upon authorization of the MLC (k), based on a physician's certification that the problem is a continuation of that for which the member was initially treated, and that benefit will result from further treatment. Refer to Section 11-B-3 of the Reserve Administration Policy Manual, COMDTINST M1001.28(series), for specific instructions regarding the extension of medical treatment beyond 10 weeks for those who are receiving treatment under a Notice of Eligibility (NOE).

g. Injury or Disease En Route to or from Active Duty. A member of the Coast Guard Reserve is authorized medical care for an injury or disease incurred while en route to or from active duty, active duty for training, or inactive duty for training.

h. Injury or Disease Not in Line of Duty. A member of the Coast Guard Reserve is not entitled to medical care for an injury or disease not incurred in the line of duty.

i. Pregnancy. Pregnancy in the Coast Guard, COMDTINST 1900.9, contains guidance regarding pregnancy and reserve members. Use of reserve servicewomen who are pregnant for ASWAC assignment is not encouraged. Reserve servicewomen may accept Special Active Duty for Training (SADT) with the understanding that duty must be completed by the 24th week of gestation.

2. Emergency Care at Other Than CG or DOD Facilities. Section 2-A-2 contains the requirements for treating reserves in emergency situations.

3. Non-Emergent Care at Other Than CG or DOD Facilities. Any non-emergent, nonfederal care must be authorized in advance by MLC (k) through contract, blanket purchase agreement or pre-authorization.

Section C - Health Care for Retired Personnel.

1. Care at Uniformed Services Medical Treatment Facilities. As set forth in 10 USC, 1074(b), retired members of the uniformed services, as specified in that Act, are entitled to required medical and dental care and adjuncts thereto to the same extent as provided for active duty members in medical facilities of the uniformed services. However, access to care is subject to mission requirements, the availability of space and facilities, and the capabilities of the medical staff as determined by the cognizant medical authority in charge. Patients enrolled in TRICARE Prime Options are not eligible for non-emergent care in Coast Guard clinics. These patients shall be referred to their TRICARE primary care manager (PCM). The PCM is responsible for appropriate care and referral of such patients.

2. Care Under the TRICARE Extra and Standard Options (formerly CHAMPUS). Subject to the cost sharing provisions set forth in 10 USC, 1086, retired members who are not qualified for benefits under Title I of the Social Security Amendments of 1965 (Medicare) are entitled to receive inpatient and outpatient care from civilian sources.

3. Care at Veterans Administration Medical Facilities.

   a. Eligibility for DVA Hospitalization. Coast Guard military personnel are eligible for hospitalization in DVA facilities after separation from active duty or while in retirement under one of the following circumstances:

      (1) For injuries or diseases incurred or aggravated while on active duty during any war, the Korean conflict period 27 June 1950 through 31 January 1955) or the Vietnam conflict period (5 August 1964 through 7 March 1975).

      (2) For service-connected or nonservice-connected disabilities, if receiving disability compensation from the DVA, or if entitled to receive disability compensation from the DVA, but has elected to receive retirement pay from the Coast Guard instead of the compensation from the DVA.

   b. Medical Care Benefits. Eligible veterans may receive hospitalization, outpatient medical care, outpatient dental care, prosthetic appliances, etc., from the VA.

Section D - Health Care for Dependents.

1. Care at Uniformed Services Medical Treatment Facilities.

   a. Authority for Health Care. Title 10 USC, 1076 provides basic authority for medical and dental care for:

      (1) dependents of active duty members and dependents of members who died serving on active duty; and

      (2) dependents of retired members and the dependents of members who died while in a retired status.

   b. Availability of Care.

      (1) Medical and dental care for dependents in uniformed services medical treatment facilities is subject to the availability of space and facilities and the capabilities of the medical and dental staff. With the approval of the commanding officer, the senior medical officer and senior dental officer are responsible for determining the availability of space and capability of the medical and dental staffs. These determinations are conclusive. Patients found enrolled in TRICARE Prime Options are not eligible for non-emergent care in Coast Guard clinics. These patients shall be referred to their TRICARE primary care manager (PCM). The PCM is responsible for appropriate care and referral of such patients.

      (2) Dependents entitled to medical and dental care under this section shall not be denied equal opportunity for that care because the facility concerned is that of a uniformed service other than that of the sponsor.

      (3) Types of Care Authorized. Subject to the provisions set forth in 10 USC, 1079 and 1086, dependents who are not qualified for benefits under Title 1 of the Social Security amendments of 1965 (Medicare) are entitled to receive inpatient and outpatient care from civilian sources. Refer to your cognizant MLC (k) for details and instructions.

2. Care Under Coast Guard Civilian Contracts. Under certain circumstances, dependents are entitled to medical and dental care provided through Coast Guard civilian contracts. See Chapter 11 for guidance.

3. Rights of Minors to Health Care Services. Where not in conflict with applicable Federal law or regulation, unit commanding officers shall follow State law defining the rights of minors to health care services and counseling in contraception, sexually transmitted disease prevention and treatment, and pregnancy. Any protection with regard to confidentiality of care or records afforded by applicable law or regulation will be extended to minors seeking care or counseling for the above mentioned services or conditions in Coast Guard facilities.

Section E - Care for Preadoptive Children and Wards of the Court.

1. General.

   a. A child placed in a sponsors home as part of a pre-adoption procedure, or by court-ordered guardianship, is not eligible for care under the Uniformed Services Health Benefits Program unless specific authority has been granted. Such authority may come from the final adoption decree, a court-ordered legal custody determination (for a period of at least 12 consecutive months), or through a Secretary's Designation authorization for limited health care in a USMTF.

   b. Eligibility for TRICARE benefits, the Uniformed Services Family Health Benefits Plan (USFHBP), or the Uniformed Services Active Duty Dependents Dental Plan is established upon the issuance of a uniformed services dependent ID card and DEERS enrollment. Authorization for these health care programs, or for direct care (USMTF use), will be reflected on the ID card and through DEERS.

   c. Prospective dependents must meet the following eligibility rules: be unmarried; have not attained the age of 21 (or 23 if a full-time student); be dependent on the sponsor for over one-half of their support; or be incapable of self-support due to mental or physical incapacity and were otherwise eligible when incapacity occurred.

   d. If legal custody or placement is for 12 months or more, a uniformed services dependent ID care, DEERS enrollment, and health care eligibility may be authorized. Personnel are encouraged to contact their servicing personnel office for assistance.

2. Secretary's Designation. The following procedures apply in situations where a pre-adoptive or court ordered guardianship or placement is for less than 12 consecutive months.

   a. Children under a prospective parent or guardians care may use a USMTF by acquiring authority from the Secretary of the uniformed service to which the USMTF belongs. This authority is normally called a Secretary's Designation. For example, requests for care in a U. S. Navy facility must be authorized by the Secretary of the Navy or their designee. The same holds true for U. S. Army and U. S. Air Force facilities. When seeking care from a Department of Defense MTF, contact that facilities Patient Affairs or Health Benefits Advisor staff for assistance.

   b. In cases involving Coast Guard facilities, authority has been delegated to the Commandant by the Secretary of Transportation to authorize treatment of pre-adoptive children and wards of the court. Letter requests must be forwarded to Commandant (G-WKH) and include the following information:

      (1) member's name, grade/rate, SSN, and duty assignment or retired status if applicable;

      (2) address of residence;

(3) name and age of the proposed adoptive child or court-ordered ward; and

(4) a copy of the court order, legal decree, or other applicable instrument issued by a court or adoption agency which indicates the child has been placed in the house for adoption or with the intent to adopt, or the court order granting guardianship of the ward to the service member and any amounts of income to which the ward is entitled.

c. Upon approval, the respective uniformed service will issue a letter of authority for care in one or more of their USMTFs located in the United States. This letter is the only authority for care (since designees are not DEERS-eligible) and must be presented (or on file) when seeking authorized care. These letters have expiration dates and may require the sponsor to request to reissue.

d. When there is a need for medical care outside the United States, the sponsor should contact the nearest USMTF requesting humanitarian consideration. The Service Secretaries have limited authority for designation of beneficiaries outside the United States.

Section F - Health Care for Other Persons.

1. Members of the Auxiliary.

   a. Authority for Care of Auxiliary Members. Basic authority for health care for members of the Auxiliary injured while performing Coast Guard duty is contained in 14 USC 832. Section 5.59 of Chapter 1, Title 33, CFR, states: "When any member of the Auxiliary is physically injured or dies as a result of physical injury incurred while performing patrol duty or any other specific duty to which he has been assigned, such member or his beneficiary shall be entitled to the same benefits as are now or as may hereafter be provided for temporary members of the Coast Guard Reserve who suffer physical injury incurred in the line of duty. Members of the Auxiliary who contract sickness or disease while performing patrol duty or any other specific duty to which they have been assigned shall be entitled to the same hospital treatment as is afforded members of the regular Coast Guard." Claims for Auxillary healthcare shall be submitted to:

      U. S. Department of Labor
      OWCP Special Claims Branch (District 25)
      800 North Capitol Street, NW, Room 800
      Washington, DC 20211

   b. Compensation Under Federal Employee's Compensation Act (FECA) Program. See the Detail of Civilian Employees, COMDTINST M12300.7 (series).

2. Temporary Members of the Reserve.

   a. Composition of the Reserve. The Coast Guard Reserve is a component part of the United States Coast Guard and consists of two classes of reservists: Regular and Temporary. Temporary members of the Reserve may be enrolled for duty under such conditions as the Commandant prescribes, including but not limited to part-time and intermittent active duty with or without pay, and without regard to age. Members of the Auxiliary, officers and members of the crew of any motorboat or yacht placed at the disposal of the Coast Guard, and persons (including government employees without pay other than compensation of their civilian positions) who by reason of their special training and experience are deemed by the Commandant qualified for such duty. The Commandant is authorized to define the powers and duties of temporary reserves, and to confer upon them, appropriate to their qualifications and experience, the same grades and ratings as are provided for regular members of the Reserve.

   b. Authority for Care of Temporary Reservists. Section 760, Title 14, USC, contains authority for health care and/or compensation of temporary reserves under conditions set forth therein.

c. Care at Coast Guard Expense. 14 USC 760(d) states: "Temporary members of the reserve who incur physical disability or contract sickness or disease, while performing any specific duty to which they have been assigned by competent Coast Guard authority, shall be entitled to the same hospital treatment afforded officers and enlisted men of the Coast Guard."

d. Compensation Under Federal Employee Compensation Act (FECA) Program. See Detail of Civilian Employees, COMDTINST M12300.7

3. Members of Foreign Military Services.

a. General. Members and dependents of foreign services assigned or attached to a Coast Guard unit for duty or training (such as Canadian Exchange Officers) or who are on active duty with a foreign military unit within the United States (such as the crew of a vessel being taken over at the Coast Guard Yard under the Military Assistance Program) are eligible for inpatient health care at DoD MTF's provided by US Code: Title 10, Section 2559. As there are several categories of foreign service members for whom medical care benefits vary, both for themselves and their dependents, if any doubt exists as to eligibility for health care and the authorized sources from which it can be obtained, contact Commandant (G-WKH) for advice.

b. Care at Uniformed Services Medical Treatment Facilities. Members of foreign military services and their dependents who are eligible, therefore, shall be provided inpatient health care at DoD MTFs upon request of the member's commanding officer or consular official, or by application of the member or dependent upon presentation of proper identification.

4. Federal Employees.

a. Benefits Under Federal Employees Compensation Act (FECA) Program. All Federal Employees assigned to Coast Guard vessels, e.g., National Marine Fishery Service (NMFS), Drug Enforcement Agents, etc., are civilian employees of the United States Government, and as such, are entitled to health care and compensation under FECA. See Detail of Civilian Employees, COMDTINST M12300.7 (series).

b. Care Aboard Ship and Outside CONUS. Federal Employees may be given medical care while serving with the Coast Guard in a locality where civilian health care is not obtainable, such as on board a Coast Guard vessel or outside the United States. Outpatient and inpatient care may be provided at Navy medical facilities outside CONUS, if reasonably accessible and appropriate nonfederal medical facilities are not available.

5. Seamen. Sick and disabled seamen may receive emergency health care aboard Coast Guard vessels.

6. Nonfederally Employed Civilians Aboard Coast Guard Vessels.

a. Authority for Care. There is no statute which either prohibits or authorizes the Coast Guard to provide health care to civilians while aboard Coast Guard vessels. There is no objection to furnishing emergency health care, but routine care should not be furnished. When these civilians are aboard Coast Guard vessels for relatively lengthy periods, the commanding officer must determine what treatment is to be given.

b. Responsibility. Commanding officers of vessels deployed for extended periods shall ensure that nonfederally employed civilians who are carried aboard Coast Guard vessels under their cognizance are physically capable of withstanding the trip contemplated and that they are free from medical conditions which could cause an interruption of the vessel's mission. Nonfederally employed civilians must furnish such evidence from a physician at no expense to the Coast Guard or Federal Government.

Section G - Medical Regulating.

1. Transfer of Patients at Coast Guard Expense.

   a. Details for the transfer of Coast Guard personnel to, from, or between hospitals and the responsibility for the expenses involved are contained in Chapter 4 of the Personnel Manual, COMDTINST M1000.6 (series).

   b. Information and requirements for the transfer of patients to, from, or between medical facilities is contained in COMDTINST M6320.8 (series), Medical Regulating to and Within the Continental United States.

2. Travel Via Ambulance of Patients to Obtain Care.

   a. Active Duty Personnel. The Coast Guard is responsible for providing ambulance service (Government or civilian), for active duty members when medically necessary. Bills related to ambulance service provided to active duty personnel, shall be processed as outlined in Chapter 11 of this Manual.

   b. Retired and Dependent Personnel. Retired personnel and dependents are not provided ambulance service for initial admission, except that a Government ambulance may be used in an emergency situation as determined by the cognizant medical authority. If an ambulance is ordered by a military hospital, TRICARE Standard can not pay for it; the military hospital must pay. TRICARE Standard cost –shares ambulances only when medically necessary; that is, the patient's condition does not allow use of regular, private transportation or taxis, "medicabs" or "ambicabs." Ambulance transportation must be needed for a medical condition that is covered by TRICARE Standard. Should either the provider or patient have additional questions regarding this issue check with the cognizant MLC(k), HBA or TRICARE Service Center.

3. Aeromedical Evacuation of Patients. When the condition of the patient requires aeromedical evacuation, the transfer shall be arranged in accordance with Medical Regulating To and Within The Continental U.S. (Joint Pub), COMDTINST M6320.8 (series). If there is no USMTF in the area, a message prepared in accordance with the above instruction shall be forwarded to MLC (k).

Section H - Defense Enrollment Eligibility Reporting System (DEERS) in Coast Guard Health Care Facilities.

1. Defense Eligibility Reporting System. This Section provides guidance for Coast Guard health care facilities on the use of the Defense Enrollment Eligibility Reporting System (DEERS) to verify patient eligibility to receive care.

   a. DEERS was established in 1979 by the Department of Defense to comply with a Congressional mandate. The two initial objectives of DEERS were to collect and provide demographic and sociographic data on the beneficiary population entitled to DOD health benefits, and to reduce the fraud and misuse of those benefits. The original scope of DEERS has since been broadened to include the maintenance and verification of eligibility status for all uniformed services beneficiaries. Worldwide implementation of DEERS and its registration were completed in 1985.

2. Responsibilities.

   a. Commandant (G-WKH) provides overall functional management of the Coast Guard DEERS program for health services facilities. In this role, Commandant (G-WKH) provides guidance to field activities, represents the Coast Guard to the DEERS Central Systems Program Office (DCSPO), and on the DEERS Central Systems Project Officers Committees.

   b. Commanders, Maintenance and Logistics Commands (k) shall appoint an MLC DEERS medical project officer and alternate, who shall ensure that facilities in their respective areas participate in and comply with DEERS program requirements.

   c. Commanding officers of units with health care facilities shall ensure that the Chief of the Health Services Division appoints the following individuals in writing:

      (1) DEERS Project Officer and alternate who are responsible for the overall management of the DEERS system in the clinic;

      (2) Site Security Manager (SSM) and alternate who are responsible for system security as outlined in paragraph 3; and

      (3) individuals authorized to deny care.

3. Security.

   a. The Site Security Manager (SSM) should be the health services division or unit computer systems administrator. The security manager is responsible for maintaining passwords, authorized user list, etc., and advising the DEERS contractor when changes occur.

   b. The SSM also requests site identification (site-ID) codes for the clinic. These codes are requested through the MLC DEERS Project Officer to Commandant (G-WKH).

As a rule, there is only one site ID required per clinic. The SSM also ensures information systems security awareness training/briefing is given to new DEERS users prior to allowing them access to DEERS and to all DEERS users annually.

c. If the clinic DEERS project officer is not the SSM, the security manager must closely coordinate activities with the DEERS project officer. Immediately after appointment, the SSM must telephone the DEERS Security Maintenance Office at (703) 820-4850 to notify that office of the appointment. When making this notification, include the following information:

(1) Site ID number;

(2) Rank or grade of SSM;

(3) Name (last, first, middle initial);

(4) Social Security Number (SSN);

(5) Duty location;

(6) Duty title; and

(7) Telephone number.

(8) After telephone notification, submit a letter of appointment and a Request for Data Base Additions, Deletions, or Changes (Figure 2-H-1) to:

(9) Security Maintenance Office
DEERS East Coast Center
1600 North Beauregard St.
Alexandria, VA 22311

d. User Password Maintenance.

(1) The DEERS security system requires a six-character user-ID and a six to eight character password. The user-ID is assigned by DEERS, and is permanent. An initial password is assigned by the DEERS government contractor. The password expires at 30 day intervals. At the end of each 30 day period, the user is required to change the initial password to one of his or her own choosing, so long as it meets the six- to eight-character requirement. Access to the data base is granted by using a unique user-ID, password, and the transaction identifier (TRAN-ID). The TRAN-ID for medical/dental is GIQD.

(2) To add a new user, submit a Request for Data Base Additions, Deletions, or Changes. Be sure to include the site-ID and SSN of any new personnel.

(3) To delete a current user, submit a Request for Data Base Additions, Deletions, or Changes requesting the deletion to the DEERS Security Maintenance Office.

(4) User IDs not used for 60 days are automatically deleted and access is not possible. To regain access, the SSM must reapply for a new user-ID by submitting a new Security Manager Update.

(5) Authorized users must be kept to the absolute minimum, consistent with job requirements.

4. Performing DEERS Checks.

a. Whom to check: All beneficiaries of the military health care system are subject to DEERS eligibility verification, with the following exceptions:

(1) Coast Guard cadets, officer candidates, and recruits while undergoing training;

(2) Active duty personnel receiving dental care at a military facility; and

(3) Secretarial Designees, including pre-adoptive children and wards of the Court, ARE NOT ELIGIBLE for care under the TRICARE programs. They are also not enrolled in DEERS. Verification of the eligibility of Secretarial Designees for care in a military facility is accomplished through the individual's actual letter of designation. Refer to Section 2-E for further information.

b. When to check: Coast Guard health services facilities should verify the eligibility of all beneficiaries prior to providing health care. The following minimum eligibility checks shall be made:

(1) 100% of all outpatient medical visits:

(2) 25% of all dental visits;

(3) 10% of pharmacy visits to fill "in-house" prescriptions;

(4) 100% of pharmacy visits with prescriptions written by civilian providers;

(5) 100% of all inpatient admissions; and

(6) 100% of dental visits when the patient may be eligible for the TRICARE Family Member Dental Program;

(7) 100% of retired members at the initial visit to a dental facility, and annually thereafter at the time of treatment.

(8) Upon initial presentation by dependents for evaluation or treatment. This check will be valid for 30 days, if the period of eligibility (dates of treatment) requested from DEERS is 30 days.

(9) When a non-active duty patient is referred to a civilian provider for supplemental care.

(10) When active duty personnel are referred to a civilian provider under the Active Duty Claims Program.

(11) When any patient (active duty, retired, dependent, or survivor) is referred to a Military Treatment Facility (MTF) or a Uniformed Services Treatment Facility (USTF).

(12) When in doubt verify enrollment and eligibility.

(13) Coordinated/Managed Care: Verification of eligibility will be conducted according to the policies and procedures of the sponsoring hospital/organization. Coast Guard facilities participating in coordinated/managed care programs are considered, by that participation, to be in compliance with the eligibility verification requirements of the DEERS program for medical patients. Dental patients will still be subject to the above checking requirements until a dental coordinated care program is established.

(14) Each clinic is required to perform a published number of checks each month. These requirements are based on the outpatient visits of each clinic from the previous year. Updated annual requirements will be published each January by Commandant Notice.

c. How to check. DEERS checks for patient registration and eligibility can be done in a number of ways. The following examples are the most common ways to verify eligibility:

(1) Telephone-Based System. Eligibility checks are done by contacting DEERS direct by telephone. Procedures for performing DEERS checks by telephone are found in Figure 2-H-2.

(2) Computer Link Using the Coast Guard Standard Terminal. Procedures for using the Standard Terminal are attached as Figure 2-H-3.

(3) DEERS-owned Computer and Software (On-Line) System. Procedures for using DEERS-owned equipment are contained in DOD DEERS Eligibility Inquiry/Nonavailability Statement Users Guide [Pub # UG 0100EL (series)].

(4) Use of PERSRU/Admin RAPIDS Terminals. Personnel in health care facilities are discouraged from performing DEERS checks using the RAPIDS terminal that may be available in their unit's Administration Office or PERSRU. Using this resource places an unnecessary burden on the PERSRU/Admin personnel, and using these terminals does not indicate that the required medical checks are being accomplished.

d. How to request site-ID, data base access, or equipment.

(1) Site ID.

(a) Site ID numbers are assigned to a facility by the DOD DEERS Office. These numbers are used to identify the origin of activity in the DEERS system, and to generate reports of system activity. Site IDs are a mandatory part of the initial request to access DEERS. The request form is attached as Figure 2-H-4. Site IDs are permanent; they need not be renewed.

(b) Health Care facilities requesting an initial Site ID, or changing the status of their existing ID shall complete Section I of Figure 2-H-4 and forward, via MLC (k), for further endorsement to:

(c) Commandant (G-WKH-3)
U. S. Coast Guard
2100 Second St., SW.
Washington, DC 20593-0001
ATTN: DEERS MEDICAL PROJECT OFFICER
Telephone: (202) 267-0835

(2) Data Base Access.

(a) Authorization for individual access to DEERS is done by written request from the clinic/unit Site Security Manager to the DEERS Security Maintenance Office using the "Request for Data Base Additions, Deletions, or Changes" form.

(b) Clinic personnel who should be considered for access to the DEERS Data Base include those working in medical/ dental records, appointments, pharmacy, patient affairs, and the health benefits advisor.

(c) Information available from the DEERS data base is subject to the provisions of the Privacy Act.

(3) Equipment Requests or Changes.

(a) Telephone Access. Requests for access to DEERS via telephone is the simplest and most user friendly means. This method is recommended for facilities making fewer than 20 checks per day. Requests for initial facility and personnel access is done by completing Figures 2-H-1 and 2-H-4 and forwarding them to DEERS security via the MLC and Commandant (G-WKH).

(b) Computer link using the Coast Guard Standard Terminal. Use of the Standard Terminal, with the proper software emulation package installed, allows facilities with a greater number of required checks to perform those checks without making repeated telephone calls. Equipment required includes a Standard Terminal workstation, Bell 212A compatible modem, appropriate emulation software (VT 100), and an outside commercial/FTS touch-tone telephone line. Facility requests for access using this equipment is done by completing Figure 2-H-4 with an attached statement that the facility has the appropriate hardware and software as listed above. The facility must also state that it will be responsible for any telephone charges incurred using this means of access. Figure 2-H-5 lists complete equipment requirements.

(c) DEERS-owned computer hardware and software system. This **top of the line** system features a direct, on-line, computerized link with the DEERS data base. The minimum justification for requesting this equipment is performing more than 100 DEERS checks per day. A limited number of

Coast Guard health care facilities have this equipment. For further information on this system, contact the Medical Project Officer at Commandant (G-WKH-1).

5. Reports. No reports from field units documenting DEERS activity are required. Two commonly generated reports concerning DEERS activity are described below:

   a. Monthly Statistical Reports. Upon receipt from DEERS, Commandant (G-WKH) will forward the Monthly Statistical Reports to each MLC (k). These reports list DEERS activity for each clinic during the preceding month. Clinics may also use the on-line statistical report screen to monitor its activity.

   b. Field Representative Visit Report. These report the findings of each training visit by the DEERS Field Representative to a clinic. These reports reflect the compliance of the facility to DEERS requirements, and whether or not further training for facility personnel is needed. Copies are provided to each MLC (k) and Commandant (G-WKH).

6. Eligibility/Enrollment Questions, Fraud and Abuse.

   a. Eligibility/Enrollment Questions: Beneficiaries of the military health care system, including active duty and retired personnel, their dependents, and survivors must provide positive proof of eligibility before being provided health care. Eligibility is determined by (a) presenting a valid ID Card and (b) verifying enrollment and eligibility in DEERS.

      (1) If an individual presents an ID card that is no longer valid (expired), the individual should be refused care and the ID card confiscated.

      (2) If the individual has a valid ID card, but is not enrolled in DEERS, they should be refused routine care, and referred to their sponsor and/or service ID card activity to be enrolled in DEERS. Following enrollment into DEERS, the patient may prove temporary eligibility (pending their enrollment showing up in the DEERS computer) by presenting a **certified** copy of Application for Uniformed Services Identification Card DD Form 1172 from the ID card activity. Upon presenting of this DEERS enrollment verification, the individual should be considered as fully eligible, and treatment provided.

   b. Fraud and Abuse: If, in the process of verifying eligibility through DEERS, clinic personnel have reason to believe the person requesting care is doing so even though that person is no longer eligible (e.g. a divorced spouse with a valid ID card, but DEERS shows **NOT ELIGIBLE**), care should be refused, and the details of the situation should be reported to the appropriate personnel activity and investigation office. Clinic personnel reporting suspected fraud should document as much information about the individual as possible (name, former sponsor's name, SSN, service and status, as well as the individual's current address and telephone number if known). Do not attempt to confiscate the ID card, or in any way restrict the

individual. Recovery of invalid or no-longer-appropriate ID cards is the responsibility of the parent service's investigation/law enforcement personnel. Reports of possible fraud should be reported to the command of the clinic, and to the DEERS Support Office (DSO) in Monterey, CA at (408) 646-1010.

7. Denial of Nonemergency Health Care Benefits for Individuals Not Enrolled in Defense Enrollment Eligibility Reporting System (DEERS).

   a. Policy.

      (1) All CONUS USMTFs will deny nonemergency health care to dependent beneficiaries not enrolled in DEERS. The DOD considers USMTFs located in Alaska, Hawaii, and Puerto Rico as being in CONUS. Patients presenting for care are required to have a valid ID card in their possession and meet DEERS enrollment requirements.

      (2) This policy effects only the delivery of nonemergency health care. Under no circumstances are Coast Guard health service personnel to deny emergency medical care or attention because a patient is not enrolled in DEERS.

      (3) Health service personnel in CGMTF's are to conduct the minimum eligibility checks for their facility as set annually by Commandant (G-WKH-1). Whenever possible, prospective checking should be accomplished soon enough to allow for notifying the patient and correcting enrollment problems before a scheduled appointment.

      (4) Patients with valid ID cards, but not enrolled in DEERS, presenting for nonemergency medical care at CGMTFs will be denied care and instructed to seek proper enrollment through their cognizant personnel office.

      (5) Patients who present for nonemergency treatment without a valid ID card and are in the DEERS data base, will not be provided health care without first providing a statement, signed by a verifying personnel officer indicating that they are eligible and providing a reason why a valid ID card is not in their possession. A copy of this statement will be maintained in the clinical record until the individual's eligibility is determined.

      (6) If the beneficiary presenting with or without an ID card is suspected of fraud, refer the case to the district (ole) branch for appropriate investigation.

      (7) Denial of health care benefits represents a serious application of new and complex regulations. Under no circumstances will a person be denied care by the clerk performing the initial eligibility check. The decision to deny care will be made only by clinic administrative officers or by a responsible person so designated in writing by the command.

8. DEERS Eligibility Overrides. The below listed situations will override DEERS data which indicates that a patient is not enrolled or eligible. Unless otherwise stated, all situations assume that the beneficiary possesses a valid ID card:

a. Dependents Recently Becoming Eligible for Benefits. Patients who have become eligible for benefits within the previous 120 days may be treated upon presentation of a valid ID card. In the case of children under age 10, the parent's ID card may be used. Examples of patients expected to fall under this provision are: spouses recently married to sponsors, newly eligible step children, family members of sponsors recently entering active duty status for a period over 30 days, parents/parents-in-law, or divorced spouses (not remarried) recently determined to be eligible. After 120 days, these beneficiaries will no longer be considered recent.

b. DD-1172. Application for Uniformed Services Identification Card form. The patient presents an original or a copy of the DD-1172 used for DEERS enrollment and possesses a valid ID card over 120 days old, but is not enrolled in DEERS. This copy of the DD-1172 should be **Certified to be a True Copy** by the ID Card issuing authority which prepared it. It should also contain a telephone number where the certifying individual can be contacted for verification. The person conducting the DEERS check shall contact the issuing personnel office to verify enrollment.

c. Sponsors Entering Active Duty Status for a Period of Greater than 30 days. If the sponsor is a reservist or guardsman recently ordered to active duty for a period of greater than 30 days, a copy of the active duty orders may be accepted as proof of eligibility for up to 120 days after the beginning of the active duty period.

d. Newborns. Newborns will not be denied care for a period of one year after birth provided the sponsor is DEERS enrolled and the parent accompanying the infant presents with a valid ID card.

e. Ineligible due to ID Card Expiration. When the data base shows a patient to be ineligible due to ID card expiration, care may be rendered as long as the patient has a new ID card issued within the previous 120 days.

f. Sponsor's Duty Station is Outside the 50 United States with an FPO or APO address. Dependents whose sponsors are assigned outside the 50 United States or to a duty station with an APO or FPO address will not be denied care as long the sponsor is enrolled in DEERS.

g. Survivors. In a small percentage of cases, deceased sponsors may not be enrolled in DEERS. This situation will be evidenced when the MTF does an eligibility check on the surviving beneficiary and does not find the sponsor enrolled or the survivor appears as the sponsor. In either of these situations, if the survivor has a valid ID card, he/she should be treated and referred to the local personnel support activity to correct the DEERS data base. In some situations, surviving beneficiaries who are receiving SBP annuities will be listed in DEERS as sponsor and will be found under their own social security number. These are eligible beneficiaries and should be treated.

h. Foreign Military Personnel. Foreign military personnel assigned via the personnel exchange program are eligible through public law or other current directives, though not enrolled in DEERS they will be treated upon presentation of a valid ID card.

Figure 2-H-2

TO: Security Maintenance Office

DEERS East Coast Center SITE ID: __ __ __ __ __ __ (DEERS)Date: _____
1600 N. Beauregard St.(Fill in six digits)
Alexandria, VA 22311

SUBJECT: Request for Data Base Additions, Deletions, or Changes

FROM: Site Security Manager: _____ _____ _____ _____
Rank Name (Last, First MI) SSAN Title
Phone #: AV: _____ COM: (_____)_____

Request the indicated actions be taken for the following individuals:
Action
SSAN Name (Last, First, MI)Duty Location
(MTF Records, HBA, Etc.)

| Action | | SSN | name | | duty location |
|---|---|---|---|---|---|
| Add | Delete | Change | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

_____
_____

Unit OPFAC Code: _____(Signature) _____
Base/Installation/Facility
Site Security Manager

- All Site Security Manager's mailing address changes should be entered in this space.
- All items must be completed. Omission of any items may prevent or delay the processing of this form.

Figure 2-H-2 (con'd)

**INSTRUCTIONS FOR DEERS TELEPHONE USERS**

A. Telephone Users.

1. Provide your LOGON-ID and Password to the Eligibility Telephone Center operator at: (800) 336-0289 or (800) 368-4416. The hours of operation are 0400-1700 (Pacific Time), Mon-Fri.

2. Approximately every 30 days the Telephone Center operator will ask you to establish a new password. At that time, you will provide the operator a new Password of 5 to 8 characters. It is very important that you remember the new Password you have chosen.

3. If you forget your password, the operator in the Telephone Center will refer you to the Security Maintenance office at (703) 578-5306, or AUTOVON 289-1953. At this time, you will be provided a Temporary Password, which you will then provide to the Eligibility Telephone Center operator on your next inquiry call.

4. The Eligibility Telephone Center operator will enter this Temporary Password into the operator's terminal and then ask for your new password (as in [2] above).

B. Telephone-Based System.

1. Telephone type. The telephone line used for eligibility checks is a rotary In-WATS telephone system. A rotary system means that when one of the lines at the eligibility center is not being used, the incoming call will automatically be transferred to that line. If a busy signal on the rotary line is received, all lines at the eligibility center are being used. If this happens, hang up and try again later.

   a. Eligibility Check Procedure. When an eligibility center operator answers the telephone, the following procedures to perform a patient's eligibility check will be used:

   b. Note: When calling, greet the operator and identify the center from where you are calling.

      (1) You will supply the following information to the operator:

         (a) Site name and site security code, UCA code (from medical, dental, or pharmacy)

         (b) DEERS ID (an optional family member prefix and sponsor's Social Security Number)

         (c) Date of birth of beneficiary if known. If not known, then 999999

         (d) FROM date (YYMMDD) of medical treatment

(e) TO date (YYMMDD) of medical treatment

(2) The operator will then perform an eligibility inquiry.

(3) If the patient is found to be on file, the operator will indicate that the patient is enrolled in DEERS and is/is not eligible. When checking eligibility for more than one member of a family, each of the family members must be identified individually.

(4) If the patient is not found on file, the operator will indicate that the patient does not appear as enrolled in DEERS.

(5) The procedure is repeated until all patients have been checked, and then the call is ended.

**SAMPLE ELIGIBILITY CHECK CALL**

The following is an example of DEERS Eligibility Center Telephone Inquiry format:

Operator: Good Morning - DEERS Eligibility Center - May I help you?

Inquirer: Good morning, this is Support Center Alameda, Security Code AC, UCA Code BA, Site Code 10123, inquiring the eligibility of 123 45 6789. The date of birth is 560324. This is a single beneficiary request.

Operator: (enters SSN, DOB, SC, UC, and SITE CODE) What period of eligibility do you wish to check?

Inquirer: 801201 through 801215 (December 1 - 15, 1980)

Operator: The beneficiary is Jane Smith, and she is enrolled and eligible for the period requested. Any more inquiries?

Inquirer: Not at this time. Thank you, good-bye.

Operator: Thank you for calling the DEERS Eligibility Center.

Figure 2-H-3

PERFORMING DEERS CHECKS USING THE COAST GUARD STANDARD TERMINAL

Ref: (a) DEERS Users Guide (UG0100ELR5) of Oct 1987

1. At the Standard Terminal "Command Bar", Type **VT100**, (Go). If you don't have a "Command Bar", see your computer System Manager.

2. To dial-up the DEERS microcomputer access, enter **ATDT8,7033795860,** then press (Return). This command tells the modem to dial the DEERS access number, and should result in a message reading "connect 1200" on your screen. This means your computer and the one at DEERS are talking to on another.

3. Upon "handshake" with the DEERS computer, enter **M** (for Menu), then **VT100** (return).

4. At Security Protection Screen, enter **DEERS** (Return). See also page 2-2 of reference (a).

5. At Transaction Code Screen, enter **LOGN** (Return). Also see page 2-3 of reference (a).

6. At Security Screen, enter **your** User ID in the "LOGON-ID" space, then press **TAB**. See page 2-4 of reference (a).

7. Enter your personal password in the designated area, then press **TAB**. See page 2-4, Step 5 of reference (a).

8. Enter GIQD in the "TRAN ID" space, then press Return. See pages 2-4 and 5, steps 6 & 7 of reference (a).

9. At the Main Menu, select the desired activity. For Eligibility checks, see pages 4-1 through 4-19 of reference (a), or as follows:

10. In Activity Code (AC) space, no entry is necessary if you wish to make an eligibility check. See page 4-11 of reference (a). Press "Tab" to continue.

11. Enter your 6 character **Site ID**, then press "Tab".

12. In "UC" block, enter **BA** for Ambulatory Medical Care checks, **CA** for Dental checks, **DA** for Pharmacy checks, or **FN** for TRICARE/HBA checks, then press "Tab". See page 4-12 of reference (a) for other codes.

13. Enter **Sponsor's SSN**, then press "Tab".

14. Enter PATIENT's Date of Birth (DOB) in the following format: **YYYYMMDD**, then press "Tab".

15. In "DDS" block, enter DEERS Dependent Suffix as follows:

    01-19 Eligible Dependent Children

    20 Sponsor

    30-39 Spouse of Sponsor

    40-44 Mother of Sponsor

    45-49 Father of Sponsor

    50-54 Mother-in-Law of Sponsor

55-59 Father-in-Law of Sponsor

60-69 Other Eligible Dependents

70-74 Unknown by DEERS

75 DDS is unknown by Inquirer

98 Service Secretary Designee

NOTE

If the DDS code for sponsor (20) is used, only sponsor data will be displayed on the Eligibility Inquiry and Family Display Screens.

In the Treatment Date block, if the treatment dates are not the current date, enter the correct dates in YYYYMMDD format, then press Tab.

16. After completing the SITE, UC, SPON SSN, PAT DOB, and DDS fields, press the ENTER/RETURN key. If there is a record on the data base with the same SSN and patient DOB or a multiple DOB match and a single DDS match, the DEERS Eligibility Screen will be redisplayed, showing the pertinent data on the patient in the lower portion of the screen.

17. Once patient eligibility has been verified, that patient's data can be cleared from the screen by pressing Return.

18. To exit from the DEERS Eligibility Inquiry System:

    a. Select the appropriate two-character code and enter it into the AC field. The codes are:

       MM - DEERS Inquiry System Main Menu Screen
       SO - Sign Off

       (1) If the MM code is used to return to the Main Menu, enter **10** in the activity field to **Sign Off**, then press **Return**.

    b. Press, Enter (Return) when prompted by the sign-off screen.

    c. When at the Original screen, enter +++ (return), then AT H (return). (Steps b and c "hang up" the modem link/telephone connection with the DEERS computer)

    d. Press, **Finish** to return to the Command Bar.

Figure 2-H-4

SITE-ID INITIAL REQUEST (DEERS)

SECTION I. (To be completed by the base/installation/facility Site Security Manager).

A new Site-ID is requested_____(base name).

SERVICE/ORGANIZATION (Check X One)
Air Force = F ___DOD = D ___ NOAA = O ___
Army = A ___Marine Corps = M ___TRICARE = C ___
Coast Guard = P__Navy = N ___ Public Health = W ___
Other = X ___

TYPE OF FACILITY (CHECK X One) FACILITY SECTION (Check X One)
Dental Clinic = D ___AAFES = S ___ FINCTR W/Title III = FT ___
Health Clinic = M ___AQCESS = G __ Med/Dent Rec = R ___
Hospital = H ___ Army Fin Off = F ___Tumor Registry = T ___
Personnel Office = P __Civ Pers Office = C ___ Other = Z ___
OPFAC code is _____

| **Sample:** | **Full Mailing Address:** |
|---|---|
| Commander | Point of Contact (Title not person's name) |
| Integrated Support Command New Orleans | |
| Attn: Medical Records | |
| 4640 Urquhart St. | |
| New Orleans, LA 70017-1010 | |

** This line of address must include a location identifier. For example, "USCG Clinic" is not acceptable; USCG Clinic New Orleans is acceptable.

Requested by (Rank/Name Signature)_____ DATE:_____
(Telephone) Comm (__)_____, FTS_____.
SECTIONS II/III. (To be completed by Service Project Officer)
Recommended by: (Rank/Name/Signature) _____ Date:____.
APPLICATIONS: (Check X One)
ACTUR ___ ARED ___ DOLI ___ OLGR ___ RAPIDS ___
AQUESS ___ DMRIS ___ GIQD ___ OLPU ___ Other ___
EQUIPMENT (Check X One) *Note: Justification must be attached if equipment is required.
CRT ___ RAPIDS ___ Telephone Center ___
Facility Equipment ___ Timeshare ___
III. 12-Month Workload: (A) Avg Admissions: ____, (B) Avg Outpat Visits: ___; (C) Dental: ___

Figure 2-H-4 (con'd)

SECTIONS IV/V. (To be completed by DCSPO representative

Director, Benefits Policy Division
DEERS and Central Systems Program Office
Six Skyline Place
5109 Leesburg Pike, Suite 502
Falls Church, VA 22041-3201

V.
Inpatient_____
Outpatient _____
Dental _____

The applications above are correct (or changed as indicated), and the equipment is confirmed. Eligibility checking requirements are in Section V. Issue Site-ID.

Director, Benefits Policy Division_____Date:_____

SECTION VI. (To be completed by Security Maintenance, DEERS East Coast Center)
Entered on DEERS Site-ID File by (initials)_____DATE _____.
Site-ID: __ __ __ __ __ __
Field Service Region _____ State or Country (OCONUS).

Figure 2-H-5

DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS)

DIAL-UP ACCESS POLICY

MICROCOMPUTER ACCESS

DEERS can be accessed by telephone by using an IBM PC or AT compatible microcomputer, or the Coast Guard Standard Terminal with the proper software emulation package installed. There are four criteria for microcomputer access to DEERS:

1. Site must have access to an outside commercial touch-tone telephone line.
2. The modem connected to the computer must be Bell 212A compatible.
3. Individuals must have DEERS assigned user-IDs and passwords,
4. An asynchronous communication software package must be installed in the computer. The most common software for the Standard Terminal is the VT-100 emulator.

An asynchronous dial-up environment is used to allow existing asynchronous terminals at military installations to interface with DMSSCNET through a modem. The required modem must be compatible with a Bell 212A capable for 300 or 1200 baud. This equipment will be communicating with a Renex Converter at the DEERS offices. The display terminal should be set up as follows:

1. Line width of 80 characters
2. 24 line screen height.

The asynchronous communications program should be configured as follows:

1. Baud rate of 300 or 1200.
2. Parity of EVEN or MARK
3. Stop bits of one (1)
4. Terminal emulation selections are listed on the Renex menu
5. Word length of seven (7)

The following telephone number is used to dial into the Renex converter box at DEERS. This number has 16 trunk lines, and should normally be available:

(703) 379-5860

Figure 2-H-5 (con'd)

ENSURING HANDSHAKE

The following criteria must be met during the interface test to ensure the handshake (communication between your computer/modem and the DEERS system) is successful:

1. Verify correct hardware and software configuration
2. Conduct a dial-up test using the above telephone number
3. Perform system access procedures to display the DEERS sign-on screen
4. If any problems or questions arise during the initial setup and testing of equipment, call the DMSSC Technical Support Group at (703) 578-5021, -22, or -23.

Section I - Health Care Facility Definitions.

1. Coast Guard Facilities.

   a. Clinic. A health care facility primarily intended to provide outpatient medical service for ambulatory patients. A clinic must perform certain non-therapeutic activities related to the health of the personnel which are necessary to support the operational mission of the unit, such as physical examinations, immunizations, medical administration, and preventive medical and sanitary measures. A clinic staff consists of at least one permanently assigned medical officer and health services technician. The staff may include dentists, nurses, pharmacists, physician assistants and other specialists as required. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for overnight care of patients who do not require complete hospital services (e.g., isolation of patients with communicable diseases) if accredited for that purpose by an external accreditation agency (JCAHO/AAAHC).

   b. Satellite Facility. A health care facility which is administered by a Coast Guard clinic but is located off-site from the clinic.

   c. Dental Clinic. A facility at a Coast Guard unit for the dental care and treatment of active duty personnel. Dental clinics are staffed with one or more dental officers and health services technicians.

   d. Sick Bay. A small medical treatment facility (afloat or ashore) normally staffed only by health services technicians for the care and treatment of active duty personnel. Civilian health care providers contracted to provide in-house services at these facilities, like any facility, may provide care only within the scope of their contracts. The fact that these civilian health care providers are on board will not change the status of the medical facility.

   e. Super Sickbay. An intermediate size medical care facility (ashore) intended to provide outpatient medical care for active duty personnel. A super sickbay will perform activities related to the health of the personnel, which are necessary to support the operational missions of all units within AOR, such as physical examinations, immunizations, medical administration, and preventive medical and sanitary measures. A super sickbay staff will normally be staffed with one medical officer and three or more health service technicians.

2. Department of Defense Medical Facilities.

   a. Nomenclature and Definitions. There are three types of DOD fixed medical treatment facilities medical centers, hospitals, and clinics. The nomenclature and definitions applicable to the classification of these facilities, as set forth below, are used by the Army, Navy, Air Force, and Marine Corps.

(1) Medical Center. A medical center is a large hospital which has been designed, staffed and equipped to provide health care for authorized personnel, including a wide range of specialized and consultative support for all medical facilities within the geographic area of responsibility and post graduate education in the health professions.

(2) Hospital. A medical treatment facility capable of providing definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the field of general medicine and surgery, preventive medicine services, and has the supporting facilities to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic.

(3) Clinic. A medical treatment facility primarily intended and appropriately staffed and equipped to provide emergency treatment and outpatient services. A clinic is also intended to perform certain non-therapeutic activities related to the health of the personnel served, such as physical examinations and preventive medicine services necessary to support a primary military mission. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for care of cases which cannot be cared for on an outpatient status, but which do not require hospitalization.

b. Primary Mission. The primary mission of Department of Defense medical facilities is to provide adequate medical care for members of the uniformed services on active duty.

3. Uniformed Services Treatment Facilities (USTFs).

a. Public Law 97-99 (1981) authorized several former USPHS hospitals (sometimes called Jackson Amendment facilities) to provide health care to active duty and retired members and their dependents. The law was modified in 1991 and the USTF program was mandated to implement a managed care delivery and reimbursement model in order to continue as part of the Military Health Services System (MHSS). This managed care plan went into effect on October 1, 1993 and is called the Uniformed Services Family Health Plan (USFHBP).

b. USFHBP is a health maintenance organization-type of plan exclusively for the dependents of active duty, retirees and their dependents. Where available, the USFHBP serves a defined population, through voluntary enrollment, and offers a comprehensive benefit package. The capacity at USFHBP sites varies and is limited. Beneficiaries enroll in the USFHBP during a yearly **open season**, and may disenroll after one year. Enrollment is confirmed by each USFHP site. Those not accepted during the open season may be enrolled as openings occur on a **first come-first served** basis. **USFHBP enrollees are not authorized to use the TRICARE Program or the direct care system (DOD and Coast Guard health care/dental facilities included) while enrolled in the USFHP**.

c. Dependents and retirees who do not enroll in the USFHBP or who are denied enrollment because the USFHBP is at capacity can only be treated at USTFs on a

space-available and fee-for-service basis. All USTFs are required to be TRICARE preferred providers.

d. Active duty personnel are not eligible to enroll in the USFHBP, however, they can still be treated at USTFs under the following conditions:

(1) for emergency care,

(2) when referred by a military treatment facility, or

(3) when authorized by the cognizant MLC for non-emergent care.

e. When active duty care is rendered, the USTFs are not authorized to bill or collect payment from active duty members, they must bill the Coast Guard instead.

Section J - Policies and Procedures Required at Coast Guard Health Care Facilities.

1. Administrative Policies and Procedures. All facilities shall develop and maintain the following written administrative policies and procedures which shall be reviewed annually and updated as needed.

   a. Standard Operating Procedure (SOP) defining objectives and policies for the facility.

   b. Organizational Chart if there is a Health Services Division or Branch. The Health Services Division/Branch or Medical Department should also be shown on the command's organizational chart.

   c. Clinic protocols, posted in the respective department, for pharmacy, medical laboratory, and medical and dental radiology.

   d. Notices posted in pharmacy and radiology advising female patients to notify department personnel if they are or might be pregnant or breast feeding (pharmacy only).

   e. Written guidelines advising patients how to obtain after-hours emergency medical and dental advice or care. These must be readily available and widely publicized within the command and the local eligible beneficiary community.

   f. Quality Assurance (QA) program guidelines including assignment of a QA coordinator and QA focus group members in writing. The QA focus group shall meet at least quarterly and maintain written minutes.

   g. Guidelines for a patient advisory committee (PAC) comprised of representatives of the health care facility and each major, identifiable, patient interest group. The PAC shall meet periodically and maintain written minutes.

   h. Persons authorized to deny care shall be so designated in writing by the command.

2. Operational Policies and Procedures. Facilities shall also develop and maintain the following written operational policies and procedures. These require annual review and signature by all health services personnel.

   a. Emergency Situation Bill including Health Services Division response to fire, earthquake, bomb threat, heavy weather, etc.

   b. Health Services Emergency Response Protocols for suicide attempt/threat, rape/sexual assault, family violence and medical emergencies in the dental clinic.

   c. Protocol for managing after-hours emergencies. Clinics at accession points and at Coast Guard units with on-base family housing shall maintain a 24-hour live watch schedule.

3. Patient Rights. Health care shall be delivered in a manner that protects the rights, privacy and dignity of the patient. Sensitivity to patient needs and concerns will always be a priority.

   a. Clinics shall post the Patient Bill of Rights and Responsibilities poster in clear view in all patient waiting and urgent care areas (see Figure 2-J-1). Copies are available from Commandant (G-WKH-1).

   b. Chaperones shall provide comfort and support to patients during exams or treatment. All patients shall be informed of the availability of chaperones.

      (1) Chaperones are defined as persons who attend patients during medical exams or treatment. Chaperones shall be of the same gender as the patient being examined. Any nursing staff member, HS or volunteer may serve as a chaperone as part of their duties. The Chief, Health Services Division shall ensure that chaperones have appropriate training or experience (such as Red Cross Orientation/Training) to enable them to carry out their duties properly. Although a patient's request for a family member or friend to be present during examination may be honored, that person is not a substitute for a chaperone.

      (2) Patients who request the presence of a chaperone shall have their request honored unless, in the opinion of the medical officer, the risk to the chaperone outweighs the benefit to the patient (e.g., during x-ray exposures).

      (3) Female patients undergoing breast examination or genital/rectal examination or treatment must have a chaperone present during the examination. Male patients may have a chaperone present at the patient's request.

      (4) If a provider thinks a chaperone is necessary, and the patient refuses to permit the services of a chaperone, the provider must consider whether to perform the examination or treatment or to refer the patient to another source of care.

      (5) Clinics shall have a written policy for reporting any episode of alleged misconduct during medical/dental examinations to the unit commanding officer. Unit commanding officers shall investigate such complaints in accordance with regulations.

   c. Chief, health services division shall enforce the patient chaperone policy and ensure chaperones are qualified to perform their duties.

   d. Chief, health services division shall ensure that allegations of misconduct are forwarded to the command in a timely manner.

   e. Clinics shall ensure that patient educational materials concerning gender-related health issues (PAP smears, cervical cancer, mammography and breast disease, testicular and prostate cancer, etc.) are readily available.

4. Health Care Provider Identification.

a. In accordance with the Patient Bill of Rights and Responsibilities, all patients have the right to know the identity and the professional qualifications of any person providing medical or dental care. The recent addition of Nurse Practitioners and commissioned Physician Assistants to our health care staffs has increased the chances of misidentification. Accordingly, health care providers shall introduce themselves and state their professional qualifications (level of provider) at each patient encounter.

b. The standard Coast Guard name tag does not reflect any information concerning the professional qualifications of the health care provider. Additionally, the standard Coast Guard name tag is often not visible to patients with poor eyesight, or it may be hidden by the provider's smock or lab coat. In lieu of the standard Coast Guard name tag, all health care providers, civilian and military, shall wear a specific health care provider identification tag on their outer smock or lab coat when engaged in direct patient care in Coast Guard Clinics and Dental Clinics. The health care provider identification tag shall be worn above the right breast pocket (or equivalent). The following criteria shall be used by local commands and clinics in manufacturing the health care provider identification tags:

(1) Size. The identification tag shall be 1" high by 3" wide.

(2) Materials. Standard plastic name tag blanks which may be purchased locally or from Government sources.

(3) Color. Standard Coast Guard blue or black with white lettering.

(4) Contents. The identification tag shall contain the following information:

(a) The rank, first initial, and last name shall be centered on the identification name tag and placed on the top line.

(b) One of the following professional titles, or any other commonly recognized professional name, centered below the name line. Abbreviations shall not be used.

1 Physician

2 Dentist

3 Physician Assistant

4 Nurse Practitioner

5 Pharmacist

6 Physical Therapist

7 Optometrist

8 Registered Nurse

9 Health Services Technician

FIGURE 2-J-1

THE COMMANDANT OF THE UNITED STATES COAST GUARD
WASHINGTON, DC 20593-0001

# PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

## *Patient Rights*

***You have a right to:***

Considerate, respectful care with suitable attendants consistent with the health care resources available and the accepted standard of care.

Impartial access to treatment regardless of race, sex, religion, or national origin.

Reasonable safety, comfort, and privacy within the clinic.

The identity and professional status of the health care providers and professionals primarily responsible for your care.

Full disclosure from the provider of care about your condition, treatment, prognosis, significant complications, risks, benefits, alternative treatments available, and any additional information required to give informed consent prior to procedures.

Personal and information privacy within the limits of the law. That is to:

a. refuse to talk with or see anyone not directly involved in your care;

b. be interviewed and examined in surroundings that assure reasonable privacy;

c. expect that any discussion or consultation involving your care will be conducted confidentially; and

d. have your health records read only by individuals who are directly involved in your treatment or the monitoring of its quality or have other legal authority to review your record.

The presence of a chaperone during examination and treatment, if you so desire.

Expect reasonable continuity of care.

Be advised if the facility proposes to engage in, or perform, research associated with your care or treatment. You have a right to refuse to participate in any research project.

Refuse treatment to the extent permitted by law and government regulations, and to be informed of the consequences of your refusal.

Be informed of facility rules and regulations which relate to your conduct.

Receive information concerning the medical or dental treatment facility mechanism to initiate, review, and resolve potential complaints.

## *Patient Responsibilities*

***You have the responsibility:***

To provide complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.

To report any unexpected changes in your condition.

To understand your treatment plan, and to ask questions about what is not clear to you.

To follow the treatment plan.

To keep appointments and to notify the clinic when you are unable to do so.

For your actions if you refuse treatment or do not follow the orders of health care providers.

To inform the facility if you believe your rights have been violated.

To be considerate of the health services personnel and to act in a mature and polite manner.

To be considerate of other patients. In particular, smoking, loud noise, unruly behavior, profanity, and improper attire are not permitted in the clinic.

To promptly return records to the clinic where they are maintained. All health records documenting care provided by any medical or dental treatment facility are the property of the U.S. Government.

Robert E. Kramek

ROBERT E. KRAMEK
*Admiral, U.S. Coast Guard*

Section K - General Standards of Care. Patients at Coast Guard clinics and sickbays shall be treated in accordance with the following general standards of care:

1. Diagnosis and therapy shall be performed by a provider with appropriate credentials.

2. Diagnoses shall be based upon clinical findings and appropriate tests and procedures.

3. Treatment shall be consistent with the working diagnosis, and shall be based upon a current treatment plan.

4. Treatment shall be rendered in a timely manner. Providers should use their professional judgement in accounting for the specific needs of patients and military readiness obligations while attempting to meet the following goals for timeliness:

   a. Sick call – If provided, the patient should be triaged immediately and be seen based on urgency of the condition. The patient should be advised of the wait time to be seen and offered a later appointment if the condition does not warrant immediate attention.

   b. Acute Illness (medical) - The wait time should not exceed 1 day. The condition must be addressed, not necessarily resolved, within this time frame.

   c. Routine Visit (medical) - The wait time should not exceed 1 week.

   d. Specialty Care (medical) - To be determined by the primary care manager making the referral based on the nature of the care required and the acuteness of the injury, condition, or illness, but should not exceed a wait time of 4 weeks to obtain the necessary care.

   e. Well Visit - The wait time should not exceed 4 weeks.

   f. Urgent Care (dental) - The wait time should not exceed 1 day. The condition must be addressed, not necessarily resolved, within this time frame.

   g. Routine Visit (dental) - The wait time should not exceed 4 weeks.

   h. Scheduled Appointment (medical or dental) - The wait time should not exceed 30 minutes of appointed time. This may sometimes be delayed by the need to address prior scheduled patients, emergency care, or unforeseen military obligations.

   i. Pharmacy - Prescription available within 30 minutes.

5. Treatment shall be provided using currently accepted clinical techniques.

6. Patients shall participate in deciding among treatment alternatives available to them.

7. All diagnosis and treatment shall be appropriately documented, including subjective complaints, pertinent positive and negative history, objective findings, clinical assessment, plan for treatment, prescriptions, post-treatment instructions, and disposition of patient.

8. Unusual circumstances, including complications of treatment, shall be fully documented.

# CHAPTER 3

# PHYSICAL STANDARDS AND EXAMINATION

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# CHAPTER 3. PHYSICAL STANDARDS AND EXAMINATIONS

## Section A - Administrative Procedures.

1. Applicability of Physical Standards.

   a. The provisions of this chapter apply to all personnel of the Coast Guard and Coast Guard Reserve on active or inactive duty and to commissioned officers of the Public Health Service assigned to active duty with the Coast Guard.

   b. Members of the other Armed Forces assigned to the Coast Guard for duty are governed by the applicable instructions of their parent Service for examination standards and for administrative purposes.

2. Prescribing of Physical Standards.
   Individuals to be enlisted, appointed, or commissioned in the Coast Guard or Coast Guard Reserve must conform to the physical standards prescribed by the Commandant. Separate standards are prescribed for various programs within the Service.

3. Purpose of Physical Standards.
   Physical standards are established for uniformity in procuring and retaining personnel who are physically fit and emotionally adaptable to military life. These standards are subject to change at the Commandant's direction when the needs of the Coast Guard dictate.

4. Application of Physical Standards.

   a. Conformance with Physical Standards Mandatory. To determine physical fitness, the applicant or member shall be physically examined and required to meet the physical standards prescribed in this chapter for the program or specialty and grade or rate involved. An examinee who does not meet the standards shall be disqualified.

   b. Evaluation of Physical Fitness. The applicant's total physical fitness shall be carefully considered in relation to the character of the duties to that the individual may be called upon to perform. Physical profiling is not a Coast Guard policy. Members shall be considered fit for unrestricted worldwide duty when declared physically qualified. The examiner must be aware of the different physical standards for various programs. Care shall be taken to ensure an examinee is not disqualified for minor deviations that are clearly of no future significance with regard to general health, ability to serve, or to cause premature retirement for physical disability. However, conditions that are likely to cause future disability or preclude completing a military career of at least twenty years, whether by natural progression or by recurrences, are also disqualifying. This policy shall be followed when an authentic history of such a condition is established, even though clinical signs may not be evident during the physical examination.

5. Interpretation of Physical Standards. Examiners are expected to use discretion in evaluating the degree of severity of any defect or disability. They are not authorized to disregard defects or disabilities that are disqualifying in accordance with the standards found in this chapter.

6. Definitions of Terms Used in this Chapter.

   a. Officers. The term "officers" includes commissioned officers, warrant officers, and commissioned officers of the Public Health Service.

   b. Personnel. The term "personnel" includes members of the Coast Guard and Coast Guard Reserve, and the PHS on active duty with the Coast Guard.

   c. Medical and Dental Examiners. Medical and dental examiners are medical and dental officers of the uniformed services, contract physicians and dentists, or civilian physicians or dentists who have been specifically authorized to provide professional services to the Coast Guard. Some USMTFs have qualified enlisted examiners who also conduct medical examinations and their findings require countersignature by a medical officer.

   d. Flight Surgeons and Aviation Medical Officers. Officers of a uniformed service who have been so designated because of special training.

   e. Command/Unit. For administrative action required on the Report of Medical Examination (SF-88), the command/unit level is the unit performing personnel accounting services for the individual being physically examined.

   f. Reviewing Authority. Commander Coast Guard Personnel (CGPC-adm) and MLC (K) are responsible for approval of physical examinations as outlined herein. Clinic Administrators may act as reviewing authority for physical examinations performed in their AOR as designated by the cognizant MLC, except for those that are aviation or dive related. Reviewing authority shall not be delegated below the HSC level. Medical Administrative Officers (LDO and CWO-Meds) may review physical examinations performed by contract physicians and USMTFs within their AOR.

   g. Convening Authority. Convening Authority is an individual authorized to convene a medical board as outlined in Physical Disability Evaluation System, COMDTINST M1850.2 (series).

   h. Time Limitation. The time limitation is the period for which the physical examination remains valid to accomplish its required purpose. The time limitation period begins as of the day after the physical examination is conducted.

7. Required Physical Examinations and Their Time Limitations.

   a. Enlistment. A physical examination is required for original enlistment in the Coast Guard and the Coast Guard Reserve. This physical examination will usually be performed by Military Entrance Processing Stations (MEPS) and is valid for twenty-

four months. Approved MEPS physicals do not require further review. Recommendations noted on separation physical examinations from other services must have been resolved with an indication that the individual meets the standards. A certified copy of that physical examination must be reviewed and endorsed by the reviewing authority Commander (CGRC). The reviewing authority must indicate that the applicant meets the physical standards for enlistment in the USCG.

(1) Recruiters who believe that applicants have been erroneously physically disqualified by MEPS, may submit the SF-88 and SF-93 (original or clean copies) along with supporting medical records to Commander (CGRC) for review.

(2) Waiver of physical standards for original enlistment may also be submitted as above, and in accordance with paragraph 3-A-8 of this instruction.

(3) Separation physical examinations from any Armed Service may be used for enlistment in the Coast Guard, provided the examination has been performed within the last twelve (12) months. The physical examination must be as complete as a MEPS exam, include an HIV antibody test date (within the last 24 months) and result, and a Type II dental examination. An SF-93 must also be included with elaboration of positive medical history in the remarks section (item #25). Forward all documents for review by Commander (CGRC).

(4) Prior Service enlisted aviation personnel must obtain an aviation physical examination from a currently qualified uniformed services flight surgeon or AMO within the previous 12 months. This physical examination will be submitted with the rate determination package to Commander (CGRC).

(5) Occasionally, applicants for initial entry into the Coast Guard will need to be examined at Coast Guard MTFs. In these cases, the physical examination will be performed per section 3-C. The examining medical officer may defer item #46 of the SF-88 to the Reviewing Authority. Otherwise, the physical standards for entry (sections 3-D and 3-E, as appropriate) must be meticulously applied when completing this item. The completed SF-88 and SF-93 will be forwarded to the reviewing authority, Commander (CGRC).

b. Pre-Commissioning/Appointments. A physical examination is required within 12 months prior to original appointment as an officer in the Coast Guard or Coast Guard Reserve for personnel in the following categories:

(1) appointment to Warrant Grade, except that physical examinations for members of the Coast Guard Ready Reserve must be within 24 months prior to the date of execution of the Acceptance and Oath of Office, form CG-9556.

(2) appointment of a Licensed Officer of the U. S. Merchant Marine as a commissioned officer (examination required within 6 months); and

(3) upon graduation from the Coast Guard Academy.

c. Separation from Active Duty.

(1) A complete physical examination (SF-88/93) is required within 12 months for retirement, involuntary separation, or release from active duty (RELAD) into the Ready Reserves (selected drilling or IRR). The physical examination shall follow the guidelines set forth for quinquennial physicals.

(2) Other members separating from the Coast Guard e.g., discharge or transfer to standby reserve (non-drilling) may request a medical and/or dental examination. The medical examination must include: notation of any current problems, a blood pressure measurement, and address items on the preventive medicine stamp. In addition to the above, the practitioner shall ascertain the health needs of the member and undertake measures deemed necessary to meet those needs. The dental examination, if requested, must at least be a Type III exam. These examinations may be annotated on a SF-600, and upon completion, do not require approval.

(3) For members enrolled in the Occupational Medical Surveillance and Evaluation Program (OMSEP), see chapter 12 of this Manual for guidance.

(4) See chapter 12 of the Personnel Manual, COMDTINST M1000.6(series), for amplification on administrative discharge procedures.

d. Overseas Transfer/Sea Duty Deployment. A modified screening examination is required for all personnel departing for a overseas assignment for 60 consecutive days or greater, to permanent assignment aboard a Polar Icebreaker, or to a vessel deploying from it's home port for 60 consecutive days or greater. Correction of defects noted on this screening must be corrected IAW Chapter 3-B-4.a of this Manual. Members who are transferring from one overseas duty station to another overseas duty station do NOT require another overseas physical examination. If they are being transferred to a foreign country, an HIV antibody test and dental examination must be completed within 6 months prior to departure. This examination shall be recorded on an SF-600 (per FIGURE 3-A-1) and, together with a copy of the last complete and approved Report of Physical Examination (SF 88) and Report of Medical History (SF 93), shall be submitted to the Reviewing Authority. This examination shall include the following:

(1) detecting, by Type II dental exam, any dental defects and to allow sufficient time to complete all essential dental treatment to provide personnel a Class I or II status prior to the execution of orders.

(2) screening for communicable diseases and ensuring that the PPD is current and the HIV antibody test has been performed and documented within six months prior to departure to foreign country;

(3) reviewing the health record to ensure that required physical examinations and all immunizations are up-to-date, and that the interval medical history since last approved complete physical examination is not disqualifying;

(4) ensuring that the examinee is corrected to 20/20 (or best correction) and possesses 2 pairs of glasses;

(5) ensure a qualitative G-6-PD screening has been done on persons being assigned to "Alert Force" status. Record result on Problem Summary List (NAVMED 6150/20). (This test need only be performed once per career); and

(6) if a member is enrolled (or will be enrolled based on new assignment) in Occupational Medical Surveillance and Evaluation Program (OMSEP), ensure appropriate periodic/basic examination is performed.

e. Applicant.

(1) Commissioning Programs. A physical examination is required for applicants for entry into the Coast Guard as follows:

(a) Coast Guard Academy: DODMERB physical examination within 24 months;

(b) Officer Candidate School: MEPS physical within 24 months of entry date, except:

1 Coast Guard personnel on active duty may obtain the physical examination at a USMTF within 24 months of entry date, and

2 Members of other Armed Services may submit a physical examination from a USMTF provided the examination has been performed within the past twelve (12) months and is as complete as a MEPS physical examination.

(c) Direct commission: MEPS physical within 24 months of entry date or oath of office for Ready Reserve Direct Commission, except aviation programs, where examination by a uniformed service flight surgeon or AMO is required within 12 months of entry date.

(2) Aviation. An aviation physical examination is required for applicants for training in all categories of aviation specialties. This physical examination is valid for 24 months for Class II applicants and 12 months for pilot applicants.

(3) Diving. A physical examination is required for all applicants for duty involving diving, and is valid for twelve months.

f. Pre-Training Screening Examinations. A screening examination is required within 1 week of reporting to the Coast Guard Academy, Officer Candidate School, Direct Commission Officer orientation, or the Recruit Training Center. This screening examination shall be sufficiently thorough to ensure that the person is free from communicable and infectious diseases, and is physically qualified. The results of this examination shall be recorded on an SF-600 and filed in the health record.

g. Retired Members Recalled to Active Duty. A physical examination is required for retired personnel who are recalled to active duty. This physical examination is valid for twelve months. A physical examination performed for retirement may be used

for recall providing the date of recall is within six months of the date of the physical examination.

h. Annual. An annual physical examination is required on all active duty personnel who are 50 years of age or older and all air traffic controllers.

i. Biennial.

(1) Biennial physical examination is required every 2 years after initial designation, until age 48, for the following :

(a) all aviation personnel (except air traffic controllers); and

(b) all Landing Signal Officers (LSO).

(2) The biennial exam will be performed within 90 days before the end of the birth month. The period of validity of the biennial physical will be aligned with the last day of the service member's birth month. (Example: someone born on 3 October would have August, September, and October in which to accomplish his/her physical. No matter when accomplished in that time frame, the period of validity of that exam is until 31 October two years later.)

(3) This process of aligning the biennial exam with the birth month is a new process effective immediately. In order to phase in this process the valid period of future biennial exams may be extended up to a total of thirty months (6 months from the current valid date) to align the valid date with the birth month. (See Table 3-A-1).

(a) Example 1: A member with an October birth month accomplishes biennial exam in May 2000 (previously valid until May 2002). Biennial exam is now valid until October 2002 (29 months total) to allow the member to align biennial exam with birth month.

(b) Example 2: A member with a June birth month accomplishes a biennial exam in October of 1999 (previously valid until October 2001). Biennial exam is now valid until June 2001 (20 months total) to allow the member to align biennial exam with birth month.

(4) The requirement to perform a biennial exam will not be suspended in the event of training exercises or deployment. Aircrew with scheduled deployment during their 90 day window to accomplish their biennial exam may accomplish their biennial exam an additional 90 days prior and continue with the same valid end date. This may result in a member having a valid biennial for 30 months. Members unable to accomplish a biennial exam prior to being deployed will be granted an additional 60 days upon return in which to accomplish their physical. Align subsequent biennial exam with the aircrew member's birth month using Table 3-A-1.

(5) Additionally, a comprehensive physical may be required during a post-mishap investigation, FEB, or as part of a work-up for a medical disqualification.

(6) Personnel designated as aircrew are expected to maintain a biennial exam schedule regardless of current aviation duty status.

Table-3-A-1

**Number of months for which a biennial exam is valid**

| | Month in which last biennial exam was given | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Birth Month | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC |
| JAN | 24 | 23 | 22 | 21 | 20 | 19 | 30 | 29 | 28 | 27 | 26 | 25 |
| FEB | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 30 | 29 | 28 | 27 | 26 |
| MAR | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 30 | 29 | 28 | 27 |
| APR | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 30 | 29 | 28 |
| MAY | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 30 | 29 |
| JUN | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 30 |
| JUL | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 |
| AUG | 19 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 |
| SEP | 20 | 19 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 |
| OCT | 21 | 20 | 19 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 |
| NOV | 22 | 21 | 20 | 19 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 |
| DEC | 23 | 22 | 21 | 20 | 19 | 30 | 29 | 28 | 27 | 26 | 25 | 24 |

Notes:

Read down the left column to the examinee's birth month; read across to month of last biennial exam; intersection number is the maximum validity period. When last biennial exam was within the 3 month period preceding the end of the birth month, the validity period will normally not exceed 27 months. When the last biennial exam was for entry into aviation training, for FEB, post-accident, post-hospitalization, etc., the validity period will range from 19 to 30 months. Validity periods may be extended by 1 month only for completion of an examination begun before the end of the birth month.

j. Quinquennial/Quinquennial Diving. A physical examination is required every five (5) years after entry on all active duty personnel, age 25 through age 50, and for all personnel maintaining a current diving qualification (also note "Diving" in item #5 of SF-88). Quinquennial physical examinations are also required for:

(1) all Selected Reservists within 30 days of their birth date starting at age 25 continuing until retirement, and

(2) reserve officers assigned to the Individual Ready Reserve (IRR) who are on a promotion list.

(3) Officers in 3-A-7.e.(1)(a) and (b) above must have a current approved physical examination documented by PMIS data base entry prior to being promoted (i.e., a quinquennial physical examination within the last 5 years).

k. Occupational Medical Surveillance and Evaluation Program (OMSEP). Those individuals who are occupationally exposed to hazardous substances, physical energies, or employed in designated occupations must undergo physical examinations as required by Chapter 12 of this Manual.

l. Miscellaneous Physical Examinations.

(1) Retention. This examination is done at the direction of the commanding officer when there is substantial doubt as to a member's physical or mental fitness for duty.

(2) Pre-confinement Physical Screening. In general, personnel who are presented for this screening, who do not require acute medical treatment or hospitalization, are fit for confinement. Cases where a member requires more than routine follow-up medical care, or has certain psychiatric conditions, that may make them unfit for confinement, should be discussed with the chief medical officer (or his/her representative) at the confining facility. Personnel requiring detoxification for alcohol or drug dependency are not fit for confinement; however, members that have been detoxified or that may require rehabilitation alone are fit for confinement. This screening shall be recorded on an SF-600 (per FIGURE 3-A-1) and, together with a copy of the last complete and approved Report of Physical Examination (SF 88) and Report of Medical History (SF 93), shall be submitted to the Reviewing Authority.

(3) Post Confinement Physical Examination. Ensure a separation physical examination has been completed prior to the member departing the confining facility. The separation physical shall meet the standards of section 3-F and must be approved by the appropriate MLC(k).

(4) Reservists. A district commander may require any reservist attached to a command within that area to undergo a complete physical examination if reasonable doubt exists as to the reservist's physical or mental fitness for duty.

(5) Non-Fitness for Duty Determination Physical Examinations. The Chief of Health Services retains the authority and responsibility to determine capability and capacity to conduct non-fitness for duty physical examinations for all eligible beneficiaries.

m. Annual Command Afloat Medical Screening. Officers and enlisted personnel scheduled to assume command afloat shall undergo a medical screening prior to assignment. The initial screening may be conducted by a medical officer where applicable, or an HS not in the prospective chain of command of the member being screened. Thereafter, all commanding officers and officers-in-charge of afloat units will have an annual command afloat medical screening. This screening will also be performed by a medical officer where available, otherwise, the screening may be performed by a Health Services Technician who IS NOT in the chain of command of

the person being screened. The screening process will include a medical history completed by the member, a visual acuity check, blood pressure measurement, and a thorough review of interval history in the member's health record. Results are to be recorded using the format in Figure 3-A-2. The medical screening form (Figure 3-A-2) and a copy of the last approved SF-88 and SF-93 shall then be forwarded to the appropriate MLC (kma) for review. The MLC (kma) will approve or disapprove the screening using section 3-F (retention standards) as the guiding directive. If a question arises as to the fitness of the individual, the MLC (kma) may request additional information from the examining unit. If the MLC (kma) is unable to render a decision as to the fitness for command, the entire command afloat screening package will be forwarded to Commandant (G-WKH) for final action. The reviewed form shall be returned to the member's command for filing in the member's health record.

n. Dental Examinations. Annual Type II dental examinations are required for all active duty personnel assigned to commands collocated with dental examiners (i.e., Coast Guard DOs, DOD DOs, or civilian contract dentists).

8. Waiver of Physical Standards.

a. Definition of Waiver. A waiver is an authorization to change a physical standard when an individual does not meet the physical standards prescribed for the purpose of the examination.

(1) Normally, a waiver will be granted when it is reasonably expected that the individual will remain fit for duty and the waiver is in the best interests of the Coast Guard. A service member will not be granted a waiver for a physical disability determined to be not fit for duty by a physical evaluation board approved by the Commandant. In these cases, the provisions for retention on active duty contained in the Physical Disability Evaluation System, COMDTINST M1850.2 (series), and the Personnel Manual, COMDTINST M1000.6 (series) apply.

(2) If a member is under consideration by the physical disability evaluation system, no medical waiver request shall be submitted for physical defects or conditions described in the medical board. All waiver requests received for conditions described in the medical board will be returned to the member's unit without action.

(3) A waiver of a physical standard is not required in a case where a Service member's ability to perform on duty has been reviewed through the physical disability evaluation system and the approved finding of the Commandant is fit for duty.

b. Authority for Waivers. Commander CGPC-epm (enlisted), CGPC-opm (officers), and CGPC-rpm (reserve) have the sole authority to grant waivers. The decision to authorize a waiver is based on many factors, including the recommendations of the Chief, Office of Health and Safety; the best interest of the Service; and the

individual's training, experience, and duty performance. Waivers are not normally authorized but shall be reviewed by Commander (CGPC) for the following:

(1) original enlistment in the regular Coast Guard of personnel without prior military service;

(2) appointment as a Cadet at the Coast Guard Academy; and

(3) training in any aviation or diving category specialty.

c. Types of Waivers.

(1) Temporary. A temporary waiver may be authorized when a physical defect or condition is not stabilized and may either progressively increase or decrease in severity. These waivers are authorized for a specific period of time and require medical reevaluation prior to being extended.

(2) Permanent. A permanent waiver may be authorized when a defect or condition is not normally subject to change or progressive deterioration, and it has been clearly demonstrated that the condition does not impair the individual's ability to perform general duty, or the requirements of a particular specialty, grade, or rate.

d. Procedures for Recommending Waivers.

(1) Medical Officer. A medical officer who considers a defect disqualifying by the standards, but not a disability for the purpose for which the physical examination is required, shall:

(a) enter a detailed description of the defect in Item 73 of the SF-88; and

(b) indicate that either a temporary or permanent waiver is recommended.

(2) Command/Unit Level. When the command receives a Report of Medical Examination (SF-88) indicating that an individual is not physically qualified, the command shall inform the individual that he/she is not physically qualified. The individual shall inform the command via letter of his/her intentions to pursue a waiver. The medical officer is required to give a recommendation on whether the waiver is appropriate and if the individual may perform his/her duties with this physical defect. This recommendation shall be completed on an (SF-502) Narrative Summary. A cover letter stating the command's opinion as to the appropriateness of a waiver, the individual's previous performance of duty, special skills, and any other pertinent information, shall accompany the medical officers report. The waiver request package shall be forwarded directly from the member's unit to Commander CGPC-epm or opm, or Commandant (CGPC-rpm) as appropriate.

e. Command Action on Receipt of a Waiver Authorization. A command receiving authorization from the Commander CGPC-epm/opm/rpm for the waiver of a physical standard shall carefully review the information provided to determine any duty limitation imposed and specific instructions for future medical evaluations.

Unless otherwise indicated in the authorization, a waiver applies only to the specific category or purpose for which the physical examination is required. A copy of the waiver authorization shall be retained in both the service and health records for the period for which the waiver is authorized. Copies of future SF-88's for the same purpose shall be endorsed to indicate a waiver is or was in effect.

9. Substitution of Physical Examinations.

a. Rule for Substitution of Physical Examinations. In certain circumstances, a physical examination performed for one purpose or category may be substituted to meet another requirement provided the following criteria are met:

(1) the examinee was physically qualified for the purpose of the previous examination and all the required tests and recommendations have been completed;

(2) the SF-88 used for substitution bears an endorsement from the Reviewing Authority or Commandant (G-WKH), as appropriate, indicating that the examinee was qualified for the purpose of the previous examination;

(3) there has been no significant change in the examinee's medical status since the previous examination;

(4) a review of the report of the previous examination indicates that the examinee meets the physical standards of the present requirement;

(5) the date of the previous examination is within the validity period of the present requirement; and

(6) all additional tests and procedures to meet the requirements of the current physical examination have been completed.

b. No substitutions are authorized for the following physical examinations:

(1) enlistment;

(2) pre-training; and

(3) applicants for or designated personnel in special programs (aviation, diving, Academy).

c. Procedures for Reporting Substitution. Substitutions of a physical examination shall be reported by submitting a copy of the SF-88 being used to meet the present requirements with the endorsement illustrated in FIGURE 3-A-1 entered on SF-600, Chronological Record of Medical Care. Retain a copy of the substitution endorsement in the health record.

FIGURE 3-A-1 (revised 05-01)

**SUBSTITUTION/OVERSEAS/SEA DUTY MODIFIED SCREENING EXAMINATION**

DATE:_____NAME_____SS#_____

UNIT: _____

PURPOSE: _____

(purpose or category for present physical examination requirements)

DATE OF PREVIOUS COMPLETED PHYSICAL:_____

STATUS OF RECOMMENDATIONS:_____

_____

_____

SUMMARY OF INTERVAL MEDICAL HISTORY:_ _____

_____

_____

SCREEN FOR COMPLETION OF THE FOLLOWING ITEMS/CHECK-OFF ITEM WHEN ITEM IS COMPLETED:

_____ Date of PPD:_____Result:_____
(within the last 48 months)

_____ Immunizations/chemoprophylaxis up-to-date & meet requirements for destination

_____ Examinee has 2 pairs of glasses (if required to correct refractive error)

_____ G-6-PD Screening (qualitative)

Date:_____Result:_____
(Required for those individuals with no record of testing prior to assignment afloat or to malaria-endemic areas. Record results on the Problem Summary Sheet)

ADDITIONAL OVERSEAS REQUIREMENTS (CHECK-OFF ITEM WHEN ITEM IS COMPLETED):

_____ Type II dental exam performed within 6 months of departure and member is Dental Class 1 or Class 2 with exception described in 4-C-3.c.(3)(b)8.

_____ Date of HIV Antibody Test:_____
(within 6 months prior to departure to foreign countries)

_____ Date DNA sample submitted to repository.

SIGNATURES:

_____
(Signature and title of dental officer)

_____
(Signature and title of medical officer or commanding officer)

_____
(Signature and title of reviewing/approving authority)

FIGURE 3-A-2 (revised 2/99)

## ANNUAL COMMAND AFLOAT MEDICAL SCREENING

Name:_____ Rank/Grade:_____

SSAN:_____Date of Birth:_____ Work Telephone:_____

Unit OPFAC:_____ Unit Name:_____ Date of Screening:_____

**To be completed by the member:** (use reverse side as needed)

List any significant medical history since your last physical examination or medical screening (describe any illnesses, injuries, etc.):_____

_____

_____

_____

_____

Have you experienced any significant changes in stress level, mood, or family life? YES NO

If yes, describe:_____

_____

_____

_____

Do you have any alcohol-related problems (including DWI)? YES NO

If yes, describe: _____

_____

_____

Are you presently taking any medication (including over-the-counter)? YES NO

If yes, list: _____

_____

_____

The information I have provided above is complete and accurate.

_____Date:_____

(Signature of member)

***The following section is to be completed by health services personnel:***

Review of Health Record performed. Significant findings are:_____

_____

_____

Best Distant Visual Acuity (with correction, if required): R:_____ L:_____

Sitting blood pressure:_____ _____

**NOTE: ATTACH A COPY OF LAST APPROVED SF-88 AND SF-93**

_____ UNIT: _____Date: _____

(Signature/Title of medical reviewer)

_____Date: _____

(Signature/MLC reviewer

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Section B - Reporting, Reviewing, Recommendations, and Actions to be Taken on Reports of Medical Examination (SF-88) and Medical History (SF-93).

1. SF-88 (Report of Medical Examination).

   a. SF-88 is the proper form for reporting a complete physical examination. SF-88 revised (10-94) is the newest version of the physical examination report and can be obtained through Coast Guard Directives Electronic Library on CGSYS III.

   b. Detailed instructions for the preparation and distribution of this form are contained in section 4-B of this Manual.

2. SF-93 (Report of Medical History).

   a. SF-93 is the proper form for reporting a member's medical history. SF-93 (6- 96) is now available through Coast Guard Directives Electronic Library on CGSYS III.

   b. Detailed instructions on the preparation and distribution of this form are contained in section 4-B of this Manual.

3. Review and Action on Findings and Recommendations of Report of Medical Examination (SF-88).

   a. Action by the Medical Examiner.

      (1) Review of Findings and Evaluation of Defects. When the results of all tests have been received and evaluated, and all findings recorded, the examiner shall consult the appropriate standards of this chapter to determine if any of the defects noted are disqualifying for the purpose of the physical examination. When physical defects are found that are not listed in the standards as disqualifying, but that, in the examiner's opinion, would preclude the individual from performing military service or the duties of the program for which the physical examination was required, the examiner shall state that opinion on the report indicating reasons. If in the examiner's opinion, a defect listed as disqualifying is not disabling for military service, or a particular program, the examiner shall indicate the basis for this opinion and recommend a waiver in accordance with the provisions of section A of this chapter.

      (2) Remediable Defects. When the physical examination of active duty personnel indicates defects that are remediable or that may become potentially disabling unless a specific medical program is followed, the examiner shall clearly state any recommendations. If the examining facility has the capability of correcting the defect or providing extended outpatient follow-up or medical care, tentative arrangements for care shall be scheduled, subject to the approval of the examinee's command. If the examining facility does not have the capabilities of providing the necessary care, tentative arrangements for admission or appointment at another facility shall be scheduled, again subject to the approval of the individual's command.

(3) Advising the Examinee. After completing the physical examination, the medical examiner will advise the examinee concerning the findings of the physical examination. At the same time, the examinee shall be informed that the examiner is not an approving authority for the purpose of the examination and that the findings must be approved by proper authorities.

(4) Disposition of Reports. The original SF-88 and the original SF-93, together with any reports of consultations or special testing reports not entered on the SF-88 or SF-93, shall be forwarded to the activity that referred the individual for the physical examination.

b. Review and Action on Reports of Physical Examination by Command.

(1) Command Responsibility.

(a) The command has a major responsibility in ensuring the proper performance of physical examinations on personnel assigned and that physical examinations are scheduled sufficiently far in advance to permit the review of the findings and correction of medical defects prior to the effective date of the action for which the examination is required. The command is also responsible to ensure that the individual complies with the examiner's recommendations and to initiate any administrative action required on a Report of Medical Examination.

(b) All SF-88's shall be reviewed by commanding officers, or their designee, to determine that the prescribed forms were used and that all necessary entries were made.

(c) When the medical examiner recommends further tests or evaluation, or a program of medical treatment (such as hearing conservation, periodic blood pressure readings, etc.), the command will ensure that these tests or examinations are completed or that the individual is directed to and does comply with the recommended program. When a necessary test, evaluation, or program can be completed within a 60 day period, the unit may hold the SF-88 to permit the forwarding of results. In all cases the command shall endorse the SF-88 to indicate what action has been taken and forward the report to the reviewing authority if the 60 day period cannot be met or has elapsed.

(d) Disposition of Reports.

1 If a physical examination is accomplished for a purpose for which the command has administrative action, the original SF-88 and SF-93 and a return self-addressed envelope shall be forwarded to the reviewing authority. No action will be taken to accomplish the purpose for which the physical examination was taken until the endorsed original of the report is returned by the reviewing authority

indicating the examinee meets the physical standards for the purpose of the examination.

2 Approved MEPS physicals do not require further review. The original physical (SF-88 and SF-93) will be carried to the training center by the individual.

3 If the physical examination is for a purpose requiring the consent or approval of the MLC commander, or Commandant, the procedures previously described for command review and action will be accomplished, except rather than forwarding the report of the examination directly to the reviewing authority, it will be included with other supporting documents (letters, recommendations, etc.) and forwarded through the chain of command.

4 Units not using a CGMTF shall send physical examinations to the appropriate CG Clinic (as designated by the cognizant MLC), MLC (k), or CGPC (adm) as appropriate.

c. Action by the Reviewing Authority.

(1) The Commandant is the final reviewing authority for all physical examinations, except for applicants to the Coast Guard Academy.

(2) Administratively, MLC (k) acts as the reviewing authority for physical examinations performed on personnel assigned to their Areas except as in (4) and (5) below.

(3) Another exception to this rule pertains to those flight physicals performed on aviation school students during training that are reviewed and approved by the Navy Operational Medicine Institute (NOMI). NOMI, not MLC (k) will be the approving authority for these physicals. CGPC will remain the waiver approval authority for these physicals, when a waiver is required prior to final approval. Upon completion of flight training and assignment to a Coast Guard unit, the NOMI approved physical will be considered valid until the last day of the member's next birth month. The unit flight surgeon will clear the aviator for all flight related duties based on the NOMI approved flight physical.

(4) Commander Coast Guard Personnel Command (CGPC-adm) is the reviewing authority for aviator candidate, flight officer candidate, aircrew candidate, and diving candidate physical examinations. Commandant (G-WKS) is also the reviewing authority for OMSEP physical examinations. Commander (CGPC-adm) shall review disapproved MEPS physicals to ensure proper application of physical standards.

(5) The Department of Defense Medical Examination Review Board (DoDMERB) is the reviewing authority for physical examinations performed on Academy applicants. MEPS is the reviewing authority for physical examinations performed in their facilities.

(6) Each SF-88 shall be carefully reviewed to determine whether the findings reported indicate the examinee does or does not meet the appropriate physical standards. If further medical evaluation is required to determine that the examinee does meet the standards, or to resolve doubtful findings, the reviewing authority shall direct the commanding officer or recruiting station to obtain the evaluation and shall provide such assistance as may be required.

(7) The reviewing authority shall endorse the original of the SF-88 indicating whether the examinee does or does not meet the physical standards required. If the examinee does not meet the physical standards, the endorsement shall indicate the particular disqualifying defect or defects. Endorsements can be in the format contained in FIGURE 3-B-1 or use of blocks #44, #46 and signature in block #51 of the SF88 (Rev. 10-94).

(8) The endorsed original of the physical examination shall be forwarded to the individual's unit for filing in the member's health record.

(9) Input of physical examination status of personnel into the PMIS system is required. Reviewing Authorities shall collect and submit data regarding all physical examinations/screenings (per paragraph 3-A-7, except subparagraph 3-A-7.f) they review to the appropriate PERSRU on a monthly basis. Data to be collected for transmittal to the PERSRUs is as follows:

(a) Member's name;

(b) Member's rank/rate;

(c) Member's SSAN;

(d) Member's unit OPFAC;

(e) Date of physical examination;

(f) Purpose of examination;

(g) Date acted upon by Reviewing Authority; and

(h) Status code for physical examination. Status codes are as follows:

1 Code A- member qualified for periodic (biennial, quinquennial, etc.) physical examination.

2 Code D- member qualified for RELAD/discharge/retirement.

3 Code O- member qualified for overseas duty.

4 Code N- member not physically qualified.

d. Disposition of Reports.

(1) When the individual meets the appropriate physical standards, forward the physical examination as indicated in FIGURE 3-B-2.

(2) When the individual does not meet the appropriate physical standards and a waiver has been recommended, endorse the physical examination and forward it in accordance with section 3-A-8.

(3) When the individual is not physically qualified for the purpose of the examination and a waiver is not recommended, the reviewing authority will arrange for the examinee to be evaluated by a medical board and provide administrative action as outlined in Commandant Instruction M1850.2(series).

4. Correction of Defects Prior to Overseas Transfer or Sea Duty Deployment.

a. Medical Defects. Before an individual departs for an overseas assignment for 60 consecutive days or greater days, to permanent assignment aboard a Polar Icebreaker, or to a vessel deploying from its home port for 60 consecutive days or greater, all remediable medical defects, such as hernias, pilonidal cysts or sinuses requiring surgery, etc., must be corrected. Those defects that are not easily corrected will be referred to Commander CGPC for consideration. These procedures also apply to personnel presently assigned to such vessels. In these cases all necessary corrective measures or waivers will be accomplished prior to the sailing date.

b. Dental Defects. All essential dental treatment shall be completed prior to overseas transfer or sea duty deployment except those described in 4-C-3.c.(3)(b). Essential dental treatment constitutes those procedures necessary to prevent disease and disabilities of the jaw, teeth, and related structures. This includes extractions, simple and compound restorations, and treatment for acute oral pathological conditions such as Vincent's stomatitis, acute gingivitis, and similar conditions that could endanger the health of the individual during a tour of duty. Missing teeth are to be replaced when occluding tooth surfaces are so depleted that the individual cannot properly masticate food. Elective dental procedures (those that may be deferred for up to twelve months without jeopardizing the patient's health, i.e., Class II patient) need not be completed prior to overseas transfer providing both of the following conditions exist:

(1) completion of such elective procedures prior to transfer would delay the planned transfer; and

(2) adequate Service dental facilities are available at the overseas base.

c. Vision Defects. A refraction shall be performed on all personnel whose visual acuity is less than 20/20 in either eye (near or distant) or whose present eyewear prescription does not correct their vision to 20/20. All personnel requiring glasses for correction shall have a minimum of two pair prior to overseas transfer or sea duty deployment. All personnel requiring corrective lenses shall wear them for the performance of duty.

5. Objection to Assumption of Fitness for Duty at Separation.

   a. Any member undergoing separation from the service who disagrees with the assumption of fitness for duty and claims to have a physical disability as defined in section 2-A-38 of the Physical Disability Evaluation System, COMDTINST M1850.2(series), shall submit written objections, within 10 days of signing the Chronological Record of Service (CG-4057), to Commander CGPC. Such objections based solely on items of medical history or physical findings will be resolved at the local level. The member is responsible for submitting copies of the following information along with the written objections:

      (1) Report of Medical Examination (SF-88);

      (2) Report of Medical History (SF-93);

      (3) signed copy of the Chronological Record of Service (CG-4057);

      (4) Appropriate consultations and reports; and

      (5) "other pertinent documentation."

      (6) The rebuttal is a member's responsibility and command endorsement is not required.

   b. The file shall contain thorough documentation of the physical examination findings, particularly in those areas relating to the individual's objections. Consultations shall be obtained to thoroughly evaluate all problems or objections the examinee indicates. Consultations obtained at the examinee's own expense from a civilian source shall also be included with the report.

   c. Commander (CGPC) will evaluate each case and, based upon the information submitted, take one of the following actions:

      (1) find separation appropriate, in which case the individual will be so notified and the normal separation process completed;

      (2) find separation inappropriate, in which case the entire record will be returned and appropriate action recommended; or

      (3) request additional documentation before making a determination.

6. Separation Not Appropriate by Reason of Physical Disability. When a member has an impairment (in accordance with section 3-F of this Manual) an Initial Medical Board shall be convened only if the conditions listed in paragraph 2-C-2.(b), Physical Disability Evaluation System, COMDTINST M1850.2(series), are also met. Otherwise the member is suitable for separation.

7. Procedures for Physical Defects Found Prior to Separation.

   a. Policy. No person shall be separated from the Service with any disease in a communicable state until either rendered noninfectious, or until suitable provisions have been made for necessary treatment after separation.

b. Remediable Non-Disqualifying Defects. Remediable physical defects that would not normally prevent the individual from performing the duties of grade or rate shall be corrected only if there is reasonable assurance of complete recovery and sufficient time remaining prior to separation.

FIGURE 3-B-1

DATE REVIEWERS UNIT _____

Does/does not meet the physical standards for (title or category or purpose of examination), as prescribed in (appropriate section of Medical Manual, COMDTINST M6000.1 (series)).

Disqualifying Defects:

Signature and Title of Reviewer

FIGURE 3-B-2

| Physical Exam Purpose | Note: | Original to: | Reviewing Authority: |
|---|---|---|---|
| Aviator Candidate | (1,2) | CGPC-opm | CGPC-adm |
| Aircrew Candidate | (1,2) | CGPC-epm | “ |
| Diving Candidate | (1,2) | CGPC | " |
| Enlistment | (2) | CGRC | " |
| Flight Surgeon (FS) | | MLC (k) | MLC (k) |
| FS Candidate | (1) | G-WKH-1 | G-WKH-1 |
| Aviator | (1) | MLC (k) | MLC (k) |
| Aircrew | (1) | MLC (k) | MLC (k) |
| Diving | (1) | MLC (k) | MLC (k) |
| Flight Officer | (1) | MLC (k) | MLC (k) |
| Annual | (1) | MLC (k) | MLC (k) |
| LSO | (1) | or | or |
| Quinquennial | (1) | Clinic | Clinic |
| Overseas/Sea Duty | (1) | Administrator | Administrator |
| Retention | (1) | " | " |
| Retirement | (1,4) | " | " |
| Involuntary | | | |
| Separation | (1,4) | " | " |
| RELAD | (1,4) | " | " |
| Precom/Appts | (1) | " | " |
| Direct Commission | (1,5) | CGRC | CGPC-adm |
| OCS | (1,5) | CGRC | CGPC-adm |
| Physician Assistant Candidate | (1,5) | CGPC-opm | CGPC-adm |

NOTES:

CGRC address: CG Recruiting Command, 4200 Wilson Blvd., Suite 450, Arlington, VA. 22203-1804

(1) The reviewing authority shall review, endorse and return the original to the member's unit for filing in the member's or applicant's health record.

(2) Forward the unendorsed physical to the appropriate Headquarters Office (as listed above) with the application/training request package. That Office will forward the physical to Coast Guard Personnel Command for review.

(3) Forward the original and one copy to Commandant (G-WKH) for review

(4) Ensure that a completed CG-4057 accompanies the completed SF-88 and SF-93.

(5) Reviewing authority for current USCG or USCGR members only. For all others, Note (2) above applies. Forward a copy of the first/front page of the SF-88 with endorsement to the appropriate Headquarters office with the application package.

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Section C - Medical Examination Techniques And Lab Testing Standards.

1. Scope.
   This section is a medical examination technique guide applicable for all physical examinations.

2. Speech Impediment.
   Administer the "Reading Aloud Test" (RAT) as listed.

   a. Have the examinee stand erect, face you across the room and read aloud, as if confronting a class of students.

   b. If the individual pauses, even momentarily, on any phrase or word, immediately and sharply say, "What's that?", and require the examinee to start over again with the first sentence of the test.

   c. On the second trial, The person who truly stammers usually will halt again at the same word phonetic combination often revealing serious stammering. Examinees who fail to read the test without stammering after three attempts will be disqualified.

   d. READING ALOUD TEST "You wished to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat usually minus several buttons; yet he still thinks as swiftly as ever. A long, flowing beard clings to his chin, giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in the winter when the ooze or snow or ice is present, he slowly takes a short walk in the open air each day. We have often urged him to walk more and smoke less, but he always answers, 'Banana Oil.' Grandfather likes to be modern in his language."

3. Head, Face, Neck, and Scalp (Item 17 of SF-88).

   a. Head and Face. Carefully inspect and palpate the head and face for evidence of injury, deformity, or tumor growth. Record all swollen glands, deformities, or imperfections noted. Inquire into the cause of all scars and deformities. If a defect is detected such as moderate or severe acne, cysts, or scarring, make a statement as to whether this defect will interfere with wearing military clothing and equipment.

   b. Neck. Carefully inspect and palpate for glandular enlargement, deformity, crepitus, limitations of motion, and asymmetry; palpate the parotid and submaxillary regions, the larynx for mobility and position, the thyroid for size and nodules, and the supraclavicular areas for fullness and masses. If enlarged lymph nodes are detected describe them in detail with a clinical opinion of their etiology.

   c. Scalp. Examine for deformities such as depressions and exostosis.

4. Nose, Sinuses, Mouth, and Throat (Item 17 of SF-88).

   a. If there are no nasal or sinus complaints, simple anterior rhinoscopy will suffice, provided that in this examination, the nasal mucous membrane, the septum, and the turbinates appear normal. If the examinee has complaints, a more detailed examination is required. Most commonly, these complaints are external nasal deformity, nasal obstruction, partial or complete on one or both sides; nasal discharge; postnasal discharge; sneezing; nasal bleeding; facial pain; and headaches.

   b. Abnormalities in the mucous membrane in the region of the sinus ostia, the presence of pus in specific areas, and the cytologic study of the secretions may provide valuable information regarding the type and location of the sinus infection. Evaluate tenderness over the sinuses by transillumination or x-ray. Examination for sinus tenderness should include pressure applied over the anterior walls of the frontal sinuses and the floors of these cavities and also pressure over the cheeks. Determine if there is any tenderness to percussion beyond the boundaries (as determined by x-ray) of the frontal sinuses. Note any sensory changes in the distribution of the supra-orbital or infra-orbital nerves that may indicate the presence of neoplasm. Note any external swelling of the forehead, orbit, cheek, and alveolar ridge.

   c. Many systemic diseases manifest themselves as lesions of the mouth and tongue; namely leukemia, syphilis, agranulocytosis, pemphigus, erythema multiform, and dermatitis medicamentosa. Note any abnormalities or lesions on lips or buccal mucous membrane, gums, tongue, palate, floor of mouth, and ostia of the salivary ducts. Note the condition of the teeth. Pay particular attention to any abnormal position, size, or the presence of tremors or paralysis of the tongue and the movement of the soft palate on phonation.

   d. Record any abnormal findings of the throat. If tonsils are enucleated, note possible presence and position of residual or recurrent lymphoid tissue and the degree of scarring. If tonsils are present, note size, presence of pus in crypts, and any associated cervical lymphadenopathy. Note presence of exudate, ulceration, or evidence of neoplasm on the posterior pharyngeal crypts. Describe any hypertrophied lymphoid tissue on the posterior pharyngeal wall or in the lateral angle of the pharynx and note if there is evidence of swelling that displaces the tonsils, indicating possible neoplasm or abscess. Perform direct or indirect laryngoscopy if the individual complains of hoarseness.

5. Ears (General) and Drums (Item 17 of SF-88). Inspect the auricle, the external canal, and the tympanic membrane using a speculum and good light. Abnormalities (congenital or acquired) in size, shape, or form of the auricles, canals, or tympanic membranes must be noted, evaluated, and recorded.

   a. Auricle. Note deformities, lacerations, ulcerations, and skin disease.

   b. External canal. Note any abnormality of the size or shape of the canal and inspect the skin to detect evidence of disease. If there is material in the canal, note whether it is normal cerumen, foreign body, or exudate. Determine the source of any exudate

in the canal. If this exudate has its origins in the middle ear, record whether it is serous, purulent, sanguinous, or mucoid; whether it is foul smelling; and, whether it is profuse or scanty.

c. Tympanic membrane. Remove all exudate and debris from the canal and tympanic membrane before examination. Unless the canal is of abnormal shape, visualize the entire tympanic membrane and note and record the following points.

(1) List any abnormality of the landmarks indicating scarring, retraction, bulging, or inflammation.

(2) Note whether the tympanum is air containing.

(3) List any perforations, giving size and position, indicating whether they are marginal or central, which quadrant is involved, and whether it is the flaccid or the tense portion of the membrane that is included.

(4) Attempt, if the tympanic membrane is perforated, to determine the state of the middle ear contents, particularly concerning hyperplastic tympanic mucosa, granulation tissue, cholesteatoma, and bone necrosis. Do the pathological changes indicate an acute or chronic process? This clinical objective examination should permit evaluating the infectious process in the middle ear and making a reasonably accurate statement regarding the chronicity of the infection; the extent and type of involvement of the mastoid; the prognosis regarding hearing; and, the type of treatment (medical or surgical) that is required.

(5) Note, for all aviation and dive physical examinations, whether the examinee can properly auto insufflate tympanic membrane.

6. Eyes (General), Ophthalmoscopic, and Pupils (Item 17 of SF-88).
External and ophthalmoscopic examinations of the eyes are required on all examinations. Contact lenses shall not be worn during any part of the eye examination, including visual acuity testing. It is essential that such lenses not be worn for 72 hours preceding examination. The strength of the contact that an examinee may possess shall not be accepted as the refraction nor will it be entered as such in Item 60, SF-88. The general examination shall include the following specific points and checks:

a. General.

(1) Bony abnormality or facial asymmetry.

(2) Position of the eyes.

(3) Exophthalmus.

(4) Manifest deviation of the visual axis.

(5) Epiphora or discharge.

(6) Position of puncta or discharge when pressure exerted over lacrimal sac.

b. Lids.

(1) Ptosis.

(2) Position of lashes, eversion or inversion.

(3) Inflammation of margins.

(4) Cysts or tumors.

c. Conjunctiva. Examine the palpebral and bulbar conjunctiva by:

(1) eversion of upper lid;

(2) depression and eversion of lower lid; and

(3) manually separating both lids.

d. Pupils.

(1) Size.

(2) Shape.

(3) Equality.

(4) Direct, consensual, and accommodative reactions.

e. Directly and obliquely examine the:

(1) Cornea. For clarity, discrete opacities, superficial or deep scarring, pannus, vascularization, pterygium, and the integrity of the epithelium.

(2) Anterior Chamber. For depth, alteration of normal character of the aqueous humor, and retained foreign bodies.

(3) Iris. For abnormalities and pathologic changes.

(4) Crystalline Lens. For clouding or opacities.

f. Ophthalmoscopic.

(1) Media. Examine with a plano ophthalmoscopic lens at a distance of approximately 18 to 21 inches from the eye. Localize and describe any opacity appearing in the red reflex or direct examination or on eye movement.

(2) Fundus. Examine with the strongest plus or weakest minus lens necessary to bring optic nerve into sharp focus. Pay particular attention to the color, surface, and margin of the optic nerve, also record any abnormality of the pigmentation or vasculature of the retina.

(3) Macula. Examine for any change.

7. Ocular Motility (Item 17 of SF-88).

a. Ascertain the motility of the eyeballs by testing for binocular eye movement (ductions and versions) in the cardinal positions of gaze. If any abnormalities are suspected, verify with the cover/uncover test.

b. Observe if the eyes move together and whether there is loss of motion in any direction (paralysis or paresis), or absence of muscle balance, whether latent (heterophoria) or manifest (strabismus). Have the examinee look at a test object and alternately cover and uncover one eye leaving the other uncovered and observe the movement, if any, in each eye. In heterophoria movement occurs only in the eye that is covered and uncovered; on being covered, it deviates and on being uncovered, it swings back into place to take up fixation with the other eye that has remained uncovered.

8. Lungs and Chest (Item 17 of SF-88).

a. A thorough examination includes a complete history (SF-93) careful physical examination, and necessary x-ray and laboratory studies. In screening examinations, the history and x-ray studies are the most immediately revealing examination techniques.

b. Remember that several disqualifying diseases such as tuberculosis and sarcoidosis may not be detectable by physical examination and the absence of abnormal physical signs does not rule out disqualifying pulmonary disease. Such diseases, as well as others (neopasms and fungus infections), may be detected only by chest x-ray.

(1) Conduct the physical examination in a thorough, systematic fashion. Take particular care to detect pectus abnormalities, kyphosis, scoliosis, wheezing, persistent rhonchi, basilar rales, digital clubbing, and cyanosis. Any of these findings require additional intensive inquiry into the patient's history if subtle functional abnormalities or mild asthma, bronchitis, or bronchiectasis are to be suspected and evaluated. The physical examination shall include the following.

(a) Inspection. The examinee should be seated in a comfortable, relaxed position with the direct light falling upon the chest. Careful comparison of the findings elicited over symmetrical areas on the two sides of the chest gives the most accurate information regarding condition of the underlying structures. Observe for asymmetry of the thoracic cage, abnormal pulsation, atrophy of the shoulder girdle or pectoral muscles, limited or lagging expansion on forced inspiration. The large, rounded relatively immobile "barrel" chest suggests pulmonary emphysema.

(b) Palpation.

1 Observe for tumors of the breast or thoracic wall, enlarged cervical, supraclavicular, or axillary lymph nodes, suprasternal notch, and thrills associated with respiration or the cardiac cycle.

2 In addition to the breast examinations with periodic physical examinations, an annual clinical breast examination is required for all active duty females aged 40 and above. Monthly self-examination is recommended for all adult female patients.

(c) Auscultation. Instruct the examinee to breathe freely but deeply through the mouth. Listen to an entire respiratory cycle before moving the stethoscope bell to another area. Note wheezing, rales, or friction rubs. Compare the pitch and intensity of breath sounds heard over symmetrical areas of the two lungs. Instruct the examinee to exhale during this process. Note any rales, paying particular attention to moist rales that "break" with the cough or fine rales heard at the beginning of inspiration immediately after cough.

(2) Do not hesitate to expand the history if abnormalities are detected during examination or in repeating the examination if chest film abnormalities are detected.

c. There are three conditions that are most often inadequately evaluated and result in unnecessary and avoidable expense and time loss. These three are asthma (to include "asthmatic bronchitis"), bronchiectasis, and tuberculosis.

(1) Asthma. In evaluating asthma, a careful history is of prime importance since this condition is characteristically intermittent and may be absent at the time of examination. Careful attention to a history of episodic wheezing with or without accompanying respiratory infection is essential. If documentation of asthma after age 12 is obtained from the evaluee's physician, this shall result in rejection even though physical examination is normal. Ask about the use of prescription or over-the-counter bronchodilators.

(2) Bronchiectasis. Individuals who report a history of frequent respiratory infections accompanied by purulent sputum or multiple episodes of pneumonia should be suspected of bronchiectasis. This diagnosis can be further supported by a finding of post-tussive rales at one or both bases posteriorly or by a finding of lacy densities at the lung base on the chest film. If bronchiectasis is considered on the basis of history, medical findings or chest film abnormalities, seek confirmatory opinion from the examinee's personal physician or refer the examinee to the appropriate chest consultant for evaluation and recommendations.

(3) Tuberculosis (TB).

(a) Active TB is often asymptomatic and not accompanied by abnormal physical findings unless the disease is advanced. If only such manifestations as hemoptysis or draining sinuses are looked for, most cases of TB will be missed.

(b) The most sensitive tool for detecting early TB is the PPD.

(c) If positive, evaluate the chest film for any infiltrate, cavity, or nodular lesion involving the apical or posterior segments of an upper lobe or superior segment of a lower lobe. Many tuberculosis lesions may be partially hidden or obscured by the clavicles. When any suspicion of an apical abnormality exists, an apical lordotic view must be obtained for clarification.

(d) It is neither practical nor possible, in most instances, to determine whether or not a TB lesion is inactive on the basis of a single radiologic examination. Therefore, refer any examinee suspected of TB to a chest consultant or to an appropriate public health clinic for evaluation.

(e) An initial PPD is mandatory and shall be made a part of the physical examination for all personnel entering on active duty for a period of 30 days or more.

(f) See Chapter 7 for complete details of the Tuberculosis Control Program.

9. Heart and Vascular System (Items 17 of SF-88).

a. General. In direct light, have the examinee stand at ease, with arms relaxed and hanging by sides. Do not permit the examinee to move from side to side or twist to assist in the examination, as these maneuvers may distort landmarks: and increase muscular resistance of the chest wall. Examine the heart by the following methods: inspection, palpation, auscultation, and when considered necessary, by mensuration.

b. Inspection. Begin from above and go downward, with special reference to the following:

(1) any malformation that might change the normal relations of the heart;

(2) pulsations in the suprasternal notch and in the second interspaces to the right and left of the sternum;

(3) character of the precordial impulse; or

(4) epigastric pulsations.

c. Palpation. First palpate to detect thrills over the carotids, thyroid glands, suprasternal notch, apex of the heart, and at the base. Use palms of hands in palpating and use light pressure, as hard pressure may obliterate a thrill. To locate the maximum cardiac impulse, have the examinee stoop and throw the shoulders slightly forward, thus bringing the heart into the closest possible relation with the chest wall. Palpate both radial arteries at the same time for equality in rate and volume. Run the finger along the artery to note any changes in its walls. Place the palm of one hand over the heart and fingers of the other over the radial artery to see if all ventricular contractions are transmitted. Palpate to determine the degree of tension or compression of the pulse. In an estimate of pulse rate, the excitement of undergoing a physical examination must be considered.

d. Auscultation. In auscultating the heart, bear in mind the four points where the normal heart sounds are heard with maximum intensity:

(1) Aortic area, second interspace to right of sternum. Here the second sound is distinct.

(2) Tricuspid area, junction of the fifth right rib with the sternum. Here the first sound is distinct.

(3) Pulmonic area, second interspace to left of sternum. Here the second sound is most distinct.

(4) Mitral area, fifth interspace to left of sternum. Here the first sound is most clearly heard.

e. Blood Pressure.

(1) Only the sitting blood pressure is required.

(2) Other positions required only if sitting blood pressure exceeds **159/90 (140/90** for aviation personnel**)**.

(3) Take the sitting blood pressure with the examinee comfortably relaxed in a sitting position with legs uncrossed and the arm placed on a rest at the horizontal level of the heart. The condition of the arteries, the tenseness of the pulse, and the degree of accentuation of the aortic second sound must be taken into consideration, as well as the relation between the systolic and diastolic pressure.

(4) Personnel recording blood pressure must be familiar with situations that result in spurious elevation. A medical officer shall repeat the determination in doubtful or abnormal cases and ensure that the proper recording technique was used.

(5) Artificially high blood pressure may be observed as follows.

(a) If the compressive cuff is too loosely applied.

(b) If the compressive cuff is too small for the arm size. Cuff width should be approximately one-half arm circumference. In a very large or very heavily muscled individual, this may require an "oversize" cuff.

(c) If the blood pressure is repetitively taken before complete cuff deflation occurs. Trapping of venous blood in the extremity results in a progressive increase in recorded blood pressure.

(6) At least five minutes of rest should precede the blood pressure recording. Due regard must be given to physiologic effects such as excitement, recent exercise, smoking or caffeine within the preceding thirty minutes, and illness.

(7) No examinee shall be rejected based on the results of a single recording. If **2** out of the 3 positions exceed **159/90**, the disqualifying blood pressures will be rechecked for 3 consecutive days in the morning and afternoon of each day and

carefully recorded. The first determination shall be recorded in Item 26 and the repeat determinations in Item 42 of SF-88.

(8) While emphasizing that a diagnosis of elevated blood pressure not be prematurely made, it seems evident that a single "near normal" level does not negate the significance of many elevated recordings.

f. Blood Pressure Determination.

(1) Use procedures recommended by the American Heart Association.

(2) Take the systolic reading as either the palpatory or auscultatory reading depending on which is higher. In most normal subjects, the auscultatory reading is slightly higher.

(3) Record diastolic pressure as the level at which the cardiac tones disappear by auscultation. In a few normal subjects, particularly in thin individuals and usually because of excessive stethoscope pressure, cardiac tones may be heard to extremely low levels. In these instances, if the technique is correct and there is no underlying valvular defect, a diastolic reading will be taken at the change in tone.

(4) Note variations of blood pressures with the position change if there is a history of syncope or symptoms to suggest postural hypertension.

(5) Obtain blood pressure in the legs when simultaneous palpation of the pulses in upper and lower extremities reveals a discrepancy in pulse volume.

g. Pulse Rate.

(1) Determine the pulse rate immediately after the blood pressure. Only the sitting position is required.

(2) In the presence of a relevant history, arrhythmia, or a pulse of less than **50** or over **100**, all pulses shall be determined and an electrocardiogram obtained.

h. Interpretation of Abnormal Signs and Symptoms. The excitement of the examination may produce violent and rapid heart action often associated with a transient systolic murmur. Such conditions may erroneously be attributed to the effects of exertion; they usually disappear promptly in the recumbent posture. Try to recognize the excitable individuals and take measures to eliminate psychic influences from the test.

i. Hypertrophy-Dilitation. An apex beat located at or beyond the left nipple line, or below the sixth rib, suggests an enlargement sufficient to disqualify for military service. Its cause, either valvular disease or hypertension in the majority of cases, should be sought. A horizontal position of the heart must be distinguished from left ventricular enlargement. EKG, ultrasound studies, fluoroscopy, and chest x-ray may be indicated for diagnosis.

j. Physiological Murmurs. Cardiac murmurs are the most certain physical signs by which valvular disease may be recognized and its location determined. The

discovery of any murmur demands diligent search for other evidence of heart disease. Murmurs may occur, however, in the absence of valvular lesions or other cardiac disease. Such physiological murmurs are not causes for rejection.

(1) Characteristics. The following characteristics of physiological murmurs will help differentiate them from organic murmurs.

(a) They are always systolic in time.

(b) They are usually heard over a small area, the most common place being over the pulmonic valve and mitral valve.

(c) They change with position of the body, disappearing in certain positions. They are loudest usually in the recumbent position and are sometimes heard only in that position.

(d) They are transient in character, frequently disappearing after exercise.

(e) They are usually short, rarely occupying all of the systole, and are soft and of blowing quality.

(f) There is no evidence of heart disease or cardiac enlargement.

(2) Most Common Types. The most common types of physiological murmurs are:

(a) Those heard over the second and third left interspaces during expiration, disappearing during forced inspiration. These are particularly common in individuals with flexible chests, who can produce extreme forced expiration. Under such circumstances, murmurs may be associated with a vibratory thrust.

(b) Cardio-respiratory murmurs caused by movements of the heart against air in a part of the lung overlapping the heart. They usually vary in different phases of respiration and at times disappear completely when the breath is held.

(c) Prolongations of the apical first sound, that are often mistaken for murmurs.

(3) Diagnosis. An EKG, chest x-ray, and echocardiogram are usually indicated to firmly establish the true cause of a murmur and should be done if there is any question of abnormality.

k. Electrocardiograms. Use standard positions for precordial leads when completing electrocardiograms.

10. Abdomen and Viscera (Item 17 of SF-88).

a. Examine the abdomen with the examinee supine, as well as standing to detect hernias.

b. Use appropriate clinical laboratory, radiologic, and endoscopic examinations to confirm a diagnosis.

11. Anus and Rectum (Item 17 of SF-88). All examinations shall include a visual inspection of the anus. Perform a digital rectal examination and test for fecal occult blood on all personnel beginning at age 40 and at any time history or physical exam findings indicate. When anorectal disease is suspected a complete exam should be performed which may include proctosigmoidoscopy as indicated.

12. Endocrine System (Item 17 of SF-88). Evaluate endocrine abnormalities during the general clinical examination. Palpate the thyroid for abnormality and observe the individual for signs of hyperthyroidism or hypothyroidism. Observe general habitus for evidence of endocrine dysfunction.

13. Genitourinary System (Item 17 of SF-88).

    a. General. All physical examinations shall search for evidence of STD or malformation.

    b. Instructions for examination according to sex.

        (1) Females. The examination shall include:

            (a) inspection of the external genitalia;

            (b) either a vaginal or rectal bimanual palpation of the pelvic organs; and

            (c) Papanicolaou (PAP) testing and visualization of the cervix and vaginal canal by speculum in accordance with section 3-C-20.f.

        (2) Males. The glans penis and corona will be exposed. The testes and scrotal contents will be palpated and the inguinal lymph nodes will be examined for abnormalities. Palpate the inguinal canals while having the patient perform a valsalva.

14. Extremities (Items 17 of SF-88). Carefully examine the extremities for deformities, old fractures and dislocations, amputations, partially flexed or ankylosed joints, impaired functions of any degree, varicose veins, and edema. In general the examination shall include:

    a. Elbow. With the examinee holding the upper arms against the body with the forearms extended and fully supinated, observe for the presence of normal carrying angle. Have the examinee flex the elbows to a right angle and keeping the elbows against the body, note ability to fully supinate and pronate the forearms. Test medial and lateral stability by placing varus and valgus strain on the joint with the elbow extended. Test the power of the flexor, extensor, supinator, and pronator muscles by having the examinee contract these muscles against manual resistance. If indicated, x-rays should include antero-posterior and lateral views.

b. Foot.

(1) Examine the feet for conditions such as flatfoot, corns, ingrown nails, bunions, deformed or missing toes, hyperhidrosis, color changes, and clubfoot.

(2) When any degree of flatfoot is found, test the strength of the feet by requiring the examinee to hop on the toes of each foot for a sufficient time and by requiring the examinee to alight on the toes after jumping up several times. To distinguish between disqualifying and nondisqualifying degrees of flatfoot, consider the extent, impairment of function, appearance in uniform, and presence or absence of symptoms. Remember, it is usually not the flatfoot condition itself that causes symptoms but an earlier state in which the arches are collapsing and the various structures are undergoing readjustment of their relationships. Report angles of excursion or limitation; comparative measurements; use of orthotics or other supports; and x-ray results if indicated.

c. Hip.

(1) With the examinee standing, observe the symmetry of the buttocks, the intergluteal clefts, and infragluteal fold. Palpate the iliac crest and greater trochanters for symmetry.

(2) If abnormalities are suspected, have the examinee stand first on one foot and then the other, flexing the nonweight bearing hip and knee and observing for ability to balance as well as for instability of the joint, as indicated by dropping downward of the buttock and pelvis of the flexed (non-weight bearing) hip. Such a positive Trendelenburg sign necessitates x-ray evaluation.

(3) While supine have the examinee flex the hip, abduct and adduct the hip and rotate the leg inward. Observe for hesitancy in performing these motions, incomplete range of motion, or facial evidence of pain on motion. Test muscle strength in each position.

(4) With examinee prone, test for ability to extend each leg with knee extended and test for power in each hip in extension.

(5) If abnormalities are detected requiring x-rays, obtain an antero-posterior and a lateral view of each hip for comparison.

d. Knee.

(1) With trousers (skirt/dress), shoes, and socks removed, observe general muscular development of legs, particularly the thigh musculature.

(2) Have examinee squat, sitting on heels, and observe for hesitancy, weakness, and presence or absence of pain or crepitus.

(3) With examinee sitting, test for ability to fully extend the knee and test power in extension by applying pressure to the lower leg with knee extended. Compare equality of power in each leg. With knee flexed, test for hamstring power by attempting to pull leg into extension; compare equality of strength in each leg. Palpate entire knee for tenderness. With examinee still sitting on the table

edge, sit and grasp the heel between the knees; then test for cruciate ligament stability by first pulling the tibia anteriorly on the femur and by then pushing the tibia posteriorly on the femur ("Drawer Sign").

(4) With the examinee supine, mark on each leg a distance of 1 inch above the patella and 6 inches above the patella, making sure this is done with muscles relaxed. Measure circumferences at these levels and note presence or absence of atrophy. Test the medial and lateral collateral ligaments by placing varus and valgus strain on the extended knee. Manipulate the knee through a complete range of flexion and extension, noting any difference between the sides and any abnormal restriction.

(5) If there is a history of knee injury assess muscular strength, ligamentous stability, and range of motion. Also look for evidence of inflammatory or degenerative processes.

(6) In the presence of any history of "locking," recurrent effusion, or instability, or when atrophy measured is more than 3/8 inch or when limitation of motion or ligamentous instability is detected, obtain x-rays including an antero-posterior, lateral, and intercondylar view.

(7) An orthopedic evaluation is required on all recruit physicals if there is evidence of any abnormality.

e. Shoulder.

(1) With the examinee stripped to the waist, inspect both anteriorly and posteriorly for asymmetry, abnormal configuration, or muscle atrophy.

(2) From the back, with the examinee standing, observe the scapulohumeral rhythm as the arms are elevated from the sides directly overhead, carrying the arms up laterally. Any arrhythmia may indicate shoulder joint abnormality and is cause for particularly careful examination. Palpate the shoulders for tenderness and test range of motion in flexion, extension, abduction, and rotation. Compare each shoulder in this respect.

(3) Test muscle power of abductors, flexors, and extensors of the shoulder, as well as power in internal and external rotation. Have the examinee attempt to lift a heavy weight with arms at the side to establish integrity of the acromioclavicular joint.

f. Wrist and Hand.

(1) Palpate the wrist for tenderness in the anatomical snuff box often present in undiscovered fractures of the carpal navicular. Observe and compare muscle strength and range of motion, flexion, extension, radial, and ulnar deviation.

(2) Inspect the palms and extended fingers for excessive perspiration, abnormal color or appearance, and tremor, indicating possible underlying organic disease.

(3) Have the examinee flex and extend the fingers making sure interphalangeal joints flex to allow the finger tips to touch the flexion creases of the palm.

(4) With the hands pronated, observe the contour of the dorsum of the hands for atrophy of the soft tissues between the metacarpals seen in disease or malfunction of peripheral nerves.

(5) With the fingers spread, test for strength, and interosseous muscle function by forcing the spread fingers against the resistance of the examinee.

(6) If indicated, obtain antero-posterior and lateral x-rays of the wrist, as well as antero-posterior and oblique views of the hand.

15. Spine and Other Musculoskeletal (Item 17 of SF-88). Carefully examine for evidence of intervertebral disc syndrome, myositis, and traumatic lesions of the low back (lumbosacral and sacroiliac strains). If there is any indication of congenital deformity, arthritis, spondylolisthesis, or significant degree of curvature, obtain orthopedic consultation and x-rays.

(1) Back. With the examinee stripped and standing, note the general configuration of the back, the symmetry of the shoulders, iliac crests and hips, and any abnormal curvature. Palpate the spinous processes and the erector spinae muscle masses for tenderness. Determine absence of pelvic tilt by palpating the iliac crests. Have examinee flex and extend spine and bend to each side, noting ease with which this is done and the presence or absence of pain on motion. Test rotary motion by gripping the pelvis on both sides and having the examinee twist to each side as far as possible.

(2) With the examinee sitting on the examining table, test patellar and ankle reflexes and fully extend the knee, note complaints of pain (this corresponds to a 90 degree straight leg raising test in supine position).

(3) With the examinee supine, test dorsiflexor muscle power of the foot and toes, with particular attention to power of the extensor hallucis longus. Weakness may indicate nerve root pressure on Sl. Flex hip fully on abdomen and knee flexed and determine presence or absence of pain on extremes of rotation of each hip with hip flexed to 90 degrees. Frequently, in lumbosacral sprains of chronic nature, pain is experienced on these motions. Place the heel on the knee of the opposite extremity and let the flexed knee fall toward the table. Pain or limitation indicates either hip joint and/or lumbosacral abnormality.

(4) While prone, have the examinee arch the back and test strength in extension by noting the degree to which this is possible.

(5) If pain is experienced on back motions in association with these maneuvers or if there is asymmetry or abnormal configuration, back x-rays, including pelvis, should be obtained. These should include antero-posterior, lateral, and oblique views.

16. Identifying Body Marks, Scars, and Tattoos (Item 17 of SF-88).

a. Examination. Carefully inspect the examinee's body, front and rear, on each side of the median line separately, commencing with the scalp and ending at the foot. Record under the "Notes" section on the face of the SF-88 all body marks, tattoos, and scars useful for identification purposes. Also state if no marks or scars are found.

b. Description of Body Marks, Scars, and Tattoos.

(1) Indicate the size, location, and character of scars, moles, warts, birthmarks, etc.

(2) When recording the location of a tattoo, include narrative description of the design. Tattoo transcriptions of words or initials shall be recorded in capital letters. Describe the size of a tattoo regarding its general dimensions only. A statement relative to color or pigment is not required.

(3) Note amputations and losses of parts of fingers and toes showing the particular digit injured and the extent or level of absence.

c. Abbreviations for Body Marks, Scars, and Tattoos.

(1) The following are authorized abbreviations for the descriptions or conditions indicated:

| | | |
|---|---|---|
| Amp.-amputation | m. -mole | w. -wart |
| f. -flat | p. -pitted | VSULA- |
| fl. fleshy | r. -raised | vaccination scar |
| s. -scar smooth | l. -linear | upper left arm |
| v. -vaccination | o. -operative | h. -hairy |

(2) Combinations of the above abbreviations are permissible: p.s. 1/2d. - pitted scar 1/2 inch diameter; f.p.s. lxl/2 - flat pitted scar l inch long and 1/2 inch wide; r.h.m. 1/4d. - raised hairy mole 1/4 inch diameter.

(3) Do not use abbreviations when describing tattoos since they are likely to be mistaken as signifying tattooed letters.

17. Neurologic (Item 17 of SF-88). Conduct a careful neurological examination being attentive to the following:

a. Gait. The individual shall: walk a straight line at a brisk pace with eyes open, stop, and turn around; (Look for spastic, ataxic, incoordination, or limping gait; absence of normal associated movements; deviation to one side or the other; the presence of abnormal involuntary movement; undue difference in performance with the eyes open and closed.)

(1) stand erect, feet together, arms extended in front; (Look for unsteadiness and swaying, deviation of one or both of the arms from the assumed position, tremors, or other involuntary movements.)

(2) touch the nose with the right and then the left index finger, with the eyes closed. (Look for muscle atrophy or pseudohypertrophy, muscular weakness, limitation of joint movement, and spine stiffness.)

b. Pupils. Look for irregularity, inequality, diminished or absent contraction to light or lack of accommodation.

c. Deep Sense (Romberg). Negative, slightly positive, or pronouncedly positive.

d. Deep Reflexes: Patellar, Biceps, etc. Record as absent (o), diminished (-), normal (+), hyperactive (++), and exaggerated (+++).

e. Sensory Disturbances. Examine sensation by lightly pricking each side of the forehead, bridge of the nose, chin, across the volar surface of each wrist, and dorsum of each foot. Look for inequality of sensation right and left. If these sensations are abnormal, vibration sense should be tested at ankles and wrists with a tuning fork. With eyes closed, the examinee shall move each heel down the other leg from knee to ankle. Test sense of movement of great toes and thumb. Look for diminution or loss of vibration and plantar reflexes. When indicated, perform appropriate laboratory tests and x-ray examinations.

f. Motor Disturbances. Evidence of muscle weakness, paresis, or any other abnormality.

g. Muscular Development. Evidence of atrophy, compensatory hypertrophies, or any other abnormality.

h. Tremors. State whether fine or coarse, intentional or resting, and name parts affected.

i. Tics. Specify parts affected. State whether they are permanent or due to fatigue or nervous tension.

j. Cranial Nerves. Examine carefully for evidence of impaired function or paresis. Remember that some of the cranial nerves are subject to frequent involvement in a number of important diseases, such as syphilis, meningitis, encephalitis lethargica, and injuries to the cranium.

k. Psychomotor Tension. Test the ability to relax voluntarily by having the examinee rest the forearm upon your palm then test the forearm tendon reflexes with a percussion hammer.

l. Peripheral Circulation. Examine for flushing, mottling, and cyanosis of face, trunk, and extremities. Question as to the presence of localized sweating (armpits and palms) and cold extremities. Carefully study any abnormalities disclosed on the neurological examination and express an opinion as to their cause and significance and whether they are sufficient cause for rejection.

18. Psychiatric (Item 17 of SF-88).

a. Personality Evaluation. In order to evaluate the adequacy of the examinee's personality for adjustment to the conditions of military service:

(1) estimate the examinee's capacity coupled with real respect for personality and due consideration for feelings;

(2) conduct the examination in private to encourage open and honest answers; and

(3) attempt to discover any difficulties that the examinee may have had with interpersonal relationships at work or during leisure activities.

b. Diagnosis of Psychiatric Disorders. The diagnosis of most psychiatric disorders depends upon an adequate longitudinal history, supplemented by information obtained from other sources, such as family, physicians, schools, churches, hospitals, social service or welfare agencies, and courts.

c. Telltale Signs of Psychiatric Disorders. Be watchful for any of the following: inability to understand and execute commands promptly and adequately; lack of normal response; abnormal laughter; instability; seclusiveness; depression; shyness; suspicion; over boisterousness; timidity; personal uncleanliness; stupidity; dullness; resentfulness to discipline; a history of enuresis persisting into late childhood or adolescence; significant nail biting; sleeplessness or night terrors; lack of initiative and ambition; sleep walking; suicidal tendencies, whether bona fide or feigned. Abnormal autonomic nervous system responses (giddiness, fainting, blushing, excessive sweating, shivering or goose flesh, excessive pallor, or cyanosis of the extremities) are also occasionally significant. Note also the lack of responses as might reasonably be expected under the circumstances.

d. Procedures for Psychiatric Examination.

(1) Mental and personality difficulties are most clearly revealed when the examinee feels relatively at ease. The most successful approach is one of straightforward professional inquiry, coupled with real respect for the individual's feelings and necessary privacy. Matters of diagnostic significance are often concealed when the examinee feels the examination is being conducted in an impersonal manner or without due concern for privacy.

(2) Pay close attention to the content and implication of everything said and to any other clues, and in a matter-of-fact manner, follow-up whatever is not self-evident nor commonplace.

e. Aviation only.

(1) Although this phase of the examination is routinely performed only on candidates for flight training, it may be made part of any aviation physical examination. The objective is to determine the examinee's basic stability, motivation, and capacity to react favorably to the special stresses encountered in flying. Report any significant personality change in an experienced aviator.

(2) Following the completion of the general examination:

(3) study carefully the examinee's family history; and

(4) determine the family's attitude towards flying and the examinee's reaction to the stresses of life in general and emotional response and control.

19. Dental (Item 18 of SF-88).

a. Who May Conduct Dental Examinations.

(1) For Academy, OCS, and direct commission applicants: a Uniformed Services dental officer.

(2) For all aviation, diving, and overseas/sea duty physical examinations: a Uniformed Services dental officer or a contract dentist.

(3) For all others: a Uniformed Services dental officer, a contract dentist, or a medical examiner if a dentist is unavailable.

b. Procedures for Conducting Dental Examinations.

(1) Applicants for Original Entry. Whenever practical, applicants for original entry into the Service shall be given a Type 2 dental examination. Otherwise, the dental officer shall determine the type of examination that is appropriate for each examinee.

(2) Active Duty Personnel. Members on active duty, who are assigned to locations where Coast Guard, USMTF, or civilian contract dental clinics are available shall be required to have an annual Type 2 dental examination.

(3) Reserve Personnel.

(a) Type 2 dental examination is required for Quinquennial Physical Examinations, and

(b) Type 2 dental examination is required for all entries onto Active Duty (any type) for periods of duty in excess of 139 days.

c. Dental Restorations and Prostheses. The minimum number of serviceable teeth prescribed for entry in various programs of the Service is predicated on having retentive units available to provide for the reception of fixed bridges or partial dentures that may be necessary for satisfactory masticatory or phonetic function. Prostheses already present should be well-designed, functional, and in good condition.

20. Laboratory Findings (Items 19 of SF-88).

a. Required Tests. Personnel undergoing physical examinations are required to have the following tests performed, except where obtaining them is not possible or expeditious, or incurring charges for them is not authorized. In such cases, these tests shall be obtained at the first duty station where facilities are available. The normal values listed below are for guidance. Abnormal laboratory values alone are

not disqualifying; however, the causative underlying condition may be. Minimal deviations may not require further evaluation and this should be noted as NCD (not considered disqualifying) in item 74 by the examiner. Normal variants should be noted as such.

b. Hematology/Serology.

(1) Hematology. Perform a hematocrit (HCT) or hemoglobin (HGB) on all examinees. Perform other hematological studies only as indicated.

(2) Red Blood Cell Measurements.

(3) Hemoglobin - Males 13-18 gm/100ml

(4) Females 11.7-16 gm/100ml

(5) Hematocrit - Males 40-54%, Females 35-47%

If any of these parameters are abnormal, an RBC and indices shall be done. Normal indices are:

| | | |
|---|---|---|
| RBC- | Males | 4.3 to 6.2 million |
| | Females | 3.8 to 5.4 million |
| | MCV- | 82-92 cubic microns |
| | MCH- | 27-32 picograms |
| | MCHC - | 30-36% |

(6) Cholesterol Testing. All cadets, officer candidates, and recruits shall be tested for serum cholesterol within a week of their arrival for training. Those persons judged by a medical officer to have cholesterol levels that indicate an increased risk of atherosclerotic vascular disease shall be informed of this and given appropriate counseling by the third week of their training. Lipid panel studies, pharmacological remedial measures, or follow-up appointments may be performed at the discretion of the managing medical officer.

(7) Serological Test for Syphilis (RPR/STS).

(a) Required for entry into the Coast Guard and for all aviation and diving candidate physicals.

(b) Unless there is a documented history of adequately treated syphilis, all examinees testing positive shall have repeat testing three or more days later. Ensure that at the time of obtaining serum the examinee neither has, nor is convalescing from, any acute infectious disease or recent fever. If available at no charge, the facilities of local or state health departments may be used for performing serological tests. Examinees with a history of treated syphilis should have declining or low titer positive reaction.

(c) If the second test is positive then obtain an FTA/ABS. If the FTA/ABS is positive, further evaluation may be required to determine the appropriate therapy.

(d) Several conditions that are known to give false RPR/STS are infectious mononucleosis, malaria, yaws, pinta, chicken pox, infectious hepatitis, immunization, and atypical pneumonia. The cause of a false positive serological test for syphilis should be explored since many diseases giving a false positive are also disqualifying.

(e) Process all members who are suspected contacts or who have clinical evidence of venereal disease and all personnel with a positive serological test for syphilis in accordance with section 7-B-3 of this Manual.

(8) Sickle Cell Preparation Test. Applicants for aviation and diving training shall be tested for sickling phenomenon, if not previously tested. Evaluate positive sickledex results by a quantitative hemoglobin electrophoresis. Greater than 40 percent Hbs is disqualifying for aviation and diving. Once the test has been completed, the results will be filed in the health record and recorded on the Problem Summary List. The test need never be repeated.

(9) HIV Antibody.

(a) The most recent HIV antibody test date will be recorded in item #42 of the SF-88 (Report of Medical Examination), on the NAVMED6150/20 (Problem Summary List), and under Remarks on the SF-601 (Immunization Record). Epidemiological information concerning HIV infection will be monitored by Commandant (G-WKH) and the policy concerning routine testing will be revised as necessary.

(b) HIV antibody testing is required as follows (see COMDTINST. 6220.1A):

1 All applicants for regular or reserve programs for enlistment, appointment, or entry on active duty;

2 Candidates for officer service (direct commission, OCS, Academy, MORE, etc.,) as part of pre-appointment or pre-contract physical examination;

3 Cadets at the Coast Guard Academy as part of the physical examination prior to commissioning;

4 All Coast Guard members who have not had at least one documented HIV antibody test in the last four years;

5 All members with PCS orders to a foreign country, within six months prior to transfer;

6 During the clinical evaluation of the patients at high risk of HIV infection being seen for other sexually transmitted diseases or as part of prenatal examinations; and

7 Patients being referred to Level II/III alcohol/drug treatment programs must be tested for HIV immediately prior to entering such a program.

(c) Accession testing will usually be performed through MEPS examination centers. Other required testing can be done through DOD MTFs or designated Coast Guard HIV Antibody Testing Centers. Other required testing will be done through designated Coast Guard-wide HIV contract laboratory, Viromed laboratories. Commanding Officers may arrange testing with the laboratory directors at local uniformed services medical facilities (USMTFS) or qualified local civilian laboratories, only with the permission of, and prior coordination with, MLC(k). Record keeping and reporting requirements must be met. Liaison with the Department of Defense indicates that there are no prohibitions to testing Coast Guard personnel at these facilities. Contact Commander, MLC(k) for permission to use USMTFS or local civilian facilities to arrange methods for reporting results.

(d) Members who are confirmed HIV antibody positive or indeterminate by Western Blot, by the Coast Guard-wide contract laboratory, will have a second confirmatory specimen drawn and submitted for analysis to the same Coast Guard-wide contract laboratory. Refer to the COMDTINST 6220.10 for proper handling instructions before submitting the second confirmatory specimen.

(e) Members who are confirmed HIV antibody positive by the second confirmatory Western Blot, by the Coast Guard-wide contract laboratory, will be referred to a DOD MTF with the capability to perform a complete evaluation. Contact the respective MLC (k), and they will assist in making arrangements for the evaluation. Ensure that both the medical and dental records accompany the member to the DOD MTF for the evaluation. This evaluation will serve as the basis for an Initial Medical Board, that will be forwarded immediately to Commander (CGPC) (see COMDTINST. 6220.10). Initiate a Disease Alert Report IAW Chapter seven of this Manual.

(f) Once a member has been confirmed HIV positive, arrange immediate medical and social services counseling, using available Coast Guard, DOD, or civilian resources to ensure that the member understands the clinical implications of the positive test, the purpose of subsequent medical evaluation, and the policies in this instruction.

(g) Members who are confirmed HIV antibody positive shall receive counseling. The individual's command will provide medical and supportive counseling to the member if this has not already been provided by the evaluating facility.

(h) All information surrounding the individual's physical condition is strictly confidential. Only key personnel, with a verifiable "need to know" such as the individual's commanding officer, should be informed of the HIV status.

(i) Coast Guard medical officers requiring HIV antibody testing for clinical diagnosis should direct the Coast Guard HIV Antibody Testing Center to send a shipment to the Coast Guard-wide contract laboratory immediately. Results should ordinarily be available within 48 hours via electronic mail or telephone from Commandant (G-WKH).

(j) HIV antibody testing required by members of other uniformed services (active duty or reserve), or by specific agreement with other Federal agencies (e.g., Department of State), must be performed through a Coast Guard HIV Antibody Testing Center.

(k) Voluntary testing and counseling of dependents, retirees, and civilian employees must be performed through a Coast Guard HIV Antibody Testing Center.

(l) Reportable Disease Data Base (RDDB). All HIV antibody test results performed on Coast Guard members must be entered into the RDDB. Procedures are already in place for direct entry of test dates into the RDDB from specimens processed through MEPS, DOD MTFs and Coast Guard HIV Antibody Testing Centers. Dates of all ELISAs performed at local civilian laboratories should be submitted directly to Commandant (G-WKH) for entry into the RDDB.

c. Chest X-ray.

(1) Will be accomplished as part of the physical examinations for application for aviation or diving programs. Chest X-rays previously performed within eighteen (18) months of application, with normal results, are acceptable if there is no change in clinical presentation.

(2) Will not be performed for routine screening purposes without a prior clinical evaluation and a specific medical indication. The senior medical officer may authorize an exception to this policy when there are obvious medical benefits to be gained by routine screening x-ray examination (e.g., Asbestos Medical Surveillance Program). Such exceptions should be authorized only after careful consideration of the diagnostic yield and radiation risk of the x-ray study, as well as other significant or relevant costs or social factors. X-ray examinations will not be ordered solely for medical-legal reasons.

d. Electrocardiogram.

(1) Electrocardiograms (ECG) shall be accomplished routinely on the following individuals:

(a) those in whom medical history or clinical findings are suggestive of cardiac abnormalities;

(b) examinees with a sitting pulse rate of less than 50 or more than 100;

(c) examinees who are 40 years old or older;

(d) applicants for aviation and diving training and all designated personnel every four (4) years until age 40, then biennially. For designated aviation personnel on physical examinations where no EKG is required, place the date and results of the last EKG in block #19-d of SF-88; and

(e) applicants for service academies.

(2) All student and designated aviation personnel shall have an ECG on file in their health record.

(3) All tracings will be compared to the baseline reading in the health record, if one is present. If significant changes are present, obtain a cardiac consultation. A report of the consult shall be submitted for review along with the SF-88. It is imperative then that proper techniques for recording the ECG be followed.

(a) The routine ECG will consist of 12 leads, namely standard leads 1, 2, 3, AVR, AVL, AVF, and the standard precordial leads V1 through V6.

(b) Take care to properly place the precordial electrodes. It is important that the electrodes across the left precordium are not carried along the curve of the rib but are maintained in a straight line. Be particular in placing the first precordial lead so as to avoid beginning placement in the third interspace rather than the fourth. Do not smear electrode paste from one precordial position to another. Include a standardization mark on each recording.

e. Urinalysis. A urinalysis is required on all physical examinations. The urine shall be tested for specific gravity, glucose, protein, blood, leukocyte esterase, and nitrite by an appropriate dipstick method. A microscopic examination is required only if any of these dipstick tests is abnormal.

(1) Specific Gravity. Normal values are 1.005-1.035. Specific gravity varies with fluid intake, time of day, climate, and medication. As a rule, elevation of the specific gravity reflects only the state of hydration, while a low specific gravity may reflect kidney disease. In evaluating abnormalities, a repeat is generally sufficient, provided the factors above are considered and explained to the individual. Where possible, the repeat should be a first morning specimen which is usually the most concentrated.

(2) Glucose. Any positive test is abnormal. A false positive for glucose may occur in individuals who take Vitamin C or drink large quantities of fruit juice. As soon as practical after discovery of the glycosuria, obtain a fasting blood

glucose. If glycosuria persists or if the fasting blood glucose exceeds 125 mg/100 ml, evaluate the individual for diabetes.

(3) Protein. A trace positive protein is often associated with a highly concentrated (specific gravity 1.024 or greater) early morning specimen and is considered normal and need not be repeated. A one plus or greater protein, or a trace positive in the presence of a dilute urine, should be evaluated by a 24-hour specimen (normal range 10-200 mg protein/24 hours).

(4) Microscopic.

(a) Normal: 0-5 WBC

0-5 RBC (clean catch specimen)

occasional epithelial cells (more may be normal in an otherwise normal urinalysis)

no casts occasional bacteria

(b) Pyuria usually indicates an infection or improper collection techniques. Appropriate follow-up is required, including repeat after the infection has cleared.

(c) Hematuria may normally occur following heavy exercise or local trauma and as a false positive in menstruating females. It always requires evaluation with the minimum being a repeat showing no hematuria.

(d) Casts, heavy bacteria, other organisms, and abnormal cells require further evaluation.

f. PAP Test.

(1) A PAP test is required at the following times on female members:

(a) on the pre-training physical examination at time of initial entry into the Coast Guard;

(b) every two years, if on extended active duty; and

(c) with quinquennial examinations, for reserves.

(2) PAP tests and pelvic examinations (by civilian or military practitioners) that have been performed within one year of periodic examinations are acceptable. In any case, results of the pelvic examination and PAP test will be recorded in Items 19-F and/or 42, as appropriate. The practitioner is responsible for communicating the result of the PAP smear (either positive or negative) to the patient.

(3) To reduce false-negative smears, endocervical sampling shall be done using a cytobrush, provided no contraindication is present (as in pregnancy or cervical stenosis). Laboratories to which smears are sent for interpretation must, as a matter of routine, indicate on their reports whether endocervical sampling was adequate. Where endocervical cell sampling is reported as inadequate, the smear shall be repeated.

g. Pulmonary Function Test (PFT). Perform a PFT on all OMSEP examinations and when clinically indicated.

(1) Screening spirometry should not be performed if the subject:

(a) is acutely ill from any cause;

(b) has smoked or used an aerosolized bronchodilator within the past hour;

(c) has eaten a heavy meal within the previous two hours; or

(d) has experienced an upper or lower respiratory tract infection during the past three weeks.

(2) Explain the procedure to the subject.

(3) Instruct the subject to remove any tight clothing or dentures and to sit or stand comfortably in front of the spirometer. The chin should be slightly elevated with the neck slightly extended. The use of a nose clip is recommended.

(4) Tell the subject to take the deepest possible inspiration, close mouth firmly around the mouthpiece and without further hesitation, blow into the apparatus as hard, fast, and completely as possible. Active coaching throughout the entire duration of the forced expiration must be done to elicit maximum subject effort. Positioning of the lips around the mouthpiece should be checked.

(5) After two practice attempts, three further tracings should be recorded. If the technician believes that the subject has not made a full inspiration prior to the forced expiration, not put forth a maximal effort, or not continued expiration sufficiently long, that particular tracing should be repeated. Repeat attempts marred by coughing. The variation between the largest and smallest FVC of three satisfactory tracings should not exceed 10%.

(6) From the three satisfactory tracings, the FVC, $FEV_1$, and $FEV_1$/FVC% should be determined. Use the highest FVC and $FEV_1$ in the calculations regardless of the curve(s) on which they occur. The tracing itself should also be maintained as part of the medical record.

(7) If the tests are baseline studies, determine the predicted values and calculate the subject's percent of the predicted normal, and transcribe results on the record sheet. In non-Caucasians, the predicted $FEV_1$ and FVC should be multiplied by 0.85 to adjust for ethnic differences. No correction factor is necessary for the $FEV_1$/FVC%.

(8) If the tests are follow-up studies, comparison should be made with the previously recorded highest value for each test. This highest value may not necessarily have occurred during baseline tests.

(9) Verify any abnormalities in either baseline or follow-up pulmonary functions by repeating spirometry in two weeks. If abnormalities persist, clinical assessment by a physician qualified to evaluate chest disease is essential. In males, a 30 millimeter annual decline in $FEV_1$ and 25 millimeters FVC can be attributed to normal aging. In females, it is 25 millimeters in both the $FEV_1$ and FVC. PFT. Abnormal functions are present when:

(a) FEV-1 or FVC is less than 80% of predicted;

(b) FEV-1/FVC% is less than 69%;

(c) decline in the FEV-1 or FVC greater than 8%;

(d) decrease in the FEV-1/FVC% greater than 6%; and

(e) see the following:

**SPIROMETRIC GUIDELINES**

| | **OBSTRUCTIVE DISEASE**<br><br>**FEV-1/FVC** | **RESTRICTIVE DISEASE FCV%**<br><br>**FCV PREDICTED** |
|---|---|---|
| **NORMAL** | > 0.69 | > .80 |
| **MILD TO MODERATE** | 0.45 -0.69 | 0.51-0.80 |
| **SEVERE** | < 0.45 | <0.51 |

h. Special Tests. In some cases, information available should be supplemented by additional tests or diagnostic procedures (eye refractions, x-rays, repeated blood pressure readings, etc.), in order to resolve doubts as to whether the examinee is or is not physically qualified. If facilities are available to perform such tests at no cost, they should be obtained as indicated in individual cases. Otherwise, applicants for

original entry in the Service will be required to obtain such tests at their own expense, if they desire further consideration.

i. Laboratory Values (OMSEP). All laboratory values not previously discussed but that accompany a physical examination (e.g., chemistry profiles, etc.,) must have accompanying normals for the laboratory that performed the tests.

j. Mammography. Mammography is required for Coast Guard active duty and reserve females beginning at age 40 and at ages 44, 48, 50, 52, 54, 56, 58, 60, and 62. Clinical findings, family history, and other risk factors may dictate that a mammogram be done at times other than those indicated in this screening schedule. Results should be documented on the routine physical exams. Mammograms done between the required screening ages can be used to satisfy the periodic requirement. This judgment is left to the practitioner. If mammography is not done at the required ages, the reason must be supplied in item 42 of the SF 88 and should include date and result of the last mammogram. Practitioners are responsible for communicating mammography results (either positive or negative) to the patient.

k. Glucose-6-Phosphate Dehydrogenase (G-6-PD). Qualitative testing (present or not) for G-6-PD deficiency is required at all accession points (TRACEN Cape May, Academy, RTC Yorktown). All other Coast Guard members with no record of testing shall be tested prior to assignments afloat or to malaria-endemic areas. The results of testing shall be annotated on the Problem Summary List. Once testing is accomplished, it need never be repeated.

21. Height, Weight, and Body Build (Items 20, 21 and 24 of SF-88).

a. Height. Measure the examinee's height in centimeters (inch) to the nearest centimeter (one-half inch), without shoes.

b. Weight.

(1) Weights are with underwear/undergarments only.

(2) Weigh the examinee on a standard set of scales calibrated and accurate. Record the weight to the nearest kilogram (pound). Do not record fractions of kilogram.

c. Frame Size. Using a cloth tape, measure the wrist of the dominant hand, measure all the way around from lateral to medial styloid process. Measure in centimeters (fraction of an inch).

d. Body Fat Percentage. Determined by MEPS.

22. Distant Visual Acuity and Other Eye Tests (Items 28 through 30 of SF-88).

a. Distant Visual Acuity, General. Visual defects are one of the major causes for physical disqualification from the armed services. Methods of testing vision have varied greatly among the armed services and from place to place in each Service. Consequently, visual test results are not always comparable. An examinee

presenting for examination at one place might be qualified for visual acuity, while at another place, disqualified. Although this is an undesirable situation, no practical solution, such as prescribing standards for equipment and conditions (room size, ventilation, paint colors, room illumination, etc.), is available to the Coast Guard as the examinations are obtained from various sources over which the Coast Guard has no control. It is therefore imperative that examiners be especially painstaking to obtain the most accurate results possible.

b. Examination Precautions.

(1) Make every effort to conduct the examination when the examinee is in normal physical condition. Follow the examination routine in the order prescribed in the following instructions. Record the vision for each eye when determined so that errors and omissions will be avoided.

(2) It may be extremely difficult to obtain an accurate measure of visual acuity. Bear in mind that individuals who are anxious to pass visual acuity tests may resort to deception. Similarly, other individuals may attempt to fail a visual acuity test to avoid undesirable duties. Hence, be prepared to cope with either possibility in order to uncover and recognize visual defects without the cooperation of the person being tested.

(3) Refer uncooperative examinees to a medical officer.

c. Examination Procedures.

(1) In order to obtain a more valid evaluation, inform examinees that contact lenses will not be worn during the evaluation and for 72 hours before. Orthokeratotic lenses shall be removed for 14 days or until vision has stabilized for 3 successive examinations.

(2) If the examinee wears glasses, they must be removed before entering the exam room. Test each examinee without unnecessary delay after entering the examining room. In order to prevent personnel from memorizing the charts, permit only one examinee to view the test charts at a time. Keep examinees awaiting testing out of hearing.

(3) Direct the examinee to a line that is 20 feet from the test chart. Hold an occluder so that it covers the examinee's left eye. Instruct the examinee to keep both eyes open and not to squint. The occluder must not be pressed against the eyeball or lids or any part of the eye being shielded, but, should be held in contact with the side of the nose. The eye shielded by the occluder should be left open in order to avoid pressure and to discourage squinting. A rigid occluder, constructed of a material such as wood, translucent plastic, or metal, of a design to discourage cheating shall be used to shield the eye not being tested.

(4) Direct the examinee to begin with the first line and to read as many lines as possible. (Watch the examinee, not the chart that is being read. Hold the occluder so the examinee cannot peep around it. The most frequently used method of increasing visual acuity is to squint. This will not be permitted.

Some examinees with astigmatism will be able to read the letters better by tilting the head to one side; do not allow this. Another well-known method used to pass a visual acuity test is to obtain eyedrops beforehand that contract the pupil; suspect this if the pupils are unusually small.)

(5) Record the smallest line read with no errors on the chart from the 20 foot distance as the vision for the right eye (0.D.).

(6) Test the visual acuity for the left eye (0.S.), preferably using a different chart, record in the same manner.

(7) Test the visual acuity for both eyes (0.U.), preferably with a third chart, record in the same manner.

(8) Test an examinee who wears glasses again with them on. Follow the same procedure as without glasses.

(9) When there is suspicion that the examinee has memorized a chart, a different chart should be used or the letters on the chart should be read in reverse order.

(10) The examinee is expected to read letters promptly. No precise time limit should be applied, but 1 or 2 seconds per letter is ample.

(11) An examinee who fails a letter should not be asked to read it again. If a rapid reader makes an obviously careless mistake, caution the examinee to "slow down" and repeat the test using another chart.

(12) Some examinees give up easily. They may need encouragement to do their best; however, do not coach them.

(13) The effects of fatigue may make a certain amount of retesting necessary. In questionable cases, one retest should be given not less than the day after the initial test.

d. Armed Forces Vision Tester (AFVT). Visual acuity may also be determined with the (AFVT) which consists of two rotating drums holding illuminated slides for testing various facets of vision. The examinee observes the distance slides looking slightly downward with the instrument set and also observes the near slides looking downward at a greater angle. The handles on the side of the instrument rotate the drums to change the slides. Beneath the eye pieces there is a lever that operates an occluder so that each eye can be tested separately. In the case of the slides for muscle balance and stereopsis, the two eyes must be tested together and the occluder should be centered so it occludes neither eye. A scoring key is provided with the instrument. The following slides are available:

(1) Rear Drum (Distance Testing).

(a) Slide 1 - Vertical Phorias.

1 The right eye sees a set of numbered steps, the left sees a dotted line. With both eyes open the examinee is asked which step the dotted line intersects. Interpretation: step l, 2 prism diopters of left hyperphoria; step 2, 1.5 left hyperphoria; step 3, 1.0 left

hyperphoria; step 4, 0.5 left hyperphoria; step 5, orthophoria; step 6, 0.5 prism diopters of right hyperphoria; step 7, 1.0 right hyperphoria; step 8, 1.5 right hyperphoria; step 9, 2.0 right hyperphoria.

2 Detecting Malingerers: i.e., if known that a score of 5 is normal, the examinee could feign a normal phoria. To avoid this, a pair of VARIABLE PRISMS is provided, by which the examiner can raise either the right or the left eye image. The prisms are mounted within the viewing box. The extent of prismatic deviation is governed by the position of two control handles.

3 The correct score--and the only score recorded--is that obtained when both control handles of the VARIABLE PRISM are pushed inward as far as they will go. This is known as the SCORING POSITION. Moving the left handle outward from this position moves the left eye image downward and outward. Similarly, moving the right handle outward moves the right eye image downward and outward.

4 The maximum amount of downward shift provided by each control corresponds to four steps. Moving the right handle outward to its extreme position therefore will change the apparent location of the dotted line from step 1 to step 5, for example, from 6 to above 9, etc. Moving the left control handle outward to its extreme position similarly will change the apparent location of the dotted line from step 5 to step 1, or from step 8 to step 4, etc. Vary the location of the right or left control handle, each time asking the examinee to report the location of the dotted line. Only the answer obtained when both handles are in the SCORING POSITION gives the examinee's test score.

(b) Slide 2 - Horizontal Phorias.

1 The examinee's right eye sees a row of numbered dots, the left eye sees an arrow, with the occluder in the open position, ask the examinee to which numbered dot the arrow is pointing. Interpretation: The reporting value minus 11 equals prism diopters of exophoria; 11 minus the reported value equals the prism diopters of esophoria.

2 DETECTING MALINGERERS: By means of the VARIABLE PRISM previously mentioned, the right and left eye images can both be shifted outward a maximum of seven dots. To produce this outward shift without a downward shift, in this test both control handles are moved outward simultaneously by the same amount. When both handles are shifted as far out as they go, the apparent

position of the arrow is moved seven dots to the left, giving a score seven below the true score.

3 As in previous test, the correct score and the only score recorded is that obtained when the control handles are in the SCORING POSITION.

(c) Slides 3 and 3A - Visual Acuity. With both eyes uncovered the examinee sees a jumble of letters. With one eye covered, the uncovered eye cannot see the letters intended for the opposite eye.

(d) Slides 4 and 4A - Visual Acuity, Large Letters. Separate charts for the left and right eye.

(e) Slides 5 and 5A - Stereopsis. Six groups of horizontal lines, five circles to a line. The groups are numbered A to F. In each horizontal row of circles, one circle stands out closer to the examinee. The degree of difficulty increases from A to F. The examinee calls the circle that stands out. Passing score: There must be no misses in groups A through D. Caution: Ensure that neither eye is inadvertently left occluded when this test is being given. Both eyes must be able to see the circles in order for any stereopsis to occur.

(2) Front Drum (Near Testing).

(a) Slide 6 - Vertical Phorias. Same as slide 1, only this is a near test.

(b) Slide 7 - Horizontal Phorias. Same as slide 2, except subtract 13.

(c) Slide 8 - Near Visual Acuity. This is given in Snellen notations.

(d) Slide 9 - Near Visual Acuity, Large Letters.

e. Score recording. Record vision test scores as a fraction in that the upper number is the distance in feet from the chart and the lower number is the value of the smallest test chart line read correctly. Thus, a person reading at a distance of 20 feet, the 30 foot test chart line is given a score of 20/30. 20/20 indicates that a person reads at a distance of 20 feet the test chart line marked 20. Similarly, 20/200 means a person can read at a distance of 20 feet only the test chart line marked 200.

f. Refraction (Item 29 of SF-88).

(1) Eye refractions are required:

(a) when applying for flight training (SNA) (This must include cycloplegic.); and

(b) when visual acuity falls below 20/20 in either eye (near or distant).

(2) Subsequent refractions are required only if the visual acuity deteriorates further.

(3) If a cycloplegic is used during the course of refraction, then the examinee must wear dark glasses until the effects disappear. The installation of 1 drop into each eye of 1% solution of pilocarpine hydrochloride in distilled water after completing the examination will constrict the pupil and thus relieve the photophobia.

g. Near Vision (Item 30 of SF-88). Test near vision on all examinees and record results in Item 61 of SF-88 using Snellen notations. The examinee should be positioned so that the light source is behind him/her and the near vision test card is well illuminated. The examiner shall instruct the examinee to hold the test card exactly 14 inches/35.5 cm in front of their eyes (measure from the inner aspect of the lower eyelid [corner of the eye] to the face of the card to ensure accurate distance). Test each eye separately. Note the smallest line of type that the examinee is able to read with each eye. Record near vision both with and without corrective lenses if glasses are worn or required. Record corrections worn in Item 42. See the chart below for conversion from the various near point letter nomenclatures to Snellen notations.

CONVERSION TABLE FOR VARIOUS NEAR POINT LETTER NOMENCLATURE

| Standard Test Chart | Snellen English Linear | Snellen Metric | Jaegar |
|---|---|---|---|
| 14/14 | 20/20 | 0.50 | J-1 |
| 14/17.5 | 20/25 | .62 | J-2 |
| 14/21 | 20/30 | .75 | J-4 |
| 14/28 | 20/40 | 1.00 | J-6 |
| 14/35 | 20/50 | 1.25 | J-8 |
| 14/49 | 20/70 | 1.75 | J-12 |
| 14/70 | 20/100 | 2.25 | J-14 |
| 14/140 | 20/200 | | |

h. Heterophoria (Item 31 of SF-88).

(1) Except for aviation personnel, special tests for heterophoria are not required unless medically indicated.

(2) Heterophoria is a condition of imperfect muscle balance in which the eyes have a constant tendency to deviate and latent deviation is overcome by muscular effort (fusion to maintain binocular single vision). Fusion is responsible for the two eyes working together in harmony and when anything prevents this, fusion is disrupted and one eye deviates. Since heterophoria is only a tendency of the eyes to deviate, no actual deviation is apparent when the eyes are being used together under ordinary conditions. The deviation becomes visible only when fusion control is weakened or abolished. When deviation occurs, its exact amount can be estimated with some accuracy by neutralizing the deviation with prisms of varying strength. If the eye deviates toward its fellow, the deviation is known as esophoria; if it deviates away from its fellow, the deviation is known as exophoria; if it deviates up or down, the deviation is known as hyperphoria. The condition of perfect muscle balance (no deviation) is orthophoria.

(3) The vertical and horizontal phorias may be tested with the Phoropter or AFVT.

i. Accommodation (Item 32 of SF-88). There is no requirement to test accommodation unless medically indicated.

j. Color Perception Tests (Item 33 of SF-88). Examinees are qualified if they pass either the Pseudoisochromatic Plates (PIP) or the Farnsworth Lantern (FALANT) test. Examinees may be found qualified "on record" if a previous certified physical examination that has a passing PIP or FALANT score is available for review. Examinees who fail the PIP are qualified if they pass the FALANT.

(1) Farnsworth Lantern Test.

(a) Administration and Scoring.

1 Instruct the examinee: "The lights you will see in this lantern are either red, green, or white. They look like signal lights at a distance. Two lights are presented at a time--in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, only three colors--red, green, and white--and top first."

2 Turn the knob at the top of the lantern to change the lights; depress the button in the center of the knob to expose the lights. Maintain regular timing of about two seconds per exposure.

3 Expose the lights in random order, starting with RG or GR combinations (Nos. 1 or 5), continuing until each of the 9 combinations have been exposed.

4 If no errors are made on the first run of nine pairs of lights, the examinee passes.

5 If any errors are made on the first run, give two more complete runs. Passing score is at least 16 out of 18 correct for the two runs.

6 An error is considered the miscalling of one or both of a pair of lights; if an examinee changes responses before the next light is presented, record the second response only.

7 If an examinee uses glasses for distance, they shall be worn.

8 If an examinee says "yellow," "pink," etc., state, "There are only 3 colors--red, green, and white."

9 If an examinee takes a long time to respond, state, "As soon as you see the lights call them."

(b) Operation of Lantern.

1 Give the test in a normally lighted room; screen from glare; exclude sunlight. The examinee should face the source of room illumination.

2 Test only one examinee at a time (do not allow others to watch).

3 Station the examinee 8 feet from the lantern.

4 The examinee may stand or sit; tilt the lantern so that the aperture in the face of the lantern is directed at examinee's head.

(2) Pseudoisochromatic Plates. When Pseudoisochromatic Plates are used to determine color perception, a color vision test lamp with a daylight filter or a fluorescent light with a daylight tube shall be used for illumination. Do not allow the examinee to trace the patterns or otherwise touch test plates. Show the plates at a distance of 30 inches and allow 2 seconds to identify each plate. If the examinee hesitates, state "read the numbers." If the examinee fails to respond, turn to the next plate without comment. Qualification is ascertained as follows:

(a) 20 plate test set. Examinee must correctly read at least 17, excluding demonstration plates.

(b) 18 plate test set. Examinee must correctly read at least 14, excluding demonstration plates.

(c) 15 plate test set. Examinee must correctly read 10 plates.

k. Depth Perception (Item 34 of SF-88). Required for all aviation personnel and when medically indicated. The AFVT is the most commonly used method of testing depth perception. When this instrument is not available or the examinee fails the AFVT, use a TITMUS or Verhoeff Stereopter. Results obtained with the TITMUS or Verhoeff are final in resolving all cases of questionable depth perception.

(1) Findings.

(a) AFVT. An error in group A, B, C, or D is disqualifying.

(b) Verhoeff. Failure to correctly report eight out of eight in two of three trials is disqualifying.

(c) ITMUS Vision Screener. "requirements being developed"

(2) Operating the Verhoeff.

(a) As a preliminary, show target #2 (the second target down when the instrument is upright) at about 40 centimeters and bring it nearer if necessary. This will acquaint the examinee with what is to be observed and at the same time determine whether there is at least a distance, however short, that can be judged correctly.

(b) Show one or two positions at close range to the examinee to clearly demonstrate that one rod is always at difference from the other two. Point out that the size of the rods is not a clue to the relative distance. The examinee is now ready for the test.

(c) Hold the apparatus 1 meter from the examinee.

(d) Eight different rod relations are possible and all eight are shown.

(e) Keep the device centered as a frontal plane normal to the subject's binocular visual midline. To avoid helpful extraneous cues it is highly important to hold the device steady, and particularly not to rotate it on its vertical axis. It is also important not to permit the subject to move the head.

(f) Do not expose the target window while the device is being placed in position or the sets are changed. A convenient method of manipulation is to grasp the device over the target window with the left hand, place the desired set into position with the right hand, then grasp the device below with the right hand and expose the target window by moving the left hand up or down. Thus while the target window is exposed, the device is supported by both hands of the examiner.

(g) The instructions to the subject are: "Report the nearest strip and the farthest strip, unless they all appear to be at the same distance, referring to the strips as 'left,' 'middle,' and 'right'." Only the report concerning the one strip out of plane (farther or nearer than the other two that are in the same plane) is to be considered.

l. Field of Vision (Item 35 of SF-88).

(1) Except for aviation personnel, special tests for field of vision are not required unless medically indicated.

(2) Procedure.

(a) Face the examinee at a distance of 2 feet.

(b) Close right eye and instruct the examinee to close left eye and focus right eye on your left eye.

(c) Bring fingers in from the periphery, midway between you and the examinee.

(d) Instruct the examinee to say when and how many fingers seen.

(e) Test all cardinal points.

(f) Repeat test for the left eye.

(g) Any evidence of abnormality should be given study on the perimeter.

(3) Normals.

(a) Temporally - $90^{o}$.

(b) Superotemporally - $62^{o}$.

(c) Superiorly - $52^{o}$.

(d) Superonasally - $60^{o}$.

(e) Inferonasally - $55^{o}$.

(f) Inferiorly - $70^{o}$.

(g) Inferotemporally - $85^{o}$.

m. Night Vision (Item 36 of SF-88). A test for night vision (dark adaptation) is not required unless indicated for medical or special reasons.

n. Red Lens Test (Item 37 of SF-88). The red lens test is required on DODMERB examinations and when medically indicated.

(1) Apparatus. A spectacle trial frame, a red lens from' the trial lens case, a small light such as a muscle balance light, and a metric rule or tape.

(2) Procedure.

(a) Seat the examinee in the darkness facing the dark wall or tangent curtain at 75 cm distance.

(b) Adjust the spectacle trial frame position and place the red lens in one cell of the trial frame.

(c) With the examinee's head in a fixed position, hold the small lamp directly before the center of the dark wall or tangent curtain at 75 cm distance from the eyes. Note the presence or absence of diplopia in this position (primary).

(d) Then slowly move the light from the central position toward the right for a distance of 50 cm in the horizontal plane. In the same manner, move the light in the remaining five cardinal directions.

(e) In the presence of diplopia, note whether it is crossed, homonymous, or vertical and the distance in centimeters from the central position at which diplopia first occurs.

(f) When diplopia is suspected and the examinee has been coached to deny its presence, a prism of 3 or 4 diopters may be placed, either base up or base down, in one cell of the trial frame. If diplopia is still denied, the statement is obviously untrue.

(3) Precautions. The examinee's head must remain fixed and the movement of the light followed only by the eyes. Do not permit tilting or rotating the face.

o. Intraocular Tension (Item 38 of SF-88).

(1) General. Determine intraocular tension each time an eye refraction is performed, during all annual physical examinations, all aviation physicals, and when medically indicated. Above normal tension is a sign of glaucoma; below normal tension of ten exists in degenerated eyeballs or as a normal finding; alterations in tension are sometimes found in cyclitis. Questionable findings on palpation and ophthalmoscopic examination shall be further evaluated.

(2) Testing Intraocular Tension.

(a) General. Routine tonometry shall be performed by a medical officer, optometrist, or a technician who has received instruction in properly performing and interpreting this test.

(b) Instrument. The tonometer estimates the intraocular pressure (IOP) or tension within the eyeball.

(c) Precaution. Determine intraocular tension after all other eye examinations have been completed. Because of corneal denuding by tonometric measurement, a refraction (cycloplegic or manifest) shall not be performed for at least 24 hours following this procedure.

(d) Readings. Intraocular pressure consistently above 25 mm Hg in either eye or a difference of 4 or more between the two eyes, shall be referred for ophthalmologic evaluation.

23. Audiometer (Item 40 of SF-88).

a. An audiometric examination is required on all physical examinations using frequencies 500, 1000, 2000, 3000, 4000, and 6000 hertz.

b. Obtain reference audiograms on all personnel upon initial entry into the Coast Guard at recruit training and all officer accession points (Academy, OCS, Direct Commission, etc.,), and at first duty station for all others.

24. Psychological and Psychomotor (Item 41 of SF-88). Psychological and psychomotor testing is not required unless medically indicated.

FIGURE 3-C-1

The following chart enumerates certain conditions, defects, and items of personal history that require thorough evaluation and sets forth the special test, examination, or report desired in each instance.

| ITEM: | EXAMINATION AND INFORMATION DESIRED: |
|---|---|
| ALBUMINURIA, findings of | Repeat test on a second specimen. If still positive do a quantitative 24 hr urine protein. |
| ASTHMA history of, | Detailed report of asthma and other allergic conditions and a statement from cognizant physician on (1) number and approximate dates of attacks of asthmatic bronchitis or other allergic manifestations; (2) signs, symptoms, and duration of each attack; (3) type and amount of bronchodilating drugs used, and history of any attacks requiring hospitalization. |
| BACKACHE, back injury or wearing of back strength, | Current orthopedic consultation and report on stability, mobility, and functional brace, history of capacity of back. Report of appropriate x-rays. Transcript of any treatment from cognizant physician. |
| BLOOD PRESSURE, elevated | Repeat blood pressure (all positions) a.m. and p.m. for 3 consecutive days. Prolonged bed rest shall not precede blood pressure determinations. |
| CONCUSSIONS | See Head Injury |
| CONVULSIONS OR SEIZURE | Neurological consultation and electroencephalogram. Transcript of any treatment from cognizant physician. |
| DIABETES, family history of parent, sibling, or more than one grandparent | Fasting glucose (normal diet with 10-12 but less than 16 hours fast). If elevated, repeat and include 2 hr post prandial. |
| DIZZINESS or FAINTING SPELLS, history of | Neurological consultation |
| ENURESIS or history of into late childhood or adolescence (age 12) | Comment on applicant's affirmative reply to question "bed wetting" to include number of past incidents and age at last episode. |
| FLATFOOT, symptomatic | Current orthopedic consultation with history. Detailed report on strength, stability, mobility, and functional capacity of foot. Report of appropriate x-rays. |
| GLYCOSURIA, finding or history | See Diabetes. |
| HAY FEVER, history of | Detailed report of hay fever and other allergic conditions and a statement from personal physician on (1) number, severity, and duration of attacks of hay fever or any other allergic manifestations, and (2) type and amount of drugs used in treatment thereof. |
| HEADACHES, frequent or severe, history of | Neurological consultation. |

FIGURE 3-C-1

| | |
|---|---|
| HEAD INJURY with loss of consciousness in past 5 years, history of | Neurological consultation; clinical abstract of treatment from physician. |
| HEMATURIA, history of or finding of | Medical consultation with evaluation report, including appropriate laboratory studies and/or complete urological evaluation if indicated. |
| HEPATITIS, history of | Serum Bilirubin, SGOT, SGPT, SGT, Anti-HCV,and $HB_S$Ag. |
| JAUNDICE, history of in past 5 years | Serum Bilirubin, SGOT, SGPT, and SGT. |
| JOINT, KNEE, internal derangement, history of | Current orthopedic consultation and report of strength, stability, mobility, and functional capacity of knee. Report of appropriate x-rays together with comparative measurement of the thighs, knees, and legs. |
| JOINT, SHOULDER, dislocation, history of | Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of shoulder. Report of appropriate x-rays. |
| MALOCCLUSION, TEETH, history of | Report of examination by a dentist with comment as to whether incisal and masticatory function is sufficient for satisfactory ingestion of the ordinary diet, statement as to presence and degree of facial deformity with jaw in natural position and clarity of speech. |
| MASTOIDECTOMY, bilateral, history of audiogram. | Current ENT consultation to include |
| MOTION SICKNESS, history of | Detailed report of all occurrences of motion sickness (such as air, train, sea, swing, carnival-ride), and the age at the time of the last occurrence. |
| NASAL POLYPS, history of | ENT consultation, with comment as to date polyps removed if no longer present. Detailed report by physician on allergic history and manifestation to include required medication. |
| SKULL FRACTURE, in past 5 years, history of | See Head Injury. |
| SLEEPWALKING, beyond childhood, history of (age 12) | Detailed comment by physician. Comment on applicant's affirmative reply to question "been a sleepwalker" to include number of incidents and age at last episode. |
| SQUINT (cross eyed)Examination | for degree of strabismus and presence of complete and continuous 3rd degree binocular fusion. Request completion of SF-88 Items 62 and 65 and notation of degree of strabismus. |
| STUTTERING or STAMMERING, | Report of Reading Aloud Test in Section 3-C-2. |
| VERTEBRA, fracture or dislocation, history of | Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of spine. Report of appropriate x-rays. |

FIGURE 3-C-3

| HEIGHT STANDARDS | | |
|---|---|---|
| Category | Minimum (cm/inches) | Maximum (cm/inches) |
| **AVIATION PERSONNEL:** | | |
| Candidate for Flight Training | 157.4/62 | 198/78 |
| Class 1 Pilot | 157.4/62 | 198/78 |
| Designated Flight Officer | 157.4/62 | 198/78 |
| Aircrew Candidate | 152.5/60 | 198/78 |
| Designated Aircrew | 152.5/60 | 198/78 |
| | | |
| **ENLISTED PERSONNEL:** | | |
| Enlistment in USCG | 152.5/60 | 198/78* |
| Enlistment in USCG Reserve | 152.5/60 | 198/78* |
| | | |
| **CANDIDATES FOR:** | | |
| USCG Academy | 152.5/60 | 198/78* |
| Officer Candidate School | 152.5/60 | 198/78* |
| Appointment of Licensed Officers of U.S. Merchant Marines in the USCG | 152.5/60 | 198/78* |
| Direct Commission in USCG | 152.5/60 | 198/78* |
| | | |

- MAXIUM HEIGHTS WAIVERABLE TO 203 CM/ 80 INCHES BY COMMANDER COAST PERSONNEL COMMAND (CGPC-adm-1)

NOTES:

1. Heights are without shoes.
2. Metric conversion: 1 inch = 2.54 cm

FIGURE 3-C-4

MINIMUM DISTANT VISUAL ACUITY REQUIREMENTS

| CATEGORY | VISION | |
|---|---|---|
| A. Aviation Personnel: | Uncorrected | Corrected |
| 1. Candidates for Flight Training | 20/50 | 20/20 |
| 2. Pilot, Class | 20/200 | 20/20 |
| 3. Pilot, Class 1R | (as waivered) | 20/20 |
| 4. Designated Flight Officer | 20/400 | 20/20 |
| 5. Flight Surgeon, Aviation Medical Examiner or Aviation MEDEVAC Specialist | 20/400 | 20/20 |
| 6. Candidate for Aircrew | 20/100 | 20/20 |
| 7. Designated Aircrew | 20/200 | 20/20 |
| 8. Landing Signal Officer (LSO) | 20/200 | 20/20 |
| 9. Air Traffic Controller Candidate | 20/100 | 20/20 |
| 10. Designated Air Traffic Controller | 20/200 | 20/20 |
| B. Officers (Note 1): | | |
| 1. Commissioned or Warrant in the USCG or USCGR | 20/400 | 20/20 |
| 2. Appointment in the USCG of Licensed Officers of the Merchant Marine | 20/400 | 20/20 |
| 3. Direct Commission in the USCGR | 20/400 | 20/20 |
| 4. Appointment as Cadet | 20/400 | 20/20 |
| 5. Precommissioning of Cadets | 20/400 | 20/20 |
| 6. OCS Candidates | 20/400 | 20/20 |
| 7. Precommissioning of Officer Candidates | 20/400 | 20/20 |
| 8. Diving Candidates | 20/100 | 20/20 |
| 9. Designated Diver | 20/200 | 20/20 |
| C. Enlisted Personnel: | | |
| 1. Enlistment in the USCG or USCGR | See 3.D.13.a | (Note 2) |
| 2. Diving Candidates | (Note 3) | 20/20 |
| 3. Designated Diver | (Note 3) | 20/20 |

Notes:

1. Refractive error does not exceed plus or minus 8.0 diopters spherical equivalent (sphere + 1/2 cylinder) and that astigmatism does not exceed 3.00 diopters and anisometropia does not exceed 3.50 diopters.

2. Corrected vision shall be 20/40 in the better eye and 20/70 in the other or 20/30 in the better eye and 20/100 in the other, or 20/20 in the better and 20/400 in the other. (Note that near visual acuity must correct to at least 20/40 in the better eye.) Refractive error does not exceed plus or minus 8.00 diopters spherical equivalent (sphere + 1/2 cylinder) and ordinary spectacles do not cause discomfort by reason of ghost images, prismatic displacement, etc.; error must not have been corrected by orthokeratology or keratorefractive surgery.

3. 20/100 in the better eye and 20/200 in the worse eye.

Section D Physical Standards for Enlistment, Appointment, and Induction.

1. Scope. This section implements Department of Defense (DOD) Directive 6130.4 "Physical Standards for Enlistment, Appointment, and Induction," December 14, 2000, which established physical standards for enlistment, appointment, and induction into the Armed Forces of the United States in accordance with section 115, title 10, United States Code (10 USC 133), and by agreement with Secretary, DOT applies to USCG. It is Coast Guard policy to conform, to the maximum extent possible, to common physical standards for the acquisition of personnel among all the Armed Forces.

2. Applicability and Responsibilities.

   a. Applicability.

      (1) This section sets forth the medical conditions and physical defects which are causes for rejection for military service. Those individuals found medically qualified based on the medical standards in effect prior to this regulation will not be reevaluated or medically disqualified solely on the basis of the new standards.

      (2) The standards of this section apply to:

         (a) Applicants for enlistment in the Regular Coast Guard. For medical conditions or physical defects predating original enlistment, these standards are applicable for enlistees' first 6 months of active duty.

         (b) Applicants for enlistment in the Coast Guard Reserve. For medical conditions or physical defects predating original enlistment, these standards are applicable during the enlistees' initial period of active duty for training until their return to Reserve Component units.

         (c) Applicants for reenlistment in the Regular Coast Guard and Coast Guard Reserve after a period of more than 6 months has elapsed since separation.

         (d) Applicants for appointment as commissioned or warrant officers in the Coast Guard and as modified by section 3-E.

         (e) Applicants for the United States Coast Guard Academy (USCGA) and all other special procurement programs, e.g., Officer Candidate School, and as modified by section 3-E.

         (f) Cadets at the United States Coast Guard Academy, except for such conditions that have been diagnosed since entrance into the Academy. With respect to such conditions, upon recommendation of the senior medical officer, USCGA, the fitness standards of section 3-F are applicable for retention in the Academy. However, the standard in paragraph 3-D-39.p applies whether section 3-E or 3-F standards of this regulation are applicable.

(g) Any individuals that may be inducted into the Coast Guard.

(3) All numbers in parentheses refer to the ICD codes.

b. Responsibilities. Commandant (G-WK) will:

(1) Revise Coast Guard policies to conform with the standards contained in DOD Directive 6130.4.

(2) Recommend to the Office of the Assistant Secretary of Defense (Health Affairs) [OASD(HA)] suggested changes in the standards after service coordination has been accomplished.

(3) Review all the standards on a quinquennial basis and recommend changes to the OASD(HA). This review will be initiated and coordinated by the DOD Medical Examination Review Board.

(4) Establish other standards for special programs.

(5) Issue Coast Guard-specific exceptions to these standards, having first submitted these, with justification, for review and approval by the OASD(HA).

3. Abdominal Organs and Gastrointestinal System. The causes for rejection for appointment, enlistment, and induction are authenticated history of:

a. Esophagus. Ulceration, varices, fistula, achalasia, or other dysmotility disorders; chronic, or recurrent esophagitis if confirmed by x-ray or endoscopic examination (530).

b. Stomach and duodenum.

(1) Gastritis, chronic hypertrophic, severe (535).

(2) Ulcer of stomach or duodenum confirmed by x-ray or endoscopy (533).

(3) Congenital abnormalities of the stomach or duodenum causing symptoms or requiring surgical treatment (751), except a history of surgical correction of hypertrophic pyloric stenosis of infancy.

c. Small and large intestine.

(1) Inflammatory bowel disease. Regional enteritis (555), ulcerative colitis (556), or ulcerative proctitis (556).

(2) Duodenal diverticula. That with symptoms or sequelae (hemorrhage, perforation, etc.) (562.02).

(3) Intestinal malabsorption syndromes. Including post surgical and idiopathic (579).

(4) Congenital (751): Condition to include Meckel's diverticulum or functional (564) abnormalities, persisting or symptomatic within the past two years.

d. Gastrointestinal bleeding. History of such, unless the cause shall have been corrected and is not otherwise disqualifying (578).

e. Hepato-pancreatico-biliary tract.

(1) Viral hepatitis (070) or Unspecified hepatitis (570). Hepatitis in the preceding 6 months or persistence of symptoms after 6 months, or objective evidence of impairment of liver function, chronic hepatitis or hepatitis B carriers (070).

(2) Cholecystitis. Acute or chronic, with or without cholelithiasis (574); and other disorders of the gallbladder, including postcholecystectomy syndrome (575); and biliary system (576).

(3) Pancreatitis. Acute (577.0) and chronic (577.1).

f. Anorectal.

(1) Anal fissure if persistent, or anal fistula (565).

(2) Anal or rectal polyp (569.0), stricture (569.2), or incontinence (787.6).

(3) Hemorrhoids. Internal or external, when large, symptomatic, or history of bleeding (455).

g. Spleen.

(1) Splenomegaly. If persistent (789.2).

(2) Splenectomy (P41.5). Except when accomplished for trauma or conditions unrelated to the spleen, or for hereditary spherocytosis (282.0).

h. Abdominal wall.

(1) Hernia. Including inguinal (550) and other abdominal (553), except for small, or asymptomatic umbilical or hiatal.

(2) History of abdominal surgery during the proceding 60 days (P54).

i. Other. Gastrointestinal bypass (P43) or stomach stapling (p44) for control of obesity. Persons with artificial openings (V44).

4. Blood and Blood-Forming Tissue Diseases. The causes for rejection for appointment, enlistment, and induction are:

a. Anemia. Any hereditary (282), acquired (283), aplastic (284), or unspecified (285) anemia that has not been permanently corrected with therapy.

b. Hemorrhagic disorders. Any congenital (286) or acquired (287) tendency to bleed due to a platelet or coagulation disorder.

c. Leukopenia. Chronic or recurrent (288), based on avilable norms for ethnic background.

d. Immunodeficiency (279).

5. Dental. The causes of rejection for appointment, enlistment, and induction are as follows:

   a. Diseases of the Jaw or Associated Tissues That Are Not Easily Remediable, and Will Incapacitate the Individual or Otherwise Prevent the Satisfactory Performance of Duty. Those diseases include temporomandibular disorder (524.6) and/or myofacial pain dysfunction that is not easily corrected, or has the potential for significant future problems with pain and function.

   b. Severe malocclusion (524). That malocclusion which interferes with normal mastication or requires early and protracted treatment; or relationship between mandible and maxilla that prevents satisfactory future prosthodontic replacement.

   c. Insufficient Natural Healthy Teeth (521), or Lack of a Serviceable Prosthesis. Such condition preventing adequate mastication and incision of a normal diet. That includes complex (multiple fixture) dental implant systems that have associated complications that severely limit assignments and adversely affect performance of worldwide duty. Dental implant system must be successfully osseointegrated and completed

   d. Orthodontic Appliancesfor Continued Treatment (V53.4). Attached or Removable. Retainer appliances are permissible, if all active orthodontic treatment has been satisfactorily completed

6. Ears. The causes for rejection for appointment, enlistment, and induction areas follows:

   a. External ear. Atresia or severe microtia (744), acquired stenosis (380.5), severe chronic or acute external (380.2), or severe traumatic deformity (738.7).

   b. Mastoids. Mastoiditis (383), residual of mastoid operation with fistula (383.81), or marked external deformity that prevents or interferes with the wearing of protective mask or helmet (383.3).

   c. Meniere's Syndrome, or Other diseases of the Vestibular System (386).

   d. Middle ear. Acute or chronic otitis media (382), cholesteatoma (385.3), or history of any inner (P20) or middle (P19) ear surgery, excluding myringotomy or successful tympanoplasty.

   e. Tympanic membrane.

7. Hearing. The cause for rejection for appointment, enlistment, and induction is a hearing threshold level greater than that described in 3-D-7-a-(3), below (389):

   a. Audiometric Hearing Levels.

      (1) Audiometers, calibrated to the International Standards Organization (ISO 1964) or the American National Standards Institute (ANSI 1969), shall be used to test the hearing of all applicants.

(2) All audiometric tracings or audiometric readings recorded on reports of medical examinations or other medical records shall be clearly identified.

(3) Acceptable audiometric hearing levels (both ears) are as follows:

(a) Pure tone at 500, 1000, and 2000 cycles per second of not more than 30 dB on the average with no individual level greater than 35 dB at those frequencies.

(b) Pure tone level not more than 45 dB at 3000 cycles per second and 55 dB at 4000 cycles per second.

8. Endocrine and Metabolic Disorders. The cause for rejection for appointment, enlistment, or induction are an authenticated history of the following:

a. Adrenal dysfunction (255). Of any degree.

b. Diabetes Mellitus (250). Of any type.

c. Glycosuria. Persistent, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4

d. Acromegaly. Gigantism, or other disorder of pituitary function (253).

e. Gout (274).

f. Hyperinsulinism (251.1).

g. Hyperparathyroidism (252.0) and hypoparathyroidism (252.1).

h. Thyroid disorders.

(1) Goiter. Persistent or untreated (240).

(2) Hyperthyroidism. Condition uncontrolled by medication (244).

(3) Cretinism (243).

(4) Hypothyroidism (242).

(5) Thyroiditis (245).

i. Nutritional Deficiency Diseases. Such diseases include beriberi (265), pellagra (265.2), and scurvy (267).

j. Other Endocrine or Metabolic Disorders. Such disorders such as cystic fibrosis (277), porphyria (277.1), and amyloidosis (277.3) that prevent satisfactory performance of duty or require frequent or prolonged treatment.

9. Upper Extremities (see also section 3-D-11, below). The causes for rejection for appointment, enlistment, and induction areas follows:

a. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement appear in EXHIBIT 3-F-1.

(1) Shoulder (726.1).

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) Elbow (726.3).

(a) Flexion to 100 degrees.

(b) Extension to 15 degrees.

(3) Wrist (726.4). A total range to 60 degrees (extension plus flexion). Radial and ulnar deviation combined arc 30 degrees.

(4) Hand.

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

(5) Fingers and thumb (726.4). Inability to clench fist, pick up a pin, grasp an object or touch tips of at least 3 fingers with thumb.

b. Hand and fingers.

(1) Absence of the distal phalanx of either thumb(885).

(2) Absence of distal and middle phalanx of an index, middle, or ring finger of either hand irrespective of the absence of little finger (866).

(3) Absence of more than the distal phalanx of any two of the following fingers: index, middle finger, or ring finger of either hand (886).

(4) Absence of a hand or any portion thereof (887), except for fingers as noted above.

(5) Polydactyly (755).

(6) Scars and deformities of the fingers or hand (905.2) that are symptomatic, or impair normal function to such a degree as to interfere with the satisfactory performance of military duty.

(7) Intrinsic paralysis or weakness, including nerve palsy (354) sufficient to produce physical findings in the hand such as muscle atrophy or weakness.

c. Wrist, Forearm, Elbow, Arm, and Shoulder. Recovery from disease or injury with residual weakness or symptoms such as to prevent satisfactory performance of duty (905.2), or grip strength of less than 75 percent of predicted normal when injured

hand is compared with the normal hand (nondominant is 80 percent of dominant grip).

10. Lower Extremities (see 3-D-11). The causes for rejection for appointment, enlistment, and induction are as follows:

a. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement appear in EXHIBIT 3-F-1.

(1) Hip. Due to disease(726.5) or injury (905.2).

(a) Flexion to 90 degrees (minimum).

(b) No demonstrable flexion contracture.

(c) Extension to 10 degrees (beyond 0 degree).

(d) Abduction to 45 degrees.

(e) Rotation - 60 degrees (internal and external combined).

(2) Knee. Due to disease (726.7) or injury (905.4).

(a) Full extension compared with contralateral.

(b) Flexion to 90 degrees.

(3) Ankle. Due to disease (726.7) or injury (905.4).

(a) Dorsiflexion to 10 degrees.

(b) Plantar flexion to 30 degrees.

(c) Eversion and inversion (total to 5 degrees).

(4) Subtalar. Due to disease (726.7) or injury (905.4).

(a) Eversion and inversion total to 5 degrees.

b. Foot and ankle.

(1) Absence of one or more small toes (895). If the function of the foot is poor, or running or jumping is prevented; absence of a foot (896) or any portion thereof except for toes as noted herein.

(2) Absence of great toe(s) (895). Loss of dorsal and/or planter flexion if the function of the foot is impaired (905.4).

(3) Deformities of the toes. Either acquired (735) or congental (755.66), including polydactyly (755.02), that prevents the wearing of military footwear, or impairs walking, marching, running, or jumping. That includes hallux valgus (735).

(4) Clubfoot and/or Pes Cavus (754.5). If stiffness or deformity prevents foot function or wearing military footwear.

(5) Symptomatic Pes planus. Acquired (34) or congenital (754.6) or pronounced cases with absence of subtalar motion.

(6) Ingrown toenails (703). If severe.

(7) Planter Fasciitis (728.7). If persistent.

(8) Neuroma (355.6). Confirmed condition and refractory to medical treatment, or will impair function of the foot.

c. Leg, knee, thigh, and hip.

(1) Loose or foreign bodies in the knee joint (717.6). History of surgical correction of knee ligaments.

(2) Physical findings of an unstable or internally deranged joint (717.9). History of uncorrected anterior (717.83) or posterior (717.84) cruciate ligament injury.

(3) Surgical correction of any knee ligaments (P81), if symptomatic or unstable.

(4) History of congenital dislocation of the hip (754.3). Osteochondritis of the hip (Legg-Perthes Disease) (732.1), or slipped femoral epiphysis of the hip (732.2).

(5) Hip dislocation (835). Dislocation within 2 years before examination.

(6) Osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) (732.4). If symptomatic.

d. General.

(1) Deformities (905.4), disease, or chronic pain (719.4) of one or both lower extremities that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life; or that would interfere with walking, running, weight bearing, or the satisfactory completion of training or military duty.

(2) Shortening of a lower extremity (736.81), resulting in a noticeable limp or scoliosis.

11. Miscellaneous Conditions of the Extremities. (see 3-D-9 and 3-D-10). The causes for rejection for appointment, enlistment, and induction areas follows:

a. Arthritis.

(1) Active, subactive, or chronic arthritis (716).

(2) Chronic osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints of more than a minimal degree, that has interfered with the following of a physically active vocation in civilian life or that prevents the satisfactory performance of military duty.

b. Chronic retropatellar knee pain syndrome with or without confirmatory arthroscopic evaluation (717.7).

c. Dislocation, if unreduced; or recurrent dislocations of any major joint. Such as, shoulder (831), hip (835), elbow (832), knee (836); or stability of any major joint (shoulder(718.1), elbow (718.3, or hip(718.5)).

d. Fractures.

(1) Malunion or non-union of any fracture (733.8). Except ulnar styloid process.w

(2) Orthopedic hardware (733.99). hardware including plates, pins, rods, wires, or screws used for fixation and left in place; except that a pin, wire or screw not subject to easy trauma is not disqualifying.

e. Injury of a bone or joint. An injury of more than a minor nature, with or without fracture or dislocation, which occurred in the preceding 6 weeks (upper extremity (923), lower extremity (924), or rib and clavicle (922)).

f. Joint replacement (V43.6).

g. Muscular paralysis, contracture, or atrophy (728). If progressive or of sufficient degree to interfere with military service, and muscular dystrophies (359).

h. Osteochondritis dessicans (732.7).

i. Osteochondromatosis or multiple cartilaginous exostoses (727.82).

j. Osteomyelitis (730). Active or recurrent

k. Osteoporosis (733).

l. Scars (709.2). Extensive, deep, or adherent to the skin and soft tissues that interfere with muscular movements.

m. Implants. Silastic or other devices implanted or correct orthopedic abnormalities (V43).

12. Eyes. The cause for rejection for appointment, enlistment, or induction are as follows

a. Lids.

(1) Blepharitis (373). Chroniccondition, of more than mild degree.

(2) Blepharospasm (333.81).

(3) Dacryocystitis. Acute or chronic (375.3).

(4) Deformity of the lids (374.4). Complete or extensive lid deformity, sufficient to interfere with vision or impair protection of the eye from exposure.

b. Conjunctiva.

(1) Conjunctivitis. Chronic condition (372.1), including trachoma (076), and allergic conjunctivitis (372.13).

(2) Ptergium (372.4). If condition encroaching on the cornea in excess of 3 millimeters, interfering with vision, progressive (372.42) or recurring after two operative procedures (372.45).

(3) Xerophthalmia (372.53).

c. Cornea.

(1) Dystrophy. Corneal dystrophy, of any type (371.5), including, keratoconus (371.6) of any degree.

(2) Keratorefractive surgery. History of lamellar (P11.7) and/or penetrating keratoplasty (P11.6). Laser surgery or appliance utilized to reconfigure the cornea is also disqualifying.

(a) Waivers for Photorefractive Keratectomy (PRK) and Laser In-situ Keratomileusis (LASIK) will be considered if the following criteria are met:

1 Pre-operative refractive error did not exceed +8.00 to-8.00 diopters (spherical equivalent) in either eye.

2 At least 12 months since surgery or last enhancement.

3 Refractive stability as demonstrated by less than 0.50 diopter change in either eye over two separate exams at least three months apart.

4 All pre-operative, operative and post-operative records are submitted for review.

5 No complications or side effects as a result of the surgery such as decreased night vision, glare sensitivity, halos around light or worsening of the pre-operative best vision due to scar formation.

6 Accession standards outlined in section 3-D and 3-E are met.

(b) PRK and LASIK are disqualifying for aviation duty and landing signal officer duty.

(c) LASIK is disqualifying for diving duty.

(3) Keratitis (370). Acute or chronic keratitis, which includes recurrent corneal ulcers, erosions (abrasions), or herpetic ulcers (054.42).

(4) Vascularization (370.6) or opacification (371) of the cornea. Condition from any cause that is progressive or reduces vision below the standards prescribed in 3-D-13.

d. Uveitis (364) or Iridocyclitis.

e. Retina.

(1) Angiomatoses (759.6). Or other congenito-hereditary retinal dystrophy (362.7) that impairs visual function.

(2) Chorioretinitis (363). Unless single episode that has healed and does not interfere with vision.

(3) Congenital or degenerative changes of any part of the retina (362).

(4) Detachment of the retina (361). A history of surgery for same, or peripheral retinal injury or degeneration likely to cause retinal detachment.

(5) Chorioretinis or inflammation of the retina (363). Condition including (histoplasmosis, toxoplasmosis or vascular conditions of the eye to include Coats' disease, Eales' disease, and retinitis proliferans), unless a single episode known cause that has healed and does not interfere with vision.

f. Optic nerve.

(1) Optic neuritis (377.3). Neuroretinitis, or secondary optic atrophy or documented history of attacks of retrobulbar neuritis.

(2) Optic atrophy (377.1) or Cortical Blindness (377.7).

(3) Papilledema (377.0).

g. Lens.

(1) Aphakia (379.3). Lens implant, or dislocation of a lens.

(2) Opacities of the lens (366). Those conditions that interfere with vision or that are considered to be progressive.

h. Ocular mobility and motility.

(1) Diplopia (368.2). Documented, constant or intermittent.

(2) Nystagmus (379.5).

(3) Strabismus (378). Uncorrectable by lenses to less than 40 diopters or accompanied by diploplia.

(4) Strabismus. Corrective surgery (P15) in the preceding 6 months.

(5) See section 3-E for additional standards for officer programs.

i. Miscellaneous defects and diseases.

(1) Abnormal visual fields due to diseases of the central nervous system (368.4), or trauma (368.9). Meridian specific visual field minimums areas follows:

(a) Temporal: 85 degrees.

(b) Superior temporal: 55 degrees.

(c) Superior: 45 degrees.

(d) Superior nasal: 55 degrees.

(e) Nasal: 60 degrees.

(f) Inferior nasal: 50 degrees.

(g) Inferior: 65 degrees.

(h) Inferior temporal: 85 degrees.

(2) Absence of an eye. Congenital (743) or acquired (360.8).

(3) Asthenopia (368.13). Severe.

(4) Exophthalmos (376). Unilateral or bilateral, non-familial.

(5) Glaucoma (365). Primary, or secondary, or pre-glaucoma as evidenced by intraocular pressure above 21 mm/Hg, or the secondary changes in the optic disc or visual field loss associated with glaucoma.

(6) Loss of normal pupillary reflex reactions to light or accommodation (367.5) or light (379.4), including Adie's syndrome.

(7) Night blindness (368.6).

(8) Retained introcular foreign body (360).

(9) Tumors. Growths or tumors of the eyelid, other than small basal cell tumors that may be cured by treatment, and small nonprogressive asymptomatic benign lesions.

(10) Any organic disease of the eye (360) or adnexa (376) not specified above, that threatens vision or visual function.

13. Vision. The cause of medical rejection for appointment, enlistment, and induction are listed below. (See section 3-E for additional standards for officer programs.)

a. Distant visual acuity. Distant visual acuity of any degree that does not correct with spectacle lenses to at least one of the following (367):

(1) 20/40 in one eye and 20/70 in the other eye.

(2) 20/30 in one eye and 20/100 in the other eye.

(3) 20/20 in one eye and not exceeding 20/400 in the other eye.

b. Near visual acuity. Near visual acuity of any degree that does not correct to 20/40 in the better eye (367).

c. Refractive error (Hyperopia 367.0, Myopia 367.1, Astigmatism 367.2). Any refractive error in spherical equivalent of worse than - 8.00 or + 8.00 diopters; or if

ordinary spectacles cause discomfort by reason of ghost images, prismatic displacement; or if corrected by orthokeratology or keratorefractive surgery.

d. Contact lenses. Complicated cases requiring contact lenses for adequate correction of vision such as corneal scars (371) and irregular astigmatism (367.2).

e. Color vision. (368.5). All applicants for initial entry into the Coast Guard, all officer candidates, all commissioning candidates, and all aviation candidates shall be tested for color vision. There is NO requirement for enlisted personnel to demonstrate normal color vision. A listing of current enlisted specialties that require normal color vision can be obtained from unit personnel offices or departments. Normal color vision IS required for all officer candidates and some commissioned warrant specialties (check with unit personnel offices for current listing).

14. Female Genitalia. The causes for rejection for appointment, enlistment, and induction areas follows:

a. Abnormal uterine bleeding (626.2). Including such bleeding as menorrhagia, metrorrhagia or polymenorrhea.

b. Amenorrhea (626.0). Unexplained

c. Dysmenorrhea (625.3). Incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities.

d. Endometriosis (617).

e. Hermaphroditism (752.7).

f. Menopausal Syndrome (627). If manifested by more than mild constitutional or mental symptoms or artificial menopause less than a 1-year duration.

g. Ovarian Cysts (620). Persistent or clinically significant.

h. Pelvic Inflammatory disease (614). Acute or chronic.

i. Pregnancy (V22).

j. Uterus. Congenital absence of (752.3) or enlargement due to any cause (621.2).

k. Vulvar or Vagina Ulceration (616.5). Including herpes genitalis (054.11) and condyloma acuminatum (078.11): acute or chronic, not amenable to treatment. Such treatment must be given and demonstrated effective prior to accession.

l. Abnormal Pap Smear (795). Graded LGSIL or higher severity; or any smear in which the descriptive terms carcinoma-in-situ, invasive cancer, condyloma accuminatum, human papilloma virus, or dysplasia are used.

m. Major abnormalities and defects of the genitalia, such as a change of sex (P64.5). A history thereof, or dysfunctional residuals from surgical correction of these conditions.

15. Male Genitalia. The cause of medical rejection for appointment, enlistment, or induction are:

a. Absence of both testicles. Congenital (752.8) or acquired (878.2), or unexplained absence of a testicle.

b. Epispadias or Hypospadias (752.6). when accompanied by evidence of infection of the urinary tract, or if clothing is soiled when voiding.

c. Undiagnosed enlargement or mass of testicleor epididymis (608.9).

d. Undescended testicle(s) (752.5).

e. Orchitis (604). Acute, or chronic epididymitis.

f. Penis. Amputation of (878), if the resulting stump is insufficient to permit micturition in a normal manner.

g. Penile infectious lesions. Including herpes genitalis (054.1) and condyloma acuminatum (078.11): acute or chronic, not amenable to treatment. Such treatment must be given and demonstrated effective prior to accession.

h. Prostatitis (601). Acute or chronic condition.

i. Hydrocele (603.9). Left varicocele (if painful), or any right varicocele (456.4)

j. Major abnormalities and defects of the genitalia, such as a change of sex (P64.5). A history thereof, or dysfunctional residuals from surgical correction of these conditions.

16. Urinary System The causes for rejection for appointment, enlistment, and induction are:

a. Cystitis (595).

b. Urethritis (597).

c. Enuresis. (788.3) or incontinence of urine beyond age 12 (788.3).

d. Hematuria, Pyuria, or other findings indicative of urnnary tract disease (599).

e. Urethral stricture (598) or fistula (599.1).

f. Kidney.

(1) Absence of one kidney. Congenital (753.0) or acquired (593.89).

(2) Infections. Acute or chronic infections (590).

(3) Polycystic kidney (753.1). Confirmed history of such a condition.

(4) Horseshoe kidney (753.3).

(5) Hydronephrosis (591).

(6) Nephritis. Acute (580) or chronic (582).

(7) Proteinuria (791). Under normal activity (at least 48 hours after strenuous exercise) greater than 200 mg/24 hours, or a protein to creatinine ratio greater than 0.2 in a random urine sample, unless nephrologic consultation determines the condition to be benign orthostatic proteinuria.

(8) Renal Calculus (592). Within the previous 12 months, recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time.

17. Head. The causes for rejection for appointment, enlistment, and induction are:

a. Injuries. Including severe contusions and other wounds of the scalp (920) and cerebral concussion (850), until a period of 3 months has elapsed. (See 3-D-27).

b. Deformities of the skull, face, or jaw (754.0). Such deformities of a degree that will prevent the individual from wearing a protective mask or military headgear.

c. Defects (756.0). Loss, or congenital absence of the bony substance of the skull not successfully corrected by reconstructive materials, or leaving residual defect in excess of one square inch (6.45cm) or the size of a 25-cent piece.

18. Neck. The causes of rejection for appointment, enlistment, and induction are:

a. Cervical ribs (756.2). If symptomatic, or so obvious that they are found on routine physical examination. (Detection based primarily on x-rays is not considered to meet this criterion.)

b. Congential cysts (744.4). Those cysts of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts.

c. Contraction (723.8). Contraction of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or military equipment, or is so disfiguring as to impair military bearing.

19. Heart. The causes for rejection for appointment, enlistment, and induction are:

a. All valvular heart diseases. Congenitial (746) or acquired (394), including those improved by surgery, except mitral valve prolapse and bicuspid aortic valve. Those latter two conditions are not reasons for rejection unless there is associated tachyarrhythmia, mitral regurgitation, aortic stenosis, insufficiency, or cardiomegaly.

b. Coronary heart disease (410).

c. Symptomatic arrhythmia or (electrocardiographic evidence of arrhythmia). A history of such condition.

(1) Supraventricular tachycardia (427.0). Or any dysrhythia originating from the atrium or sinoatrial node, such as atrial flutter, and atrial fibrillation unless there has been no recurrence during the preceding 2 years while off all medications. Premature atrial or ventricular contractions are disqualifying when sufficiently symptomatic to require treatment or result in physical or psychological impairment

(2) Ventricular Arrythmias (427.1). Those arrythmias including ventricular fibrillation, tachycardia, and multifocal premature ventricular contractions. Occasional asymptomatic premature ventricular contractions are not disqualifying.

(3) Ventricular Conduction disorders. Such disorders with left bundle branch block (426.2), Mobitz type II second degree AV block (426.12). third degree AV block (426.0). Wolff-Parkinson-White syndrome (426.7) and Lown-Ganong-Levine Syndrom (426.81) associated with an arrhythmia are also disqualifying.

(4) Conduction Disturbances. Conduction disturbances such as first degree AV block (426.11), left anterior hemiblock (426.2), right bundle branch block (426.4) or Mobitz type I second degree AV block (426.13) are disqualifying when symptomatic or associated with underlying cardiovascular disease.

d. Hypertrophy or dilatation of the heart (429.3).

e. Cardiomyopathy (425). Including myocarditis (422), or history of congestive heart failure (428) even though currently compensated.

f. Pericarditis (420).

g. Persistent tachycardia (785) (Resting pulse rate of 100 or greater).

h. Congenital anomalies of heart and great vessels (746). Except forcorrected patent ductus arteriosus.

20. Vascular System. The causes for rejection for appointment, enlistment, and induction are:

a. Abnormalities of the arteries and blood vessels (447). Abnormalities including aneurysms (442) even if repaired, atherosclerosis (440), and arteritis (446).

b. Hypertensive Vascular Disease (401). Such disease evidenced by the average of three consecutive averaged diastolic blood pressure measurements greater than 90 mmHg or three consecutive averaged systolic blood pressures greater than 140 mmHg at any age. High blood pressure requiring medication or a history of treatment including dietary restriction is also disqualifying.

c. Pulmonary (415) or systemic embolization (444).

d. Peripheral Vascular Disease. Including diseases such as Raynaud's phenomenon (443).

e. Vein diseases. Vein disease including recurrent thrombophlebitis (451), thrombophlebitis during the preceding year, or any evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration (454).

21. Height. The causes for rejection for appointment, enlistment, and induction in relation to height standards are established by each of the military Services. Standards for the Coast Guard are:

a. Men: Height below 152.5 cm (60 inches) or over 198 cm (78 inches).

b. Women: Height below 152.5 cm (60 inches) or over 198 cm (78 inches).

22. Weight. The causes for rejection for appointment, enlistment, and induction in relation to weight standards are contained in COMDTINST 1020.8(series).

23. Body Build. The cause for rejection for appointment, enlistment, and induction are:

a. Congenital malformation of bones and joints. (See 3-D-9 through 3-D-11).

b. Deficient muscular development that would interfere with the completion of required training.

c. Evidence of congenital asthenia or body build that would interfere with the completion of required training.

24. Lungs, Chest Walls, Pleura, and Mediastinum. The causes for rejection for appointment, enlistment, and induction are:

a. Abnormal elevation of the diaphragm (793.2). Such elevation may be either side.

b. Abscess of the lung (513).

c. Acute infectious process of the lung (518). Until cured.

d. Asthma (493). Including reactive airway disease, exercise-induced bronchospasm, or asthmatic bronchitis, reliably diagnosed at any age. Reliable diagnostic criteria shall consist of any of the following elements.

(1) Substantiated history of cough, wheeze, and/or dyspnea which persists or recurs over a prolonged period of time, generally more than 6 months.

(2) If the diagnosis of asthma is in doubt, a test for reversible airflow obstruction (greater than a 15 percent increase in FEV I following administration of an inhaled bronchodilator), or airway hyperreactivity (exaggerated decrease in airflow induced by a standard bronchoprovocational challenge such as methacholine inhalation or a demonstration of exercise-induced bronchospasms) must be performed.

e. Bronchitis (490). That which is chronic, symptoms over 3 months occurring at least twice a year.

f. Bronchiectasis (494).

g. Bronchopleural fistula (510).

h. Bullous or generalized pulmonary emphysema (492).

i. Chronic Mycotic disease (117) of the lung. Such diseases including coccidioidomycosis.

j. Chest Wall Malformation (754) or fracture (807). Those conditions that interfere with vigorous physical exertion.

k. Empyema (510). That condition includes residual pleural effusion (511.9), or unhealed sinuses of chest wall (510).

l. Extensive pulmonary fibrosis (515).

m. Foreign body in lung, trachea or bronchus (934).

n. Lobectomy. With residual pulmonary disease or removal of more than one lobe (P32.4).

o. Pleurisy with effusion (511.9). That condition occurring within the previous 2 years if known origin, or unknown origin.

p. Pneumothorax (512). That condition occurring during the year preceding examination if due to simple trauma or surgery, during the 3 years preceding examination from spontaneous origin. Recurrent spontaneous pneumothorax after surgical correction or pleural sclerosis.

q. Sarcoidosis. (See 3-D-35-j.)

r. Silicone breast implants. Those encapsulated (85.53P), if less than 9 months since surgery or with symptomatic complications.

s. Tuberculous lesions. (see subsection 3-D-35-l.)

25. Mouth. The cause for rejection for appointment, enlistment, and induction are:

a. Cleft lip or palate defects (749). Unless satisfactorily repaired by surgery.

b. Leukoplakia (528.6).

26. Nose and Sinuses. The causes for rejection of appointment, enlistment, and induction are:

a. Allergic manifestations.

(1) Atrophic rhinitis. (472).

(2) Allergic rhinitis, vasomotor rhinitis (477). If moderate or severe and not controlled by oral medications, desensitization, or topical corticosteroid medication.

b. Vocal cord paralysis (478.3). Or, symptomatic disease of the larynx (478.7).

c. Anosmia or parosmia (352).

d. Epistaxis (784.7). Recurrent condition.

e. Nasal polyps (471). Unless surgery was performed at least 1 year before examination.

f. Perforation of nasal septum (478.1). If symptomatic or progressive.

g. Sinusitis (461). Acute.

h. Sinusitis chronic (473). Such condition exists when evidenced by chronic purulent nasal discharge, hyperplastic changes of the nasal tissue, symptoms requiring frequent medical attention, or x-ray findings.

i. Larynx ulceration, polyps, or granulation tissue, or chronic laryngitis (476).

j. Tracheostomy (V44), or tracheal fistula (530.84).

k. Deformities or conditions (750.9). Those of the mouth, tongue, palate, throat, pharynx, larynx, and nose that interfere with chewing, swallowing, speech, or breathing.

l. Pharyngitis (462) and nasopharyngitis (472.2). Chronic conditions.

27. Neurological Disorders. The causes for rejection for appointment, enlistment, and induction are:

a. Cerebrovascular conditions. Any history of subarachnoid (430) or interacerebral (431) hemorrhage, vascular insufficiency, aneurysm or arteriovenous malformation (437).

b. Congenital malformations (742). If associated with neurological manifestations, or if known to be progressive; meningocele (741), even if uncomplicated.

c. Degenerative and hereditodegenerative disorders. Those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), and peripheral nerves or muscles (337).

d. Recurrent headaches (784). Headaches of all types of sufficient severity or frequency as to interfere with normal function within the previous 3 years.

e. Head injury.

(1) Applicants with a history of head injury with:

(a) Late post-traumatic epilepsy (occurring more than 1 week after injury).

(b) Permanent motor or sensory deficits.

(c) Impairment of intellectual function.

(d) Alteration of personality.

(e) Central nervous system shunts.

(2) Applicants with a history of severe closed head injury are unfit for a period of at least 5 years after the injury. After 5 years they may be considered fit if complete neurological and neuropsychological evaluation shows no residual dysfunction or complications. Applicants with a history of severe penetrating head injury are unfit for a period of at least 10 years after the injury. After 10 years they may be considered fit if complete neurological and neuropsychological evaluation shows no residual dysfunctionn or complications. Severe head injuries are defined by one or more of the following.

(a) Unconsciousness or amnesia. Conditions alone or in combination of 24-hours duration or longer.

(b) Depressed skull fracture.

(c) Laceration or contusion of the dura mater or the brain.

(d) Epidural, subdural, subarachnoid or intracerebral hematoma.

(e) Associated abscess or meningitis.

(f) Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.

(g) Focal neurologic signs.

(h) Radiographic evidence of retained metallic or bony fragments.

(i) Leptomeningeal cysts or arteriovenous fistula.

(j) Early post-traumatic seizure(s) that occur only within 1 week of injury but more than 30 minutes after injury.

(3) Applicants with a history of moderate head injury. Those applicants are unfit for a period of at least 2 years after the injury. After 2 years they may considered fit if complete neurological evaluation shows no residual dysfunction or complications. Moderate head injuries are defined as

unconsciousness or amnesia, alone or in combination, of 1 to 24 hours duration, or linear skull fracture.

(4) Applicants with a history of mild head injury. Those applicants with mild head injuries, as defined by a period of unconsciousness or amnesia, alone or in combination, of 1 hour or less, are unfit for at least 1 month after the injury. After 1 month they be acceptable if complete neurological evaluation shows no residual dysfunction or complications.

(5) Persistent post-traumatic seizure. Such conditions, as manifested by headache, vomiting, disorientation, spatial disequilibrium, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome, are disqualifying until full recovery has been confirmed by complete neurological and neuropsychological evaluation.

f. Infectious diseases.

(1) Meningitis (322), encephalitis (323), or poliomyelitis (045). Such diseases occurring within 1 year before examination, or if there are residual neurological defects.

(2) Neurosyphilis (094). That disease of any form (general paresis, tabes dorsalis, meningovascular syphilis).

g. Narcolepsy (347), sleep apnea syndrome (780.57).

h. Paralysis, weakness, lack of coordination, chronic pain, or sensory disturbances (344).

i. Epilepsy (345). That epilepsy occurring beyond the age of 5 years, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal electroencephalogram (EEG). All such applicants shall have a current neurology consultation with current EEG results. EEG may be requested by reviewing authority

j. Chronic disorders. Disorders such as myasthenia gravis (358), and multiple sclerosis (340).

k. Central nervous system shunts of all kinds (V45.2).

28. Disorders with Psychotic Features. The causes for rejection for appointment, enlistment, and induction are a history of a disorders with psychotic features (295).

29. Neurotic, Anxiety, Mood, Somatoform, Dissociative, or Factitious Disorders (300). The causes for rejection for appointment, enlistment, and induction are:

a. History of such disorders resulting in any or all of the below:

(1) Admission to a hospital or residential facility.

(2) Care by a physician or other mental health professional for more than 6 months.

(3) Symptoms or behavior of a repeated nature that impaired social, school, or work efficiency.

30. Personality, Conduct, and Behavior Disorders. The cause for rejection for appointment, enlistment, and induction are a history of such disorder resulting in any or all of the below:

a. Personality (301), Conduct (312), or Behavior (313) disorders. Disorders as evidenced by frequent encounters with law enforcement agencies, antisocial attitudes or behavior that while not sufficient cause for administrative rejection, are tangible evidence of impaired capacity to adapt to military service.

b. Personality (301), Conduct (312), or Behavior (313) disorders. Where it is evident by history, interview, or psychological testing that the degree of immaturity, instability, personality inadequacy, impulsiveness, or dependency will seriously interfere with adjustment in the Coast Guard as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow workers, and other social groups.

c. Other behavior disorders including, but not limited to, conditions such as the following:

(1) Authenticated evidence of functional enuresis (307.6) or encopresis (307.7).

(2) Sleepwalking (307.6).

(3) Eating disorders that are habitual or persistent (307.1 or 307.5) occurring beyond age 12.

(4) Stammering (307.0) of such a degree that the individual is often unable to express himself or herself clearly, or to repeat commands.

d. Specific academic skills defects. Chronic history of academic skills (314) or perceptual defects (315), secondary to organic or functional mental disorders that interfere with work or school after age 12. Current use of medication to improve or maintain academic skills.

e. Suicide. History of attempted suicide or other suicidal behavior (300.9).

31. Psychosexual Conditions. The causes for rejection for appointment, enlistment, or induction are transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias (320).

32. Substance Misuse. The causes for rejection for appointment, enlistment, or induction are:

a. Alcohol dependence (303).

b. Drug dependence (304).

c. Non-dependent use of drugs characterized by the following:

(1) The evidence of use of any controlled, hallucinogenic, or other intoxicating substance at the time of examination (305), when the use cannot be accounted for as a result of a prescription by a physician.

(2) Documented misuse or abuse of any controlled substance (including cannabinoids or anabolic steroids) requiring professional care (305).

(3) The repeated self-procurement and self-administration of any drug or chemical substance, including cannabinoids or anabolic steroids, with such frequency that it appears that the applicant has accepted the use of or reliance on those substances as part of his or her pattern of behavior (305).

(4) The use of LSD (305.3) in a 2-year period before examination.

d. Alcohol abuse (305). Use of alcoholic beverages, which leads to misconduct, unacceptable social behavior, poor work or academic performance, impaired physical or mental health, lack of financial responsibility, or a disrupted personal relationship.

33. Skin and Cellular Tissues. The causes for rejection for appointment, enlistment, and induction are:

a. Acne (706). Severe acne, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by or interfere with the wearing of military equipment and not amenable to treatment. Patients under treatment with isotretinoin (Accutane) are medically unacceptable until 8 weeks after completion of a course of therapy.

b. Atopic dermatitis (691) or eczema (692). Occurring with active or residual lesions in characteristic areas (face and neck, antecubital and/or popliteal fossae, occasionally wrists and hands), or documented history thereof after the age of 8.

c. Contact dermatitis (692.4). Dermatitis especially involving rubber or other materials used in any type of required protective equipment.

d. Cysts.

(1) Cysts (706.2), other than pilonidal. Cysts of such a size or location as to interfere with the normal wearing of military equipment.

(2) Cysts, pilonidal (685). Pilonidal cysts evidenced by the presence of a tumor mass or discharging sinus. History of pilonidal cystectomy within 6 months before examination.

e. Dermatitis factitia (698.4).

f. Bullous dermatoses (694). Conditions such as dermatitis herpetiformis, pemphigus, and epidermolysis bullosa.

g. Chronic lymphedema (457).

h. Fungus infections (117). Systemic or superficial types, if extensive and not amenable to treatment.

i. Furunculosis (680). Extensive, recurrent, or chronic.

j. Hyperhidrosis of hands or feet (780.8). Chronic or severe.

k. Ichthyosis. Or other congenital (757) or acquired (216) anomalies of the skin, such as nevi or vascular tumors that interfere with function or are exposed to constant irritation.

l. Keloid formation (701-4). If the tendency is marked or interferes with the wearing of military equipment.

m. Leprosy (030.9).

n. Lichen planus (697.0).

o. Neurofibromatosis (Von Recklinghausen's disease) (237.7).

p. Photosensitivity (692.72). Any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria; any dermatosis aggravated by sunlight such as lupus erythematosus.

q. Psoriasis (696.1). Unless mild by degree, not involving nail-pitting, and not interfering with the wearing of military equipment or clothing.

r. Radiodermatitis (692.82).

s. Scars (709.2). Scars so extensive, deep, or adherent that they may interfere with the wearing of military clothing or equipment, exhibit a tendency to ulcerate, or interfere with function. Includes scars at skin graft donor or recipient sites if in an area susceptible to trauma.

t. Scleroderma (710.1).

u. Tattoos (709.9). Entrance may be denied to any applicant who has a tattoo or other applied body marking contrary to the core values of the Coast Guard in accordance with “Tattoo and Body Markings Policy for CG Accessions, COMDTINST 1000.1.”

v. Urticaria (708.8). Chronic.

w. Warts. Plantar warts (078.19) that are symptomatic.

x. Xanthoma (272.2). If disabling or accompanied by hyperlipemia.

y. Any other chronic skin disorder of a degree or nature such as Dysplastic nevi syndrom (448.1), which requires frequent outpatient treatment or hospitalization, or interferes with the satisfactory performance of duty.

34. Spine and Sacroiliac Joints. The causes for rejection for appointment, enlistment, and induction are:

a. Arthritis (720). (see 3-D-11.a)

b. Complaint of a disease or injury of the spine or sacroiliac joints, with or without objective signs, that has prevented the individual from successfully following a physically active vocation in civilian life (724), or that is associated with pain referred to the lower extremities, muscular spasms, postural deformities, or limitation of motion.

c. Deviation or curvature of spine (737) from normal alignment, structure, or function if:

(1) It prevents the individual from following a physically active vocation in civilian life.

(2) It interferes with the wearing of a uniform or military equipment.

(3) It is symptomatic and associated with positive physical finding(s) and demonstrable by x-ray.

(4) There is lumbar scoliosis greater than 20 degrees, thoracic scoliosis over 20 degrees, and kyphosis or lordosis greater than 55 degrees when measured by the Cobb method.

d. Fusion. Congenital fusion (756.15), involving more than two vertebrae. Any surgical fusion (81.0P).

e. Healed fractures or dislocations of the vertebrae (805). A compression fracture, involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 1 year before examination and the applicant is asymptomatic. A history of fractures of the transverse or spinous processes is not disqualifying if the applicant is asymptomatic.

f. Juvenile epiphysitis (732.6). That with any degree of residual change indicated by x-ray or kyphosis.

g. Ruptured nucleus pulposus (722). Herniation of intervertebral disk or surgery for this condition.

h. Spina bifida (741). When symptomatic, or there is more than one vertebra involved, dimpling of the overlying skin, or a history of surgical repair.

i. Spondylolysis (756.1) and Spondylolisthesis (738.4).

j. Weak or painful back (724). Back condition requiring external support; that is, corset or brace. Recurrent sprains or strains requiring limitation of physical activity or frequent treatment.

35. Systemic Diseases. The causes for rejection for appointment, enlistment, and induction are:

a. Amyloidosis (277.3).

b. Ankylosing spondylitis (720).

c. Eosinophilic granuloma (277.8). Eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, shall not be a cause for rejection once healing has occurred. All other forms of the histiocytosis X spectrum should be rejected.

d. Lupus erythematosus (710) and mixed connective tissue disease (710.9).

e. Polymyositis dermatomyositis complex (710).

f. Progressive systemic sclerosis (710). Condition including CRST variant. A single plaque of localized scleroderma (morphea) that has been stable for at least 2 years is not disqualifying.

g. Reiter's disease (099.3).

h. Rheumatoid arthritis (714).

i. Rhabdomyolysis (728.9).

j. Sarcoidosis (135). Unless there is substantiated evidence of a complete spontaneous remission of at least 2 years duration.

k. Sjogren's syndrome (710.2).

l. Tuberculosis (010).

(1) Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

(2) One or more reactivations.

(3) Residual physical or mental defects from past tuberculosis that will prevent the satisfactory performance of duty.

(4) Individuals with a past history of active tuberculosis more than 2 years prior to enlistment or induction, are qualified if they have received a complete course of standard chemotherapy for tuberculosis. In addition, individuals with a tuberculin reaction 10 mm or greater and without evidence of residual disease are qualified once they have been treated with chemoprophylaxis

(5) Vasculitis (466). Such as Bechet's, Wegener's granulomatosis polyarteritis nodosa.

36. General and Miscellaneous Conditions and Defects. The causes for rejection for appointment, enlistment, and induction are:

a. Allergic manifestations (995.0). A reliable history of anaphylaxis to stinging insects. Reliable history of a moderate to severe reaction to common foods, spices or food additives.

b. Any acute pathological condition. Those including acute communicable diseases, until recovery has occurred without sequelae.

c. Chronic metallic poisoning. Poisoning with lead, arsenic, or silver (985), or beryllium or manganese (985).

d. Cold injury (991). Residuals of injury; such as frostbite, chilblain, immersion foot, trench foot, deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.

e. Cold urticaria (708.2) and angiodema, hereditary angiodema (277.6).

f. Filariasis (125), Trypanosomiasis (086), Schistosomiasis (120).

g. Heat pyrexia (992) heatstroke (992), or sunstroke (992). Documented evidence of a predisposition (including disorders of sweat mechanism and a previous serious episode), recurrent episodes requiring medical attention, or residual injury (especially cardiac, cerebral, hepatic, and renal). Malignant Hyperthermia (995.89).

h. Industrial solvent and other chemical intoxication (982).

i. Motion sickness (994.6). An authenticated history of frequent, incapacitating motion sickness after the 12th birthday.

j. Mycotic (114) infection of internal organs.

k. Organ transplant recipient (V42).

l. Presence of HIV-1 or antibody (042). That presence confirmed by repeatedly reactive Enzyme-Linked Immunoassay (ELISA) serological test and positive immunoelectrophoresis (Western Blot) test, or other DoD approved screening and confirmatory test.

m. Reactive tests for syphilis (093). Test such as the RPR or VDRL followed by a reactive, confirmatory fluorescent treponemal antibody absorption (FTA-ABS) test unless there is a documented history of adequately treated syphilis. In the absence of clinical findings, the presence of reactive RPR or VDRL followed by a negative FTA-ABS test is not disqualifying if a cause for the false positive reaction can be identified and is not otherwise disqualifying.

n. Residual of tropical fevers. Fevers such as malaria (084) and various parastic or protozoan infestations that prevent the satisfactory performance of military duty.

o. Rheumatic fever (390). That condition during the previous 2 years, or any history or recurrent attacks; Sydenham's chorea at any age.

p. Sleep apnea (780.57).

37. Tumors and Malignant Diseases. The causes for rejection for appointment, enlistment, and induction are:

a. Benign tumors (M8000). Those that interfere with function, prevent wearing of the uniform or prtective equipment, shall require frequent specialized attention, or have a high malignant potential.

b. Malignant tumors (V10). Exception for basal cell carcinoma, removed with no residual. In addition, the following cases should be qualified, if on careful review they meet the following criteria:

(1) Individuals who have a history of childhood cancer and who have not received any surgical or medical cancer therapy for 5 years and are free of cancer

(2) Individuals with a history of Wilm's tumor and germ cell tumors of the testis treated surgically and/or with chemotherapy in childhood after a 2-year disease-free interval off all treatment.

(3) Individuals with a history of Hodgkins' disease treated with radiation therapy and/or chemotherapy and disease free off treatment for 5 years.

(4) Individuals with a history of large cell lymphoma after 2-years disease-free interval off all therapy.

c. Miscellaneous. Any condition that, in the opinion of the examining medical officer, will significantly interfere with the successful performance of military duty or training (796).

FIGURE 3-D-1

| EVALUATION FOR RISK OF HEAD INJURY SEQUELAE | | |
|---|---|---|
| DEGREE OF HEAD INJURY | MINIMUM | EVALUATION REQUIREMENTS |
| MILD | ONE MONTH | COMPLETE NEUROLOGICAL EXAMINATION BY A PHYSICIAN |
| MODERATE | TWO YEARS | COMPLETE NEUROLOGICAL EVALUATION BY A NEUROLOGIST OR INTERNIST<br>CT SCAN |
| SEVERE | FIVE YEARS FOR CLOSED HEAD TRAUMA<br><br>TEN YERS FOR PENETRATING HEAD TRAUMA | COMPLETE NEUROLOGICAL EVALUATION BY NEUROLOGIST OR NEUROSURGEON<br>CT SCAN<br>NEUROPSYCHOLOGICAL EVALUATION |

FIGURE 3-D-2

CLASSIFICATION AND COMPARATIVE NOMENCLATURE OF CERVICAL SMEARS

| Original | Classification | CIN System | Bethesda System |
|---|---|---|---|
| Class I: | No abnormal cells | Normal smear; | |
| Class II: | Atypical cells present below the level of cervical neoplasia | | Atypical squamous cells of undetermined significance |
| Class III: | Smear contains abnormal cells consistent with dysplasia | Mild dysplasia = CIN1<br>Moderate dysplasia = CIN2 | Low-grade SIL (Changes associated with HPV & CIN1) |
| Class IV | Smear contains abnormal cells consistent with carcinoma-in-situ | Severe dysplasia and carcinoma-in-situ = CIN3 | High-grade SIL (CIN2, CIN3, and carcinoma-in-situ) |
| Class V: | Smear contains abnormal cells consistent with carcinoma squamous cell carcinoma | | Squamous cell carcinoma |

Abbreviations: CIN = cervical intraepithelial neoplasia

Section A - SIL = squamous intraepithelial lesion

Section E Physical Standards for Programs Leading to Commission.

1. Appointment as Cadet, United States Coast Guard Academy.

a. Physical Examinations.

(1) Applicants are encouraged to review the physical standards as published in the Academy Bulletin with their private physician prior to submitting their application for cadet candidate. This review serves to rule out, at this stage of the potential cadet's processing, applicants who obviously will not meet the required physical standards for appointment. In some cases, the physician may recommend a complete physical examination. Inaccuracy in ascertaining defects and determining the candidate's physical status at the time of this review results in unnecessary work for the Coast Guard and disappointment to the candidate when defects are subsequently found during the formal physical examination.

(2) Candidates and their parents and sponsors are urged to refrain from requesting waivers for medical defects. The Coast Guard bases its decision to disqualify an individual on medical facts revealed in a thorough physical examination. Candidates unable to satisfy the minimum requirements are not suited for commission in the Regular Coast Guard, and consequently are not eligible for training at the Academy. A request for waiver for a medical defect invariably results in disappointment to all concerned.

(3) Two physical examinations are required:

(a) formal physical examination before appointment is tendered; and

(b) pretraining examination at the time of reporting to the Academy.

(4) Formal physical examinations prior to accepting of candidates must be performed by a U. S. Public Health Service, Navy, Army, Air Force, or Veteran's Administration medical officer authorized to perform each exam by Department of Defense Medical Examination Review Board (DODMERB). All candidates are instructed where to report for such examinations.

b. Physical Standards. All candidates for the Coast Guard Academy must meet the physical standards for enrollment as an officer candidate. DODMERB is reviewing authority.

c. Retention. The standards for retention of a cadet at the Academy are the same as those for enrollment as an officer candidate, except that the Superintendent of the Academy is authorized to establish physical fitness and weight control programs designed to have cadets maintain weight closer to the ideal than the standards stipulated elsewhere for Service personnel. These stricter goals during cadet years are intended to take advantage of the Academy's unique environment of rigorous physical activity combined with opportunities for diet control and weight monitoring.

These programs will instill lifelong behavior patterns to support the Service weight control standards.

2. Commissioning of Cadets. The preappointment physical examination of cadets in the graduating class should be held at least 6 months prior to acceptance of the commission. This physical examination should be conducted to determine physical fitness for commission in the Regular Service (section 3-D and 3-E) with recommendations made accordingly. Cadets should not be summarily disqualified for commissioning merely because they do not meet the standards for appointment as cadets provided that they may reasonably be expected to be physically capable of completing a full and effective Coast Guard career. In general, relatively minor defects that would be disqualifying for original commission direct from civilian life are not disqualifying for commission of a cadet in whom the Government has a considerable investment.

3. Enrollment as an Officer Candidate.

   a. Physical Examination. The physical examination for an officer candidate must be conducted by a medical officer and a dentist. Particular care must be exercised during the examination in order that candidates may not be rejected later as a result of reexamination at Officer Candidate School. A complete physical examination is given officer candidates upon arrival at OCS to determine medical fitness and freedom from disease. Physician Assistant Officer Candidates will only receive an initial OCS candidate physical.

   b. Physical Standards for Enrollment. The standards contained in section 3-D (section 3-F for enlisted OCS candidates), as modified below, are applicable for enrollment as an officer candidate. Conditions not enumerated, that in the medical examiner's opinion will not permit a full productive career, shall be recorded in detail with appropriate recommendations.

      (1) Distant Visual Acuity. Uncorrected visual acuity shall be not worse than20/400 in either eye provided that vision is correctable to 20/20 and that refractive error does not exceed plus or minus 8.0 diopters spherical equivalent (sphere + 1/2 cylinder), astigmatism does not exceed 3.00 diopters, and anisometropia does not exceed 3.50 diopters. Eyes must be free from any disfiguring or incapacitating abnormality and from acute or chronic disease. All personnel requiring corrective lenses shall wear them for the performance of duty.

      (2) Near visual acuity of any degree that does not correct to 20/40 in the better eye.

      (3) Normal color perception.

      (4) Teeth.

         (a) All candidates shall be given a Type II dental examination by a dental officer, as part of the pre-training physical examination.

         (b) Caries. No more than four teeth may exhibit multi-surface caries.

(c) Endodontics. The need for endodontic intervention on seven or more canals is disqualifying.

(d) Maxillary and Mandibular Bones. Malunited fractures of maxillary or mandibular bones and deformities of maxillary or mandibular bones interfering with mastication or speech are disqualifying. The presence of extensive necrosis or osseous lesions requiring surgical intervention are also disqualifying.

(e) Oral Tissues. Extensive loss of oral tissues that would prevent the replacement of missing teeth with a satisfactory prosthetic appliance is disqualifying. Unresolved oral inflammatory diseases are disqualifying. Hypertrophic, hyperplastic, or leukoplakic conditions of the soft tissue of the oral cavity may be disqualifying and will be considered on a case-by-case basis.

(f) Periodontal Disease. The presence of advanced periodontal disease is disqualifying.

(g) Serviceable Teeth. A sufficient number of teeth, natural or artificial, in functional occlusion to assure satisfactory incision, mastication, and phonation are required. The minimum requirement is edentulous upper and lower jaws corrected by full dentures. A requirement for placement of a prosthesis to meet the above requirements is disqualifying.

(h) Temporomandibular Joint. Current symptoms and/or history of chronic temporomandibular joint dysfunction is disqualifying (see also section 3-D-16.b).

4. Commissioning of Officer Candidates.

a. The physical examination given upon arrival at OCS precludes the need for a commissioning physical examination providing there has been no intervening change in physical status and a visual acuity and color perception examination are given prior to actual commissioning.

b. The physical standards for commissioning are the same as for enrollment as an officer candidate. Final determination as to physical fitness for commissioning is made by the Commandant.

5. Direct Commission in the Coast Guard Reserve.

a. Nonaviator. The physical examination and standards for direct commission in the Reserve are the same for enrollment of officer candidates, except that Ready Reserve Direct Commission (RRDC) examinations must be within 24 months prior to the date of execution of the Acceptance and Oath of Office (CG-9556).

b. Aviator. Candidates for direct commission in the Reserve as aviators must obtain an aviation physical examination from a currently qualified uniformed services flight

surgeon or AMO within the last 12 months. The candidate must meet the standards for Class I, contained in section 3-G.

6. Direct Commission of Licensed Officers of U. S. Merchant Marine.

   a. Physical Examination. Two physical examinations are required: a preliminary physical at the time of the written examination; and a preappointment physical examination taken by successful candidates within six months of actual commission. The physical examination must be conducted by a medical officer of the uniformed services on active duty. Final determination of physical fitness will be made by the Commandant.

   b. Physical Standards. The physical standards for direct commission of Licensed Officers of the U. S. Merchant Marine are the same as for enrollment of officer candidates. All these standards must be met without waiver.

7. Appointment to Warrant Grade.

   a. Physical Examination. A complete physical examination is required within 12 months prior to appointment to Warrant Officer, except that physical examinations for members of the Coast Guard Ready Reserve must be within 24 months prior to the date of execution of the Acceptance and Oath of Office (CG-9556).

   b. Physical Requirements. The physical standards for appointment of Coast Guard members to Warrant Officer are the same as for retention of officers in the regular Coast Guard. See section 3-F for the standards. The physical standards for all other applicants are the same as for enrollment of officer candidates.

Section F Physical Standards Applicable to All Personnel (Regular and Reserve) For: Reenlistment; Enlistment of Prior Service USCG Personnel; Retention; Overseas Duty; and Sea Duty.

1. General Instructions.

   a. Scope. This section establishes specific physical standards applicable to all personnel (regular and reserve) for:

      (1) enlistment/reenlistment of prior service USCG personnel within 6 months of discharge from active duty in the Regular Coast Guard;

      (2) retention;

      (3) overseas duty; and

      (4) sea duty.

   b. Physical Examinations. Physical examinations should be conducted by at least one medical and one dental officer of the uniformed services or by contract physician/dentist.

   c. Fitness for Duty. Members are ordinarily considered fit for duty unless they have a physical impairment (or impairments) that interferes with the performance of the duties of their grade or rating. A determination of fitness or unfitness depends upon the individual's ability to reasonably perform those duties. Members considered temporarily or permanently unfit for duty shall be referred to an Initial Medical Board for appropriate disposition.

2. Use of List of Disqualifying Conditions and Defects. This section lists certain medical conditions and defects that are normally disqualifying. However, it is not an all-inclusive list. Its major objective is to achieve uniform disposition of cases arising under the law, but it is not a mandate that possession of one or more of the listed conditions or physical defects means automatic retirement or separation. The listed conditions or defects (and any other not listed) considered as disqualifying shall be referred to an Initial Medical Board, or waiver requested, as appropriate. See additional guidance in paragraphs 3-B-6 and 3-B-7 concerning separation physicals.

3. Head and Neck.

   a. Loss of substance of the skull. With or without prosthetic replacement when accompanied by moderate residual signs and symptoms.

   b. Torticollis (wry neck). Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

4. Esophagus, Nose, Pharynx, Larynx, and Trachea.

a. Esophagus.

(1) Achalasia. Manifested by dysphagia (not controlled by dilation), frequent discomfort, inability to maintain normal vigor and nutrition, or requiring frequent treatment.

(2) Esophagitis. Persistent and severe.

(3) Diverticulum of the esophagus. Of such a degree as to cause frequent regurgitation, obstruction and weight loss, that does not respond to treatment.

(4) Stricture of the esophagus. Of such a degree as to almost restrict diet to liquids, require frequent dilation and hospitalization, and cause difficulty in maintaining weight and nutrition.

b. Larynx.

(1) Paralysis of the larynx. Characterized by bilateral vocal cord paralysis seriously interfering with speech or adequate airway.

(2) Stenosis of the larynx. Causing respiratory embarrassment upon more than minimal exertion.

(3) Obstruction edema of glottis. If chronic, not amenable to treatment and requiring tracheotomy.

c. Nose, Pharynx, Trachea.

(1) Rhinitis. Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting and concomitant severe headaches.

(2) Sinusitis. Severe and chronic that is suppurative, complicated by polyps, and does not respond to treatment.

(3) Trachea. Stenosis of trachea that compromises airflow to more than a mild degree.

5. Eyes.

a. Diseases and Conditions.

(1) Active eye disease. Or any progressive organic disease regardless of the stage of activity, that is resistant to treatment and affects the distant visual acuity or visual field so that:

(a) distant visual acuity does not meet the standards; or

(b) the diameter of the field of vision in the better eye is less than $20^{o}$.

(2) Aphakia, bilateral. Regardless of lens implant(s).

(3) Atrophy of optic nerve.

(4) Glaucoma. If resistant to treatment, or affecting visual fields, or if side effects of required medications are functionally incapacitating.

(5) Diseases and infections of the eye. When chronic, more than mildly symptomatic, progressive and resistant to treatment after a reasonable period.

(6) Ocular manifestations of endocrine or metabolic disorders. Not disqualifying, per se; however, residuals or complications, or the underlying disease may be disqualifying.

(7) Residuals or complications of injury. When progressive or when reduced visual acuity or fields do not meet the standards.

(8) Retina, detachment of.

(a) Unilateral.

1 When visual acuity does not meet the standards.

2 When the visual field in the better eye is constricted to less than $20^{o}$.

3 When uncorrectable diplopia exists.

4 When detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.

(b) Bilateral. Regardless of etiology or results of corrective surgery.

b. Vision.

(1) Aniseikonia. Subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by iseikonic lenses.

(2) Binocular diplopia. Which is severe, constant, and in zone less than $20^{o}$ from the primary position.

(3) Hemianopsia. Of any type, if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not normally disqualifying.

(4) Night blindness. Of such a degree that the individual requires assistance in any travel at night.

(5) Visual Acuity.

(a) Visual acuity that cannot be corrected to at least 20/50 in the better eye.

(b) Complete blindness or enucleation of an eye.

(c) When vision is correctable only by the use of contact lenses or other corrective device (telescope lenses, etc.).

(6) Visual Fields. When the visual field in the better eye is constricted to less than $20^{o}$.

(7) Color Perception. Normal color perception is required for retention of commissioned officers (certain warrant officer specialties do not require normal color perception) and selected ratings [See the Personnel Manual,COMDTINST M1000.6 (series) and Chapter 5-C-12]. Retesting for color perception is not required if results of previous tests are documented in the health record, and there has been no history of a change in color vision.

c. Corneal Refractive Surgery.

(1) The refractive surgery procedures radial keratotomy (RK),and intracorneal rings (ICR) are disqualifying and not waiverable.

(2) Photorefractive keratectomy (PRK) and laser in-situ keratomileusis (LASIK) are disqualifying for aviation duty, landing signal officer duty and not waiverable.

(3) LASIK is disqualifying for diving duty and not waiverable.

(4) Photorefractive keratectomy (PRK) is not disqualifying for non-aviation members, including diving personnel, and does not require a waiver if the following conditions are met:

(a) Must follow guidelines for elective health care contained in 2.A.6.

(b) There must be post surgical refractive stability defined as less than 0.50 diopter change over two separate exams at least three months apart.

(c) Must meet all vision standards in 3-F.5.b (divers must meet vision standards in 3-H.2.h). If the member is unable to meet these standards they will be considered for separation as outlined in the Physical Disability Evaluation System, COMDTINST M1850.2(series).

(5) LASIK is not disqualifying for non-aviation personnel, excluding diving personnel and does not require a waiver as long as the following conditions are met:

(a) Must follow guidelines for elective health care contained in 2.A.6.

(b) There must be post surgical refractive stability defined as less than 0.50 diopter change over two separate exams at least three months apart.

(c) Must meet all vision standards in 3-F.5.b. If the member is unable to meet these standards they will be considered for separation as outlined in the Physical Disability Evaluation System, COMDTINST M1850.2(series).

6. Ears and Hearing.

a. Ears.

(1) Infections of the external auditory canal. Chronic and severe, resulting in thickening and excoriation of the canal, or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization.

(2) Malfunction of the acoustic nerve. Evaluate hearing impairment.

(3) Mastoiditis, chronic. Constant drainage from the mastoid cavity, requiring frequent and prolonged medical care.

(4) Mastoidectomy. Followed by chronic infection with constant or recurrent drainage requiring frequent or prolonged medical care.

(5) Meniere's Syndrome. Recurring attacks of sufficient frequency and severity as to interfere with satisfactory performance of military duty, or require frequent or prolonged medical care.

(6) Otitis Media. Moderate, chronic, suppurative, resistant to treatment, and necessitating frequent or prolonged medical care.

b. Hearing. Retention will be determined on the basis of ability to perform duties of grade or rating.

7. Lungs and Chest Wall.

a. Tuberculous Lesions. See chapter 7 of this Manual.

(1) Pulmonary tuberculosis.

(a) When an active duty member's disease is found to be not incident to military service, or when treatment and return to useful duty will probably require more than 15 months, including an appropriate period of convalescence, or if expiration of service will occur before completion of period of hospitalization. (Career members who express a desire to reenlist after treatment may extend their enlistment to cover period of hospitalization.)

(b) When a Reservist not on active duty has TB that will probably require treatment for more that 12 to 15 months including an appropriate period of convalescence before being able to perform full-time military duty. Individuals who are retained in the Reserve while undergoing treatment may not be called or ordered to active duty (including mobilization), active duty for training, or inactive duty training during the period of treatment and convalescence.

b. Nontuberculous Conditions. Pulmonary diseases, other than acute infections, must be evaluated in terms of respiratory function, manifested clinically by measurements

that must be interpreted as exertional or altitudinal tolerance. Symptoms of cough, pain, and recurrent infections may limit a member's activity. Many of the conditions listed below may coexist and in combination may produce unfitness.

(1) Atelectasis, or massive collapse of the lung. Moderately symptomatic with paroxysmal cough at frequent intervals throughout the day, or with moderate emphysema, or with residuals or complications that require repeated hospitalization.

(2) Bronchial Asthma. Associated with emphysema of sufficient severity to interfere with the satisfactory performance of duty, or with frequent attacks not controlled by inhaled or oral medications, or requiring oral corticosteroids more than twice a year.

(3) Bronchiectasis or bronchiolectasis. Cylindrical or saccular type that is moderately symptomatic, with productive cough at frequent intervals throughout the day, or with moderate other associated lung disease to include recurrent pneumonia, or with residuals or complications that require repeated hospitalization.

(4) Bronchitis. Chronic, severe persistent cough, with considerable expectoration, or with moderate emphysema, or with dyspnea at rest or on slight exertion, or with residuals or complications that require repeated hospitalization.

(5) Cystic disease of the lung, congenital. Involving more than one lobe of a lung.

(6) Diaphragm, congenital defect. Symptomatic.

(7) Hemopneumothorax, hemothorax, or pyopneumothorax. More than moderate pleuritic residuals with persistent underweight, or marked restriction of respiratory excursion and chest deformity, or marked weakness and fatigability on slight exertion.

(8) Histoplasmosis. Chronic and not responding to treatment.

(9) Pleurisy, chronic or pleural adhesions. Severe dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions and demonstrable moderate reduction of pulmonary function.

(10) Pneumothorax, spontaneous. Repeated episodes of pneumothorax not correctable by surgery.

(11) Pneumoconiosis. Severe with dyspnea on mild exertion.

(12) Pulmonary calcification. Multiple calcifications associated with significant respiratory embarrassment or active disease not responsive to treatment.

(13) Pulmonary emphysema. Marked emphysema with dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

(14) Pulmonary fibrosis. Linear fibrosis or fibrocalcific residuals that cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

(15) Pulmonary sarcoidosis. If not responding to therapy and complicated by demonstrable moderate reduction in pulmonary function.

(16) Stenosis, bronchus. Severe stenosis associated with repeated attacks of bronchopulmonary infections requiring frequent hospitalization.

c. Surgery of the Lungs and Chest. Lobectomy. If pulmonary function (ventilatory tests) is impaired to a moderate degree or more.

8. Heart and Vascular System.

a. Heart.

(1) Arrhythmias. Associated with organic heart disease, or if not adequately controlled by medication or if they interfere with satisfactory performance of duty.

(2) Arteriosclerotic disease. Associated with congestive heart failure, repeated anginal attacks, or objective evidence of myocardial infarction.

(3) Endocarditis. Bacterial endocarditis resulting in myocardial insufficiency or associated with valvular heart disease.

(4) Heart block. Associated with other symptoms of organic heart disease or syncope (Stokes-Adams Syndrome).

(5) Myocarditis and degeneration of the myocardium. Myocardial insufficiency resulting in slight limitation of physical activity.

(6) Pericarditis.

(a) Chronic constrictive pericarditis unless successful remedial surgery has been performed.

(b) Chronic serous pericarditis.

(7) Rheumatic valvulitis and valvular heart disease. Cardiac insufficiency at functional capacity and therapeutic level of class IIC or worse, American Heart Association. A diagnosis made during the initial period of service or enlistment that is determined to be a residual of a condition that existed prior to entry in the service is disqualifying regardless of severity.

b. Vascular System.

(1) Arteriosclerosis obliterans. When any of the following pertain:

(a) intermittent claudication of sufficient severity to produce pain and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest; or

(b) objective evidence of arterial disease with symptoms of claudication, ischemic chest pain at rest, or with gangrenous or permanent ulcerative skin changes in the distal extremity; or

(c) involvement of more than one organ system or anatomic region (the lower extremities comprise one region for this purpose) with symptoms of arterial insufficiency.

(2) Congenital anomalies. Coarctation of aorta and other congenital anomalies of the cardiovascular system unless satisfactorily treated by surgical correction.

(3) Aneurysms. Aneurysm of any vessel not correctable by surgery and producing limiting symptomatic conditions precluding satisfactory performance of duty. Aneurysm corrected by surgery but with residual limiting symptomatic conditions that preclude satisfactory performance of duty.

(a) Satisfactory performance of duty is precluded because of underlying recurring or progressive disease producing pain, dyspnea, or similar symptomatic limiting conditions.

1 reconstructive surgery including grafts, when:prosthetic devices are attached to or implanted in the heart; and

2 unproven procedures have been accomplished and the patient is unable to satisfactorily perform duty or cannot be returned to duty under circumstances permitting close medical supervision.

(4) Periarteritis nodosa. With definite evidence of functional impairment.

(5) Chronic venous insufficiency (postphlebitic syndrome). When more than mild and symptomatic despite elastic support.

(6) Raynaud's phenomenon. Manifested by trophic changes of the involved part characterized by scarring of the skin or ulceration.

(7) Thrombophlebitis. When repeated attacks require such frequent treatment as to interfere with satisfactory performance of duty.

(8) Varicose veins. Severe and symptomatic despite therapy.

(9) Any condition requiring anti- thrombotic medication other than aspirin.

c. Miscellaneous.

(1) Erythromelalgia. Persistent burning pain in the soles or palms not relieved by treatment.

(2) Hypertensive cardiovascular disease and hypertensive vascular disease.

(a) Diastolic pressure consistently more than 90 mm Hg following an adequate period of therapy on an ambulatory status; or

(b) Any documented history of hypertension regardless of the pressure values if associated with one or more of the following:

1 cerebrovascular symptoms;

2 arteriosclerotic heart disease if symptomatic and requiring treatment;

3 kidney involvement, manifested by unequivocal impairment of renal function; or

4 grade III (Keith-Wagener-Barker) changes in the fundi.

(3) Rheumatic fever, active, with or without heart damage. Recurrent attacks.

(4) Residual of surgery of the heart, pericardium, or vascular system under one or more of the following circumstances:

(a) when surgery of the heart, pericardium, or vascular system results in inability of the individual to perform duties without discomfort or dyspnea;

(b) when the surgery involves insertion of a pacemaker, reconstructive vascular surgery employing exogenous grafting material; or

(c) similar newly developed techniques or prostheses, the individual is unfit.

9. Abdomen and Gastrointestinal System.

a. Defects and Diseases.

(1) Achalasia. Manifested by dysphagia not controlled by dilation with frequent discomfort, or inability to maintain normal vigor and nutrition.

(2) Amebic abscess residuals. Persistent abnormal liver function tests and failure to maintain weight and normal vigor after appropriate treatment.

(3) Biliary dyskinesia. Frequent abdominal pain not relieved by simple medication, or with periodic jaundice.

(4) Cirrhosis of the liver. Recurrent jaundice or ascites; or demonstrable esophageal varices or history of bleeding therefrom.

(5) Gastritis. Severe, chronic gastritis with repeated symptomatology and hospitalization and confirmed by gastroscopic examination.

(6) Hepatitis, chronic. When, after a reasonable time (1 to 2 years) following the acute stage, symptoms persist, and there is objective evidence of impaired liver function.

(7) Hernia.

(a) Hiatus hernia. Severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment.

(b) Other. If operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

(8) Ileitis, regional. (Crohn's disease); Except when responding well to ordinary treatment other than oral corticosteroids or immune-suppressant medications.

(9) Pancreatitis, chronic. Frequent severe abdominal pain; or steatorrhea or disturbance of glucose metabolism requiring hypoglycemic agents.

(10) Peritoneal adhesions. Recurring episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, and intractable constipation requiring frequent hospital admissions.

(11) Proctitis, chronic. Moderate to severe symptoms of bleeding, or painful defecation, tenesmus, and diarrhea, with repeated hospital admissions.

(12) Ulcer, peptic, duodenal, or gastric. Repeated incapacitation or absences from duty because of recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management, and supported by laboratory, x-ray, and endoscopic evidence of activity.

(13) Ulcerative colitis. Except when responding well to ordinary treatment other than oral corticosteroids or immune-suppressant medications.

(14) Rectum, stricture of. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, difficult bowel movements requiring the regular use of laxatives or enemas, or requiring repeated hospitalization.

b. Surgery.

(1) Colectomy, partial. When more than mild symptoms of diarrhea remain or if complicated by colostomy.

(2) Colostomy. When permanent.

(3) Enterostomy. When permanent.

(4) Gastrectomy.

(a) Total.

(b) Subtotal, with or without vagotomy, or gastrojejunostomy, with or without vagotomy, when, in spite of good medical management, the individual:

1 develops "dumping syndrome" that persists for 6 months postoperatively; or

2 develops frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively; or

3 continues to demonstrate significant weight loss 6 months postoperatively. Preoperative weight representative of obesity should not be taken as a reference point in making this assessment.

4 Not to be confused with "dumping syndrome," and not ordinarily considered as representative of unfitness are: postoperative symptoms such as moderate feeling of fullness after eating; the need to avoid or restrict ingestion of high carbohydrate foods; the need for daily schedule of a number of small meals with or without additional "snacks."

(5) Gastrostomy. When permanent.

(6) Ileostomy. When permanent.

(7) Pancreatectomy.

(8) Pancreaticoduodenostomy, pancreaticogastrostomy, pancreaticojejunostomy. Followed by more than mild symptoms of digestive disturbance, or requiring insulin.

(9) Proctectomy.

(10) Proctopexy, proctoplasty, proctorrhaphy, or proctotomy. If fecal incontinence remains after appropriate treatment.

10. Endocrine and Metabolic Conditions (Diseases).

a. Acromegaly. With function impairment.

b. Adrenal hyperfunction. That does not respond to therapy satisfactorily or where replacement therapy presents serious problems in management.

c. Adrenal hypofunction. Requiring medication for control.

d. Diabetes Insipidus. Unless mild, with good response to treatment.

e. Diabetes Mellitus. When requiring insulin or not controlled by oral medications.

f. Goiter. With symptoms of breathing obstruction with increased activity, unless correctable.

g. Gout. With frequent acute exacerbations in spite of therapy, or with severe bone, joint, or kidney damage.

h. Hyperinsulinism. When caused by a malignant tumor, or when the condition is not readily controlled.

i. Hyperparathyroidism. When residuals or complications of surgical correction such as renal disease or bony deformities preclude the reasonable performance of military duty.

j. Hyperthyroidism. Severe symptoms, with or without evidence of goiter, that do not respond to treatment.

k. Hypoparathyroidism. With objective evidence and severe symptoms not controlled by maintenance therapy.

l. Hypothyroidism. With objective evidence and severe symptoms not controlled by medication.

m. Osteomalacia. When residuals after therapy preclude satisfactory performance of duty.

11. Genitourinary System.

a. Genitourinary conditions.

(1) Cystitis. When complications or residuals of treatment themselves preclude satisfactory performance of duty.

(2) Dysmenorrhea. Symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than l day/month.

(3) Endometriosis. Symptomatic and incapacitating to degree that necessitates recurrent absences of more than 1 day/month.

(4) Hypospadias. Accompanied by chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings, and the condition is not amenable to treatment.

(5) Incontinence of urine. Due to disease or defect not amenable to treatment and so severe as to necessitate recurrent absences from duty.

(6) Menopausal syndrome, physiologic or artificial. With more than mild mental and constitutional symptoms.

(7) Strictures of the urethra or ureter. Severe and not amenable to treatment.

(8) Urethritis, chronic. Not responsive to treatment and necessitating frequent absences from duty.

b. Kidney.

(1) Calculus in kidney. Bilateral or symptomatic and not responsive to treatment.

(2) Congenital abnormality. Bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(3) Cystic kidney (polycystic kidney). When symptomatic and renal function is impaired, or if the focus of frequent infection.

(4) Glomerulonephritis, chronic.

(5) Hydronephrosis. More than mild, or bilateral, or causing continuous or frequent symptoms.

(6) Hypoplasia of the kidney. Associated with elevated blood pressure or frequent infections and not controlled by surgery.

(7) Nephritis, chronic.

(8) Nephrosis.

(9) Perirenal abscess. With residuals that preclude satisfactory performance of duty.

(10) Pyelonephritis or pyelitis. Chronic, that has not responded to medical or surgical treatment, with evidence of persistent hypertension, eyeground changes, or cardiac abnormalities.

(11) Pyonephrosis. Not responding to treatment.

c. Genitourinary and Gynecological Surgery.

(1) Cystectomy.

(2) Cystoplasty. If reconstruction is unsatisfactory or if residual urine persists in excess of 50 cc or if refractory symptomatic infection persists.

(3) Nephrectomy. When, after treatment, there is infection or pathology in the remaining kidney.

(4) Nephrostomy. If drainage persists.

(5) Oophorectomy. When, following treatment and convalescent period, there remain incapacitating mental or constitutional symptoms.

(6) Penis, amputation of.

(7) Pyelostomy. If drainage persists.

(8) Ureterocolostomy.

(9) Ureterocystostomy. When both ureters are markedly dilated with irreversible changes.

(10) Ureterocystostomy, cutaneous.

(11) Ureteroplasty.

(a) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for a nephrectomy.

(b) When bilateral, evaluate residual obstruction or hydronephrosis and consider unfitness on the basis of the residuals involved.

(12) Ureterosigmoidostomy.

(13) Ureterostomy. External or cutaneous.

(14) Urethrostomy. When a satisfactory urethra cannot be restored.

12. Extremities.

d. Upper.

(1) Amputations. Amputation of part or parts of an upper extremity equal to or greater than any of the following:

(a) a thumb proximal to the interphalangeal joints;

(b) two fingers of one hand; or

(c) one finger, other than the little finger, at the metacarpophalangeal joint and the thumb of the same hand at the interphalangeal joint.

(2) Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated in 3-F-EXHIBIT 1.

(a) Shoulder.

1 Forward elevation to 90° .

2 Abduction to 90° .

(b) Elbow

1 Flexion to 100° .

2 Extension to 60° .

(c) Wrist. A total range, extension plus flexion, of 15°

(d) Hand. For this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints.

1 An active flexor value of combined joint motions of 135° in each of two or more fingers of the same hand.

2 An active extensor value of combined joint motions of 75° in each of the same two or more fingers.

3 Limitation of motion of the thumb that precludes apposition to at least two finger tips.

(3) Recurrent dislocations of the shoulder. When not repairable or surgery is contraindicated

e. Lower.

(1) Amputations.

(a) Loss of a toe or toes that precludes the ability to run, or walk without a perceptible limp, or to engage in fairly strenuous jobs.

(b) Any loss greater than that specified above to include foot, leg, or thigh.

(2) Feet.

(a) Hallux valgus. When moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.

(b) Pes Planus. Symptomatic more than moderate, with pronation on weight bearing that prevents wearing military shoes, or when associated with vascular changes.

(c) Talipes cavus. When moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, or that prevents wearing a military shoe.

(3) Internal derangement of the knee. Residual instability following remedial measures, if more than moderate; or with recurring episodes of effusion or locking, resulting in frequent incapacitation.

(4) Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated in 3-F-EXHIBIT 2.

(a) Hip.

1 Flexion to 90° .

2 Extension to 0 .

(b) Knee.

1 Flexion to 90° .

2 Extension to 15°

(c) Ankle.

1 Dorsiflexion to 10°

2 Plantar Flexion to 10°

(5) Shortening of an extremity. Which exceeds two inches.

f. Miscellaneous.

(1) Arthritis.

(a) Due to infection. Associated with persistent pain and marked loss of function with x-ray evidence and documented history of recurring incapacity for prolonged periods.

(b) Due to trauma. When surgical treatment fails or is contraindicated and there is functional impairment of the involved joint that precludes satisfactory performance of duty.

(c) Osteoarthritis. Severe symptoms associated with impaired function, supported by x-ray evidence and documented history of recurrent incapacity for prolonged periods.

(d) Rheumatoid arthritis or rheumatoid myositis. Substantiated history of frequent incapacitating and prolonged periods supported by objective and subjective findings.

(e) Seronegative Spondylarthropaties. Severe symptoms associated with impaired function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods.

(2) Chondromalacia or Osteochondritis Dessicans. Severe, manifested by frequent joint effusion, more than moderate interference with function or with severe residuals from surgery.

(3) Fractures.

(a) Malunion. When, after appropriate treatment, there is more than moderate malunion with marked deformity or more than moderate loss of function.

(b) Nonunion. When, after an appropriate healing period, the nonunion precludes satisfactory performance of military duty.

(c) Bone fusion defect. When manifested by more than moderate pain or loss of function.

(d) Callus, excessive, following fracture. When functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

(4) Joints.

(a) Arthroplasty. With severe pain, limitation of motion and function.

(b) Bony or fibrous ankylosis. Severe pain involving major joints or spinal segments in an unfavorable position, or with marked loss of function.

(c) Contracture of joint. Marked loss of function and the condition is not remediable by surgery.

(d) Loose bodies within a joint. Marked functional impairment complicated by arthritis that precludes favorable treatment or not remediable by surgery.

(5) Muscles.

(a) Flaccid paralysis of one or more muscles, producing loss of function that precludes satisfactory performance of duty following surgical correction or if not remediable by surgery.

(b) Spastic paralysis of one or more muscles producing loss of function that precludes satisfactory performance of duty.

(6) Myotonia congenita.

(7) Osteitis deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.

(8) Osteoarthropathy, hypertrophic, secondary. Moderately severe to severe pain present with joint effusion occurring intermittently in one or multiple joints and with at least moderate loss of function.

(9) Osteomyelitis, chronic. Recurrent episodes not responsive to treatment, and involving the bone to a degree that interferes with stability and function.

(10) Tendon transplant. Fair or poor restoration of function with weakness that seriously interferes with the function of the affected part.

13. Spine, Scapulae, Ribs, and Sacroiliac Joints.

a. Congenital anomalies.

(1) Spina bifida. Demonstrable signs and moderate symptoms of root or cord involvement.

(2) Spondylolysis or spondylolisthesis. With more than mild symptoms resulting in repeated hospitalization or significant assignment limitation.

b. Coxa vara. More than moderate with pain, deformity, and arthritic changes.

c. Herniation of nucleus pulposus. More than mild symptoms following appropriate treatment or remediable measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty.

d. Kyphosis. More than moderate, or interfering with function, or causing unmilitary appearance.

e. Scoliosis. Severe deformity with over two inches of deviation of tips of spinous processes from the midline.

14. Skin and Cellular Tissues.

a. Acne. Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or other military equipment.

b. Atopic dermatitis. More than moderate or requiring periodic hospitalization.

c. Amyloidosis. Generalized.

d. Cysts and tumors. See section 3-F-20.

e. Dermatitis herpetiformis. Which fails to respond to therapy.

f. Dermatomyositis.

g. Dermographism. Interfering with satisfactory performance of duty.

h. Eczema, chronic. Regardless of type, when there is more than minimal involvement and the condition is unresponsive to treatment and interferes with the satisfactory performance of duty.

i. Elephantiasis or chronic lymphedema. Not responsive to treatment.

j. Epidermolysis bullosa.

k. Erythema multiforme. More than moderate and chronic or recurrent.

l. Exfoliative dermatitis. Chronic.

m. Fungus infections, superficial or systemic. If not responsive to therapy and interfering with the satisfactory performance of duty.

n. Hidradenitis suppurative and folliculitis decalvans.

o. Hyperhydrosis. Of the hands or feet, when severe or complicated by a dermatitis or infection, either fungal or bacterial, and not amenable to treatment.

p. Leukemia cutis and mycosis fungoides.

q. Lichen planus. Generalized and not responsive to treatment.

r. Lupus erythematous. Chronic with extensive involvement of the skin and mucous membranes and when the condition does not respond to treatment.

s. Neurofibromatosis. If repulsive in appearance or when interfering with satisfactory performance of duty.

t. Panniculitis. Relapsing febrile, nodular.

u. Parapsoriasis. Extensive and not controlled by treatment.

v. Pemphigus. Not responsive to treatment, and with moderate constitutional or systemic symptoms, or interfering with satisfactory performance of duty.

w. Psoriasis. Extensive and not controllable by treatment.

x. Radiodermatitis. If resulting in malignant degeneration at a site not amenable to treatment.

y. Scars and keloids. So extensive or adherent that they seriously interfere with the function of an extremity.

z. Scleroderma. Generalized, or of the linear type that seriously interferes with the function of an extremity or organ.

aa. Ulcers of the skin. Not responsive to treatment after an appropriate period of time or if interfering with satisfactory performance of duty.

bb. Urticaria. Chronic, severe, and not amenable to treatment.

cc. Xanthoma. Regardless of type, but only when interfering with the satisfactory performance of duty.

dd. Other skin disorders. If chronic, or of a nature that requires frequent medical care or interferes with satisfactory performance of military duty.

15. Neurological Disorders.

a. Amyotrophic sclerosis, lateral.

b. Atrophy, muscular, myelopathic. Includes severe residuals of poliomyelitis.

c. Atrophy, muscular. Progressive muscular atrophy.

d. Chorea. Chronic and progressive.

e. Convulsive disorders. (This does not include convulsive disorders caused by, and exclusively incident to the use of, alcohol.) Following a seizure, the member is NFFD, and will remain unfit until he/she is controlled with medications with no seizures for twelve months. A medical board is not required if the convulsive disorder is well controlled.

f. Friedreich's ataxia.

g. Hepatolenticular degeneration.

h. Migraine. Manifested by frequent incapacitating attacks or attacks that last for several consecutive days and unrelieved by treatment.

i. Multiple sclerosis.

j. Myelopathy transverse.

k. Narcolepsy, cataplexy, and hypersomnolence.

l. Obstructive Sleep Apnea. when not correctable by use of CPAP or surgical means.

m. Paralysis, agitans.

n. Peripheral nerve conditions.

(1) Neuralgia. When symptoms are severe, persistent, and not responsive to treatment.

(2) Neuritis. When manifested by more than moderate, permanent functional impairment.

o. Syringomyelia.

p. General. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, convulsions not controlled by medications, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance loss of consciousness, speech or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.

16. Psychiatric Disorders. (see section 5-B concerning disposition)

a. Disorders with Psychotic Features. Recurrent psychotic episodes, existing symptoms or residuals thereof, or recent history of psychotic reaction sufficient to interfere with performance of duty or with social adjustment.

b. Affective disorders; anxiety, somatoform, or dissociative disorders. Persistence or recurrence of symptoms sufficient to require treatment (medication, counseling, psychological or psychiatric therapy) for greater than 6 months. Regardless of the length of treatment, any member requiring medication for any of the above disorders must be removed from aviation duty. (Incapacity of motivation or underlying personality traits or disorders will be administratively handled see "Personnel Manual, COMDTINST M1000.6 (series) for further guidance".

c. Mood disorders. Bipolar disorders or recurrent major depression. All other mood disorders associated with suicide attempt, untreated substance abuse, requiring hospitalization or requiring treatment (including medication, counseling, psychological or psychiatric therapy) for more than 6 months, or requiring more than 36 months of prophylactic treatment (while asymptomatic) following initial therapy. Prophylactic treatment requiring more than one drug associated with significant side effects (such as sedation, dizziness or cognitive changes) or frequent follow-up that limit duty options. Any member requiring medication for any of the above disorders must be removed from aviation duty, but may request waiver from CGPC. (Incapacity of motivation or underlying personality traits or disorders will be administratively handled see "Personnel Manual, COMDTINST M1000.6 (series) for further guidance."

d. Personality; sexual; factitious; psychoactive substance use disorders; personality trait(s); disorders of impulse control not elsewhere classified. These conditions may render an individual administratively unfit rather than unfit because of a physical impairment. Interference with performance of effective duty will be dealt with through appropriate administrative channels (see section 5-B).

e. Adjustment Disorders. Transient, situational maladjustment due to acute or special stress does not render an individual unfit because of physical impairment. However, if these conditions are recurrent and interfere with military duty, are not amenable to treatment, or require prolonged treatment, administrative separation should be recommended (see Section 5-B).

f. Disorders usually first evident in infancy, childhood, or adolescence, disorders of intelligence. These disorders, to include developmental disorders, may render an individual administratively unfit rather than unfit because of a physical impairment. Anorexia Nervosa and Bulimia are processed through PDES, while the remaining are handled administratively, if the condition significantly impacts, or has the potential to significantly impact performance of duties (health, mission, and/or safety). See section 5-B of this Manual and Chapter 12 of the personnel manual for further guidance.

17. Dental. Diseases and abnormalities of the jaws or associated tissues when, following restorative surgery, there remain residual conditions that are incapacitating or interfere with the individual's satisfactory performance of military duty, or deformities that are disfiguring. Personnel must be in a Class 1 or Class 2 dental status (see figure 3-C-2) to execute sea duty or overseas duty orders. Prior service personnel must meet the enlistment dental standards contained in section 3-D.

18. Blood and Blood-Forming Tissue Diseases. When response to therapy is unsatisfactory, or when therapy requires prolonged, intensive medical supervision.

a. Anemia.

b. Hemolytic disease, chronic and symptomatic.

c. Leukemia, chronic.

d. Polycythemia.

e. Purpura and other bleeding diseases. Any condition requiring long-term coumadin.

f. Thromboembolic disease.

g. Splenomegaly, chronic.

19. Systemic Diseases, General Defects, and Miscellaneous Conditions.

a. Systemic Diseases.

(3) Blastomycosis.

(4) Brucellosis. Chronic with substantiated recurring febrile episodes, severe fatigability, lassitude, depression, or general malaise.

(5) Leprosy. Any type.

(6) Myasthenia gravis.

(7) Porphyria Cutanea Tarda.

(8) Sarcoidosis. Progressive, with severe or multiple organ involvement and not responsive to therapy.

(9) Tuberculosis (TB).

(a) Meningitis, tuberculosis.

(b) Pulmonary TB, tuberculous empyema, and tuberculous pleurisy.

(c) TB of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.

(d) TB of the female genitalia.

(e) TB of the kidney.

(f) TB of the larynx.

(g) TB of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery will be evaluated on an individual basis considering the associated involvement, residuals, and complications.

b. General Defects.

(1) Visceral, abdominal, or cerebral allergy. Severe or not responsive to therapy.

(2) Cold injury. Evaluate on severity and extent of residuals, or loss of parts as outlined in section 3-F-12.

c. Miscellaneous Conditions.

(1) Chronic Fatigue Syndrome, Fibromyalgia , and Myofascial Syndrome when not controlled by medication or with reliably diagnosed depression.

d. Conditions that individually or in combination, not elsewhere provided for in this section, if:

(1) the individual is precluded from a reasonable fulfillment of the purpose of employment in the military service; or

(2) the individual's health or well-being would be compromised if allowed to remain in the military service; or

(3) the individual's retention in the military service would prejudice the best interests of the Government.

(4) required chronic and continuous DEA controlled (Class I-V) medications, such as Ritalin, Amphetamine, Cylert, Modafanil.

(5) required chronic anti-coagulant, other than aspirin, such as Coumadin.

20. Tumors and Malignant Diseases.

a. Malignant Neoplasms. Which are unresponsive to therapy or when the residuals of treatment are in themselves disqualifying under other provisions of this section or in individuals on active duty when they preclude satisfactory performance of duty.

b. Neoplastic Conditions of Lymphoid and Blood Forming Tissues. Render an individual unfit for further military service.

c. Benign Neoplasms. Except as noted below, benign neoplasms are not generally a cause of unfitness because they are usually remediable. Individuals who refuse treatment are unfit only if their condition precludes satisfactory performance of military duty. However, the following normally render the individual unfit for further military service:

(1) Ganglioneuroma; or

(2) Meningeal fibroblastoma. When brain is involved.

21. Sexually Transmitted Disease.

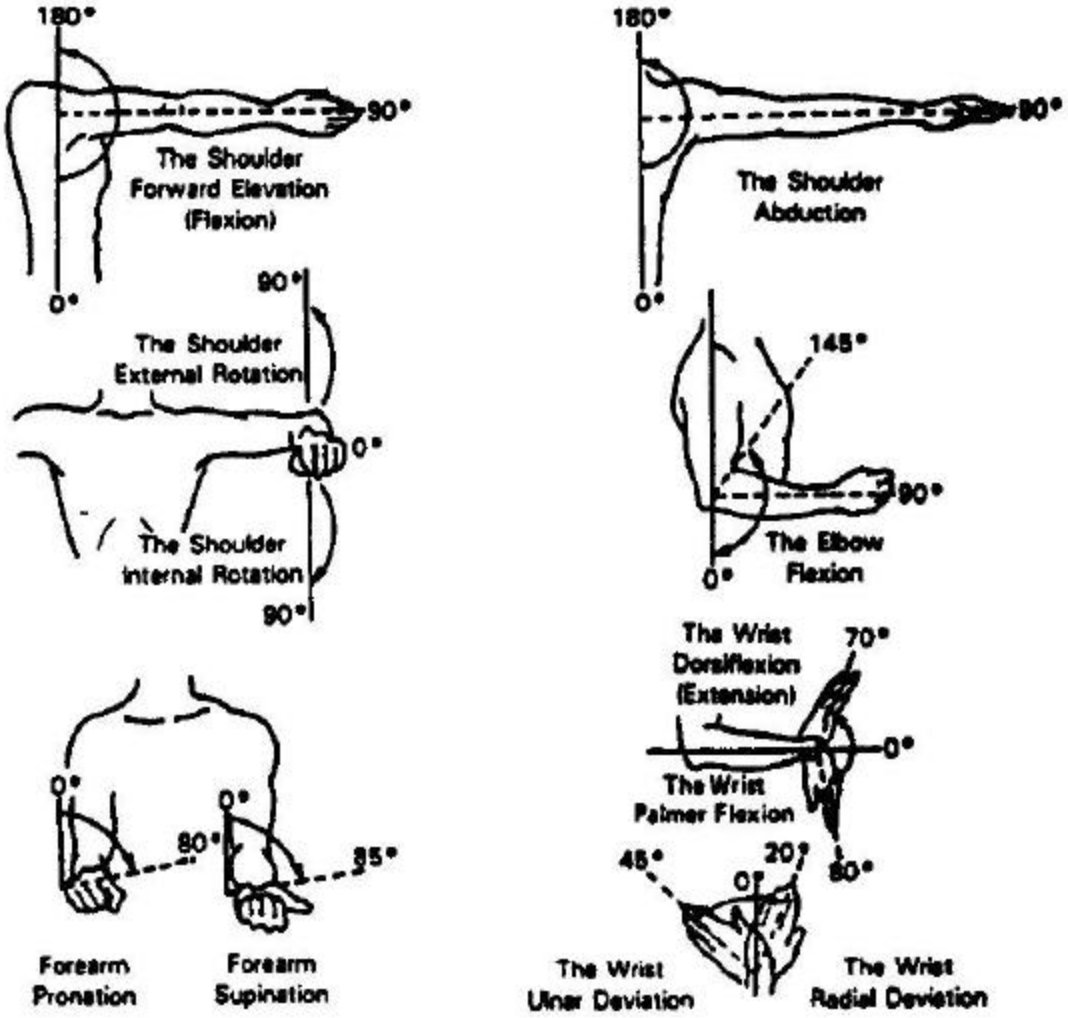
a. Symptomatic neurosyphilis. In any form.

b. Complications or residuals. Of venereal diseases of such chronicity or degree of severity that the individual is incapable of performing useful duty.

22. Human Immunodeficiency Virus (HIV). An Initial Medical Board will be convened on all members who are diagnosed as HIV antibody positive. Members who are HIV antibody positive, but are otherwise asymptomatic, are not eligible for worldwide deployment but may remain on active duty in a non-deployable billet. Those members who remain asymptomatic must have a Disposition Medical Board prior to separation. Members who are HIV antibody positive and demonstrate immunologic deficiency, neurologic involvement, progressive clinical or laboratory abnormalities associated with HIV, as well as those diagnosed as having aids related complex or acquired immunodeficiency syndrome are disqualified for reenlistment and retention.

23. Transplant recipient. Any organ or tissue except hair or skin.

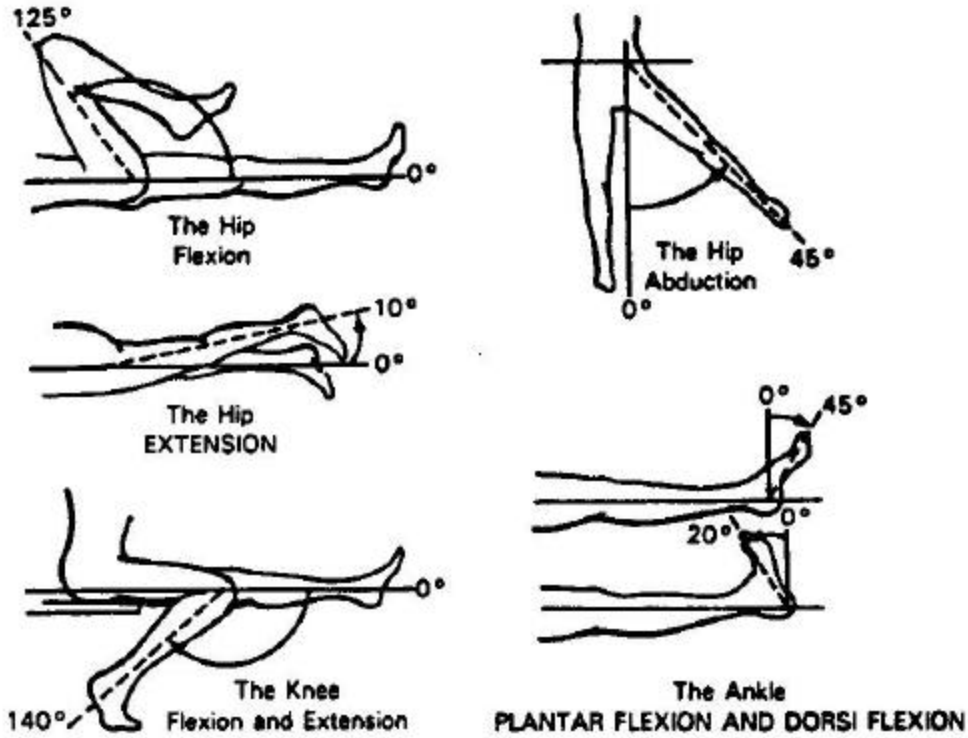
## 3-F – EXHIBIT 1
## MEASUREMENT OF ANKYLOSIS AND JOINT MOTION
## UPPER EXTREMITIES




This Exhibit provides a standardized description of ankylosis and joint motion measurement of the upper extremities. The anatomical position is considered as 0° with two major exceptions: (1) in measuring shoulder rotation, the arm is abducted to 90° and the elbow is flexed to 90° so that the forearm reflects the midpoint (0°) between internal and external rotation of the shoulder; and (2) in measuring pronation and supination, with the arm next to the body and the elbow flexed to 90°, the forearm is in mid position (0°) between pronation and supination when the thumb is uppermost.

CH-10

**3-F — EXHIBIT 2**
**MEASUREMENT OF ANKYLOSIS AND JOINT MOTION**
**LOWER EXTREMITIES**




This Exhibit provides a standardized description of ankylosis and joint motion measurement of the lower extremities. The anatomical position is considered as 0°.

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Section G Physical Standards for Aviation.

1. Classification of Aviation Personnel.

   a. Aviation Personnel in General. Classification of Coast Guard aviation personnel is similar to that prescribed for Navy aviation personnel. The term "aviation personnel" includes all individuals who, in the performance of their duty, are required to make frequent aerial flights. Aviation personnel are divided into two classes: Class 1 and Class 2.

   b. Class 1. Class 1 consists of aviation personnel engaged in actual control of aircraft, which includes aviators, student aviators, and student flight surgeons that are chosen to perform solo flights.

   c. Class 1R. Class 1R consists of aviation personnel engaged in actual control of aircraft who:

      (1) meet Class 1 standards but are age 50 or over; or

      (2) have a waiver (temporary or permanent) of physical standards which forbids unrestricted flight. The flight restriction(s) to which the Class 1R pilot is subject will be defined by the waiver authority. In all cases, however, Class 1R aviators will fly as a dual pilot with a Class 1 aviator.

   d. Changing Classes. Except for changes in class due solely to age, individuals requiring a change in their classification for more than two months must submit the following to Commander CGPC:

      (1) SF-502, Narrative Summary, completed by a flight surgeon/aviation medical officer stating the need for the class change and whether a permanent or temporary change is requested; and

      (2) command endorsement.

   e. Class 2. Class 2 consists of aviation personnel not engaged in actual control of aircraft. This includes aviation observers, technical observers, flight surgeons, aviation medical officers, aviation MEDEVAC specialists, flight officers, aircrew members, air traffic controllers, and other persons ordered to duty involving flying.

2. General Instructions for Aviation Examinations.

   a. Object of Aviation Physical Examinations.

      (1) The examination for flying shall be limited to members of the aeronautical organization and authorized candidates. The object of an aviation physical examination is to ensure individuals involved in aviation are physically and mentally qualified for such duty, and to remove from aviation those who are temporarily or permanently unfit because of physical or mental defect.

(2) The main objective in examining candidates for flight training is selecting individuals who can fly safely and continue to do so for at least 20 years.

(3) For designated aviators, the objective is to determine if the individual can fly safely during the next 24 months.

b. Performance of Aviation Physical Examinations. To promote safety and to provide uniformity and completeness, an aviation physical examination must be performed by a currently qualified flight surgeon/aviation medical officer (AMO) authorized by the Commandant. Only physicians who have successfully passed a course at a school of aviation medicine of the U. S. Armed Forces leading to the designation of "Aviation Medical Officer" or "Flight Surgeon" are so authorized. Civilian physicians who were military flight surgeons and who are currently certified by the Federal Aviation Administration as aviation medical examiners may also be authorized.

c. Scope of Aviation Physical Examination. In addition to the general service requirements specified in section 3-D, certain special requirements must be met by the various categories of individuals concerned with aviation. The extent of the examination and the physical standards vary for the several categories of aviation personnel. The term "flight or aviation physical examination" is therefore incomplete unless the character of the duty that the examinee is to perform is specified--this incomplete term shall not be used in item #16 of SF 88 (rev 10-94) as the purpose of the examination. Examiners shall conduct aviation physical examinations in accordance with the general procedures specified in this section and in section 3-C.

d. Required Aviation Physical Examinations. Each individual in the Service who is assigned to duty requiring performance of frequent aerial flights, regardless of classification, must have passed an aviation physical within the preceding 24 months. In some cases, more frequent examinations are required. Aviation physical examinations are required as indicated in this section. They may also be ordered whenever needed to determine an individual's physical fitness for the type aviation duty to which assigned.

(1) Entry on Active Duty. Reserve aviation personnel who perform frequent aerial flights must have passed an aviation physical examination, commensurate with the type of duty to be performed, within the 24 months preceding active duty or active duty for training. Aviators who are not members of aviation reserve units must have satisfactorily passed an aviation physical examination within six months immediately preceding the actual control of aircraft.

(2) Biennial. All aviation personnel, including Reservists on inactive duty for training, who will actually control aircraft or perform frequent aerial flights must obtain a biennial aviation physical examination commensurate with the type of duty to be performed. The examination is required every two (2) years after initial designation. Upon reaching age 50, the examinations become annual.

(3) Direct Commission. An aviation physical examination is required prior to direct commissioning of aviators in the Reserve. The aviator is required to meet Class I standards.

(4) Candidates for Designation as Class 1. All candidates for flight training, whether or not they are already in the Service, must pass a physical examination for flight training duty. The examination date must not precede the application date by more than 12 months.

(5) Candidates for Designation as Class 2. An approved aviation physical examination less than 24 months old is required both when applying for a Class 2 aviation training program and prior to a Class 2 designation.

(6) FAA Airmen Medical Certificate. After receiving Federal Aviation Administration (FAA) Aviation Medical Examiner (AME) training, Coast Guard flight surgeons/AMOs may request authorization from Commandant (G-WKH) to perform Second and Third Class physical examinations and issue FAA Medical Certificates to all military personnel on active duty including active duty for training. The FAA Administrator furnishes AME's with the necessary instructions, guides, and forms required for this purpose. Except in those instances where there is a military requirement for FAA certification, examination and issuance of medical certificates shall not interfere with the flight surgeon's primary duties. Whenever possible, certificates should be obtained in conjunction with a required aviation physical examination.

(7) Aircraft Accidents. Any Coast Guard member involved in a Class A or B aircraft mishap in which damage to the aircraft or injury to any crewmember occurs shall undergo a complete aviation physical examination as part of the mishap investigation. Examinations after other mishaps are left to the discretion of the flight surgeon/AMO.

(8) Quinquennial. The quinquennial examination of a Reserve aviation special duty officer must be an aviation physical examination.

(9) Separation. An aviation physical examination is not required of aviation personnel being separated from active duty. The requirements for examination are the same as those for the separation from active duty of non-aviation personnel.

e. Boards. Assignment to and continuation of duty involving flying is an administrative process. Except for enlisted personnel in aviation ratings, fitness to perform aviation duties is a determination independent of the determination of fitness for continued service.

(1) Board of Flight Surgeons. When a fitness for continued service determination is not required or in cases where the disposition is appropriately administrative [e.g., a condition not a ratable disability or covered under sections 12-A or 4-C of the Personnel Manual,COMDTINST M1000.6 (series)] a Board of Flight Surgeons shall be convened. The board shall consist of two medical officers, one of whom must be a flight surgeon or AMO. When formation of such a board is not feasible, a single flight surgeon/AMO may be considered the

minimum with the approval of Commandant (G-WKH). An example of the appropriate use of a Board of Flight Surgeons is an aviator found not aeronautically adaptable due to fear of flying. The results of the board shall be recorded on a Narrative Summary (SF-502) and submitted to Commander CGPC via the appropriate chain of command.

(2) Special Board of Flight Surgeons.

(a) The U.S. Navy has established this board to consider unusual, complicated, or controversial cases beyond the capabilities or experience level of a local Board of Flight Surgeons. The Naval Aerospace Medical Institute (NAMI) is staffed and equipped to evaluate such cases. Special Boards must be arranged through Commandant (G-WKH).

(b) NAMI specialists may be requested as consultants without convening a full Special Board. Specialty consultations may be requested and arranged by local command.

f. Reporting Fitness for Flying Duties.

(1) Aviation personnel admitted to the sicklist or hospitalized shall be suspended from all duty involving flying. Upon the recommendation of a medical officer (not restricted to a flight surgeon/aviation medical officer), the commanding officer may relieve from flying duty or suspend the flight training of an individual deemed unfit for such duty. In all instances, a Grounding Notice (Aero-Medical NAVMED 6410/1) shall be issued.

(2) When aviation personnel are subsequently deemed fit to resume flying duties, they shall be examined by a flight surgeon/ aviation medical officer and a Clearance Notice (Aero-Medical NAVMED 6410/2) shall be submitted to the commanding officer. Based on this recommendation, the commanding officer may authorize resumption of such duty or training.

(3) Class 1 or 2 aviation personnel, upon reporting to a new duty station or upon returning from an extended absence from flying duty for any reason or when otherwise indicated, shall be interviewed by a flight surgeon/aviation medical officer in order to determine their current health, verify that a current aviation physical examination has been conducted, and to administratively review their health record. If the flight surgeon/aviation medical officer deems it appropriate, a physical examination may be conducted to determine their physical fitness to continue or resume their flying duties. The appropriate Grounding or Clearance Notice shall be completed in all such cases and the necessary notation made in the individual's health record on an SF-600. Specific guidance for some special circumstances are:

(a) Post-hospitalization. A post-hospitalization examination may be required.

(b) Alcohol Abuse. Members under aviation class 1 or 2 retention standards involved in alcohol related incidents or who are referred for alcohol screening shall be recommended for grounding. If, after alcohol screening, a specific medical diagnosis of Alcohol Abuse (305.00 DSM III-R) or Alcohol Dependence (303.90 DSM III-R) cannot be made, the individual can be returned to aviation duties without a formal waiver. Those aviation personnel who are diagnosed as Alcohol Abusers or Alcohol Dependent can return to duties involving flight only after favorable action by the appropriate waiver authority. In addition, class 2 aircrewmen with either of these diagnoses must be cleared by the flight surgeon/AMO before returning to flight-line duties or activities involving aircraft maintenance. Candidates for Student Naval Aviator or Aircrew Candidates with a history of alcohol dependence or abuse will be considered for a waiver after successful rehabilitation (outpatient or inpatient) and an interval of aftercare (1 year for dependence and 90 days for abuse) dating from the onset of rehabilitation.

1 The waiver request must include:

a The flight surgeon's Narrative Summary (SF 502);

b How the problem was identified;

c Drinking history: When subject member first drank, history of DUIs, blackouts, frequent sick-call visits, withdrawal symptoms, morning drinking, domestic difficulties, impaired job performance, etc.;

d Lab data (LFTs, red cell indices, etc.,);

e Any Narrative Summary from rehabilitation authority;

f Commanding officer's endorsement in accordance with paragraph 3-A-8.d.(2). This must include details of any mandated aftercare plan.

2 The waiver process should not be initiated until the aviation member:

a Completes Level II or III rehabilitation program or the civilian equivalent;

b Demonstrates compliance with their aftercare program for at least three months.

3 Waiver contingencies will usually incorporate the recommendations of the rehabilitation authority and may include one or more of the following:

a Total abstinence;

b Active participation in a sobriety program (which includes AA);

c Follow-up by the flight surgeon at least quarterly for a year then at least annually thereafter.

(c) Pregnancy. After confirmation of pregnancy, female members should not be assigned to duties involving flight until cleared by her flight surgeon (FS)/aviation medical officer (AMO). Nausea, decreased appetite, easy fatigability, dizziness, and vaginal bleeding are some of the potential problems that may cause the FS/AMO to recommend temporary grounding for pregnant aviation personnel. Close monitoring is required by the FS/AMO to ensure early identification of problems associated with pregnancy, that could be hazardous to the pregnant member or others. In addition, the FS/AMO will assess the ergonomic and toxic hazards to which the pregnant member and her fetus may be exposed in her particular aviation environment. Potential occupational health problems will be brought to the attention of the patient and the command. No member will perform duties as a rescue swimmer upon confirmation of pregnancy. No pregnant member shall perform duties involving flying after the end of the second trimester, nor shall they undergo chamber (physiologic) training or training involving swimming after the end of the second trimester. (Note: Any pregnant member undergoing chamber or dunker training must receive, from a flight surgeon or AMO, a status profile chit indicating she is "OK DIF/Dunker/Chamber.")

(4) Areas without flight surgeons/AMOs assigned or when the assigned flight surgeon/AMO is on leave or TAD:

(a) The authority to issue a Grounding Notice includes all medical officers, dental officers, and health service technicians.

(b) Flight surgeons (FS) and aviation medical officers (AMO) are the only personnel authorized to issue clearance notices (ie. Up chits) for the resumption of flight duties. In the absence of an assigned flight surgeon, MOs, DOs, and HSs may issue a clearance notice related to the scope of the specialty of the provider after concurrence has been received from an FS or AMO. Concurrence can be obtained by either message or verbal communication. Clearance notices issued by an MO, DO, or HS must include the name, rank, and duty station of the authorizing FS/AMO as well as the time and date of communication for authorization.

(c) Channels of communication between commands without flight surgeons/AMOs and the nearest USMTF with a flight surgeon will be established to facilitate concurrence prior to issuing a clearance notice.

g. Reporting Aviation Physical Examinations.

(1) Definition of "Physically Qualified".

(a) Class 1 aviation personnel have passed an aviation physical examination when a flight surgeon/aviation medical officer or Board of Flight Surgeons finds that, according to the standards prescribed in this Manual, the examinee is physically qualified and aeronautically adapted for actual control of the aircraft, and has been approved by appropriate Reviewing Authority.

(b) Class 2 aviation personnel have passed an aviation physical examination when a flight surgeon or physical evaluation board including a flight surgeon finds that, according to the standards prescribed in this Manual, the examinee is physically qualified and aeronautically adapted for flying, and has been approved by appropriate Reviewing Authority.

(2) Aeronautical Adaptability. After the examination has been completed, the examiner shall review all the available information and make an assessment of the individual's qualifications for the type of flying duty to be performed. Generally, clinical syndromes except adjustment disorders should lead to a finding of "not physically qualified." Adjustment disorders, psychological factors affecting physical condition and conditions not attributable to a mental disorder that are a focus of attention or treatment and Axis II conditions (personality traits and disorders) as a primary diagnosis should lead to a finding of "physically qualified but not aeronautically adapted."

(3) Comments and Recommendations. Examiners are encouraged to use the space on the SF-88 entitled "Remarks" or "Notes." In this space, the examiner may express an opinion on specific defects and the examinee's overall capabilities. Comments by the examinee or the examinee's immediate superior are occasionally most valuable, especially when removal from flight status is recommended. Examiners shall enclose such comments in writing as an addendum to the formal report whenever such information is considered relevant to making a final recommendation.

3. Restrictions Until Physically Qualified.

a. Restrictions by Reviewing Authority.

(1) Except as authorized in this section, no person shall assume initial duty involving the actual control of aircraft until notification has been received from Commandant (G-WKH) that such person is physically qualified for that duty.

(2) Pending receipt of the endorsed copy of the SF-88 or other communication from Commandant (G-WKH) or MLC(k) that the report of routine biennial physical examination has been approved, aviation personnel are physically qualified and aeronautically adapted for flight duty if a flight surgeon certifies that the individual has no physical or mental defect that is disqualifying.

(3) When any member on flight status has been restricted by the Commandant (G-WKH) or MLC(k), such restriction remains technically in effect until it is changed by the same authority. However, in order to avoid delay in the return to flight status of those clearly qualified to perform such duties, commanding

officers are authorized, after consideration of a favorable recommendation made to Commandant (G-WKH) by a flight surgeon, to waive this technical restriction pending the action of the Commandant.

b. Restriction by Commanding Officer.

(1) Upon recommendation by any medical officer or other health services department personnel, the commanding officer may relieve from flying duty or suspend the flight training of any individual reported physically incapacitated for such duty or suspend the flight training of any individual reported physically incapacitated for such duty. When the individual is subsequently reported physically fit by a flight surgeon, the commanding officer may authorize resumption of such duty or training.

(2) Aviation personnel may be continued in a flying status pending correction of minor defects such as obtaining new eyewear prescriptions or dental restorations with the concurrence of a flight surgeon. When corrective action is completed, an entry shall be made in Item 72 of the SF-88 and the physical then forwarded for review.

4. Standards for Class l.

a. General. The physical examination and physical standards for Class 1 are the same as those prescribed in sections 3-C and 3-D of this Manual, as modified by the following subparagraphs.

b. History.

(1) History of any of the following is disqualifying: seizures, isolated or repetitive (grand mal, petit mal, psychomotor, or Jacksonian); head injury complicated by unconsciousness in excess of 12 hours or post traumatic amnesia or impaired judgment exceeding 48 hours; malaria, until adequate therapy has been completed and there are no symptoms while off all medication for 3 months.

(2) For persons already in the Coast Guard a complete review of their health record is most important. Flight surgeons are authorized to postpone the examination of persons who fail to present their health record at the time of examination. In exercising this prerogative, due consideration must be made in cases where access to the individual's health record is administratively impracticable.

c. Therapeutics and General Fitness. Note on the SF-88 if the individual received medication or other therapeutic procedures within 24 hours of the examination. In general, individuals requiring therapeutics or who have observed lowering of general fitness (dietary, rest, emotional, etc.,) which might affect their flying proficiency shall not be found qualified for duty involving flying.

d. Height. Minimum 157.4 cm (62 inches). Maximum 198 cm (78 inches).

e. Chest. Any condition that serves to impair respiratory function may be cause for rejection. Pulmonary function tests are recommended to evaluate individuals with a history of significant respiratory system problems.

f. Cardiovascular System. Cardiac arrhythmia, heart murmur, or other evidence of cardiovascular abnormalities shall be carefully studied. Evidence of organic heart disease, rhythm disturbances or vascular diseases, if considered to impair the performance of flying duties, is cause for rejection.

g. Teeth. The following are disqualifying:

(1) Any carious teeth that would react adversely to sudden changes in barometric pressure or produce indistinct speech by direct voice or radio transmission.

(2) Any dental defect that would react adversely to sudden changes in barometric pressure or produce indistinct speech by direct voice or radio transmission.

(3) Fixed active orthodontic appliances require a waiver from CGPC (opm or epm). (fixed retainers are exempts).

(4) Routine crown and temporary dental work is not disqualifying for aviation missions. Recommend that temporary crowns be cemented with permanent cement like polycarboxylate or zinc oxyphosphate cement until the permanent crown is delivered. Recommend temporary grounding of 6-12 hours after procedures. Such work may be disqualifying for deployment.

h. Distant Visual Acuity. Distant visual acuity shall be not less than 20/200 in either eye and if less than 20/20 must be correctable to 20/20 with standard lenses. When the visual acuity of either eye is less than 20/20 correction shall be worn at all times while flying.

i. Oculomotor Balance. The following are disqualifying:

(1) esophoria greater than 10 prism diopters;

(2) exophoria greater than 10 prism diopters;

(3) hyperphoria greater than 1.5 prism diopters;

(4) prism divergence at 20 feet and 13 inches is optional. These tests shall be accomplished only on designated aviators who have sustained significant head injury, central nervous system disease, or who have demonstrated a change in their phorias.

j. Eyes. Any pathologic condition that may become worse or interfere with proper eye function under the environmental and operational conditions of flying disqualifies. History of radial keratotomy is disqualifying.

k. Near Visual Acuity. Uncorrected near vision (both eyes) shall be not less than 20/200 correctable to 20/20, with correction worn in multivision lenses while flying if uncorrected near vision is less than 20/40 in either eye.

l. Color Vision. Normal color perception is required.

m. Depth Perception. Normal depth perception is required. When any correction is required for normal depth perception it must be worn at all times.

n. Field of Vision. The field of vision for each eye shall be normal as determined by the finger fixation test. When there is evidence of abnormal contraction of the field of vision in either eye, the examinee shall be subjected to perimetric study for form. Any contraction of the form field of $15^{o}$ or more in any meridian is disqualifying.

o. Refraction. There are no refractive limits.

p. Ophthalmoscopic Examination. Any abnormality disclosed on ophthalmoscopic examination that materially interferes with normal ocular function is disqualifying. Other abnormal disclosures indicative of disease, other than those directly affecting the eyes, shall be considered with regard to the importance of those conditions.

q. Ear. The examination shall relate primarily to equilibrium and the patency of eustachian tubes. A perforation or evidence of present inflammation is disqualifying. The presence of a small scar with no hearing deficiency and no evidence of inflammation, does not disqualify. Perforation, or marked retraction of a drum membrane associated with chronic ear disease, is disqualifying.

r. Sickle Cell Preparation Test. Quantitative hemoglobin electrophoreses greater than 40% HGs is disqualifying.

5. Standards for Class 1R. Physical requirements for service are the same as for Class 1, except:

a. Age 50 or older, or

b. Have a waiver (temporary or permanent) of physical standards that forbids unrestricted flight.

6. Candidates for Flight Training.

a. Standards. Candidates for flight training shall meet all the requirements of Class 1, with the following additions or limitations:

(1) Height. Candidates for Class I training must also satisfy the following anthropometric requirements: Refer to figure 3-G-1 through figure 3-G-4 for guidelines on measurements.

(a) **sitting height**: 33 inches to 40.9 inches. Record in parentheses in Item 42, SF-88 (SH_____), see figure 3-G-1 for proper measurements;

(b) **sitting eye height:** 28.5 inches or greater. Record in parentheses in Item 42, SF-88 (SEH_____), see figure 3-G-2 for proper measurements;

(c) **thumb tip reach:** 28.5 inches or greater. Record in parentheses in Item 42, SF-88 (TTR____), see figure 3-G-3 for proper measurements;

(d) **buttock-knee length:** 21 inches to 27.9 inches. Record in parentheses in Item 42, SF-88 (BKL____), see figure 3-G-3 for proper measurements;

(e) **add**: sitting eye height (SEH) and thumb tip reach (TTR), 57 inches or greater. Record in parentheses in Item 42, (SEH + TTR =____).

(2) Uncorrected distant visual acuity must be not less than 20/50 each eye and correctable 20/20 each eye. Uncorrected near visual acuity must be not less than 20/20 each eye (may be waiverable).

(3) While under the effects of a cycloplegic, the candidate must read 20/20 each eye. The following are disqualifying:

(a) total myopia greater than (minus) -2.00 diopters in any meridian;

(b) total hyperopia greater than (plus) +3.00 diopters in any meridian;

(c) astigmatism greater than (minus) -0.75 diopters; (Report the astigmatic correction in terms of the negative cylinder required.)

(d) the purpose of this cycloplegic examination is to detect large latent refractive errors that could result in a change of classes during an aviation career. Therefore, the maximum correction tolerated at an acuity of 20/20 shall be reported. Cycloplegics reported as any other acuity, e.g., 20/15 will be returned.

(4) Hearing. Audiometric loss in excess of the limits set forth in the following table is disqualifying:

| FREQUENCY | 500 | 1000 | 2000 | 3000 | 4000 |
|---|---|---|---|---|---|
| EITHER EAR | 30 | 25 | 25 | 45 | 55 |

(5) Personality. Must demonstrate, in an interview with the flight surgeon, a personality make-up of such traits and reaction that will indicate that the candidate will successfully survive the rigors of the flight training program and give satisfactory performance under the stress of flying.

(6) Chest x-ray. Aviation trainees must have had a chest x-ray within the past three years.

(7) Report of Medical History (SF-93). In addition to the normal completion of the SF-93, the following statement shall be typed in block 8 and signed by the applicant: "I certify that I do not now use, nor have I ever used, contact lens for any purpose, and that I am not aware that my uncorrected vision has ever been less than 20/40." If the applicant cannot sign this statement, include a full explanation by the examining flight surgeon, and an ophthalmology consultation.

b. Reporting.

(1) The importance of the physical examination of a candidate should be recognized not only by the examining flight surgeon but also by health services personnel assisting in the procedure and preparing the report. Candidates often come from a great distance or from isolated ships. If the examination cannot be completed in one working day, seek the commanding officer's help in making it possible for the candidate to remain available for a second working day. Careful planning should keep such cases to a minimum. If a report, upon reaching Commandant (G-WKH), is found to be incomplete and must be returned, the candidate will suffer undue delay in receiving orders and in some cases will be completely lost to the Coast Guard as a candidate. The preparation of the SF-88 in the case of a candidate requires extreme care by all concerned.

(2) In a report of the examination of a candidate, rigid adherence to set standards is expected. The examining officers are encouraged to use freely that portion of the report that provides for "remarks" or "notes." Comments made under "remarks" are the examiner's opinion. Information from any source may be molded into an expression of professional opinion. A final recommendation of the examiner must be made. When such recommendation is not consistent with standards set by Commandant (G-K) the examiner shall note that fact on the form under "remarks" or "notes" and a reasonable explanation made. When space on an SF-88 is inadequate, use a Continuation Sheet (SF-507).

7. Requirements for Class 2 Flight Officers.

a. Flight Officer Candidates. Flight officer candidates shall meet the standards for Class 1 except that depth perception is not required.

b. Designated Flight Officers. Flight officers shall meet the standards for flight officer candidate except that uncorrected distant visual acuity must be not less than 20/200 in either eye and shall be correctable to 20/20.

8. Requirements for Class 2 Aircrew.

a. Aircrew Candidates. Unless otherwise directed by Commander CGPC-epm, personnel will not be permitted to undergo training leading to the designation of aircrewmen unless a flight surgeon/aviation medical officer has found them physically qualified for such training. Should it be desirable, for exceptional reasons, to place in training a candidate who does not meet the prescribed physical standards, the commanding officer may submit a request for a waiver, with the SF-88 and SF-93, to Commandant (G-PRJ), justifying the request. Aircrew candidates shall meet the standards for Class 1, except that minimum height is 152.5 cm/60 inches and uncorrected distant visual acuity must be not less than 20/100 each eye, correctable to 20/20 each eye.

b. Designated Aircrew. Aircrew shall meet the standards for Class 1, except the minimum height is 152.5 cm/60 inches.

9. Requirements for Class 2 Medical Personnel.

   a. Flight Surgeon (FS)/Aviation Medical Officer (AMO)/FS Candidates. While assigned to a Duty Involving Flight Operations billet, FS/AMOs shall meet the standards for Designated Flight Officer, except that minimum height is 152.5 cm (60 inches).

   b. Aviation MEDEVAC Specialists (AMS)/AMS Candidates. Health Services technicians (HS) who are assigned to flight orders. Aviation MEDEVAC Specialists shall meet the standards for Designated Flight Officer, except that minimum height is 152.5 cm (60 inches).

10. Requirements for Class 2 Technical Observers. The term "technical observer" is applied to personnel who do not possess an aviation designation but who are detailed to duty involving flying. The examination shall relate primarily to equilibrium and the patency of eustachian tubes. They shall meet the standards prescribed for general duty. These personnel are not required to undergo a physical examination for flying provided a complete physical examination, for any purpose, has been passed within the preceding 60 months and intervening medical history is not significant. The physical examination need not be conducted by an FS/AMO. Technical observers who are required to undergo egress training must have a current (general purpose) physical examination and a status profile chit indicating "OK DIF/Dunker/Chamber."

11. Requirements for Class 2 Air Traffic Controllers. Air traffic controllers, tower controllers, and ground control approach operators shall meet the general physical standards for Class 1, except:

   a. Articulation. Must speak clearly and distinctly without accent or impediment of speech that would interfere with radio communication. Voice must be well modulated and pitched in medium range. Stammering, poor diction, or other evidence of speech impediments, that become manifest or aggravated under excitement are disqualifying.

   b. Height. Same as general service.

   c. Visual Acuity.

      (1) Candidate's visual acuity shall be no worse than 20/100 for each eye correctable to 20/20 each eye and the correction shall be worn while on duty.

      (2) Personnel already designated shall have distant visual acuity no worse than 20/200 each eye correctable to 20/20 each eye and the correction shall be worn while on duty.

      (3) Air traffic controllers whose vision becomes worse than 20/200 either eye may not engage in the control of air traffic in a control tower but may be otherwise employed in the duties of their rating.

   d. Depth Perception. Normal depth perception is required.

e. Heterophoria. The following are disqualifying:

(1) esophoria or exophoria greater than 6 prism diopters; and

(2) hyperphoria greater than 1 prism diopter.

12. Requirements for Landing Signal Officer (LSO).

a. Physical Examinations for Landing Signal Officer (LSO).

(1) Candidates. Officer and enlisted candidates for training as LSO's shall have a physical examination prior to the training leading to qualification. LSO duties for flight deck require stricter visual acuity standards than those for general duty in the Coast Guard. Examination by a FS/AMO is not required.

(2) Reexamination. Biennial reexamination is required of all currently qualified LSO's.

b. Physical Standards for LSO's. In addition to the physical standards required for officer and enlisted personnel, the following standards apply:

(1) Distant Visual Acuity. The uncorrected distant visual acuity shall be no worse than 20/200 in each eye and must be correctable to 20/20 in each eye. If the uncorrected distant visual acuity is less than 20/20 in either eye, corrective lenses must be worn while performing LSO duties.

(2) Depth Perception. Normal depth perception is required.

(3) Color Vision. Normal color perception is required.

13. Contact Lenses.

a. Class 1 personnel may be authorized by their local flight surgeon to wear contact lenses while flying, provided the following conditions are met:

(1) Only gas permeable disposable soft lenses may be used.

(2) The lenses are to be removed during the hours of sleep.

(3) The lenses are disposed of after 2 weeks of use.

(4) All prescribed optometry follow-up visits are adhered to. After routine safe use has been established and documented by the prescribing optometric authority, an annual optometric recheck is the minimum required. A copy of the record of any visit to an eye care professional will be furnished by the member to the local flight surgeon for review and placement in the member's health record.

(5) Following any change in the refractive power of the contact lens, the member must be checked on the AFVT to ensure that Coast Guard Class I standards for acuity and depth perception are met. In addition, the flight surgeon shall document that there is no lens displacement, when user moves his/her eyes through all 8 extreme ranges of gaze.

(6) Contact lens case, saline for eye use, and an appropriate pair of eyeglasses are readily accessible (within reach) to the lens wearer while in-flight.

(7) Contact lens candidate submits request to the command agreeing to abide the above conditions.

(8) The flight surgeon authorizes use of contact lenses after ensuring that such use is safe and the user fully understands the conditions of use. This authorization expires after one year. Initial and any annual re-authorizations shall be documented by an entry in the health record.

(9) Contact lens use is not a requirement for aviation operations. The decision to apply for authorization is an individual option. Accordingly, lens procurement and routine optometric care related to contact lens use at government expense are not authorized.

b. The optional wearing of contact lenses by Class 2 personnel performing duty involving flying and by air control personnel in the actual performance of their duties is authorized under the following circumstances:

(1) Individuals are fully acclimated to wearing contact lenses and visual acuity is fully corrected by such lenses;

(2) Individuals wearing contact lenses while performing flight or air control duties have on their person, at all times, an appropriate pair of spectacles;

(3) A flight surgeon has specifically authorized the wearing of contact lenses while performing flight or air control duties (An entry shall be made on SF-600 in the individual's health record authorizing wearing of contact lenses.); and

(4) Wearing contact lenses while performing aviation duties is an individual option. Accordingly, procuring contact lenses at government expense is not authorized.

**Figure 3-G-1**

# Sitting Height

## Purpose

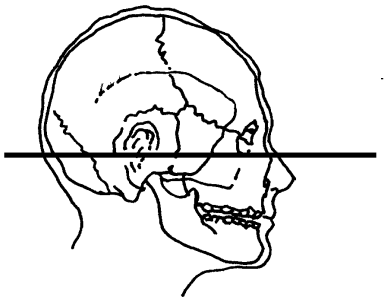
This measurement is important in the design and layout of work stations occupied by Navy personnel. Controls must be placed in numerous locations, and the minimum acceptable space between the helmet and the canopy of cockpits must be considered.

## Equipment Required

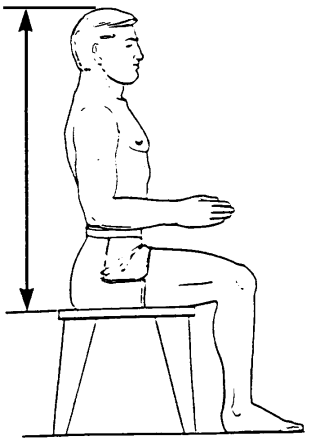
Anthropometer

## Measurement Procedure

1. The subject sits erect facing forward with the head level (see illustration below), the shoulders and upper arms relaxed, and the forearms and hands extended forward horizontally with the palms facing each other. The thighs are parallel, and the knees are flexed 90° with the feet in line with the thighs.



2. Measure the vertical distance between the sitting surface and the top of the head with an anthropometer. The shoulders and upper extremities should be relaxed. Measure at the maximum point of quiet respiration.



***NOTE:*** *Measurements are to be taken to the nearest eighth of an inch. The measurement should be taken at least twice. If there is a large variation between the two measurements, recheck the body position and repeat measurements.*

**Figure 3-G-2**

# Eye Height, Sitting

## Purpose

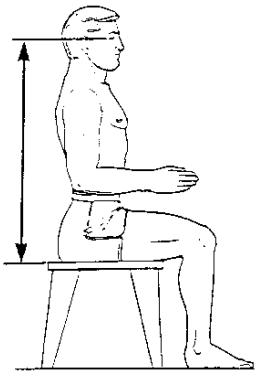
Sitting Eye Height plays a decisive role in instrument panel layout, viewing angles, and seat adjustment, since the pilot must have optimum vision both inside and outside of the cockpit.

## Equipment Required

Anthropometer

## Measurement Procedure

1. The subject sits erect facing forward with the head level (see illustration below), the shoulders and upper arms relaxed, and the forearms and hands extended forward horizontally with the palms facing each other. The thighs are parallel and the knees are flexed 90° with the feet in line with the thighs.



2. Measure the vertical distance between the sitting surface and the corner or angle formed by the meeting of the eyelids on the outer corner of the right eye with an anthropometer.

***NOTE:*** *Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.*

**Figure 3-G-3**

# Thumbtip Reach

## Purpose

This measurement is important in the design and layout of work stations occupied or used by Navy personnel. Thumbtip reach is particularly useful for the placement of controls in various locations within cockpits.

## Equipment Required

Wall--mounted linear scale.

## Measurement Procedure

1. The subject stands erect in a corner looking straight ahead with the feet together and heels 7.87 inhes (20 cm) from the back wall.
2. With the buttocks and shoulder placed against the wall, the right arm and hand (palm down) are stretched horizontally along the scale while the thumb continues along the horizontal line of the arm with the index finger curving around to touch the pad at end of the thumb.

3. The subject's right shoulder is held against the rear wall. The horizontal distance from the back wall to the tip of the right thumb is measured.

***NOTE 1****: Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.*

**Figure 3-G-4**

# Buttock-Knee Length

## Purpose

This measurement is usually associated with ejection seat clearance and threshold values between the knee and the glare shield (or canopy bow).

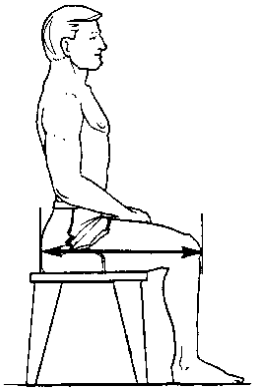
## Equipment Required

Anthropometer

## Measurement Procedure

1. While the subject sits erect, draw a landmark on the bottom tip of the right knee cap. The subject's thighs should be parallel, with the knees flexed at 90°. The feet should be in line with the thighs, and lying flat on the surface of a footrest or the floor.

2. The anthropometer is placed flush against the buttock plate at the most posterior point on either buttock, and the anterior point to the right knee is measured with an anthropometer.



***NOTE 1**: Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.*

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Section H Physical Examinations and Standards for Diving Duty.

1. Examinations.

   a. Candidates. Acceptable candidates for duty that involves diving or underwater swimming must conform to the physical standards contained in section 3-D except as modified below.

   b. Reexamination. Reexamination of all divers shall be conducted every five (5) years after designation until age 48.

   c. Examination Just Prior to Age 40. Qualified divers who desire to continue in that specialty and are about to reach age 40 must be examined by a medical officer. The SF-88 and SF-93, along with the examiner's recommendation as to whether the individual is or is not physically qualified to continue as a diver shall be forwarded to CG Personnel Command (adm-1) for final decision and in time to reach Headquarters before the individual attains age 40. A certain latitude may be allowed for a diver of long experience and a high degree of efficiency in diving. The individual must be free from any diseases of the cardiovascular, respiratory, genitourinary, and gastrointestinal systems, and of the ear. The individual's ability to equalize air pressure must be maintained.

   d. Examination Prior to Dives. Divers should ordinarily be examined prior to each unusually hazardous dive and prior to extensive operations when practicable to do so. Medical officers available during extensive operations, should make observations, by personal interview if possible, of all divers prior to their initial dive each day.

2. Standards.

   a. Disqualifying History. Any of the following is disqualifying:

      (1) tuberculosis, asthma, chronic pulmonary disease;

      (2) chronic or recurrent sinusitis, otitis media, otitis externa;

      (3) chronic or recurrent orthopedic pathology; and

      (4) chronic or recurrent gastrointestinal disorder.

   b. Age Requirements. Candidates beyond the age of 30 shall not be considered for initial training in diving, the most favorable age being 20 to 30. For officers undergoing training in deep sea diving for the specific purpose of becoming diving supervisors or salvage officers, the upper age limit is 39 years.

   c. Nose, Sinuses, Mouth, and Throat. Obstruction to breathing or chronic hypertrophic or atrophic rhinitis is disqualifying. Septal deviation is not disqualifying in the presence of adequate ventilation. Chronically diseased tonsils are disqualifying

pending tonsillectomy. Presence or history of chronic or recurrent sinusitis is cause for rejection.

d. Ears (General) and Drums.

(1) Acute or chronic disease of the auditory canal, membrane tympani, middle or internal ear is disqualifying. Perforation or marked scarring or thickening of the drum is disqualifying. The eustachian tubes must be freely patent for equalization of pressure changes.

(2) All candidates shall be subjected in a recompression chamber to a pressure of 50 pounds per square inch to determine their ability to clear their ears effectively and otherwise to withstand the effects of pressure.

e. Skin and Lymphatics. There shall be no active acute or chronic disease of the skin characterized by infectiveness and/or offensiveness in close working conditions and interchange of diving apparel.

f. Psychiatric. The special nature of diving duties requires a careful appraisal of the candidate's emotional, temperamental, and intellectual fitness. Past or recurrent symptoms of neuropsychiatric disorder or organic disease of the nervous system are disqualifying. No individual with a history of personality disorder shall be accepted. Neurotic trends, emotional immaturity or instability and antisocial traits, if of sufficient degree to militate against satisfactory adjustment are disqualifying. Stammering or other speech impediment that might become manifest under excitement is disqualifying.

g. Dental. Acute infectious diseases of the soft tissues of the oral cavity are disqualifying until remedial treatment is completed. Advanced oral disease and generally unserviceable teeth are cause for rejection. Candidates with moderate malocclusion, or extensive restorations and replacements by bridges, may be accepted, if such do not interfere with effective use of self-contained underwater breathing apparatus (scuba). Fixed active orthodontic appliances require a waiver from CGPC-opm or epm (fixed retainers are exempt).

h. Distant Visual Acuity. Diving candidates and designated divers shall have a minimum uncorrected distant visual acuity of 20/100 in the better eye and 20/200 in the worse eye, both of which must be correctable to 20/20. Waiver considerations will be on a case-by-case basis. Emphasis on the ability to perform previous diving duties/recreational diving, if any, should be elaborated on in the applicant's letter requesting a waiver of the physical standards.

# CHAPTER 4

# HEALTH RECORDS AND FORMS

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# CHAPTER 4. HEALTH RECORDS AND FORMS

## Section A - Health Records.

1. Purpose and Background.

   a. The health record is the chronological medical and dental record of an individual while a member of the Coast Guard or the Coast Guard Reserve. The primary reasons for compiling a health record are listed below.

      (1) To develop an accurate clinical history that will help in future diagnosis and treatment.

      (2) To protect the Government, the individual concerned, and the individual's dependents. It may be used in adjudicating veterans claims by making permanently available in a single record all entries relative to physical examinations, medical and dental history, preliminary to entry and throughout the individual's entire Coast Guard career. This is accomplished by opening or maintaining medical and dental records:

         (a) upon entry into the Service;

         (b) as required to maintain concise, yet complete, records during period of service; and

         (c) at time of separation.

      (3) To facilitate appraisal of the physical fitness or eligibility for benefits by making the information contained in the health record available to Coast Guard selection boards, disability evaluation system, Board of Correction of Military Records, for income tax purposes, and for claims to the Department of Veterans Affairs.

      (4) To furnish a basis for collecting statistical information.

      (5) To identify deceased persons through dental records when other means are inadequate.

   b. As an individual's service career progresses, the health record increases in value to the Government, the individual, and the individual's family and dependents. Accuracy, therefore, is of the utmost importance in making entries, including entries regarding minor ailments or injuries which appear trivial at the time, but which must be recorded to protect the Government and the individual.

2. Contents of the Health Record.

   a. Each member's health record shall consist of CG-3443 (Health Record Cover) with medical records and dental records arranged as follows:

(1) SECTION I - HISTORY OF CARE. Maintain the Adult Preventive and Chronic Care Flowsheet on top of this Section. All other forms in Section I are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence. Do not separate corresponding forms SF-88 and SF-93.

(a) Adult Preventive and Chronic Care Flowsheet Form DD 2766

(b) Consultation Sheet SF-513

(c) Narrative Summary Clinical Resume * SF-502

(d) Report of Medical Examination SF-88 (Rev.10-94), and History and Report of OMSEP Examination Form CG-5447 (Rev.6-00)

(e) Report of Medical History SF-93 (Rev.6-96)

(f) Report on or Continuation of *, ** SF-507

(g) Medical Board Report Cover Sheet * NAVMED 6100/1

(2) SECTION II - RECORDS OF CARE. All forms in this Section (and their civilian equivalents) are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence.

(a) Chronological Record of Care SF-600

(b) Emergency Care and Treatment SF-558

(3) SECTION III - RADIOLOGICAL REPORTS. All forms in this Section are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence.

(a) Radiographic Consultation Request/Report SF-519A

(b) Medical Record-Radiographic Reports SF-519

(4) SECTION IV - LABORATORY REPORTS AND ECG REPORTS. All forms in this Section are to be filed together in reverse chronological order (i.e., most recent on top) in the following bottom to top sequence.

(a) Clinical Record - Laboratory Reports SF-514

(b) Clinical Record - Electrocardiographic Record SF-520

(5) SECTION V - MISCELLANEOUS. All forms in this Section shall be arranged in the following bottom to top sequence.

(a) Chronological Record of Service CG-4057

(b) Special Duty Medical Abstract * NAVMED 6150/2

(c) Record of Occupational Exposure to Ionizing Radiation * DD-1141

(d) Occupational Health Surveillance Questionnaire * CG-5197

(e) Syphilis Record * SF-602

(f) Request for Administration of Anesthesia and for Performance of Operations and other Procedures * SF-522

(g) Eyewear Prescription DD-771

(h) Immunization Record SF-601

(6) SECTION VI - DENTAL RECORD AND INTERNATIONAL VACCINATION RECORD. All forms in this Section shall be arranged in the following bottom to top sequence.

(a) International Certificate of Vaccination PHS-731

(b) U.S. Coast Guard Dental Record CG-3443-2

1 Sensitivity Sticker * PHS-2410

2 Dental Health Questionnaire CG-5605

3 Health Record - Dental -- (Continuation) * SF-603A

4 Health Record - Dental SF-603

Note:

* --- When required

** -- SF-507's are attached to and filed after the form they continue

*** - Optional Form

b. File forms of the same number in their assigned sequence, with the most recent on top of each previous form, e.g., SF-600 dated 94/02/15 is filed on top of SF-600 dated 94/02/14.

c. Record all dates on the Health Record Cover in the following sequence (all numerals): year/month/day (e.g., 51/02/07).

d. Reports, including laboratory, X-ray, and consultations, shall be reviewed and initialed by the responsible MO, DO, PYA or NP before they are filed in the health record.

e. The health record is a legal document. As such, legibility of all information is essential. Patient ID information shall be typed, printed, or stamped. All entries shall be neat and legible. All signatures shall be accompanied by the stamped or typed name and rank of the practitioner.

3. Opening Health Records.

a. General.

(1) A health record will be opened at the recruiting office for each individual upon entry into the Coast Guard.

(2) A new health record will be opened upon reenlistment of personnel with prior USCG service when such enlistment is not effected the day following discharge. In all cases, request the individual's health record covering prior military service from the National Personnel Records Center, St. Louis, MO.

(3) Other Specific Occasions for Opening Health Record.

| **OCCASSION** | **OPENED BY** |
|---|---|
| Officer appointed from civilian | First duty station |
| Reserve Officer | Unit where procured |
| Cadet | Academy |
| Retired Personnel recalled to Active Duty | First duty station |
| Original Record Lost or Destroyed | Responsible Custodian |

4. Terminating Health Records.

a. General Instructions.

(1) Upon discharge without immediate reenlistment or enlistment in the Coast Guard Reserve, or retirement, forward the health record (Medical Personnel Data Record or MED PDR) to the servicing PERSRU within 2 days of the member's separation. **DO NOT GIVE THE ORIGINAL HEALTH RECORD TO THE MEMBER UPON FINAL SEPARATION**. Cite the reason for separation on the reverse side of Chronological Record of Service (form CG-4057). The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to Commander (CGPC-adm3) or Commandant (G-RSM-3) for Reservists. (See Section 4-B-27 for additional requirements for CG-4057.) Health record documents are not filed in the HQ PDR. They will be returned to the unit if received by Commander, (CGPC adm-3) in error.

(2) Discharge for immediate reenlistment at the same unit, revocation of appointment as a temporary officer to continue on active duty in permanent status, or retirement with continuation of active duty are not termination of service.

(3) When a health record is terminated and the dental record is not available for inclusion therein, forward a letter of explanation with the health record.

b. Release from active duty (RELAD) with concurrent transfer to the Coast Guard Reserve or discharge from active duty with immediate enlistment in the Coast Guard Reserve. Upon RELAD, forward the health record (MED PDR) to the servicing PERSRU within 2 days of the member's separation. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to District (rs) in which the member will reside after separation.

c. Disappearance, Other Than Desertion. Whenever an individual disappears and the facts regarding such disappearance are insufficient to justify a conclusion of death, enter a complete account of the circumstances on an SF-600 in the health record. Do not terminate the health record until final disposition.

d. Desertion.

(1) When an individual is officially declared a deserter, enter an explanatory note on SF-600. Forward the health record (MED PDR) to the servicing PERSRU within 2 days of determination of deserter. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to Commander (CGPC) or Commander (CGPC-rpm) for Reservists.

(2) Upon return of a deserter to his/her own command, a physical examination shall be performed and recorded on an SF-88. Retain the original for incorporation into the health record, and forward a copy to Commander (CGPC) or Commander (CGPC-rpm) for Reservists with a request for the deserter's health record.

e. Discharge of Personnel Convicted by Civilian Authorities. When the Commandant directs the discharge of personnel convicted by civilian authorities, the commanding officer will make arrangements for their physical examination, to be recorded on an SF-88. In the event no medical officer is available, obtain a statement signed by the warden of the penitentiary or reformatory that the person to be discharged from the Coast Guard is physically and mentally qualified for discharge and is not in need of hospitalization. The warden's statement, accompanied by the terminated health record, will be forwarded with the closed out service record.

f. Discharge of Courts-Martial Prisoners Confined in Federal Penitentiaries, Reformatories, and the Naval Disciplinary Command. When the Commandant directs the discharge of a courts-martial prisoner confined in a Federal penitentiary, reformatory, or the Naval Disciplinary Command, the command to which the prisoner has been administratively assigned shall arrange with the warden for

physical examination of the prisoner. Results of this physical examination will be entered on the SF-88 and signed by the medical officer of the designated penal institution. The command to which the prisoner has been administratively assigned will terminate the health record, using the information furnished on the SF-88 and the account of medical, dental, and first aid treatments supplied by the penal institution. The terminated health record, SF-88, and the resume will then be forwarded with the closed out service record.

g. Retired Personnel (Includes Temporary Retirement). Upon notification of retirement, make an entry on CG-4057 under "Remarks" indicating place, date, and category under which retired. The command having custody of the health record will sign the CG-4057 and forward it to the command having administrative control of the member for inclusion in the closed out service record.

h. Cadets. When a cadet's service is terminated, the health record will be terminated and forwarded to the Cadet Record Office, for processing. Following this procedure, the record will be forwarded to the Registrar's Office and held until the departing cadet's class graduates. When this occurs, the record will be forwarded to the Federal Personnel Records Center, St. Louis, MO. This includes cadets who graduate from the Academy but do not accept or are not tendered a commission.

i. Officers (Reserve) to Inactive Duty and Officers (Regular) who Resign to Accept a Reserve Commission. In the case of reserve officers being released to inactive duty and regular officers who resign and accept a commission in the reserve, the health record will be terminated.

j. Death. Upon notification of death, make an entry on CG-4057 under "Remarks" indicating place, time, date, and a short explanation of the circumstances surrounding death. A commissioned officer will sign the CG-4057 and then deliver it and the terminated health record to the commanding officer (no later than the day following death) for inclusion in and transmittal with the member's service record to Commander (CGPC) or Commander(CGPC-rpm).

5. Custody of Health Records.

a. General Responsibilities.

(1) Health records are the property of the Federal government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). Health record custody and security requirements are applicable to all documents which contain health information, whether or not filed in the health record, such as Inpatient Medical Records and mental health treatment records. Disposal of all health record documents shall be in accordance with Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).

(a) Since health records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).

(b) Except as contained in the Privacy and Freedom of Information Acts Manual, the information contained in health records shall not be disclosed by any means of communication to any person, or to any agency unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the requestor's responsibility to obtain the consent.

(2) Health records shall be retained in the custody of the Chief, Health Services Division of the unit to which the individual is attached. At units where there is no medical officer attached, the health record will become the responsibility of the executive officer in accordance with Coast Guard Regulations, COMDTINST M5000.3(series), who may delegate custody to the senior health services department representative. At units without a health services technician the custody of the health record is the responsibility of the unit's executive officer. Maintenance of these health records may be delegated to health services personnel of another unit (e.g., groups, support centers, etc.). **At no time shall individual members keep or maintain their own health record**. If there is a need to check out a health record for an appointment at another health care facility, the health record custodian shall have the member complete and sign the health record receipt form (NAVMED 6150/7). The health record custodian shall place the record in an envelope, hand it to the member, and tell the member to return the record as soon as possible following the appointment. The envelope used for record transportation shall bear a printed request reminding outside providers to treat the contents as confidential, and requesting providers to include copies of their consultations or case notes for placement in the health record. The responsibilities contained herein are also applicable to Reserve components.

(3) Individuals may examine their own health record in the presence of a health services department representative, providing:

(a) such examination does not interrupt the unit's scheduled mission, and

(b) there is no information contained therein that would be detrimental to the individual's mental well-being, as determined by the member's attending physician.

(4) Health records are subject to inspection at any time by the commanding officer, executive officer, duly appointed counsel in the case of formal hearings, or duly appointed Coast Guard officials who are conducting authorized investigations. Such inspections will be conducted in the presence of a health services department representative to aid in the interpretation of information contained in the health record.

(5) Health services personnel making entries in health records shall ensure all entries, including signatures, are neat and legible. Signature information shall include the stamped or printed name and grade or rate of the signer. Facsimile signature stamps may only be used on the PHS-731 and the SF-601.

(6) If an erroneous entry is made in a health record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.

(7) Health services personnel are responsible for the completeness of the entries made on any medical or dental form while the health record is in their custody. No sheet shall be removed from the health record except under conditions specified in this Manual.

(8) Members are not authorized to write in, alter, remove documents from, or otherwise change their health record or its contents. Request for changes to health record contents shall be made in accordance with procedures contained in Chapter 16 of the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3.

6. Transfer of Health Records.

a. When active duty or reserve personnel are transferred, The Chief Health Services Division, his designee, the Executive Officer, or the senior Health Services department representative will make the necessary entries in the health record and ensure that the current health record, dental record (SF-603) and Certificate of Vaccination (PHS-731), if applicable, are properly completed.

b. A DD877 shall be initiated for each record transferred (see Figure 4-B-24). The DD877 shall be attached to the front cover of the record. The health record will be forwarded to the Coast Guard clinic or Independent Duty Health Services Technician servicing the gaining unit. **Only certified mail with return receipt will be used for records transfer**. (See Article 4-D-7.c. of this Manual for policy regarding transfer of Clinical Records of dependents.)

c. Transfer to Federal Penitentiaries, Reformatories, or the Naval Disciplinary Command. A letter of transmittal and a copy of the health record shall accompany a member who is being transferred under sentence of a courts-martial (who has not been or will not be discharged immediately) to a penal institution for execution of the unexpired sentence. The original health record, with a letter of transmittal stating the name of the penal institution to which the prisoner is being transferred and the length of the sentence, shall be forwarded to the command to which the member has been administratively assigned which shall maintain the health record until the prisoner has been discharged from the Service. A copy of the letter of transmittal shall also be forwarded to Commander (CGPC).

7. Creating an Additional Volume.

   a. Due to chronic medical conditions, long narrative summaries, medical boards, etc., the record may fill to capacity which may cause the loss or damage to new records.

   b. Procedures for creating a second volume:

      (1) Obtain a new Health Record (CG-3443) and transcribe the information from the original jacket.

      (2) Write "VOLUME II" in bold print in the lower left corner of the new jacket cover. Insert forms required by this chapter.

      (3) Write "VOLUME I" in bold print in the lower left corner of the original jacket cover.

      (4) Transfer all documents pertaining to current or chronic illness to the new record.

      (5) Remove the most recent SF-600 from VOLUME I and place it in VOLUME II. Insert a blank SF-600 on top of the remaining forms in VOLUME I and draw a diagonal line across the page. Enter the following on this line:

      CLOSED. NO FURTHER ENTRIES IN THIS RECORD. REFER TO VOLUME II.

      (6) Insert the most recent Report of Medical Examination (SF 88) and the Report of Medical History (SF 93) into VOLUME II.

      (7) Transcribe the immunization and HIV test date information onto a blank SF-601 and insert it in the appropriate section of VOLUME II.

      (8) Place the original Problem Summary List (NAVMED 6150/20) into VOLUME II and a copy of this form in VOLUME I with the annotation, "CLOSED. NO FURTHER ENTRIES.", below the last entry.

      (9) Place the original Chronological Record of Service (CG 4057) in VOLUME II and a copy in VOLUME I.

8. Lost, Damaged, or Destroyed Health Records.

   a. If a health record is lost or destroyed, a complete new health record shall be opened by the unit health record custodian. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing health record should be recovered, any additional information or entries in the replacement record shall be inserted in the old record.

b. Health records which become illegible, thus destroying their value as permanent records, shall be restored and duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Take particular care in transcribing the date on SF-88 into the new record as such information may be required by the Department of Veterans Affairs to determine the individual's right to pension or other Federal benefits. Stamp or mark "DUPLICATE" on the cover of the new record. Explain the circumstances necessitating the duplication on an SF-600. Forward health records replaced by duplicate records to CGPC-adm-3.

9. Accuracy and Completeness Check.

a. Upon transfer of an individual, the health record custodian at both the detaching unit and the receiving unit shall inspect the health record for accuracy and completeness, in accordance with the following guidelines:

(1) that all immunizations are up-to-date (See Immunizations and Chemoprophylaxis, COMDTINST 6230.4 (series));

(2) that PPD screening is current in accordance with Section 7-D of this Manual;

(3) that all required audiograms are completed, especially on personnel involved in the hearing conservation program;

(4) that required forms have been properly completed and are in the correct order;

(5) that all deficiencies in physical requirements shall be scheduled for correction, all missing forms shall be replaced, and all other clerical or administrative errors corrected; and

(6) that all OMSEP requirements are met.

b. The health record custodian shall ensure that all identified deficiencies are corrected immediately. Appointments shall be scheduled and the individual's supervisor notified of the need to correct deficiencies as soon as possible.

c. Upon separation of the individual from the Service, the unit terminating the health record will inspect the health record, correct all errors, fill in omissions, and make sure the patient identification information is completed on all forms.

Section B - Health Record Forms.

1. CG-3443 (Health Record cover). (See FIGURE 4-B-1) Each patient's health record shall be maintained in a CG-3443 (Health Record Cover). The CG-3443 shall be completed according to the following instructions:

   a. Last Name. Record in all capital letters.

   b. Given Name(s). Record given name(s) in full without abbreviations. If the individual has no middle name or initial then use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s) record each initial in quotation marks. When "Jr." or "II" or other similar designations are used they shall appear after the middle name or initial.

| | | | |
|---|---|---|---|
| **DOE** | **John** | **Buck** | **Jr**. |
| **Surname** | **First Name** | **Middle Name** | |

   c. Beneficiary. Enter the appropriate beneficiary code to describe the patient (enter "20" for active duty members).

      (1) 01 to 19 - Dependent children in order of birth

      (2) 20 - Sponsor

      (3) 30 - Spouse

      (4) 31-39 - Unremarried former spouse

      (5) 40 - Dependent mother (active duty)

      (6) 45 - Dependent father (active duty)

      (7) 50 - Dependent mother-in-law (active duty)

      (8) 55 - Dependent father-in-law (active duty)

      (9) 60 - Other dependents

      (10) 80 - Humanitarian (non-eligible)

      (11) 90 - Civilian employee

      (12) 99 - Other eligible

   d. Sponsor's Social Security Number. Enter.

   e. Blood Type and Rh Factor. Enter the blood-type and Rh factor in the appropriate boxes. Use utmost caution when recording this information. If not known, complete a blood-type and Rh factor test as required.

f. Special Status. Check the appropriate block to indicate whether the individual is in aviation or diving status, has a waiver, requires occupational monitoring, or has an allergy.

g. Date of Birth. Enter year, month and day (e.g., 51/02/07).

h. Local Use. Use the spaces provided below the sensitivity sticker location for local use information such as rank, unit, etc. as needed.

2. CG-5266 (Drug Sensitivity Sticker).

a. General. Form CG-5266 should be initiated for anyone having documented history of sensitivity or hypersensitivity to specific drugs, serums, or vaccines, including PPD converters. Other non-drug allergies should be indicated on this form only if they will affect potential therapy (e.g., egg yolks). Every effort shall be made to verify the reported sensitivity and to confirm that it is allergic in nature.

b. Detailed Instructions.

(1) Prepare two originals. (One each for the health and dental records.)

(2) List the name of each drug, serum, vaccine, or anesthetic indicated on the Problem Summary List (NAVMED 6150/20).

(3) Affix the CG-5266 vertically to the indicated location on the health record cover (form CG-3443) and vertically to the lower left corner on the front of the dental record cover (CG-3443-2).

3. DD2766 (Adult Preventive and Chronic Care Flowsheet Form. (Figure 4-B-2)

a. General. The Adult Preventive and Chronic Care Flowsheet Form documents significant/chronic health problems, allergies, chronic medications, hospitalizations/surgeries, health counseling, immunizations, PPD, DNA & HIV testing, screening (preventive medicine) exams, other medical readiness items (such as blood type, G6PD, sickle cell, glasses, dental exam, etc), and chart audits. In-house training sessions should be conducted prior to the implementation of this form

b. Detailed Instructions. DD2276 should be inserted as the first page of the medical record and all sections completed by the health care provider with the following guidelines exceptions:

(1) Information from previous Problem Summary Lists should be copied and updated onto the DD2276 as it is placed in the health record.

(2) Sections 8.a., 10.e. and 10.i. are not required to be completed.

(3) Use a pencil to darken the circles on Section 7, Screening Exam.

(4) The medical officer should enter the date and location of every deployment the member participates in Section11, Pre/Post Deployment History. Pre and post deployment questionnaires are documented in Section 11 for participants in DOD deployment.

4. SF-600 (Chronological Record of Medical Care).

a. General.

(1) This form provides a current, concise, and comprehensive record of a member's medical history. Properly maintained, the SF-600 should: aid in evaluating a patient's physical condition; greatly reduce correspondence to obtain medical records; eliminate unnecessary repetition of expensive diagnostic procedures; and serve as an invaluable permanent record of health care received. The SF-600 shall be continuous and include the following information as indicated: complaints; duration of illness or injury, physical findings, clinical course, results of special examinations; treatment; physical fitness at time of disposition; and disposition. The SF-600 also serves as the patient's prescription from which pharmacy services are provided.

(2) When a new SF-600 is initiated, complete the identification block with the name (last, first, middle initial), sex (M or F), year of birth, component (active duty or reserve), service (USCG, USN, USA, etc.), Social Security Number, and the member's grade/rate and organization at the time the form is completed.

(3) File SF-600's on the right side of the medical record with the most current SF-600 on top.

(4) Enter sick call entries on SF-600 in the following SOAP format (See FIGURE 4-B-3).

**SOAP METHOD OF SICK CALL WRITE UPS**

**S: (Subjective)**.

cc: (Chief Complaint) sore throat, cough, diarrhea, etc.

hpi: (History Present Illness) onset of symptoms, all problems, review of symptoms

pmh: Past Medical History) any related problems in past that may be present with chief complaint

fh: (Family History) any diseases, chronic/acute, possibly related to present complaint

all: (Allergies) any known allergies to drugs/medications, etc.

**0: (Objective)**.

First visual assessment/evaluation of the patient's general appearance: limping, bleeding, doubled over, etc.

PE: All results of physical exam, vital signs, lab, x-ray, and any other study results

**A: (Assessment)**.

Imp: (Impression, Diagnosis) includes R/0 (rule out)

**NOTE: THIS IS TO INCLUDE, AFTER IMPRESSION, WHAT YOU ARE GOING TO DO NOW AND WHY--SUCH AS, SUTURING, TOURNIQUET, ETC.**

**P: (Plan)**.

List of medications given, lab, x-ray, special studies ordered, duty status, return appointments, referrals, etc.

(5) The entries for all treatments shall be complete with regard to place, date, problem number (if appropriate), number of sick days, diagnosis of all conditions for which treated and signature of individual furnishing treatment. Note all facts concerning the origin of the disease, pregnancy status, symptoms, course, treatment, and if a conflicting opinion is expressed subsequently by the same, or another medical officer, fully state the reason for such change. The record need not be voluminous, but it shall be thorough, concise, clearly phrased, and complete in each case. All entries, including signatures, must be legible.

(6) When a member is injured or contracts a disease while on leave, or when for any other reason the facts concerning an injury or sickness have not been entered in the individual's health record, the record custodian shall ascertain the facts in the case and make the necessary entries on SF-600. Discuss and document the instructions given to the patient. Include the intended treatment and, as appropriate, possible alternative treatments, possible complications, and long term prognosis. Information regarding previous treatments should be entered giving the following: date, place, and full details of treatment; laboratory reports; x-ray results; etc. The following shall also be entered:

(7) "Date:
**"Transcribed From Official Records.**

**Signature/Rate Duty Station of Transcriber"**

(8) When an individual is required to carry the PHS-731, enter a statement of acknowledgment on the SF-600.

(9) When an individual is diagnosed as having a Sexually Transmitted Disease (STD) make an entry to record that an interview was conducted and that the following was discussed with the patient:

(a) symptoms,

(b) complications,

(c) treatments, and contacts.

5. Treatment at Other Than Unit Assigned. When an activity furnishes sick call treatment to an individual whose health record is not available, an entry shall be made on a new SF-600 and forwarded to the individual's duty station for inclusion in the health record.

6. SF-88 (Report of Medical Examination).

a. Purpose. SF-88 is used to record and use information obtained from physical examinations.

b. Preparation. (See FIGURE 4-B-4)

(1) When Prepared. SF-88 (Rev. 10-94) shall be prepared and submitted to the reviewing authority whenever a complete physical examination is required.

(2) Required Entries. Certain groups of personnel are required to meet physical standards somewhat different from other groups. Accordingly, the use of all the spaces or use of the same spaces on the SF-88 is not necessarily required for reporting the results of the various categories of physical examinations. If a certain item of the medical examination is required and facilities for accomplishing it are not available, an entry **"NFA"** (No Facilities Available) shall be made in the appropriate space. An entry **"NE"** (Not Evaluated) shall be made in the appropriate space for any item of the clinical evaluation (Items 18-43) which was not evaluated. For other items listed on the SF-88 which were not required for a particular category of physical examination, an entry **"NI"** (Not Indicated) shall be made in the appropriate space. Reference should be made to other pro-visions of Chapter 3 which prescribe the nature and scope of each physical examination and indicate the applicability of items of the SF-88 to the particular program. Unless otherwise indicated by such provisions, the minimum requirements for completing an SF-88 are:

(a) All Examinations. Items 1-30, 33, 38, 40 and 41-51 shall be completed for all physical examinations, if facilities are available. Item 19 (cc), shall be completed for all female personnel.

(b) Aviation Personnel. Additionally, Items 31,32, and 34-38 shall be completed for physical examinations of aviation personnel.

(3) A physical examination must be thorough, recorded accurately, and contain sufficient information to substantiate the final recommendation. Before signing and forwarding, the examiner shall review the completed SF-88 for completeness and accuracy. Failure to do so reflects seriously on the examiner's thoroughness. Remember that the reviewing authority does not have the advantage of a direct examination and must rely on the examiner's written record and appropriate additional information in arriving at a decision.

c. Details for Entries on SF-88.

(1) Item 1: Last Name - First Name - Middle Name. Record the surname in all capital letters. Record the given name(s) in full without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial in quotation marks (i.e., MANUEL, Thomas "W"). If the individual has no middle name, enter the letter "(n)" in parenthesis [i.e., TARVIN, Laurie (n)]. Designations, such as, "Jr." or "II" shall appear after the middle name or initial. In the absence of a middle name or initial, these designations shall appear after the "(n)."

(2) Item 2: Identification No. Enter SSN.

(3) Item 3: Grade and Component or Position. Use official abbreviation of the current grade or rate, branch of Service, class and status; i.e., regular, reserve, or retired and if active or inactive. Example: HSCS, USCG; LTJG, USCGR; SN, USCG (TEMPRET); ETCM, USCG (RET). If not Service member, enter "civilian."

(4) Item 4: Home Address. Enter the evaluee's present residence and not the home of record.

(5) Item 5. Emergency contact, name and address.

(6) Item 6: Date of Birth. e.g., 4 SEP 49. Enter age in parentheses above date

(7) Item 7. Age

(8) Item 8. Sex, check appropriate box.

(9) Item 9. Relationship of contact. Refers to Item 5. Wife/husband/brother/sister/friend.

(10) Item 10. Place of Birth. Enter city, town, or village and the state. For foreign born, enter the name of the country as known at the time of the individual's birth.

(11) Item 11. Race. Check appropriate box.

(12) Item 12a. Agency. Enter the OPFAC number of the unit to which the examinee is attached.

(13) Item 12b. Organization Unit. List name of ship or station to which the examinee is assigned. If applicant for entry into Service, enter the recruiting office concerned.

(14) Item 13. Total Years of Government Service. Enter years and months (e.g., 06 yrs 04 mos).

(15) Item 14. Examining Facility or Examiner. For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.

(16) Item 15. Rating or Specialty of Examiner. (i.e. Family Practitioner, Nurse Practitioner, or Flight Surgeon.

(17) Item 16: Purpose of Examination. Enter the specific purpose(s) of the examination, such as: Original Enlistment; Applicant Coast Guard Academy; Enlistment; Prior Service; Diving Applicant; BASIC OMSEP; IMB (Initial Medical Board)/DMB (Disposition Medical Board), etc. Do not use the incomplete terms "flight physical," "diving physical," or "aviation physical." Avoid using nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program. When necessary, continue under Item 42, Notes.

(18) Items 17: Clinical Evaluation. Check each item in appropriate column. In the area reserved for notes, describe every abnormality in detail. Enter pertinent item number before each comment. Continue in Item 42 and use Continuation Sheets (SF-507), if necessary.

(19) Item 18. Complete dental chart with the symbols shown. Under "Remarks" enter type of dental examination performed and the dental classification assigned. Indicate whether or not the examinee meets the dental standards for which the examination is being done. Record all dental defects and diseases discovered. Enter disqualifying dental defects in detail. When oral disease or dental defects are discovered on examination of active duty personnel, the dental examiner shall make suitable recommendations for instituting corrective measures. If a dental officer is not available, the medical officer shall determine the examinee's dental qualification. Enter the statement "Examination not performed by a dental officer" under remarks of Item 44.

(20) Item19 A-F: Laboratory Findings. Enter all laboratory results in quantitative values.

(a) Item A: Urinalysis. Enter specific gravity and results of albumin, sugar, and if required, microscopic tests in the indicated spaces.

(b) Item B: Chest X-ray. Enter place where x-ray was taken, film number, date, and interpretation.

(c) Item C: Serology. Enter date, test used, and results.

(d) Item D: EKG. When required, enter interpretation.

(e) Item E: Blood Type and Rh Factor. Record blood group and Rh factor. Required on initial entry physical examinations only!

(f) Item F: Other Tests. Enter results of complete blood counts. Enter all other tests done and their results which are not indicated on the form and which were performed in connection with the physical examination (e.g., sickle cell test, PAP test, PPD, etc.). The results will be continued in Item 42 or on Continuation Sheets (SF-507), if necessary. If provided on the lab report, include "normal" range values for all tests performed by a civilian or military lab. Use quantitative values and not "WNL" or other such qualitative forms.

(21) Item 20: Height. Measure without shoes and record to the nearest one-half centimeter (one-half inch).

(22) Item 21: Weight. Measure with the evaluee in under garments and record results to the nearest kilogram (pound).

(23) Item 22: Hair Color. Enter the hair color as: flaxen, sand (yellow-red), auburn (red-brown), brown (light, medium or dark must be specified), black, gray, etc. Note if the hair is curly, very thin, or if the person is bald.

(24) Item 23: Color Eyes. Enter appropriate color.

(25) Item 24: Build. Indicate by "X" in appropriate block.

(26) tem 25: Temperature. Leave blank.

(27) Item 57: Blood Pressure. Record the actual value in numerals for both systolic and diastolic.

(28) Item 26: Pulse. Record the actual pulse rate.

(29) Item 28: Distant Vision. Test and record using the Snellen scale. Record vision in the form of a fraction and in round numbers, that is 20/20, 20/40, not 20/20-2 or 20/40-3.

(30) Item 29: Refraction. Enter the lens prescription when the evaluee wears (or requires) lenses for correction of visual acuity. Do not enter the term "lenses."

(31) Item 30: Near Vision. Test and record using the Snellen scale.

(32) Item 31: Heterophoria. Enter when indicated.

(33) Item 32: Accommodation. Enter when indicated.

(34) Item 33: Color Vision. Enter the test used and the results.

(a) Farnsworth Lantern. Record the results as "Passed FALANT" or "Failed FALANT" followed by the fraction of correct over total (i.e., 9/9 or 17/18).

(b) Pseudoisochromatic Plates (PIP). Record results as "Passed PIP" or "Failed PIP" followed by the fraction of correct over total (i.e., 12/14 or 14/14).

(c) Enter "Passed on record" or "failed on record" if the results of a previous PIP or FALANT examination are available on record for review.

(35) Item 34: Depth Perception. When indicated, enter test used in left portion of Item 65.

(a) AFVT. In the appropriate space in the right-hand portion of Item 34, record the letter designation of the highest group passed (i.e., Passed F).

(b) Verhoeff. In the appropriate space in right-hand portion of Item 34, record perfect score as 16/16.

(36) Item 35: Field of Vision. Enter when indicated.

(37) Item 36: Night Vision. Enter when indicated.

(38) Item 37: Red Lens Test. Enter when indicated.

(39) Item 38: Intraocular Tension. When indicated, enter the results in millimeters of mercury.

(40) Item 39: Hearing. Leave blank. Use of the Whispered Voice Test is not authorized.

(41) Item 40: Audiometer. Required on ALL physical examinations. Use ANSI 1969 standards, do not use ISO or ASA standards.

(42) Item 41: Psychological and Psychomotor. Enter when indicated (e.g. AA, RAT, etc.).

(43) Item 42: Notes and Significant or Interval History. Use this space for recording items such as:

(a) any pertinent medical history;

(b) summary of any condition which is likely to recur or cause more than minimal loss of duty time;

(c) wrist measurements;

(d) most recent HIV antibody test date (see Article 3-C-20.b.(5) of this Manual);

(e) date of PPD and results; and

(f) Preventive Medicine stamp per Use of Preventive Medicine Stamp, COMDTINST 6200.11(series), for exams originating in Coast Guard sickbays and clinics.

(44) Item 43: Summary of Defects and Diagnoses. List ALL defects in order to protect the Government in the event of future disability compensation claims. All defects listed which are not considered disqualifying shall be so indicated by the abbreviation NCD (Not Considered Disqualifying). When an individual has a disease or other physical condition that, although not disqualifying, requires medical or dental treatment clearly state the nature of the condition and the need for treatment. If a medical or dental condition is disqualifying, and treatment is scheduled to be completed prior to transfer to overseas or sea duty, indicate the date the member is expected to be fully qualified, e.g., "Dental appointment(s) scheduled, patient will be class I (dentally qualified) by (date)".

(45) Item 44: Recommendations. Indicate any medical or dental recommendations. Specify the particular type of further medical or dental specialist examination indicated (continue in Item 44 or use SF-507, if necessary).

(46) Item 45A: Physical Profile. Leave blank.

(47) Item 46: Examinee's Qualification. State whether or not the examinee is qualified for the purpose of the examination. If the purpose for the examination is an IMB or DMB, state whether or not the examinee is qualified or not qualified for retention and to perform the duties of his/her rank/rate at sea and foreign shores.

(48) Item 47: Disqualifying Defects. Indicate item number only.

(49) Items 47-51: Names and Signatures of Examiners. The name, grade, branch of Service, and status of each medical and dental examiner shall be typewritten, printed, or stamped in the left section. Each examiner shall sign using ballpoint pen or ink pen (black or blue-black ink only) in the appropriate section. Do not use facsimile signature stamps. When attachment sheets are used as a supplement or continuation to the report, they shall be serially

numbered (both sides); however, indicate only the actual number of attached sheets in the bottom right block on SF-88.

7. SF-93 (Rev. 6-96) (Report of Medical History). (See FIGURE 4-B-5)

a. Purpose. SF-93 provides a standardized report of the examinee's medical history to help the examiner evaluate the individual's total physical condition, and to establish the presence of potentially disabling conditions which are not immediately apparent upon physical examination. In preparing the form, encourage the examinee to enter all medical problems or conditions experienced, no matter how minor they may be. The examiner must investigate and evaluate all positive medical history indicated on the form.

b. Preparation and Submission of SF-93. Prepare and submit SF-93 with all physical examinations except: Periodic OMSEP and Substitution/Overseas/Sea Duty Modified Physical Examination.

c. Preparation Procedures. SF-93 shall be prepared by the examinee and the examining medical officer.

(1) The examinee shall furnish a true account of all injuries, illnesses, operations, and treatments since birth. False statements or willful omissions in completing the SF-93 may result in separation from the Service upon arrival at the Academy, Recruit Training Center, Officer Candidate School, or later in the individual's career.

(2) A copy of the SF-93 must be included in the member's health record. Entries must be printed, in the examinee's and examiner's own handwriting, using either ball-point pen or ink pen (black or dark blue). Pencils or felt-tip pens will not be used. Information in the numbered blocks on the form will be entered in the following manner:

(a) Block 1: Enter name as follows: SMITH, Hannibell H. Record the surname in all capital letters. Record the given name(s) in full, without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial within quotation marks. If the individual has no middle name, enter the letter "(n)" in parenthesis. Designations such as "Jr." or "II" will appear after the middle name or initial or after "(n)" if there is no middle name.

(b) Block 2: Enter SSN.

(c) Block 3. Use official abbreviation of current grade or rate, branch of the Service, class and status; i.e., regular, reserve, or retired and if active or inactive. Example: HSCM, USCG; LTJG, USCGR; HSC, USCG (RET); HS3, USCG (TEMPRET). If not a Service member, enter "civilian."

(d) Block 4a-d: Home Address - Enter the evaluee's present residence and not the home of record.

(e) Block 5: Examining Facility or Examiner - For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.

(f) Block 6: Purpose of Examination - Enter the specific purpose(s) of the examination, such as: Original Enlistment; Applicant, Coast Guard Academy; Separation; Enlistment, Prior Service; Diving Applicant; BASIC OMMP; etc. Do not use the incomplete terms "flight physical," "diving physical." Avoid using nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program.

(g) Block 7a: The examinee shall enter a statement as to present health and a list of medications presently being taken. For individuals receiving examinations more frequently than quinquennial, there is often little change in the medical history from year to year. As an alternative to having the examinee complete Section 10 of the SF 93 at a periodic examination, the following statement may be entered in block 7a and initialed by the person undergoing the examination.

"I have reviewed my previous Report of Medical History and there have been no changes since my last medical examination, except as noted below." _____(initials)

(h) Blocks 10-22: Self-explanatory.

(i) Block 23. List all immunizations received.

(j) Block 25: Prior to performing the physical examination, the examiner will review the completeness of the information furnished on the SF-93. When this is done, summarize the medical history under Block 25 as outlined below and then sign the form. If additional space is needed, use Continuation Sheet, SF-507.

(k) Do not use the term "usual childhood illnesses"; however, childhood illnesses (those occurring before age 12) may be grouped together enumerating each one. Incidents, other than those occurring in childhood, shall have the date recorded rather than the examinee's age. Do not use "NS" or "non-symptomatic" for items of history. Use "NCNS," "No Comp., No Seq." after items of recorded history where applicable. Elaborate on all items of history answered affirmatively except "Do you have vision in both eyes". The following specific questions shall also be asked on examination for initial entry into the Coast Guard, and for aviation and diving duty applicants:

1 "Is there a history of diabetes in your family (parent, sibling, or more than one grandparent)?"

2 "Is there a history of psychosis in your family (parent or sibling)?"

3 "Do you now or have you ever worn contact lenses?"

4 "Do you now or have you ever used or experimented with any drug, other than as prescribed by a physician (to include LSD, marijuana, hashish, narcotics, or other dangerous drugs as determined by the Attorney General of the United States)?"

5 "Have you ever required the use of an orthodontic appliance attached to your teeth or a retainer appliance? Month and year last worn? Are they still necessary?"

6 "Are there any other items of medical or surgical history that you have not mentioned?" All affirmative answers to the above questions shall be fully elaborated in Item 25. Negative replies to the above questions shall be summarized as follows: "Examinee denies history of psychosis, use of drugs, history of wearing of contact lenses, requirement for any orthodontic appliance, all other significant medical or surgical history; family history of diabetes." A rubber stamp or the overprinting of this information in Item 25 is recommended.

(3) Distribution. Attach the original SF-93 to the original SF-88 and submit to reviewing authority. A copy of the SF-93 and SF-88 shall be kept on file at the unit pending the return of the approved SF-93 and SF-88. After review and endorsement, the reviewing authority shall forward the original SF-93 and SF-88 to the members parent command for insertion into the members health record.

8. SF-558 (Emergency Care and Treatment) (Rev 9-96). (See Figure 4-B-6) This form provides a comprehensive yet concise record of emergency health care. It shall be used whenever an individual receives emergency treatment. Detailed instructions for completing the form are as follows:

a. Patient's Home Address or Duty Station. Complete all blocks in this section.

b. Arrival. Record the date and time the patient arrived at the clinic or emergency room for care.

c. Transportation to Facility. Record the name of the ambulance company or unit that transported the patient for care, if appropriate. If patient was not transported by ambulance or other emergency vehicle, enter "N/A'.

d. Third Party Insurance. List detailed insurance if known by patient. If potential third party liability exists, forward a copy of SF-558 to Commandant (G-WRP-2). Note: Disregard DD2568 in chart, enter N/A).

e. Current Medications. List all medications patient is presently taking.

f. Allergies. Record any substance or drug to which the patient has a known or suspected allergy. If none, enter "NKA" (No Known Allergy).

g. Injury or Occupational Illness. Most fields. When, refers to date injury was sustained. Where, refers to location injury occurred. How, refers to what happened (briefly).

h. Emergency Room Visit. Self-Explanatory.

i. Date of Last Tetanus Shot. Self-Explanatory.

j. Chief Complaint. Record a brief description of why the patient is seeking health care.

k. Category of Treatment. If Condition is Result of Accident/Injury. Check the block that best describes the patients' condition upon arrival.

(1) Emergent. A condition which requires immediate medical attention and for which delay is harmful to the patient; such a disorder is acute and potentially threatens life or function.

(2) Urgent. A condition which requires medical attention within a few hours or danger can ensue; such a disorder is acute but not necessarily severe.

(3) Non-Urgent. A condition which does not require the immediate resources of an emergency medical services system; such a disorder is minor or non-acute

l. Vital Signs. Take and record all vital signs. Indicate the time vitals were taken. Use 24-hour clock annotation i.e. 0215.

m. Lab Orders and X-Ray Orders. Self-Explanatory, check appropriate box.

n. Orders. List orders given by provider. Record all medications, appointments made. Or any other follow-up plans.

o. Disposition. Check appropriate box. Ensure patient understands this section.

p. Patient/Discharge Instructions. Be specific. Ensure patient understands instructions given.

q. Patients Signature and Date. Have the patient or person accompanying the patient sign the form. This signature only acknowledges that instructions were given to the patient.

r. Time Seen by Provider. Record the time when the patient received treatment. Use 24-hour clock annotation i.e. 0215.

s. Test Results. Record results of tests ordered on patient.

t. Provider History/Physical. Self-explanatory, use standard S.O.A.P. format.

u. Consult With. List all individuals that on-scene provider received medical advice from. Example Dr. Richard Smith.

v. Diagnosis. Record patient diagnosis.

w. Providers Signature and Date. The medical officer or other health care provider shall sign and date the form.

x. Codes. List all ICD-9 codes applicable to the patient.

y. Patients' Identification. Ensure all patient identification information is entered.

9. DD-2215 Reference Audiogram. Suspend from future use. Do not remove existing forms from health record (file under section IV).

10. DD-2216 Hearing Conservation Data. Suspend from future use. Do not remove existing forms from health record (file under section IV).

11. SF-502 (Narrative Summary). (See FIGURE 4-B-7) SF-502's are used for a variety of purposes, such as:

    a. to summarize the important facts about a patient's hospitalization;

    b. to summarize the findings of a medical board; or

    c. to report the results of a Board of Flight Surgeons.

    If received subsequent to the individual's discharge from the hospital, it shall be inserted in the health record immediately upon receipt.

12. NAVMED 6100/1 (Medical Board Report Cover Sheet).

    a. The NAVMED 6100/1 is used in preparing a medical board. A copy of the NAVMED 6100/1 and the complete medical board shall be inserted into the individual's health record.

    b. Detailed instructions for preparing and distributing this form are contained in Physical Disability Evaluation System, COMDTINST M1850.2 (series).

13. SF-513 (Consultation Sheet). (See FIGURE 4-B-8)

a. Purpose. SF-513 is used whenever a patient is referred to another facility for evaluation.

b. Detailed Instructions. Complete the form as follows:

(1) To. Facility or department to which the patient is being referred.

(2) From. Unit referring the patient.

(3) Date of Request. Self-explanatory.

(4) Reason for Request. Specify the reason for referring the patient, i.e., chest pains, infected sebaceous cyst, etc.

(5) Provisional Diagnosis. Self-explanatory.

(6) Doctor's Signature. Must be signed by a medical officer, dental officer, or health services department representative. Accompanying this signature should be the qualifying degree of the individual requesting the consult.

(7) Approved. Leave Blank.

(8) Place of Consultation. Check the appropriate block.

(9) Emergency/Routine. Check the appropriate block.

(10) Identification No. Enter the patient's SSN.

(11) Organization. Enter patient's branch of service.

(12) Register No. If inpatient, enter the appropriate register number. If outpatient, leave blank.

(13) Ward No. If outpatient enter "OP." If inpatient, enter appropriate ward number.

(14) Patient's Identification. Enter the appropriate patient identification information.

(15) The remainder of the form is completed by the consultant.

c. When the consultation sheet (SF-513) is completed and returned by the consultant, the following actions are required:

(1) Originator shall review and sign the SF-513;

(2) Originator shall complete a Visit Profile sheet (CG-5460B) as directed by Use of Clinic Automated Management System (CLAMS), COMDTINST 6010.18(series) for later entry into CLAMS; and

(3) The SF-513 shall then be filed in the appropriate dental or medical section of the health record.

14. SF-520 (Electrocardiographic Report). (See FIGURE 4-B-9)

a. Purpose. SF-520 is used to report the results of all electrocardiograms.

b. Detailed Instructions. The individual performing the electrocardiogram shall complete the form as follows:

(1) Previous ECG. Check appropriate block

(2) Clinical Impression. Reason why the electrocardiogram was requested, e.g., chest pain, physical examination, etc.

(3) Medication. Enter any medications that the patient is taking.

(4) Emergency/Routine. Check appropriate block.

(5) Bedside/Ambulant. Check appropriate block.

(6) Age. Enter patient's age as of last birthday.

(7) Sex. Enter "M" or "F," as appropriate.

(8) Race. Leave blank.

(9) Height. Enter to nearest one-half centimeter (one-half inch).

(10) Weight. Enter to the nearest kilogram (pound).

(11) B.P. Enter recumbent blood pressure.

(12) Signature of Ward Physician. Signature of medical officer ordering the electrocardiogram.

(13) Date. Date the ECG was performed using appropriate format.

(14) Register No. Enter patient's social security number.

(15) Ward No. Enter "OP" (outpatient) or appropriate ward no.

(16) Patient's Identification. Enter the appropriate patient identification information.

(17) The remainder of the form is completed by the medical officer evaluating the electrocardiogram.

c. The baseline ECG shall be appropriately marked "Baseline ECG."

15. SF-515 (Tissue Examination). (See FIGURE 4-B-10)

    a. Prepare a SF-515 whenever a tissue specimen is forwarded to a laboratory for examination.

    b. Ensure patient's identification information is completed.

16. SF-541 (Gynecologic Cytology). (See FIGURE 4-B-11)

    a. Prepare a SF-541 whenever a vaginal or cervical smear (PAP test) is forwarded to a laboratory for examination.

    b. Ensure patient's identification information is completed.

17. SF-514 (Laboratory Reports). (See FIGURE 4-B-12)

    a. This is a display form for mounting graphic reports, automated printout reports, or printed reports associated with special equipment.

    b. Attach the laboratory reports to the indicated spaces with the most recent on top.

    c. Ensure patient's identification information is completed.

    d. Clinical Record - Laboratory Report Display (SF-545). May be used in lieu of SF-514. This is a display form for mounting laboratory requests and report forms. When a patient will require the same type of test several times, a separate display sheet shall be used for each type of test. In low use situations, the various test result forms should be mounted on alternate strips 1, 3, 5, and 7.

        (1) The following Standard Forms should be mounted serially on strips 1, 2, 3, 4, 5, 6, and 7:

            (a) Chemistry I (SF-546),

            (b) Hematology (SF-549),

            (c) Urinalysis (SF-550), and

            (d) Serology (SF-551).

        (2) The following Standard Forms be mounted on alternate strips 1, 3, 5, and 7:

            (a) Chemistry II (SF-547);

            (b) Chemistry II (Urine) (SF-548);

            (c) Parasitology (SF-552);

            (d) Spinal Fluid (SF-555); and

(e) Immunohematology (SF-556).

e. In many instances there will be a mixed assortment of Standard Forms to be mounted in a patient's chart and obviously these should be mounted in the most practical sequence.

f. Instructions for attaching the laboratory report forms to this display sheet are printed at the bottom of the SF-545. A check mark in the space in the lower right corner identifies the name of the laboratory forms that are displayed on this sheet or indicates that a variety or assortment of forms is displayed on the sheet.

18. SF-545a - Clinical Record - Laboratory Report Display for SF-553, SF-554, and SF-557. This is a display form for mounting Microbiology I, Microbiology II, and miscellaneous forms for inclusion in the health record. It may be used, when indicated, in addition to SF-514.

19. SF-546 - 557 (Laboratory Requests).

a. SF-546 (Chemistry I). Used to request most blood chemistry tests. Fill in the identification data as described previously. The specimen sources information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER. The names of the blood chemistry tests are listed individually on this form. At the bottom of the list there is provision for ordering a battery or profile of tests. When requesting the identifying names of the battery or profile of tests must be written into the space provided. There is also space for writing in the names of other tests not specifically listed.

b. SF-547 (Chemistry II). Used to request blood gas measurement, T3, T4, serum, iron binding capacity, glucose tolerance, and other chemistry tests. Fill in the identification data as described previously. The specimen source information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER.

c. SF-548 (Chemistry II, Urine). Used to request chemistry tests on urine specimens. The specimen interval information is given by checking the box marked 24 HOURS or by specifying information in the position marked OTHER.

d. SF-549 (Hematology). Used to request routine hematology tests. The specimen source information is given by checking box marked VEIN, the box marked CAP for capillary, or by specifying information in the position marked OTHER.

e. SF-550 (Urinalysis). Used to request urinalysis tests, including routine urinalysis with microscopic examination. The specimen source information is given by checking the box marked ROUTINE or by specifying information in the position marked OTHER. (Note that routine urinalysis may be ordered by simply placing an "X" in front of the word MICROSCOPIC in the requesting section.) The space marked PSP is for requesting and reporting phenolsulfonphthalein measurements.

The space marked HCG is for requesting and reporting measurements of human chorionic gonadotropin.

f. SF-551 (Serology). Used to request tests that measure serum antibodies, including tests for syphilis.

(1) The space marked RPR is for requesting and reporting measurements of the Rapid Reagent Card Test for Syphilis

(2) The space marked TA is for requesting and reporting measurements of the Latex Fixation Test for Thyroglobulin Antibodies.

(3) The space marked COLD AGG is for requesting and reporting of Cold Agglutinins.

(4) The space marked ASO is for requesting and reporting Antistreptolysin 0 titers.

(5) The space marked CRP is for requesting and reporting measurements of C Reactive Protein.

(6) The space marked FTA-ABS is for requesting and reporting for fluorescent treponemal antibody-absorption test.

(7) The space marked FEBRILE AGG is for requesting and reporting measurements of Febrile Agglutinins.

(8) The space marked COMP FIX is for requesting and reporting Complement Fixation Tests. The name of the specific antibody should also be written in this space.

(9) The space marked HAI is for requesting and reporting Hemagglutination Inhibition Tests. The name of the specific antibody should also be written in this space.

g. SF-552 (Parasitology). Used to request tests for intestinal parasites, malaria and other blood parasites, as well as most test on feces. Fill in identification data as described previously.

h. SF-553 (Microbiology I). Used to request most bacteriological isolations and sensitivities.

(1) The type of the patient's infection, according to origin, is indicated by checking one of the boxes in the space marked INFECTION in the upper right area of the form.

(2) The examination requested is indicated by checking either the box marked SMEAR, SENSITIVITY, CULTURE, or COLONY COUNT.

(3) The report of the examination is written or stamped on the form by the laboratory personnel.

(4) The names of the bacteria identified or isolated are listed in the space marked PREDOMINANT ORGANISM(S).

(5) The sensitivity listing and results are stamped or written in the space marked SENSITIVITY.

i. SF-554 (Microbiology II). Used to request tests for fungi, acidfast bacillus (TB), and viruses.

(1) The type of infection according to origin is indicated by checking one of the boxes in the space marked INFECTION.

(2) The examination(s) requested is checked in the sections for fungus test or AFB tests or viral cultures.

(3) The test results are stamped or written on the form by the laboratory personnel.

j. SF-555 (Spinal Fluid). Used to request most spinal fluid tests.

k. SF-556 (Immunohematology). Used to request blood grouping, typing, and blood bank tests.

l. SF-557 (Miscellaneous). Used to request and report tests such as electrophoresis and assays of coagulation factors, which are not ordered on other laboratory forms.

(1) Fill in the identification data as described previously.

(2) The specimen source is specifically described in the space marked SPECIMEN SOURCE.

(3) Write the name of the test requested in the request section of the form.

20. SF-519 (Radiographic Reports). (See FIGURE 4-B-13)

a. This is a display form for mounting Radiographic Reports (SF-519-A). Attach the SF-519-A to the indicated spaces, with the most recent report on top.

b. Use SF-519-A to request x-ray examinations. All patient data must be completed as indicated. Ensure that examinations requested are in standard terms or abbreviations. ALL pertinent clinical history, operations, physical findings, pregnancy status, and provisional diagnoses must be recorded in the appropriate space. This information is needed by the radiologist in order to render a proper interpretation of the film.

c. Complete the required patient's identification information.

21. DD-771 (Eyewear Prescription). Type DD-771 for clarity and to avoid errors in interpretation, using the following format: (See FIGURE 4-B-14)

a. Date. Enter as follows, 22 JAN 87, etc.

b. Order Number. Enter unit identifying number, issued by NOSTRA or Fitzsimons Army medical Center, above the order number block. Complete order number block if desired.

c. To. Appropriate fabricating facility.

d. From. Enter complete unit address of unit ordering the eyewear.

e. Name, Service Number/Social Security Number. Enter as ALBERT, Michael W. HSC 123-45-6789.

f. Age. Self-explanatory.

g. Unit and Address. Enter complete mailing address of unit to which individual is attached. If retiree, use the individual's home or mailing address.

h. Active Duty, etc. Check appropriate block.

i. USA, USN, etc. Check appropriate block.

j. Spectacles. Check appropriate block.

k. Aviation Spectacles. Use this block only when ordering aviation frames. Check as appropriate:

(1) N-15 tinted lenses;

(2) Coated lenses (coated with an anti-glare compound) are not authorized for Coast Guard personnel.

l. Other. Leave blank.

m. Interpupillary Distance. Copy directly from patient's Prescription, previous DD-771, or SF-600.

n. Eye Size. As above. (Not required for aviation goggles)

o. Bridge Size. As above. (Not required for aviation goggles)

p. Temple Length and Style. As above. (Not required for aviation goggles)

q. Number of Pairs. Enter the number of pairs requested.

r. Case. Enter the number of cases requested.

s. Single Vision.

(1) Sphere. Copy directly from individual's prescription, previous DD-771, or SF-600 (+1.00, -1.25, etc.). Prescriptions are filled in multiples of 0.25 diopters only.

(2) Cylinder. As above, except that prescriptions or multivision lenses must be in "minus cylinder" form, (-0.50, -0.75, etc.).

(3) Axis. Copy directly from individual's prescription, previous DD-771, or SF-600. The axis must contain three (3) digits such as: 180, 090, 005, etc.

(4) Decentration. Need not be completed unless specified as a part of prescription.

(5) Prism. As indicated on individual's prescription, previous DD-771, or SF-600.

(6) Base. As above.

t. Multivision. If the individual needs multivision lenses (bifocals, trifocals, etc.) then the prescription must be in minus cylinder form.

u. Special Lenses or Frames. This block is used for special instructions or justification for aviation spectacles, or nonstandard lenses, and frames, etc.

(1) When replacement eyewear is ordered from a prescription extracted from the health record, enter the following entry in this block: "REPLACEMENT ORDER: PRESCRIPTION FROM REFRACTION PERFORMED ON DATE."

(2) When eyewear is ordered for recruits, enter the following entry in this block: "RECRUIT - PLEASE EXPEDITE."

(3) When tinted lenses are ordered for non-aviation personnel, enter a written justification in this block. "Tinted lenses STATE JUSTIFICATION."

(4) When nonstandard temples or frames are ordered, enter type frame or temple requested, and justification:

(a) Riding Bow Cables, (Justification);

(b) Adjustable Nose Pads, (Justification).

(5) When an individual's pupillary distance is less than 60 mm it must be verified and an entry placed in this block: "PD of ____ verified and correct."

v. Signature of Approving Authority. Shall be signed by the senior medical officer, designated representative, or the commanding officer where no medical officer is present.

w. Signature of the Prescribing Officer. Shall be signed by the medical officer or person performing the refraction. When this is not possible, i.e., examination obtained from a civilian source, transcribed from the health record, etc., the person transcribing the information shall sign as prescribing officer. Flight surgeons may sign prescriptions as both the prescribing and approving authority.

22. SF-601 (Immunization Record). (See FIGURE 4-B-15)

a. All prophylactic immunizations; sensitivity tests; reactions to transfusions, drugs, sera, food and allergies, and blood typings shall be recorded on SF-601 and also on the PHS-731. The recordings shall be continued on the current record until additional space is required under any single category.

b. In such cases, insert a new SF-601 in the health record and retain the old SF-601. Concurrently, make a thorough verification of the entries and bring all immunizations up-to-date. Replacement of the current SF-601 is not required because of change in grade, rating, or status of the member concerned.

c. The name of the individual administering the immunization or test, or determining the nature of the sensitivity reaction, shall be typed or a rubber stamp used. Signatures on SF-601 are not required. However, in the event of their use, make sure they are legible.

d. The individual administering the immunizations is responsible for completing all entries in the appropriate section, including required entries on reactions.

e. Enter information concerning a determined hypersensitivity to an immunization or vaccine under "Remarks and Recommendations". Type appropriate entries (such as HYPERSENSITIVE TO TYPHOID) in capitals. Enter "HIV antibody testing done (enter date(s))".

f. For Yellow Fever vaccine, record the origin and batch number.

23. SF-602 (Syphilis Record). (See FIGURE 4-B-16)

a. This form shall be prepared and inserted in the health record for each person for whom a confirmed diagnosis of syphilis or any of its complications or sequela has been established.

b. The medical officer shall carefully and thoroughly explain to the patient the nature of the infection and the reasons why treatment, prolonged observation and the repeated performance of certain prescribed tests are necessary. The patient shall then be requested to sign the statement in Section II of SF-602.

24. DD-1141 (Record of Occupational Exposure to Ionizing Radiation). (See FIGURE 4-B-17)

a. Requirements. The custodian of the medical records shall prepare and maintain as DD-1141 for each person occupationally exposed to ionizing radiation. Enter all exposures in rems.

b. Recording Procedures.

(1) Initial Determination of Accumulated Dose.

(a) In the initial preparation of DD-1141, obtain complete reports of previous exposure. For each period in which the individual was engaged in activities where occupational exposure was probable, and no record, or only an incomplete record of exposure during the period can be obtained, assume that an occupational exposure of 1.25 rems was incurred per quarter of each calendar year or fraction thereof.

(b) In cases where the nature of the radiation is unknown, assume gamma radiation.

(c) If an individual was exposed at more than one facility, calculate the cumulative exposures and record them in Items 7 through 12 as appropriate. Enter the sum of the whole body exposure in Item 13, and a statement regarding the sources of that information in Item 16, REMARKS.

(2) Current Record.

(a) Quarterly, make appropriate entries on each individual's DD-1141 from the exposure records received from the Public Health Service Contractor.

(b) Maintain separate DD-1141 to record exposures other than whole body, with appropriate descriptions under Item 16, REMARKS.

c. Completion Instructions.

(1) Item 1. Leave blank.

(2) Item: 2. Enter last name, first name, and middle initial. If the combination of last name and first name exceed 19 spaces, enter last name and initials only.

(3) Item 3. Enter SSN.

(4) Item: 4. Enter in not more than 10 spaces, rate, grade, title or position the individual is currently holding. Use standard service abbreviations: i.e., CAPT; HSCS; HSl; etc. Abbreviate civilian occupation titles as needed; i.e., Radiological Physicist to Rad Physic; Radiation Physiologist to Rd Physiol; Electrical Welder to Elec Wldr; etc.

(5) Item 5. Enter date of birth: i.e., 4 SEP 87.

(6) Item 6. Enter name of activity or unit.

(7) Items 7 & 8. "Period of Exposure." Enter the day, month, and year: i.e., 1 MAR 87.

(8) Items 9-12. "Dose This Period." Enter radiation dose received this period to three decimal places: i.e., 02.345rem. Use five digits including zeros as necessary for all entries.

(a) Item 9. Enter skin dose (soft) which includes low energy gamma and x-ray of less than 20 KVE effective energy and beta radiation. Total skin dose is the addition of columns 9 and 12.

(b) Item 10. Enter gamma and x-ray dose greater than 20 KVE effective energy in REM.

(c) Item 11. Enter neutron dose in REM.

(d) Item 12. Enter sum of items 10 and 11.

(9) Item 13. Add item 12 to previous item 13; enter total in item 13.

(10) Item 14. Enter permissible dose calculated from the age formula 5(N-18) REM, where N equals the present age in years.

(11) Item 15. Recorder certify entries by initial.

(12) Item 16. Enter other pertinent information such as known exposure from internally deposited radioactive material or from any external radioactive sources. Describe briefly any activity or assignment bearing a potential for exposure and estimate dose-time relationships, if feasible. If this form is used for other than whole body and skin of whole body, specify the use; i.e., hands and forearms, feet and ankles, thyroid, etc. When recorded dose is not obtained from film badge readings, specify whether estimates were obtained from pocket dosimeters, area or air monitoring, bioassay, etc.

25. CG-4057 (Chronological Record of Service). (See FIGURE 4-B-18)

a. Purpose. Use this form:

(1) to maintain a chronological record of assignments for each active duty member of the Coast Guard;

(2) as a statement of agreement or disagreement with the assumption of fitness for duty upon separation from the Coast Guard; and

(3) to terminate the health record.

b. Chronological record of assignments. Prepare original only. Record the member's full name in all capitals, together with the Social Security Number. Make entries each time a member leaves or returns from PCS, TAD, or hospitalization at a unit different than the one to which currently assigned.

c. Agreement or disagreement with the assumption of fit for duty at the time of separation. Members not already in the physical disability evaluation system, who disagree with the assumption of fitness for duty at separation shall indicate on the reverse of form CG-4057. They shall then proceed as indicated in paragraph 3-B-5. of this Manual. Members who agree with the assumption shall check the box indicating agreement. This is a health services department responsibility when there is a health services department representative attached; otherwise it becomes a personnel action.

d. Terminating the health record. The reverse side of the form is also used to terminate a member's health record upon definite separation from active service. The date of termination is the effective date of separation. Make appropriate entries giving the reason for termination, the date of termination and the grade and signature of the responsible commissioned officer in the bottom portion of the form. Additionally, an entry, signed by the member whose health record is being terminated, acknowledging the receipt of a copy all available NAVMED 6150/20's, a copy of separation examination if done (either SF-88 or SF-600 entry), a signed copy of the CG-4057, and the PHS-731 shall be made in the Remarks section of the CG-4057.

e. This form is also used to notify the individual of the possibility of certain disability benefit entitlements from the Department of Veterans Affairs after separation.

f. If either side of the CG-4057 is filled, the reverse side shall have a line drawn diagonally through it in red and a second CG-4057, marked "Supplement" at the top, started.

26. NAVMED 6150/2 (Special Duty Medical Abstract). (See FIGURE 4-B-19)

a. General. The purpose of the NAVMED 6150/2 is to provide a record of physical qualifications, special training, and periodic examinations of members designated for performing special duty, such as aviation and diving. The object of the special duty examination, and the instructions incident thereto, is to select only those individuals who are physically and mentally qualified for such special duty, and to remove from such status those members who may become temporarily or permanently unfit for such duty because of physical or mental defects. Also, in this connection, special money disbursements are often based upon the determination of a member's physical and mental qualifications or continued requalification for performing a special duty. Therefore, accuracy and content of information are essential in reporting information applicable to these categories.

b. Entries.

(1) Record entries upon completion of each physical examination and completion of designated special training. When a previously qualified member is suspended from special duty for physical reasons, enter the period of suspension and reason therefore on the NAVMED 6150/2.

(2) The scope of the physical examination and technical training prescribed for these special categories often differs from the general service requirements; therefore, entries reporting results which pertain to these particular examinations or training involved shall be approved only by medical officers.

27. PHS-731 (International Certificate of Vaccination).

a. General.

(1) Prepare PHS-731 for each member of the Coast Guard (for reserve personnel when ordered to Active Duty for Training). This form shall be carried only when performing international travel or when reporting for Active Duty for Training. When not required for either of the preceding reasons, the completed certificate shall be retained in the individual's health record. Appropriate entries shall be made on PHS-731 and SF-601 when immunizations are administered.

(2) A reservist not on extended active duty who plans international travel either under official orders or privately, may request that the appropriate district commander (r) furnish a PHS-731 for this purpose. The reservist shall return the PHS-731 to the district commander (r) when travel is completed.

(3) When properly completed and authenticated, the PHS-731 contains a valid certificate of immunization for international travel and quarantine purposes in accordance with World Health Organization Sanitary Regulations.

(4) All military and nonmilitary personnel performing international travel under Coast Guard cognizance shall be immunized in accordance with Commandant Instruction 6230.4 (series) and shall have in their possession a properly completed and authenticated PHS-731.

b. Detailed Instructions.

(1) Stamp or type the following address on the front of PHS-731:

Commandant (G-WK)

U. S. Coast Guard

2100 Second St., S.W.

Washington, DC 20593-0001

(2) Enter data by hand, rubber stamp, or typewriter.

(3) Enter the day, month, and year in the order named (i.e., 4 SEP 87).

(4) Record the origin and batch number for yellow fever vaccine.

(5) Entries for cholera and yellow fever must be authenticated by the Department of Defense Immunization Stamp and the actual signature of the medical officer. Other immunizations may be authenticated by initialing. Entries based on prior official records shall have the following statement added: "Transcribed From Official Records."

c. Remove the PHS-731 from the health record and give it to the individual upon separation from the Service.

28. CG-5214 (Emergency Medical Treatment Report). (See Figure 4-B-20)

a. Purpose. CG-5214 provides a multiple copy record of all emergency medical care rendered by Coast Guard personnel outside of a clinic or sickbay. All care rendered by crews of Coast Guard emergency vehicles must be documented with a CG-5214.

(1) Part 1, Copy to Patient. This copy shall be placed in the patients' health record if available.

(2) Part 2, Copy to Receiving Unit. This copy shall be given to the hospital, clinic, or EMS crew assuming responsibility for patient care.

(3) Part 3, Copy to Triage Officer. In multi-casualty incidents, this copy shall be given to the triage officer to account for the patients' treatment priority and status. Otherwise, this copy shall be kept on file at the clinic or sickbay.

(4) Part 4, (hard copy) to Commandant (G-WKH-1). This copy shall be forwarded to Commandant (G-WKH-1) using the mailing label on the reverse side.

b. Preparation and Submission of CG-5214. The form provides an accurate account of the patient's injury or illness, and a detailed report of all treatments rendered en route to a receiving facility. If possible, the report should be completed during the transport phase. Detailed instructions for completing the CG-5214 are as follows:

(1) Victim Identification.

(a) Item 1: Name. Enter last, first, and middle initial.

(b) Item 2: Sex. Check one.

(c) Item 3: Estimated Age. Enter in years or months.

(2) Description of Incident.

(a) Item 4: Date. Enter date incident occurred.

(b) Item 5: Type of Incident. Check one and give pertinent details under "Nature of Emergency/Mechanism of Injury".

(c) Item 6: Time on Scene. Enter (using 24 hour clock).

(d) Item 7: Time of Incident. Enter (using 24 hour clock).

(e) Item 8: Location. Enter exact geographical area.

(3) Observation of Victim. Stick-Man figure: Place applicable injury letter code over injured area.

(4) Skin. Circle applicable number.

(5) Vital Signs. Note time observed (24 hour clock).

(6) Level of Consciousness. Check only one per time observed.

(7) Pupils. Check only one per time observed.

(8) Pulse. Place numerical value under rate and check appropriate space for quality.

(9) Breathing. Place numerical value under rate and check appropriate space for quality.

(10) Blood Pressure. Enter systolic and diastolic values under applicable time.

(11) Temperature. Circle either oral or rectal and enter in numerical value.

(12) Mast. Beside "Mast BP" enter blood pressure values. Circle applicable compartments inflated.

(13) Triage Information. Circle one of the following:

(a) Priority I: Patients with airway and/or breathing problems, cardiac arrest, uncontrolled bleeding or controlled bleeding with symptoms of shock, severe head or abdominal injuries, and severe medical problems to include possible heart attack, severe burns, and severe poisonings.

(b) Priority II: Patients with less serious burns, multiple fractures, potential C-Spine injuries without shock, or medical conditions of a less serious note.

(c) Priority III: Patients with obvious minor injuries or patients who are obviously dead or mortally wounded.

(14) Medications. List any medications the patient is currently taking.

(15) Allergies. List any known allergies for the patient.

(16) Medications Administered. Note the time, dosage, and route of administration for any medications administered to the patient.

(17) Rescuer Information.

(a) Item 10: Name. Enter last, first, and middle initial.

(b) Item 11: Level. Circle appropriate certification level.

(c) Item 12: Unit. Rescuer's assigned unit.

(d) Item 13: OPFAC#. Enter.

(e) Item 14: rescue Vehicle. Identity of the responding vehicle, vessel, or aircraft.

(f) Item 15: Receiving Unit. Hospital, EMS vehicle, or clinic assuming responsibility for patient care.

(g) Time Patient Transferred. Enter (24 hour clock).

29. DD877 (Request for Medical/Dental Records or Information).

a. Purpose. The DD 877 is a self-carboning triplicate form which is used to forward health and clinical records between clinics and units as well as to request records from clinics, units, or MTFs. Shown in (Figure 4-B-21).

b. General. This form shall be initiated and included with health and clinical records as directed in Chapter 4-A-6. And 4-D-7. Of this Manual

c. Detailed Instruction.

(1) Each DD877 must have all boxes completed.

(2) In all instances when a DD877 is initiated, remarks concerning the reason for sending the record, the name of the gaining unit for the member/ sponsor and a request for action will be included on the form. When preparing a DD877 for a record to be forwarded, place the following in section 9., REMARKS: "Health {clinical} record for this member (family member) is forwarded to you for appropriate filing. Member (sponsor) assigned to (insert gaining unit name)."

(3) For members entering the inactive reserve, enter the following in section 9, remarks**: " member entering inactive reserve in your district**. Per Medical Manual, COMDTINST M6000.1B, Chapter 4-B-4.b.,this health record is forwarded for appropriate action."

(4) A copy of the DD877 will be retained at the unit sending the record for 6 months after the record is mailed, then may be discarded.

**Figure 4-B-1**

HEALTH RECORD COVER

Last Name First Middle

0 1 2 3 4 5 6 7 8 9

Place Sensitivity Sticker Here (if needed)

Blood Type | Rh

Special Status

☐ Aviation
☐ OMMP
☐ Waiver
☐ _____

YY MM DD
Date of Birth

**U.S. Coast Guard**

HEALTH RECORD

**PRIVACY STATEMENT; HEALTH CARE RECORDS**

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN): Section 632 of Title14, United States Code and Section 1071-1087, Title 10 United States Code, Executive Order 9397.
2. PRINCIPLE PURPOSE FOR WHICH INFORMATION IS TO BE USED:
The purpose for requesting personal information is to assist health care personnel in developing records to facilitate and document your health in order to provide health care and to provide a complete account of such care rendered including diagnosis, treatment, and end result. The SSN is necessary to identify the person and records.
3. ROUTINE USES; This information may be used to plan and coordinate health care. It may be used to provide health care, conduct research, teach, complile statistical data, determine suitability of persons for service or assignment, implement, preventive health and communicative disease control programs, adjudicate claims and determine benefits, evalutate care rendered, determine professional certification and hospital accreditation, conduct authorized investigations, provide physical qualifications of patients to other Federal, State, and local agencies uopn request in the pursuit of their official duties, and report health conditions required by law to Federal, State, and local agencies. It may be used for other lawful purposes, including law enforcement and litigation.
4. The above Privacy Act Statement applies to all requests for personal information made by health care personnel or for health care purposes. Failure to provide the requested information for these health records may result in an inability of Coast Guard health care personnel to afford treatment.
5. No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the commanding officer for decision.

**DEPT. OF TRANSP, USCG, CG-3443 (REV 9-92)** **SN 7530-00-F01-4180**
**PREVIOUS EDITIONS ARE OBSOLETE**

**FIGURE 4-B-2**

## ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

*(This form is subject to the Privacy Act of 1974 – Use DD form 2005)*

**1. ALLERGIES**

| a. MEDICATION ALLERGIES | b. OTHER ALLERGIES |
|---|---|
| | |

| **2. CHRONIC ILLNESS** | **3. MEDICATIONS** |
|---|---|
| | |
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**4. HOSPITALIZATIONS/SURGERIES**

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|---|
| |
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| |

SAMPLE FORM

**5. COUNSELING**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F | FITNESS | a. DATE | | | | | |
| D | DENTAL | b. AGE | | | | | |
| I | INJURY PREVENTION | c. TOPIC | | | | | |
| N | NUTRITION/FOLATE | | | | | | |
| C | CANCER PREVENTION | | | | | | |
| S | SAFE SEX | d. DATE | | | | | |
| FP | FAMILY PLANNING | e. AGE | | | | | |
| Rx | PRESENT MEDICATIONS | f. TOPIC | | | | | |
| MH | MENTAL HEALTH/STRESS/SUICIDE/ OCCUPATIONAL STRESS | | | | | | |
| H | HORMONE/CALCIUM REPLACEMENT | g. DATE | | | | | |
| To | TOBACCO | h. AGE | | | | | |
| A | ALCOHOL/SUBSTANCE ABUSE | i. TOPIC | | | | | |
| t | TRAVEL | | | | | | |
| O. | OCCUPATIONAL EXPOSURE (HEARING THRESHOLD CHANGES/CUMULATIVE TRAUMA DISORDER) | j. DATE | | | | | |
| | | k. AGE | | | | | |
| | | i. TOPIC | | | | | |
| | | | | | | | |
| | | | | | | | |

**ADVANCE DIRECTIVES: DATE FILED**

| **PATIENT'S IDENTIFICATION** (Use this space for mechanical imprint) | **RECORDS MAINTAINED AT:** | | |
|---|---|---|---|
| *SUPPLIED (Navy)*<br>*2766-0102-LF-984-8400, pkg-100* | **PATIENT'S NAME**<br>**LAST** \| **FIRST** \| **M.I.** | | **SEX** |
| | **RELATIONSHIP TO SPONSOR** | **STATUS** | **RANK/GRADE** |
| | **SPONSOR'S NAME** *(Last ,First, Middle Initial)* | | DEPT/SERVICE |
| | **ORGANIZATION** | **SSN/ID NUMBER** | **DATE OF BIRTH** |

**DD FORM 2766, (Rev 01- 00)** **PAGE 1 of 4 PAGES**

# FIGURE 4-B-2 Con't

## ADULT PREVENTION AND CHRONIC CARE FLOWSHEET

**6. FAMILY HISTORY** *(M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfater)*

| | |
|---|---|
| **a. CANCER** *(Specify)* | |
| **b. CARDIOVASCULAR DISEASE** *(Specify)* | |
| **c. DIABETES** *(Specify)* | |
| **d. MENTAL ILLNESS/CHEMICAL DEPENDENCY** *(Specify)* | |
| | |

**7. SCREENING EXAMS** *( * = Actual Result, * * = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused NA = Not Indicated) (● = Next Due)*

| a. TEST | b. FREQUENCY | c. YEAR / d. AGE | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | e. DATES | | | | | |
| (1) CLINICAL DISEASE PREV EVAL/PHA (HEAR) | ANNUAL | | O | O | O | O | O | O |
| * (2) WEIGHT | ANNUAL FOR ACTIVE DUTY | | O | O | O | O | O | O |
| * (3) HEIGHT | ANNUAL FOR ACTIVE DUTY | | O | O | O | O | O | O |
| * (4) BLOOD PRESSURE | ONCE q 2 YRS for BP< 130/85, ANNUAL IF GREATER | | O | O | O | O | O | O |
| * (5) CHOLESTEROL** | *q 5 YRS FOR AGE ≥ 18 q YR if PREV ABN | | O | O | O | O | O | O |
| (6) HEARING | CLINICAL DISCRETION | | O | O | O | O | O | O |
| (7) SKIN EXAM *(Cancer)* | ANNUAL IF AT RISK | | O | O | O | O | O | O |
| (8) ORAL/DENTAL ** | ANNUAL | | O | O | O | O | O | O |
| (9) EYE/VISION ** | ROUTINE ACUITY WITH PERIODIC ASSESSMENT DIABETES ANNUAL GLAUCOMA CHECK: Blacks q 3-5 yrs age 20-39 All q 2-4 years age 40-64 | | | | O | O | O | O |
| (10) BREAST EXAM | ANNUAL: ≥ 40 YRS | | O | O | O | O | O | O |
| (11) MAMMOGRAM ** | BASELINE@ 40, q 2 YRS 40-50, ANNUALLY > 50 | | O | O | O | O | O | O |
| (12) PAP ** *(Digital Rectal Exam)* | BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY AFTER 3 NL ANUUAL EXAMS, PERFORM q 1-3 years | | O | O | O | O | O | O |
| (13) FECAL OCCULT BLOOD | ANNUAL ≥ 50 yrs | | O | O | O | O | O | O |
| (14) SIGMOID | EVERY 3-5 YRS: ≥ 50 YRS | | O | O | O | O | O | O |
| (15) COLONOSCOPY | HIGH RISK q 5 YRS ≥ YRS | | O | O | O | O | O | O |
| (16) TESTICULAR | HIGH RISK ANNUAL 13-39 YRS | | O | O | O | O | O | O |
| (17) PROSTATE ** **( DIGITAL RECTAL EXAM)* | WITH P.E. ≥ 40 YRS *(Presently Recommended annually)* | | O | O | O | O | O | O |
| (18) RUBELLA SCREEN *(Females)* | ONCE BETWEEN AGES 12 –18 YRS *(Unless prev vaccinated)* | | O | O | O | O | O | O |
| (19) OCCUPATIONAL SCREENING EXAMS | APPROPRIATE TO EXPOSURES | | O | O | O | O | O | O |
| (20) | | | O | O | O | O | O | O |
| (21) | | | O | O | O | O | O | O |
| (22) | | | O | O | O | O | O | O |

SAMPLE FORM

**DD FORM 2766, (Rev 01-00)** **PAGE 2 OF 4 PAGES**

# FIGURE 4-B-2 Con't

## ADULT PREVENTION AND CHRONIC CARE FLOWSHEET

### 8. OCCUPATIONAL HISTORY/RISK

| | | | | |
|---|---|---|---|---|
| a. PRP | | YES | | NO |
| b. .FLYING STATUS | | YES | | NO |

### 9. IMMUNIZATIONS *(Enter numeric class in sub block)*

| (1) IMMUNIZATION | (2) DATE *(ddmmmyyyy)* | (1) IMMUNIZATION | (2) DATE *(DDMMMYYYY)* | (1) IMMUNIZATION | (2) DATE *(ddmmmyyyy)* | (1) IMMUNIZATION | (2) DATE *(ddmmmyyyy)* |
|---|---|---|---|---|---|---|---|
| a. HEP A # 1 | | f. MMR # 1 | | j. TD *(q 10 YRS) (Last)* | | | |
| b. HEP A # 2 | | g. MMR #2 | | k. TD *(DUE)* | | | |
| c. HEP B # 1 | | h. PNEUMOCOCCUS | | l. YELLOW FEVER *(LAST)* | | | |
| d. HEP B #2 | | i. POLIO OPV = O IPV = I | | m. YELLOW FEVER | | | |

| n. TYPHOID *(Enter numeric class in sub block) ORAL = O TYPHUM Vi = 1. TYPHOID USP = 2* | (1) DATE | (2) DATE | (3) DATE | (4) DATE | (5) DATE | (6) DATE |
|---|---|---|---|---|---|---|
| | | | | | | |

| O. ANTHRAX | (1) INITIAL DATE | (2) 2 WEEK DATE | (3) 4 WEEK DATE | (4) 6 MONTH DATE | (5) 12 MONTH DATE | (6) 18 MONTHDATE |
|---|---|---|---|---|---|---|
| | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| p. PPD *(Enter mm and date)* | (1) (a) mm | (2) (a) mm | (3) (a) mm | (4) (a) mm | (5) (a) mm | (6) (a) mm | (7) (a) mm |
| | (b) DATE | (b) DATE | (b) DATE | (b) DATE | (b) DATE | (b) DATE | (b) DATE |
| q. INFLUENZA | (1) DATE | (2) DATE | (3) DATE | (4) DATE | (5) DATE | (6) DATE | (7) DATE |
| r. VARICELLA | (1) DATE | (2) DATE | u. JAPANESE B ENCEPHALITIS | (1) DATE | (2) DATE | (3) DATE | (4) DATE |
| s. MENINGO | (1) DATE | (2) DATE | v. OTHER (Specify) | | (1) DATE | (2) DATE | (3) DATE |
| t. ADENO | (1) DATE | (2) DATE | | | (1) DATE | (2) DATE | (3) DATE |

SAMPLE FORM

### 10. READINESS *(Glucose-6-phosphate dehydrogenase)*

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| a. DNA | DATE: | b. BLOOD TYPE | DATE: | RESULT: | c. G-PD | DATE | RESULT: | d. SICKLE CELL | DATE: | RESULT: |

| e. PERMANENT PROFILE CHANGE | (1) DATE | (2) P: | (3) U: | (4) L: | (5) H: | (6) E: | (7) S: |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| f. GLASSES/GAS/MASK Rx: | (1) DATE | (2) DATE | (3) DATE | (4) DATE | (5) DATE | (6) DATE |
| g. DENTAL EXAM *(Enter numeric class in sub block)* | (1) DATE | (2) DATE | (3) DATE | (4) DATE | (5) DATE | (6) DATE |
| h. HIV TESTING | (1) DATE | (2) DATE | (3) DATE | (4) DATE | (5) DATE | (6) DATE |
| I. FITNESS *(In sub block enter P = Pass, F = Fail, W = Waiver)* | (1) DATE | (2) DATE | (3) DATE | (4) DATE | (5) DATE | (6) DATE |
| | (1) DATE | (2) DATE | (3) DATE | (4) DATE | (5) DATE | (6) DATE |
| | (1) DATE | (2) DATE | (3) DATE | (4) DATE | (5) DATE | (6) DATE |

### 11. PRE/POST DEPLOYMENT HISTORY

| | | | | | | |
|---|---|---|---|---|---|---|
| a. LOCATION | | | | | | |
| (1) PREDEPLOYMENT | (a) DATE | (b) DATE | (c) DATE | (d) DATE | (e) DATE | (f) DATE |
| (2) POSTDEPLOYMENT | (a) DATE | (b) DATE | (c) DATE | (d) DATE | (e) DATE | (f) DATE |
| b. LOCATION | | | | | | |
| (1) PREDEPLOYMENT | (a) DATE | (b) DATE | (c) DATE | (d) DATE | (e) DATE | (f) DATE |
| (2) POSTDEPLOYMENT | (a) DATE | (b) DATE | (c) DATE | d) DATE | (e) DATE | (f) DATE |
| c. CHART AUDIT | ○ | ○ | ○ | ○ | ○ | ○ |

**FIGURE 4-B-2 Con't**

**ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET**
*(Continuation Sheet)*

| TEST | FREQUENCY | DATES | | | | | |
|---|---|---|---|---|---|---|---|
| | | (a) | (b) | (c) | (d) | (e) | (f) |
| | | | | | | | |
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SAMPLE FORM

**REMARKS**

| | | | |
|---|---|---|---|
| **RECORDS MAINTAINED AT:** | | | |
| **PATIENT'S NAME** LAST / FIRST / M.I. | | | **SEX** |
| **RELATIONSHIP TO SPONSOR** | **STATUS** | **RANK/GRADE** | |
| **SPONSOR'S NAME** *(Last, First, Middle Initial)* | | **DEPT/SERVICE** | |
| **ORGANIZATION** | **SSN/ID NUMBER** | **DATE OF BIRTH** | |

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# FIGURE 4-B-3

PREVIOUS EDITION IS USABLE | AUTHORIZED FOR LOCAL REPRODUCTION

| MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE |
|---|---|
| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry)* |
| | |
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SAMPLE FORM

| HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART/SERVICE | RECORDS MAINTAINED AT |
|---|---|---|---|
| SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR | |

| PATIENT'S IDENTIFICATION: *(FOR TYPED OR WRITTEN ENTRIES, GIVE: name-last, first, middle ID NO or SSN; Sex; Date of Birth; Rank/Grade.);* | REGISTER NO. | WARD NO. |
|---|---|---|
| | | |

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
**STANDARD FORM 600 (Rev. 6-97)**
Prescribed by GSA/ICMR
FIRMR 941 CFR) 201-9.202-1

# FIGURE 4-B-4

| MEDICAL RECORD | REPORT OF MEDICAL EXAMINATION | DATE OF EXAM |
|---|---|---|

| | | |
|---|---|---|
| 1. LAST NAME – FIRST NAME- MIDDLE NAME | 2. IDENTIFICATION NO. | 3. GRADE AND COMPONENT OR POSITION |
| 4. HOME ADDRESS *(Number, street or RFD, city or town, state and ZIP code)* | 5. EMERGENCY CONTACT *(Name and address of contact)* | |
| 6. DATE OF BIRTH / 7. AGE | 8. SEX ☐ FEMALE ☐ MALE | 9. RELATIONSHIP OF CONTACT |
| 10. PLACE OF BIRTH | 11. RACE ☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ ALASKA NATIVE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER | |
| 12a. AGENCY | 12b. ORGANIZATION | 13. TOTAL YEARS GOVERNMENT SERVICE: a. MILITARY / b. CIVILIAN |
| 14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS | 15. RATING OR SPECIALTY OF EXAMINER | |
| | 16. PURPOSE OF EXAMINATION | |

## #19 CLINICAL EVALUATION

| NORMAL | *(Check each item in appropriate column; enter "NE" if not evaluated.)* | ABNORMAL | NORMAL | *(Check each item in appropriate column; enter "NE" if not evaluated.)* | NORMAL |
|---|---|---|---|---|---|
| | A. HEAD, FACE, NECK AND SCALP | | | O. PROSTATE *(Over 40 or clinically indicated)* | |
| | B. EARS-GENERAL *(INTERNAL CANALS)* *( Auditory acuity under items 39 and 40)* | | | P. TESTICULAR | |
| | | | | Q. ANUS AND RECTUM *(Hemorrhoids, Fistulae) (Hemocult Results)* | |
| | C. DRUMS | | | R. ENDOCRINE SYSTEM | |
| | D. NOSE | | | S. G-U SYSTEM | |
| | E. SINUSES | | | T. UPPER EXTREMITIES *(Strength, range of motion)* | |
| | F. MOUTH AND THROAT | | | U. FEET | |
| | G. EYES-GENERAL *(Visual acuity and refraction under items 18 ,29, and 30)* | | | V. LOWER EXTREMITIES *(Except feet)(Strength range of motion)* | |
| | H. OPTHALMOSCOPIC | | | W. SPINE, OTHER MUSCULALSKELETAL | |
| | I. PUPILS *(Equality and reaction)* | | | X. IDENTIFYING BODY MARKS, SCARS, TATTOOS | |
| | J. OCULAR MOTILITY *(Associated parallel movements nystagmus)* | | | Y. SKIN, LYMPHATICS | |
| | K. LUNGS AND CHEST | | | Z. NEUROLOGIC (Equilibrium tests under item 41) | |
| | I. HEART *(Thrust, size, rhythm, sounds)* | | | AA. PSYCHIATRIC (Specify and personality deviation) | |
| | M. VASCULAR SYSTEM (*Varicosities, etc.)* | | | BB. BREASTS | |
| | N. ABDOMEN AND VISCERA *(Include hernia)* | | | CC. PELVIC *(Females only)* | |

NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary.)*

SAMPLE FORM

18. DENTAL *(Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)*

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 / 1 2 3 / 32 31 30 | Restorable Teeth | / 1 2 3 / 32 31 30 | Non-Restorable Teeth | x 1 2 3 x 32 31 30 | Missing Teeth | x x x 1 2 3 x x x 32 31 30 | Replaced by dentures | ( x ) 1 2 3 ( x ) 32 31 30 | Fixed Partial dentures | | | | | | | |
| RIGHT | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | LEFT |
| | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | |

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

## 19. TEST RESULTS (Copies of results are preferred as attachments)

| | | | |
|---|---|---|---|
| A. URINALYSIS : (1) SPECIFIC GRAVITY | | | B. CHEST X-RAY OR PPD *(Place, date, film number and result)* |
| (2) URINE ALBUMIN | (4) MICROSCOPIC | | |
| (3) URINE SEROLOGY | | | |
| C. SYPHILIS SEROLOGY *(Specify test used and results)* | D. EKG | E. BLOOD TYPE AND RH FACTOR | F. OTHER TESTS |

NSN 7540-00-834-4038
88-120

**STANDARD FORM 88** (Rev.10-94)
Prescribed by GSA/ICMRFIRMR (41 CFR) 201-0-20

# FIGURE 4-B-4 (Reverse)

| NAME | IDENTIFICATION | NO. OF SHEETS ATTACHED |
|---|---|---|
| | | |

## MEASUREMENTS AND OTHER FINDINGS

| 20. HEIGHT | 21. WEIGHT | 22. COLOR HAIR | 23. COLOR EYES | 24. BUILD | 26. TEMP |
|---|---|---|---|---|---|
| | | | | ☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE | |

| 26. BLOOD PRESSURE *(Arm at heart level)* | | | | | | 27. PULSE *(Arm at heart level)* | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| A. SITTING | SYS. | B. RECUMBANT | SYS. | C. STANDING *(5 MIN)* | SYS. | A. SITTING | B. RECUMB | C. STANDING *(3 mins)* | D. AFTER EXERCISE | E. 2 MINS AFTER |
| | DIAS. | | DIAS | | DIAS | | | | | |

| 28. DISTANT VISION | | 29. REFRACTION | | | 30. NEAR VISION | |
|---|---|---|---|---|---|---|
| RIGHT 20/ | CORR. TO 20/ | BY | S. | CX | CORR. TO | BY |
| LEFT 20/ | CORR. TO 20/ | BY | S. | CX | CORR. TO | BY |

31. HETEROPHORIA *(Specify distance)*

| FSO | EXO | R.H. | L.H. | PRISM DIV. | PRISM CONV. CT | PC | PD |
|---|---|---|---|---|---|---|---|

| 32. ACCOMMONDATION | 33. COLOR VISION *(Test used and result)* | 34.DEPTH PERCEPTION *(Test used and score)* | UNCORRECTED |
|---|---|---|---|
| RIGHT LEFT | | | CORRECTED |

| 35. FIELD OF VISION | 36. NIGHT VISION *(Test used and SCORE)* | 37. RED LENS TEST | 38. INTRAOCULAR TENSION |
|---|---|---|---|
| RIGHT LEFT | | | RIGHT LEFT |

39. HEARING

RIGHT WV /15 SV /15

LEFT WV /15 SV /15

40. AUDIOMETER

| | 250 | 500 | 1000 | 2000 | 3000 | 4000 | 6000 | 8000 |
|---|---|---|---|---|---|---|---|---|
| | 256 | 512 | 1024 | 2048 | 2896 | 4096 | 6144 | 8192 |
| RIGHT | | | | | | | | |
| LEFT | | | | | | | | |

41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Test used and scored)*

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY.

(Use additional sheets if necessary)

44. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

44.RECOMMENDATIONS-FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

45A. PHYSICAL PROFILE

| P | U | L | H | E | S |
|---|---|---|---|---|---|
| | | | | | |

46. EXAMINEE *(CHECK)*

A. ☐ IS QUALIFIED FOR

B. ☐ IS NOT QUALIFIED FOR

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

| A | B | C | E |
|---|---|---|---|
| | | | |

| | |
|---|---|
| 48. TYPED OR PRINTED NAME OF PHYSICIAN | SIGNATURE |
| 49. TYPED OR PRINTED NAME OF PHYSICIAN | SIGNATURE |
| 50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)* | SIGNATURE |
| 51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY | SIGNATURE |

**STANDARD FORM 88 (REV. 10-94) PAGE2**

# FIGURE 4-B-5

| MEDICAL RECORD | REPORT OF MEDICAL HISTORY | DATE OF EXAM |
|---|---|---|

**NOTE: this information is for offical and medically-confidential use only and will not be released to unauthorized persons**

| 1 NAME OF PATIENT (*Last,first,middle)* | | | 2. IDENTIFICATION NUMBER | 3. GRADE |
|---|---|---|---|---|
| 4a. HOME ADDRESS (*Street or RFD; City or Town: State; and ZIP code)* | | | 5. EXAMINING FACILITY | |
| 4b. CITY | 4c. STATE | 4d Zip Code | | |
| 6. PURPOSE OF EXAMINATION | | | | |

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (*Use additional pages if necessary)*

| a. PRESENT HEALTH | b. CURRENT MEDICATION | REGULAR OR INTERM. |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| c. ALLERGIES *(Include insect bites/stings and common foods)* | | |
| | d. HEIGHT | e. WEIGHT |
| 8. PATIENT"S OCCUPATION | 9. ARE YOU *(Check one)* ☐ RIGHT HANDED ☐ LEFT HANDED | |

SAMPLE FORM

10. PAST/CURRENT MEDICAL HISTORY

| CHECK EACH ITEM | YES | NO | DON'T KNOW | CHECK EACH ITEM | YES | NO | DON'T KNOW | CHECK EACH ITEM | YES | NO | DON'T KNOW |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Household contact with anyone with tuberculosis | | | | Shortness of breath | | | | Bone, joint or other deformity | | | |
| | | | | Pain or pressure in chest | | | | Loss of finger or toe | | | |
| Tuberculosis or positive TB test | | | | Chronic cough | | | | Painful or "trick" shoulder or elbow | | | |
| Blood in sputum or when coughing | | | | Palpitation or pounding heart | | | | | | | |
| | | | | Heart trouble | | | | Recurrent back pain or any back injury | | | |
| Excessive bleeding after injury or dental work | | | | High or low blood pressure | | | | | | | |
| | | | | Cramps in your legs | | | | "Trick" or locked knee | | | |
| Suicide attempt or plans | | | | Frequent indigestion | | | | Foot trouble | | | |
| Sleepwalking | | | | Stomach, liver, or intestinal trouble | | | | Nerve injury | | | |
| Wear corrective lenses | | | | Gall bladder trouble or gallstones | | | | Paralysis (*include infantile)* | | | |
| Eye surgery to correct vision | | | | | | | | Epilepsy or seizure | | | |
| Lack vision in either eye | | | | Jaundice or hepatitis | | | | Car, train, sea or air sickness | | | |
| Wear a hearing aid | | | | Broken bones | | | | Frequent trouble sleeping | | | |
| Stutter or stammer | | | | Adverse reaction to medication | | | | Depression or excessive worry | | | |
| Wear a brace or back support | | | | Skin diseases | | | | Loss of memory or amnesia | | | |
| Scarlet fever | | | | Tumor, growth, cyst, cancer | | | | Nervous trouble of any sort | | | |
| Rheumatic fever | | | | Hernia | | | | Periods of unconsciousness | | | |
| Swollen or painful joints | | | | Hemorrhoids or rectal disease | | | | Parent/sibling with diabetes cancer, stroke or heart disease | | | |
| Frequent or severe headaches | | | | Frequent or painful urination | | | | | | | |
| Dizziness or fainting spells | | | | Bed wetting since age 12 | | | | X-ray or other radiation therapy | | | |
| Eye trouble | | | | Kidney stone or blood in urine | | | | Chemotherapy | | | |
| Hearing loss | | | | Sugar or albumin in urine | | | | Asbestos or toxic chemical exposure | | | |
| Recurrent ear infections | | | | Sexually transmitted disease | | | | | | | |
| Chronic or frequent colds | | | | Recent gain or loss of weight | | | | Plate, pin or rod in any bone | | | |
| Severe tooth or gum trouble | | | | Eating disorder (anorexia, bulimia, etc.) | | | | Easy fatigability | | | |
| Sinusitis | | | | | | | | Been told to cut down or criticized for alcohol use | | | |
| Hay Fever or allergic rhinitis | | | | Arthritis, Rheumatism or Bursitis | | | | | | | |
| Head injury | | | | | | | | Used illegal substances | | | |
| Asthma | | | | Thyroid trouble or goiter | | | | Used tobacco | | | |

NSN 7540-00-181-8638
Previous edition not usable

**STANDARD FORM 93** (REV.6/96) (EG)
Prescribed by ICMR/GSA
FIRMR (41 CFR) 201-9.202-1
Designed using Perform Pro,WHS/DIOR, Apr 97

FIGURE 4-B-5 (reverse) SF 93 History

| 11. FEMALES ONLY | | | | | | |
|---|---|---|---|---|---|---|
| Check each item | YES | NO | DON'T KNOW | DATE OF LAST MENSTRUAL PERIOD | DATE OF LAST PAP SMEAR | DATE OF LST MAMMOGRAM |
| Treated for a female disorder | | | | | | |
| Changed in menstrual pattern | | | | | | |

CHECK EACH ITEM. IF " YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

| ITEM | YES | NO |
|---|---|---|
| 12. Have you been refused employment or been unable to hold a job or stay in school because of: | | |
| a. Sensitivity to chemicals, dust, sunlight, etc. | | |
| b. Inability to perform certain motions. | | |
| c. Inability to assume certain positions. | | |
| d. Other medical reason ( *If yes, give reasons.)* | | |
| 13. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details.)* | | |
| 14. Have you ever been denied life insurance? *( If yes, state reason and give details)* | | |
| 15. Have you had, or have you been advised to have, any operation? *( If yes, describe and give age at which occurred)* | | |
| 16. Have you ever been a patient in any type of hospital? *( If yes, specify when, where, why, and name of doctor and complete address of hospital.)* | | |
| 17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.)* | | |
| 18. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.)* | | |
| 19. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)* | | |
| 20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.)* | | |
| 21. Have you ever been arrested or convicted of a crime, other than minor traffic violations? (I*f yes, provide details.)* | | |
| 22. Have you ever been diagnosed with a learning disability? *( If yes, give type, where, and how diagnosed.)* | | |

SAMPLE FORM

23. LIST ALL IMMUNIZATIONS RECEIVED

I certify that I have received the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

| 24a. TYPED OR PRINTED NAME OF EXAMINEE | 24b. SIGNATURE | 24c. DATE |
|---|---|---|

**NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."**

25.PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*physician shall comment on all positive answers in item 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)*

| 26.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER | 26b. SIGNATURE | 26 c. DATE |
|---|---|---|

**STANDARD FORM 93** (REV.6-96) **BACK**

FIGURE 4-B-6

NSN 7540-01-075-3786

| MEDICAL RECORD | EMERGENCY CARE AND TREATMENT *(Patient)* | LOG NUMBER | TREATMENT FACILITY |
|---|---|---|---|
| | | RECORDS MAINTAINED AT | |

| PATIENT'S HOME ADDRESS OR DUTY STATION | | | ARRIVAL | |
|---|---|---|---|---|
| STREET ADDRESS | | | DATE *(Day, Month, Year)* | TIME |
| CITY | STATE | ZIP CODE | TRANSPORTATION TO FACILITY | |

| SEX | DUTY/LOCAL PHONE | | MILITARY STATUS | | | | THIRD PARTY INSURANCE | | |
|---|---|---|---|---|---|---|---|---|---|
| | AREA CODE | NUMBER | ITEM | YES | NO | N/A | ITEM | YES | NO |
| | | | PRP | | | | ADDITIONAL INSURANCE | | |
| AGE | HOME PHONE | | FLYING STATUS | | | | DD 2568 IN CHART | | |
| | | NUMBER | MEDICAL HISTORY OBTAINED FROM | | | | NAME OF INSURANCE COMPANY | | |

| CURRENT MEDICATIONS | INJURY OR OCCUPATIONAL ILLNESS | | | | EMERGENCY ROOM VISIT | |
|---|---|---|---|---|---|---|
| | | YES | NO | WHEN *(DATE)* | DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO |
| | IS THIS AN INJURY | | | WHERE | TETANUS | |
| ALLERGIES | INJURY/SAFETY FORMS | | | | DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO |
| | HOW | | | | | |

CHIEF COMPLAINT

SAMPLE FORM

| CATEGORY OF TREATMENT | | VITAL SIGNS | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ EMERGENT | TIME | TIME | | | | | |
| | | B/P | | | | | |
| ☐ URGENT | | PULSE | | | | | |
| | INITIALS | RESP | | | | | |
| ☐ NON-URGENT | | TEMP | | | | | |
| | | WT | | | | | |

| LAB ORDERS | | | | | | | | X-RAY ORDERS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | CBC/DIFF | | ABG | | PT/PTT | | BHCG/URINE/BLOOD/QUANT | | | CXR PA & LAT/ PORTABLE | | C-SPINE |
| | URINE C&S | | UA | | | | CHEM: | | | ACUTE ABDOMEN | | LS SPINE |
| | BLOOD C&S X | | | | | | | | | ANKLE R/L | | HEAD CT |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

**ORDERS**

☐ PULSE OX ☐ MONITOR ☐ ECG

| TIME | ORDERS | BY | COMPLETED BY | TIME | PATIENT'S RESPONSE |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| DISPOSITION | DISPOSITION QUARTERS/OFF DUTY | PATIENT/DISCHARGE INSTRUCTIONS |
|---|---|---|
| ☐ HOME ☐ FULL DUTY | ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS | |
| MODIFIED DUTY UNTIL | RETURN TO DUTY | |

| CONDITION UPON RELEASE | ADMIT TO UNIT/SERVICE | REFERRED | TO | WHEN |
|---|---|---|---|---|
| ☐ IMPROVED ☐ UNCHANGED | TIME OF RELEASE | **I have received and understand these instructions.** | | |
| ☐ DETERIORATED | | PATIENT'S SIGNATURE | | |

PATIENT'S IDENTIFICATION *(For typed or written entries, give: name-last, first, middle; ID no. (SSN or other); hospital or medical facility)*

**EMERGENCY CARE AND TREATMENT (*Patient*)**
MEDICAL RECORD
**STANDARD FORM 558 (REV 9-96)**
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

FIGURE 4-B-6 (*Doctors notes)*

NSN 7540-01-075-3786

| **MEDICAL RECORD** | **EMERGENCY CARE AND TREATMENT** ***(Doctor)*** | TIME SEEN BY PROVIDER |
|---|---|---|

**TEST RESULTS**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| CBC | WBC | SMAC | | | ABG/PULSE OX | | | **RADIOLOGY** | CHECK IF READ BY RADIOLOGIST | ☐ |
| | H/H | | | | SUP 02 | PH | PO2 | RESULTS | | |
| | PLT | | | | PCO2 | SAT | OTHER | | | |
| | | | | U/A | DIP | | | EKG INTERPRETATION | | |
| PT | | | | | MICRO | | | | | |
| APTT | | BHCG | ETOH | GLU | | | | | | |

PROVIDER HISTORY/PHYSICAL

SAMPLE FORM

| CONSULT WITH | TIME | ACTION | RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | PROVIDER SIGNATURE AND STAMP |
| | | | |
| | | | |
| DIAGNOSIS | | | CODES |

PATIENT'S IDENTIFICATION (*For typed or written entries, give: Name-last, first ,middle; ID no. (SSN or other); hospital or medical facility)*

**EMERGENCY CARE AND TREATMENT (*Doctor)***
MEDICAL RECORD
**STANDARD FORM 558 (REV 9-96)**
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

## FIGURE 4-B-7

| MEDICAL RECORD | NARRATIVE SUMMARY (CLINICAL RESUME) | |
|---|---|---|
| DATE OF ADMISSION | DATE OF DISCHARGE | NUMBER OF DAYS HOSPITALIZED |

(Sign and date at end of narrative)

SAMPLE FORM

| SIGNATURE OF PHYSICIAN | DATE | IDENTIFICATION NO. | ORGANIZATION |
|---|---|---|---|
| | | | |

| PATIENT'S IDENTIFICATION (For typed or written entries give: Name last, first; middle; grade; rank; rate ;hospital or medical facility) | REGISTER NO. | WARD NO. |
|---|---|---|
| | | |

**NARRATIVE SUMMARY (CLINICAL RESUME)**

**MEDICAL RECORD**
STANDARD FORM 502 (rev-7-91)
Prescribed by GSA/ICMR,FIRMR
(41-CFR) 201-9.202.1

FIGURE 4-B-8

| MEDICAL RECORD | CONSULTATION SHEET | | |
|---|---|---|---|
| **REQUEST** | | | |
| TO: | FROM: *(requesting physician or activity)* | | DATE OF REQUEST |
| REASON FOR REQUEST *(Complaints and findings)* | | | |
| PROVISIONAL DIAGNOSIS | | | |
| DOCTOR'S SIGNATURE | APPROVED | PLACE OF CONSULTATION<br>☐ BEDSIDE ☐ ON CALL | ☐ROUTINE ☐ TODAY<br>☐72 HOURS ☐ EMERGENCY |
| **CONSULTATION REPORT** | | | |
| RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO | |
| SIGNATURE AND TITLE | | | DATE |
| HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT | |
| RELATION TO SPONSOR | SPONSOR'S NAME *(last, first, middle)* | SPONSOR'S ID NUMBER | |
| PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name –last, first, middle; ID No.(SSN or other); Sex; Date of Birth; Rank/Grade)* | | REGISTER NO. | WARD NO. |

SAMPLE FORM

**CONSULTATION SHEET**
MEDICAL RECORD
STANDARD FORM 513 (Rev. 4-98)
Prescibed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

## FIGURE 4-B-9

| **Clinical Record** | **ELECTROCARDIOGRAPHIC RECORD** | Previous ECG ☐ Yes ☐ NO |
|---|---|---|

| Clinical Impression | Medication | ☐ Emergency ☐ Routine | ☐ Bedside ☐ Ambulant |
|---|---|---|---|

| Age | Sex | Race | Height | B.P. | Signature of Ward Physician | Date |
|---|---|---|---|---|---|---|
| | | | | | | |

| Rhythm | Axis Deviation | Rates Auric. Vent. |
|---|---|---|

| IIntervals PR QRS QT | P Waves |
|---|---|

| QRS Complexes |
|---|

| RS-T Segment | T Waves |
|---|---|

Unipolar Extremity Leads *(specify)*

SAMPLE FORM

Precordial Leads *(specify)*

Summary, Serial Changes, and Implications:

(Continue on Reverse)

| No. ECG | Signature of Physician | Patient's Identification No. | Date |
|---|---|---|---|

| Patient's Identification (For typed or written entries give; Name – Last First, middle; grade, date hospital or medical facility) | Register No. | Ward No. |
|---|---|---|

**Electrocardiographic Records**
**Standard Form 520**
**General Services Administration and**
**Interagency Committee on Medical Records**
**FPMR 101-11.806-8**
**October 1975 520-106**

FIGURE 4-B-10

AUTHORIZED FOR LOCAL REPRODUCTION

| MEDICAL RECORD | TISSUE EXAMINATION |
|---|---|

| SPECIMEN SUBMITTED BY | DATE OBTAINED |
|---|---|
| SPECIMEN | |
| BRIEF CLINICAL HISTORY *(include duration of lesion and rapidity of growth, if a necoplasm)* | |
| PREOPERATIVE DIAGNOSIS | |
| OPERATIVE FINDINGS | |
| POSTOPERATIVE DIAGNOSIS | SIGNATURE |
| | NAME OF SIGNER |
| | TITLE OF SIGNER |

**PATHOLOGICAL REPORT**

| NAME OF LABORATORY | ACCESSION NO(S) | | |
|---|---|---|---|
| | | | |

GROSS DESCRIPTION, HISTOLOGIC EXAMINATION AND DIAGNOSES

SAMPLE FORM

| SIGNATURE OF PATHOLOGIST | NAME OF PATHOLOGIST | DATE |
|---|---|---|

| HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT |
|---|---|---|

| RELATION TO SPONSOR | SPONSOR'S NAME (*Last, first middle)* | SPONSOR'S ID NUMBER (*SSN or Other)* |
|---|---|---|

| PATIENT'S IDENTIFICATION (For typed or written entries, give: Name-last, first, middle; ID no. SSN or other); Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO. |
|---|---|---|

**TISSUE EXAMINATION**
Medical Record

**STANDARD FORM 515** (Rev 8-97)
Prescribed by GSA/ICMR FPMR 101-11.203(b)(10)

## FIGURE 4-B-11

| **Medical record** | **GYNECOLOGIC CYTOLOGY** |
|---|---|

**Section I – Clinical data to be Completed by Examining Installation**

| Date Obtained | LMP First Day | Date Received in Laboratory |
|---|---|---|
| | | |

Source of Specimen

☐ Combined Cerve and Vagina ☐ Cerve ☐ Vagina ☐ Other (Specify)

| Age | Pregnancy ☐ Yes ☐ No | Gravida | Para | Previous Abnormal Cytologic Examination ☐ Yes, Give Date_____ ☐ No |
|---|---|---|---|---|

| Clinical History *(Surgery, Drugs, hormones, radiation, etc.)* | Physical Examination *(Pelvic findings, etc.)* |
|---|---|
| | |

| Specimen Submitted By *(Facility)* | Signature and title | Submitting Facility Accession Number |
|---|---|---|
| | | |

**Section II – Cytologic Findings Form Reporting Installation Only**

| Name of Laboratory | Accession Number |
|---|---|
| | |

| Check One | Yes | No | Check One | Yes | No | |
|---|---|---|---|---|---|---|
| Granulocytes | | | Endocervial Cells | | | Maturation Index |
| Leukocytes | | | | | | Parabasals |
| Trichamonas | | | Screened By | | | Intermediates |
| Candida | | | | | | Superficials |

Comments and recommendations

SAMPLE FORM

| Pathologist's Signature | Title | Date |
|---|---|---|
| | | |

| Patients Identification (For typed or written entries give; Name – Last first, Middle; grade, date, hospital or medical facility) | Register No. | Ward No. |
|---|---|---|
| | | |

**Standard form 541**
**Provided by GSA and ICMB**

## FIGURE-4-B-12

| CLINICAL RECORD | LABORATORY REPORTS |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | ATTACH 3D REPORT ALONG HERE AND ↖ SUCCEEDING ONES ON ABOVE LINES |
| | ATTACH 2D REPORT WITH TOP AT THIS LINE ↖ |
| | ATTACH 1ST REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE ↖ |
| ATTACHING MARGIN | |

SAMPLE FORM

**ATTACH ALL TEST REPORTS TO THIS SHEET**

| PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; grade; date; hospital or medical facility)*, | REGISTER NO. | WARD NO. |
|---|---|---|
| | | |

**LABORATORY REPORTS**

**Standard Form 514**
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
October 1975 514-108

**FIGURE 4-B-13**

| MEDICAL RECORD | RADIOLOGICAL CONSULTATION REQUESTS/REPORTS |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | ATTACH 3D REPORT ALONG HERE ↖ AND SUCCEEDING ONES ON ABOVE LINES |
| | ATTACH 2D REPORT WITH TOP AT THIS LINE ↖ |
| ATTACH REPORTS WITHIN THIS MARGIN | ATTACH 1ST REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE ↖ |

SAMPLE FORM

**RADIOLOGICAL CONSULTATIONS REQUESTS/REPORTS**
**STANDARD FORM 519** (Rev. 2-84)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201.45.505
519-11
NSN 7540-00-634-4160

## FIGURE 4-B-14

*(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 – Use DD Form 2006.)*

| EYEWEAR PRESCRIPTION | DATE | ACCOUNT NUMBER | ORDER NUMBER |
|---|---|---|---|
| **TO:** *(LAB)* | | **FROM:** | |
| **NAME** *(Last, First)* | | **SSN** | **GRADE** |
| **ADDRESS/UNIT** | | **PHONE** | |
| **ADDRESS CONTINUED** | | **SHIP TO:** ☐ **CLINIC** ☐ **PATIENT** | |
| **CITY, STATE, ZIP** | | | |

SAMPLE FORM

| AD | RES | NG | RET | OTHER | A | N | AF | MC | CG | PHS | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

| FRAME | EYE | BRIDGE | TEMPLE | COLOR |
|---|---|---|---|---|
| | | | | |

| PD DIST / NEAR | LENS | TINT | MATERIAL | PAIR | CASE |
|---|---|---|---|---|---|
| | | | | | |

| | SPHERE | CYLINDER | AXIS | DECENTER | H PRISM | H BASE | V PRISM | V BASE |
|---|---|---|---|---|---|---|---|---|
| **R** | | | | | | | | |
| **L** | | | | | | | | |

| MULTIVISION | | | LAB USE | |
|---|---|---|---|---|
| NEAR ADD | SEG HT | TOTAL DECENTER | | |
| | | | | |
| | | | **PRIORITY** | **TECH INITIALS** |

SPECIAL COMMENTS/JUSTIFICATION *(* Use this space to specify blocks marked "Other.")*

| PRESCRIBING OFFICER/AUTHORITY | SIGNATURE |
|---|---|
| | |

**DISTRIBUTION: ORIGINAL –** Retained by Lab. **COPY 1** – Returned with eyewear. **COPY 2 –** Entered in health record.

**DD FORM 771, JUL 96 (EG)** PREVIOUS EDITION IS Designed using Perform Pro, WHS/DIOR, Aug 96

# FIGURE 4-B-15

**HEALTH RECORD** **IMMUNIZATION RECORD** *All entries in ink to be made in block letters*

**VACCINATION AGAINST SMALLPOX** *(Number of previous vaccination scars)*

| | DATE | ORIGIN | BATCH NUMBER | REACTION | STATION | PHYSICIAN'S NAME |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |

**YELLOW FEVER VACCINE**

| | DATE | ORIGIN | BATCH NUMBER | STATION | PHYSICIAN'S NAME |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

SAMPLE FORM

**TYPHOID VACCINE**

| | DATE | DOSE | PHYSICIAN' NAME | | DATE | DOSE | PHYSICIAN'S NAME |
|---|---|---|---|---|---|---|---|
| 1 | | | | 4 | | | |
| 2 | | | | 5 | | | |
| 3 | | | | 6 | | | |

**TETANUS-DIPHTHERIA TOXOIDS**

| | DATE | DOSE | PHYSICIAN'S NAME | | DATE | DOSE | PHYSICIAN'S NAME |
|---|---|---|---|---|---|---|---|
| 1 | | | | 4 | | | |
| 2 | | | | 5 | | | |
| 3 | | | | 6 | | | |

**CHOLERA VACCINE**

| | DATE | PHYSICIAN'S NAME | | DATE | PHYSICIAN'S NAME | | DATE | PHYSICIAN'S NAME |
|---|---|---|---|---|---|---|---|---|
| 1 | | | 4 | | | 7 | | |
| 2 | | | 5 | | | 8 | | |
| 3 | | | 6 | | | 9 | | |

**PATIENTS IDENTIFICATION** *(Mechanically Imprint, Type or Print):*

◀ Patient's Name – last, first, middle initial; Sex; age or Year Of Birth; Relationship to Sponsor; Component/Status; Department/Service.

◀ Sponsor's Name – last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization.

IMMUNIZATION RECORD
Standard Form 601 – October 1975 (Rev.)
General Services Administration & Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505

## FIGURE 4-B-15 (Reverse)

| ORAL POLIOVIRUS VACCINE | | | | | | | |
|---|---|---|---|---|---|---|---|
| | DATE | DOSE | PHYSICIAN'S NAME | | DATE | DOSE | PHYSICIAN'S NAME |
| 1 | | | | 3 | | | |
| 2 | | | | 4 | | | |

| INFLUENZA VACCINE | | | | | | | |
|---|---|---|---|---|---|---|---|
| | DATE | DOSE | PHYSICIAN'S NAME | | DATE | DOSE | PHYSICIAN'S NAME |
| 1 | | | | 3 | | | |
| 2 | | | | 4 | | | |

| INFLUENZA VACCINE | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | DATE | TYPE | DOSE | PHYSICIAN'S NAME | | DATE | TYPE | DOSE | PHYSICIAN'S NAME |
| 1 | | | | | | | | | |
| 2 | | | | | 6 | | | | |
| 3 | | | | | 7 | | | | |
| 4 | | | | | 8 | | | | |

SAMPLE FORM

| SENSITIVITIES TEST *(Tuberculin,etc.)* | | | | | | |
|---|---|---|---|---|---|---|
| | DATE | TYPE | DOSE | ROUTE | RESULTS | PHYSICIAN'S NAME |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |

**REMARKS:**

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO 2.

**STANDARD FORM 601 PAGE 2** (Rev. 10-75)

# FIGURE 4-B-16

**HEALTH RECORD** SYPHILIS RECORD

**SECTION 1. – HISTORY OF PAST VENEREAL INFECTIONS OR TREATMENTS**

| DATE | DISEASE *(Give stage)* | PRIOR TO MIL. SERVICE YES | PRIOR TO MIL. SERVICE NO | TREATMENT *(Give type, amount and dates)* | TREATING AGENCY | PLACE |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |

**SECTION II = HISTORY OF PRESENT INFECTION**

**CAME TO MEDIAL ATTENTION BY:** **VOLUNTARY** ☐ CONTACT REPORT ☐ PHYSICAL INSPECTION ☐ FOOD HANDLER ☐

**INCIDENT TO HOSPITALIZATION** **PREMARITAL** ☐ **PRENATAL** ☐ **OTHER** *(Specify)* ☐

**DATES: ONSET SYMPTOMS** **REQUESTED TREATMENT** **DIAGNOSIS ESTABLISHED**

**DIAGNOSIS** *(Include stage and diagnosis No.)*

**LIST VD CONTACT FORM SERIAL NOS.**

**DIAGNOSTIC CRITERIA** *(Enter results of test)*

**CLINICAL DATA** *(Including chief complaint, physical findings – eye, cardiovascular and nervous system, even in early syphillis)*

SAMPLE FORM

**RECOMMENDED TREATMENT AND FOLLOW-UP** **SIGNATURE OF PHYSICIAN** **DATE**

HAVE BEEN INFORMED BY THE MEDICAL OFFICER THAT I HAVE BEEN DIAGNOSED AS HAVING SYPHILIS AS INDICATED ABOVE; THE NATURE OF THIS DISEASE HAS BEEN EXPLAINED TO ME; I UNDERSTAND THAT MY COOPERATION IS NECESSARY IN THE TREATMENT AND PROLONGED OBSERVATION *(including certain prescribed tests)* FOR THE CARE OF THIS DISEASE.

SIGNATURE OF PATIENT AND DATE

**SECTION III. - TREATMENT**

| | TREATMENT | DATE STARTED | DATE ENDED | SIGNATURE OF PHYSICIAN |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |

**PATIENT'S IDENTIFICATION** *(Mechanically Imprint, Type or Print):*

◀ Patient's Name – last, first, middle initial; Sex; age or Year Of Birth; Relationship to Sponsor; Component/Status; Department/Service.

◀ Sponsor's Name – last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization.

**SYPHILIS RECORD**
Standard Form 602 – March – 1975 (Rev.)
General Services Administration &
Interagency Comm on Medical Records

# FIGURE 4-B-16 (Reverse)

**SECTION IV. – CUMULATIVE LABORATORY SUMMARY**

**RESULTS OF DARKFIELD EXAMINATION**

| | DATE | RESULTS | SOURCE OF SPECIMEN | LABORATORY | NAME OF CONFIRMING OFFICER |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |

**RESULTS OF SEROLOGICAL TESTS FOR SYPHILIS**

| | DATE | TYPE | RESULT *(Include titer value)* | LABORATORY | | DATE | TYPE | RESULT *(Include Titer value)* | LABORATORY |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | 5 | | | | |
| 2 | | | | | 6 | | | | |
| 3 | | | | | 7 | | | | |
| 4 | | | | | 8 | | | | |

**FLUORESCENT ANTIBODY TESTS**

| | DATE | |
|---|---|---|
| 1 | | |
| 2 | | |

SAMPLE FORM

**RESULTS OF SPINAL FLUID EXAMINATION**

| | DATE | CELLS | TOTAL PROTEIN | SEROLOGICAL TEST *(Including titer)* | LABORATORY WHERE DONE |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |

**SECTION V. – EVALUATION OF THERAPY**

| | DATE | FACILITY WHERE EVALUATED | RESULT | | DATE OF RETREATMENT | PHYSICIAN'S SIGNATURE |
|---|---|---|---|---|---|---|
| | | | Satisfactory | UNSATISFACTORY | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |

***Satisfactory result cannot be reported without normal spinal fluid findings.**
****Specify: Infectious Relapse: Sero-Relapse, Neuro-Relapse, Incomplete data on Spinal Fluid, Other** *(Specify)*

**REASON FOR INADEQUATE FOLLOW-UP** *(Date, place and type of separation – Give authority for discharge)*

| PATIENT'S HOME ADDRESS ON SEPARATION | CIVILIAN HEALTH DEPT. TO WHICH CASE RESUME WAS SENT |
|---|---|
| | |

**REINFECTION** *(Give date new record was opened)*

REMARKS

**SECTION VI. – MEDICAL OFFICER CLOSING THIS RECORD**

| NAME *(Typed or printed)* | SIGNATURE | STATION | DATE |
|---|---|---|---|
| | | | |

**SECTION VII. – MEDICAL OFFICER SENDING ABSTRACT TO VETERAN'S ADMINISTRATION ON DISCHARGE**

| NAME *(Typed or printed* | SIGNATURE | STATION | DATE |
|---|---|---|---|
| | | | |

Page 2 of SF-602 (rev. 3-75)

## FIGURE 4-B-17

### RECORD OF OCCUPATIONAL EXPOSURE TO IONIZING RADIATION

*For instructions See Reverse of Sheet*

| Identification Number | Name (*Last, First, Middle Initial)* | Social Security Number | Rank/Rate/Title | Date of Birth |
|---|---|---|---|---|
| | | | | |

| Place Where Exposure Occurred | Period of Exposure | | **Dose This Period**<br>1. Method of monitoring is presumed to be film badge reading unless otherwise specified under item 16, "REMARKS." | | | | **Accumulated Dose** | | Initial |
|---|---|---|---|---|---|---|---|---|---|
| Acticty | From (Day-Mo-Yr) | To (Day-Mo-Yr) | Skin Dose (Salt) | Gamma and X-Ray | Neutron | Total This Period | Total Life Time | Permis-sible Lifetime | Persons Making Entry |
| | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |

SAMPLE FORM

16. Remarks:

**TO BE RETAINED PERMANENTLY IN INDIVIDUAL'S MEDICAL RECORD**

DD Form 1141

## FIGURE 4-B-18

| Department of Transportation<br>U.S. Coast Guard<br>CG-4057 (Rev 2-01) | CHRONOLOGICAL RECORD OF SERVICE | |
|---|---|---|
| **DATE ATTACHED** | **UNIT OR STATION** | **DATE DETACHED** |
| | | |
| | | |
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| | | |
| | | |
| | | |
| **Name (Last, First, Middle)** | | **Social Security Number** |

SAMPLE FORM

## FIGURE 4-B-18 (Reversed)



### AGREEMENT/DISAGREEMENT

I agree ☐ (or) do not agree ☐ that at the time of separation:

(2) I am reasonably able to perform my current duties, or

(2) I have a high expectation of recovery in the near term from illness, injury or surgical procedure such that I would again be able to perform my usual duties.

| Date | Grade/Rate | Signature of Member |
|---|---|---|
| | | |

### TERMINATION OF HEALTH RECORD

Remarks

Impairments, which have been documented in your health record, including any separation exam, while establishing service connection, do not in themselves indicate a disability. To receive disability benefits from the Coast Guard, you must be found unfit to perform your assigned duties through the physical disability evaluation system before you are separated.

After you are separated, any claims for disability benefits must be submitted to the Department of Veterans Affairs. If you have questions about certain benefits to which you might be entitled you should contact the DVA Regional Office nearest your home as soon as practical.

I have read the above statements and acknowledge receipt of a copy of the following:

1. CG-4057, Chronological record of Service.
2. SF-88 report of Medical Examination date_____ (if performed).
3. PHS-731, International Certificate of Vaccination.
4. DD Form 2766, Adult Preventive and Chronic Care Flowsheet.

| Date | Grade/Rate | Signature of Member |
|---|---|---|
| | | |

### COMMAND CERTIFICATION

Health record terminated this date by reason of_____

In accordance with Chapter 4, Medical Manual, COMDTINST M6000.1 (series)

| Date | Title | Signature |
|---|---|---|
| | | |

## FIGURE 4-B-19

| NAVMED – 6150/2 (REV 8-70) | SPECIAL DUTY MEDICAL ABSTRACT (NAVMED 6150/2) |
|---|---|
| **Health Record** | **Special Duty Medical Abstract** |

**Summary of Physical Examination for Special Duty**

| Date | Place | Purpose | Result – Recommendation *(Defects Reverse)* | BUMED Action | Sig. Of M.D. |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |

**Suspension From Special Duty**

| Date *(From) (To)* | No. of Days | Reason for Suspension | Signature of Medical Officer |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

SAMPLE FORM

**Periodic Special Duty Requalification**

| Date | Signature of . O. | Date | Signature of M.O. | Date | Signature of M.O. |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Name (Last) (First) (Middle) | Grade/Rate | Service/Soc. Sec. | Organization |
|---|---|---|---|
| | | | |

## FIGURE 4-B-19 (Reverse)

**SPECIAL DUTY MEDICAL ABSTRACT (NAVMED 6150/2)**

| **Altitude Training, Air Compression and Oxygen Tolerance** | | | |
|---|---|---|---|
| Date | Station | Type of Run – Reaction | Signature or M.O. |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| **Explosive Decompression Training** | | | |
| Date | Station | Altitudes - Reaction | Signature or M.O. |
| 1. | | | |
| 2. | | | |
| **Submarine Escape and Diving Training** | | | |
| Date | Station | Type of Run - Reaction | Signature or M.O. |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| **Visual and Disorientation Training** | | | |
| Date | Station | Type of Training | Signature or M.O. |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| **Centrifuge and Ejection Seat Training** | | | |
| Date | Station | Type of run – Reaction | Signature or M.O. |
| 1. | | | |
| 2. | | | |
| | | | |
| Remarks | | | |

SAMPLE FORM

# FIGURE 4-B-20

## EMERGENCY MEDICAL TREATMENT REPORT

**VICTIM IDENTI-FICATION**

1. Name_____
_____
2. Sex (check one) male _____
female _____
3. Estimated age yrs_____ mos_____

**RESCUER INFOR-MATION**

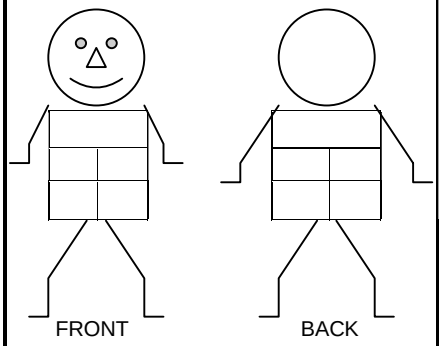
10. Name: _____ 11. Level:
12. Unit: _____
13. OPFAC #: _____
14. Rescue Vehicle:_____
15. Receiving Unit:_____
16. Time Patient Transferred:_____

**DESCRIP-TION OF INCIDENT**

4. Date: _____ 5. Type of incident:
6. Time on Scene: _____ a) marine _____
7. Time of incident: _____ b) aviation _____
c) Industrial _____
8. Location:_____ d) auto _____
_____ e) domestic _____
f) other _____

NATURE OF EMERGENCY / MECHANISM OF INJURY

**OBSERVA-TION OF VISTIM**




**H –** hemorrhage **F –** fracture
**L -** laceration **B -** burns
**S –** soft tissue injury O2 Liters_____

**TREATMENT**

**IRCLE AS NEEDED)**

– DRESSING
- TX SPLINT
- SPLINT
- C/COLLAR
- BACK BOARD
- TOURNIQUET
- CPR
- AIRWAY
- OXYGEN
.0 - MAST
.1 - MILLER B/B

**MEDICATIONS:**

**ALLERGIES**

_____

**MEDICAL HISTORY / COMMENTS /ETC.**
(include additional vitals, oxygen, fluids, etc.)

SAMPLE FORM

**SKIN**

(Circle appropriate number of numbers)

| | | |
|---|---|---|
| 1 – normal | 4 - cyanotic | 7 - cold |
| 2 – pale/ashen | 5 – dry | 8 – warm |
| 3 – flushed | 6 – moist | 9 - hot |

| | TIME / OBSERVED | | | | |
|---|---|---|---|---|---|
| **VITAL SIGNS** | | | | | |
| **LEVEL OF CONSCIOUS** | Alert | | | | |
| | Responds to Verbal | | | | |
| | Responds to Pain | | | | |
| | Uncon/Unresponsive | | | | |
| **PUPILS** | Perl | | | | |
| | Unequal | | | | |
| | Nonreactive | | | | |
| | Dilated | | | | |
| | Pinpoint | | | | |
| **PULSE** | Rate (Numeric) | | | | |
| | Strong | | | | |
| | Weak | | | | |
| **BREATHING** | Rate (Numeric) | | | | |
| | Regular | | | | |
| | Shallow | | | | |
| | Labored | | | | |
| **BLOOD PRESSURE** | Blood Pressure | | | | |
| **TEMP** | Temperature (circle) ORAL RECTAL | | | | |
| **MAST** | **MAST BP** | | | | |
| | COMPARTMENT | | R | L | ABD |

| TIME | MEDICATIONS ADMINISTERED | DOSAGE |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**TRIAGE INFORMATION** (CIRCLE ONE) **PRIORITY I** **PRIORITY II** **PRIORITY III**

**DEPT. OF TRANSPORTATION., USCG CG-5214 (Rev. 10-88)** **PATIENT COPY**
**Previous Edition May be Used**

# FIGURE 4-B-21

| REQUEST FOR MEDICAL/DENTAL RECORD OR INFORMATION | REQUESTING ACTIVITY Complete Items 1 through 10 *(Except 8b); also* Complete Item 19.<br>ADDRESSEE – Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, Final referrer shall return to requester. | Date |
|---|---|---|

| | |
|---|---|
| 1. PATIENT *(Last Name – First Name – Middle Name)* | 3. STATUS ☐ MILITARY ☐ VA BENEFICIARY<br>☐ DEPENDENT ☐ FEDERAL EMPLOYEE<br>☐ OTHER *(Specify)* |
| 2. ORGANIZATION AND PLACE OF TREATMENT | 3a. NAME OF SPONSOR *(If dependent)* |

| | |
|---|---|
| 4. TO *(Include ZIP Code)* | 5. IDENTIFYING INFORMATION<br>a. SERVICE NUMBER<br>b. GRADE/RATE<br>C. SOCIAL SECURITY ACCOUNT NO.<br>D. VA CLAIM NUMBER<br>E. DATE OF BIRTH *(If federal employee)* |

| | |
|---|---|
| 6. DATES OF TREATMENT | 7 DISEASE OR INJURY |

| 8. a. RECORDS REQUESTED | MIL | VA | B. RECORDS FORWARDED | MIL | VA |
|---|---|---|---|---|---|
| CLINICAL | ☐ | ☐ | | ☐ | ☐ |
| OUTPATIENT | ☐ | ☐ | | ☐ | ☐ |
| HEALTH RECORD | ☐ | | | ☐ | |
| DENTAL RECORD | ☐ | ☐ | | ☐ | ☐ |
| X--RAY | ☐ | ☐ | | ☐ | ☐ |
| MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS | ☐ | | | ☐ | |
| ABSTRACT OF RATING SHEET | | | | | ☐ |
| REPORT OF PHYSICAL EXAMINATION | ☐ | ☐ | | ☐ | ☐ |
| ALL AVAILABLE RECORDS *(Except X-rays unless specifically requested)* | ☐ | | | ☐ | |
| OTHERS *(List under remarks)* | ☐ | ☐ | | ☐ | ☐ |

9. REMARKS

10. SIGNATURE

SAMPLE FORM

## REPLY/REFERRAL

| | |
|---|---|
| 11. TO: | 12. REMARKS<br>☐ RECORDS CHECKED IN 8B FORWARDED.<br>☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.<br>☐ MORE INFORMATION NEEDED. |
| 13. SIGNATURE / 14. DATE | |

## REPLY/SECOND REFERRAL

| | |
|---|---|
| 15. TO: | 16. REMARKS<br>☐ RECORDS CHECKED IN 8B FORWARDED.<br>☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.<br>☐ MORE INFORMATION NEEDED. |
| 17. SIGNATURE / 18. DATE | |

| | |
|---|---|
| 19. **RETURN TO**: *(Include ZIP Code)* | *REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.* |

**DD FORM 877, SEP 67**

Section C - Dental Record Forms.

1. CG-3443-2 (Dental Record Cover)

   a. Open a CG-3443-2 for each individual upon arrival at a training center or initial entry into the Coast Guard or Coast Guard Reserve. When an individual on the retired list returns to active duty, submit a request for a copy of the closed out dental record to Commandant (G-PIM). Whenever the original record is lost or destroyed, a new dental record shall be opened immediately. Normally the dental record shall be kept in the Health Record Cover (CG-3443) of each individual unless otherwise specified.

   b. All dental forms and radiographs will be contained in the Dental Record.

   c. Detailed Instructions.

      (1) Surname. Record the surname in all capital letters.

      **DOE**

      **SURNAME**

      (2) Given name(s). Record in full without abbreviation. If the individual has no middle name or initial then record the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are used, they shall appear after the middle name or initial.

      **DOE JANE ANN**

      **SURNAME First Name Middle Name**

      (3) Social Security Number (SSN). Enter Social Security Number.

      (4) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.), and the year: i.e., 4 SEP 49.

      (5) Change in Grade or Rate. Enter as they occur.

      (6) Blood Type. Enter the individual's blood type in the appropriate box. If not known, perform a blood type test.

      (7) RH Factor. Enter the individual's RH factor in the appropriate box. If not known, perform an RH factor test.

      (8) Drug Sensitivity Sticker. When required, affix the Drug Sensitivity Sticker (CG-5266) to the lower left corner of the front of the Dental Record Cover. Do not cover other identification data. See FIGURE 4-C-1.

      (9) Dental Radiographs.

(a) Dental Bitewing Radiograph Storage. Bitewing radiographs shall be stored in the standard stock 5 year x-ray card (FSC# 6525-00-142-8732). This shall replace the single bitewing x-ray card (FSC# 6525-00-817-2364). X-ray film is mounted in the x-ray card with the raised dot side of the film on the back side of the card.

2. NAVMED 6600/3 (Dental Health Questionnaire)

a. General. CG-5605 will help the dental officer detect any present or past health problem (i.e., positive Human Immunodeficiency Virus (HIV)) that might interfere with definitive dental treatment. All positive answers from the health history section must be followed up by the dental officer for impact on health care and so annotated on the CG-5605 and/or the SF-603A.

b. Detailed Instructions. Insert the Dental Health Questionnaire as the first page of the dental record. Patients shall fill out a new Dental Health Questionnaire at least annually, or when information changes. Maintain the two most recent forms in the dental record with the current CG-5605 on top. See FIGURE 4-C-2.

(1) Chief Complaint. Have the patient enter the problem they are presently having.

(2) Check and Sign. Have the patient enter yes/no in each box of the history. The signature indicates the authenticity of the history.

(3) Summary of Pertinent Findings. Include baseline BP reading.

3. SF-603 (Dental Record). (See FIGURE 4-C-3)

a. General. The Dental Record is a continuous history and must contain accurate and complete entries of dental examinations and treatments. Each entry shall clearly indicate the name of the dental officer conducting the examination and/or rendering the treatment. Dental hygienists or other auxiliary personnel providing care shall also follow this requirement. Each dental officer is personally responsible for ensuring that all entries are properly recorded.

b. Numerical Classification for Record Purposes. Chart markings have been standardized so that dental conditions, treatments needed, and treatments completed may be readily identified. This facilitates efficient continuity of treatments and may establish identification in certain circumstances.

(1) For the purpose of brevity and exactness, use the following classification of teeth in keeping the dental record.

| TOOTH | DESIGNATION |
|---|---|
| Right Maxillary Third Molar | 1 |
| Right Maxillary Second Molar | 2 |

| | |
|---|---|
| Right Maxillary First Molar | 3 |
| Right Maxillary Second Bicuspid | 4 |
| Right Maxillary First Bicuspid | 5 |
| Right Maxillary Cuspid | 6 |
| Right Maxillary Lateral Incisor | 7 |
| Right Maxillary Central Incisor | 8 |
| Left Maxillary Central Incisor | 9 |
| Left Maxillary Lateral Incisor | 10 |
| Left Maxillary Cuspid | 11 |
| Left Maxillary First Bicuspid | 12 |
| Left Maxillary Second Bicuspid | 13 |
| Left Maxillary First Molar | 14 |
| Left Maxillary Second Molar | 15 |
| Left Maxillary Third Molar | 16 |
| Left Mandibular Third Molar | 17 |
| Left Mandibular Second Molar. . | 18 |
| Left Mandibular First Molar | 19 |
| Left Mandibular Second Bicuspid | 20 |
| Left Mandibular First Bicuspid | 21 |
| Left Mandibular Cuspid | 22 |
| Left Mandibular Lateral Incisor | 23 |
| Left Mandibular Central Incisor | 24 |
| Right Mandibular Central Incisor | 25 |
| Right Mandibular Lateral Incisor | 26 |
| Right Mandibular Cuspid | 27 |
| Right Mandibular First Bicuspid | 28 |
| Right Mandibular Second Bicuspid | 29 |
| Right Mandibular First Molar | 30 |
| Right Mandibular Second Molar | 31 |
| Right Mandibular Third Molar | 32 |

(2) Indicate deciduous teeth by placing a block "D" around tooth number. If both permanent and deciduous teeth are present, place a "D" in location of deciduous tooth and enter the appropriate tooth number inside the "D."

(3) Indicate a supernumerary tooth by placing "s" in the location of the supernumerary tooth and in the remarks section enter a statement that the examinee has a supernumerary tooth.

(4) Indicate deciduous and supernumerary teeth on the SF-603 in SECTION I, Part 5 (Diseases, Abnormalities, and Radiographs) and enter a statement in the remarks section of Section 5.

c. Detailed Instructions.

**SECTION I. DENTAL EXAMINATION**

(1) Purpose of Examination. To assess the oral health status of cadets, officer candidates and enlisted recruits upon initial entry into the Coast Guard, and to provide periodic (but at least annual) examinations of active duty personnel. Enter an "X" in the appropriate box. Mark the "Initial" box for the dental examination made upon entrance into the Coast Guard. All other examinations fall under the "Other" category and shall be identified: i.e., "Academy", "Reenlistment", etc.

(2) Type of Examination. Enter an "X" in the proper box of item 2, "Type of Exam."

(a) Type 1, Comprehensive Examination. Comprehensive hard and soft tissue examination, which shall include: oral cancer screening examination; mouth-mirror, explorer, and periodontal probe examination; adequate natural or artificial illumination; panographic or full-mouth periapical, and posterior bitewing radiographs as required; blood pressure recording; and when indicated, percussive, thermal, and electrical tests, transillumination, and study models. Included are lengthy clinical evaluations required to establish a complex total treatment plan. For example, treatment planning for full mouth reconstruction, determining differential diagnosis of a patient's chief complaint, or lengthy history taking relative to determining a diagnosis. Use S.O.A.P. format to record the results of a Type 1 examination.

(b) Type 2, Oral Examination (annual or periodic). Hard and soft tissue examination, which shall include: oral cancer screening examination; mouth mirror and explorer examination with adequate natural or artificial illumination; periodontal screening; appropriate panographic or intraoral radiographs as indicated by the clinical examination; and blood pressure recording. An appropriate treatment plan shall be recorded. This type is the routine examination which is normally performed one time per treatment regimen per patient, unless circumstances warrant another complete examination. Use S.O.A.P. format to record the results of Type 2 examination.

(c) Type 3, Other Examination. Diagnostic procedure as appropriate for: consultations between staff; observation where no formal consult is prepared; certain categories of physical examination; and emergency oral examination for evaluation of pain, infection, trauma, or defective restorations.

(d) Type 4, Screening Evaluation. Mouth mirror and explorer or tongue depressor examination with available illumination. This includes the initial dental processing of candidates without necessarily being examined by a dentist, or other dental screening procedures.

(e) If not specified by this Manual, it shall be the professional responsibility of the dental officer to determine the type of examination which is appropriate for each patient. However, Type 3 and Type 4 examinations are not adequate to definitively evaluate the oral health status of patients. When the dental officer determines that a comprehensive periodontal examination is to be accomplished, use the Navy Periodontal Chart, NAVMED 6660/2 (3-90).

(3) Dental Classification of Individuals. Dental classifications are used to designate the health status and the urgency or priority of treatment needs for active duty personnel. Use the following guidelines and criteria for the classification of patients. When a criterion for a specific condition is not listed, the dental officer shall evaluate the prognosis for a dental emergency and assign the appropriate classification.

(a) Class 1. Patients who do not require dental treatment. The following are criteria for such classification.

1 no dental caries or defective restorations;

2 healthy periodontium, no tooth accumulated materials (hard or visible soft deposits);

3 stable occlusion, asymptomatic temporomandibular joint;

4 unerupted or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis, and are not recommended for prophylactic removal; and

5 no edentulous spaces for which a prosthesis is indicated.

(b) Class 2. Patients who have dental conditions that are unlikely to result in a dental emergency within 12 months. Class 2 dental patients are considered fit for operational duties, but the dental diseases or conditions causing designation shall be reevaluated at each dental examination. Any one of the following is a sufficient criterion for such a classification:

1 Dental caries, decalcification, or tooth fractures extending beyond the dentinoenamel junction, or causing definitive symptoms;

2 Restorations with fractures or marginal defects;

3 Periodontal diseases or periodontium exhibiting;

a nonspecific gingivitis. Inflammation of the gingiva characterized by changes in color, gingival form, position, surface appearance, bleeding upon brushing or flossing, or the presence of blood or exudate after probing with a periodontal probe;

b slight or mild adult periodontitis. Progression of the gingival inflammation into the deeper periodontal structures and alveolar bone crest with accompanying periodontal probing depths of from 3 to 4mm, slight loss of connective attachment, and slight loss of alveolar bone;

c moderate periodontitis. Gingival inflammation with destruction of the periodontal structures including radiographic or clinical evidence of loss of alveolar bone support, with possible early furcation involvement of multirooted teeth or tooth mobility;

d stable or nonprogressive mucogingival conditions. This includes conditions such as irregular marginal contours, gingival clefts, and aberrant frena or muscle attachments, which could potentially progress, or pathosis but are currently stable and compatible with periodontal health; or

e past history of periodontal disease or therapy when the disease is currently under control in a long-term maintenance program.

4 The presence of supragingival or subgingival tooth accumulated materials without concomitant periodontal disease.

5 Prosthodontics indicated. Edentulous areas, provisional/interim/temporary prostheses, defective prostheses, provisional crowns, large extracoronal direct restorations, or endodontically treated teeth without full coverage, that need prosthetic treatment but delay will not compromise the patients immediate health or masticating function.

6 Unerupted, nonfunctional, or malposed teeth without historical, clinical, or radiographic signs or symptoms of pathosis, but which are recommended for prophylactic removal to prevent future pathologic conditions (e.g., unopposed or unerupted third molars, or malposed teeth which complicate plaque control measures).

7 Preventive dentistry requirements not fulfilled.

8 Those conditions described in subparagraphs 4. through 7. above are not considered disqualifying for overseas, sea duty, or isolated duty assignment.

(c) Class 3. Patients who have dental conditions that are likely to cause a dental emergency within 12 months. The following conditions have the potential to cause an emergency, and any one is sufficient criterion for disqualification for overseas or isolated duty assignment:

1 Periodontal diseases or periodontium exhibiting:

2 advanced periodontitis. Significant progression of periodontitis with major loss of alveolar bone support and probable complex furcation involvement of multirooted teeth and increased tooth mobility. The periodontal probing depth may reach 7mm and deeper;

a. periodontal abscess;

b. acute necrotizing ulcerative gingivitis (NUG);

c. periodontal manifestations of systemic diseases and hormonal distubances (e.g., acute herpetic gingivostomatitis);

d. refractory, rapidly progressive periodontitis. Rapid bone and attachment loss, or slow but continuous bone and attachment loss resistant to normal therapy; or

e. juvenile and prepubertal periodontitis, either localized or generalized.

3 Acute or chronic pulpitis.

4 Indication of periradicular pathosis with or without existing root canal filling which may require treatment.

5 Presence of a tooth or teeth undergoing endodontic therapy.

6 Stomatitis.

7 Pericoronitis.

8 Prosthodontics required to replace an existing prosthesis exhibiting dental caries, or a large defective amalgam restoration requiring replacement with a casting. Also, appliances required due to:

9 insufficient masticatory function, active arch collapse from tooth loss, or essential performance of military duties (e.g., replacement of missing teeth for esthetics or phonetics);

10 soft tissue inflammation, such as papillary hyperplasia under a denture base;

11 an essential prosthesis in need of repair in order to be functional; or

12 a provisional, interim, or temporary prosthesis which cannot be maintained for a 12 month period.

13 Unerupted, partially erupted, nonfunctional or malposed teeth associated with historical, clinical or radiographic evidence of pathosis, or with a high potential to cause a dental emergency.

14 Soft or hard tissue lesions requiring an incisional or excisional biopsy for the definitive diagnosis and treatment of the lesions, including the period of time awaiting the results of the histopathologic examination.

15 Appropriate postoperative treatment not yet completed, including suture removals for surgery and occlusal adjustments for restorative dentistry.

16 All conditions requiring immediate treatment for relief of pain, traumatic injuries, or acute oral infections.

17 Orthodontic therapy in progress, with either fixed or removable appliances.

(4) Priority of Dental Treatment. To further indicate priority of treatment within a class, the following groupings shall be used when necessary (listed in order of decreasing priority).

(a) Group 1. Coast Guard active duty personnel in receipt of orders to sea, overseas, or combat duty.

(b) Group 2. Coast Guard active duty personnel upon return from sea, overseas, or combat duty.

(c) Group 3. Other Coast Guard personnel.

(d) Group 4. Active duty personnel of other Services assigned to duty with the Coast Guard.

(e) Group 5. Active duty personnel of other Services.

(f) Missing Teeth and Existing Restorations.

(g) Markings shall be made on examination chart as follows:

1 Missing Teeth. Draw a large "X" on the root(s) of each tooth that is not visible in the mouth.

2 Edentulous Mouth. Inscribe crossing lines, one extending from the maxillary right third molar to the mandibular left third molar and the other from the maxillary left third molar to the mandibular right third molar.

3 Edentulous Arch. Make crossing lines, each running from the uppermost aspect of one third molar to the lowest aspect of the third molar on the opposite side.

4 Amalgam Restorations. In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape, and block solidly.

5 Nonmetallic Permanent Restorations (includes oxyphosphate cements). In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape.

6 Gold Restorations. Outline and inscribe horizontal lines within the outline.

7 Combination Restorations. Outline showing overall size, location, and shape; partition and junction materials used and indicate each, as in "4." above.

8 Porcelain Facings and Pontics. Outline.

9 Acrylic Resin Facings and Pontics. Outline each aspect.

10 Porcelain Post Crowns. Outline the crown and approximate size and position of the post(s).

11 Acrylic Resin Post Crowns. Outline crown and approximate size and position of the post(s).

12 Porcelain Jacket Crowns. Outline each aspect.

13 Acrylic Resin Jacket Crowns. Outline each aspect.

14 Fixed Bridges. Outline each, showing overall size, location, teeth involved and shape by the inscription of diagonal lines in abutments and pontics.

15 Removable Appliances. Place an "X" through the missing tooth, place a line over replaced teeth and describe briefly in "Remarks."

16 Root Canal Fillings. Outline canal filled and black in solidly.

17 Apicoectomy. Draw a small triangle apex of the root of the tooth involved, the base line to show the approximate level of root amputation.

18 Drifted Teeth. Draw an arrow from the designating number of the tooth that has moved; the point of the arrow to indicate the approximate position to which it has drifted. Under "Remarks" note the relationship to the drifted tooth in respect to occlusion.

(h) If an individual is appointed or enlisted with dental defects which have been waived, the defects shall be described fully in the dental record under "Remarks" (Section I). (See FIGURE 4-C-3)

(i) The examining dental officer shall sign, date, and record the place of examination where indicated.

(5) Diseases, Abnormalities, and Radiographs.

(a) Markings on the examination chart of Diseases, Abnormalities, and Radiographs shall be made as follows:

1 Caries. In the diagram of the tooth affected, draw an outline of the carious portion, showing size, location and shape, and block in solidly.

2 Defective Restoration. Outline and block in solidly the restoration involved.

3 Impacted Teeth. Outline all aspects of each impacted tooth with a single oval. Indicate the axis of the tooth by an arrow pointing in the direction of the crown.

4 Abcess. Outline approximate size, form, and location.

5 Cyst. Outline the approximate form and size in relative position of the dental chart.

6 Periodontal Disease. Inscribe a horizontal continuous line on the external aspect of root(s) involved in a position approximating the extent of gingival recession or the clinical depth of the pocket. If known, indicate the position of the alveolar crest by a second continuous line in relative position to the line indicating the gingival tissue level.

7 Extraction Needed. Draw two parallel vertical lines through all aspects of the tooth involved.

8 Fractured Tooth Root. Indicate fracture with a zigzag line on outline of tooth root.

(b) A statement regarding hypersensitivity to procaine or any other drug known to the person for whom a Dental Record is prepared shall be entered under "Remarks." (Example: HYPERSENSITIVITY TO PROCAINE)

(c) Complete items A through E.

(d) The examining dental officer shall sign, date, and record the place of examination where indicated.

(e) NOTE: Section I, Subsections 4 and 5 of SF 603 are used to record findings of initial and replacement examinations. These charts shall not be altered thereafter.

**SECTION II. PATIENT DATA**

(1) Patient Data. Complete items 6 through 14 as indicated.

**SECTION III. ATTENDANCE RECORD**

(1) Restorations and Treatments (Completed during service) (Item 15).

(a) Record restorations or treatments provided a patient after the initiation of a Dental Record on the chart "Restorations and Treatments" of Section III, in accordance with the following:

1 Carious Teeth Restored. In the diagram of the tooth involved, draw an outline of the restoration showing size, location and shape, and indicate the material used. Amalgam restorations would be outlined and blocked in, silicate cement restorations outlined only, etc.

2 Extractions. Draw a large "X" on the root(s) of each tooth extracted.

3 Root Canal Fillings. Outline each canal filled on the diagram of the root(s) of the tooth involved and block it in solidly.

4 Apicoectomy. Draw a small triangle on the root of the tooth involved, apex away from the crown, the base line to show the approximate level of tooth amputation.

5 Bridge and Crowns. Outline and fill in as specified above.

6 Removable Appliances. Place a line over numbers of replaced teeth and give a brief description under "Remarks."

7 Unrecorded Operations and Conditions. Operations performed by other than Coast Guard dental officers subsequent to the original

examination will be indicated by the dental officer discovering the condition just as if they had been done by a Coast Guard dental officer. Make appropriate entries indicating the nature of the treatment and adding the abbreviation "CIV" or other abbreviation as the case may be. The date entered will be the date of the discovery.

8 Other. Similarly, note operations known to have been performed by Coast Guard dental officers whose identity is not recorded, except use the abbreviation "CGDO." The date entered shall be the date the operation is discovered. Account for teeth which are shown as missing in the chart, Missing Teeth and Existing Restorations, and which have erupted subsequently, by an entry in the following manner: "1 and 32," eruption noted, date, and signature of dental officer making the notation. Record other conditions of comparable importance in a similar manner.

(b) Record a series of treatments for a specific condition not producing lasting changes in dental characteristics by entering of initial and final treatment dates (i.e., POT daily 1 AUG 87 thru 5 AUG 87 or Vin Tr. twice daily 1 AUG 87 thru 10 AUG 87).

(c) Authenticate each entry in this record by a written entry in the spaces provided under "Services Rendered."

(2) Subsequent Disease and Abnormalities (Item 16). Chart subsequent conditions, in pencil only, using the instructions in Chapter 4-C.3.(6). Once treatment is completed and documented in item 17, erase pencil entry in item 16 and permanently transfer in ink to item 15 (Restorations and Treatments).

(3) Services Rendered (Item 17). The accuracy and thoroughness in recording patient histories and treatment progress notes are essential elements in the diagnosis and treatment of the dental patient. In addition to the conventional listing of the tooth number and procedure, every effort shall be made to specifically identify dental materials used intraorally. Use trade names where possible. This includes, but is not limited to; bases and liners, metallic and nonmetallic restorative materials, denture frameworks and bases, impression materials, medicaments, and anesthesia. Record prescribed medications.

(a) Standard S.O.A.P. format. The S.O.A.P. format shall be used to document all sickcall and emergency dental treatments, to document Type 1 and Type 2 examinations, and to record the results of the examination of patients in preparation for comprehensive treatment planning. S.O.A.P. format is not required to document ongoing delivery of treatment which has been previously planned. All entries are to be on the SF-603/603-A, item 17. The S.O.A.P. format uses a problem oriented record as a tool in management of patient care. The acronym is derived from the first letter of the first four record statements as follows:

1 **"S" Subjective data**. This data includes the reason for the visit to the dental clinic, and if appropriate, a statement of the problem (chief complaint) and the qualitative and quantitative description of the symptoms appropriate to the problem.

2 **"O" Objective data**. A record of the type of examination and the diagnostic aids, including the ordering of radiographs, and the actual clinical findings, x-ray results, or laboratory findings appropriate to the problem. This is to include all the provider's findings such as carious teeth, inflammation, periodontal status, pocket depths, blood pressure measurement, etc.

3 **"A" Assessment**. This portion is the assessment of the subjective data, objective data, and the problem statement which leads the provider to a diagnosis, e.g.,"needs" (existing conditions or pathoses).

4 **"P" Plan**. This is the plan of treatment to correct or alleviate the stated problems or needs, irrespective of the treatment capability of the dental treatment facility. Include recommended treatment and, as appropriate, possible complications, alternative treatment, and prognosis with and without intervention. Include consultations, a record of the specific treatment performed, pre- and postoperative instructions, prescriptions, and any deviations from the original treatment plan.

(b) The following classification of tooth surfaces are listed in order of precedence and shall be used in connection with recording restorations of defective teeth:

| **Surface** | **Designation** |
|---|---|
| Facial (Labial) (Anterior teeth) | F |
| Buccal (Posterior teeth) | B |
| Lingual | L |
| Occlusal (Posterior teeth) | 0 |
| Mesial | M |
| Distal | D |
| Incisal (Anterior teeth) | I |

(c) Use combinations of designators to identify and locate caries, operations, or restorations in the teeth involved; for example, 8-MID would refer to the mesial, incisal, and distal aspects of the left mandibular cuspid; 30-MODF, the mesial, occlusal, distal, and facial aspects of a right mandibular first molar.

| Surface | Designation |
|---|---|
| Mesial-Occlusal | MO |
| Distal-Occlusal | DO |
| Mesial-Incisal | MI |
| Distal-Incisal | DI |
| Occlusal-Facial | OF |
| Occlusal-Lingual | OL |
| Incisal-Facial | IF |
| Incisal-Lingual | IL |
| Mesial-Occlusal-Distal | MOD |
| Mesial-Occlusal-Facial | MOF |
| Mesial-Occlusal-Lingual | MOL |
| Mesial-Incisal-Distal | MID |
| Mesial-Incisal-Facial | MIF |
| Mesial-Incisal-Lingual | MIL |
| Distal-Occlusal-Facial | DOF |
| Distal-Occlusal-Lingual | DOL |
| Mesial-Occlusal-Distal-Facial | MODF |
| Mesial-Incisal-Distal-Facial | MIDF |
| Mesial-Occlusal-Distal-Facial-Lingual | MODFL |
| Mesial-Incisal-Distal-Facial-Lingual | MIDFL |

(d) The use of abbreviations is not mandatory but is desirable for purposes of brevity in view of the limited space available in the dental record for recording services rendered. Whenever there is a possibility of misinterpretation due to the use of abbreviations, dental operations shall be written in full. When abbreviations are used, they shall conform to the following:

| Operation, Condition, or Treatment | Abbreviation |
|---|---|
| Abrasion | Abr. |
| Abscess | Abs. |
| Acrylic | Acr. |
| Adjust (ed)(ment) | Adj. |
| Alveolectomy | Alvy. |
| Amalgam | Am. |

| | |
|---|---|
| Anesthesia | Anes. |
| Apicectomy | Apcy. |
| Base | B. |
| Bridge (denotes fixed unless otherwise noted) | Br. |
| Caries | Car. |
| Calculus | Cal. |
| Cavity Varnish | C.Var. |
| Cement | Cem. |
| Composite Resins | Comp. Res. |
| Crown | Cr. |
| Deciduous | Dec. |
| Defective | Def. |
| Denture (full unless otherwise noted) | Dtr. |
| Drain. | Drn. |
| Dressing | Drs. |
| Equilibrate (action) | Equil. |
| Eugenol | Eug. |
| Examination | Exam. |
| Extraction (ed) (Uncomplicated unless otherwise noted) | Ext. |
| Filling(s) | Fil. |
| Fluoride | Fl. |
| Fracture(s) | Frac. |
| General | Gen. |
| Gingival (itis) (state type in parenthesis). | Ging. |
| Gutta percha | G.P. |
| Impacted (ion) | Imp. |
| Impression | Impr. |
| Incised | Inc. |
| Inlay | Inl. |
| Inserted | Ins. |
| Maxillary | Max. |
| Mandibular | Man. |
| Partial | Pr. |

| | |
|---|---|
| Parietal | Par. |
| Periapical | Per. |
| Pericoronitis | Percor. |
| Periodontitis | Perio. |
| Porcelain | Porc. |
| Post Operative Treatment | POT. |
| Prepared (ation) | Prep. |
| Prophylaxis | Pro. |
| Reappoint (ment) | Reapt. |
| Recement (ed) | Recem. |
| Reconstruct (ed) | Rct. |
| Reduce (d) | Red. |
| Regional | Rel. |
| Repaired | Rpd. |
| Sedative (ation) | Sed. |
| Sequestrum | Seq. |
| Surgical | Surg. |
| Suture (s)(d) | Su. |
| Treatment (ed) | Tr |
| Unerupted | Uner. |
| Vincents | Vin. |
| Zinc Chloride | ZnCl. |

(4) Space is provided in the lower right margin under Section III for the patient's name which is for convenience in filing in the dental record. Record the last name in capital letters. Do not abbreviate any part of the name.

4. SF-603-A (Dental Continuation).

a. General. Use a SF-603-A whenever the original SF-603 becomes filled or when the record cannot be satisfactorily brought up-to-date by entries on the appropriate chart.

b. Detailed Instructions.

(1) Enter individual's name and SSN in the space provided on the right margin of both the front and back side of the form.

(2) Number the continuation sheet in the upper right corner following the phrase "DENTAL-Continuation." Thus, the earliest SF-603-A is labeled "DENTAL-Continuation #1" and subsequent sheets are labeled "DENTAL-Continuation #2", "DENTAL-Continuation #3", etc. (See FIGURE 4-C-4).

(3) File the SF-603-A forms on top of the SF-603 form in reverse chronological order, i.e., the most recent on top.

5. SF-513, Consultation Sheet.

a. Purpose. SF-513 shall be used whenever a patient is referred to another facility for evaluation or treatment.

b. Detailed Instructions. Complete the form as detailed in paragraph 4-B-14.b.

6. Lost Dental Records.

a. Forward "stray" dental records, disposition of which cannot be determined, to Commandant (G-PIM) with a letter of explanation.

b. When a Dental Record is missing, prepare a new record. Prominently mark the Dental Record Cover (CG-3443-2) and the Health Record, Dental (SF-603) "REPLACEMENT." Request the old Dental Record from the individual's last unit or Commandant (G-PIM).

c. In case a lost Dental Record is recovered, make entries in the recovered record of any data recorded in a replacement record, then destroy the replacement record.

7. Special Dental Records Entries. When dental treatment is refused, make an appropriate entry on the SF-603/603-A, **signed by both the dental officer and patient.**

8. Dental Examination Requirements.

a. Any peculiarities or deviations from normal are particularly valuable for identification purposes and shall be recorded on SF-603 under "Remarks." Abnormalities such as erosion, mottled enamel, hypoplasia, rotation, irregularity of alignment and malocclusion of teeth, presence of supernumerary teeth, denticles, Hutchinson's incisors, fractures of enamel or teeth, abnormal interdental spaces, mucosal pigmentation, leukoplakia, diastema, hypertrophied frenum labium, torus palantinus and torus mandibularis, embedded foreign bodies and descriptions of unusual restorations or appliances are, when noted, especially useful in this connection. Malocclusion shall be simply and clearly described. Dentures and other removable dental appliances shall also be described under "Remarks".

b. When all teeth are present, and free of caries or restorations, take special effort to discover and record any abnormalities, however slight. If no caries, restorations, or abnormalities are found, make an entry to that effect on SF-603 under "Remarks."

c. Inquire about the patients' tobacco use during routine dental examinations and document. Advise users of the health risks associated with tobacco use, the benefits of stopping, and where to obtain assistance in stopping if available. Advise all pregnant tobacco users of the health risks to the fetus.

d. Oral hygiene and periodontal status at time of examination shall be recorded. Upon initial examination, complete items 5A-5C, SF-603, with additional comments placed in "Remarks" if needed. For all subsequent examinations, describe oral hygiene level and periodontal status in item 17 of SF-603/603-A.

e. For all patients 16 years of age or older, blood pressure readings shall be taken and recorded on the CG-5605 at initial and subsequent dental examinations. Although not required, the blood pressure may also be recorded on the SF-603/603-A in the "O" portion of the SOAP entry.

9. Recording of Dental Treatments on SF-600. Make entries of dental treatment on SF-600 when the patient is on the sick list and when treatment is related to the condition for which the patient is admitted. Such entries shall be made and signed by the dental officer. Notes concerning conditions of unusual interest and of medical or dental significance may be made when appropriate.

FIGURE 4-C-1

# U. S. COAST GUARD

## DENTAL RECORD

### PRIVACY ACT STATEMENT: HEALTH CARE RECORDS

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):** Section 632 of Title 14 United States Code and Sections 1071-1087, Title 10 United States code, Executive Order9397.

2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS TO BE USED:** The purpose for requesting information is to assist medical personnel in developing records to facilitate and document your health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result. The social Security Number (SSN) necessary to identify the person and records.

3. **ROUTINE USES:** This information may be used to plan and coordinate health care. It may be used to provide medical treatment, conduct research, teach, compile statistical data, determine suitability of persons for service or assignment, implement preventive health and communicative disease control program; adjudicate claims and determine benefits; evaluate care rendered; determine professional certification of patients to other Federal, State and local agencies upon request in the pursuit of there official duties; and report medical conditions required by law to federal, State and local agencies. It may be used for other lawful purposes including law enforcement and litigation.

4. The above Privacy Act Statement applies to all requests for personal information made by medical treatment personnel or for medical treatment purposes. Failure to provide the requested information for these medical records may result in an inability of Coast Guard medical personnel to afford treatment.

5. No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the Commanding Officer for decision.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| LAST NAME | FIRST NAME | MIDDLE NAME | SOCIAL SECURITY NUMBER | | DATE OF BIRTH *(DAY, MO,YR)* | | | |
| GRADE OR RATE | CHANGES IN GRADE OR RATE | | | | BLOOD TYPE *(Check one)* | | | |
| | | | | | ☐ O | ☐ A | ☐ B | ☐ AB |
| | | | | | RH FACTOR *(Check one)* | | | |
| | | | | | ☐ POSTIVE | ☐ NEGATIVE | | |

DRUG SENSITIVITY
SPECIFIC DRUG(S)

ATTACH TO FRONT OF CHART JACKET

DEPT OF TRANSP. USCG CG 3443-2

Figure 4-C-2

# DENTAL HEALTH QUESTIONNAIRE

Personal Data - Privacy Act of 1974

ARE YOU IN FLIGHT STATUS? . . . YES ☐ NO ☐ | OCCUPATION/JOB:

ARE YOU PRESENTLY ILL OR UNDER THE CARE OF A PHYSICIAN? . . . . **YES** ☐ **NO** ☐

IF YES, PLEASE DESCRIBE: _____

ALLERGIES (including medication, Latex, jewelry, metal, etc.): _____

CURRENT MEDICATIONS: _____
(including aspirin, over-the-counter medications, etc.): _____

HISTORY OF HOSPITALIZATIONS: _____

ANY FAMILY HISTORY OF: Heart Disease ☐ Cancer ☐ Diabetes ☐ Seizures ☐

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

| | Yes | No | Don't Know | | Yes | No | Don't Know | | Yes | No | Don't Know |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Epilepsy or Seizures | | | | Hemophilia | | | | Ulcers | | | |
| Fainting or dizziness | | | | Bruise or bleed easily | | | | Kidney problems | | | |
| Anxiety reaction | | | | Heart problems/Angina | | | | Venereal disease | | | |
| Stroke | | | | Hypertension | | | | Diabetes | | | |
| Glaucoma | | | | Rheumatic fever | | | | Thyroid disease | | | |
| Cold Sores (Herpes) | | | | Heart murmur | | | | HIV/AIDS | | | |
| Persistent cough | | | | Mitrol valve prolapse | | | | Arthritis | | | |
| Emphysema | | | | Congenital heart lesions | | | | Painful joints (incl. jaw) | | | |
| TB/PPD positive | | | | Heart surgery | | | | Prosthetic joint | | | |
| Asthma | | | | Prosthetic heart valve | | | | Hives | | | |
| Hay Fever | | | | Pacemaker | | | | Steroid medication | | | |
| Sinus problems | | | | Blood transfusions | | | | Drug addiction | | | |
| Anemia | | | | Liver disease | | | | Alcoholism | | | |
| Sickle cell disease | | | | Yellow jaundice | | | | Unexplained weight change | | | |
| G-6-PD deficiency | | | | Hepatitis - type: | | | | Cancer/radiation therapy | | | |

HAVE YOU EVER BEEN TOLD THAT YOU SHOULD NOT DONATE BLOOD? ----------
HAVE YOU EVER BEEN TOLD THAT YOU NEED ANTIBIOTICS BEFORE DENTAL TREATMENT? ----------
FEMALES: Are you taking birth control pills? ----------
Are you or might you be pregnant? Estimated delivery: _____
DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? Please describe: _____

_____ Patient's signature _____ Date

SUMMARY OF PERTINENT FINDINGS / RECOMMENDED TREATMENT MODIFICATIONS (Dentist's use only) B/P: _____

WELLNESS SCREEN:

Tobacco use _____ Exercise _____ Diet/nutrition _____
Alcohol use _____ Stress _____ Seat belt use _____

Dental Officer's Signature _____ Date

| PATIENT'S IDENTIFICATION | PATIENT'S NAME (Last, First, MI) | | SEX |
|---|---|---|---|
| | DATE OF BIRTH | RELATIONSHIP TO SPONSOR | SERVICE |
| | SPONSOR'S NAME | | RANK/GRADE |
| | SSN | | ORGANIZATION/COMMAND |
| | PHONE #: DAY | EVENING | |

DEPT. OF TRANSP., USCG, CG-5605 (4-96)

Figure 4-C-3

GENERAL SERVICES ADMINISTRAT.
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505

**HEALTH RECORD** | **DENTAL**

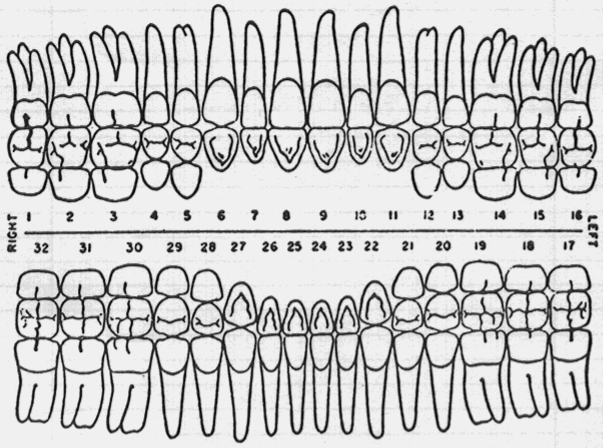
**SECTION I. DENTAL EXAMINATION**

1. PURPOSE OF EXAMINATION: INITIAL | SEPARATION | OTHER (*Specify*)

2. TYPE OF EXAM.: 1 2 3 4

3. DENTAL CLASSIFICATION: 1 2 3 4 5

4. MISSING TEETH AND EXISTING RESTORATIONS

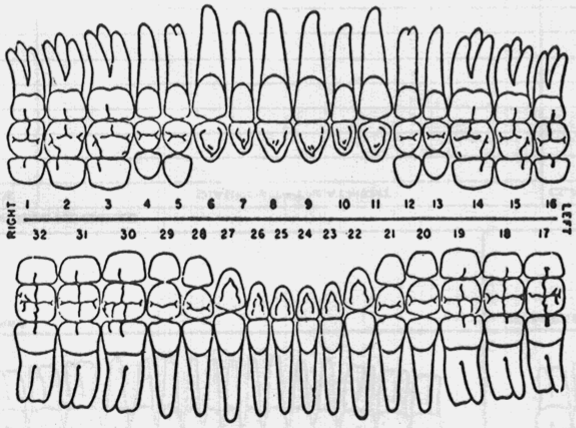



REMARKS

PLACE OF EXAMINATION | DATE

SIGNATURE OF DENTIST COMPLETING THIS SECTION

5. DISEASES, ABNORMALITIES, AND X-RAYS




A. CALCULUS: SLIGHT | MODERATE | HEAVY

B. PERIODONTOCLASIA: LOCAL | GENERAL; INCIPIENT | MODERATE | SEVERE

C. STOMATITIS (*Specify*): GINGIVITIS | VINCENT'S

D. DENTURES NEEDED
(*Include dentures needed after indicated extractions*)

| FULL | | PARTIAL | |
|---|---|---|---|
| U | L | U | L |

ABNORMALITIES OF OCCLUSION—REMARKS

E. INDICATE X-RAYS USED IN THIS EXAMINATION: FULL MOUTH PERIAPICAL | POSTERIOR BITE-WINGS | OTHER (*Specify*)

DATE | PLACE OF EXAMINATION | SIGNATURE OF DENTIST COMPLETING THIS SECTION

**SECTION II. PATIENT DATA**

| 6. SEX | 7. RACE | 8. GRADE, RATING, OR POSITION | 9. ORGANIZATION UNIT | 10. COMPONENT OR BRANCH | 11. SERVICE, DEPT., OR AGENCY |
|---|---|---|---|---|---|
| | | | | | |

| 12. PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME | 13. DATE OF BIRTH (DAY-MONTH-YEAR) | 14. IDENTIFICATION NO. |
|---|---|---|
| | | |

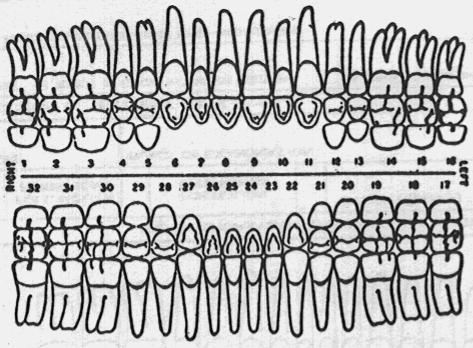
NSN 7540-00-634-4179

**DENTAL**
Standard Form 608
603-104

Figure 4-C-3 (Reverse)

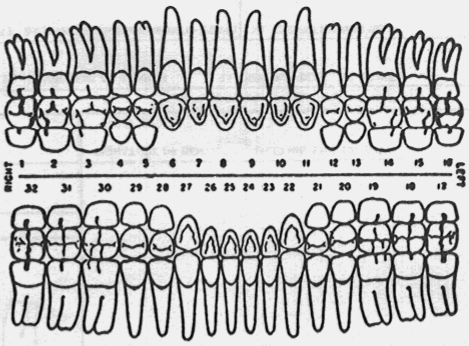
**SECTION III. ATTENDANCE RECORD**

**15. RESTORATIONS AND TREATMENTS (*Completed during service*)**




**REMARKS**

**16. SUBSEQUENT DISEASES AND ABNORMALITIES**




**REMARKS**

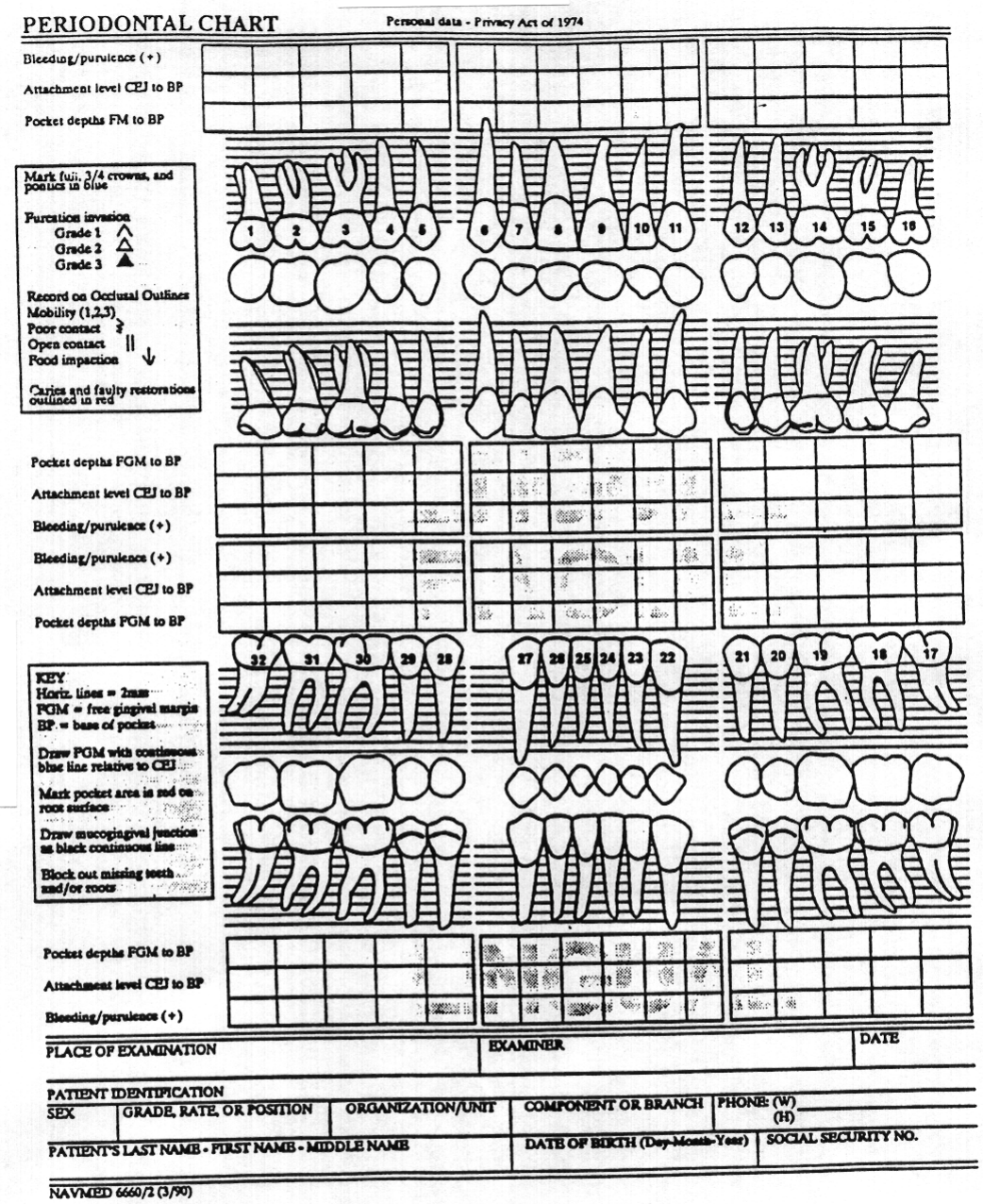
**17. SERVICES RENDERED**

| DATE | DIAGNOSIS—TREATMENT | CLASS | OPERATOR AND DENTAL FACILITY | INITIALS |
|---|---|---|---|---|
| | | | | |

PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME

☆U.S. GOVERNMENT PRINTING OFFICE: 1985 O - 491-248 (20242)

Figure 4-C-4



PERIODONTAL CHART

Personal data - Privacy Act of 1974

Bleeding/purulence (+)

Attachment level CEJ to BP

Pocket depths FM to BP

Mark full, 3/4 crowns, and pontics in blue

Furcation invasion
Grade 1
Grade 2
Grade 3

Record on Occlusal Outlines
Mobility (1,2,3)
Poor contact
Open contact
Food impaction

Caries and faulty restorations outlined in red

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Pocket depths FGM to BP

Attachment level CEJ to BP

Bleeding/purulence (+)

Bleeding/purulence (+)

Attachment level CEJ to BP

Pocket depths FGM to BP

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

KEY
Horiz. lines = 2mm
FGM = free gingival margin
BP = base of pocket

Draw FGM with continuous blue line relative to CEJ

Mark pocket area in red on root surface

Draw mucogingival junction as black continuous line

Block out missing teeth and/or roots

Pocket depths FGM to BP

Attachment level CEJ to BP

Bleeding/purulence (+)

PLACE OF EXAMINATION | EXAMINER | DATE

PATIENT IDENTIFICATION

SEX | GRADE, RATE, OR POSITION | ORGANIZATION/UNIT | COMPONENT OR BRANCH | PHONE: (W) (H)

PATIENT'S LAST NAME - FIRST NAME - MIDDLE NAME | DATE OF BIRTH (Day-Month-Year) | SOCIAL SECURITY NO.

NAVMED 6660/2 (3/90)

Figure 4-C-4 (cont'd)

**PERIDONTAL CHART**

Patient's Name: _____ SSN: _____

**Chief Complaint:**

_____

Pertinent Med Dent Hx:

| Age | Sex | Race | HT | WT | BP |
|---|---|---|---|---|---|
| | | | | | |

Extraoral Findings:

_____

Intreoral Findings:

_____

Periodontal Findings:

_____

Occlusion:

_____

Pediographic Assesment:

_____

Etiology/Contributing Factors:

_____

Diagnosis:

Prognosis (1-5 years) (Circle One): Good Fair Poor Hopeless

Overall Individual: _____

Tentative Treatment Plan:

_____

_____

_____

Section D - Clinical Records.

1. Purpose and Background. The Clinical Record (CG-3443-1) is the chronological medical and dental record of a nonactive duty beneficiary (dependent or retiree) eligible for health care at a Coast Guard facility. The primary reasons for compiling a clinical record are:

   a. To develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result.

   b. to protect the Government, the individual concerned, and the individual's dependents: It may be used;

      (1) to provide, plan and coordinate health care;

      (2) to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies;

      (3) to compile statistical data; for research; to teach health services personnel;

      (4) to determine suitability of persons for service or assignments;

      (5) to adjudicate claims and determine benefits; for law enforcement or litigation;

      (6) to evaluate care provided; and

      (7) to evaluate personnel and facilities for professional certification and accreditation.

   c. to aid in identifying deceased persons when other means may be inadequate.

2. Contents of Clinical Records.

   a. Each clinical record shall consist of CG-3443-1 with dental and medical records arranged in the following bottom to top sequence:

      (1) Left Side - Dental: CG-3443-2 Dental Record Cover* with CG-5266 (Drug Sensitivity Sticker)*, containing the following:

         (a) SF-522, Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures*

         (b) SF-603-A, Dental Record - Continuation*

         (c) SF-603, Dental Record*

         (d) CG-5605, Dental Health Questionnaire*

(2) Right Side - Medical:

(a) PHS-731, International Certificate of Vaccination*****, attached to the lower right corner of the inside of the Clinical Record Cover

(b) DD-1141, Record of Occupational Exposure to Ionizing Radiation*****

(c) SF-507, Continuation Sheet******

(d) SF-602, Syphilis Record*

(e) SF-601, Immunization Record*****

(f) DD-771, Spectacle Order Form*****

(g) SF-520, Electrocardiographic Report*****

(h) SF-519, Radiographic Reports

(i) SF-514, Laboratory Reports (or SF-545, Laboratory Report Display*****)

(j) SF-541, Gynecologic Cytology*****

(k) SF-515, Tissue Examination*****

(l) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures*****

(m) SF-513, Consultation Sheet*****

(n) SF-502, Narrative Summary*****

(o) CG-5447, Occupational Medical Surveillance and Evaluation Program*****

(p) SF-93, Report of Medical History*****

(q) SF-88, Report of Medical Examination*****

(r) SF-558, Emergency Care and Treatment

(s) SF-600, Chronological Record of Medical Care

(t) DD-2766, Adult Preventive and Chronic Care Flowsheet Form

(u) CG-5266, Drug Sensitivity Sticker*****

***** When required

****** SF-507's are attached to and filed after the form is continued

b. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 89 on top of SF-600 dated 20 MAY 86.

c. Enter all dates on Clinical Record forms, including the Clinical Record Cover, in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.

3. Extraneous Attachments. In order to ensure that the clinical record is an accurate, properly documented, concise and dependable record of the medical and dental history of the individual, keep extraneous attachments to a minimum. When they are necessary, file them beneath all other forms.

4. Opening Clinical Records. Open a Clinical Record when an eligible non-active duty beneficiary initially reports to a Coast Guard health care facility for treatment.

5. Terminating Clinical Records. The Clinical Record shall be terminated four years after the last record entry. Make an entry on SF-600 explaining the circumstances under which the record was terminated. Forward the record to:

| **Dependent Records**: | **Retiree Records**: |
|---|---|
| National Personnel Records Center | National Personnel Records |
| GSA (Civilian Personnel Records) | Center (MPR) |
| 11 Winnebago Street | 9700 Page Blvd. |
| St. Louis, MO 63118 | St. Louis, MO 63132 |

6. Custody of Clinical Records.

a. Clinical Records shall be retained in the custody of the Chief, Health Services Division of the unit providing care. At times when there is no medical or dental officer, the clinical record will become the responsibility of the senior health services department representative.

b. The name, grade, or rate of the health care provider making entries in clinical records shall be typed, stamped, or printed under their official signatures. Do not use facsimile signature stamps.

c. If an erroneous entry is made in a Clinical Record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.

d. Each health care provider is responsible for the completeness of the entries they make on any medical or dental form in the Clinical Record.

e. Nothing shall be removed from the Clinical Record except under conditions specified in this Manual.

7. Safekeeping of Clinical Records. Clinical Records are the property of the Federal government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).

   f. Since Clinical Records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).

   g. Except as contained in the The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3(series), the information contained in Clinical Records shall not be disclosed by any means of communication to any person or to any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the requestor's responsibility to obtain the consent.

8. Transfer of Clinic Records.

   a. When dependents of active duty personnel accompany their sponsor to a new duty station, the Chief, Health Services Division, his designee, the Executive Officer, or the senior health services department representative shall ensure that the "TRANSFERRED TO" line of the health Record Receipt form, NAVMED 6150/7, is completed in accordance with Chapter 6-B-5 of this Manual.

   b. A DD 877 shall be initiated for each record transferred. Records will **be mailed via certified mail with return receipt,** to the Coast Guard clinic serving the gaining unit. Express mail and Federal Express should be used only when absolutely necessary and not as a general rule. In instances where the family member will not be located near a Coast Guard Clinic, the record may be mailed to the appropriate MTF. This form can be located on the internet at; http://web1.whs.osd.mil/ICDHOME/DD-0999.htm

   c. If the family members will no longer receive care through a military primary care manager, the family member may be given a copy of the clinical record contents to carry with them. The original clinical record will be retained at the clinic serving the unit where the sponsor was last assigned.

   d. Clinics will give family members written information containing address and POC information to facilitate requests for record copies after transfer. All requests for clinical record copies must be in writing. The family member may request that a copy of the record be forwarded to their new care provider once they arrive at the new location, or they may request that the original record be forwarded to their new military primary care manager once they arrive at the new location. In these cases, the clinic shall send a copy of the clinical record contents to the care provider within 10 working days of receipt of the written request. If the clinic cannot comply with this requirement for some reason, the family member will be notified within 10

working days of the request of a projected date when the record copy will be available.

e. In any instance where there is concern about potential loss of the clinical record, or that its contents may become unavailable to the treating clinic or its provider, the Clinic Administrator or the Chief, Health Services Division shall direct that copies of parts or all of the clinical record shall be made and retained at the clinic.

f. Originals and copies of clinical records shall be retained and subsequently archived in accordance with directions contained in the Paperwork Management Manual, COMDTINST 5212.12(series).

9. Lost, Damaged, or Destroyed Clinical Records.

a. If a Clinical Record is lost or destroyed, the unit which held the record shall open a new record. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing Clinical Record is recovered, insert in it any additional information or entries from the replacement record, then destroy the replacement record cover.

b. Clinical Records which become illegible, thus destroying their value as permanent records, shall be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record became illegible. The new record shall be stamped or marked "DUPLICATE" on the cover. The circumstances necessitating the duplication shall be explained on the SF-600. Forward Clinical Records replaced by duplicate records to the National Personnel Records Center.

10. Clinical Record Forms.

a. CG-3443-1 (Clinical Record Cover). (See FIGURE 4-D-1)

(1) General. The Clinical Record Cover is used whenever a Clinical Record is opened on dependents or retirees.

(2) Detailed Instructions.s

(a) Last Name. Record the last name in all capital letters.

**SMITH**

(b) Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.

| | | |
|---|---|---|
| SMITH, | Helen | (n) |
| **Last Name** | **First Name** | **Middle Name** |

(c) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 3 FEB 77.

(d) Social Security Number. Enter sponsor's SSN.

(e) Status. Check the appropriate block; i.e., Retiree USCG, Dependent USPHS, etc.

(f) Other. Use this block to indicate special status or other information useful for either proper monitoring of the patient or for aid in indentifying the patient or record.

(g) Occupational Monitoring. Indicate the reason for occupational monitoring if monitoring is required.

(h) Med-Alert. Check this block to indicate that the patient has a medical problem that must be considered in rendering treatment; i.e., allergy, diabetes, cardiac problems, etc. Describe the specific medical problem within the medical record on Problem Summary List, NAVMED 6150/20.

b. SF-522 (Authorization for Anesthesia, Operations, etc.).

(1) Complete SF-522 describing the general nature of the procedure and have the patient sign prior to administering anesthesia (local or general) except for dental anesthesia. Also, complete SF-522 prior to administering immunizing agents.

Insert the form immediately behind Consultation Sheet (SF-513) or as indicated in Section 4-D-2. Complete the form as indicated in FIGURE 4-D-2.

Figure 4-D-1

| LAST NAME | FIRST NAME | MIDDLE NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER (OPTIONAL) |
|---|---|---|---|---|
| | | | | |

# U.S. Coast Guard
## CLINICAL RECORD

### STATUS

DEPENDENT ☐
RETIREE ☐

USCG ☐
USPHS ☐
USN ☐
USMC ☐
USAF ☐
USA ☐

CIVILIAN EMPLOYEE ☐

OTHER _____ SPECIFY

OCCUPATIONAL MONITORING _____ SPECIFY

### PRIVACY ACT STATEMENT; HEALTH CARE RECORDS

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):** Section 632 of Title 14, United States Code and Sections 1071-1087, Title 10 United States Code, Executive Order 9397 and Title 5 United States Code Section 7901.

2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS TO BE USED:** The purpose for requesting personal information is to assist medical personnel in developing records to facilitate and document your health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result. The Social Security Number (SSN) is not mandatory; however it is desirable for identification and recall of records.

3. **ROUTINE USES:** The information may be used to plan and coordinate health care. It may be used to provide medical treatment; conduct research; teach; compile statistical data; implement preventive health and communicative disease control programs; adjudicate claims and determine benefits; evaluate care rendered; determine professional certification and hospital accreditation; conduct authorized investigations; provide physical qualifications of patients to other Federal, State and local agencies upon request in the pursuit of their official duties; and report medical conditions required by law to Federal, State and local agencies. It may be used for other lawful purposes including law enforcement and litigation.

4. The above Privacy Act Statement applies to all requests for personal information made by medical treatment personnel or for medical treatment purposes. Failure to provide the requested information for these medical records may result in an inability of Coast Guard medical personnel to afford treatment.

5. No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the Commanding Officer for decision.

**MED-ALERT** ☐

DEPT. OF TRANSP., USCG, CG—3443—1 (10-77)

Figure 4-D-2

| MEDICAL RECORD | REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES |
|---|---|

**A. IDENTIFICATION**

1. OPERATION OR PROCEDURE

**B. STATEMENT OF REQUEST**

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____

*(Description of operation or procedure in layman's language)*

_____

_____

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

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

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

4. Exceptions to surgery or anesthesia, if any, are: _____

*(If "none", so state)*

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

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

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

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

**C. SIGNATURES**

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

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

_____

*(Signature of Counseling Physician/Dentist)*

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

| _____ | _____ | _____ |
|---|---|---|
| *(Signature of Witness, excluding members of operating team)* | *(Signature of Patient)* | *(Date and Time)* |

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

| _____ | _____ | _____ |
|---|---|---|
| *(Signature of Witness, excluding members of operating team)* | *(Signature of Sponsor/Legal Guardian)* | *(Date and Time)* |

| PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)* | REGISTER NO. | WARD NO. |
|---|---|---|
| | | |

**STANDARD FORM 522** (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FPMR 101-11.806-8
522-109

NSN 7540-00-634-4165

Section E - Employee Medical Folders.

1. Purpose and Background. The Employee Medical Folder (EMF), (SF-66 D), is the chronological medical record of Federal employees eligible for health care at Coast Guard facilities. These are the primary reasons for compiling an EMF.

   a. Develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of care rendered, including diagnosis, treatment, and end result.

   b. To protect the Government and the individual concerned.

   c. The information in the EMF is routinely used: to provide, plan and coordinate health care; to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies; to compile statistical data; for research; to teach health services personnel; to determine suitability of persons for service or assignments; to adjudicate claims and determine benefits; for law enforcement or litigation; to evaluate care provided; and to evaluate personnel and facilities for professional certification and accreditation.

2. Custody of Employee Medical Folders (EMF's).

   a. EMF's are the property of the Federal government handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).

      (1) Since EMF's contain personal information of extremely critical or sensitive nature, they are considered class III records according to The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), requiring maximum security (high security locked cabinets or areas).Except as contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), the information contained in the EMF shall not be disclosed by any means of communication to any person or to any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the responsibility of the requester to obtain the consent.

   b. EMF's shall be retained in the custody of the medical officer of the unit at which the individual is employed. At no time shall individual employees keep or maintain their own records.

   c. Individuals may examine their EMF in the presence of a health services department representative, providing it does not interrupt the scheduled mission of the unit and

there is no information contained therein which would be detrimental to the individual's mental well-being.

d. Health services personnel making entries in EMF shall ensure that all entries, including signatures, are neat and legible. Signature information shall include the name and grade or rate. Do not use facsimile signature stamps.

e. If an erroneous entry is made in an EMF, draw a diagonal line through the complete entry. Make an additional entry showing wherein and to what extent the original entry is in error.

f. Health services personnel are responsible for the completeness of the entries made on any form while the EMF is in their custody. No sheet shall be removed from the EMF except under conditions specified in this Manual.

g. Health services personnel shall ensure that, if EMF's are located in the same office as the Official Personnel Folder (OPF), the records are maintained physically apart from each other.

3. Contents of the Employee Medical Folders.

a. Each medical folder shall consist of SF-66 D (Employee Medical Folder) with medical records arranged in the following bottom to top sequence:

(1) Left Side Dental: Leave blank.

(2) Right Side - Medical:

(a) PHS-731, International Certificate of Vaccination*****, attached to the lower right corner of the inside of the EMF

(b) DD-1141, Record of Occupational Exposure to Ionizing Radiation*****

(c) SF-507, Continuation Sheet******

(d) CG-5447, Occupational Medical Surveillance and Evaluation Program*****

(e) SF-602, Syphilis Record*****

(f) SF-601, Immunization Record*****

(g) DD-771, Spectacle Order Form*****

(h) SF-520, Electrocardiographic Report*****

(i) SF-519, Radiographic Reports

(j) SF-514, Laboratory Reports (or SF-545, LaboratoryReport Display*****)

(k) SF-541, Gynecologic Cytology*****

(l) SF-515, Tissue Examination*****

(m) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures*****

(n) SF-513, Consultation Sheet*

(o) SF-502, Narrative Summary*

(p) SF-93, Report of Medical History*SF-88, Report of Medical Examination*

(q) SF-558, Emergency Care and Treatment*

(r) SF-600, Chronological Record of Medical Care

(s) CG-5357, Outpatient Record

(t) DD-2766, Adult Preventive and Chronic Care Flowsheet

(u) CG-5266, Drug Sensitivity Sticker*

(v) * When required

(w) ** SF-507's are attached to and filed after the form is continued.

b. <u>File forms of the same number in their assigned sequence</u>, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 87 on top of SF-600 dated 20 MAY 86.

c. <u>Enter all dates in the following sequence: day</u> (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.

4. <u>Accountability of Disclosures</u>. The accountability of disclosure of records, as required by the Privacy Act of 1974, will be maintained in accordance with Chapter 8, of COMDTINST M5260.2 (series). The information will be retained for five years after the last disclosure or for the life of the record, whichever is longer.

5. <u>Opening Employee Medical Folder</u>. Open an EMF when an eligible Federal employee initially reports for treatment.

6. <u>Terminating Employee Medical Folders</u>. Terminate the EMF in accordance with the Coast Guard Paperwork Management Manual, COMDTINST 5212.12 (series). Make an entry on SF-600 explaining the circumstances under which the folder was terminated.

7. Transferring to Other Government Agencies. When transferring an EMF to other agencies, complete a Request for Medical/Dental Records or Other Information (DD-877).

8. Lost, Damaged, or Destroyed Employee Medical Folders.

   a. If an EMF is lost or destroyed, the unit which held the record shall open a complete new Employee Medical Folder. Stamp or mark "REPLACEMENT" on the cover. If the missing folder is recovered, insert in it any additional information or entries from the replacement folder, then destroy the replacement folder.

   b. EMF's which become illegible, thus destroying their value as permanent records, will be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Stamp or mark "DUPLICATE" on the new record cover. Document the circumstances necessitating the duplication on an SF-600. Forward EMF's replaced by duplicate records to the National Personnel Records Center.

9. SF-66 D (Employee Medical Folder). (See FIGURE 4-E-1) Detailed instructions are:

   a. Last Name. Record the last name in all capital letters.

      **BROOKS**

   b. Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.

      BROOKS Cecilia (n)

      **Last Name First Name Middle Name**

   c. Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 8 JUN 62.

   d. Social Security Number. Enter SSN.

Figure 4-E-1

Standard Form 66 D
April 1985
U.S. Office of Personnel Management
FPM Supplement 293-31
66-501

# EMPLOYEE MEDICAL FOLDER

**CAUTION**
**MEDICAL RECORD—RESTRICTED USAGE**

1. Your use of the contents of this folder must be in accordance with the instructions in The Guide to Personnel Record Keeping.
2. You must safeguard this folder and its contents while it is in your possession.
3. You are required to keep this folder in a locked place when it is not in use.
4. You are normally prohibited from disclosing the contents of this folder to anyone; exceptions are those officials of your agency demonstrating an official need for the record and those other disclosures permitted by the Privacy Act of 1974 (5 U.S.C. 552a).
5. After use, promptly return this folder to the employee responsible for its filing.
6. Willful violations of these requirements are subject to criminal penalties (5 U.S.C. 552a(i)).

Place label between lines.
Type information on label as shown.

Name (Last, First, M.I.) DOB:
SSN:

NSN 7540-01-209-4939
For Label Use:
NSN 7530-00-577-4376 (cut sheet) or
NSN 7530-00-082-2661 (marginally punched)

GPO : 1985 O 460-496 (22)

Section F -Inpatient Medical Records.

1. Purpose and Background.

   a. Certain Coast Guard health care facilities have the capability and staffing to provide overnight care. Overnight care is defined as any period lasting more than four hours during which a beneficiary remains in the facility under the care or observation of a provider. By definition, overnight care may last less than 24 hours or it may last several days. Overnight care is utilized when a patient's condition or status requires observation, nursing care, frequent assessment, or other monitoring.

   b. Inpatient Medical Records (IMRs). Facilities providing overnight care shall create an Inpatient Medical Record (IMR) separate from the Health Record for the purpose of recording and preserving information related to the overnight care. The IMR shall be assembled as soon as a person is identified as needing overnight care. The IMR shall contain the following forms in a TOP TO BOTTOM sequence:

      (1) Inpatient Medical Record Cover Sheet and Privacy Act Statement (Figure 4-F-1)

      (2) SF-508, Doctor's Orders (most recent on top)

      (3) SF-506, Clinical Record/Physical Exam

      (4) SF-502, Narrative Summary

      (5) SF-509, Doctor's Progress Notes (most recent on top)

      (6) SF-511, Vital Signs Record

      (7) SF-514, Laboratory Report Display

      (8) SF-519, Radiologic Reports

      (9) Patient Care Kardex

      (10) Medication Kardex

      (11) SF-513, Consultation sheet

      (12) Miscellaneous forms (e.g., audiograms)

   c. Abbreviated Inpatient Medical Records (AIMRs). For patients who receive overnight care lasting 24 hours or less, an Abbreviated Inpatient Medical Record (AIMR) shall be created. The AIMR shall consist of at least an Inpatient Medical Record Cover Sheet, Privacy Act Statement, and an DD-2770, Abbreviated Medical Record form. SF-545, Laboratory Reports; SF-519, Radiologic Consultation Reports; Kardexes; and other forms may be included at the discretion of the clinic.

The AIMR shall be maintained while in use, completed, stored, and retired following the same requirements as listed for IMRs below.

d. During the time that the patient is receiving care, the IMR may be maintained in a loose-leaf binder, clipboard, or other convenient device, at the facility's discretion. Devices should be chosen and maintained so that the privacy of the patient information contained therein is protected at all times. Keeping or storing the record at the patient's bedside is discouraged for privacy reasons.

e. Once the patient is released from overnight care, providers shall have 48 hours to complete their notations in the record (excluding dictated entries). All laboratory, radiologic and consultation forms shall also be included in the IMR within 48 hours of the patient's release from overnight care.

f. Dictated entries shall be entered in the medical record within 7 days of discharge. The record may be held in medical records and flagged as needing a dictated entry.

g. After all notations, lab reports, radiology reports and consultations have been entered into the IMR, the IMR forms shall be placed in a bifold paper jacket (form CG-3443-1), and secured via a two prong device. The medical records staff is responsible for ensuring that the documents are in the correct order and are stored properly.

2. Maintenance and Storage. IMRs are the property of the Federal Government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance concerning these acts is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). All requirements and directions for handling and storing IMRs also apply to AIMRs.

a. Since IMRs contain personal information of an extremely critical or sensitive nature, they are considered to be Class III records requiring maximum security (high security locked cabinets or areas). IMRs shall be stored in well ventilated and sprinklered areas. Fire-resistant cabinets or containers shall be used for storage whenever possible.

b. IMRs shall be retained at the health care facility which created the record. IMRs will not be transferred with personnel who change duty stations. Copies of the IMR may be given to the individual if such a request is made in writing, or may be released to other persons, e.g., physicians or hospitals, if the patient requests or authorizes such release in writing. All release requests and authorizations will be inserted into the IMR cover.

c. IMRs will be retained at the creating health care facility for two (2) years after the date the patient is released from overnight care.

3. Disposition of IMRs. The IMR will be forwarded to the National Personnel Records Center (NPRC) as described in Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series), two years after the date the patient was released from

inpatient care. The NPRC requirements must be met in order for the NPRC to accept the records.

a. Records must be sent in prescribed standard cubic foot cartons. Cartons are available from the General Services Administration Federal Supply Service (FSS). The FSS stock number is NSN 8115-00-117-8344. All non-standard cartons will be returned at the expense of the originating organization.

b. NPRC does not accept accessions of less than one cubic foot. Small amounts shall be held until a volume of one cubic foot or more is reached.

c. Print the accession number on each box, starting in the upper left hand corner (see Figure 4-F-2). Mark the front of the box only. The accession number consists of the RG, which is always 26 for the Coast Guard, the current FY in which the records are being shipped, and a four digit number assigned by NPRC (see 4-F-3.j. for SF-135 preparation). Mark the front of the box only. Ensure that the information printed on the box is not obscured in any way, and that removal of tape or other sealing materials will not remove vital information.

d. Number each box consecutively, e.g., 1 of 8, 2 of 8, 3 of 8...8 of 8; or 1/8, 2/8, 3/8...8/8, in the upper right hand corner. See Figure 4-F-2 for placement.

e. Records shall be arranged in each storage box either alphabetically or numerically. Print the identifier of the first and last record/folder that is contained in the box on the center front of each box as shown in Figure 4-F-2.

f. Enclose in the first box of each accession one copy of the SF-135 and any alphabetical or numerical listing needed to reference the records.

g. Ship records together so they arrive at the NPRC at the same time. Shipments of 10 cubic feet or more shall be palletized as shown in Figure 4-F-3.

h. Records must be shipped within 90 days of being assigned an accession number. Failure to ship within 90 days will void the accession number.

i. Each clinic that transfers IMRs to NPRC must keep a master list (hard copy) of the records sent. The master list must be retained at the clinic for a period of 50 years.

j. All shipments to NPRC must be accompanied by SF-135, Records Transmittal and Receipt form. The transmittal form must include the name on the record and the individual's social security number. The accession number elements include the RG which is always 26 for the Coast Guard, the current FY during which the record is shipped, and the 4 digit sequential number assigned by NPRC. Also include the date sent. Complete SF-135 preparation and submission instructions are contained in the Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).

4. Inpatient Medical Record Forms and Required Entries.

a. SF-508, Doctor's Orders.

(1) Purpose. SF-508 is used to record written and verbal orders of the medical or dental staff; record that nurses have noted orders; record automatic stop dates for medications and time limited treatments; and record the RN review of orders which shall be performed every 24 hours.

(2) Preparation. (See Figure 4-F-4)

(a) When Prepared. SF-508 shall be used to communicate doctor's orders for all persons admitted to the medical facility inpatient area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 The date and time at which the order is written by the provider will be listed under the start column. If a verbal order is received, the date and time at which the order was received will be noted by the person who received the order in the start column. All verbal orders must be countersigned by the admitting provider on the next working day.

3 Certain orders may be defined as time limited, e.g., complete bedrest for 24 hours, tilts q 8 hours X 3, etc. In addition, the facility shall define the length of time between renewal of orders for medications, treatments, etc. For orders which are time limited, the date and time when the order expires shall be noted under the stop column.

4 All doctor's orders shall be listed on the form under drug orders. Orders shall be printed clearly in black ink. Only approved abbreviations shall be used. Nursing staff and/or health services technicians are required to contact the provider who wrote the order if there are any questions or difficulty encountered in reading the written order.

b. SF-506, Clinical Record/Physical Exam.

(1) Purpose. SF-506 is part of the inpatient medical record. It is used to record information obtained from physical examinations.

(2) Preparation. (See Figure 4-F-5)

(a) When Prepared. SF-506 shall be prepared when a patient is admitted to the medical facility.

(b) Required Entries.

1 Patient identification information may be written in or printed using a patient identification card.

2 Fill in the date that the exam is conducted in the upper left corner. The patient's self reported height may be used. Patients shall be weighed accurately on the day of admission and the weight entered as present weight. Vital signs to include temperature, pulse and blood pressure are recorded in the appropriate boxes. Rectal temperatures shall be identified by an "R" after the temperature reading. Axillary temperatures in adults are unreliable and will not be used.

3 A physical examination must be thorough, recorded accurately, and contain sufficient information to substantiate the treatment plan and interventions. Examination notations may be continued on the reverse of the form. If the back of the form is used, this must be indicated on the front of the form. The examiner will sign the form at the end of his/her notations and use a printed ink stamp to clearly mark name, rank, and SSN.

c. SF-509, Progress Notes.

(1) Purpose. SF-509 is part of the inpatient medical record. It is used to record the progress of the patient's condition, therapy or other treatment(s), as well as any other information relevant to the patient's condition or treatment such as laboratory tests and results.

(2) Preparation. (See Figure 4-F-6)

(a) When Prepared. SF-509 shall be prepared when a patient is admitted to the medical facility inpatient area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 Fill in the left column with the date and time at which the entry is being created. Begin writing to the right of the solid brown line. Notes will be written in SOAP format (see 4-B-5.a.(4)). The person creating the note will sign the form at the end of his/her notations and use a printed ink stamp to clearly mark name, rank, and SSN.

d. SF-511, Vital Signs Record.

(1) Purpose. SF-511 shall be used to document vital sign measurements, height, weight, hospital day and, if appropriate, postoperative day for patients admitted to the medical facility inpatient area.

(2) Preparation. (See Figure 4-F-7)

(a) When Prepared. SF-511 shall be prepared when a patient is admitted to the medical facility inpatient area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 Hospital day one shall be the day of admission.

3 If the patient undergoes an invasive procedure, "op" shall be written after the word post in the left column. The day of surgery shall be noted by writing "DOS" in the appropriate column. The day following the day of surgery is post-op day one. Post-op days shall be numbered consecutively thereafter.

4 The month in which the patient is admitted shall be written on the fifth line, first column. The year shall be completed by writing in the correct numerals after "19" on the fifth line.

5 The calendar date on which the patient is admitted shall be written in on the line next to the word day, e.g., if the patient is admitted on 3 June, the hospital day is one, and a "3" is written on the line next to the word day.

6 The hour at which the vital sign measurements are to be made are noted in the spaces next to the word hour. Use 24 hour clock notations, e.g., 11 p.m. is 2300, etc.

7 Once vital signs have been measured, they shall be recorded on the form using the symbols for pulse and temperature. Symbols are placed in the columns, not on the brown dotted lines.

8 Blood pressure measurements are written in the spaces to the right of the words "blood pressure". The first measurement made after midnight is written in the top left column, the second is written below it. The first measurement made after noon is written in the top box in the right side column, the second below that, etc. Blood pressure may also be represented by x marks placed at the systolic

and dyastolic measurements corresponding to the scale for pulse measurements (see Figure 4-F-7).

9 Other vital signs measurements or intake and output measurements may be written in the spaces on the lower part of the form, or a local overprint/stamp may be used.

10 Both sides of the form will be used. If the second side of the form is used, the word "continued" will be clearly written on the bottom of the first page.

e. SF-514, Laboratory Reports.

(1) Purpose. SF-514 is part of the inpatient medical record. It is used to keep laboratory report forms neat, in proper order, make them easily accessible to caregivers, and stores them as part of the inpatient medical record. SF-545, Clinical Record - Laboratory Report Display may be used in lieu of SF-514.

(2) Preparation. (See Figure 4-B-12)

(a) When Prepared. SF-514/SF-545 shall be prepared when a patient is admitted to the inpatient medical area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 Reports (or chits) may be attached to the form using either the self adhesive on the back of the chit, or by neatly placing a strip of clear adhesive tape horizontally across the top of the report, so that the lower half of the tape strip is touching the chit and the upper half is sticking to the SF-514/SF-545.

f. SF-519, Radiologic Consultation Reports.

(1) Purpose. SF-519 is part of the inpatient medical record. It is used to collect radiologic reports for easy access by caregivers and to store the reports with the inpatient medical record.

(2) Preparation.

(a) When Prepared. SF-519 shall be prepared when a patient is admitted to the inpatient medical area.

(b) Required Entries. Reports shall be attached to the form using the self stick adhesive on the back of the report or clear adhesive tape. See 4-B-19.

g. DD-2770 *(replaces SF 539)* Abbreviated Medical Record.

(1) Purpose. DD-2770 is used to record history, exam findings, patient progress, doctor's orders, vital signs, output, medications and nurse's notes for patients requiring overnight care who remain 24 hours or less.

(2) Preparation. (See Figure 4-F-8)

(a) When Prepared. DD-2770 may be used for any overnight care patient for whom total stay is anticipated to be 24 hours or less. If length of stay exceeds 24 hours, a full IMR must be initiated to provide proper documentation of the patient's stay. The DD-2770 shall be prepared when a short stay patient is admitted to the inpatient medical area.

(b) Required Entries.

1 Patient identification information may by written in or overprinted using a patient identification card.

2 History, chief complaint, and condition on admission must be documented in the top box on page one. Date of admission shall be noted here also.

3 Physical examination findings shall be noted in the center box on page one. Physical exam findings shall be completely noted and appropriate to the condition. Deferred exams, such as rectal exams, shall be noted as such.

4 The patient's progress over the 24 hour period between admission and discharge will be noted by the medical officer in the third box on page one. Date of discharge and final diagnosis shall be noted here also.

5 The physician shall sign the form in the box provided and use a printed ink stamp to clearly mark his/her name, rank, and SSN. The date the form is signed shall be written in the box provided next to the signature.

6 The location of the clinic or dispensary, for example, Dispensary TRACEN Cape May, shall be written or stamped in the box marked organization.

7 Doctor's orders shall be written only in the space provided on page two. Each order group written shall be dated and signed. A printed ink stamp shall be used by medical officers to mark name, rank, and SSN. All medical and dental orders given during the patient's stay must be recorded. A second page should be started if the number of orders exceeds space available on one page.

8 Vital sign measurements shall be recorded in the spaces provided with the date and time of each notation. Bowel movements and urine output are noted in the columns marked stools and weight.

9 Medications administered and brief notes regarding the patient's condition shall be made in the nurse's notes area. Medication name, dose, route, and time given shall be recorded for each dose of medication administered. Each notation shall be signed with the name, military rank, or title for civilians, e.g., RN or LPN, of the person making the note.

**FIGURE 4-F-1**

**INPATIENT MEDICAL RECORD COVER SHEET**
(See Privacy Act Statement on Reverse)

Name: _____ SSN: _____ Rank/Rate: _____
Last, First, MI

Unit: _____

Date of Birth: ___/___/____ Religon: _____
YY MM DD

Home Address: _____

Next of Kin: _____ Relationship: _____

Address: _____ Phone #: _____

_____ _____

Previous Admission: ☐ Yes ☐ No If yes, Date: ___/___/____
YY MM DD

Date of Present Admission: ___/___/____ Time: _____ Hours
YY MM DD

| Provisional Diagnosis | Provisional Diagnosis |
|---|---|
| 1. _____ | 1. _____ |
| 2. _____ _ | 2. _____ |
| 3. _____ | 3. _____ |

Date of Discharge: ___/___/____ Time: _____ Hours
YY MM DD

**DISPOSITION**

Duty Status: ☐ FFD ☐ NFFD ☐ FFLD Restrictions: _____

_____

Activity Restrictions: _____

Diet: _____

Medications: _____

Follow-up Appointment(s): _____

_____ _____
**Admitting Medical Officer** **Discharging Medical Officer**

Time Unit Notified: ___/___/____ Time: _____ Hours
YY MM DD

Name of Staff Member Notifying: _____

Name of Person at Unit Receiving Call: _____
Name and Rank/Rate

## FIGURE 4-F-1 (reverse)

### PRIVACY ACT STATEMENT

In accordance with 5 USC 552a (e)(3), the following applies to persons providing personal information to the U.S. Coast Guard.

1. Section 632, Title 14 USC, § 1071 – 1087. Title 10 USC, and Executive Order 9397 authorizes collection and application of this information.

2. The principal purpose for which this information is intended is to assist medical personnel in developing records to facilitate and document your health condition(s), in order to provide a complete account of care rendered, including diagnosis, treatment, and results. The social security number is necessary to identify the person and records. Family information is required for notification of next of kin in the unlikely event of an emergency.

3. The routine use of this information is for review by attending medical officers and for future reference in rendering health care.

4. Disclosure of this information is voluntary. However, failure to provide the requested information may result in an inability of the Coast Guard medical personnel to deliver comprehensive treatmen.

**Please note the following and indicate your wishes**:

I DO / DO NOT GIVE PERMISSION FOR THE ATTENDING MEDICAL OFFICER AND THE DISPENSARY STAFF TO DISCUSS MY MEDICAL CONDITION OR THE SITUATION OF MY ADMISSION WITH MY PARENTS OR LEGAL GUARDIANS, UPON MY REQUEST.

_____ _____
Signature Date

_____
Witness

— — — — — — — — — — — — — — — — — — — — —

### PERSONNEL AUTHORIZED SEPARATE RATIONS

I understand that this facility provides three meals daily for all patients. Further, persons authorized to mess separately will be required to make repayments for meals consumed during their stay.

I have read and understand the statement about separate rations.

_____ _____
Signature Date

**FIGURE 4-F-2**

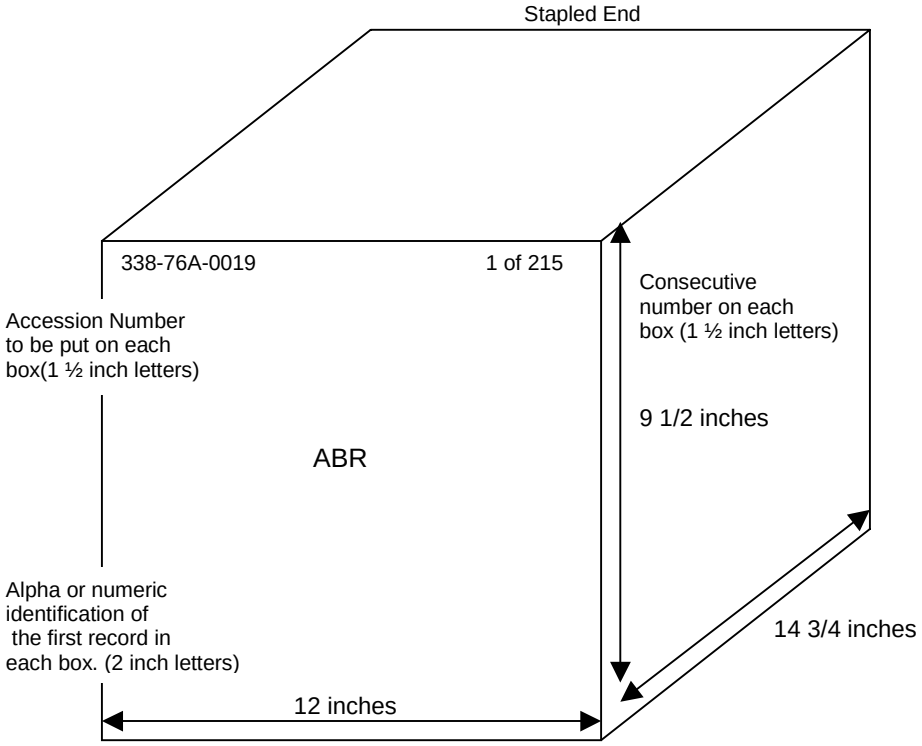

Stapled End
338-76A-0019
1 of 215
Consecutive number on each box (1 ½ inch letters)
Accession Number to be put on each box(1 ½ inch letters)
9 1/2 inches
ABR
Alpha or numeric identification of the first record in each box. (2 inch letters)
14 3/4 inches
12 inches

**FIGURE 4-F-3**

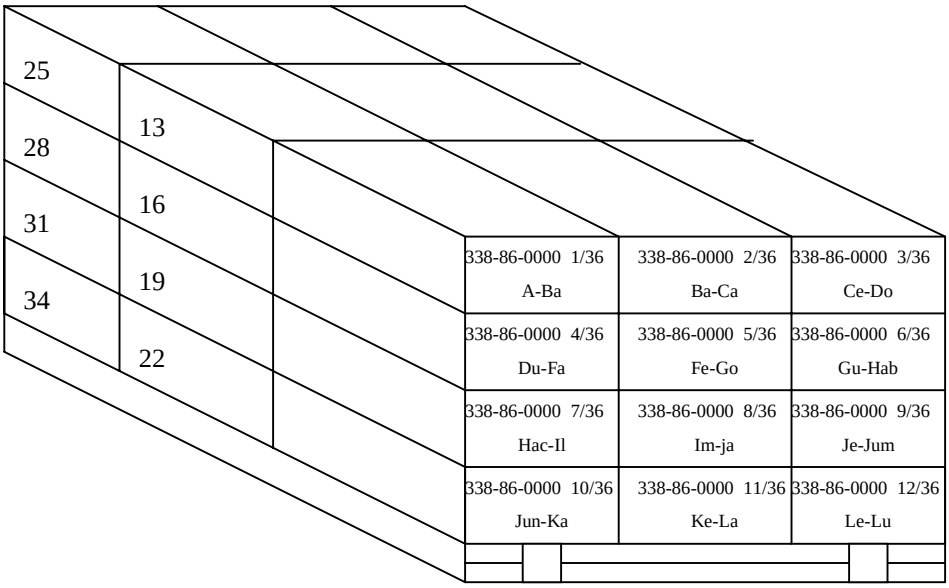

25
28
31
34
13
16
19
22
338-86-0000 1/36
A-Ba
338-86-0000 2/36
Ba-Ca
338-86-0000 3/36
Ce-Do
338-86-0000 4/36
Du-Fa
338-86-0000 5/36
Fe-Go
338-86-0000 6/36
Gu-Hab
338-86-0000 7/36
Hac-Il
338-86-0000 8/36
Im-ja
338-86-0000 9/36
Je-Jum
338-86-0000 10/36
Jun-Ka
338-86-0000 11/36
Ke-La
338-86-0000 12/36
Le-Lu

Figure 4-F-4

**INSTRUCTIONS**

NURSE: Retain a copy and send to Pharmacy after each order is written.

| **MEDICAL RECORD** | | **DOCTOR'S ORDERS** *(Sign all orders)* | | |
|---|---|---|---|---|
| HOUR | | RX | **DRUG ORDERS** | DOCTOR'S SIGNATURE | NURSE'S SIGNATURE |
| START | STOP | | | | |
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*If needed, continue on Page 2.*

| PATIENT'S IDENTIFICATION | *(For typed or written entries give: Name – last, first, middle; grade; rank; rate; hospital or medical facility)* | REGISTER NO. | WARD NO. |
|---|---|---|---|

**DOCTOR'S ORDERS**

**STANDARD FORM 508** (Rev. 10-7
Prescribed by GSA and ICMR
FPMR 101-11 806-8
508-110

FIGURE 4-F-5

Standard Form 506 (Rev 2-99) AUTHORIZED FOR LOCAL REPRODUCTION

| Clinical Record | | PHYSICAL EXAMINATION | | | | | |
|---|---|---|---|---|---|---|---|
| Date of Exam | Height | Weight | | | Temperature | Pulse | Blood Pressure |
| | | Average | Maximum | Present | | | |

Instructions: Describe (1) General Appearance and Mental Status; (2) Head and Neck (General); (3) Eyes; (4) Ears; (5) Nose; (6) Mouth; (7) Throat; (8) Teeth; (9) Chest (General); (10) Breast; (11) Lungs; (12) Cardiovascular; (13) Abdomen; (14) Hernia; (15) Genitalia; (16) Pelvic; (17) Rectal; (18) Prostate; (19) Back; (20) Extremities; (21) Neurological; (22) Skin; (23) Lymphatics.

SAMPLE FORM

(Continue reveres side)

| RELATIONSHIP TO SPONSOR | SPONSOR'S NAME | | | SPONSOR'S ID NUMBER (SSN or Other) |
|---|---|---|---|---|
| | LAST | First | MI | |
| DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | | |

| PATIENT'S IDENTIFICATION (For typed or written entries give: Name-Last First, Middle; grade; date; hospital or medical facility) | REGISTER NO | WARD NO |
|---|---|---|

PHYSICAL EXAMINATION RECORD
Standard Form 506 (Rev 2-99)
Prescribed by GSA/ICMR (41 CFR) 101-11 .203(b)(10)

Figure 4-F-5 (Reverse)

SF 506 (Rev 2-99)

| LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER |
|---|---|---|---|
| | | | |

**PHYSICAL EXAMINATION**

SAMPLE FORM

INITIAL IMPRESSION

| SIGNATURE OF PHYSICIAN | NAME OF PHYSICIAN |
|---|---|
| | |

**Standard Form 506 (Rev. 2-99) BACK**

FIGURE 4-F-6

| MEDICAL RECORD | PROGRESS NOTES |
|---|---|
| DATE | |
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| | (Continue on reverse side) |

| PATIENT'S IDENTIFICATION *(For typed or written entries give: name – last, first, middle; grade; rank; rate; hospital or medical facility)* | REGISTER NO. | WARD NO. |
|---|---|---|
| | | |

SAMPLE FORM

**PROGRESS NOTES**
**MEDICAL RECORD**
**STANDARD FORM 509 (REV-7-91)** EG
Prescribed by GSA/ICMR (41 CFR) 201-9.202-1
Designed using Perform Pro. WHS/DIOR, Jul94

Figure 4-F-7

**MEDICAL RECORD** | **VITAL SIGNS RECORD**

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

| PULSE (O) | TEMP. F (●) | TEMP. C (Centigrade Equivalents, for Reference only) |
|---|---|---|
| | 105° | 40.6° |
| 180 | 104° | 40.0° |
| 170 | 103° | 39.4° |
| 160 | 102° | 38.9° |
| 150 | 101° | 38.3° |
| 140 | 100° | 37.8° |
| 130 | 99 ° | 37.2° |
| | 98.6 ° | 36.0° |
| 120 | 98 ° | 36.7° |
| 110 | 97 ° | 36.1° |
| 100 | 96 ° | 35.6° |
| 90 | 95 ° | 35.0° |
| 80 | | |
| 70 | | |
| 60 | | |
| 50 | | |
| 40 | | |

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: | WEIGHT

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

REGISTER NO. | WARD NO.

**VITAL SIGNS RECORD**

**STANDARD FORM 511** (Rev. 9-79)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

FIGURE 4-F-8

| **ABBREVIATED MEDICAL RECORD** | 1. ADMISSION DATE*(yyyymmdd)* |
|---|---|
| 2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW | |
| 3. PHYSICAL EXAMINATION *(Including pertinent positives and negatives)* | |
| 4. IMPRESSION *(enter admission note with plan on progress notes)* | |
| 5. ADMITTING OFFICER | |
| a. SIGNATURE | b. DATE SIGNED *(YYYYMMDD)* |
| 6. DISCHARGE NOTE *(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)* | 7. DISCHARGE DATE *(YYYYMMDD)* |

SAMPLE FORM

| 8. DISCHARGE OFFICER | | | |
|---|---|---|---|
| a. NAME *(Last, First, Middle Initial* | b. GRADE | c. TITLE | d. SIGNATURE |

| 9. PATIENT IDENTIFICATION *(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)* | 10. OUTPATIENT/HEALTH RECORD MAINTAINED AT: |
|---|---|
| | 11. COPY PLACED IN OUTPATIENT RECORD (x WHEN DONE) |

**DD FORM** 2770, APR 1998 (EG*) Replaces SF 509*

Section G – Mental Health Records.

1. Active duty: Complete mental health assessments and visits will be done in an IMB, DMB or traditional psychiatric evaluation format and recorded on SF-600, SF-513, IMB, DMB, or typed psychiatric evaluation forms as appropriate. Active duty episodic visits and routine appointments will be recorded on SF-600 in SOAP format. The Objective ("O') section would include mental status observations and any other pertinent physical findings. Records of active duty mental health assessments and visits will be kept in the main health record (CG-3443). An additional separate mental health record may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner's office. New patients would be evaluated IAW traditional psychiatric evaluation.

2. Non- Active duty: Separate records of mental health care may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner's office. Alternatively, the mental health practitioner may elect to keep records of visits in the dependent or retiree's main based record (CG-3443-1). Should the practitioner elect to maintain a separate office based record for non-active duty patients, the main health record (orange jacket) must include, at a minimum, the diagnosis in the problem summary listing, current psychiatric medications on the SF-600, and lab work ordered by the mental health provider. New patients would be evaluated IAW traditional psychiatric evaluation. Episodic and follow up visits would be recorded in a SOAP format.

3. Psychiatric evaluation format: The psychiatric evaluation shall include, at a minimum: patient information, chief complaint, history of present illness, past history (psychiatric symptoms, diagnoses, and care medical illness, surgeries, current medications, allergies, alcohol & drug history), personal history, family history, mental status exam, assessment (DSM-IV), prognosis, and plan. Included in all assessments and other visits as appropriate will be an estimation of potential for harm to self or others. In addition, notes should contain sufficient information to establish that the criteria for any new DSM based diagnosis are met.

4. Custody of Mental Health Records: Records kept in the mental health practitioner's office are property of the CG and copies should be available to other civilian practitioners or agencies at the patient's request. These records should also be available to other CG providers, as part of an official records review process, and as directed in Section 4.A.5. of this Manual.

# CHAPTER 5

# DEATHS AND PSYCHIATRIC CONDITIONS (PERSONALITY)


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CHAPTER 5. DEATHS AND PSYCHIATRIC CONDITIONS (PERSONALITY)

Section A - Deaths.

1. General. Chapter 11 of the Personnel Manual, COMDTINST M1000.6(series) contains further guidance concerning casualties and decedent affairs.

2. Duties of Medical Officers or Health Services Department Representatives in the Event of A Death at A Coast Guard Unit. The medical officer or health services department representative shall report immediately to the scene and:

   a. advise the commanding officer of the name, grade or rate, and social security number of the decedent;

   b. advise the commanding officer of the time and place of death;

   c. advise the commanding officer, insofar as possible, as to the cause of death;

   d. ensure notification of the quarantine officer or coroner if required; and

   e. arrange with local civilian authorities for issuing a death certificate.

3. Determining Cause of Death. When an active duty Coast Guard member dies aboard a Coast Guard vessel or station under unnatural or suspicious circumstances, or when the cause of death is unknown, an administrative investigation shall immediately be convened in accordance with Section 11-A-3 of the Personnel Manual, COMDTINST M1000.6(series) and Chapter 5 of the Administrative Investigations Manual, COMDTINST M5830.1 (series).

4. Death Certificates for Deaths Occurring Away From Command or in Foreign Ports.

   f. When an active duty member dies while away from his/her duty station, the commanding officer or designated representative shall obtain a death certificate from civilian authorities. If the civilian death certificate does not furnish all necessary information, the district commander of the district in which the death occurred shall request additional information.

   g. If death occurs abroad, request the nearest United States Consular Office to obtain a death certificate from civilian authorities.

   h. When an active duty member, or a Reserve performing inactive duty for training, is in a missing status because of events in international waters and no identifiable remains can be recovered, and no civilian death certificate is issued, a report (including recommendations) shall be made as per Section 11-A, Personnel Manual, COMDTINST M1000.6 (series).

5. Relations with Civilian Authorities. When a Coast Guard member dies outside the limits of a Coast Guard reservation, the body shall not be moved until permission has been obtained from civilian authorities (e.g., coroner's office and/or medical examiner). In

order that there may be full understanding and accord between the Coast Guard and civilian authorities, appropriate procedures will be developed for each command area, in consultation with the civilian authorities, covering deaths of personnel within and without the limits of Coast Guard commands. In general, and except where the state has retained concurrent jurisdiction with the United States, civilian authorities have no jurisdiction over deaths occurring on Coast Guard reservations. A transit or burial permit, however, issued by civilian authorities is required for removal of a body from a Coast Guard reservation for shipment or burial.

6. Reporting Deaths to Civilian Authorities. When a death occurs at a Coast Guard activity in any state, territory, or insular possession of the United States, the death must be reported promptly to civilian authorities. Local agreements concerning reporting and preparing death certificates shall be made between the commanding officer, or designated representative, and the civilian authorities.

7. Death Forms for Civilian Agencies and Individuals. Forward all requests for completing blank forms concerning death of Coast Guard personnel to Commandant (G-WP) for action.

8. Identification of Remains. Identification of remains may be established by marks and scars, dental records, fingerprints, and personal recognition. In questionable cases, a dental officer shall examine the remains and record observations on a SF-603 for comparison with other available records.

Section B - Psychiatric Conditions (including personality disorders).

1. General. The following diagnostic categories conform to DSM IV-R and indicate the appropriate reference for disposition. In determining qualification for appointment, enlistment, and induction, or appropriate disposition (when the condition has been determined to be disqualifying for retention in accordance with paragraph 3-F-16), the diagnosis appears under DSM IV Axis I or Axis II. Conditions generally considered treatable and not grounds for immediate separation, mental health treatment may be authorized for members when medically necessary to relieve suffering and/or maintain fitness for unrestricted duty. The decision to provide treatment for mental health conditions will be based on a review of all factors, including the opinion of experts, probability of a successful outcome, and the presence of other physical or mental conditions.

   a. If a successful outcome (availability for worldwide assignment) is not realized within six months of the initiation of therapy, the patient's condition must be reassessed. If the reassessment indicates that the prognosis for a successful outcome is poor, the member shall be processed for discharge pursuant to Chapter 12 of the Personnel Manual or through the Physical Disability Evaluation System (PHYSICAL DISABILITY EVALUATION SYSTEM).

2. Personality Disorders. These disorders are disqualifying for appointment, enlistment, and induction under Section 3-D-33 herein or shall be processed in accordance with Chapter 12, Personnel Manual, COMDTINST M1000.6 (series). These are coded on Axis II.

   a. 301.00 Paranoid.

   b. 301.20 Schizoid.

   c. 301.22 Schizotypal.

   d. 301.4 Obsessive compulsive.

   e. 301.50 Histrionic.

   f. 301.6 Dependent.

   g. 301.7 Antisocial.

   h. 301.81 Narcissistic.

   i. 301.82 Avoidant.

   j. 301.83 Borderline.

   k. 301.9 Personality disorder NOS (includes Passive-aggressive).

l. Personality trait(s) considered unfitting per paragraph 3-F-16.c.

3. Adjustment Disorders. These disorders are generally treatable and not usually grounds for separation. However, when these conditions persist or treatment is likely to be prolonged or non-curative, (e.g., inability to adjust to military life/sea duty, separation from family/friends) process in accordance with Chapter 12, Personnel Manual, COMDTINST M1000.6 (series) is necessary.

   a. 309.0 With depressed mood.

   b. 309.24 With anxiety.

   c. 309.28 With mixed anxiety and depressed moods.

   d. 309.3 With disturbance of conduct.

   e. 309.4 With mixed disturbance of emotions and conduct.

   f. 309.90 Adjustment disorder unspecified.

4. Organic Mental Disorders. These disorders are either disqualifying for appointment, enlistment, and induction under Section 3-D-29 of this manual or shall be processed in accordance with Physical Disability Evaluation System (PHYSICAL DISABILITY EVALUATION SYSTEM), COMDTINST M1850.2 (series).

   a. Dementias arising in the senium and presenium.

      (1) Dementia of the Alzheimer type, with early onset.

         (a) 290.00 Uncomplicated.

         (b) 290.11 With delirium.

         (c) 290.12 With delusions.

         (d) 290.13 With depressed mood.

      (2) 290.4 Vascular Dementia (various subtypes).

      (3) 294.x Dementia due to other medical conditions (various subtypes).

      (4) 294.8 Dementia NOS.

   b. Other Organic Mental Disorders associated with Axis III physical disorders or conditions, or etiology is unknown, including but not limited to the following.

      (5) 293.0 Delirium due to general medical condition.

      (6) 293.81 Psychotic disorder with delusions due to a general medical condition.

      (7) 293.82 Psychotic disorder with hallucinosis due to a general medical condition.

      (8) 293.83 Mood disorder due to a general medical condition.

(9) 294.00 Amnestic disorder due to general medical condition.

(10) 310.1 Personality change due to a general medical condition.

5. Psychoactive Substance Use Disorders. These disorders are disqualifying for appointment, enlistment, or induction under Section 3-D-35 of this manual or shall be processed in accordance with Chapter 20, Personnel Manual, COMDTINST M1000.6 (series).

   a. 303.90 Alcohol dependence (alcoholism).

   b. 304.00 Opioid dependence.

   c. 304.10 Sedative, hypnotic, or anxiolytic dependence.

   d. 304.20 Cocaine dependence.

   e. 304.30 Cannabis dependence.

   f. 304.40 Amphetamine dependence.

   g. 304.50 Hallucinogen dependence.

   h. 304.60 Inhalant dependence.

   i. 304.90 Other (or unknown) substance, including PCP dependence.

   j. 305.00 Alcohol abuse.

   k. 305.20 Cannabis abuse.

   l. 305.30 Hallucinogen abuse.

   m. 305.40 Sedative, hypnotic, or anxiolytic abuse.

   n. 305.50 Opioid abuse.

   o. 305.60 Cocaine abuse.

   p. 305.70 Amphetamine abuse.

   q. 305.90 Other (or unknown) Substance abuse, including inhalant and PCP abuse.

6. Schizophrenia. These disorders are disqualifying under Section 3-D-30 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).

   a. 295.10 Disorganized type.

   b. 295.20 Catatonic type.

c. 295.30 Paranoid type.

d. 295.60 Residual type.

e. 295.90 Undifferentiated type.

7. Psychotic Disorders Not Elsewhere Classified. These disorders are disqualifying under Section 3-D-30 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).

a. 295.40 Schizophreniform disorder.

b. 295.70 Schizoaffective disorder.

c. 297.30 Induced psychotic disorder.

d. 298.80 Brief psychotic disorder.

e. 298.90 Psychotic disorder NOS.

8. Delusional (Paranoid) Disorder. 297.1, Delusional (Paranoid) Disorder, is disqualifying under Section 3-D-30 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).

9. Neurotic Disorders. These disorders are now included in Anxiety, Somatoform, Dissociative, and Sexual Disorders.

10. Mood Disorders. These disorders are disqualifying for enlistment under Section 3-D-31 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).

a. Bipolar I Disorders.

(1) 296.0X Bipolar I disorder, single manic episode (various subtypes).

(2) 296.40 Bipolar I disorder, most recent episode hypomanic.

(3) 296.4X Bipolar I disorder, most recent episode manic (various sub-types).

(4) 296.5X Bipolar I disorder, most recent depressed (various sub-types).

(5) 296.6X Bipolar I disorder, most recent episode mixed, (various sub-types).

(6) 296.7 Bipolar I disorder, most recent episode unspecified.

(7) 296.89 Bipolar II disorder.

(8) 301.13 Cyclothymia.

b. Depressive Disorders.

(1) 296.XX Major depressive disorder (various sub-types).

(2) 300.4 Dysthymic disorder (or depressive neurosis).

(3) 311 Depressive disorder NOS.

11. Anxiety Disorders (or Anxiety and Phobic Neuroses). These disorders are disqualifying for appointment, enlistment, or induction under Section 3-D-32 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series) except as noted on (5) below.

    a. Panic Disorders.

        (1) 300.01 Without agoraphobia.

        (2) 300.21 With agoraphobia.

        (3) 300.22 Agoraphobia without history of panic disorder.

        (4) 300.23 Social phobia.

        (5) 300.29 Specific phobia. [Chapter 12, Personnel Manual,COMDTINST M1000.6 (series).]

    b. Other Anxiety disorders.

        (1) 300.00 Anxiety disorder NOS.

        (2) 300.02 Generalized anxiety disorder.

        (3) 300.3 Obsessive-compulsive disorder (or obsessive compulsive neurosis).

        (4) 309.81 Post-traumatic stress disorder.

12. Somatoform Disorders. These disorders are disqualifying for appointment, enlistment, or induction under Section 3-D-32 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).

    a. 300.11 Conversion disorder.

    b. 300.70 Hypochondriasis (or hypochondrical neurosis). Body Dysmorphic disorder. Somatoform disorder NOS.

    c. 300.81 Somatization disorder or undifferentiated somatoform disorder.

    d. 307.80 Pain disorder associated with psychological factors.

13. Dissociative Disorders (or Hysterical Neuroses, Dissociative Type). These disorders are disqualifying for appointment, enlistment, or enlistment under Section 3-D-32 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).

    a. 300.12 Dissociative amnesia.

    b. 300.13 Dissociative fugue.

    c. 300.14 Dissociative identity disorder.

d. 300.15 Dissociative disorder NOS.

e. 300.6 Depersonalization disorder.

14. Sexual Disorders. These disorders are processed in accordance with Chapter 12 of the Personnel Manual, COMDTINST M1000.6 (series).

a. Gender Identity Disorders.

(1) 302.6 Gender identity disorder in children (history of) or NOS.

(2) 302.85 Gender identity disorder in adolescents or adults.

b. Paraphilias.

(1) 302.2 Pedophilia.

(2) 302.3 Transvestic fetishism.

(3) 302.4 Exhibitionism.

(4) 302.81 Fetishism.

(5) 302.82 Voyeurism.

(6) 302.83 Sexual masochism.

(7) 302.84 Sexual sadism.

(8) 302.89 Frotteurism.

(9) 302.9 Paraphilia NOS (includes Zoophilia).

15. Sexual Dysfunctions. These are not grounds for action as they have no direct bearing upon fitness for duty.

a. 302.70 Sexual dysfunction NOS.

b. 302.71 Hypoactive sexual desire.

c. 302.72 Female arousal disorder. Male erectile disorder.

d. 302.73 Female orgasmic disorder.

e. 302.74 Male orgasmic disorder.

f. 302.75 Premature ejaculation.

g. 302.76 Dyspareunia.

h. 302.79 Sexual aversion disorder.

i. 302.9 Sexual Disorder NOS.

j. 306.51 Vaginismus.

16. Factitious Disorders. These disorders are disqualifying for appointment, enlistment, or induction under Section 3-D-32 of this manual or should be processed in accordance with Chapter 12 of the Personnel Manual, COMDTINST M1000.6 (series).

    a. 300.16 With predominantly psychological symptoms.

    b. 300.19 Factitious disorder NOS.

    c. 301.51 With predominantly physical symptoms, or combined.

17. Disorders of Impulse Control Not Elsewhere Classified. These disorders are disqualifying for enlistment under Section 3-D-33 of this manual or should be processed in accordance with Chapter 12 of the Personnel Manual COMDTINST M1000.6 (series).

    a. 312.30 Impulse control disorder NOS.

    b. 312.31 Pathological gambling.

    c. 312.32 Kleptomania.

    d. 312.33 Pyromania.

    e. 312.34 Intermittent explosive disorder.

    f. 312.39 Trichotillomania.

18. Disorders Usually First Evident in Infancy, Childhood, or Adolescence. Except as indicated in parentheses, these disorders are disqualifying for appointment, enlistment, or induction under Section 3-D-33 of this manual, or shall be processed in accordance with Chapter 12 of the Personnel Manual, COMDTINST M1000.6 (series), if the condition significantly impacts, or has the potential to significantly impact performance of duties (health, mission, and safety).

    a. Mental Retardation (Note: these are coded on Axis II).

        (1) 317 Mild mental retardation, IQ 50-70.

        (2) 318.X Moderate, severe, or profound mental retardation, IQ 35-49.

        (3) 319 Mental retardation, severity unspecified.

    b. Disruptive Behavior Disorders.

        (1) 314.0X Attention deficit hyperactivity disorder (various types).

        (2) 312.8 Conduct disorder.

        (3) 312.9 Disruptive behavior disorder or attention deficit disorder, NOS.

        (4) 313.81 Oppositional defiant disorder.

    c. Other Disorders of Infancy, Childhood, or Adolescence.

(1) 307.30 Stereotypic movement disorder.

(2) 309.21 Separation anxiety disorder.

(3) 313.23 Selective mutism.

(4) 313.82 Identity problem.

(5) 313.89 Reactive attachment disorder of infancy or early childhood.

d. Eating Disorders. Eating disorders have a potential to affect fitness for duty, but the diagnosis of an eating disorder does not automatically mean the member is unsuitable for continued service. Individuals suspected of having an eating disorder shall be referred for evaluation by an Armed Forces psychiatrist or Armed Forces clinical psychologist. Treatment may be authorized in accordance with the same criteria as other mental conditions. See paragraph 5.B.1 of this Manual.

(1) 307.1 Anorexia nervosa. (Shall be processed through Physical Disability Evaluation System (COMDTINST M1850.2 ))

(2) 307.50 Eating disorder NOS. Shall be processed in accordance with Chapter 12.B.12 or 12.A.15.h (as applicable) of the Personnel Manual, COMDTINST M1000.6(series), if the condition significantly impacts or has the potential to significantly impact performance of duties (health, mission, and safety).

(3) 307.51 Bulimia nervosa. (Shall be processed through Physical Disability Evaluation System (COMDTINST M1850.2))

(4) 307.52 Pica.

(5) 307.53 Rumination disorder.

e. Tic Disorders.

(1) 307.20 Tic disorder NOS.

(2) 307.21 Transient tic disorder.

(3) 307.22 Chronic motor or vocal tic disorder.

(4) 307.23 Tourette's disorder.

f. Communication Disorder.

(1) 307.0 Stuttering.

(2) 315.31 Expressive or mixed (expressive-receptive) language disorder.

(3) 315.39 Phonological disorder.

g. Elimination Disorders.

(1) 307.46 Sleepwalking disorder.

(2) 307.46 Sleep terror disorder.

(3) 307.6 Enuresis (not due to a general medical condition).

(4) 307.7 Encopresis (without constipation and overflow incontinence.)

h. Pervasive Developmental Disorder.

(1) 299.00 Autistic disorder.

(2) 299.80 Pervasive developmental disorder NOS.

i. Specific Learning Developmental Disorders - (Note: These Are Coded on Axis II).

(1) 315.00 Reading disorder.

(2) 315.1 Mathematics disorder.

(3) 315.2 Disorder of written expression.

(4) 315.4 Developmental coordination disorder.

(5) 315.9 Learning disorder NOS.

19. 316.00 Psychological Factors Affecting Physical Condition. This disorder is not generally grounds for action alone. The physical condition must be specified on Axis III and will determine fitness.

20. V Codes for Conditions Not Attributable to a Mental Disorder that are a Focus of Attention or Treatment. These disorders are generally not of such severity as to lead to disqualification for enlistment or to separation. Where separation is indicated, process in accordance with Chapter 12 of the Personnel Manual, COMDTINST M1000.6 (series).

a. V15.81 Noncompliance with medical treatment.

b. V61.1 Partner relational problem.

c. V61.20 Parent-child relational problem.

d. V61.8 Sibling relational problem.

e. V62.2 Occupational problem.

f. V62.3 Academic problem.

g. V62.81 Relational problem NOS.

h. V62.82 Bereavement.

i. V62.89 Borderline intellectual functioning.

j. V62.89 Phase of life problem or religious or spiritual problem.

k. V65.2 Malingering. (May be grounds for legal, administrative, or medical board proceedings in accordance with Section 2-A-4 of this manual depending on the circumstances)

l. V71.01 Adult antisocial behavior.

m. V71.02 Child or adolescent antisocial behavior.

21. Additional Codes. These are nondiagnostic codes for administrative use and require no action.

a. V71.09 No diagnosis or condition on Axis I.

b. V71.09 No diagnosis on Axis II.

c. 300.9 Unspecified mental disorder (nonpsychotic).

d. 799.9 Diagnosis or condtion deferred on Axis I.

e. 799.9 Diagnosis deferred on Axis II.

Section C - Command directed Mental Health Evaluation of Coast Guard Service members.

1. General. A commander, (including commanding officers, of clinics) shall refer a Service member for an emergency mental health evaluation as soon as is practicable whenever a Service member indicates an intent to cause serious injury to himself or others, and the commander believes that the Service member may be suffering from a mental disorder.

   a. Active Duty Mental Health Conditions and Emergencies, COMDTPUB P6520.1 refers to Public Law 102-484, Section 546, also known as the "Boxer Amendment" The Coast Guard is not included and therefore not subject to the Boxer's Amendment. These restrictions are intended to prevent the unwarranted mental health evaluations or involuntary hospitalization as a form of harassment or retaliation.

   b. Prior to transporting a Service member for an emergency evaluation, or shortly thereafter if the time and nature of the emergency does not permit, the commanding officer shall consult directly with a mental health care provider (or other health care provider if a mental health care provider is not available) at the MTF. The purpose of this consult is to communicate the observations and circumstances which led the commander to believe that the Service member's behavior constituted an emergency. The commander will then forward to the mental health care provider consulted a memorandum documenting the information discussed.

2. When not an emergency, commanding officers suspecting a mental health evaluation may be indicated will:

   a. Contact the appropriate point of contact at the servicing Coast Guard Medical clinic and speak directly with the point of contact to request a command-directed mental health evaluation. Signs of mental illness can include changes in behavior, mood, or thinking that interfere with normal functioning. The health care provider will clarify the request, urgency of the referral, and schedule an appointment.

   b. Provide a memorandum from the commanding officer to the DoD MTF/clinic commander documenting this contact, subject: Command Referral for Mental Health Evaluation of (Service Member Rank, Name, Branch of Service and SSN. (sample letter Figure 1).

   c. Counsel the Service member and insure that the Service member is provided written notice of the referral. A sample memorandum from the commanding officer to the MTF/clinic commander documenting this contact, subject: Notification of Commanding Officer Referral for Mental Health Evaluation (Non-Emergency). The notice will include the following: (sample letter Figure 2)

      (1) Date and time the mental-health evaluation is scheduled.

      (2) A brief, factual description of the Service member's behavior and verbal expressions that indicate a mental-health evaluation is necessary.

(3) Names of mental-health professionals the commander has consulted before making the referral. If consultation is not possible, commanders must include the reasons in the notice.

d. Request the Service member sign the notice to report for a mental- health evaluation. If the Service member refuses to sign, the commander will note this response in the notice.

e. Provide an escort to Service member referred for a mental- health evaluation.

3. Commanders shall provide a copy of the following rights to Service members who are referred:

a. A Service member has the right to obtain a second opinion at his own expense. The evaluation should be conducted within a reasonable period of time, usually within 10 days and will not delay nor substitute for an evaluation performed by a DoD mental health care.

b. No person may restrict the Service member from communicating with an attorney, IG, chaplain, Member of Congress, or other appropriate party about the member's referral.

c. Other than emergencies, the Service member will have at least 2 workdays before a scheduled mental-health evaluation to meet with an attorney, chaplain, IG, or other appropriate party. If a commander has reason to believe the condition of the Service member requires an immediate mental-health evaluation, the commander will state the reasons in writing as part of the request for evaluation.

d. If military duties prevent the Service member from complying with this policy, the commander seeking the referral will state the reasons in a memorandum.

4. No one will:

a. Refer a Service member for a mental-health evaluation as a reprisal for making or preparing a lawful communication to a Member of Congress, an authority in the Service member's chain of command, an IG, or a member of a DoD audit, inspection, investigation, or law enforcement organization.

b. Restrict a Service member from lawfully communicating with an IG, attorney, Member of Congress, or others about the Service member's referral for a mental-health evaluation.

c. These policies are not designed to limit the commander's authority to refer Service members for emergency mental-health evaluations and treatment when circumstances suggest the need for such action.

5. The specific procedures required by these regulations apply to mental health evaluations directed by a service member's commander as an exercise of the commander's discretionary authority. Evaluations NOT covered by these procedures include:

   a. Voluntary self-referrals;

   b. Criminal responsibility and competency inquiries conducted under Rule for Court-Martial 706 of the Manual for Courts-Martial;

   c. Interviews conducted according to the Family Advocacy Program;

   d. Referrals to the Alcohol and Drug Abuse Prevention and Control Program;

   e. Security clearances.

   f. Diagnostic referrals from other health care providers not part of the Service member's chain of command when the Service member consents to the evaluation; and;

   g. Referrals for evaluations expressly required by regulation, without any discretion by the Service member's commander, such as enlisted administrative separations.

6. Procedures for using the memorandum requesting a mental health evaluation in emergency situations Commanders will:

   a. When completing the memorandum Commanders should include as many details as possible.

   b. Make one copy to give to the Service member.

   c. Ensure that the Service member's escort hand carries the memorandum to the treatment facility. The memorandum will not be hand carried by the Service member being referred. This memorandum will not be sent through distribution channels, nor will it become part of the Service member's health record. The memorandum will be filed in the Department of Psychiatry of the medical treatment facility where the Service member was evaluated.

FIGURE 1

Sample: Commanding Officer request for routine (non emergency) Mental Health Evaluation

Date:

Memorandum for Commanding Officer (Name of Medical Treatment Facility (MTF) or Clinic)

From: Commanding Officer, (Name of Command)
Subject: Command Referral for Mental Health Evaluation of (Service Member Rank, Name, Branch of Service and SSN)

Reference (a) Medical Manual COMDTINST M6000.1B, Chap 5-C
(b) Active Duty Mental Health Conditions and Emergencies, COMDTPUB P6520.1

1. In accordance with references (), I hereby request a formal mental health evaluation of (rank and name of Service member).
2. (Name and rank of Service member) has (years) and (months) active duty service and has been assigned to my command since (date). Armed Services Vocational Aptitude Battery (ASVAB) scores upon enlistment were: (list scores). Past average performance marks have ranged from _____ to _____ (give numerical scores). Legal action is/is not currently pending against the Service member. (If charges are pending, list dates and UCMJ articles). Past legal actions include: (List dates, charges, non judicial punishments (NJPs) and/or findings of Courts Martial.)
3. I have forwarded to the Service member a memorandum that advises (rank and name of Service member) of his (or her) rights. This memorandum also states the reasons for this referral, the name of the mental health care provider(s) with whom I consulted. A copy of this memorandum is attached for your review.
4. (Service member's rank and name) has been scheduled for evaluation by (name and rank of metal healthcare provider) at (name of MTF or clinic) on (date) at (time).
5. Should you wish additional information, you may contact (name and rank of the designated point of contact) at (telephone number).
6. Please provide a summary of your findings and recommendations to me as soon as they are available.

(Signature)
Rank and Name of Commanding Officer

Attachment:
As stated

FIGURE 2

Sample: Service member notification of Commanding Officer referral for Mental Health Evaluation.

Date:

Memorandum for (Service member's rank, name and SSN)
From: Commanding Officer, (Name of Command)
Subject: Notification of Commanding Officer referral for Mental Health Evaluation (non emergency).

References: (a) Medical Manual COMDTINST M6000.1B, Chap 5-C
(b) Active Duty Mental Health Conditions and Emergencies, COMDTPUB P6520.1

1. In accordance with references (), this memorandum is to inform you that I am referring you for a mental health evaluation.

2. The following is a description of your behaviors and/or verbal expressions that I considered in determining the need for a mental health evaluation: (Provide dates and a brief factual description of the Service member's actions of concern.)

3. Before making this referral, I consulted with the following mental health care provider(s) about your recent actions: (list rank, name, corps, branch of each provider consulted) at (name of Medical Treatment Facility (MTF) or clinic) on (date(s)). (Rank(s) and name(s) of mental healthcare provider(s)) concur(s) that this evaluation is warranted and is appropriate.

OR

Consultation with a mental healthcare provider prior to this referral is (was) not possible because (give reason; e.g., geographic isolation from available mental healthcare provider, etc.)

4. Per references (a) and (b), you are entitled to the rights listed below:
The right to obtain a second opinion and be evaluated by a mental healthcare provider of your own choosing, at your own expense, if reasonably available. Such an evaluation by an independent mental healthcare provider shall be conducted within a reasonable period of time, usually within 10 business days, and shall not delay nor substitute for an evaluation performed by a DoD mental healthcare provider.

   a. The right to communicate without restriction with an IG, attorney, Member of Congress, or others about your referral for a mental health evaluation. This provision does not apply to a communication that is unlawful.

b. The right, except in emergencies, to have at least two business days before the scheduled mental health evaluation to meet with an attorney, IG, chaplain, or other appropriate party. If I believe your situation constitutes an emergency or that your condition appears potentially harmful to your well being and I judge that it is not in your best interest to delay your mental health evaluation for two business days, I shall state my reasons in writing as part of the request for the mental health evaluation.

c. If you are assigned to a naval vessel, deployed or otherwise geographically isolated because of circumstances related to military duties that make compliance with any of the procedures in paragraphs (3) and (4), above, impractical, I shall prepare and give you a copy of the memorandum setting forth the reasons for my inability to comply with these procedures.

5. You are scheduled to meet with (name and rank of the mental healthcare provider) at (name of MTF or clinic) on (date) at (time).

(Signature)
Rank and Name of Commanding Officer

I have read the memorandum above and have been provided a copy.
Service member's signature:_____ Date:_____
OR:
The Service member declined to sign this memorandum which includes the Service member's Statement of Rights because (give reason and/or quote Service member).

Witness's signature:_____ Date:_____
Witness's rank and name:_____ Date:_____

(Provide a copy of this memorandum to the Service member.)

# CHAPTER 6

# REPORTS, FORMS, AND RECORDS

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# CHAPTER 6. REPORTS, FORMS, AND RECORDS

## Section A - Reports.

1. Health Services Statistical Report, (RCN 6000-1).

   a. The HSSR is produced by the Clinic Automated Management System (CLAMS) and is based on data entered at the terminal during the reporting month.

   b. During production of the HSSR a set of screen prompts will allow entry of required information from the terminal keyboard. Prompt criteria include:

      (1) Onboard staffing and billets for HSs, medical practitioners, and dental officers.

      (2) Prescriptions. A number may already appear in this field. This number will be the number of prescriptions issued for the selected month (calculated from the database).

      (3) Inspections. Count one for each inspection logged (e.g., galley, berthing, water, pool, food handlers).

      (4) SAR. Count one for each SAR or MEDEVAC sortie (air or boat) with health services personnel aboard.

      (5) Training Hours Given (medical officers). Count any medical training by medical officers (all hands, suturing demonstration, demonstrating knee injury evaluation to one or more HSs, hypothermia lecture for local boaters group, etc.) greater than 15 minutes duration. Total all training increments lasting longer than 15 minutes by all medical officers and round to the nearest hour.

      (6) Expense Data (month). Enter the corresponding expenses for the selected month. Note: when starting the HSSR Report from a month other than October, it may be necessary to enter the year-to-year figures initially in order for the subsequent YTD figures to be correct.

      (7) Expense Data (OPTAR). The corresponding Operating Target for the selected fiscal year. The amounts set initially will continue to appear, unless they are changed.

      (8) Tickler OPFACs. CLAMS tabulates the percentage of USCG active duty persons in compliance with mandatory medical/dental requirements (shots, exams, audiograms, etc.) and displays this on the HSSR. Personnel in clinic/sickbay "Binnacle OPFACs" are automatically included in this "tickler file" scrutiny. Outlying units which fall within a clinic/sickbay's tickler radius but are too remote for binnacle reporting CLAMS calls "Tickler OPFACs". The user must enter these additional "Tickler OPFACs" at the time the HSSR is made. Once entered they will continue to display unless changed. NOTE: HSs at group/cutter sickbays are responsible for their own binnacle and "tickler" activity. This applies even in those situations where the majority of care for the group/cutter personnel is provided by a nearby USCG clinic.

c. The report shall be submitted to the commanding officer for approval and signature by the FIFTH working day of the following month.

d. A signed copy of the HSSR shall be filed in the health care facility and be accessible for MLC audit.

2. Report of Potential Third Party Liability (RCN 6000-2). (Refer to Health Care Third Party Claims Recovery, COMDTINST 6010.16 (series) for current policy). Submit this report on form CG-4899 (Rev. 10-91), Report of Potential Third Party Liability. A sample form CG-4899 (Rev. 10-91) is included as Figure 6-A-1. If applicable, attach to Nonfederal Health Care Certification Form, CG-5534, when submitting nonfederal health care bills for processing.

3. MLC/Headquarters Clinic Operations Report (RCN 6000-3). Generate and submit the MLC/Headquarters Report in accordance with the instructions contained in the CLAMS User's Guide. This report is submitted on disk or transmitted electronically to Commandant (G-K) monthly for clinics and every 6 months (October/April) for sickbays. Outpatient health care of non-USCG patients and dental statistical reporting are incorporated into this report. Reports from clinics and sickbays must be sent to Commandant (G-K) within five working days of the following month. Delay of report submission from sickbays is permissible should operational commitments (e.g., underway) interfere with timely reporting.

4. Disease Alert Report (RCN-6000-4). Disease Alert Reports provide appropriate commands with information that can be used to protect lives and health, and maintain command effectiveness. Detailed instructions are contained in Section 7-B of this manual.

5. Report of Theft of Controlled Substances (RCN 6000-5).

   a. Discrepancies noted on Controlled Substance Inventory Board Reports shall be investigated as discussed in Chapter 10 of this manual. Submit findings to appropriate MLC (K).

   b. MLC (K) shall review and determine further action, including whether a Form DEA-106 shall be submitted. A copy of all DEA-106 reports submitted shall be sent to Commandant (G-WKH).

6. Inpatient Hospital Report (RCN 6000-6). When notified that a member of the Coast Guard is hospitalized, transferred to another facility, or discharged from inpatient status, the unit commanding officer shall notify the appropriate MLC (p) and (k) via message in accordance with current MLC directives. When listing diagnosis, use only ICD-9 codes; do not include a description of the ailment. See Paragraph 2-A-2 of this manual for additional policy concerning emergency care at other than Coast Guard or DOD facilities. CLAMS also produces a letter containing this information.

7. Health Care Equipment Inventory Report (RCN 6000-7). Health care equipment inventories are maintained by the MLCs' and are used for planning and budgeting purposes. All units with health care equipment shall verify their health care equipment inventory. Annually, in January, MLC (k) will forward to each unit within their area of responsibility a copy of their previous health care equiptment inventory report. Units shall annotate changes and submit to MLC (k) with their annual budget request. MLC (k) will compile all inventories and forward them to Commandant (G-WKH) in conjunction with separate entity from the unit's personal property list. This inventory report reflects only major health care equipment or items with an original cost of more than $300.00.

8. Health Services Division Status Report (RCN 6000-8). This annual report provides Headquarters and MLCs' with individual clinics' status, problems, and initiatives in the medical, dental, pharmacy, and quality assurance areas. See Commandant Instruction 6010.22(series) for specific instructions regarding preparation and submission of this report.

9. Shorten Clinic Automated Report System (SCARS). Sickbays that have not been able to implement CLAMS can use SCARS to produce the MLC/Headquarters Clinic Operations Report until they are able to use CLAMS. Note that the semiannual MLC/Headquarters Clinic Operations Report (RCN 6000-3) is separate and distinct from the monthly Health Services Statistical Report (RCN 6000-1). Sickbays having to produce an HSSR without benefit of CLAMS will follow the HSSR format found in the CLAMS User's Guide, but need not complete the "Onboard billet percent", "Binnacle data", and workload items which do not apply to their operations. SCARS prompts the HS to enter data totals in response to a succession of screen prompts. Six months totals for outpatient visits (OPVs)., prescriptions filled, lab test done, HBA visits, inspections, referrals, SARS, and expense data will be sought. The percent of active duty and civilian employees in compliance with mandate requirements (like audiogram, HIV test, etc.) must also be complied and entered. Six month totals can be tabulated from HSSRs. Compliance percentages are calculated by SCARS. (Number in compliance divided by the number for whom the requirement applies. If you have 30 people in the hearing conservation program and 15 have had an audiogram in the last year, your compliance is 15/30 x 100; or 50%).

Figure 6-A-1

| DEPARTMENT OF TRANSPORTATION<br>U.S. COAST GUARD<br>CG-4899 (Rev-04-01) | **REPORT OF POTENTIAL THIRD PARTY LIABILITY** |
|---|---|

**INSTRUCTIONS:** Complete all blocks to the best of your knowledge. If unknown or not applicable, leave blank. Mail original to Commandant (G-WRP-2) and a copy to appropriate MLC (k).

**SECTION I – IDENTIFICATION OF INJURED PERSON**

| | | | |
|---|---|---|---|
| **A. NAME** (Last ,First and Middle Initial) | **B. SSAN** | **C. RANK/RATE** | **D. WORK TELEPHONE**<br>☐ FTS ☐ COMM |
| **E. HOME ADDRESS** (Including zip code) | | **F. DATE OF BIRTH** | **G. HOME TELEPHONE** |
| **H. STATUS OF BENEFICIARY**<br>☐ **ACTIVE DUTY** ☐ **RESERVE** ☐ **RETIRED**<br>☐ **DEPENDENT (Complete Section 2 below)** | | **I. UNIT NAME** | **J. BRANCH OF SERVICE** |

**SECTION 2 – IDENTIFICATION OF SPONSOR**
**(Complete only if injured person is a dependent; otherwise, leave blank)**

| | | | |
|---|---|---|---|
| **A. NAME** (Last ,First and Middle Initial) | **B. SSAN** | **C. RANK/RATE** | **D. WORK TELEPHONE**<br>☐ FTS ☐ COMM |
| **E. HOME ADDRESS** (Including zip code) | | | **F. HOME TELEPHONE** |
| **G. STATUS OF BENEFICIARY**<br>☐ **ACTIVE DUTY** ☐ **RESERVE** ☐ **RETIRED** | | **H. UNIT NAME** | **I. BRANCH OF SERVICE** |

SAMPLE FORM

**SECTION 3 - ACCIDENT**

| | |
|---|---|
| **A. ACCIDENT INFORMATION (Include zip code with address):**<br>☐ **AUTOMIBILE (city/state):**<br>☐ **JOB RELATED (employers name/address):**<br>☐ **PROPERTY RELATED (owners name/address):** | **B. DATE AND TIME** |
| **C. BRIEFLY DESCRIBE THE ACCIDENT (include who caused the injury and how it happened):** | |

**SECTION 4 – ATTORNEY INFORMATION**

| | | |
|---|---|---|
| **A. NAME OF YOUR ATTORNEY** | **B. ADDRESS (Include zip code)** | **C. TELEPHONE NUMBER** |

**SECTION 5 – AMBULANCE SERVICE**

| | | |
|---|---|---|
| **A. NAME OF AMBULANCE** | **B. ADDRESS (Include zip code)** | **C. TELEPHONE NUMBER** |

| | |
|---|---|
| **MAIL TO:**<br>Commandant (G-WRP-2)<br>U.S. Coast Guard<br>2100 2nd St. S.W.<br>Washington, DC 20593-0001 | **PRIVACY ACT STATEMENT**<br>Sections 2651-2563 of Title 42 to the U.S. Code authorize collection of this information. Furnishing the Social Security No. is empowered by Exec. Order 9397 and is mandatory to identify authorized beneficiaries. This information is principally used to document incidents that lead to injured party(ies) receiving medical care at the expense of the U.S. Coast Guard. Routine uses including lawful enforcement and investigations for recovery from third party liability. **If the requested information is not furnished, recovery of Federal funds may be hampered, possibly limiting continued delivery of comprehensive health care.** |

Figure 6-A-1 (reversed)



| SECTION 6 – MOTOR VEHICLE ACCIDENT<br>(DATA PERTAINING TO VEHICLE IN WHICH YOU WERE DRIVING OR RIDING) | | |
|---|---|---|
| A. NAME OF DRIVER Military? ☐ YES ☐ NO | B. HOME ADDRESS (Include zip code) | C. WORK TELEPHONE<br>☐ FTS ☐ COMM |
| D. NAME OF OWNER Military ☐ YES ☐ NO | E. YEAR/MAKE/MODEL OF AUTOMOBILE | F. LICENSE PLATE NUMBER |
| G. OWNER'S INSURANCE COMPANY AND POLICY NUMBER | H. ADDRESS(ES) (Include zip code) | I. TELEPHONE NUMBER |
| J. NAMES OF INJURED PASSENGER(S) | K. ADDRESS(ES) (include zip code) | L. TELEPHONE NUMBER |
| | | |
| **(DATA PERTAINING TO OTHER VEHICLE)** | | |
| M. NAME OF DRIVER Military? ☐ YES ☐ NO | N. ADDRESS (Include zip code) | O. TELEPHONE NUMBER |
| P. NAME OF OWNER Military ☐ YES ☐ NO | Q. YEAR/MAKE/MODEL OF AUTOMOBILE | R. LICENSE PLATE NUMBER |
| **SECTION 7 – ALL OTHER ACCIDENTS**<br>(DATA PERTAINING TO INSURANCE OTHER THAN AUTOMOBILE) | | |
| A. RESPONSIBLE PARTY'S INSURANCE COMPANY AND POLICY NUMBER | B. ADDRESS (Include zip code) | C. TELEPHONE NUMBER |
| D. TYPE OF INSURANCE<br>☐ HOME OWNERS ☐ PERSONAL MEDICAL INSURANCE ☐ WORKERS COMPENSATION | | |
| E. INJURED PARTY'S INSURANCE COMPANY AND POLICY NUMBER | F. ADDRESS (Include zip code) | G. TELEPHONE NUMBER |
| H. TYPE OF INSURANCE<br>☐ HOME OWNER ☐ PERSONAL MEDICAL INSURANCE ☐ WORKERS COMPENSATION | | |

SAMPLE FORM

| SECTION 8 – MILITARY/CIVILIAN HOSPITALIZATION | | | |
|---|---|---|---|
| A. NAME OF HOSPITAL(S) | B. ADDRESS(ES) (Include zip code) | C. DATE(S) OF TREATMENT<br>FROM TO | D. PAYMENT MADE BY:<br>☐ SELF<br>☐ INSURANCE<br>☐ CHAMPUS |
| | | FROM TO | ☐ SELF<br>☐ INSURANCE<br>☐ CHAMPUS |

| SECTION 9 – MILITARY/CIVILIAN DOCTORS/DENTISTS | | | |
|---|---|---|---|
| A. NAME OF DOCTORS | B. ADDRESS(ES) | C. DATE(S) OF TREATMENT<br>FROM TO | D. PAYMENT MADE BY:<br>☐ SELF<br>☐ INSURANCE<br>☐ CHAMPUS |
| | | FROM TO | ☐ SELF<br>☐ INSURANCE<br>☐ CHAMPUS |
| | | FROM TO | ☐ SELF<br>☐ INSURANCE<br>☐ CHAMPUS |

E. IS TREATMENT COMPLETE?
☐ YES ☐ NO IF NO, WHEN DO YOU EXPECT IT TO BE COMPLETE?_____

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Section B - Forms and Records.

1. Status-Profile (CG-5460A).

a. Purpose. CG-5460A shall be used by active duty persons and civilian employees who are either signing into the clinic/sickbay for the first time under CLAMS, or need a duty status chit. It has a limited space for patient identification at the top, a duty status slip (with copies) in the middle, visit information on the lower half, and a detailed patient information section on the back. See Figure 6-B-1.

b. Detailed Instructions.

(1) Top Left. Mechanical imprinting of patient's name, if available. Have the patient fill in the appropriate data if mechanical imprinting is not used.

(2) Top Right. Date of visit is entered by the patient. The sponsor's social security number (SSN) and status (active duty or civilian employee) are also required if mechanical imprinting is not used.

(3) Rear. For a patient's first clinic visit after installation of the CLAMS data base, more information is required on the form.

(4) Middle Section. Duty status chits are issued under CLAMS in the same manner as they were before CLAMS. Fit for duty (FFD) chits are required for grounded members cleared for aviation duties, and for members returned to full duty before their restricted duty status has expired. The provider fills out and signs the duty status chit (with firm pressure, because two tear-off patient copies are produced at the same time). DIF (under FIT FOR FULL DUTY) stands for Duties Involving Flight.

(5) A diagnosis must be included on each duty status chit issued, including FFD chits. If the practitioner does not want the diagnosis to appear on the binnacle list, enter an asterisk (*) after the written diagnosis. Thus a data base entry of "gonorrhea*" will appear as "  " on the binnacle list. If inpatient, place a "$" after the diagnosis. The status on the binnacle list will then appear as NFFD (INPT).

(6) If the illness or injury resulting in the duty restriction was (S)ports, (O)ccupational, (M)otor vehicle, or (A)locohol related, check the applicable (S)(O)(M)(A) block(s). More than one block can be checked if appropriate.

(7) Lower Half. This portion is for recording specific workload information. If the visit meets the criteria as an outpatient visit (OPV), as defined by Paragraph 6-B-1.c. of this manual, the caregiver's initials are required. For medical and dental record purposes, the OPV caregiver is the individual who ultimately assumes responsibility for the patient's treatment. You are the caregiver for a visit if:

(a) your SOAP note is recorded in the health record;

(b) you assumed ultimate responsibility for the patient’s treatment; and

(c) you signed the medical record entry.

(8) Answering a question about a finding or treatment for another practitioner does not make you the caregiver of record. Also, a health services technician who performs a preliminary assessment (history, exam, and a plan) and then turns the patient over to a medical officer or other practitioner is not the OPV caregiver and should not initial a box. A telephone call by a health services technician to the duty practitioner in regard to a patient may constitute a transfer of responsibility, provided the duty practitioner's assessment and plan are recorded in the health record for his signature.

(9) Left Side (lower half). There are two boxes available for OPV caregiver initials. A physician, physician assistant, nurse practitioner, physical therapist, mental health practitioner, health services technician, or medical extern initials the first box. The second box is also used when another problem which meets the OPV criteria is addressed by a second practitioner.

(a) Check one visit length: "Limited" (less than 15 minutes), "Intermediate" (15-30 minutes), or "Extended" (more than 30 minutes), based on the number of minutes the OPV caregiver actually spent with the patient or working on the patient's problem (reading x-rays, checking lab work, etc.).

(b) In the column of boxes under the visit length, indicate the type(s) of care provided during the visit. Use check marks for all boxes except initials (discussed above), audit codes, lab test(s), and medical x-rays. Check "routine exam" box only when an SF-88 type exam is done on an active duty member.

(c) If the OPV deals with one of the audit codes listed on the back of the form, place the appropriate 2 letter code in the audit code box. These codes will help you generate lists of patients for the quality assurance monitoring and evaluation audits, and will save you the time and effort which would otherwise be required to prepare a list of patients seen for a particular problem.

(d) Clinics may create their own codes for their own purposes if desired. These would be in addition to the audit codes listed on the back of the form. Two codes may be entered for each OPV. CLAMS will allow searching for any additional codes that may be developed.

(e) Lab and X-ray. Enter the number of tests performed.

(f) Health benefits advice by itself does not constitute an OPV. However, facilities shall account for work and time expended performing this function. For episodes of health benefits advice (by telephone or in person) lasting more than three minutes, the advisor shall enter his/her initials in the box provided.

(g) There is no block for recording prescription count. Prescription counts will be automatically tallied by the pharmacy module of CLAMS. Patients using the pharmacy only (outside prescription or a refill) do not need to fill out a Status-Profile or Visit profile form, except for their first visit when you will need all patient information. If for some reason you are not using CLAMS for this purpose, you will be prompted to enter your total number of prescriptions filled when you are printing the HSSR.

(h) Check the NON-OPV box if no aspect of medical or dental care meets the criteria for an OPV. If you check NON-OPV, do not enter OPV caregiver(s) initials.

(10) Center (lower half). Place provider initials in the box by any referral(s) made or ordered. Initial the FED (Federal facility, e.g., USMTF, USTF) or NFED (non-federal, e.g., non-fed med, supplemental care, TRICARE, outside contract, etc.) column, as appropriate.

(a) In-house referrals to contract providers as well as referrals to other Coast Guard clinics are exempt from this reporting. Do not mark a referral box for one of these.

(b) Check the box for any tickler items performed.

(c) Check the box for third party, if applicable.

(d) Note dental referrals by circling the appropriate letter:

1 D - Prosthodontics

2 E - Endodontics

3 P - Periodontics

4 O - Orthodontics

5 S - Oral Surgery

6 K - Pedodontics

(11) Right Side (lower half). Dental follows the same general guidelines as the left (medical) side, e.g., the initials of the attending dental officer, dental extern,

health services technician, or dental hygienist go in the OPV Caregiver box, whereas the person who performs a simple prophylaxis initials the box labeled "Prophy Giver."

(a) Initial the "Prophy Giver" box if a prophy is performed. If the patient is treated in any other manner, intial the "OPV Caregiver" box.

(b) If an annual or semiannual Type 2 dental exam is performed, record "1" in the "Exam" box. Do not record any numeral other than "1". Do not take credit for post-op visits, perio exams, etc. in this box. A "1" in this box sets a tickler file, and it should not be polluted with less-than-thorough hard and soft tissue exams.

(c) If an unscheduled patient is seen for emergency treatment, record "1" in the Emergency box.

(d) Record the number of teeth restored in the "Restoration(s)" box. (For example, a maxillary first molar with MO and OL restorations placed counts as 1 tooth restored. Pins, bases, number of attempts, etc., do not alter the method of counting.)

(e) Record the number of surfaces restored in the "Surface(s)" box. Pins, bases, etc., do not affect the number of surfaces restored.

(f) Record the number of canals permanently sealed in the "Root Canal(s)" box.

(g) In the "Pulpotomy(ies)" box, record the number of primary tooth pulpotomies performed as a definitive treatment. Also, record the number of symptomatic permanent teeth opened, pulpotomized, and referred to a specialist for definitive therapy.

(h) Record the number of impacted teeth (soft tissue or bony) extracted in the "Impactions" box.

(i) Record the number of non-impacted teeth extracted in the "Extractions" box.

(j) Record the number of other surgical procedures (e.g., periodontal surgery, free gingival graft, alveoplasty, biopsy, ridge reduction, etc.), per quadrant, in the "Other Surg/Quad" box.

(k) Record the number of quadrants treated with non-surgical perio therapy (curettage and root planing, usually with anesthesia) in the "Non-Surgical Perio/Quad" box. Also, include a thorough periodontal examination and charting (NOT PSR) as 1 quadrant of non-surgical perio treatment. Only dental officers may record non-surgical perio treatment. No more than

two quadrants may be recorded per visit. Generally, no other therapy should be recorded for this visit; non-surgical perio is a planned step in definitive perio therapy. Only patients with documented periodontal disease receive non-surgical perio therapy. A prophy should be scheduled at a separate visit. Full-mouth cavitron therapy is a prophy, not four quadrants of non-surgical perio.

(l) Record the number of teeth (not surfaces) sealed, or receiving preventive resins, in the "Sealant" box.

(m) Record the number of treatment appliances (e.g., orthodontics, spacers, habit devices, stents, mouthguards, etc.), one per arch, delivered or adjusted, in the "Treatment Appliances/Arch" box.

(n) Record the number of full or partial dentures delivered in the "Denture Partial/Full/Arch" box.

(o) Record the number of permanently cemented cast units, other than resin-bonded retainers (Maryland bridges), in the "Cast Unit(s)" box. Pontics count as one cast unit apiece.

(p) Record the number of acid etch units (Maryland bridges, resin-bonded retainers) bonded in the "Acid Etch Units" box. Count each pontic and each wing as one unit.

(q) If a dental officer returns to the clinic to care for a beneficiary after hours, record 1 in the "After Hours OPV" box.

(r) If a dental officer engages in a diagnostic/therapeutic conversation with a patient over the phone, and the patient's dental record is so noted in SOAP format, record "1" in the "Telephone OPV" box.

(s) At the end of the visit, enter the dental classification, in arabic numerals, in the "Class" box.

(t) Enter the number of minutes required for diagnosis (for either Annual Exam or Emergency visits) in the "Dx Minutes" box.

(u) Enter the sum of the PSR scores (for Annual Exams) in the "PSR Total" box.

(v) If a biopsy is done, check the "Biopsy" box to set a tickler file. Also indicate a surgical procedure in the "Other Surg/Quad" box.

(w) If a dental procedure is begun, but not finished, during a visit, the dental caregiver shall initial the (dental) OPV Caregiver box for an OPV credit,

but shall not put a number in a box below until the treatment is completed during a subsequent visit.

c. Definition of an Outpatient Visit (OPV or "visit"). For the purposes of this instruction, an OPV occurs each time an eligible beneficiary presents to a Coast Guard Medical Treatment Facility (medical or dental) for examination, diagnosis, treatment, evaluation, consultation, counseling or advice; or is treated or observed in quarters; and a signed and dated entry is made in the patient's health record, dental record, or other record of medical treatment (See Note 1 following 6-B-1.c.(3)). An exception is that consecutive visits to specialty clinics (e.g., physical therapy and occupational therapy) will not require a signed and dated entry for each visit unless there is a change in the prescribed treatment or a significant physical finding is evident. In all instances, however, an acceptable record audit trail shall be maintained. A clinic log shall be maintained as a source document to support an audit trail.

(1) Classification of a service as a visit is not dependent upon the professional level of the person providing the service (includes medical officers, dental officers, dental hygienists, optometrists, nurses, and health services technicians).

(2) A patient visiting a Coast Guard Medical Treatment Facility (CGMTF) in the morning and again in the afternoon shall count as two visits (providing the requirements of Note 1 are satisfied). Conversely, avoid double counting; for example, a visit during which both a medical officer and a health services technician (in the same clinic) have been involved shall count as only one visit. Other examples of patient health care contacts occurring at the CGMTF which shall be included and counted as visits are:

(a) Each time a patient is seen in the CGMTF, even if referred elsewhere for admission.

(b) Each time a patient is seen in the CGMTF's urgent care room, or other designated area outside of regularly established clinic hours.

(c) Each time medical or dental advice or consultation is provided by telephone and is properly documented in the health care records. (See Note 1.)

(d) Each time a therapist provides primary care (e.g., patient assessment while serving in a physician extender role) and then refers a patient for specialized treatment in that same clinic, then one visit for primary care and one visit for treatment shall be counted.

(e) Each time an examination, evaluation, or treatment is provided in the home, school, community center, or other location outside the CGMTF by a staff member from the CGMTF.

(f) Subject to the provisions of Note 1, each time one of the following tasks is performed when not a part of routine medical care, and provided it is associated with a physical examination or treatment for a specific condition requiring follow-up: therapeutic or desensitization injections; cancer detection checks (e.g., PAP smears); blood pressure checks; weight checks; and new prescriptions (do not include refills).

(g) Each time a screening physical examination is performed (e.g., school or employment examination), providing an appropriate health record entry is made (See note 1).

(3) Nonvisits. DO NOT report the following as visits:

(a) Prescriptions from health care providers outside the CGMTF, chest x-ray surveys/examinations, laboratory tests, immunizations, or other diagnostic or screening test that are not part of a specific treatment.

(b) Furnishing of health care advice or information, either directly or by telephone, that does not satisfy the requirements of Note 1.

Note 1. The key to reporting visits is adequate documentation on appropriate medical records, e.g., SF-600, SF-513, and all records of treatment to support an audit trail. For example, "refill prescription for birth control pills" with date and signature of the health care provider is not sufficient. The entry should indicate that discussion of use of pills and counseling did take place, for example, "discussed with patient; no apparent problem with use-patient advised to have a PE and PAP prior to next request for renewal; 6 months prescription for ovulen given."

(c) Visits to other MTFs or private sector facilities, even when referred from the CGMTF. The CGMTF already receives credit for an OPV for the visit that generated the referral (see 6-B-1.c.(2)(a)).

2. Visit Profile (CG-5460B). This form must be used by all dependents and retirees who are signing into the health care treatment facility for treatment. It can also be used by active duty and civilian employees if they have previously been entered into the CLAMS database and do not need a duty status chit. If a visit profile form is started on a patient who turns out to need a duty status chit, discard the Visit Profile and start over on a Status-Profile. Visit Profile sheets should be used by most active duty patients for the dental clinic, most non-sickcall visits (except refill or filling outside prescription), health benefit visits, weight checks, follow-up lab testing, immunizations, allergy shots, audiogram, etc. See Figure 6-B-2.

a. Top Half. A new patient must fill out all information on the top half of the form. A staff member (front desk or provider) should carefully review the form completeness before the patient leaves the building since the patient cannot be properly entered into the data base without all of this information.

b. Top Left. Mechanical imprinting of the patient's name, if available; if not, the patient fills in. Reason For Visit box is optional and is provided for facility triage.

c. Date (top right) must be filled in at each visit.

d. Top Right. If mechanical imprinting was not used or if the addressograph card lacks some information, this section should be filled in at each visit. Otherwise, leave blank.

e. Bottom. The Third Party block is to be filled out by the clinic staff. Note that it includes dependent/retiree referral for inpatient care at a DOD facility.

f. Reverse. Blank except for Privacy act information and audit codes. This is a good place to put any addresses to which request for old medical records should be sent.

g. The bottom half of this form is virtually identical to the Status-Profile form. Refer to the Status-Profile form instructions for these sections.

3. U.S. Coast Guard Health Care Equipment Request (CG-5211). Definitions for major and minor health care equipment, health care equipment procurement procedures, and the criteria used to approve health care equipment requests are described below.

a. Definitions.

(1) Major health care equipment. Any item of health care equipment which meets the following criteria:

(a) costs $1000.00 or more;

(b) does not lose its identity when installed or placed into service; and

(c) has a life expectancy of one year or more.

(2) Minor health care equipment. Health care equipment that costs at least $300.00, but less than $1000.00, and meets the criteria described above.

b. Health Care Equipment Requests.

(1) Major Health Care Equipment. Units shall submit requests for major health care equipment on form CG-5211 (see Figure 6-B-3) the appropriate MLC (K). If the MLC (K) is unable to evaluate the CG-5211 within 15 working days of receipt, MLC (K) shall notify the commanding officer of the requesting unit regarding the delay. Each MLC (K) shall review the request and provide a forwarding endorsement that, as a minimum, addresses the following areas:

(a) how the equipment is or is not appropriate for the requesting health care facility;

(b) why the purchase is or is not cost effective; and

(c) how the equipment will or will not impact on the quality of patient care.

(2) Commander MLC(k) will evaluate major health care equipment requests, and within 30 days of receipt of the CG-5211, will notify the unit that one of the following actions will be taken:

(a) purchase of the requested equipment;

(b) purchase of a substitute item of a different make or model in order to standardize health care equipment and/or ensure cost effectiveness;

(c) or return the request via the chain of command with an explanation of why the equipment request was disapproved.

(3) Minor Health Care Equipment. Units shall submit requests for minor health care equipment, using form CG-5211, to the appropriate MLC (K). If the MLC (K) is unable to evaluate the CG-5211 within 15 working days of receipt, the MLC (K) shall notify the commanding officer of the requesting unit regarding the delay. Commanders (k), MLCs may disapprove the request or approve the request and provide funding.

(4) Health care equipment costing less than $300.00 is a unit responsibility and shall be purchased using unit funds.

(5) Emergency Procurement. A request for an emergency procurement may be relayed to the appropriate MLC (K) by telephone, followed by a faxed copy of a completed form CG-5211.

c. Criteria for Approval of Health Care Equipment Requests.

(1) Factors For Replacing Equipment. The fact that an item of health care equipment is approaching, or has passed, its normal life expectancy is not considered sufficient cause for replacement in and of itself. Units that request replacement equipment shall provide justification on the CG-5211. Factors which are considered sufficient cause for equipment replacement include:

(a) documented unreliability of equipment, demonstrated by unusual maintenance expenses or high frequency of repairs;

(b) excessive repair costs, onetime or repetitive; or

(c) equipment is obsolete and new technology exists that reduces pain and discomfort, improves treatment, increases diagnostic accuracy, significantly reduces costs by conserving personnel, supplies, or utilities, or increases efficiency by reducing patient treatment time.

(2) Factors For Initial Procurement. Due to changes in the beneficiary population or unit mission, a health care facility may require health care equipment not previously held by that facility. Units requesting an initial procurement shall provide justification of form CG-5211.

4. Health Record Receipt Form (NAVMED 6150/7). The Health Record Receipt Form shall be used as a permanent record of receipt and disposition of health records which are maintained at Coast Guard health care treatment facilities.

   a. Detailed instructions.

      (1) For each health record maintained at Coast Guard facilities, complete the first four lines of a Health Record Receipt form and place into the health record folder.

      (2) Whenever the health record is temporarily removed from the files, complete the charge-out information required on the bottom half of the Health Record Receipt, and retain in the health record file where that record is normally kept. Return the Health Record Receipt to the record when it is returned to the file.

      (3) When a member departs from a unit on permanent change of station, or TAD for over 30 days, forward their health record to servicing PERSRU for transmittal to gaining PERSRU.

         (a) When the record is forwarded, enter the following in the "REMARKS" section of NAVMED 6150/7:
         Date _____.
         Health record mailed to servicing PERSRU this date.
         _____.
         HS's Signature

         (b) Cut the form at the double lines above the "INSTRUCTIONS" section, and maintain the top section on file for two years.

5. Referral for Civilian Medical Care (DD-2161). This dual-purpose form shall be used to refer non-active duty patients from Coast Guard facilities to nonfederal facilities, either for supplemental health care or when the patient is disengaged from care. The DD-2161 will also be used to disengage non-Coast Guard active duty patients from Coast Guard facilities when the scope of care is beyond the ability of the Coast Guard to provide such care. The Coast Guard facility shall contact the parent service to ensure the active duty patient has the proper direction on where to obtain necessary care. A signed DD-2161 disengaging the patient will accompany the patient when he departs the Coast Guard facility and a copy shall be kept on file. When used to refer patients for supplemental health care, include a copy with the CG-5534 when the invoice for care is submitted for payment. Complete appropriate sections on top and reverse of form when disengaging a patient from care. Maintain a file of copies of completed forms.

6. Health Services Log. Each unit with health services personnel shall maintain a Health Services Log. This log is used to document the daily operations of the clinic or sickbay. At a minimum it is used to record all individuals reporting to sick call or for treatment, inspections and inventories conducted, and the results of potable water test.

a. Sickbays and clinics shall submit the Health Services Log to the commanding officer for review, approval, and signature on a schedule to be determined by the commanding officer.

b. The patient listing portion of the Health Services Log can be produced by CLAMS. At a minimum it must contain the name of patient, date of visit, Division or Department, members unit OPFAC (for active duty Coast Guard only), and branch of service.

7. Binnacle List. The Binnacle List can be produced by CLAMS. At a minimum it must be sorted by OPFAC and Department/Division and include patient name, diagnosis (command discretion), status, date of onset of status, and duration of status or date of status expiration. The Binnacle Lists(s) shall be distributed to local command(s) as determined by the health care facility command.

8. Adult Preventive and Chronic Care Flowsheet Form (DD2766). This form should replace the now obsolete Summary of Care Form (NAVMED 6150/20) as a means of documenting significant chronic health problems, allergies, chronic medications, hospitalizations/surgeries, health counseling, immunizations, PPD, DNA & HIV testing screening (preventive medicine) exams, other medical readiness items (such as blood type, G6PD, sickle cell, glasses, dental exams, etc.), and chart audits. Medical officers should familiarize themselves with the use of this form prior to its widespread use at their clinics. It is recommended that an in training session be provided to all medical providers at the CG clinic, before the forms are placed in the health records. The old Problem Summary List presently used on the Coast Guard AD health records can then be removed after the information contained in it is copied onto the DD2766 form. The process to complete this form is mostly self-explanatory. Only three items contained in this form do not apply to the Coast Guard. These items, which are located on page 3, are 8.a, 10.e, and 10.i. Only a pencil shall be used to darken the circles present on the flow chart of page 2 section 7. Item 11, located on page 3, is used to document the completion of the pre & post deployment questionnaires that are required for CGAD members who deploy with DOD. The medical officer should enter the location and date of every deployment that the AD member participates in.

Figure 6-B-1

DEPARTMENT OF TRANSPORTATION
U.S. COAST GUARD
CG-5460A (Rev. 9-92)

**STATUS PROFILE**

*PRINT OUT ON CARBONLESS PAPER*
*New Patient Information and Privacy Act Statement on Page 2*

DATE: Month ___ Day ___ Year ___

NAME: Last ___ First ___ MI ___

SPONSOR'S SOCIAL SECURITY NUMBER: ☐☐☐ ☐☐ ☐☐☐☐ Active ☐ Civilian Employee ☐

Purpose of Visit

NEW PATIENTS: Please complete information on reverse side

- CLINIC USE ONLY BELOW THIS LINE -

**DUTY STATUS**

☐ FIT FOR FULL DUTY
☐ OK DIF/DUNKER/CHAMBER
☐ LIMITED DUTY For _____ Day (s)
☐ NOT FIT FOR DUTY For _____ Day(s)
☐ SIQ
☐ Inpatient

LIMITATIONS
- ☐ Desk Work Only
- ☐ Grounded
- ☐ No Sports or PT
- ☐ No Boat or Sea Duty
- ☐ No Prolonged Standing or Walking
- ☐ Work Hours as Tolerated
- ☐ No Climbing
- ☐ No Lifting Over ☐ Pounds
- ☐ No Use of:
- ☐ Other

DIAGNOSIS
- S ☐
- O ☐
- M ☐
- A ☐

RETURN TO CLINIC: Month ___ Day ___ Time ___
☐ Return to clinic as needed for follow-up
☐ Flight Surgeon evaluation required for return to duties involving flight

SIGNATURE

**MEDICAL OPV(s)**

| Provider's initials | | |
|---|---|---|
| | | Limited Visit (0-15) |
| | | Intermediate (15-30) |
| | | Extended (>30) |
| | | Audit Code (s) |
| | | After Hours OPV |
| | | Lac Repair/Cast/Splint |
| | | Biopsy |
| | | Narrative Summary |
| | | Pap |
| | | Telephone OPV |
| | | Routine Exam |
| | | Subst/Overseas |
| | | OMMP Basic Exam |
| | | Command Afloat |

**NON-OPV** ☐

| | | |
|---|---|---|
| | | Audit Code (s) |

ACCIDENT/THIRD PARTY
☐ Check if this accident could result in a third party claim.

| FED | REFERRALS | NFED |
|---|---|---|
| | Alcohol | |
| | Dental D E P O S K | |
| | Dermatology | |
| | Emergency | |
| | ENT | |
| | Eye | |
| | General Practice | |
| | GYN/OB | |
| | Internal Medicine | |
| | Mammogram | |
| | Mental Health | |
| | Orthopedics | |
| | Other | |
| | Pediatrics | |
| | Physical Therapy | |
| | Surgery | |

**TICKLER UPDATE**

| | |
|---|---|
| | Audiogram |
| | PPD/CXR for TBC |
| | HIV |
| | Influenza |
| | Tetanus/Diptheria |
| | Yellow Fever |

**DENTAL OPV(s)**

| | |
|---|---|
| | OPV Caregiver |
| | Prophy Giver |
| | Annual Exam |
| | Emergency |
| | Restoration (s) |
| | Surfaces (s) |
| | Root Canal (s) |
| | Pulpotomy (ies) |
| | Impaction (s) |
| | Extraction (s) |
| | Other Surg/Quad |
| | Non-Surg Perio/Quad |
| | Sealant (s) |
| | Treatment Appliances/Arch |
| | Denture Partial/Full/Arch |
| | Cast Unit (s) |
| | Acid Etch Unit (s) |
| | After Hours OPV |
| | Telephone OPV |
| | Audit Code |

Class
Dx Minutes
PSR Total
Biopsy

MISC.
1. ___
2. ___
3. ___

PREVIOUS EDITION MAY BE USED

Figure 6-B-1 (reverse)

Page 2 CG-5460A (Rev. 9-92)

## AUDIT CODES

**AG** -- Acute Gastroenteritis
**AV** -- Abnormal Vaginal Bleeding
**BA** -- Bronchial Asthma
**BM** -- Breast Mass
**BS** -- Blood in Stool
**CH** -- Cholesteral Problem
**CP** -- Chest Pain
**DE** -- Depression
**DM** -- Diabetes Mellitus
**DY** -- Dyspepsia
**FP** -- Failed Procedure/Retreatment
**HA** -- Headache
**HE** -- Hematuria
**HI** -- Head Injury
**IP** -- Infection-Postop
**HT** -- Hypertension
**LB** -- Low Back Pain
**MS** -- Minor Surgery
**OM** -- Otitis Media
**PF** -- Pediatric Febrile Illness
**PP** -- Pelvic Pain
**PY** -- Pyoderma
**SI** -- Sinusitisn
**ST** -- Strep Throat
**TD** -- Thyroid Disorder
**TM** -- TMJ Problem
**UR** -- URI
**UT** -- Urinary Tract Infection
**WC** -- Well Child Exam
**WP** -- Wisdom Tooth Problem

**NEW PATIENT INFORMATION**

**ACTIVE DUTY (All Services) AND CIVILIAN EMPLOYEES**

**SERVICE** USCG ☐ USA ☐ USN ☐ USAF ☐ USMC ☐ OTHER

**UNIT**

**ADDRESS**
Street

City

State Zip

**PHONE** Home: ( ) Work: ( )

**DEPT/DIVISION**

**CHECK AS APPROPRIATE**
☐ Hearing Conservation Program
☐ Command Afloat
☐ Landing Signal Officer
☐ Civilian Employee
☐ Male
☐ Female
☐ Alert Force
☐ Aviation
☐ OMMP

DATE OF BIRTH: Month _____ Year ____

**DRUGS ALLERGY/REACTION**
1. _____ 2. _____
3. _____ 4. _____ 5. _____

**PRIVACY ACT STATEMENT**

1. Authority for collection of the information is Title 5, 10 and 14 United States Code and Executive Order 9397.
2. Principle Purpose(s) for which information is intended to be used is the documentation of your health care. The SSN is required to identify authorized beneficiaries and retrieve health records.
3. The routine uses will be to plan and coordinate future health care needs through the use of data collection.
4. Disclosure of the information is mandatory because of the need to document all active duty medical incidents and for all other personnel/beneficiaries to document their eligibility. If the requested information is not furnished, comprehensive health care will not be possible. Emergency/Urgent health care will not be denied.

Figure 6-B-2

DEPARTMENT OF TRANSPORTATION
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**VISIT PROFILE**

*See Privacy Act Statement on Page 2*

DATE: Month Day Year

**NAME**: Last First MI

**SPONSOR'S SOCIAL SECURITY NUMBER**

**SPONSOR'S STATUS**
- ☐ Active Duty
- ☐ Retired
- ☐ Reservist
- ☐ Civilian Employee
- ☐ Non-Beneficiary

**DEPENDENT'S INFO**
Sponsor: ☐ Active ☐ Retired
- ☐ Spouse
- ☐ Child (circle birth order) 1 2 3 4 5 6 ____
- ☐ Unremarried Former Spouse
- ☐ Sponsor's Parent/In-Law

**PURPOSE OF VISIT**

**NEW PATIENT'S INFORMATION:**

**DATE OF BIRTH** Month ____ Day ____ Year ____

**LIST ANY DRUG ALLERGY OR DRUG REACTION**
1. 4.
2. 5.
3. 6.

Check what time period you intend to use (any) clinic service(s) in the future.
- ☐ One time visit
- ☐ Less than 6 months
- ☐ More than 6 months

**SERVICE**
- ☐ USCG
- ☐ USA
- ☐ USN
- ☐ USAF
- ☐ USMC
- ☐ OTHER

**ADDRESS**
Street
City
State Zip

**PHONE** Home ( ) Work ( )

Do you have medical insurance other than CHAMPUS? ☐ Yes ☐ No

**- CLINIC USE ONLY BELOW THIS LINE -**

**MEDICAL OPV(s)**

Provider's initials

- Limited Visit (0-15)
- Intermediate (15-30)
- Extended (>30)
- Audit Code (s)
- After Hours OPV
- Lac Repair/Cast/Splint
- Biopsy
- Narrative Summary
- Pap
- Telephone OPV
- Routine Exam
- Subst/Overseas
- OMMP Basic Exam
- Command Afloat

**NON-OPV**

- Audit Code (s)

**ACCIDENT/THIRD PARTY**
☐ Check if this accident could result in a third party claim.

| FED | REFERRALS | NFED |
|---|---|---|
| | Alcohol | |
| | Dental D E P O S K | |
| | Dermatology | |
| | Emergency | |
| | ENT | |
| | Eye | |
| | General Practice | |
| | GYN/OB | |
| | Internal Medicine | |
| | Mammogram | |
| | Mental Health | |
| | Orthopedics | |
| | Other | |
| | Pediatrics | |
| | Physical Therapy | |
| | Surgery | |

**TICKLER UPDATE**
- Audiogram
- PPD/CXR for TBC
- HIV
- Influenza
- Tetanus/Diptheria
- Yellow Fever

**DENTAL OPV(s)**

- OPV Caregiver
- Prophy Giver
- Annual Exam
- Emergency
- Restoration (s)
- Surfaces (s)
- Root Canal (s)
- Pulpotomy (ies)
- Impaction (s)
- Extraction (s)
- Other Surg/Quad
- Non-Surg Perio/Quad
- Sealant (s)
- Treatment Appliances/Arch
- Denture Partial/Full/Arch
- Cast Unit (s)
- Acid Etch Unit (s)
- After Hours OPV
- Telephone OPV
- Audit Code

- Class
- Dx Minutes
- PSR Total
- Biopsy

**MISC.**
1.
2.
3.

PREVIOUS EDITION MAY BE USED

Figure 6-B-2 (reverse)



**PRIVACY ACT STATEMENT**

1. Authority for collection of the information is Title 5, 10 and 14 United States Code and Executive Order 9397.
2. Principle Purpose(s) for which information is intended to be used is the documentation of your health care. The SSN is required to identify authorized beneficiaries and retrieve health records.
3. The routine uses will be to plan and coordinate future health care needs through the use of data collection.
4. Disclosure of the information is mandatory because of the need to document all active duty medical incidents and for all other personnel/beneficiaries to document their eligibility. If the requested information is not furnished, comprehensive health care will not be possible. Emergency/Urgent health care will not be denied.

## AUDIT CODES

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**DM** -- Diabetes Mellitus
**DY** -- Dyspepsia
**FP** -- Failed Procedure/Retreatment
**HA** -- Headache
**HE** -- Hematuria
**HI** -- Head Injury
**IP** -- Infection-Postop
**HT** -- Hypertension
**LB** -- Low Back Pain
**MS** -- Minor Surgery
**OM** -- Otitis Media
**PF** -- Pediatric Febrile Illness
**PP** -- Pelvic Pain
**PY** -- Pyoderma
**SI** -- Sinusitisn
**ST** -- Strep Throat
**TD** -- Thyroid Disorder
**TM** -- TMJ Problem
**UR** -- URI
**UT** -- Urinary Tract Infection
**WC** -- Well Child Exam
**WP** -- Wisdom Tooth Problem

Figure 6-B-3

| DEPARTMENT OF TRANSPORTATION<br>U.S. COAST GUARD<br>CG 5211 (REV.1-93) | **U.S. COAST GUARD HEALTH CARE EQUIPMENT REQUEST**<br>*(This form may be typed or handwritten.)* |
|---|---|

**A. UNIT INFORMATION**: THIS SECTION IS TO BE COMPLETED BY THE REQUESTING UNIT

| UNIT: | OPFAC: |
|---|---|

| EQUIPMENT TO BE REPLACED: | MANUFACTURER;<br>MODEL: | REPAIR<br>COST:_____ |
|---|---|---|
| ACQUISITION DATE: | | |

PLANNED REPLACEMENT ☐ EMERGENCY REPLACEMENT ☐ NEW REQUIREMENT ☐

SUPPLY SOURCE:

FEDERAL STOCK SYSTEM ☐ GSA /VA CONTRACT ☐ OPEN MARKET ONLY ☐

| EQUIPMENT REQUESTED: | MANUFACTURE:<br><br>MODEL: | EQUIPMENT COSTS:<br>_____ |
|---|---|---|
| ACCESSORIES: 1. _____ 2. _____ 3. _____<br>MODEL: _____ _____ _____<br>SERIES: _____ _____ _____ | | ACCESSORY COST:<br>_____ |
| ARE THERE ANY INSTALLATION COST? YES ☐ NO ☐<br>ARE THERE ANY UNUSUAL REQUIREMENTS? YES ☐ NO ☐ | | INSTALLATION COSTS:<br>_____ |
| MANUFACTURE'S ADDRESS: _____<br>_____<br>POC:_____ TELEPHONE NO:_____ | | TOTAL COST:<br>_____ |

COMMENTS: (*IF A REPLACEMENT, EXPLAIN WHY EXISTING EQUIPMENT NO LONGER SATISFIES REQUIREMENTS. IF NEW REQUIREMENT, PROVIDE FULL JUSTIFICATION.)*

| SIGNATURE OF PREPARER: | DATE | SIGNATURE OF COMMANDING OFFICER: | DATE: |
|---|---|---|---|

Figure 6-B-3 (Reverse)

| **B. COMMANDER, MAINTENANCE AND LOGISTICS COMMAND** | | |
|---|---|---|
| MINOR HEALTH CARE EQUIPMENT | APPROVED ☐ | DISAPPROVED ☐ |
| COMMENTS: | | |
| SIGNATURE OF APPROVED OFFICER: | | DATE: |
| MAJOR HEALTH CARE EQUIPMENT | RECOMMENDED ☐ | NOT RECOMMENDED ☐ |
| COMMENTS: | | |
| SIGNATURE OF REVIEWING OFFICER: | | DATE: |

| **C. COMMANDANT (G-KRM)** | APPROVED ☐ | DISAPPROVED ☐ |
|---|---|---|
| COMMENTS: | | |
| SIGNATURE OF APPROVING OFFICER: | | DATE: |

# CHAPTER 7

# PREVENTIVE MEDICINE

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# CHAPTER 7. PREVENTIVE MEDICINE

## Section A - General

1. Scope. The scope of preventive medicine involves all activities that prevent illness and disease, including immunization; communicable disease control; and epidemiology.

2. Responsibility.

   a. The unit medical officer is responsible to the commanding officer for implementing all directives issued by the Commandant which relate to the health of members of the command. Additionally, the medical officer shall continually evaluate the command's health care capabilities to fulfill Occupational Medical Surveillance and Evaluation Program (OMSEP) requirements. The command shall execute those procedures it can perform as the Commandant requires. Deficiencies in capabilities shall be made known in writing to the commanding officer with alternative plans for accomplishments recommended.

   b. Preventive medicine technicians are skilled, highly trained individuals, experienced in preventive medicine. If assigned or available to a unit, that unit shall fully use their services.

3. Preventive Medicine Practices.

   a. Develop and supervise a definite, adequate environmental health program to prevent disease and maintain the Commandant's established sanitation standards;

   b. Observe the incidence of disease or disability in personnel and, when indicated, in adjacent communities;

   c. Use epidemiological methods to determine the cause of such disease, especially when an unusual or high incidence is discovered;

   d. Recommend measures to minimize or remove the causes of disease; and maintain effective liaison with civilian health agencies; Army, Air Force, Navy, and Public Health Service preventive medicine components; and with other command officers and components.

4. Availability of Consultative Services. Request MLC (kse) for special technical advice, surveys, or investigation through appropriate channels. If unusual conditions or circumstances requiring special attention arise, submit a special report through the appropriate chain of command to Commandant (G-WK).

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Section B Communicable Disease Control.

1. General.

   a. The health services department representative is responsible for:

      (1) Recognizing communicable diseases;

      (2) Recommending preventive and control measures to the commanding officer;

      (3) Submitting required reports; and

      (4) Complying with state and local health department reporting requirements.

   b. The reference documents in this area are:

      (1) *Control of Communicable Diseases in Man*, current edition, American Public Health Association, 1740 Broadway, New York, NY 10019.

      (2) "Medical Environmental Disease Intelligence and Countermeasures" on CD-ROM (DI-1810-207-99, or current version) from Armed Forces Medical Intelligence Center (AFMIC), 1607 Porter Street, Fort Detrick, MD 21701-5004

      (3) Appropriate state and local laws and regulations.

2. Disease Outbreak.

   a. An outbreak is the occurrence in the command or surrounding community of a group of similar illnesses clearly in excess of the expected frequency and derived from a common or propagated source (e.g., streptococcal diseases, upper respiratory infections, influenza, etc.). The number of cases indicating the presence of an outbreak varies according to the agent; size and type of population exposed; previous experience or lack of exposure to the disease; and the time and place of occurrence.

   b. On recognizing an outbreak the health services department representative shall:

      (1) Inform the commanding officer and recommend preventive and control measures;

      (2) Investigate to determine the source of the agent and how it was spread; and

      (3) Send a message RCN 6000-4, Disease Alert Report, if the outbreak may:

         (a) Affect operational readiness;

         (b) Pose a threat to the community;

         (c) Pose a threat to another command (e.g., through transfer of personnel); or

         (d) Be of such political or journalistic significance that inquiry might be made of higher commands.

3. RCN 6000-4, Disease Alert Report.

a. Circumstances Requiring Reports.

(1) An outbreak meets any of the criteria above;

(2) Any person is diagnosed as having a disease listed in Figures 7-B-1 or 7-B-2;

(3) Epizootics of diseases transmissible from animals to man on or near the reporting activity;

(4) A Coast Guard vessel or aircraft is quarantined at a foreign port;

(5) Health services department personnel deem a condition worthy of reporting; or

(6) Conditions legally mandated by local health jurisdiction to be reported.

b. Initial Report.

(1) If the outbreak/disease is of urgent nature , submit the initial report by telephone, followed up by rapidraft letter to MLC (k), who will report the occurrence to G-WKH. If the outbreak is not urgent in nature, submit only rapidraft letter to Commandant (G-WKH) through MLC (k). Additional information addressees shall include:

(a) District commander(s) involved;

(b) Commanding officer of the patient'(s) unit(s); and

(c) Other affected commands, including the appropriate Surgeon General and unit command if other service personnel are involved.

(2) Use the format in Figure 7-B-3 for all Disease Alert Reports.

(3) Report to local public health department as required by law.

c. Progress Reports. Submit progress reports as appropriate to inform the initial report's addressees of progress, change, or other significant developments.

d. Final Report (required for outbreaks). Submit to Commandant (G-WKH) through the appropriate chain of command, a final letter report, which must contain this information:

(1) Number of disease cases, both total and by hour, day, or week;

(2) Numbers of deaths, persons permanently disabled, and staff days lost from work;

(3) Causal or contributory factors, including the recent itinerary of vessels, aircraft, and other mobile units;

(4) Control measures taken and their effectiveness; and

(5) Recommendations to prevent or ameliorate similar future outbreaks.

4. Sexually Transmitted Disease Responsibilities.

a. Health services department shall provide a coordinated, comprehensive sexually transmitted disease control program including:

(1) Educational programs;

(2) Contact investigation, reporting, and treatment if the contacts are eligible for care;

(3) Completing and submitting Contact Interview Form (Figure 7-B-4);

(4) Annotating and maintaining health records properly.

b. Senior Medical Officer (SMO). The senior medical officer oversees the medical management of the local disease control program; recommends disease control activities to the commanding officer; establishes and maintains liaison with local health authorities to help detect and prevent sexually transmitted diseases (STDs); and ensures confidentiality of contact reports and patients names.

c. Medical Officer. The practitioner who first sees the patient shall perform diagnostic evaluation procedures. The provider must fill out SF-602, Syphilis Record, on ALL patients diagnosed as having syphilis and file this form in the patient's medical record. Test any patient treated for gonorrhea for syphilis and vice versa, and in both cases, also for HIV antibody. The provider must perform diagnostic evaluations; ensure proper analysis of urethral smears and dark field specimens; and identify organisms from material submitted for culture or serologic test. The syphilis serologic test (RPR, STS) is a general screening test. The FTA-ABS is a specific antibody test that detects *Treponema pallidum*. The medical officer is responsible for noting all STDs using ICD9CM codes on the NAVMED 6150/20.

d. Health Services Technician or Preventive Medicine Technician. A health services technician or preventive medicine technician assigned to administer the local STD control program should be pay grade E-5 or higher. The HS performs these actions:

(1) Interviews all STD patients for contact information;

(2) After the interview, annotates and signs the SF-600 in each STD patient's medical record to indicate he or she interviewed the patient and discussed symptoms, complications, treatments, and contacts;

(3) Instructs gonorrhea patients to return for a Test of Cure (TOC) in five days.

(a) Active duty personnel will report to regular sick call for TOC. Place a suspense notice to check with the attending medical officer to ensure the patient receives TOC;

(b) Gives dependents and retired personnel regular appointments for local STD control;

(4) Completes CDC 73.954, Contact Interview Form, on all STD patients and contacts;

(5) The first working day of each week, cross references all positive STDs from the clinic laboratory log book to ensure all STD patients have been contacted and interviewed.

5. Treatment. Treat STDs according to the most current recommendation of either the Armed Forces Epidemiologic Board or the Centers for Disease Control (CDC), USPHS, published in the Morbidity and Mortality Weekly Report (MMWR), Sexually Transmitted Diseases Treatment Guidelines, as appropriate.

6. Drug Prophylaxis. Drug prophylaxis for sexually transmitted disease prevention is prohibited.

7. Reporting.

a. Completing a CDC 73.954, Contact Interview Form.

(1) Prepare original and three copies as soon as possible after diagnosing a sexually transmitted disease. Figure 7-B-4 is a sample of the form.

(2) Execute a separate 4-part form for each contact in cases of multiple contacts

(3) Enter these data on the 3rd and 4th copies ONLY:

(4) Under "Name," enter also Social Security Number and rate or grade,

(5) Under "Home Address," enter also the unit to which the patient is attached.

(6) Enter the interviewer's name and unit mailing address on the back of all sheets. The interviewer signs the original.

(7) Disposition

(a) Within CONUS. The reporting unit retains the green copy on file and sends the original and pink copies to the state where the contact occurred. The reporting unit sends the yellow copy to MLC(k), which acts as the STD control officer for the area. MLC(k) will notify G-WKH-1 upon receipt of the yellow copy.

(b) Outside CONUS. To report contacts in foreign countries, send the original and pink copies with a transmittal letter to the consular office closest to the contact site to ask that office to send the forms to the proper health authorities. Send the yellow copy to MLC (k) of the unit's home district indicating where the original and pink copies were sent. The reporting unit files the green copy.

FIGURE 7-B-1

LIST OF REPORTABLE DISEASES

Key: All of the following conditions are required to be reported in the Coast Guard. Conditions with "X" in the column titled:

1. "Telephone" are the minimum conditions that must be telephoned to MLC(k);
2. "New" are those which are new requirements for the CG;
3. "Joint Svc" are those agreed upon by the DoD;
4. "CDC" have been listed by the Centers for Disease Control and Prevention as notifiable at the National Level.

| NOTIFIABLE CONDITION | Telephone | New | Joint SVC | CDC |
|---|---|---|---|---|
| AIDS (Acquired Immune Deficiency Syndrome) | X | | | **X** |
| Amebiasi | | | X | |
| Anthrax | X | | X | **X** |
| Biological warfare agent exposure | X | X | X | |
| Botulism | **X** | | **X** | **X** |
| Brucellosis (Undulent Fever) | | | **X** | **X** |
| Campylobacter(Active duty only) | | **X** | **X** | **X** |
| Chancroid | | | | **X** |
| Chlamydia | | **X** | **X** | **X** |
| Cholera | | | **X** | **X** |
| Coccidioidomycosis | | **X** | **X** | **X** |
| | | | | |
| Dengue | | | **X** | |
| Diptheria | | | **X** | **X** |
| | | | | |
| Encephalitis | **X** | | **X** | **X** |
| *Escherichia coli* O157:H7 | | X | X | X |
| | | | | |
| Food Poisoning (Call SMO if 5 or more persons are involved in any similar illness within a 24 hour period) | x | | | |
| Filariasis | | **X** | **X** | |
| Giardiasis | | **X** | **X** | |
| Gonorrhea | | | | |
| | | | | |
| Hemolytic uremic syndrome (post diarrheal) | | **X** | | **X** |
| Hemorrhagic Fever, specify type if known | **X** | | **X** | |
| Hepatitis A (Infectious) | **X** | | **X** | **X** |
| Hepatitis B (serum) | | | **X** | **X** |
| Hepatitis C (non-A non-B) | | | **X** | **X** |

| | | | | |
|---|---|---|---|---|
| Herpes, Genital | | | | |
| HIV Infection – Confirmed positive serology | **X** | | | |
| Influenza (AD only) | | **X** | **X** | |
| | | | | |
| Legionellosis | | | **X** | **X** |
| Leishmaniasis | | | **X** | |
| Leprosy (Hansen's Disease) | | | **X** | **X** |
| Leptospirosis (Weil's Disease) | | | **X** | |
| Lymphgranuloma Venereum | | | | |
| Malaria, specify type | **X** | | **X** | **X** |
| Measles (Rubeola) | | | **X** | **X** |
| | | | | |
| Meningococcal disease | **X** | **X** | **X** | **X** |
| | | | | |
| Mumps | | | **X** | **X** |
| | | | | |
| Occupational Disease (See Figure 7-B-2) | | | | |
| | | | | |
| Pertussis (Whooping Cough) | | | **X** | **X** |
| Plague | **X** | | **X** | **X** |
| Pneumococcal pneumonia (AD only) | | **X** | **X** | |
| Poliomyelitis, Paralytic | | | **X** | **X** |
| | | | | |
| Psittacosis | | | | **X** |
| Q-fever | **X** | | **X** | |
| Rabies, human | **X** | | **X** | **X** |
| Rabies, animal | | | **X** | **X** |
| | | | | |
| Rheumatic Fever (Acute)(Active duty only) | **X** | | **X** | |
| Rift Valley Fever | | **X** | **X** | |
| Rocky Mountain Spotted Fever | | | **X** | **X** |
| Rubella (German Measles) | | | **X** | **X** |
| Salmonellosis | | | **X** | **X** |
| | | | | |
| Schistosomiasis | | **X** | **X** | |
| Shigellosis | | | **X** | **X** |
| Smallpox (Variola) | **X** | | **X** | |
| Syphilis (including congenital) | | | **X** | **X** |
| Tetanus | | | **X** | **X** |
| Toxic shock syndrome | | **X** | **X** | **X** |
| | | | | |
| Trichinosis | | | **X** | **X** |
| Trypanosomiasis | | **X** | **X** | |

| | | | | |
|---|---|---|---|---|
| Tuberculosis (including clusters of new PPD converters) | **X** | **X** | **X** | **X** |
| Tularemia | **X** | | **X** | |
| Typhoid Fever | | | **X** | **X** |
| | | | | |
| Typhus Fever | | | **X** | |
| Varicella (Active duty only) | | **X** | **X** | |
| Yellow Fever | | | | |

Also, report unusual outbreaks of any disease.

FIGURE 7-B-2

**LIST OF REPORTABLE OCCUPATIONAL DISEASES**

| ICD-9-CM TERM | ICD-9-CM CODE | CMIT SYNONYM/ ANALOGUE | CMIT TEXT | CMIT ID NUMBER | |
|---|---|---|---|---|---|
| DUST DISEASES OF THE LUNG | | | | | |
| Coal Workers' Pneumoconiosis | 500 | Anthracosis | 46 | 03 | 4678 |
| Asbestosis | 501 | Asbestosis | 62 | 03 | 4198 |
| Silicosis | 502M | Silicosis | 633 | 03 | 4626 |
| Talcosis | 502M | Pneumoconiosis, Talc | 556 | 03 | 5935 |
| Chronic Beryllium Disease of the Lung | 503M | Beryllium Disease Chronic | 77 | 03 | 2612 |
| Byssinosis | 504 | Byssinosis | 107 | 03 | 4073 |
| POISONING (Systemic Toxic Reactions) | | | | | |
| Hemolytic Anemia, Non-Autoimmune | 283.1 | Anemia, Hemolytic Acquired, Physical, Chemical Agents | 31 | 05 | 4225 |
| Aplastic Anemia | 284.8 | Anemia, Aplastic | 29 | 05 | 3322 |
| Agranulocytosis Or Neutropenia | 288.0 | Agranulocytosis | 17 | 05 | 2863 |
| Methemoglobinemia | 289.7 | Methemoglobinemia | 440 | 05 | 3295 |
| Toxic Encephalitis | 323.7 | Encephalitis, Hemorrhagic, Acute | 207 | 09 | 4982 |

| | | | | | |
|---|---|---|---|---|---|
| PARKINSON'S DISEASE SYNDROME (Secondary) | 524 | 332.1 09 | PARKINSONIAN 4071 | | |
| Parkinson's Disease (Secondary) | 332.1 | Maganese Poisoning | 424 | 09-03 | 5963 |
| Cerebellar Ataxia | 334.3 | Ataxia, Cerebellar, | 64 | 09 | 3287 |
| | ACUTE | | | | |
| Inflammatory and Toxic Neuropathy | 357.7 | Neuropathy | 475 | 09 | 2307 |
| Cataract | 366.4E | Cataract, Toxic | 118 | 10 | 4532 |
| Toxic Hepatitis | 570<br>573.3 | Hepatitis<br>Chemical-Induced Toxicity | 303 | 06 | 2008 |
| Acute Renal Failure | 584 | Kidney, Failure, Acute | 367 | 07 | 2229 |
| Chronic Renal Failure | 585 | Kidney Failure, Chronic | 367 | 07 | 3028 |
| Toxic Effects of Methyl Alcohol | 980.1 | Methyl Alcohol Poisoning | 440 | 00 | 1097 |
| Toxic Effects of Gasoline or Petrol | 981 | Gasoline, Non-Leaded Poisoning | 259 | 00 | 4355 |
| Toxic Effects of Benzene and Homologues | 982.0 | Benzene, Poisoning | 76 | 00 | 1941 |
| Toxic Effects of Carbon Disulfide | 982.2 | Carbon Disulfide | 112 | 00 | 1042 |
| Toxic Effects of Solvents Other than Petroleum-based, Other | 982.8 | Methyl Ethyl Ketone Poisoning | 441 | 00 | 3427 |
| Toxic Effects of Corrosive Aromatics | 983.0 | Nitrobenzene Poisoning | 482 | 00 | 1416 |
| Toxic Effects of | 983.0 | Aniline Poisoning | 44 | 00 | 2662 |

| | | | | | |
|---|---|---|---|---|---|
| Corrosive Aromatics | | | | | |
| Toxic Effects of Corrosive Acids | 983.1 | Nitric Acid Poisoning | 481 | 00 | 1255 |
| Toxic Effects of Caustic Alkalis | 983.2 | Alkali Poisoning | 20 | 00 | 3087 |
| Toxic Effects of Mercury and its Compounds | 985.0 | Mercury Poisoning | 439 | 00 | 5512 |
| Toxic Effects of Arsenic and its Compounds | 985.1 | Arsenic Poisoning | 55 | 00 | 2946 |
| Toxic Effects of Arsenic and its Compounds | 985.1 | Arsine Poisoning | 56 | 00 | 5897 |
| Toxic Effects of Cadium and its Compounds | 985.5 | Cadium Poisoning | 107 | 00-03 | 5768 |
| Toxic Effects of Other Metals | 985.8 | Thallium Poisoning | 681 | 00 | 2910 |
| Toxic Effects of Other Metals | 985.8 | Silver Poisoning | 633 | 00 | 4660 |
| Toxic Effects of Other Metals | 985.8 | Zinc Chloride Poisoning | 752 | 00 | 3606 |
| Brass-Founders' Ague | 985.8 | Metal Fume Fever | 440 | 00 | 5749 |
| Toxic Effects of Carbon Monoxide | 986 | Carbon Monoxide Poisoning | 112 | 00 | 3938 |
| Toxic Effects of Other Hydrocarbon Gas | 987.1 | Methane Poisoning | 440 | 00 | 3425 |
| Toxic Effects of Chlorine Gas | 987.6 | Chlorine Poisoning | 129 | 00 | 3486 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Oxygen Poisoning | 511 | 00 | 3825 |
| Toxic Effects of | 987.8 | Ozone Poisoning | 511 | 00 | 3104 |

| | | | | | |
|---|---|---|---|---|---|
| Gases, Fumes or Vapors | | | | | |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Phosgene Poisoning | 545 | 00 | 3105 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Toluene Diisocyanate Poisoning | 694 | 00 | 2770 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Toluene Poisoning | 694 | 00 | 2098 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Acetone Poisoning | 6 | 00 | 3216 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Ammonia Poisoning | 25 | 00 | 5589 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Carbon Tetrachloride Poisoning | 113 | 00 | 3192 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Diobrane Poisoning | 181 | 00 | 4845 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Fluorine and Compounds Poisoning, Acute | 248 | 00 | 4521 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Fluorine and Compounds Poisoning, Chronic | 248 | 00 | 2119 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Hydrogen Sulfide Poisoning | 319 | 00 | 4331 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Hydrofluoric Acid Poisoning | 319 | 00 | 5607 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Methyl Chloride Poisoning | 441 | 00 | 5093 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Methyl Bromide Poisoning | 441 | 00 | 5404 |
| Toxic Effects of Gases, Fumes or Vapors | 987.8 | Carbon Dioxide Poisoning | 112 | 00 | 3107 |
| Toxic Effects of | 987.9 | Phosphine Poisoning | 546 | 00 | 2433 |

Gases, Fumes or Vapors

| | | | | | |
|---|---|---|---|---|---|
| Toxic Effects of Hydrocyanic Acid Cyanides | 989.0 | Cyanide Poisoning | 161 | 00 | 3541 |
| Toxic Effects of Chlorinated Hydrocarbons | 989.2 | Toxaphene Poisoning | 697 | 00 | 1926 |
| Toxic Effects of Organiphosphate and Carbanate | 989.3 | Phosphate Ester Insecticide Poisoning | 546 | 00 | 2457 |

RESPIRATORY CONDITIONS DUE TO TOXIC AGENTS

| | | | | | |
|---|---|---|---|---|---|
| Extrinsic Asthma | 493.0 | Asthma, Bronchial | 64 | 03 | 4622 |
| Farmer's Lung | 495 | Farmer Lung | 236 | 03 | 4418 |
| Bagassosis | 495.1 | Bagassosis | 71 | 03 | 2403 |
| Bird Fanciers' Lung | 495.2 | Bird Breeder Disease | 80 | 03 | 1458 |
| Suberosis | 495.3 | Suberosis | 664 | 03 | 5383 |
| Maltworker's Lung | 495.4 | Maltowkrer Lung | 423 | 03 | 5485 |
| Mushroom Workers' Lung | 495.5 | Mushroom Picker Disease | 456 | 03 | 4796 |
| Maple Bark Strippers' | 495.6 | Maple Bark Stripper Disease | 425 | 03 | 2047 |
| Other Allergic Pneumonitis (Sequoiosis Or Red cedar Asthma) | 495.8 | Sequoiosis | 629 | 03 | 2269 |
| Acute Bronchitis Pneumonitis | 506.0 | Bronchitis, Acute | 101 | 03 | 2389 |
| Pulmonary Edema To Fumes and Vapors | 506.1 | Pulmonary Edema | 586 | 03 | 4190 |
| Other Pneumonitis Due to solids and liquids (detergent Asthma) | 507.8 | Pneumonia, Extrensic | 557 | 03 | 5650 |

| | | | | | |
|---|---|---|---|---|---|
| Raynaud's Phenomenon (Secondary) | 443.0 | Vibration Disease | 737 | 04 | 1428 |
| Cataract Associated With Other Disorders | 366.4 | Cataract, Heat Ray | 117 | 10 | 4527 |
| Cataract Associated With Other Disorders | 366.4 | Cataract, Irradiatiohn | 118 | 10 | 3538 |
| Noise Effects on Inner Ear | 388.1 | Hearing Disorder Sensorineural | 285 | 10 | 5433 |
| Radiation Sickness | 990 | Radiation, Accidental Reaction | 595 | 10 | 1287 |
| Heat Exhaustion Unspecified | 992.5 | Heat Exhaustion | 291 | 00 | 3421 |
| Heat Exhaustion Unspecified | 992.5 | Heat Cramp | 291 | 02 | 1321 |
| Heat Exhaustion Unspecified | 992.5 | Heat Stroke | 292 | 00 | 3483 |
| Other and Unspecified Effect Of High Altitude | 993.2 | Hypoxia | 341 | 00 | 1890 |
| Dysbarism | 993.3 | Dysbarism | 189 | 00 | 3279 |
| Dysbarism | 993.3 | Decompression Sickness | 169 | 00 | 4252 |
| Caisson Disease | 993.3 | Nitrogen, Narcotic Action | 482 | 00 | 1352 |
| Motion Sickness (from Travel, any Vehicle) | 994.6 | Motion Sickness | 448 | 00 | 2357 |

## SKIN DISEASES OR DISORDERS

| | | | | | |
|---|---|---|---|---|---|
| Contact and Allergic Dermatitis | 692 | Dermatitis, Contact | 173 | 01 | 1685 |
| Contact and Allergic Dermatitis | 692 | Dermatitis Atopic | 172 | 01 | 2124 |
| Contact and Allergic Dermatitis | 692 | Dermatitis | 172 | 01 | 4298 |

## ALL OTHER DISEASES

## REPRODUCTIVE DISORDERS

| | | | | | |
|---|---|---|---|---|---|
| Infertility, Male | 606 | Sterility, Male | 305 | 07 | 4761 |

## OCCUPATIONAL CANCERS

| | | | | | |
|---|---|---|---|---|---|
| Hemangiosarcoma Of the Liver | 155M | Hapatocarcinoma | 305 | 06 | 3133 |
| Hemangiosarcoma Of the Liver | 155M | Vinyl Chloride Poisoning | 738 | 06-02 | 5437 |
| Mesothelioma (MN of Peritoneum) | 158 | Ascites, Chylous | 62 | 06 | 1081 |
| Mesothelioma (MN of Peritoneum) | 158 | Peritonitis | 538 | 06 | 4415 |
| Malignant Neoplasm Of Nasal Cavities | 160.0 | Nose, Carcinoma | 483 | 03 | 2650 |
| Malignant Neoplasm Larynx | 161 | Larynx, Carcinoma Extrinsic | 382 | 03 | 1491 |
| Malignant Neoplasm Trachea, Bronchus and Lung | 162 | Lung, Carcinoma Bronchogenic | 410 | 03 | 1647 |

| | | | | | |
|---|---|---|---|---|---|
| Mesothelioma (MN of Pleura) | 163 | Pleura, Mesothelioma, Primary | 553 | 03 | 3834 |
| Malignant Neoplasm Of Bone | 170 | Osteogenic Sarcoma | 499 | 02 | 4950 |
| Malignant Neoplasm Of Scrotum | 187.7 | Scrotum, Carcinoma Epidermoid | 625 | 07 | 1490 |
| Malignant Neoplasm Of Bladder | 188 | Bladder, Carcinoma Epidermoid | 81 | 07 | 1469 |
| Malignant Neoplasm Of Kidney, Other and Unspecified Organs | 189 | Kidney, Pelvis, Carcinoma Transitional Cell | 371 | 07 | 1084 |
| Malignant Neoplasm Of Kidney, Other and Unspecified Organs | 189 | Kidney, Pelvis, Carcinoma Epidermoid | 371 | 07 | 1664 |
| Malignant Neoplasm Of Kidney, Other and Unspecified Organs | 189 | Kidney, Pelvis, Leukoplakia | 371 | 07 | 1780 |
| Malignant Neoplasm Of Kidney, Other and Unspecified Organs | 189 | Kidney, Leiomyosarcoma | 370 | 07 | 2506 |
| Malignant Neoplasm Of Kidney, Other and Unspecified Organs | 189 | Kidney, Leiomyoma | 370 | 07 | 3487 |
| Malignant Neoplasm Of Kidney, Other and Unspecified Organs | 189 | Ureter, Carcinoma | 716 | 07 | 2821 |
| Lymphoid Leukemia Acute | 204 | Leukemia, Lymphoblastic | 392 | 05 | 1922 |
| Lymphiod Leukemia Chronic | 204 | Leukemia, Lymphocytic Chronic | 393 | 05 | 3351 |
| Myeloid Leukemia Acute | 205 | Leukemia, Myeloblastic Acute | 393 | 05 | 2391 |

| | | | | | |
|---|---|---|---|---|---|
| Erythroleukemia | 207 | Leukemia, Myelocytic Chronic | 394 | 05 | 2363 |
| Erythroleukemia | 207 | Leukemia, stem cell | 394 | | |

FIGURE 7-B-3

**RCN 6000-4, DISEASE ALERT REPORT**

Telephone or submit rapidraft with the following information:

1. PATIENT.

    a. Last Name, First Name, Middle Initial
    b. Rate/Grade
    c. Branch of Service
    d. Social Security Number
    e. Date of Birth
    f. Race.
    g. Sex

2. UNIT ADDRESS.
3. DIAGNOSIS. By ICD-9-CM classification number.
4. CLINICAL HISTORY.
5. LABORATORY RESULTS.
6. TREATMENT AND PROGNOSIS.
7. EPIDEMIOLOGY INFORMATION. Provide all information of epidemiological significance to the case (e.g., contacts, prior treatment, immunizations, etc.)
8. COMMUNITY THREAT.
9. POINT OF CONTACT.
10. REPORTING. List other agencies (e.g., State health departments) notified of the case.

Figure 7-B-4

**Disease:** 1. [ ] 2. [ ]

**Note:** See the reverse side of page one of this record for the codes and the reverse side of pages two and three for an abbreviated set of instructions. See the full set of Interview Record instruction for further definition.

**Control Number** A

| Patient name (Last) | (First & Nicknames) | Case # | Inform ID |
|---|---|---|---|

| Home Address (Street) | City | Res. Co. | State | Zip Code | Home Phone |
|---|---|---|---|---|---|

| Date of Birth | Age | Race | Ethnicity | Sex | Pregnant | Pregnancy in Last 12 Months? |
|---|---|---|---|---|---|---|
| | | W B A/Pt At/An O/U | H Non-Hisp | M F | Y # wks N U | Y N U |

Method of Case Detection:
- [ ] Provider Referred to: _____
- [ ] Cluster _____
- [ ] Patient Referred to: _____
- [ ] Prenasal
- [ ] Delivery
- [ ] Insit. Screening
- [ ] Community Screening
- [ ] Reactor
- [ ] Provider Report
- [ ] Volunteer

Information Source [ ]

| Supv No. | Clinic Code | Medical Record No. |
|---|---|---|
| | | |

| Date Assigned | Assigned to Wkr: | Date Treated | Case IX'd | Interview Period |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |

| Period Partners | Sex | N/S | Both |
|---|---|---|---|
| | | | |
| | | | |

1. Pre-Test Counseled? Y N
2. Tested for HIV? Y N
3. Post-Test Counseled? Y N

Previous HIV Test: No P N I U
Date? _____
Provider: [ ]

Current HIV Test: No P N I U
Date? _____
Provider: [ ]

Since 1978 (Check all that apply)

| | Initial | Final |
|---|---|---|
| 1. Sex w/Male? | Y | Y |
| 2. Sex w/Female? | Y | Y |
| 3. Used IV Drugs? | Y | Y |
| 4. Hemophilia? | Y | Y |
| **Known Hetrosexual Relations w/:** | | |
| 5. IVDU? | Y | Y |
| 6. Bisexual Male? | Y | Y |
| 7. Person w/Hemophilia | Y | Y |
| 8. HIV Positive Transfusion Recip? | Y | Y |
| 9. Person w/Aids or HIV HIV Risk UNK? | Y | Y |
| 10. One Born in Pattern II | Y | Y |
| 11. Rec'd Blood Transfusion | Y | Y |
| 12. Worked in Health Care Setting? | Y | Y |
| 13. Sex for Drugs/Money? | Y | Y |

| Onset Date | Duration (Days) | Description | Lab Results Date | Test | Results | Treatment | Other Infections |
|---|---|---|---|---|---|---|---|
| | | | | | | 1. | |
| | | | | | | 2. | |

| Init No. | Date of Interview | Type | P/CL | Ref | Exposure Dates First | Freq. | Last | FR Num | Name | Sex | Disease 1 Disp | Disp Date | Diag | Wkr No. | Disease 2 Disp | Disp Date | Diag | Wkr No. | Post Test CNSL | SO SP | Invst Ager |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | | | | | | | | |
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| 2. | | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | | | | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | | | | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | | | | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | | | | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | | | | | | | | |

Local Use: A B C D E F G

Date Closed (1): _____ Date Closed (2): _____

U.S. Department of Health And Human Services
Public Health Service
Centers for Disease Control

CDC 73.54 8-91

Section C Immunizations

1. General. Immunizations and Chemoprophylaxis, COMDTINST M6230.4 (series), lists policy, procedure, and responsibility for immunizations and chemoprophylaxis. This section contains guidelines not specifically defined there.

2. Unit Responsibilities.

   a. Active duty and reserve unit commanding officers are responsible for immunizing all individuals under their purview and maintaining appropriate records of these immunizations. If local conditions warrant and pertinent justification supports the cognizant MLC may grant authority to deviate from specified immunization procedures on request.

   b. Unit commanding officers will arrange local immunizations for their unit's members. If this is not possible, he or she will request assistance from the Coast Guard Medical Treatment Facility overseeing units in the geographic area.

3. Equipment and Certification Requirement.

   a. All immunization sites must have the capability to administer emergency medical care if anaphylaxis or other allergic reactions occur. A designated Coast Guard medical officer must certify the registered nurse or HS selected to administer immunizations is qualified to do so because he or she has received instruction and displayed proficiency in these areas:

      (1) Vaccine dosages;

      (2) Injection techniques;

      (3) Recognizing vaccine contraindications;

      (4) Recognizing and treating allergic and vasovagal reactions resulting from the vaccination process;

      (5) Proper use of anaphylaxis medications and related equipment (e.g., oxygen, airways; and

      (6) Verification the individual is currently certified in Basic Cardiac Life Support (BCLS).

   b. The immunization site must have available: syringes with 1:1000 aqueous solution of epinephrine, emergency airways, oxygen, hand operated resuscitator, and intravenous (IV) fluids with an IV injection set.

4. Immunization Site Responsibilities.

   a. Where available, a medical officer or nurse practitioner should be present when routine immunizations are given. The Office of Health and Safety recognizes medical officers and nurse practitioners as qualified by virtue of their standard training.

b. In the event one of the above practitioners (medical officer or nurse practitioner) can not be present, a registered nurse or HS3 or above can be certified to administer the immunization process of active duty and reserve personnel when the following guidelines and procedures are met:

(1) The designated Coast Guard medical officer who normally would oversee their independent activity must train and certify in writing registered nurses and HSs conducting immunizations in a medical officer's absence.

(2) An emergency-equipped vehicle must be readily available to transport patients to a nearby (within 10 minutes) health care facility staffed with an ACLS-certified physician or an EMS with ACLS capability must be within a 10-minute response time of the site.

(3) Hypovolemic shock often is present in cases of anaphylaxis. Therefore medical personnel must be ready and able to restore fluid to the central circulation. In anaphylaxis treatment, epinephrine administration, airway management, summoning help are critical steps toward the treatment of this condition.

c. The individual(s) administering the immunizations shall review the SF-601(Immunization Record) and PHS-731 (International Certificate of Vaccination) for each unit member to be immunized. Only a medical officer has authority to immunize persons sensitive to an immunizing agent. The unit health record custodian or HS will ensure proper entries are made on each immunize person's SF-601 and PHS-731.

d. In some clinical situations, the medical indication may be to immunize even though the circumstances above cannot be met (e.g., tetanus toxoid for wound prophylaxis, gamma globulin for hepatitis A exposure, etc.). Such incidents commonly occur at sea and remote units or during time-sensitive situations (SAR, etc.). If the medical benefits outweigh the chance of a serious allergic reaction, take every available precaution possible, and administer the vaccine. When available, obtain radio, telephone, or message advice from the Medical Officer.

e. If an adverse reaction to a vaccine is suspected, the facility shall notify the Vaccine Adverse Event Reporting System (VAERS) using form VAERS-1. Obtain this form from the FDA by calling 1-800-822-7967. Units providing vaccinations shall maintain a supply of these forms. A copy of each submitted VAERS-1 will be forwarded to G-WKH.

f. Every health care provider who administers vaccines against Diphtheria, Tetanus, Pertussis, Hepatitis A, Hepatitis B, Haemophilus Influenza type b (HIB), Influenza, Lyme Disease, Measles, Mumps, Rubella, Pneumococcus, Polio and Varicella must distribute written vaccine information materials (Vaccine Information Sheet-VIS) to any adult being immunized or to the legal guardian/representative of the individual receiving the vaccine(s). The Department of Health and Human Services has developed vaccine information materials for these vaccines that meet the requirement

of the law. These are available from the Centers for Disease Control and Prevention, National Immunization Hotline, at telephone number (800) 232-2522 or at: http://www.cdc.gov/nip/publications/VIS/default.htm.

g. Per the National Childhood Vaccine Injury Act (NCVIA) of 1986, health care providers are not required to obtain the signature of the vaccine recipient, parent or legal guardian acknowledging receipt of the VIS. However, to document that the VIS was given, health care providers must note in the patient's permanent medical record (1) the date printed on the VIS and (2) the date the VIS is given to the patient or legal guardian. In addition, the NCVIA requires, for all vaccines, that health care providers document in the patient's permanent medical record the following: (1) date the vaccine was given, (2) the vaccine manufacturer and lot number and (3) the name and address of the health care provider administering the vaccine. For all beneficiaries, the health care provider will make a notation on the SF-600 stating that the vaccine recipient or legal guardian/representative has been given information on the vaccine(s) prior to the vaccine(s) being given, if applicable. For all vaccines, facilities administering vaccines must record in the recipient's health record, and, in the service member's International Certificate of Vaccination (PHS-731), the manufacturer and lot number of the vaccine, and the name, address and title of the person administering the vaccine.

5. Immunization on Reporting for Active Duty for Training.

a. When a member reports for active duty for training, the receiving unit shall review the individual's SF-601 and PHS-731 for completeness, administer any delinquent immunizations whenever possible, enter on SF-601 and PHS-731, and return these to the individual when active duty for training terminates.

b. The individual's Reserve unit shall give the member a re-immunization schedule for the following year if one is needed for that period.

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Section D Tuberculosis Prevention and Control Program

1. Introduction.

a. Description. Tuberculosis (TB) is an infectious disease transmitted from person to person by very small (1-5 microns) particles called droplet nuclei, which can remain suspended in any indoor air space for long time periods. An individual with active pulmonary tuberculosis propels droplet nuclei into the air by coughing, speaking, or sneezing. They also can be produced by manipulating tuberculous lesions or discharging infected secretions. Inhaling droplet nuclei can carry them to the lung alveoli, where the bacteria suspended in the particles can multiply, causing a pulmonary infection.

b. Problem. In the United States, reported cases of tuberculosis declined steadily until 1984. Since then, however, the disease has unexpectedly rebounded in this country. Many experts agree this resurgence is due at least partially to a deterioration in the infrastructure of our health care delivery system. An additional concern is the domestic increase of drug-resistant forms of tuberculosis, resulting in increased costs, longer duration of treatment, and higher mortality rates.

c. Purpose. This section prescribes policy and procedure to ensure Coast Guard members can conduct their mission without undue risk of tuberculosis transmission and, further, the highest quality medical follow-up for those infected with the disease.

d. Definitions.

(1) Active Case. A person who has a clinical disease demonstrated by radiograph (x-ray) and culture or signs and symptoms of extrapulmonary TB. This term does not include a person whose only finding is a positive skin test.

(2) Casual Contact. A person acquainted with an individual with active tuberculosis who has spent some time with the infected person in a possibly contagious, though brief, situation.

(3) Clinically Significant Exposure. An exposure to someone with active tuberculosis which could be expected to result in transmitting the infection. This generally means repeated, close contact with a person with active pulmonary TB, particularly when in a confined environment such as a room or residence, such as family members who share the same household as persons with TB or health care workers who routinely care for TB patients.

(4) Close Contact. A person who has spent extended periods of time with a person who has active tuberculosis, especially in enclosed spaces, e.g., living in the same household.

(5) Contact. A person who has had some association with an active case .

(6) Edema. The escape of a fluid, usually serous (pertaining to the watery part of the blood) fluid, from its natural vessel into body tissues or cavities. Soft tissue edema causes pitting.

(7) Erythema. An area of abnormally red skin due to inflammation.

(8) Fomites. Any materials, including clothing or bedding, capable of absorbing and spreading a disease's infecting organism.

(9) High-Risk Groups. Defined groups of persons among whom the prevalence and incidence of tuberculosis is substantially higher than the general population.

(10) Induration. A firm, hardened, usually raised area of soft tissue congestion; erythema may or may not be present. Must be distinguished from edema by the absence of pitting.

(11) Mantoux Test. An intracutaneous (within the skin) test for tuberculin sensitivity, using a purified protein derivative (PPD) of tuberculin.

(12) MDRTB. Multiple drug resistant tuberculosis.

(13) *Mycobacterium tuberculosis.* The organism that causes tuberculosis disease.

(14) Positive Skin Test Reaction. See 3.C.(2).(f).

(15) Pulmonary. Referring to the lungs. The most common and most infectious form of TB occurs in the lungs (pulmonary TB), but many other parts of the body can be sites of infection.

(16) Tuberculin Conversion/Convertor. A TST reaction that has increased from what is considered non-reactive to reactive within two years. Both reactions must be documented.

(17) TB. Tuberculosis, a communicable disease of humans and animals caused by the *Mycobacterium tuberculosis* microorganism, manifesting itself in lesions of the lung, bone, and other organs.

(18) TST. Tuberculin Skin Test, a test based on a hypersensitivity-type immune reaction to tuberculin. The test is used to determine past or present infection from *Mycobacterium tuberculosis*.

(19) Tuberculin. A substance derived from *Mycobacterium tuberculosis* cultures used to diagnose tuberculosis.

(20) Tuberculin Non-reactive/Non-reactor. A TST reaction which is too small to be considered evidence of infection. (See Figure 7-D-1). Sometime imprecisely referred to as a "negative" test.

(21) Tuberculin Reactive/Reactor. A TST reaction considered evidence of infection. (See Figure 7-D-1). Sometimes imprecisely referred to as a "positive" test.

(22) Vesiculated. Having small, blister-like, fluid-filled sacs or cysts.

e. Program Summary. The Tuberculosis Prevention and Control Program consists of four parts: the TB screening and contact investigation programs, personal protective measures and patient management.

2. Tuberculosis Screening Program. The program is intended to identify both persons who have only been infected by *Mycobacterium tuberculosis* and those who have active, clinical disease. The former may benefit from preventive therapy, and the latter from treatment.

a. Type of testing: Different testing procedures are used:

(1) Tuberculosis Skin Testing. The Purified Protein Derivative (PPD) is the primary method for routine TB screening. It is used for individuals with previously non-reactive, doubtful, or unrecorded skin tests.

(2) Chest Radiograph. This method is if active TB is suspected in persons with a previously reactive tuberculin skin test (TST). Routine periodic chest radiographs will generally not be performed.

b. Summary of Testing Procedures. At a minimum, TB screening is required when a person enters military service and during periodic physical examinations. A medical officer or this manual describe when to test more frequently.

c. When to Test Personnel.

(1) Initial Tuberculosis Screening. A PPD is mandatory in the physical examination of any person entering initial active duty for 30 days or more and any other active duty member whose records contain no report of a completed tuberculin test.

(2) Screening Personnel at Low Risk of Exposure.

(a) Tuberculin Non-reactive Personnel. All active duty personnel whose last recorded reaction was recorded as non-reactive at a minimum must have a PPD during their quinquennial physical examination.

(b) Tuberculin Reactive Personnel. All personnel whose last recorded TST reaction was considered reactive receive chest radiographs only when previous medical follow-up has not been done and properly documented in the individual's health record, or when a medical officer deems it clinically indicated. All TST reactors or their medical records must be medically reviewed annually to screen for indicators of active disease.

(3) Screening Personnel at Increased Risk of Exposure.

(a) Tuberculosis Non-reactive Personnel. Personnel whose last recorded TST reaction was considered to be nonreactive and who are at increased risk of TB, such as health care workers, will be skin tested annually, usually during routine immunizations. EMT or law enforcement and other personnel, in addition to testing at their quinquennial physical

examination, will be tested after clinically significant contact with high risk groups (e.g., following interdiction of and prolonged, confined contact with migrants who have signs of active tuberculosis). (COMDTINST M6220.9 (series) provides more information regarding tuberculosis and AMIO, but this instruction is the definitive guidance on frequency of testing.)

(b) Tuberculin Reactive Personnel. Personnel whose last recorded TST was considered reactive will receive chest radiographs or sputum smear examinations only when a medical officer deems necessary.

(4) Separation from Service. Those individuals whose last test was nonreactive shall have a PPD as part of their separation process. A chest radiograph will be done for a separation physical only if the individual has a confirmed positive PPD. Results of the PPD or chest radiograph must be evaluated and recorded in the health record prior to separation.

d. Testing Procedures.

(1) Tuberculin Skin Test Materials.

(a) Tuberculin, Purified Protein Derivative (PPD). The only approved tuberculin skin test material for a routine Mantoux test is premixed Tween-80-stabilized intermediate strength PPD (5 Tuberculin Units (TU) equivalent). Multiple puncture tuberculin tests (e.g., Tine tests) are not authorized. A medical officer can direct using first-strength PPD (1 TU) when a person has a verbal or questionable history of a reactive TST but no documentation of such.

(b) Syringes and Needles. The disposable 1 ml tuberculin syringe graduated in 0.1 ml intervals and fitted with a 25-gauge 5/8-inch needle is a convenient combination for administering the PPD.

(2) Tuberculin Skin Test Methods.

(a) Personnel Authorized to Perform the Tuberculin Test. Only trained health services personnel are authorized to perform PPDs. The local medical authority shall verify they are competent to administer and read the PPD.

(b) Techniques. Following aseptic preparation of the skin, an intradermal injection of 0.1 ml of the tuberculin solution shall be made upon the volar aspect of the left forearm. The point of the needle should be visible just within the dermis, beneath the outer layers of the epidermis. The results should be a definite wheal, pale and sharply demarcated. Be careful to avoid subcutaneous or epidermis injection. If it is recognized that the first test was improperly planted, another test dose can be given at once, selecting a site several centimeters away from the original

injection. A note in the record should indicate the site chosen for both the fist and second tests.

(c) Documentation. Document the PPD test in the SF-601 under Sensitivity Tests with the date tested. Do not record results until the actual time of reading.

(d) Two-Step TST. Because of delayed hypersensitivity, an adult who has never been skin tested and will receive periodic skin testing should receive two-step skin testing to distinguish boosted reactions from reactions due to new infection. Persons in this category include new accessions to the Coast Guard (officer and enlisted). In such cases consult a medical officer for procedure.

(e) Measuring and Recording Results.

1 After an interval of between 48 and 72 hours examine the PPD site. Classify injection response according to the extent of the induration (not erythema or edema) measured in millimeters (mm) at the widest diameter transverse to the long axis of the forearm.

2 When reading the PPD, the forearm should be in good light and flexed a little at the elbow. Lightly pass a forefinger over the test area. The induration can be felt even when it does not produce a visible elevation. For those skilled in its use, the pen-tracking method is both authorized and more accurate. To measure, mark induration borders with a ball-point pen.

3 To record the result, enter by hand this information under Sensitivity Tests on SF-601 and PHS 731: date, type of tuberculin, its strength or dilution (e.g., PPD 5 TU), and the resulting diameter of induration expressed in millimeters. Report absence of induration as "zero mm." If induration is present, use Arabic numerals to record the widest diameter. A sample entry is: "17 SEP 86 PPD (5TU) 6mm induration." Also measure and record any vesiculation. In red ink record the result indicating a PPD converter on the Sensitivity Sticker (section 4-B-2) and the Problem Summary List (section 4-B-3). Using rubber stamps or automatic imprinting devices to record results or recording results as “negative” are both prohibited.

4 A medical officer must evaluate grossly vesiculated reactions. Warn the person about possible secondary bacterial infection from scratching the reaction.

(f) Failure to Return for Skin Test Reading. Personnel who do not return at the proper time to have the skin test interpreted must be retested. Do not

under any circumstances record the PPD as "zero mm" if the person does not return within the prescribed time frame. Each time a person fails to return for timely reading, document the SF-601 with "no reading done" and the date.

(g) Interpreting Skin Test Readings. Consider a skin test reactive according to Figure 7-D-2.

Figure 7-D-2

| Size of Induration | Considered Reactive for |
|---|---|
| Reactions < 5mm are considered non-reactive | |
| 5 mm | • Persons with HIV infection or risk factors for HIV infection but unknown HIV status;<br>• Persons who have had recent close contact with persons who have active TB;<br>• Persons who have fibrotic chest radiograph consistent with healed tuberculosis;<br>• Patients with organ transplants and other immunosuppressed patient. |
| 10mm | • Injecting drug users known to be HIV seronegative;<br>• Persons with other medical conditions with reported increased risk for progressing from latent TB infection to active TB. These medical conditions include diabetes mellitus, chronic renal failure, some hematologic disorders and other malignancies, weight loss of ≥10% below ideal body weight, silicosis, gastrectomy, and jejunoileal bypass;)<br>• Residents and employees of high-risk congregate settings: prisons, long-term care facilitiess, health-care facilities, and homeless shelters;<br>• Some medically underserved, low income populations, including migrant workers and homeless persons;<br>• Foreign-born persons recently arrived (i.e., within the last five years) from countries with a high TB prevalence;<br>• Children < 4 years of age, any child or adolescent exposed to adults in high-risks categories. |
| 15mm | • Persons who meet none of the above criteria. |

(3) Chest Radiographs. Those individuals who have been determined to need a chest radiograph will have a standard, erect posteroanterior view. A medical officer may determine other appropriate views.

e. Responsibility for Local Program Management.

(1) The command holding affected persons' health records is responsible for monitoring health records and managing local skin testing and chest radiograph programs.

(2) The activity maintaining the health record assures the tuberculin skin test status is clearly and properly documented on SF-601 and PHS-731 Immunization Records of each active duty member's health record; the activity also must clearly, properly record tuberculin reactors' chest radiograph status on SF-600, Chronological Record of Medical Care, and NAVMED 6150/20, Problem Summary List. Further, the activity is responsible for initiating tests for persons whose health records do not contain appropriate, timely entries.

3. Tuberculosis Contact Investigation Program.

a. Contact Investigation Procedures. On discovering a case of active TB in a command, take these actions:

(1) Submit a Disease Alert Report.

(2) Determine the patient's close contacts.

(3) Screen or give these contacts a TST test for TB and repeat the screening 3, 6, 9, and 12 months later.

(4) Report summary results of the investigation to Commandant (G-WKH) through the appropriate chain of command.

(5) Evaluate possible secondary cases.

b. Initiating a Contact Investigation. Initiate a contact investigation when notified a member of the command has diagnosed active PMTB or when a medical officer so requests.

c. Performing a Contact Investigation.

(1) Conducting an investigation
Initial Investigation of Contacts. Each person who is a close contact of an known case of active, infectious tuberculosis shall undergo a screening examination for TB. Those personnel who are previous tuberculin reactors, and do not have a document of appropriate medical follow-up, or have signs of PMTB, shall receive a chest radiograph [unless otherwise contraindicated, see 7-D-4.b.(5)(c)]. All other contacts shall receive a PPD. Individuals identified to be close contacts who are not eligible for health care through the Coast Guard should be referred to the local public health department or private medical facility of choice.

(a) Establishing Limits for Contact Investigations. The infectiousness of a source case is determined by first evaluating close contacts for evidence of new infection or disease. If there is no evidence of infection in this group no further investigation is necessary. Remember that TB is a slow

progressing disease and initial screening results should only be interpreted as baseline information if it is determined that the source case may have a recent infection or disease. If there is evidence of infection in close contacts (as determined after an appropriate time-lapse), extend the investigation to progressively lower-risk contacts, e.g., casual or other contacts. This should proceed until the levels of infection detected approximate the levels of infection in the local community. NOTE: If a newborn or an immunocompromised person (e.g., HIV infected person) is identified as a close contact, they should be evaluated for prophylaxis per current Centers for Disease Control and Prevention Guidelines. Figure 7.D.3 shows a decision tree for establishing contact limits.

(2) Determining Close Contacts.

(a) Active Tuberculosis at a Shore Facility. The local medical officer must classify a TB patient's "close contacts" at a shore facility, generally including all those sharing the same berthing facilities, in close contact during duty hours, regular liberty mates, and the patient's cohabitants. Consult the appropriate MLC (k) for advice in specific instances.

(b) Active Tuberculosis Aboard a Cutter. When a case of active TB is discovered aboard the cutter the entire ship's company shall be considered close contacts included in the contact investigation.

(c) Other Situations. Commands or activities in which exceptionally close conditions occur, such as isolated duty stations, shall follow the procedures listed for cutters.

(3) Follow-up Investigation of Contacts.

(a) Follow-up Period. Follow up tuberculosis contacts for 12 months (see paragraph 5.a.(3)). Record follow-up results on an SF-600 in each contact's medical record. Take particular care to record all items before an involved member from the command transfers.

4. Protective measures

a. General. Depending on the level, nature, and intensity of exposure, a person's risk of TB infection can be reduced. Tuberculosis spreads almost exclusively by airborne transmission from persons who have active pulmonary TB. The risk of infection is negligible for those who have casual or brief contact with high-risk persons, particularly if exposure occurs in a open space. Special personal protective equipment, e.g., masks, gloves, or gowns, is not required for routine limited contact in such a setting.

b. Respiratory protective devices (RPD).

(1) RPDs may be warranted if TB exposure is longer or more intense. Coast Guard personnel will comply with guidelines established by the Centers for Disease Control and Prevention (CDC), the National Institute of Occupational Safety and Health (NIOSH), and pertinent Coast Guard directives, e.g., COMDINST M6260.2 (series), governing using RPDs or other personal protective equipment.

(2) Surgical masks do not filter small enough particles to protect a wearer from TB infection, and must not be used for this purpose. However, surgical masks can help contain infectious droplets from the infected person, and when worn by this person, may reduce the risk of passing the infection.

(3) The minimum RPD for wearer safety is a NIOSH-approved, high-efficiency particulate air (HEPA) respirator. Respiratory protective devices must fit and be worn correctly to be effective. Technical Guide: Practices for Respiratory Protection, COMDTINST M6260.2 (series), describes how to evaluate, fit, and train persons to wear RPDs to protect against TB transmission.

c. Air Circulation. At least 6 air exchanges per hour (ACH) are required to reduce concentrations of droplet nuclei in the air in an enclosed space requires; higher ACH rates eliminate more bacteria. If possible 12 ACH or more is recommended. Recirculated air should filter through fixed HEPA filters. Fresh or filtered air should be provided in optimum airflow patterns that prevent stagnation.

d. Handling High-Risk Populations. When transporting or otherwise in a confined space with a person known or suspected to have active TB, take these precautions:

(1) If he or she can tolerate one, have the patient wear a mask.

(2) Take measures to increase airflow within the enclosed space. Vent air to the outside whenever possible.

(3) Avoid unnecessary close contact with the patient.

(4) Separate suspected TB cases from others if conditions permit.

(5) Emergency Medical Technicians (EMTs) should wear HEPA respirators when working with persons demonstrating clinical signs of TB.

(6) Consult competent medical authority to determine if specific circumstances warrant HEPA mask use.

5. Managing Personnel with Reactive Tuberculin Tests or Suspected TB.

a. Evaluation for Tuberculosis.

(1) Personnel Requiring Evaluation. As soon as possible evaluate persons who meet any of these criteria for the presence of active tuberculosis:

(a) Tuberculin reactor on initial testing.

(b) Tuberculin skin test converter.

(c) Close contact of an active case of TB who develops a TST reaction ≥5mm..

(d) Previous tuberculin reactor but never evaluated for active TB.

(e) Previous tuberculin reactor, now with suspicious chest radiograph findings.

(f) Anyone with history, signs, symptoms, or laboratory tests suggesting TB.

(2) Initial Examination. Persons listed in Paragraph 4.a.(1) will have a medical history, physical examination and chest radiograph.

(3) Further Examination. A medical officer or a civilian physician most evaluate more thoroughly those individuals whose findings suggest active TB.

b. Managing Tuberculin Reactors Without Evidence of Active TB.

(1) Personnel evaluated and found not to have active TB will be considered for preventive therapy according to Figure 7-D-3. Prophylaxis is intended to prevent latent infections from progressing to clinically active disease.

Figure 7-D-3

| Age | Induration Size | Risk Factor |
|---|---|---|
| Any Age | > 5mm | Known or suspected HIV infection<br>Close contact with newly diagnosed active TB<br>Previously untreated or inadequately treated persons with chest radiographs showing fibrotic lesions compatible with old healed tuberculosis. If diagnosis is doubtful after consulting with a medical officer, administer a booster TST |
| | > 10mm | Injecting drug users<br>Persons with medical conditions reported to increase tuberculosis risk including silicosis; gastrectomy; jejunoileal bypass; weight 10% or more below ideal body weight; chronic renal failure; conditions requiring prolonged high-dose corticosteroid therapy or other immunosuppressive drugs; some hematologic disorders (leukemia and lymphomas); and other malignancies |
| Under 35 | > 10mm | Foreign-born persons from high-prevalence countries including those in Asia, Africa, Central and South America, and eastern Europe<br>Residents of correctional facilities |
| | > 15mm | No risk factors, but not previously treated |
| **Recent TST converters** | | |
| Under 35 | | > 10mm *increase* within a 2 year period |
| Over 35 | | > 15mm *increase* within a 2 year period |
| Previously known (old) tuberculin reactor not properly evaluated in the past or who did not complete appropriate preventive therapy | | |
| Under 35 | | If risk factors and induration sizes listed above are present |
| Over 35 | | Generally not a candidate for INH unless specific risk factors for active disease are present |

Note: A previously known tuberculin reactor may be treated without repeat testing if a properly documented tuberculin TST result is in the medical record. If a person gives an undocumented history of a tuberculin reaction and INH prophylaxis may be indicated, a first strength PPD (1 TU) may be administered under the direction of a medical officer, to confirm the reported reaction.

(2) Initial Evaluation for Prophylaxis. Before initiating a course of prophylaxis a medical officer must evaluate the person as follows:

(a) An appropriate history and physical examination.

(b) Chest radiograph for newly identified tuberculin reactors, unless otherwise contraindicated. Give one to previously known reactors only if no documents exist of proper medical evaluation with radiograph at time of reactive TST or if clinically indicated.

(c) Baseline liver function tests (LFT), including AST, ALT, LDH, total bili, and GGT, and a CBC.

(d) Perform HIV antibody testing on all newly identified active duty tuberculin reactors. Query civilian employees and dependents with newly-identified reactive TSTs about HIV risk behaviors. Counsel persons with HIV risk factors and offer them an HIV serological screening test.

(e) Review conditions that may contraindicate prophylaxis as follows: pregnancy, breast feeding, ETOH abuse, known sensitivity to the agent, peripheral neuropathy, IV drug abuse, acute or chronic liver disease, therapy with medication with a potential for significant interaction (Tegretol, phenytoin, etc.). If any of these conditions exist, the provider must decide whether to initiate prophylaxis, weighing therapeutic risks and benefits.

(3) Prophylaxis. Recommended regimens are listed in Figure 7-D-4. There are other considerations not listed in the Figure for HIV infected persons.

Figure 7-D-4

| Drug | Interval and Duration | Comments |
|---|---|---|
| Isoniazid (INH) | Daily X 9 Mo[1,2] | In HIV-infected patients, INH may be administered concurrently with NRTIs or NNRTIs. |
| | 2X Weekly X 9 Mo[1,2] | Directly observed therapy (DOT) must be used. |
| INH | Daily X 6 Mo[2] | Not indicated for HIV-infected persons or those with fibrotic lesions on chest X-ray. |
| | 2X Weekly X 6 Mo[2] | DOT must be used. |
| Rifampin plus pyrazinamide | Daily X 2 Mo | May also be offered to persons who are contacts of patients with IHN-resistant, rifampin-susceptible TB; In HIV-infected patients protease inhibitors or NNRTIs should generally not be administered concurrently with rifampin. |
| | 2X Weekly X 2-3 Mo | DPT must be used |
| Rifampin | Daily X 4 Mo | For persons who cannot tolerate pyrazinamide. |

Notes: [1]Recommended regimen for children younger than 18 years of age.
[2]Recommended regimen for pregnant women.

(a) Supervision. Persons whose risk of developing active TB is high and whose compliance is questionable may require directly observed therapy (DOT).

(b) (b) Monitoring. Appropriately trained personnel must monitor persons taking INH monthly for the first two months and at least every two months thereafter. Follow persons 35 and older monthly for the first three months. Initially dispense a maximum of one month's supply of medication and up to two months' supply thereafter to coincide with follow-up visits. If signs or symptoms of toxicity appear, discontinue INH immediately; a medical officer should reevaluate. Prophylaxis should not be prescribed if periodic monitoring cannot be done. Monitoring consists of:

1 Reviewing significant symptoms of INH side effects: fever, rash, jaundice, fatigue, anorexia, dark urine, joint pain, paresthesia of hands, feet, or eyelids.

2 Obtaining follow-up LFTs as follows:

One month after instituting INH; then at least at three month intervals for all individuals.

At 1, 2, 3, and 5-6 months (8-10 month interval for those with a one-year course) for all persons 35 and older.

If evidence of possible reaction to therapy occurs.

3 Upon termination of INH prophylaxis, LFTs and a CBC will be done.

4 The periodic evaluations will be documented in the patient medical record.

c. Patient Education. The health services representative must ensure the patient understands the meaning of the skin test result or TB exposure, INH chemoprophylaxis hazards (hepatitis, drug fever, severe rash, etc.) and benefits, the warning signs of the drug's potential side effects; and the danger of alcohol consumption while taking INH. The necessity for faithful adherence to the course of treatment, in the absence of side effects, cannot be too strongly stressed. A notation of the counseling offered shall be made on an SF-600 in the medical record.

d. Persons Leaving the Service While on Chemoprophylaxis.

(1) Members who retire prior to completing chemoprophylaxis shall be advised that continued treatment is necessary and may be obtained at most Uniformed Services Medical Treatment Facilities.

(2) Members who are discharged or released to inactive duty prior to completing Isoniazid chemoprophylaxis shall be advised of the importance of continuing the program. Care may be provided by the Veterans Administration, county health department, private physicians, etc. To facilitate follow-up, personnel shall be provided with a statement signed by a medical officer containing the date treatment began, the type and dosage of prescribed medications, course of therapy, and the present status. At a minimum, the local Health Department where the individual plans to reside should be notified.

(3) A medical board or limiting duties is not indicated for those with no evidence of active disease except as noted in paragraph 4.b.(6) regardless of the status of preventive therapy.

(4) Special Situations and Procedures.

(a) Exposure to Drug-resistant TB. Consult with CDC or a state health department before starting prophylaxis for persons known to be exposed to patients with drug-resistant strains of TB.

(b) Children. A pediatrician or medical officer with training in pediatrics must follow children receiving TB prophylaxis.

(c) Pregnant Women. Complete the same initial procedures for adults except DO NOT PERFORM A RADIOGRAPH unless an actual clinical

indication of pulmonary disease exists. Consult the patient's obstetrician. Generally, defer treatment until after delivery or breast feeding. Place the patient's name in a "tickler" so that she can be contacted upon termination of pregnancy.

(d) Child Care Workers. Child care workers must receive annual PPDs or medical evaluations, as appropriate.

(5) Aviators.

(a) Personnel on flying status shall be grounded for the first seven days of chemoprophylaxis because of the slight risk (less than 1%) of convulsions among persons taking INH. At the end of seven days of treatment, flight surgeon must be consulted to return the member to flying status.

(b) A flight surgeon shall evaluate aviators receiving INH monthly to carefully brief the individual about possible adverse reactions.

(c) Aviation personnel should be considered for grounding if, at any time during treatment, liver function test are significantly abnormal or symptoms of liver dysfunction appear.

e. Managing Suspected Cases of Active TB. When a patient is evaluated and suspected of having TB:

(1) Submit a Disease Alert Report (see Figure 7-B-2).

(2) Expeditiously refer the patient to the nearest USMTF, including those initially admitted to civilian medical facilities. If at all possible, refer before beginning definitive treatment.

(3) Initiate contact tracing.

(4) Decontaminate spaces (see Paragraph 7-D-7).

f. Reporting Requirements. The health services division chief of the medical treatment facility where the diagnosis of active TB is suspected or established, shall notify the patient's commanding officer within 48 hours. The notification shall include the date that the diagnosis was established or suspected and the probability that the patient is infectious. If, in the case of suspected active TB, the diagnosis of TB is subsequently ruled out, a message to that effect must be sent to both the patient's commanding officer and to the address of the Disease Alert Report, immediately.

(1) Follow-up Procedures. The command investigating TB contacts shall maintain a "tickler" file or similar effective system to assure prompt evaluation of persons requiring periodic examination and testing. Medical evaluations and other indicated procedures are an appropriate part of the periodic examination.

(2) Completing Follow-up. When the 12 months expire, those individuals whose tuberculin response or chest radiograph were unchanged shall revert to routine program screening.

(3) Separated Members. Contacts separated from the Coast Guard shall be counseled regarding the need for medical evaluation and the appropriate referrals made.

(4) Managing Tuberculin Converters or Possible Cases. Those individuals found to have "converted" or who developed changes on a chest radiograph shall be evaluated as outlined in Section 7-D-4 of this manual. Close contacts who increase the size of induration on a TST, even though the reaction is still considered nonreactive, should also be considered for evaluation.

(5) Secondary Cases. If a subsequent active TB case is discovered among the contacts, it is not necessary to begin an entirely new investigation. However, start contact studies on any personnel exposed to the secondary case not tested in the original investigation.

g. Responsibility for Managing the Contact Investigation Program.

(1) The commanding officer of the permanent duty station of a person diagnosed with active TB shall initiate the contact investigation. If the individual has a permanent change of station during the preceding year, the commanding officer of the former duty station shall be notified to initiate a contact investigation if determined appropriate by the medical officer or civilian physician making the diagnosis. If assistance is required contact the appropriate MLC (k).

(2) The commanding officer of any activity is responsible for successfully continuing or completing contact studies under way among members assigned to or transferred to the unit. Additionally, the commanding officer shall ensure:

(a) The records of members transferred from the unit while undergoing contact studies are complete (including radiographs) so the member's gaining unit can continue the studies.

(b) Prompt submission of the summary letter report on the tuberculosis contact investigation to Commandant (G-WKH) through the chain of command.

h. Reporting Requirements. The command initiating the contact investigation shall prepare and submit study summaries to Commandant (G-WKH) with a copy to the appropriate MLC (k). Submit progress summary reports and the final RCS-G-K-13012, Disease Alert Report, with this information:

(1) Unit identification.

(2) Source case(s)'s name, grade, rate, and Social Security Number .

(3) Status of investigation, e.g., initial, 3-, 6-, 9-, or 12-month summary reports.

(4) For each reporting period provide:

(a) Number of tuberculin non-reactive individuals skin-tested.

(b) Number of skin-tested tuberculin non-reactive persons found to be converters.

(c) Number of tuberculin-reactive individuals receiving chest radiographs.

(d) Number of tuberculin-reactive persons found to have suspicious changes on the chest radiograph.

(e) Number of contacts placed on or receiving isoniazid chemoprophylaxis.

(f) Name, grade, rate, Social Security Number, and exact diagnosis of each secondary tuberculosis case.

(g) Comments on investigation including any problems.

6. Tuberculosis Control Among Dependents and Other Civilians.

a. Dependents.

(1) As part of health education efforts, commands shall impress upon dependents the importance of routine TB preventive measures. Within their capabilities, commands in known high-risk areas should extend the active duty program to those dependents residing in the area. Dependent contacts of active cases of TB shall be given periodic screening with either tuberculin test or chest radiographs, as appropriate. Chemoprophylaxis will be administered, when indicated.

(2) If active TB is diagnosed in a military dependent, the medical treatment facility (MTF) establishing the diagnosis shall notify the appropriate public health authorities. Dependents may obtain care through the local public health department, military MTF, or through civilian sources, as appropriate. The MTF making the diagnosis should provide advice on available treatment alternatives.

b. Positive Skin Tests in Children Under 6 Years of Age. Preventive treatment is definitely recommended for all positive tuberculin reactors under six years old. The Mantoux method shall be used to confirm “positive” responses elicited by other tuberculin testing methods.

c. Alien Dependents. See "Tuberculosis Among Foreign-Born Persons Entering the United States," Centers for Disease Control and Prevention, MMWR, Dec 28, 1990 (Vol. 39), and the U.S. Immigration and Naturalization Act for the waiver procedure an alien with PMTB to enter CONUS.

d. Civilian Personnel. If a civilian employee under Coast Guard cognizance is discovered to have active TB, the medical administrative officer or the medical officer of the activity shall make arrangements for contact investigation of close work associates. Local public health authorities shall be notified. Coast Guard personnel who are close contacts of the employee shall have detailed entries made in their medical records and receive appropriate follow-up.

7. Decontaminating Spaces Occupied by Persons with Active PMTB.

a. Pulmonary tuberculosis is transmitted by small airborne droplets or droplet nuclei from persons in close contact or possibly through ventilation systems, such as on ships. Other dried secretions and fomites in themselves do not pose significant hazards unless aerosolized. Therefore, only normal laundry and cleaning procedures with sodium hypochlorite (household bleach) are necessary for linen and bedding of a person with active PMTB. Take care not to shake dirty linen to launch particles on it into the air.

b. When a case of PMTB is discovered aboard a ship, the filters in the ventilation system exhausting the berthing, messing areas, work spaces, and medical spaces must be replaced and cleaned. In this situation contact the Commandant (G-WKH) or appropriate MLC (k), for specific instructions. Increase circulation of fresh air and, if possible, exposure of spaces to natural light (sunlight) will rapidly clear any infectious, airborne droplet nuclei from the spaces.

c. No other sanitation measures are necessary. Consult a medical officer for advice in specific instances.

FIGURE 7-D-1

**SUMMARY OF TESTING PROCEDURES**

| TUBERCULIN (PPD) SKIN TEST | RECOMMENDED ACTION |
|---|---|
| Unknown | Perform a PPD, using intermediate strength PPD (5 TU). |
| History of strongly reactive or vesiculated reaction | Perform a PPD using the regular dose of first strength PPD (1TU). If this test's results are negative, follow up with a subsequent test using a full dose of intermediate strength PPD (5TU). |
| Last test reactive | Determine if an appropriate medical follow-up and/or chemoprophylaxis has been pursued. If not, perform a standard posterior-anterior chest radiograph. If the chest radiograph and a review of signs and symptoms reveal no findings, consider prophylaxis. If proper medical follow-up previously has been pursued, counsel the patient on the need to monitor him- or herself for signs of active pulmonary tuberculosis. Further follow-up is not indicated. |

Evaluate these classes of personnel as Section 7-D-4 outlines.

1. Those with unknown or previously nonreactive tuberculin status who are found upon testing to be PPD reactors.
2. Those with reactive skin tests who have not been medically examined for tuberculoses before.
3. Those with suspicious chest radiograph findings.

NOTE: A reactive single/multiple puncture TB skin test, i.e., Monovac or Tine Test, to test children; must always be verified by PPD.

# CHAPTER 8

# FISCAL AND SUPPLY MANAGEMENT


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## CHAPTER 8. RESOURCE MANAGEMENT

A. RESOURCE MANAGEMENT. The Health Services Program has three resource management levels.

1. Unit.

a. A unit's commanding officer (CO) is charged with ensuring all unit aspects operate effectively and efficiently. For units with health care facilities, this means using personnel, funds, equipment, expendable supplies and materials, health care spaces, and external health care providers economically and efficiently. The CO oversees all health care equipment maintenance. Commanding officers will ensure management of command resources provides the best amount of care to all eligible beneficiaries at the least cost to the Government.

(1) In general, care provided in Coast Guard clinics is more cost-effective than any other source's. The fixed cost of physical plant, staff, and equipment is divided by the number of beneficiaries served; thus, the more care provided, the lower the cost per visit. Therefore, units should set goals to provide the maximum amount of care possible. Achieve these goals by operating properly staffed clinics at times most convenient to beneficiaries, scheduling to decrease the time patients wait, efficiently managing health care providers' valuable time, and publicizing the availability of services to beneficiaries in the surrounding communities.

(2) If the current level or mix of resources is inefficient, the commanding officer will report this fact through the chain of command and recommend corrections. Timeliness is extremely important in dealing with changes in resource requirements. Good resource planning should address these needs long before it becomes necessary for a unit commanding officer to deny care to any authorized beneficiary due to lack of resources.

b. The unit commanding officer directly controls the unit's financial plan or budget, including unit health care resources. Monthly the CO reports medical and dental workloads, operating targets, adjustments to the targets, and actual expenditures to Commandant (G-WKH) on the unit's Health Services Statistical Report. From an oversight or management review perspective, repeated or recurring amounts of unit Fund Code-57 (AFC-57) moneys dedicated to health care are the "base" funds. COs must justify additional unit operating funds above this base solely on the criterion of increased workloads.

c. The unit commanding officer will review all uses of unit funds and reallocate funds during the current fiscal year. The unit commanding officer must first inform the chain of command before he or she can reduce the amount of care the unit's clinic provides to eligible beneficiaries. The CO will report the circumstances supporting

the decision and identify what resources are required to ensure normal health care facility operations through the end of the fiscal year. The District or Maintenance and Logistics Commander's Budget Review Board (for district or MLC units respectively) will address these current fiscal year AFC-57 unit requests.

2. Maintenance and Logistics Command (MLC). Maintenance and Logistics Commands administer the health services program in their respective area of responsibility. Administrative functions include:

   a. Approving and funding care non-Federal and Department of Veteran's Affairs sources provide;

   b. Approving or disapproving requests to procure health care equipment costing more than $750.00 for units with CG Clinics/AFC-57 funding and over $300.00 for units without CG clinics/AFC-57 funding;

   c. Approving clinic budgets. Each clinic's parent command shall submit a zero-based AFC-57 direct care funding request to the appropriate MLC (k) through the chain of command. This request should include predicted equipment procurement requests to Commandant (G-CBU) using the automated ATU budget process according to current directives. The MLC request should include a line item for each clinic, proposed equipment funding, and an estimate of non-Federal care cost.

   d. Targeting AFC 57 and AFC 73 funds to pay for Department of Defense for all health care the Army, Navy, Air Force, TRICARE and USTF programs provided to Coast Guard beneficiaries.

3. Headquarters.

   a. Commandant (G-WK) obtains health services program resources from the budget process for these purposes:

      (1) Targeting AFC-57 funds to the MLC (k)s to pay for all non-Federal and VA medical care provided in each region;

      (2) Targeting AFC-57 funds to the MLC (k)s to acquire health care equipment; and

      (3) Targeting AFC-57 funds to allotment target units in response to budget requests the MLC (k)s submit.

   b. Commandant (G-WK) is also the program manager for replacing, expanding, or creating health care facilities with Acquisition, Construction, and Improvement Appropriation funds and works with Commandant (G-A) and the MLC's Facilities Design and Construction Center staffs on plans and layouts.

B. GENERAL PROPERTY MANAGEMENT AND ACCOUNTABILITY

1. Basic Policies. The Director of Health and Safety:

   a. Establishes procedures to manage and account for health care material pursuant to the personal property management policies contained in the Property Management Manual COMDTINST M4500.5A;

   b. Directs and coordinates the health care supply system;

   c. Determines requirements for health care material; and

   d. Establishes allowance lists, advises, and assists field units.

2. Physical Property Classifications. Property is divided into two categories: real property and personal property. Health care material is personal property and is accounted for in accordance with Property Management Manual COMDTINST M4500.5A

3. Property Responsibility and Accountability.

   a. Clinic administrators are responsible and accountable for the property their facilities use. Additionally, they serve as the health services finance and supply officer.

   b. In the absence of a clinic administrator, the senior commissioned health services department representative acts as the property custodian.

   c. If health services technicians only are assigned to a facility, the senior health services technician acts as the property custodian.

4. Expending Property Unnecessarily. All persons having custody of health care property shall avoid any unnecessary expenditures of such property within their authority's limits and shall prevent such expenditures by others.

5. Stock Levels, Reorder Points, and Stock Limits.

   a. General. Stock levels, reorder points, and stock limits discussed below apply to all health care facilities, especially those at major shore units such as the Academy, ISC Alameda, and Training Center Cape May. These large facilities with multiple components (e.g., pharmacy, laboratory, dental clinic, etc.) need to maintain a greater stock depth to serve their clientele. COMDTINST M4500.5A (series) contains overall supply policy and procedures.

b. Terms.

(1) Operating Stock. That quantity of material on hand needed to meet daily operating needs during the interval between delivery of replenishments.

(2) Safety Stock. That amount of inventory in addition to operating stock needed to sustain operations if deliveries are delayed or demands unexpectedly heavy.

(3) Reorder Point. Low Limit. Both terms mean the predetermined inventory level for a specific item at which it is reordered.

c. Stock Inventory and Transactions. All health care facilities shall maintain sufficient amounts of stock to prevent out-of-stock conditions. To do so, maintain stock inventory and transaction records, either electronically (on computer) or by using stock cards, inventory records, etc.

(1) Generally, health services supply activities at facilities with multiple components are authorized one month's safety stock. Experience may prove this level is not adequate for certain items or in certain circumstances. These units are authorized to maintain more a larger supply if and wherever exceptional circumstances dictate. Establish procedures to ensure reviews of stock records periodically to identify items reaching a low limit (reorder point) or the authorized allowance and quantity and to revise low limits if current usage so indicates.

(2) Ships and small shore units may use the minimum quantities indicated in the Health Services Allowance List to establish reorder points. If the list does not indicate a minimum allowance, e.g., for "optional" items, establish reorder points for commonly used items based on current usage rates. Do not order excessive quantities of material.

(3) When a ship receives orders to deploy or a station notice of a change in operating conditions that may require additional material, promptly review authorized allowance quantities to replenish critical items in time for the deployment or operational change.

(4) Pharmacies procuring drugs through prime vendor systems (either directly or through pharmacy officer staffed clinics) should try to stock one-month quantities of regularly used items. Ongoing inventories of these limited quantities are not required except where applicable for controlled substances. Pharmacies shall "sight inventory" monthly before ordering.

6. Transferring and Loaning Property. Written approval is required from Commandant (G-WKH) to loan health care property to any state, community, organization, or private individual. Property or transferred to other military units is at the commanding officer's discretion. Obtain custody receipts in such instances. Use NAVSUP 460, Equipment

Stock Card and Custody Record, or a local form for local transactions and DD-1149 to transfer property from one activity to another.

C. CUSTODY, ISSUES, AND DISPOSITION

1. Transferring Custody. When transferring custody of health services property and supplies a joint inventory is required, conducted by both the departing and relieving custodians and an independent person who has no direct interest in the inventory outcome. If a joint inventory is impossible, the departing custodian shall conduct an inventory and submit a written report to the commanding officer before departing. As soon as possible after reporting, the relieving custodian also shall conduct an inventory, report the same to the commanding officer, and indicate any discrepancies noted between the two. In both cases, the inventories should include the participation of an independent person. Additionally, in all cases, an acknowledgment of inventory correctness must be entered in the unit Health Services Log. See "Pharmacy Operations and Drug Control," Chapter 10, for detailed information on controlled substances.

2. Storerooms.

   a. At large facilities, bulk stock of health care supplies and materials used by the various facility components (e.g., pharmacy, laboratory, dental clinic, etc.) shall be kept in a specifically designated storeroom. If facility layout permits, it may be advantageous to permit designated individuals responsible for a particular component (pharmacy, dental clinic, etc.) to manage their area's expendable supplies. The individual responsible for medical supply shall process their procurement requests. Otherwise, manage clinic supplies from a designated storeroom.

   b. An individual familiar with supply procedures shall be in charge of the storeroom; he or she shall report directly to a medical administration officer.

   c. In the interest of proper management, centralize clinic procurement request processing. Medical administrator(s) shall verify all procurement requests, including prime vendor "ZOA" documents, to ensure funds are available in that component's budget allocation.

3. Issuing Material.

   a. Supplies issued by or removed from the storeroom should be immediately recorded on the appropriate stock record. In large facilities where the health services storeroom is a distinct organizational entity, stores issued shall be made only upon receiving a properly prepared and authenticated local requisition document.

   b. Use DD 1149 to issue, return, or transfer equipment between activity components.

4. Inspecting Storerooms.

a. Health services store items require periodic inspection (every three months for consumable supplies and equipment) to detect signs of deterioration or expiration. Accomplish such inspections by physically examining representative samples of various age groups of stock on hand.

b. It is extremely important to issue oldest stock first ("First in, First out"). This is true of all items but is mandatory for potency-dated items and those subject to spoilage.

5. Disposing of Property.

a. In disposing of health services personal property, follow COMDTINST M4500.5A (series) procedures regardless of the circumstances or conditions requiring disposal (e.g., over-ordering, decline in demand, fair wear and tear requiring survey, or damage requiring replacement).

b. Certain conditions may require Board of Survey action. COMDTINST M4500.5A (series) contains procedures for this action.

(1) Take precautions to assure compliance with local health and sanitation requirements when surveying and destroying poisonous chemicals (e.g., arsenic, strychnine, cyanide, etc. preparations).

(a) Ordinarily, dispose of small amounts of liquid preparations and soluble substances through the sewage system. Large quantities of soluble poisonous material may constitute pollution dangerous to public health or fish and wildlife.

(b) If destroying large amounts of drugs (including controlled substances), coordinate this action with local air and water pollution control authorities. Then destroy by complete incineration with appropriate safeguards against toxic fumes or by such other methods as local health and sanitation officials recommend if disposal through sewage system or incineration are inappropriate.

(c) Never deposit poisonous drugs and chemicals in dump piles or dumpsters.

(2) Either burn or dissipate through the sewage system drugs requiring destruction other than poisonous chemicals.

c. Dispose of used, contaminated, defective, or expired health care material in a manner that ensures it is both impossible to reuse and harmless to the environment. Completely destroy all drugs to preclude reusing them or any portion of them. Follow these specific procedures:

(1) Sharps. Place all items likely to puncture or lacerate trash handlers in rigid plastic autoclavable disposable sharp containers. Do not attempt to sterilize or cover used blades or needles (this is hazardous to personnel); simply place them in the container. At appropriate intervals, seal, autoclave, and dispose of containers as regular non-hazardous trash. These containers are NOT reusable.

(2) Tablets, Capsules, Powders. Remove from original container, crush or dissolve tablets and capsules, and flush into sewage system. Dispose of original container as trash. Follow biohazardous material disposal regulations when discarding chemotherapeutic and other hazardous agents (including biologicals).

(3) Syrettes. Cut along syrette's crimped end and discard contents into sewage system. Place in a sharps disposable container.

(4) Injectables/Parenterals. Pour bottle contents into the sewage system. Place empty vials in the trash. Follow biohazardous material disposal regulations when discarding chemotherapeutic and other hazardous agents (including biologicals).

(5) Auto Injectors. Activate the injector against a hard surface and discard contents into a suitable container. Dump container contents into the sewage system and then place the auto injector in a sharps disposable container.

(6) Incinerate biohazardous materials, including used bandaging materials, or if sterilized, dispose of them as trash.:

(7) Chapter 10 contains detailed instructions on surveying and destroying controlled substances.

(8) Destroy the above materials in an appropriate area using appropriate personnel protection: rubber gloves, protective goggles, and proper ventilation.

d. Do NOT dispose of medical materials at sea. Prepare materials for disposal and retain them on board in a secure area until disposed in accordance with Federal, state, and local laws.

e. Commandant Notices and other directives requiring disposal of defective material constitute authorization to effect immediate disposal of any of the suspect items on hand.

D. HEALTH SERVICES SEGMENT OF THE COAST GUARD SUPPLY SYSTEM

1. Health Services Control Point. Commandant (G-WKH-2) is the Health Services Control Point for Coast Guard health care material; in that capacity he or she takes these actions.

   a. Prepares and distributes the Health Services Allowance List, COMDTINSTs M6700.5, M6700.6, and M6700.7(series).

   b. Informs and assists field units; and

   c. Reviews and responds to requests to change units' base operating funds allotment targets. Annually provides funds for routine health care supplies to the field as part of the recurring base of funds distributed through the Administrative Target Unit (ATU) budget process.

2. Responsibility for General Stores Items.

   a. Supply Officer.

      (1) Procures, receives, stores, issues, ships, transfers, and accounts for command stores and equipment;

      (2) Maintains specified records; and

      (3) Submits required reports for stores and equipment.

   b. Health Services Department Representative. Except where specific responsibility has been assigned, the Health Services Department Representative does not determine general supply requirements but acts in an advisory capacity for those items the department uses. The Health Services Department Representative will maintain close contact with the Supply Officer on special department needs and advise the latter when the requirement for any item will exceed the quantity normally carried in stock. The individual designated in writing as responsible for Health Services supply operations shall maintain a supply policy and procedures manual.

3. Supply Support Assistance.

   a. Direct problems with supply support of health care supplies (except controlled drugs) that cannot be resolved through the supply source, to Commander, Maintenance and Logistics Command (k). Direct problems with supply support of controlled drugs to Commandant (G-WKH).

   b. Commandant (G-WKH) will coordinate initial outfitting of new classes of units and vessels. Commander, Maintenance and Logistics Command (k) will help in the initial

outfitting process, limited to submitting requisitions and staging, when Commandant (G-WKH) so requests through Commandant (G-CPM).

4. Authorized Allowances. Coast Guard units are assigned specific minimum required allowances of health care supplies and equipment as described in COMDTINST M6700.5 (Shore Units), M6700.6 (Vessels), and M6700.7 (Shore Units and Vessels)(series).

5. Supply Sources.

   a. Standard Items. Items listed in the DOD Medical Catalog (microfiche) are "standard". Obtain items with an Advice Acquisition Code (AAC) of "D" from the Defense Personnel Support Center (DPSC) through the Automated Requisition Management System (ARMS).

   b. Non-standard Items.

      (1) Obtain "non-standard" items, i.e., those not described as above, from commercial sources.

      (2) All commercial procurements shall be made under the applicable acquisition regulations and Coast Guard Acquisition Procedures, COMDTINST M4200.19 (series). Commercial procurement of health care supplies, equipment, and repair and maintenance service is authorized in these conditions:

         (a) Time does not permit obtaining standard items from Government sources; or

         (b) A legitimate need exists for nonstandard items;

         (c) Equipment requires repair or maintenance.

      (3) These items are authorized:

         (a) Newly listed standard items not available from government sources;

         (b) Necessary non-standard health care supplies and equipment;

         (c) Medical Catalog (microfiche) items bearing the Acquisition Advice Code "L";

         (d) Equipment repair and maintenance (excluding installation); and

         (e) Health care technical books, publications, and professional journals.

      (4) Local or commercial procurement is not authorized for these items:

         (a) Non-standard items differing only slightly from standard items of identical capability; and

         (b) Preferred trade names and proprietary products in lieu of standard items.

c. Prime Vendor Items.

(1) A prime vendor is one pre-arranged on behalf of the government procurement system. The Defense Personnel Support Center (DPSC) negotiates prime vendors, equivalent to Federal "depot" sources, for medical commodities.

(2) Where available, DPSC prime vendors shall serve as the primary source of supply for pharmaceuticals. Use other sources if it is determined their price or service better meet the unit's needs.

6. Equipment.

a. New Installations. The appropriate construction project (AC&I) funds normally will pay for equipment for newly constructed facilities. To ensure standardization, authorization and approval MUST be obtained from Commandant (G-WKH) before requisitioning or procuring health care equipment for new installations.

b. Replacement Equipment. See Section 6-A for detailed information on health services equipment replacement procedures and reporting requirements.

c. Receipts.

(1) The unit shall retain one copy of signed receipts for health services material for record purposes.

(2) Send one copy of signed receipts for all health care equipment to MLC (k).

(3) Maintain copies of receipts for controlled substances and security materials separately for record purposes.

d. Maintenance.

(1) Each unit is responsible for maintaining health care equipment in optimum, safe operating condition. Maintenance shall include:

(a) Measures necessary to ensure the equipment's operating safety and efficiency (preventive maintenance);

(b) Manufacturer's representatives' required checks to meet warranty requirements;

(c) Removing from service if deficiencies are detected; and

(d) Replacing defective parts.

(2) Preventive maintenance is systematic inspection of and service to equipment to maintain it in optimum operating condition. A properly executed program will

detect and correct minor problems before they render the equipment inoperable. Manufacturers usually require preventive maintenance to maintain the warranty. Maintenance records are also valuable tools for evaluating equipment needs and justifying future equipment procurement requests.

(3) Each clinic shall designate a Preventive Maintenance Coordinator who ensures the program is established and functions effectively. If a Biomedical Equipment Repair Technician (BMET) is assigned to the unit, he or she fills this role. If not, designate an individual with mechanical aptitude or a desire to work with equipment to fill this role. Clinics may contract for preventive maintenance services if funding permits and are encouraged to enter into cooperative agreements with DOD MTFs whenever possible. Each unit shall:

(a) Establish a preventive maintenance schedule for all health care equipment. Each unit shall determine maintenance intervals based on manufacturers' recommendations and frequency of use.

(b) Maintain a written record of all preventive maintenance and repairs performed on health care equipment using NAVMED 6700/3CG, Medical/Dental Equipment Maintenance Record; see Figure 8-D-1. Use side A to record preventive maintenance and safety checks and side B to record repairs.

(c) Charge clinic health care equipment maintenance costs to unit AFC-57 funds and sickbay health care equipment maintenance costs to unit AFC-30 funds.

(d) MLC and HQ units shall establish and maintain a program to replace their health care equipment.

7. Uniform. USPHS officers assigned to Coast Guard detail shall wear the Coast Guard uniform as prescribed in USCG Uniform Regulations, COMDTINST M1020.6 (series). They shall wear USPHS devices on Coast Guard blue background in place of the Coast Guard shield on the combination cap, garrison cap, shoulder boards, and sleeve insignias. For officers transferring from another USPHS assignment to the Coast Guard detail, the unit shall issue Coast Guard uniforms consisting of one service dress blue uniform with two pairs of trousers, three light blue long-sleeve shirts, three light blue short-sleeve shirts, a raincoat and a wind-breaker according to the Comptroller Manual. Vol. III, COMDTINST M4400.19A (series). Women will receive a hat frame; they may substitute a skirt for one pair of trousers in their uniform issue. USPHS officers may wear lab coats and smocks as prescribed in USCG Uniform Regulations, Section 11-B.

E. EYEGLASSES AND OPHTHALMIC SERVICES

1. General. This section describes ophthalmic services (refractions and spectacle issue) provided.

2. Personnel Authorized Refractions.

   a. Coast Guard medical treatment facilities and USMTFs to the extent of available facilities, including ophthalmologists' and optometrists' services, may furnish refractions to active duty and retired uniformed services members.

   b. Where USMTF's are not available, MLC (k) may authorize refractions at other facilities for active duty members only.

   c. USMTFs may furnish non-active duty eligible beneficiaries refractions if facilities are available. USMTFs may not furnish eyeglasses to dependents at government expense except as Section 8-E-8 authorizes.

   d. Reserve members on active duty for training for more than 30 days are authorized repair or replacement of standard eyeglasses during the active duty if the member did not damage or lose the eyeglasses through his or her own negligence.

3. Procuring and Issuing Standard Prescription Eyewear.

   a. Coast Guard units shall order standard eyewear from optical laboratories as outlined in this section.

      (1) Civilian sources are acceptable for procuring eyewear providing the prescription is for standard frames and lenses are available from fabrication labs. Transcribe this request on DD-771, Eyewear Prescription.

      (2) If fabrication would entail a prolonged delay (more than eight weeks) and the member's vision is so poor he or she cannot safely perform assigned duties, procure non-standard eyewear from local civilian sources using non-Federal health care funds.

      (3) Members requiring corrective lenses shall have two pair at all times, including eyeglasses issued from government sources or purchased at their own expense.

      (4) Requests for tinted eyewear for non-aviation members must be justified solely on the duties they perform, e.g., majority of duty time in bright sunlight, etc.

      (5) Replacement eyewear may be obtained without repeating a visual acuity check, provided the replacement prescription is less than two years old. If a corrected

visual acuity check is required and indicates the current prescription is inadequate, and obtain a refraction.

b. Available Eyewear and Standard Eyewear Sources of Supply.

(1) These types of eyewear are available:

| Type of Correction | Cellulose acetate frame | |
|---|---|---|
| | **Glass Lens** | **Plastic Lens** |
| Single Vision, white [1] | X | X |
| Single Vision, tinted [1, 2] | X | X |
| Bifocal, 25mm segment, white [1] | X | X |
| Bifocal, 25mm segment, tinted [1, 2] | X | X |
| Trifocal, white | X | |
| Cataract Aspheric | | X |
| Trifocal, white and tinted [1, 2] | | X |
| (1) Eyewear provided in FG-58 (Flight Goggle) mounting for authorized personnel<br>(2) Only N-15 and N-32 tints authorized | | |

(2) Process all requests for standard prescription eyewear through these military optical laboratories; they are the only optical laboratories from which Coast Guard units are authorized to order standard prescription eyewear.

| Units East of the Mississippi River | Units West of the Mississippi River |
|---|---|
| Naval Ophthalmic Support and Training Activity<br>Yorktown, VA 23691-5071 | Optical Fabrication Laboratory<br>Fitzsimons Army Medical Center<br>Denver, CO 80045-5001 |

(a) The appropriate optical laboratory will either manufacture the eyewear or send the DD-771 to another facility for manufacture, depending the uniformed service to which the member or retiree belongs.

(b) The Coast Guard pays only for glasses ordered and processed for Coast Guard active duty or retired personnel; therefore, it is extremely important to properly complete the DD-771 service identification block to indicate the patient's service affiliation.

(3) Procurement Procedures. Order all prescription eyewear using DD-771, Eyewear Prescription. It is extremely important to accurately complete the prescription form. If the prescription is wrong, the patient is inconvenienced; the Coast Guard

is required to pay for eyewear even if it cannot be used; and the supply activity will reject an improperly prepared prescription, resulting in delay. Use these guidelines to prepare DD-771. See Section 4-B for more detailed instructions.

(a) Use a separate DD-771 for each type of eyewear.

(b) If no health services personnel are available at the unit, send the prescription obtained from the health record or local civilian source to the health record custodian to prepare and submit the DD-771.

(c) Submit all three DD-771 copies to the approving authority or supply activity; disregard the distribution instructions. Remove all carbon sheets before submission. File a photocopy of the DD-771 in the member's health record.

(d) TRACEN Cape May shall send recruits' eyewear prescriptions separately and mark the envelope, "RECRUIT—PLEASE EXPEDITE".

(e) Report delays longer than eight weeks in receiving eyeglasses to the appropriate MLC (k).

(4) Health Record Entries. Record on a separate DD-771 the current prescription, including frame measurements and all other data necessary to reorder eyewear, for each individual requiring eyeglasses.

4. Aviation Prescription Lenses. These personnel are authorized two pair of clear aviation spectacles (FG-58) and one pair of tinted spectacles (N-15) in matte chrome only:

a. Aviators Engaged in Actual Flight Operations. Aviation spectacles may be ordered for distant vision correction , or for distant vision and near vision correction (bifocal lenses). Those aviation personnel engaged in flight operation who desire near vision only correction in aviation frames must order bifocal lenses containing plano top portion and the near vision correction on the bottom. Spectacles containing only near vision correction are not authorized in aviation frames. This type correction will only be order in cellulose acetate frames.

b. Landing Signal Officers (LSO).

c. Coast Guard Ceremonial Honor Guard personnel.

d. Small Boat Crew required to wear a helmet while performing their assigned duties.

5. Contact Lenses. Contact lenses are issued only to active duty personnel for postocular surgical difficulties or to enable a member to overcome a handicapping disease or impairment. MLC (k) will not approve contact lenses solely for cosmetic reasons.

a. Submit letter requests for contact lenses to MLC (k) under Section 2-A-6.d.; include the type of lenses and cost.

b. If MLC (k) approves, he or she will provide an authorization number by return correspondence. Units will write this number on all correspondence and billings before submitting to MLC (k).

6. Sunglasses for Polar Operations. Military fabrication laboratories no longer issue polar operation sunglasses. Activities requiring such glasses may use the process below to obtain them:

   a. Non-prescription Lenses. If issuing, the command must purchase and issue non-prescription lenses as part of the cold weather clothing allowance and pay the lenses' costs from operating expenses. The command should issue the lenses on a custodial basis; departing members should return them to the command for reissue.

   b. Prescription Lenses. Procure prescription lenses in the specifications below under the guidelines in Comptroller Manual, COMDTINST M4400.19A (series), Vol. III.

      (1) Aviation-type frames; and

      (2) Lenses must contain Type 1 or 1-A metallic coat.

7. Safety Glasses.

   a. Non-prescription or prescription safety glasses meeting American National Standards Institute Standard Z87.1 shall be for industrial wear to military and civilian personnel working in any environment hazardous to eyes, e.g., welders, machinists, mechanics, riggers, and grinders.

   b. Non-prescription safety glasses shall be furnished on a custody receipt when a prescription lenses are not required..

   c. Prescription safety glasses are no longer available from military optical laboratories. Procure them under the guidelines in the Financial Resources Management Manual (COMDTINST M7100.3A).

8. Dependent Care in Isolated Areas. Spectacles may be furnished to command-sponsored dependents of uniformed services members assigned outside CONUS.

9. Contemporary Prescription Eyewear Procurement. This optional program enables active duty members to obtain contemporary prescription eyewear on a cost-shared basis. COMDTINST 6490.1A (series), contains current policies and procedures to obtain contemporary prescription eyewear.

# CHAPTER 9

# HEALTH SERVICES TECHNICIANS ASSIGNED TO INDEPENDENT DUTY

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# CHAPTER 9. HEALTH SERVICES TECHNICIANS ASSIGNED TO INDEPENDENT DUTY

## Section A - Independent Duty Afloat.

1. Introduction. An independent duty health services technician (IDT) is a Health Services Technician (HS) assigned to an afloat unit that has no attached medical officer. Assignment to independent duty is challenging. The role is one of tremendous responsibility and at times can tax even the most experienced HS's skill, knowledge and ability. Along with the increased responsibility and sometimes arduous duty comes the potential for personal satisfaction unsurpassed by any other job assignment.

2. Mission And Responsibilities.

   a. Mission. The Health Services Technician serving independently is charged with the responsibility for the prevention and control of disease and injury, and the treatment of the sick and injured.

   b. Responsibilities. The Commanding Officer (CO) is responsible for the health and physical readiness of the crew of the unit. In the absence of a permanently attached Medical Officer (MO) the vessel's Executive Officer (XO) is designated by Coast Guard Regulations as the unit's medical officer. The role of the IDT is to assist the command in maintaining the good health and physical readiness of the crew. To accomplish this responsibility, the IDT must be informed of planned operations and anticipate any operational demands resulting from such operations. To this end, the IDT will consult and advise the Command in all matters with potential to effect crew readiness or the health of personnel. Some of the duties of the IDT include:

      (1) Assessment and treatment of illness and injury;

      (2) Prevention of illness and injury through an aggressive environmental health program. Such a program includes inspection of living and working spaces; food service and storage areas and food storage and handling practices; integrated pest management practices; potable water quality surveillance; and recognition and management of communicable diseases;

      (3) Provision of Health Services training aligned with the needs and mission of the unit;

      (4) Security and proper use of Health Services supplies, material and property;

      (5) Supply and logistics to ensure supplies, materials and equipment necessary to carry out the mission of the Health Services Department are obtained and maintained in sufficient quantity and condition to support the unit mission and operation;

      (6) Health Services Department administration, maintenance and security of health records;

      (7) Strict adherence to Chapter 2 of this Manual which contains information about general and specific duties of the HS serving independently.

3. Chain Of Command. The IDT will normally be assigned to the Administrative Department and will report directly to the Executive Officer (XO).

4. Operation Of The Health Services Department. The IDT is tasked with a wide variety and high volume of duties and responsibilities. This section sets forth policy and guidelines designed to assist the IDT in carrying out assigned duties and responsibilities.

   a. Health Services Department Standard Operating Procedure. In order to successfully manage the Health Services Department the IDT must use time management and organizational skills and tools. One such tool is a written Standard Operating Procedure (SOP) for the Health Services Department. The SOP will govern the activity of the IDT and has as its guiding precept the goals and missions of the unit. The SOP will be developed and submitted in written form to the CO for approval via the chain of command. In addition, the SOP will be reviewed at least annually by the IDT, XO and CO. The approved SOP will be kept in the Health Services Department for easy referral. Copies of pertinent sections will be posted as appropriate. The SOP will include:

      (1) A copy of the IDT's letter of assumption of duties as Health Services Department Representative;

      (2) A written daily schedule of events for both underway and inport periods;

      (3) Copies of all letters of designation, assignment, and authority that directly impact upon the IDT or Health Services Department. Examples include those granting "By direction" authority, designation as working Narcotics and Controlled Substances custodian, and assignment of a Designated Medical Officer Advisor (DMOA);

      (4) A copy of the unit's organizational structure. This document will show graphically the IDT's chain of command;

      (5) A listing of duties and responsibilities assigned to the IDT and the frequency that they are to be carried out. The listing will include both primary and collateral assigned duties;

      (6) A listing of all required reports, the format required for submission, the frequency or date required, required routing and required "copy addressees". Incorporation of this information in tabular format provides a quick and easy guide for reference purposes;

      (7) A water bill, for the safe handling of potable water;

      (8) A unit instruction or SOP for the management of rape or sexual assault cases. The document must provide policy for Health Services Department action in such cases, names of organizations, points of contact and telephone numbers for local resources as well as contact information for agencies and facilities which must be notified. It must contain a prearranged mechanism for timely completion of a physical examination for the purpose of evidence gathering that meets requirements of all applicable law enforcement agencies. Additionally, it must define limitations that will exist if the unit is underway at the time the incident occurs;

(9) A unit instruction or SOP for the management of suicide threat or attempt. The document must provide policy for Health Services Department action in such cases, names of organizations, points of contact and telephone numbers for local resources, contact information for agencies and facilities which must be notified as well as a listing of required information, reports or actions.

(10) A unit instruction or SOP action required in the event of family violence. The document must provide policy for Health Services Department action in such cases, names of organizations, points of contact and telephone numbers for local resources, contact information for agencies and facilities which must be notified as well as a listing of required information, reports or actions.

b. Other Necessary Documents. The IDT is an integral part of many unit activities and various unit bills and doctrines require specific action by the IDT. Since these are changed frequently, incorporation of Health Services Department responsibilities contained in these various documents into the Health Services Department SOP is not recommended. Applicable portions should be kept in the Health Services Department for quick reference, however. These include:

(1) A battle doctrine for the unit.

(2) Portions of the unit mass casualty bill pertaining to Health Services Department responsibility;

(3) Portions of the unit general emergency bill pertaining to Health Services Department responsibility;

(4) Portions of the unit man overboard bill pertaining to Health Services Department responsibility;

(5) Portions of the unit replenishment at sea, special sea detail, flight quarters and bomb threat bills pertaining to Health Services Department responsibility.

c. Departure From the Daily Schedule of Events. The day-to-day operation of the Health Services Department is complex and impacted upon by the operational needs of the unit. It will of necessity change when events of higher priority or concern occur. If deviation from the daily schedule of events is required, notification of the XO (IDT's Division Officer) will be made at the earliest opportunity. When deviation from daily schedule of events occurs frequently, the daily schedule of events will be reviewed and if necessary, changed. Any changes will be incorporated into the Health Services Department SOP and approved by the Commanding Officer.

d. Relief and Assumption of Duties as the IDT. Proper documentation of the status of the Health Services Department, the condition of its equipment, stores, and records is required at the time of relief and assumption of the duties and responsibilities as the IDT. The process is complex and requires both the incoming and outgoing IDT to jointly perform the following:

(1) A complete inventory of all medical stores, spaces, and equipment, including durable medical equipment. The Health Services Allowance List Afloat

(COMDTINST M6700.6D series) provides a listing of supplies and the equipment required by each class of vessel.

(a) A controlled substances inventory must be done. Use direction provided in Chapter 10 of this Manual.

(b) A complete inventory of all unit property in custody of the Health Services Department;

(2) A review of ongoing actions affecting the status of Health Services, e.g., outstanding requisitions, survey or repairs, and proper documentation of all such transactions;

(3) A review of the Health Services Department SOP;

(4) A review of the most recent Maintenance and Logistics Command (MLC) Quality Assurance Assistance Survey for the unit. A copy of the survey annotated with any finding of incomplete or uncorrected discrepancies will be included as an enclosure to the letter of relief;

(5) A review of crew training files required for Tailored Ships Training Availability (TSTA) evaluation. Paragraph A.6. of this chapter provides a listing of requirements;

(6) A review of all health records for completeness and accuracy;

(7) A complete health, safety and sanitation inspection of the vessel, to include status of potable water systems (records of bacteriological, halogen content and pH testing), food stores inspections, and berthing and habitability of living and berthing spaces.

e. Letter of Relief and Assumption of Duties. Upon completion of the Health Services Department review a basic Coast Guard letter will be prepared and submitted by the oncoming IDT via the chain of command and will advise the Commanding Officer of the status of the Health Services Department. A copy of the letter will be forwarded to the cognizant MLC. The letter of Relief and Assumption of Duties will provide the following:

(1) Date of assumption of duties; a statement that the duties and responsibilities of the IDT have been assumed; and a statement that a thorough review of the Health Services Department has been conducted. Any discrepancies of material or record keeping will be annotated on a copy of the unit's most recent MLC Quality Assurance site survey and this survey submitted as an enclosure to the letter of Relief and Assumption of Duties as IDT for the vessel;

(2) Any discrepancies noted upon relief will be handled as a matter of individual command prerogative. Responsibility for correction, adjustment of account or inventory records, action required to replace missing items, as well as any necessary disciplinary action will be determined by the command;

(3) In cases in which no "on site" relief occurs, all of the preceding action will be completed. The supply officer of the unit will participate in the review process in place of the outgoing IDT.

f. Actions Upon Proper Relief. Upon assumption of duties as the unit's IDT, one of the first tasks to complete is a thorough review of all SOPs and department instructions. Check the references, make contact with any listed Points of Contact. If possible, make visits and introductions in person. Find out how each system works and how it is accessed.

5. Providing Health Care Afloat. Provision of health care is undoubtedly the most challenging and rewarding part of the job of an IDT. An IDT bears a tremendous responsibility. This responsibility can never be taken lightly. This section is intended to provide a brief summary of the various facets of providing medical care afloat.

a. Designated Medical Officer Advisor (DMOA). Each independent HS will be assigned a DMOA in accordance with Chapter 2 of this Manual. Good communication between the IDT and the unit DMOA can eliminate many problems affecting health care delivery to the crew. The IDT will schedule a visit to the DMOA as soon as is practical after reporting aboard. The purpose of the visit is to allow first-hand communication of expectations, support facility requirements, and any unique needs or concerns. Open communication can be maintained through regular visits when practical, or at minimum, regular telephone calls. With regard to provision of direct care, the IDT will seek DMOA or another MO's advice whenever there are questions about a patient's condition or when the following conditions exist:

(1) Return to sick call before assigned follow-up because of failure to improve or condition has deteriorated;

(2) Member cannot return to full duty status after 72 hours duration because of unresolved illness;

(3) Undetermined fever of 102 degrees Fahrenheit or higher (when taken orally) persisting for 48 hours;

(4) Fever of 103 degrees Fahrenheit or higher (when taken orally);

(5) Unexplained pulse rate above 120 beats per minute;

(6) Unexplained respiratory rate above 28 breaths per minute or less than 12 breaths per minute.

(7) Depression with suicidal thoughts;

(8) Change in mental status;

(9) Chest pain or arrhythmia;

(10) Unexplained shortness or breath;

(11) Rape or sexual assault.

b. Gender Considerations. Chapter 1.A. of this Manual provides specific direction for health services technicians about patient privacy, same gender attendant requirements, and examination restrictions.

c. Avoiding Common Problems. Scheduling and obtaining the routine medical care needed by crewmembers during short inport periods can tax the organizational skills of even the most experienced IDT. There are, however, actions that the IDT can take which will enhance the chances of getting the routine appointments needed for all members. Some of these are:

(1) Identify the routine medical and dental needs of the crew well in advance of return to port. The vessel's supporting clinic has an established appointment scheduling procedure within which the IDT must work whenever operational schedules allow. Provide requests via message (or other written form as appropriate) for appointment scheduling ahead of "appointment schedule opening" for the inport period whenever possible. Request reply by message prior to the vessel's scheduled return to port. Provide the list of scheduled appointments to division officers and shop chiefs for the purpose of identifying in advance operationally related conflicts or leave. Provide request for any appointment rescheduling or changes by message as soon as possible;

(a) When routine medical or dental care is to be made directly to a DOD MTF, the IDT must determine the facility requirements for referral of patients and follow any local procedures.

(2) Communicate with the vessel's supporting clinic. Visit the supporting clinic, if practical, as soon as possible after return to port. Discuss the crew's medical and dental needs with the clinic supervisor and DMOA (if located at the facility);

(3) Post a listing of appointment dates and times as soon as it becomes available. Provide each division officer and shop chief a listing of the appointments applicable to the division or shop;

(4) Hold members accountable to be at their appointed place and time. Provide feedback to division officers and shop chiefs on any appointment failure. Notify XO of more than one failure.

d. Consultations. During the management of complex or protracted cases, consultations or specialty referral may be necessary. When such services are needed, the IDT will normally make referral to a Coast Guard clinic or in some cases, a Department of Defense medical treatment facility (DoD MTF). When referring a patient to see a medical officer at a CG health services clinic, the IDT shall ensure that a SF-600 entry is completed using the SOAP format and that an appointment is scheduled. The clinic will normally provide treatment or arrange care if treatment is beyond its scope. When consultations or referral for specialty care are made directly to a DOD MTF, the IDT must determine the facility requirements for referral of patients and follow any local procedures. Referrals to a DOD MTF will normally be documented using a Consultation Sheet (SF 513) or a Referral for Civilian Medical Care DD (2161). The consultation will provide a concise history of the condition to be evaluated as well as any pertinent findings. A provisional diagnosis is normally expected by the consultant. Chapter 4 of this Manual provides direction on completion of a SF 513. The patient and the patient's supervisor must be informed of all consultation or referral appointment dates and times. Courtesy is an important part of maintaining good working relationships with the facilities that the independent duty HS accesses for consultation and referral. Timely notification of the referral facility when appointment changes or cancellations occur (along with brief explanation of why the change is required) help maintain those relationships. Whenever possible, provide at least 24 hours notice of changes or cancellations.

e. Medical Evacuation (MEDEVAC) of Injured or Ill Crewmembers. Medical evacuation must be considered when care needed by a patient to preserve life or limb, provide pain relief beyond capability onboard, or to provide other medical or dental treatment for which delay until the unit's next scheduled port call would provide undue hardship or pain for the patient. The unit's ability to MEDEVAC a patient will be affected by the vessel's current mission, availability of air transport assets, and location. When considering or executing a MEDEVAC:

(1) Keep the XO informed. At first indication that a MEDEVAC may become necessary, notify the XO;

(2) Request, via the XO, communication with the IDT's DMOA, a medical officer familiar with the vessel's current area of operation or a flight surgeon if MEDEVAC is to be by aircraft. In addition to a thorough patient presentation, information about the unit's location in relation to medical resources ashore and realistic estimations of time requirements to reach a point that MEDEVAC is possible, must be available. Keep the XO and the DMOA/medical officer/flight surgeon advised of any change in the patient's condition;

(3) Thoroughly document the MEDEVAC process. Ensure that a complete patient record is maintained in the patient's health record. Maintain a complete record of events in the Health Services log. Make entries as events occur. It is very difficult to reconstruct an accurate log entry "after the fact".

(4) Keep the patient informed. Explain in as much detail as possible the actions being taken and expected outcome of the actions. As time of departure approaches, describe for the patient what to expect during transport and upon

arrival at destination. If a Coast Guard Beneficiary Representative is attached to the medical facility to which the patient is being MEDEVACed, provide this information to the patient.

(5) Ensure that all documentation about the patient's condition is contained in the health record and that it and any medication needed by the patient during transport are securely packaged and ready for transport with the patient. Ensure that information necessary for unit contact and contact of the unit's supporting clinic are provided and easily located by the receiving medical facility. Anticipate the patient's need for personal items, including a valid Armed Forces Identification Card, and ensure these are packaged for transport with the patient. Limit such items to those that are necessary. Encourage the patient to limit cash.

(6) Notify the unit's supporting clinic of the MEDEVAC and any needed assistance for the patient.

(7) Provide an inpatient hospitalization notification message in accordance with current directives. See Chapter 6.A. of this Manual.

f. Surgical Procedures. Most routine minor surgical procedures will be delayed until the vessel is in port. Surgical procedures while underway will be limited to only those procedures that are needed in order to return a patient to a fit for full duty status. These procedures include:

(1) Placing and removing sutures in a wound;

(2) Incision and drainage;

(3) Unguinectomy;

(4) Paring down painful plantar warts.

g. Refusal of Treatment. Medical, dental, and surgical treatment will not be performed on a mentally competent member who does not consent to the recommended procedure except:

(1) Emergency care is required to preserve the life or health of the member;

(2) Isolation and quarantine of suspected or proven communicable diseases as medically indicated or required by law to ensure proper treatment and protection of the member or others.

h. Motion Sickness. Members that manifest chronic motion sickness, that do not respond to conventional therapy, and are unable to perform their duties as a result, will be considered for administrative separation from active duty as per the Personnel Manual, COMDTINST M1000.6 (series).

i. Antibiotic Therapy. The IDT may prescribe and administer antibiotics included on the Health Services Allowance List Afloat. Whenever possible, the IDT should consult with his/her DMOA or a medical officer for a recommendation or concurrence prior to administering antibiotic therapy. If consultation is not possible prior to administration a message must be sent to the DMOA providing case history, ICD9CM code and treatment provided.

j. Health Services Treatment Space. The Health Services treatment space will be manned at all times when patients are inside. All items are to be stowed in their proper place and secured. All medical records shall be locked in a cabinet. At no time should the Health Services space be left unlocked when the IDT is not onboard.

k. Patient Berthing. Some units have facilities for short term berthing of patients in the Health Services Department. These facilities are provided to facilitate close patient observation or treatment. No person other than the sick or injured will be berthed in the Health Services Department. The IDT may sleep in the Health Services Department when attending an injured or sick patient, but will have a regularly assigned berthing space. Personal gear and clothing are not to be stored in the Health Services Department. The Health Services Department will not be used as berthing spaces for augmented personnel.

l. Not Fit For Sea Duty. Members who are medically, surgically, or orthopedically unfit for sea duty (including wearing a cast or needing to use crutches), and unable to perform their duties will not be placed onboard the vessel. Personnel will either be placed on Limited Duty ashore or on Convalescent Leave.

m. Convalescent Leave. Convalescent leave is a period of leave not charged against a member's leave account. It can be a recommendation to the command when a patient is Not Fit For Duty (usually for a duration expected to be greater than 72 hours) and whose recovery time can reasonably be expected to improve by freedom from the confines of quarters. It should be considered only when required as an adjunct to patient treatment. The command must evaluate each recommendation. Commands are authorized to grant convalescent leave as outlined in Chapter 4 of the Personnel Manual.

n. Controlled Substances. Regulations for the handling, storage, and issue of narcotics and controlled substances are found in Chapter 10 of this Manual. The contents of this section are not intended to contradict the guidance provided there. This section serves to amplify policy provided with respect to medicinal narcotics and controlled substances onboard afloat units.

(1) Narcotics and controlled substances require special handling. All controlled substances shall be obtained through the unit's collateral duty pharmacy officer.

(2) The CO will designate a commissioned officer as the controlled substances custodian (CSC). The CSC will follow the accounting procedure provided in Chapter 10 of this Manual. The IDT will normally be assigned as custodian for

narcotics and controlled substances working stock. Such assignment must be made in writing.

(3) All issues from working stock will be documented with a properly completed, written prescription. All non-emergent care requires contact with a medical officer before dispensing any controlled medication. The medical officer's orders will be documented on a prescription and in the patient's health record. The words "By verbal order of" will precede the ordering medical officer's initials, last name, time of order and date of order both on the prescription and in the patient's health record. In the event of a true emergency, a medical officer's order is not needed to dispense a controlled substance. Once the emergency situation is over or alleviated, the IDT will contact a medical officer, detail the circumstances and the controlled substances that were administered. Upon concurrence by the medical officer, the prescription prepared for the patient will be annotated with the words "By concurrence of" the ordering physician's initials, last name, time of concurrence and date of concurrence.

(4) The XO will countersign all prescriptions prepared by the IDT prior to issue of any controlled substance or narcotic.

(5) Controlled substances stored aboard cutters shall be limited to amounts in the Health Services Allowance List (HSAL). If the need exists for the unit to carry additional quantities of controlled substances based on use or potential for operational need, a written request signed by the Commanding Officer will be forwarded to the unit's cognizant MLC (k). The request must include, nomenclature, quantity, and brief justification.

o. Dental. It is the duty of the IDT to arrange for the necessary dental examinations of the crew. All personnel should be Class I or Class II prior to deployment.

(1) All personnel must receive an annual dental exam.

(2) The IDT will arrange, usually via message, for the large group of dental appointments needed for crewmembers returning from deployment. A signup sheet and announcement to the crewmembers is advised, and early communication with the staff of the dental clinic is recommended in order to allow sufficient time for the scheduling of a large amount of dental visits. Urgent cases obviously are to be scheduled first, regardless of rank or position of the member. Once back in port, active communication with a designated POC in the dental clinic is advised in order to handle cancellations, substitutions and last minute appointment changes. Although it may be time consuming, it is easier to deliver patient reminders the morning of the scheduled appointment than to try and explain a group of no-show crewmembers to a dental officer or XO.

p. Rape or Sexual Assault. All victims of rape or sexual assault must be treated in a professional, compassionate and non-judgmental manner. Examination of rape and sexual assault victims will be limited to only visual examination of any wound or injury and treated according to present standards of care. In all cases, a medical officer will be contacted for advice. In the event that no medical officer is available (underway), an IDT may conduct the visual examination. A chaperone of the same gender as the patient will be present if such examination is conducted. All aspects of the patient encounter must be carefully documented. Physical examination to gather evidence of rape or sexual assault is strictly prohibited. Also, see paragraph A.4.a. of this chapter.

q. Suicide Prevention. An encounter with a suicidal person is always a deeply emotional event. It is important for the IDT to act in a caring and professional manner. Early intervention and good communication skills are essential. If suicidal ideation is suspected it is important to remember:

(1) Take all threats and symptoms seriously. Immediately seek professional help from the nearest MTF for any member considering suicide. At no time should the person be left unattended;

(2) Actively listen to the patient. Do not argue, judge, attempt to diagnose, or analyze the person's true intentions. It is important to provide a calm, caring, professional demeanor throughout the entire situation. Thoroughly document the patient encounter using the SOAP format;

(3) Arrange for an escort and a driver to transport the patient to the nearest Coast Guard clinic, MTF or civilian emergency room with facilities appropriate to the situation. The unit's SOP for suicide threat or attempt should contain this information for ready use if needed. If underway, then a MEDEVAC must be considered. An IMARSAT phoncon with a flight surgeon, if MEDEVAC by aircraft is required, the IDT's DMOA or a medical officer familiar with the area of operation is required.

r. Decedent Affairs. Chapter 5 of this Manual contains guidance about action that the Health Services Department must take when there is a death aboard a Coast Guard unit. Chapter 11 of the Personnel Manual, COMDTINST M1000.6A (series) contains further guidance concerning casualties and decedent affairs, as does the Decedent Affairs Guide, COMDTINST 1770.1C (series). It is unlikely that the IDT will be assigned as the Casualty Assistance Calls Officer (CACO) for the command, but the IDT will undoubtedly be heavily involved with the process of proper disposition of remains, so familiarity with the information required is helpful. The IDT should also perform the following:

(1) An entry in the Health Services Log will be made detailing all available information concerning the death;

(2) The health record of the deceased member will be terminated in accordance with Chapter 4 of this Manual.

s. Disposition of Remains.

(1) As soon as possible, remains will be transferred to the nearest Military Treatment Facility (MTF) for further disposition. When transfer cannot be accomplished immediately, the remains will be placed into a body pouch and refrigerated at a temperature of 36 to 40 degrees Fahrenheit to prevent decomposition. The space must contain no other items and must be cleaned and disinfected before reuse. Remains will be identified with a waterproof tag, marked with waterproof ink, and affixed with wire ties to the right great toe of the decedent and also to each end of the body pouch. The minimum information needed on each tag includes the full name, SSN and rate of the decedent. Whenever possible, do not remove items attached to the deceased at time of death. Such items may include (for example) IV lines, needles, lengths of cord or line, etc. These may be important during an autopsy.

(a) Additionally, do not discard or launder clothing of the deceased. These items are sometimes important to surviving family members and in some cultures are part of the mourning process for the deceased. This is a cultural consideration but should be a part of the decision process.

t. Physical Disability Evaluation System. The medical board process is detailed in Chapter 17.A. of the Personnel Manual, COMDTINST M1000. 6A (series) and the Physical Disability Evaluation System, COMDTINST M1850.2 (series).

(1) Death Imminent. Chapter 17 A of the Personnel Manual and the Physical Disability Evaluation System Manual describe the actions a unit must take to initiate an expedited review process. The purpose of the expedited review process is to provide a member whose death is imminent, with the counsel to represent the member's best interests, and an opportunity to make timely decisions that will maximize applicable benefits for the member's dependents. The IDT must become familiar with the actions required. As with decedent affairs, the IDT may not have primary responsibility for completing all actions in a death imminent case, but will be required to provide necessary information in a timely manner.

6. Training. The purpose of training provided to the crew of an afloat unit include: assurance that crewmembers are able to provide aid for themselves and their shipmates in an emergency or a combat situation; and to promote the general health and well being of the crew. To this end, a written Health Services Department Training Plan will be prepared and submitted to the unit training officer for incorporation into the unit training plan.

a. Health Services Department Training Plan. A plan for training of the crew will be established. The plan will be established in written form and kept on file. It will be based on a minimum 12 month cycle and be included in the cutter training schedule. At a minimum, the following training will be given annually:

(1) Basic first aid;

(2) Shock, hemorrhage control, bandaging;

(3) Airway management and assisted ventilation;

(4) Route to battle dressing stations (BDS), use of items in first aid kits, gunbags and boxes;

(5) Personal and dental hygiene;

(6) STD/HIV prevention;

(7) Heat and cold stress programs, including hypothermia;

(8) Respiratory protection program;

(9) Hearing conservation;

(10) Poisoning;

(11) Sight conservation;

(12) Blood borne pathogens;

b. Documentation of Training. Documentation of the training is a TSTA requirement as well as a requirement of several Coast Guard programs. The rule of thumb to remember is "If it isn't written down, it didn't happen." An outline must be prepared and kept on file for all training topics presented and a training log maintained for all training provided. The training log will contain a record of all HS training given to the crew, stretcher-bearers, and HSs. It will contain the following information:

(1) Date;

(2) Topic;

(3) Duration;

(4) Group or department receiving the training;

(5) Instructor's name;

(6) Names (signatures of those present) of members trained.

c. Training Format. Training will normally be presented in either lecture format or demonstration and practical application. Lecture format presentations should be limited to 15 to 20 minutes and demonstrations and practical application should not exceed 1 hour.

(1) Practical application must be of high priority in training the crew and stretcher-bearers in first aid, casualty evaluation, treatment, reports to damage control central, and transporting casualties to battle dressing stations. There is no

substitute for "hands on" practice in developing effective first aid and patient transport skills.

d. Departmental Training. Specific training not applicable to the entire crew, but appropriate to individual departments, should be incorporated into the Health Services Training Plan. Such departmental training is normally needed because of workplace exposure to potential health hazards. Training subjects appropriate to various departments are listed in the following subparagraphs. The list is not all inclusive. It is provided as a guideline.

(1) Weapons department:

(a) Hearing conservation,

(b) Heat stress (ship's laundry personnel),

(c) Respiratory protection,

(d) Basic life support (fire control personnel),

(e) Review of prevention and treatment of electric shock casualties,

(f) Eyesight protection.

(2) Engineering department:

(a) Hearing conservation,

(b) Potable water,

(c) Heat stress,

(d) Respiratory protection,

(e) Eyesight protection,

(f) Hazards associated with human waste.

(3) Supply department:

(a) Food service sanitation (food service personnel);

(b) Heat stress (scullery personnel).

(4) Operations department:

(a) Basic life support (electronics shop personnel),

(b) Review of prevention and treatment of burns, electric shock and hemorrhage.

(5) Deck department:

(a) Eyesight protection,

(b) Hearing conservation,

(c) Heat stress,

(d) Respiratory protection.

e. Drills. Drills are a necessary part of unit training. Drills help to reinforce performance of skills and actions that must be completed during stressful or potentially dangerous situations. Drills that have close relation to health and safety of the crew will be incorporated into the Health Services Department Training Plan. The cutter training board should integrate Health Services Department Training Plan drills into the unit's training schedule.

(1) The following drills will be conducted semi-annually:

(a) Battle dressing station;

(b) Personnel casualty transportation;

(c) Mass casualty.

(2) The following drills, at minimum, will be conducted quarterly:

(a) Compound fracture;

(b) Sucking chest wound;

(c) Abdominal wounds;

(d) Amputation;

(e) Facial wounds;

(f) Electrical shock;

(g) Smoke inhalation;

(h) Casualty transport.

f. Training and Assignment of Stretcher-Bearers. No less than four stretcher-bearers will be assigned from each repair locker. The training for stretcher-bearers will include all subjects given to the crew with emphasis on basic first aid, casualty evacuation, triage, use of all stretcher types maintained onboard the unit, casualty carrying methods, Battle Dressing Station (BDS) setup and organization and basic life support. Stretcher-bearers must also complete the advanced first aid portion of the Damage Control Personnel Qualification Standards (DC PQS).

g. Training for the IDT. Careful study, practice, and concentration on all facets of the Health Services Technician rate are necessary to prepare an HS to be successful as an IDT. In addition to the requirements of the rate, attendance of certain "C" schools is required. These are:

(1) Air Force Medical Services Craftsman - Independent Duty Medical Technician or Navy Surface Forces Independent Duty Technician;

(a) Health Services Technicians that have successfully completed an afloat tour as an HS within five years are exempt from this requirement. Additionally, members that have successfully completed multiple TAD periods afloat as an HS may be considered for waiver of this requirement if in the opinion of his/her Designated Medical Officer (DMO) the member has the skills and experience needed for independent duty. Request for waiver are to be submitted in letter format, through the requesting member's chain of command to Commandant (G-WKH-1). Chapter 3 of the Cutter Training and Qualification Manual, COMDTINST M3502.4 (series) contains information about waiver of requirements.

(2) Coast Guard Introduction to Environmental Health or Navy Basic Shipboard Series. (Note: This is not required for graduates of Navy Surface Forces Independent Duty Technician.);

(3) Emergency Medical Technician - Basic Level. IDTs assigned to floating units are required to maintain currency with the National Registry of Emergency Medical Technicians (NREMT) at the Basic level. Short Term Training Requests are to be completed in accordance with the Training and Education Manual, COMDTINST M1500.10(series) and forwarded to Commandant (G-WKH-1). Funding will be provided by Commandant (G-WK). See the Emergency Medical Services Manual, COMDTINST M16135.4 (series) for additional information.

7. Supply And Logistics.

a. Custody of Health Services Equipment and Material. As directed by the Commanding Officer, the IDT is responsible and accountable for the health services material onboard the cutter. As such, the IDT is the custodian of all health service equipment and material. The custodian will not permit waste or abuse of supplies or equipment and will use techniques such as stock rotation, planned replacement and preventive maintenance to minimize waste of resources.

b. Inventory. An accurate record of medical stores and equipment must be maintained. The inventory of medical stores, spaces and equipment will be prepared using the Stock Record Card Afloat (NAVSUP Form 1114) or in line item form (computerized database is an approved and preferred alternative if all necessary information is captured) and include:

(1) Quantity and shelf-life of each item currently on board;

(2) Balance on hand, high-level, low-level (reorder point for each item);

(3) Manufacturer, lot number and expiration date (pharmaceuticals);

(4) Quantity placed on order, date received.

c. Unit Property. Unit property in Health Services Department custody must also be safeguarded and accounted for. The unit property custodian should be contacted before transfer or destruction of such property.

d. Funding and Account Record Keeping. Funds used to purchase supplies and equipment, and to pay for the various expenses of operating the unit are broken down into Account Funding Code (AFC) expenditure categories. This method allows for efficient budgeting and accounting. Fund categories generally used by IDTs fall within the AFC subhead 30 or 57 expenditure categories.

(1) AFC 30 is a general ship fund used by the supply department to purchase generally needed operating supplies and services. Examples include pens, paper, books, training aids, etc. AFC 30 funding can be used to pay for Health Services Department supplies and equipment not obtainable through Defense Supply Center Philadelphia Prime Vendor Program (via the unit's supporting clinic) or the major medical equipment request process (see Chapters 6 and 8 of this Manual). Restrictions exist on what may be purchased with AFC 30 funds. Specific questions can be answered by unit supply personnel.

(2) AFC 57 is a funding category used to purchase health care related supplies and equipment, and to pay for health care. AFC 57 funds are distributed to the MLCs and further allocated by them to the units within their areas of responsibility.

(3) With the full implementation of the Prime Vendor programs for Pharmaceuticals and for Medical and Surgical Supplies, AFC 57 fund allocations will be made to the Prime Vendor ordering point assigned for the unit.

e. Budgets and Budgeting. In general, IDTs do not need to plan and submit an AFC 57 budget request because medical supplies and equipment funding are controlled by the MLCs and Prime Vendor ordering points. If additional AFC 57 resource needs are anticipated, the IDT’s supporting clinic should be contacted for direction on how the resources are to be requested. The budget build process does have value for the IDT value, however. AFC 30 funds will need to be planned for and requested and medical equipment in need of planned replacement must be identified and CG 5211s submitted. The budget build process is a good way to handle these needs. AFC 30 fund budget planning is relatively straight forward, although it can be time consuming. AFC 30 expenditures for Health Services should be broken into general use categories. Examples of categories are books and publications, non consumable goods and services such as hydro testing and replacement of oxygen cylinders, and travel for continuing education. Budgeting categories can be as simple or complicated as the IDT desires to make it. Once categories have been established, a ledger for the Health Services Department should be "opened" and the expenditure

categories entered into it. The use of a "spreadsheet" program is an efficient way to keep an accounting record but a ledger book works just as well. Attention to detail is the key. In general, a system using four to five categories works well.

(1) In preparing a budget for the upcoming year, it is important to look back over what was purchased in the previous year. To do this, collect all records of AFC 30 orders and expenditures. Review each line item and record the amount spent into the appropriate budget category. The steps for preparing a budget and carrying it out along with general timelines are contained in this paragraph. They are:

| | |
|---|---|
| March | Look back process. Review amount of funds spent over the first two quarters of the fiscal year as well as spending patterns for the previous fiscal year. Note general categories on which funds were spent and in which quarter items were ordered. This will allow projection of quarterly funding needs into the upcoming year. |
| April/May | Review status of the Health Services Department medical library and determine which texts and references must be updated.<br><br>Review status of HS certifications and continuing medical education. Funding for training, conferences or seminars not normally funded by AFC 56 funds must be budgeted for as AFC 30 budget line items.<br><br>Review preventive maintenance records and include cost projections in AFC 30 budget. Prepare and submit CG 5211s for medical equipment to be replaced.<br><br>Seek guidance from XO on known or planned activities outside normal operations. An example is a yard period (which will require higher than normal supplies of various personal protective equipment (PPE)) or extended deployments in which normal supply is difficult. |
| June | Submit finalized budget proposal through chain of command. AFC 30 budget information will be added to the unit budget. Be prepared to "defend" the budget request submitted. Documentation of the data gathering process and retrieval of the raw data used to justify the funding requested will likely be required. AFC 56 funds requests will be consolidated by the command and forwarded to the unit's district, MLC or Area commander, as appropriate. |

(2) Careful stewardship, good record keeping and accounting make existing funding and justification for increased funding levels easier.

f. Obtaining Pharmaceuticals, Medical and Surgical Supplies. Chapter 8-B of this Manual provides policy applicable to the management of Health Services supplies. Prime Vendor programs for both Pharmaceuticals and Medical/Surgical Supplies have been established and it is through these programs that essentially all pharmaceuticals and supplies will be obtained. Medical Prime Vendor Program Implementation within the Coast Guard, COMDTINST M6740.2 (series) provides detailed instruction about this program. From an "afloat" perspective important aspects of the program include:

(1) Each afloat unit has been assigned a Prime Vendor ordering point for Pharmaceuticals and for Medical/Surgical Supplies. The cognizant MLC (k) assigns the POCs and periodically updates the information. The Prime Vendor ordering point may be different for each of the programs.

(2) Funding for both Prime Vendor for Pharmaceuticals and Prime Vendor for Medical/Surgical Supplies is provided to the assigned Prime Vendor ordering point by the cognizant MLC (k).

(a) Internal accounting procedures vary among Prime Vendor ordering points. Some have established individual "accounts" for the units they are responsible for while others manage funds from a central account. Regardless of the accounting method used by the Prime Vendor ordering point, the IDT must establish and maintain a system to track expenditures.

(3) Prime Vendor ordering points establish pharmaceutical and medical/surgical supply ordering procedures for their assigned units. Pharmaceutical and medical supply items ordered will be those required by the Health Services Allowance List (HSAL) in quantities required for the unit type. Deviation from the HSAL requirements will normally occur only after justification of the need is made by the IDT to the DMOA for the unit. It will be made in writing and kept on file for review during MLC site surveys.

g. Health Services Supporting Clinic. The supporting clinic for a vessel is the IDT's partner in providing health care for the vessel's crew. Local agreements and resources may be available to allow the supporting clinic to provide a broader range of services to the IDT and the vessel's crew but at a minimum, the following will be provided.

(1) All supplies and equipment (under $300.00) listed in the HSAL for the class of vessel and on the HS Core Formulary. The unit no longer receives AFC 57 funding for the operation of the Health Services Department. These funds are provided instead to the vessel's supporting clinic with the intent that the supporting clinic will provide all required items for the IDT to operate the Health Services Department.

(2) Assign the IDT a DMOA in writing. The DMOA shall be available for questions about patient care, as well as completing record reviews quarterly.

(3) Perform medical boards for the IDT unit as necessary.

(4) Provide a resource for advice and support in all administrative areas of health care provision to include medical administration; physical examination review (within the approving authority of the Clinic Administrator), health benefits, medical billing and bill payment processing assistance, dental care pharmacy administration, supply and logistics, bio-medical waste management, IDT continuing education, and quality assurance support. Any services provided at the clinic shall be extended to the IDT to the maximum extent possible

h. Preventive Maintenance of Health Services Equipment. Chapter 8 of this Manual details the preventive maintenance program for Health Services equipment. Chapters 1 and 2 of the Health Services Allowance List Afloat, COMDTINST M6700.6(series) provide guidance on the maintenance of specific items carried onboard ship (i.e. gunbags, portable medical lockers, stokes litter, etc.). An important part of medical readiness is a program of preventive maintenance and planned equipment replacement. Repair and routine replacement part costs should be recorded on side B of NAVMED 6700/3CG (Medical/Dental Equipment Maintenance Record). Capture of this data will allow more accurate forecasting of AFC 30 funding needs for preventive maintenance.

i. Replacement of Health Care Equipment. Chapters 6 and 8 of this Manual provide direction on how to obtain replacement of healthcare equipment. An effectively managed planned equipment replacement program minimizes repair costs, and avoids loss of critical equipment at unscheduled times. Additionally, used but still serviceable equipment can be used by other facilities by "turn-in and reissue" through the Defense Reutilization Management Office (DRMO). At least annually, normally during the budgeting process, review the preventive maintenance costs for each piece of Health Care equipment. When repair and maintenance costs for the year exceed 50 percent of the current replacement cost of the equipment, then a CG 5211 (U. S. Coast Guard Health Care Equipment Request) should be submitted to the unit's cognizant MLC(k) requesting replacement.

j. Disposal of Unserviceable or Outdated Medical Material.

(1) Equipment and Supplies. The Property Management Manual, COMDTINST M4500.5 (series) provides guidance on when a formal survey is required. In general, a formal survey is not required except when equipment has been lost or stolen. If uncertain about whether or not a formal survey should be done, the unit's supply officer should be consulted.

(2) Pharmaceuticals and Medicinals. Destruction of pharmaceuticals and medicinals will rarely be required. Chapter 8.C. of this Manual directs that materials will not be disposed of at sea, rather prepared for destruction and held in a secure area until the vessel's return to port where they can be disposed of in accordance with federal, state and local laws.

(a) Prime Vendors provide a partial credit for some materials returned to them. IDTs and supporting clinics will establish local policy for transfer of expired or short shelf-life pharmaceuticals. A transfer and

replacement of pharmaceuticals within 6 months of expiration should be made with the supporting clinic to minimize waste.

(b) If destruction is required, it will be accomplished in a well-ventilated area. Liquid substances present potential exposure through splash back. At a minimum, splash proof goggles and neoprene rubber gloves will be worn when working with liquid substances that may be absorbed through the skin. The wearing of protective equipment such as a splash apron is also encouraged. Thorough hand washing after the destruction process must be accomplished. Medical material must be disposed of in a manner so as to ensure that the material is rendered non-recoverable for use and harmless to the environment. Destruction is to be complete, to preclude the use of any portion of a pharmaceutical. Chapter 8. C. of this Manual provides detailed information about destruction and disposal of unsuitable medications.

k. Disposal of Medical Waste. Federal regulation defines how medical waste must be stored and disposed of, and the records that must be kept to document the storage and disposal. The information in the following paragraphs is provided as a general explanation of program requirements rather than an in-depth instruction on handling of medical waste. Medical waste must be classed in one of two categories: potentially infectious or non-infectious waste. In depth guidance about storage, disposal and required record keeping for medical waste can be found in Chapter 13 of this Manual, in Quality Assurance Implementation Guide (QAIG) 16, and in Chapter 6 of the Safety and Environmental Health Manual, COMDTINST M5100.47 (series). An additional source of information is the unit's hazardous material control officer. In general, the disposal and record keeping requirements for the waste depend on the waste category and are:

(1) Potentially infectious waste is defined as an agent that may contain pathogens that may cause disease in a susceptible host. Used needles, scalpel blades, ("sharps"), syringes, soiled dressings, sponges, drapes and surgical gloves will generate the majority of potentially infectious waste. Potentially infectious waste (other than sharps) will be double bagged in biohazard bags, autoclaved if possible and stored in a secure area until disposed of ashore;

(2) Used sharps will be collected in an autoclavable "sharps" container and retained on board for disposal ashore. "Sharps" will not be clipped. Needles will not be recapped;

(3) An adequate supply of storage and disposal material (containers, bags, etc.,) must be maintained on board to ensure availability even on a long or unexpected deployment;

(4) A medical bio-hazardous waste log must be establish and maintained, and must be kept on file for a period of 5 years. A medical bio-hazardous waste log must include the following information:

(a) Date of entry;

(b) Type of waste;

(c) Amount (in weight or volume);

(d) Storage location;

(e) Method of disposal;

(f) Identification number (if required by the state regulating authority). If such a number is required, the authority will provide it;

(5) Non-infectious waste includes disposable medical supplies that do not fall into hazardous waste. Non-infectious waste will be treated as general waste and does not require autoclaving or special handling. It should be placed into an appropriate receptacle and discarded with other general waste.

8. Health Services Department Administration.

a. Required Reports, Logs, and Records. Clear, accurate record keeping is of paramount importance for the IDT. The quality of care provided to the unit's crew is reflected in the thoroughness of record and log entries completed by the IDT. During compliance inspections, TSTA and customer assistance visits, the IDT and the unit will be evaluated at least in part on the accuracy and completeness of the reports and records created and maintained by the IDT.

b. The following records will be maintained in the Health Services Department. They will be in book/log form and in sufficient detail, to serve as a complete and permanent historical record for actions, incidents and data.

(1) Health Services Log. A Health Services Department log will be maintained by the IDT. This log is a legal document. Entries will be clearly written in a concise, professional manner. The log may be either hand written or prepared using a typewriter or word processor but must be kept on file in “hard copy” form. It is used to document the daily operation of the Health Services Department. Chapter 6.B.8. of this Manual provides the requirement for this log. At a minimum, it will contain the names of all individuals reporting to sickcall for treatment, inspections, inventories conducted, and the results of potable water testing. The log will be signed daily by the IDT and submitted for review, approval and signature on a schedule to be determined by the Commanding Officer. It is worth noting that the Health Services Log will provide the information used in the Binnacle List (see required reports in this Chapter and Chapter 6 of this Manual), so a complete record containing information required in the binnacle list as well as other information of interest will streamline preparation of the report.

(a) Training Log. See “Training” in this chapter.

(b) Potable Water Quality Log. This log will document the date, location and results of free available Chlorine residual or Bromine testing and

bacteriological testing. Such logs will be maintained in chronological order, record the date and time of test, type of test, collection site, and results of testing. Potable water quality logs must be kept onboard for 2 years. A sample Potable Water Quality Log is available for local reproduction in Chapter 1, Appendix 1.A of the Water Supply and Waste Water Disposal Manual, COMDTINST M6240.5 (series).

(c) Biohazard waste log. This log will contain information as provided in Chapter 13 of this Manual. Chapter 6 of the Safety and Environmental Health Manual, COMDTINST M5100.47 (series) also provides information and guidance on record retention.

(d) Health Records. Health records will be maintained as outlined in Chapter 4 of this Manual. They will be checked for accuracy as outlined in Chapter 4 of this Manual. Navmed 6150/7 Health Record Receipt Form will be used whenever a Health Record leaves the custody of the IDT. A quarterly check using the unit's alpha roster will ensure that any oversight is identified in a reasonably timely manner. All records checked out and not returned shall be reported to the command. In the event of Abandon Ship, make necessary arrangements to salvage health records, if possible. Salvaging health records will be secondary to treating and evacuating casualties.

(2) Required reports. Numerous reports are required at various intervals. A brief explanation along with a reference is provided for those not mentioned elsewhere in this chapter. Additionally, the information is provided in tabular format at the end of this section.

(a) Binnacle List. The binnacle list is normally a part of the Health Services Department Log. It is a listing of the names of the members provided treatment, and the duty status determination resulting from the treatment. The list must be kept daily and submitted to the command for review as directed by the CO. It is normally reviewed each week by the XO and signed by the CO.

(b) Injury Reports. See paragraph 10.a.(16) of this chapter.

(c) Disease Alert Reports. See Chapter 7 of this Manual for requirements.

(d) Inpatient Hospitalization Report. See paragraph 5.e. of this Chapter and Chapter 6.A. of this Manual

(e) Food Service Sanitation Inspection Report. See the Food Service Sanitation Manual and paragraph 10.a.(2) of this chapter.

(f) Potable Water Quality Discrepancy Report. Required by chapter 1-K.6 of the Water Supply and Waste Water Disposal Manual, COMDTINST M6240.5 (series) when potable water quality fails to meet requirements or is suspect.

Reports Required Weekly

| Report Name | Format or Form Required | Reference | Frequency or Date |
|---|---|---|---|
| Binnacle List | locally designed form | COMDTINST M6000.1(series) Chap 6.B.8 | Compiled daily, submitted weekly (or as directed by command). |
| Food Service Establishment Inspection Report | CG 5145 | COMDTINST M6240.4(series) Chap 11. | |

Reports Required Quarterly

| Report Name | Format or Form Required | Reference | Frequency or Date |
|---|---|---|---|
| Controlled Substances Inventory Board | Perpetual Inventory of Narcotics, Alcohol and Controlled Drugs, NAVMED 6710/5 | Chapter 10.B. of this Manual | 5th working day of the month |

Reports Required "As Needed"

| Report Name | Format or Form Required | Reference | Frequency or Date |
|---|---|---|---|
| Injury Report for Not Misconduct and In-Line-of-Duty Determination | CG-3822 | See paragraph 10.a.( 16) of this chapter | As needed. See paragaph 10.a.( 16) of this chapter |
| Disease Alert Reports | RCN 6000-4 | See chapter 7.B. of this Manual | As needed |
| Inpatient Hospitalization Report | Message format | See chapter 6.A. of this Manual | As needed |
| Report of Potential Third Party Liability | CG 4889 | COMDTINST 6010.16 (series) and chapter 6 of this Manual | As needed |
| Potable Water Quality Discrepancy Report | | COMDTINST M6240.5 (series) | when potable water quality fails to meet require-ments or is suspect |
| Emergency Medical Treatment Report | CG 5214 | COMDTINST M16135.4 (series) | As needed |

9. Combat Operations .

a. Battle Dressing Station (BDS). The Health Services Allowance List contains a list of all items required in the BDS, provides information about required frequency of inventory and documentation.

b. Route and Access Marking to the BDS. On cutters that have a BDS, the routes to the BDS shall be marked in accordance with the Coatings and Color Manual, COMDTINST M10360.3(series). In general:

(1) Self adhering Red Cross decals in both photo-luminescene (internal) and nonphoto-luminescene (exterior marking) are authorized;

(2) When establishing and marking the routes to the various stations throughout the cutter, the markers shall be located frequently enough to enable the person following the route to have a clear view of the next marker of the route to be followed;

(a) On the interior surfaces of the cutter, the signs shall be placed not less than 12 inches above the deck and no higher than 36 inches above the deck. On exterior surfaces, signs shall be placed approximately 60 inches above the deck.

(3) Label plates with red letters will be installed at each direct access to BDS;

(4) An adhesive reflective marking system will be used and maintained. The purpose of this system is to provide emergency information during a situation involving the loss of lighting.

c. Use of BDS. On cutters with separate BDSs, the BDS is not to be used for any purpose other than the treatment of injured personnel in an emergency situation. No items are to be placed in a manner which will block access or restrict use of the BDS.

d. First Aid Kits, Gun Bags and Portable Medical Lockers.

(1) Supplies stored in emergency medical kits (first aid kits, gun bags, and portable medical lockers) must be protected from weather and pilferage, and will be maintained as directed in the Health Services Allowance List. An inventory list for each kit will be maintained and a monthly inspection of all first aid kits, gun bags and portable medical lockers will be performed by the IDT. Each kit will be secured with a wire seal or other anti-pilferage device that will indicate when it has been accessed. Each kit will be inspected for tampering (seal intact). The inspection will be noted in the Health Services Log. Once per quarter, the contents of all first aid kits, gun bags and portable medical lockers will be inventoried. The inspection will be noted in the Health Services Log.

(2) Antidote locker. A separate poison control locker, marked with a red cross and the words “ANTIDOTE LOCKER” will be prominently located immediately outside the sickbay for ready access by the crew.

(a) The antidote locker will be secured with a wire seal or other anti-pilferage device that will indicate when the locker has been accessed.

(b) An alphabetical inventory, listing the contents and shelf location, will be posted on the inside of the locker. The telephone number of the local poison control center will also be displayed.

(c) The antidote locker will be inspected monthly by the IDT and the results will be recorded on the inventory list and in the Health Services Log.

e. Oxygen Cylinders. Ensure that oxygen handling and storage precautions are posted next to all oxygen cylinders onboard the vessel. Oxygen is considered a drug and under no circumstances will oxygen be used for any purpose other than patient care. Oxygen cylinders (for ready use) must have the content level read every morning by the HS in order to ensure readiness in case of an emergency. Empty cylinders will be clearly tagged as empty and stored separately from full cylinders. Oxygen cylinders must be hydrostatically tested every 5 years. Damage Control Department personnel will be a good source of information on where to have Oxygen cylinders refilled or hydrostatically tested. Oxygen for medical use must be grade D.

10. Environmental Health. Environmental health program related activities make up a large percentage of the daily responsibility of the IDT. The link between environmental health and mission accomplishment cannot be over-emphasized. From a military perspective, environmental health and environmental health related problems accounted for almost eighty percent of personnel losses during past conflicts in which the United States was involved. For the purposes of this chapter, environmental health encompasses the disciplines of preventive medicine, sanitation and occupational health.

a. Environmental Health Program Components. An effective environmental health program requires the IDT to have a working knowledge of a large number of unit systems and work processes. An aggressive program of inspection and observation is required. These include:

(1) Environmental Health Inspection.

(a) The IDT will make routine daily messing and berthing space "walk through" and make note of any conditions that require immediate action. These "walk through" should be done in an informal manner but items requiring correction will be brought to the attention of the department head responsible for the berthing area.

(2) Food Service Sanitation. The Food Service Sanitation Manual, COMDTINST M6240.4 (series) provides in-depth information regarding food service sanitation. This section is intended to provide information specific to the duties of an IDT on an afloat unit. In general, the IDT will monitor the food service operation to ensure the protection of the crew from food borne illnesses. The duties of the IDT will include:

(a) Maintain sanitary oversight of the galley and all food service, preparation, storage and scullery spaces. Such oversight includes stores on-load, storage, preparation, and serving of food; disposal of garbage; proper cleaning and sanitizing of equipment and utensils; personal hygiene of food handlers; proper storage temperature of food products, and the condition and cleanliness of the spaces;

(b) Food service areas will be inspected weekly and the findings will be reported on a Food Services Establishment Inspection Report (CG-5145);

(c) Conduct an inspection of the subsistence items and food for fitness for human consumption. Ensure that subsistence items were received from sources approved by the U.S. Department of Agriculture (USDA) or an approved source from a foreign port that complies with all laws relating to food and food labeling;

(d) Conduct an initial physical screening of food services personnel for detection of any condition or communicable disease that could result in transmission of disease or food borne illness.

(3) Storage of Food Items. Proper storage procedures play a major part in preventing food borne illnesses. The IDT will make routine inspections of food storage areas to ensure that spaces are properly maintained to prevent supplies from being:

(a) Infested by insects and rodents;

(b) Contaminated by sewage, chemicals, or dirt;

(4) Subsistence items will be inspected by the HS upon receipt to determine food quality and ensure the stores are free from insect or rodent infestation. The results of this inspection will be recorded in the Health Services Log.

(5) Coffee Mess. Food consumption, with the exception of coffee and condiments, will be limited to messing areas and lounges. Coffee messes provide a potential food source for insects and rodents if they are not properly located and kept scrupulously clean. For these reasons, permission to establish a coffee mess must be obtained from the Commanding Officer by the department desiring to establish a mess prior to its establishment. Messes will be physically located in a place that can be easily cleaned. Food contact areas (surrounding counter or table tops) must be non porous and kept free of spillage and food debris. Strict sanitary measures are to be used. Coffee mess regulations specifying sanitary operation of the mess will be posted. Use of community cups and spoons are prohibited. Inspection of coffee messes may be documented using a Food Service Sanitation Inspection Report (CG 5145) or through a locally generated inspection report forms.

(6) Water Supply. Water is used by all members of ship's company and so a tremendous potential exists for ship wide illness should potable water not be

properly loaded from sources free from contamination, protected from contamination onboard, and a halogen residual maintained in the potable water tanks and throughout the distribution system. The IDT will be notified whenever the potable water distribution system is opened for maintenance or repair. Establishment of a working relationship with the ship's engineering company, and the "water king" will aid the IDT in maintaining a proactive stance in regard to prevention of contamination of the vessel's potable water. The IDT will make a monthly inspection of the potable water system and report conditions with potential to affect the health of the crew to the Commanding Officer.

(7) Halogen Residual Testing. Chlorine/Bromine residual testing will be performed before receiving any water onboard, and also about 30 minutes after an initial halogenation has been accomplished. A water log shall be kept and the results of the daily halogen testing recorded in it. The Color Comparator Test set is used for determining Halogen and pH levels. Nomenclature and ordering information is available in the HSAL. Four test sites should be selected: forward, aft, amidships and as far above the 0-1 deck as possible. This will give the widest range of sample points. Lack of a residual or a residual reading that is significantly lower than results at the other locations indicate possible contamination. Systematic testing from areas with low residuals "backward" to areas with "average" residuals will help locate the source or general area of contamination.

(8) Bacteriological Test of Water. At least weekly, potable water samples for bacteriological analysis will be collected from two of the four test sites selected for halogen residual testing, as well as a sample collected directly from the potable water tanks. At least weekly, samples of ice must also be collected from any machines making ice used for human consumption and tested for bacteriological growth. The results of bacteriological testing will be entered into the Potable Water Quality Log.

(9) Habitability. The need for sanitary and hygienic living and working spaces is essential for good health and morale of the crew. General guidance on habitability standards can be found in Chapter 2 of NAVMED P-5010 (series). Habitability inspection can most easily be accomplished if it is made a part of the material inspection of all ship's spaces normally scheduled by each command

(10) Barber Shops. Any space used for cutting hair may be designated a Barber Shop by the command. It will not be located in food service areas or berthing areas. Sanitation inspection of the ship's barber shop will be performed on a schedule determined by the command. General guidance on standards can be found in Chapter 2 of NAVMED P-5010 (series).

(11) Ship's Laundry. Laundry spaces will be maintained in a clean and sanitary condition. Because of the potential for elevated temperature and high humidity within the space when laundry equipment is in operation, the ship's laundry will be identified as a heat stress monitoring space and monitored accordingly.

Sanitation inspection of the ship's laundry will be performed on a schedule determined by the command. General guidance on standards can be found in Chapter 2 of NAVMED P-5010 (series).

(12) Fitness and Exercise Facilities. The fitness and exercise facility will be inspected for cleanliness and compliance with general sanitation standards on a schedule determined by the command. General guidance on standards can be found in Chapter 2 of NAVMED P-5010 (series).

(13) Insect Control. Roaches, stored product pests, and to a lesser degree flies, can have significant impact on the health and general morale of a ship's company. Insect control starts in the warehouse from which stores are received. When practical, a visit by the IDT to assess storage conditions can help decrease numbers of pests brought on board. Dockside inspection of all food stores brought on board is a must if insects are to be excluded. Produce with "loose" husks or skin such as onions provide common harborage for roaches as does the corrugation of cardboard boxes. Careful inspection with a good light and adjuncts such as an aerosolized flushing agent can identify harborages from which cans and stores can be removed prior to their being brought aboard.

(a) Roach Control. A ship provides myriad harborages for roaches. Frequent and regular surveillance by the IDT using a good light and a flushing agent can pinpoint areas of infestation. Roach traps containing pheromones work well in areas with small or isolated infestations. Larger or more widespread areas must be controlled initially with insecticide. Insecticide application will be made only by HSs that hold current certification to apply pesticides. Such personnel have been properly trained in pesticide selection, application, safety and handling precautions. This training is available through Navy Environmental Preventive Medicine Units (NEPMU)s. Pesticide application may be available through Coast Guard Integrated Support Commands with attached Preventive Medicine Technicians. Any insect surveillance activity, general report of findings, or pesticide application, will be reported in the Health Services Log. Pest control services may also be contracted for from civilian pest control firms. Such services are paid for from ships AFC 30 funds and are contracted in the same manner as any other contract for services. While proper selection and application of the materials used is the legal responsibility of the licensed pest control operator, the IDT must be informed of all applications made. The contractor must provide a report of pest control operations which includes, trade and chemical name of product used, strength and formulation applied, type of application (crack and crevice, etc.,) location of application. Requirement for such a report will be included in the contract for services. Report of pest control operations will be held on file for 3 years.

(b) Stored Products Pests. A relatively small infestation of flour, grains, beans and cereals with stored products pests can spread quickly and lead

to the loss of most or all of such products in a storage area if an infestation is not identified quickly and action taken to control it. In general, such action consists of identifying infested or suspect lots, removing them from storage with other food stuffs with the potential to become infested, and application of pesticide to control flying insects. Underway, control is limited to identification of infested or suspect lots and their removal.

(14) Rodent Control.

(a) Exclusion is by far the most effective means of rodent control available to the IDT. Proper installation of rat guards is required on all mooring and service lines when the vessel is in port. Information about proper installation of rat guards can be found in Chapter 8 of the Manual of Naval Preventive Medicine (NAVMED P-5010) and in the Safety and Environmental Health Manual, COMDTINST M5100.47(series). The IDT will inspect all mooring and service lines upon arrival in any port, including home port, to verify the proper placement of rat guards on all of the lines.

(b) In the event that rodents do gain access to the vessel, an aggressive campaign using traps and/or poisoned bait (if the IDT has been properly trained to apply and use such substances) must be undertaken. Trapping is the preferred method. Assistance may be available from Coast Guard Integrated Support Commands with attached Preventive Medicine Technicians or through the cognizant MLC (k).

(c) A current deraterization exemption certificate (CDC 75.5(F.4.452)) must be kept onboard at all times. The certificate may be obtained from Coast Guard Integrated Support Commands with attached Preventive Medicine Technicians; Navy units or bases with attached Preventive Medicine Technicians or NEPMUs. The deraterization certificate must be renewed every 6 months, and must be included as a pre-deployment checklist item.

(15) Immunizations and Prophylaxis. The IDT will ensure that all personnel receive required immunizations in accordance with the Immunizations and Chemoprophylaxis,COMDTINST 6230.4 (series). MLCs (k) and NEPMUs can provide up to date information on immunization requirements, disease intelligence and preventive medicine precautions required for vessels deploying to OUTCONUS ports.

(16) Safety. A ship is a very dangerous place and dangers inherent to the shipboard environment are heightened by worker's lack of attention, short-cuts, "horseplay," inadequate training or understanding of a job or process, fatigue or over-familiarity. The IDT must remain vigilant in regard to the safety and safe work practices of the crew. A safe work environment can't be maintained from the Health Services Department space. The IDT must become familiar with

the work processes that are on-going and be able to recognize when they are not being done in the proper manner or with the proper materials.

(a) Mishap Reporting. When accidents or mishaps do occur, certain reports or action may be required. The Safety and Environmental Health Manual, COMDTINST M5100.47 (series) contains requirements and guidance about mishap reporting. Such reports are not normally completed by the IDT, but input may be required regarding severity of injury and required treatment.

(b) Accident Reports. The Administrative Investigations Manual, (AIM) COMDTINST 5830.1 (series) contains a requirement that an Injury Report for Not Misconduct and In-Line-of-Duty Determination (CG-3822) be completed whenever an injury results in temporary or permanent disability. This report is referred to in the Physical Disability Evaluation System, COMDTINST M1850.2(series) as an "Line of Duty (LOD) Report" and requirement is made that it be completed for all initial medical boards involving or resulting from trauma. Since it is difficult to determine the outcome of a serious injury in the early stages of treatment, a CG-3822 (also commonly known as an "Accident Report") is usually completed in such cases. It is not necessary to complete an "Accident Report" for any and all injuries unless command policy dictates otherwise.

(c) Vessel's Safety Board. The IDT is a required member of the vessel’s Safety Board. The IDT should strive to be an active participant in the board, to identify potential problems or accident trends, and suggest solutions to current or potential safety problems. Be proactive. Educate supervisors whenever possible.

(17) Hazard Communication. The Hazard Communication Program is a unit wide program. Each unit will have appointed a Hazardous Materials Control Officer with overall responsibility for carrying out the program. The Safety and Environmental Health Manual, COMDTINST M5100.47(series)and Hazard Communication for Workplace Materials, COMDTINST 6260.21(series) contain in-depth information about this program. The IDT must be aware of the program requirements and its impact upon the operation of the Health Services Department. Additionally, the IDT must know the location of the unit's central MSDS file and have immediate access to product information which may be needed to render proper treatment to exposed crewmembers. Computerized databases available on CD-ROM are acceptable for this purpose if the Health Services Department contains appropriate access to the information.

(18) Heat Stress Program. Coast Guard Cutter Heat Stress Program, COMDTINST M6260.17(series) provides details about this program. All areas of the vessel that expose crewmembers to extreme heat will have a dry bulb thermometer

installed. Such areas normally include (but are not limited to) ship's laundry, scullery and engine room spaces.

(a) Wet Bulb Globe Thermometer (WGBT). A WGBT apparatus must be used to determine stay times of personnel working within heat hazardous spaces or areas and so familiarity with this equipment is required. The apparatus is normally operated by the IDT or member of the engineering department. Recommendations for safe work rest cycles will be provided by the IDT to the Engineering Watch Officer (EWO). Coast Guard Cutter Heat Stress Program, COMDT M 6260.17(series) provides information about the program. The WGBT is listed on the Health Services Allowance List (HSAL) and is procured as health care equipment. A CG 5211 (U. S. Coast Guard Health Care Equipment Request) should be submitted to the unit's cognizant MLC (k). Current calibration of the ship's WGBT apparatus is a TSTA "critical" item. Delinquent calibration can result in cancellation of some or all TSTA drills by the training evaluation team. Contact the cognizant MLC (k) for locations to send WGBTs for calibration.

(19) Sight Conservation Program. Eye protection and safety should be stressed in the workplace. Safety glasses or goggles will be provided for all crewmembers involved in eye-hazardous tasks. Tools with strong potential for eye hazard will be identified with an adhesive warning label. Fixed machinery with eye hazard potential will have posted nearby an easily visible warning placard, and eye protection will be easily accessible and clearly visible.

(20) Eyewash Stations. Eyewash stations will be located in any space or work area with strong potential for splashes to, or foreign body injury of the eye. Eyewash stations will be maintained in accordance with the station's manufacturer requirements. Eyewash stations shall be flushed weekly for 15 seconds and flushed and drained according to the recommendations of the biostat ingredient manufacturer used in the station. This interval is usually every six months. Eyewash stations will be "tagged" with a maintenance record tag and inspection or maintenance activities will be recorded when performed. Inspections of eyewash stations will be recorded in the Health Services Log.

## CHAPTER 10

## PHARMACY OPERATIONS AND DRUG CONTROL

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## CHAPTER 10. PHARMACY OPERATIONS AND DRUG CONTROL

Section A - Pharmacy Administration

1. Responsibilities.

   a. The person designated in writing as responsible for the pharmacy is accountable to the Chief, Health Services Division, or the executive officer for properly storing and dispensing drugs, record keeping, and maintaining a pharmacy policy and procedures manual.

   b. The person in charge of the pharmacy shall acquire, store, compound, and dispense medications according to applicable Federal laws (principally Title 42, United States Code [42 USC] and Title 21, Code of Federal Regulations [21 CFR] ) and observe the highest standards of professional practice and established pharmaceutical procedures.

   c. Through medical administration persons responsible for daily pharmacy operations shall request adequate funding to provide the level of pharmaceutical care required in Section 10.A.2.c.

   d. Health Services Division Chiefs shall ensure that all short-term, interim, or temporarily assigned pharmacy personnel have successfully completed Quality Assurance Guide (QAIG) #41 (Pharmacy Watchstander Qualification Guide(PWQG)) and that all regular assigned pharmacy personnel have completed pharmacy technician "C" school training. These minimum standards of qualifications must be documented in the training file of all pharmacy watchstanders. The PWQG does not replace the requirement for "C" school trained pharmacy technicians, but will assist clinic personnel in becoming more productive members of the Coast Guard health services team and in doing so further enhance the mission of the Coast Guard clinics.

   e. Pharmacy officer collateral duty oversight shall be provided for all clinics and sickbays that do not have pharmacy officers assigned. A Pharmacy Officer Collateral Duty Program shall be administered by the cognizant Maintenance and Logistic Command (k), who shall:

      (1) Determine cost requirements for the pharmacy officer collateral duty program and submit funding requests to Commandant (G-WKH) in the annual operating summary of budget estimates (CG-4144) process.

      (2) Provide direction and funding to pharmacy officers for matters relating to assignments in pharmacy officer collateral duty program.

      (3) Develop work plans which specifies units for which the pharmacy officer is responsible.

      (4) Ensure that visit schedule will be:

         (a) the most cost effective;

(b) feasible to maintain responsibilities at the unit where the pharmacy billet is assigned; and

(c) coordinated with the unit commanding officer possessing the billet.

(5) Establish the content and frequency of a reporting system for pharmacy officers on assignment and provide a copy of this report to the unit commanding officer where the billet is assigned.

(6) Ensure that rating officers of pharmacy officers on assignment in the pharmacy collateral duty program obtain input for completing the USPHS Commissioned Officers' Effectiveness Report from the other units where the pharmacy officer provides oversight.

(7) Oversees the following pharmacy officer responsibilities.

(a) Report to the Chief, Health Services Division of the unit to which they are assigned.

(b) Follow the established chain of command.

(c) Serve as a member of the Pharmacy and Therapeutics Committee, and assist those units to which they are assigned with developing and maintaining a drug formulary. This formulary shall be standardized to provide a list of medications stocked in the "therapeutic category" format.

(d) Provide direct assistance for all aspects of the Pharmaceutical Prime Vendor Program.

(e) Assist each unit in eliminating or minimizing the purchase of medication through nonfederal sources by using formulary process and redistributing medication as needed.

(f) Develop an inventory of limited use pharmaceuticals/pharmaceutical supplies for distributing to each unit.

(g) Serve as the point of contact for redistribution of medication that are due to expire or are in excessive supply.

(h) Identify special order medication, label them for each patient and assure that they are not considered formulary items. These should be marked for a specific patient only and removed when the patient no longer requires them.

(i) Analyze and develop the most cost effective methods for providing non-formulary medication for chronic conditions.

(j) Provide oversight to the health services technician(s) who normally operate the unit pharmacy and assist in dispensing operation as required.

(k) Provide and document in-service training to the clinic staff.

(l) Review all pharmacy operations and policies including controlled substance activities.

(m) Assist the unit in preparation for MLC Quality Assurance Surveys.

(n) Submit a report of the content and frequency established by MLC (k).

2. Prescribers.

a. Authorized prescribers include:

(1) Medical officers and dental officers as defined in this Manual's Sections 1.B.1. and 1.B.4.;

(2) Civilian physicians employed by the Coast Guard;

(3) HSs may prescribe drugs listed in the Coast Guard Health Services Technician Formulary, COMDTINST 6570.1 (series). While performing isolated duty at LORAN stations or underway, HSs may prescribe additional drugs listed in Health Services Allowance List, Part 2 (Vessels), COMDTINST 6700.6(series). HSs in these situations should seek medical advice if available; and

(4) Civilian physicians, dentists, and allied health care providers (nurse practitioners, physician assistants, optometrists, etc.) as authorized by State law in their licensing jurisdiction to write prescriptions in practicing their profession.

b. Prescriptions by uniformed service physicians and dentists, other than Coast Guard, shall be honored when ever possible. For example, Department of Defense prescription policies (TRICARE/TRI SERVICE) shall be considered/observed to the fullest extent possible within the scope of the primary care nature of Coast Guard Health Care facilities. Prescriptions by these providers shall be written on the prescription forms authorized by their service.

c. Prescriptions for eligible beneficiaries from licensed civilian physicians, dentists, or podiatrists shall be honored for products on the clinic's formulary. Clinic formularies shall be established based on the Coast Guard Core Formulary and the prescribing habits of the providers assigned to that clinic. Items will not be maintained on the formulary primarily to meet civilian prescription demand. Military practitioners or contract providers shall not countersign civilian prescriptions nor shall civilian prescriptions be rewritten during cursory outpatient visits with the intent of authorizing the prescription for dispensing at the facility. If additional funding is required for specific, high cost drugs, it shall be requested via the AFC-57 budget.

d. Authorized prescribers shall not prescribe controlled medications for themselves and/or their family members. If such medication is required and no other prescriber

is assigned to the facility, the commanding officer or executive officer shall approve and countersign each prescription before the prescriber fills it.

3. Prescriptions.

a. Prescriptions written by Coast Guard physician's assistants and nurse practitioners may be filled at the facility where written or at a neighboring MTF as permitted by local prescribing policy. Prescriptions written by health services technicians shall be filled only at the facility were written. Coast Guard clinics may agree among themselves to honor another Coast Guard clinic's physician assistants' or nurse practitioners' prescriptions if stock shortages so necessitate. Other Coast Guard facilities may honor Coast Guard physician assistants' and nurse practitioners' refills (for other than controlled substances) if the patient presents his or her health care record containing the original entry.

b. Accept telephoned and oral prescriptions only in emergencies. The prescriber must write and sign the prescription as soon afterwards as possible. A clinic may choose to accept FAXed prescriptions provided it receives the original prescription before dispensing the medication.

c. Health Services Technicians shall not contact civilian prescribers to resolve prescription problems but return the problem prescription to the patient and explain why he or she cannot dispense it. The HS may provide the names of suggested available products to the patient. Professional supervisors (pharmacy officers or senior medical officers) may authorize, via the Pharmacy Policy and Procedures Manual, pharmacy technicians to make telephone contact with civilian prescribers to resolve problems. All authorized telephone transactions will be clearly defined; those transactions not listed shall be unauthorized.

d. Prescriptions shall be personalized. If more than one member of a family is prescribed the same drug, a separate prescription blank must be used for each member

e. Items prescribed must treat conditions within the normal scope of professional practice and the ethics of the prescriber.

f. Prescriptions for medications to treat cosmetic conditions (baldness, wrinkles, etc.) and for weight loss will not be honored nor shall medications for these conditions be stocked at Coast Guard facilities.

g. Do not fill prescriptions for animals other than those the Government owns.

h. If a physician assistant has clinical privileges at a local DOD facility, he or she may use its prescription form to write prescriptions to be filled at that facility, provided the form contains the statement "To be filled only at [insert designated DOD facility]."

i. The prescriber's facility has the responsibility to procure and dispense all medications its staff members (including in-house contract prescribers) prescribe. In the rare

event a patient must carry a prescription elsewhere for dispensing, the prescriber shall write the facility's name in addition to the other required information on the form.

j. Providers are tasked with the cost-effective use of medications. Commandant (G-WKH) maintains a list of and prescribing guidelines for selective medications, listed in Figure 10-A-2. Clinics shall ensure in-house prescriptions meet the requirements to use these items cost-effectively.

4. Prescribing in the Medical Record.

a. At all clinics and sickbays, prescribe medications on an SF-600 in the medical record, or when appropriate, SF-558, Emergency Care and Treatment. The medical record thus becomes a more comprehensive repository for all patient health information and also ensures the pharmacy staff has access to the necessary clinical information (age, weight, allergies, lab values, vital signs, etc.) to provide complete pharmaceutical care. In clinics that maintain dental records separately, the dental staff may use prescription forms.

b. Procedures.

(1) Document (S.O.A.P. format) the patient visit on an SF-600 or SF-558 in the chart. Under the "Plan" section list the drug name, strength, directions, quantity, and refills. Start each new drug entry on a new line (examples: "HCTZ 50 mg, #1 tab po QD #90 RF X 1"; "Clonidine 0.1 mg, #1 tab po BID #180 RF X 1"). If prescribing for a dental condition, label the SF-600 section "Dental Rxs" and list the same information required here and in 10-A-4.b.(2).

(2) In the "Plan" section, state a disposition to assist pharmacy staff in coordinating quantities of all chronic medications until the next appointment. Complete the entry with the authorized prescriber's signature (examples: RTC PRN; F/U appt. 10 days; RTC 3 months).

(3) The terms chronic and maintenance medications are synonymous. A maintenance medication is defined as any medication used to treat a chronic condition. The term "maintenance" implies that a prescriber and patient have gone through a dosage titration process and have determined that the patient should be "maintained" on an effective dose of a medication that is well tolerated. Ultimately, the individuals in a position to make such a determination are the patient and the prescriber. The standard quantity issued for chronic conditions is a 90-day supply. If it is necessary to deviate from this amount, prescribe quantities in 30-day increments (30, 60, 90, etc.) if possible. If pharmacy staff in consultation with the prescriber deem it advantageous to the patient due to travel, deployment, operational commitments, packaging, etc., they may dispense larger quantities.

(4) Pharmacy staff shall completely draw a single horizontal line through errors or changes and conspicuously write "Error" next to the item. The person changing the entry shall initial the change or error. Return incorrect or incomplete entries to the prescriber for revision.

(5) Pharmacy staff shall write the prescription number or put the multi-part strip label on the SF-600 and initial to identify the person who prepared the prescription.

(6) Pharmacy staff shall write the manufacturer's name, lot number, and expiration date to the right of the drug prescription (not required with CLAMS OR CHCS). Sickbays not on CLAMS OR CHCS also shall maintain a drug dispensing log containing prescription number, patient's name, patient's SSN, drug name, drug manufacturer, and lot number. Retain this log for record purposes for 3 years.

(7) For refills, pharmacy staff shall note the date, pharmacy identity and "Rx Refill" on the SF-600, followed by medication name, quantity, original prescription date, manufacturer's name, lot number, expiration date, and remaining refills. If processing through CLAMS OR CHCS, the only required information is the pharmacy identity, current date and medication name. The pharmacy staff member charting the refill shall initial the entry. The use of personal stamps to further identify pharmacy personnel is encouraged. Any other services (counseling, vital signs, etc.) provided to the patient shall also be noted in the medical record. See Figure 10-A-2 for examples.

(8) In addition to the SF-600 or SF-558 entry, written prescriptions are required for all controlled substances or cases where a prescription must be taken to another pharmacy.

(9) All prescriptions generated from sources outside the clinic shall be filled or refilled using CLAMS OR CHCS or the procedures specified in this Chapter and maintained on file in the pharmacy. The pharmacy need not maintain a health care record if the patient receives only basic pharmaceutical care from the facility.

5. Signatures. No prescription or order shall be filled unless it bears the signature of an individual authorized to write prescriptions. All prescriptions shall be imprinted/stamped with the prescriber's name, rank, and professional discipline (MD, DDS, HS2, etc.). Prescriptions for controlled substances shall also provide the social security number of the prescriber or DEA number. Pharmacy personnel shall maintain signature examples for in-house and contract prescribers. Professional judgment shall be used to verify authenticity of prescriptions from other sources.

6. Dispensing.

a. The pharmacy shall serve as the source of supply from which clinics or satellite activities normally obtain required pharmaceuticals and related supplies. In addition, the pharmacy dispenses required, authorized preparations directly to patients.

b. Except for OTC program items, the pharmacy shall dispense all stocked items only on receiving a properly written, verified prescription. If pharmacy staff receive an illegible prescription or question its authenticity, dosage, compatibility, or directions to the patient, staff shall obtain clarification from the prescriber before dispensing the medication(s).

c. Clinics shall have a system (computerized, written, etc.) in place to ensure they can obtain prescriptions in case of a product recall.

d. Clinics shall submit all pertinent patient adverse reactions or product quality problems on the FDA MEDWATCH system on FDA Form 3500. Obtain MEDWATCH forms and information from the FDA at 1-800-FDA-1088.

e. When dispensing medication, the dispenser shall identify the patient and ensure his or her eligibility.

f. Use child-resistant containers to dispense all prescription legend medications except nitroglycerin, which is dispensed in the original container. The practitioner or patient may specifically request a conventional closure; a practitioner must so indicate on the prescription order. If the patient requests such a closure, enter a statement so saying on the back of the prescription; have the patient sign it. When refilling prescriptions, the pharmacy must ensure the safety closure still functions and the label is legible before dispensing in the original container.

g. Prescriptions (except for controlled substances-see 10-B-4.c.) may be refilled when authorized by the prescriber. The maximum quantity shall be a year's supply of medication. No prescription shall be refilled after more than one year from the date it was written. PRESCRIPTIONS SHALL NOT BE REFILLED FROM THE LABEL ON THE CONTAINER ONLY.

h. Coast Guard clinics are encouraged to establish non-prescription medication programs under the following guidelines:

(1) Commanding Officer of Coast Guard units assigned health care personnel may elect to operate a nonprescription drug program. Units not staffed with an HS, may operate a nonprescription medication program if quarterly oversight (direct visit) is provided by a Coast Guard clinic or supporting Independent Duty HS. Units electing to offer a nonprescription drug program shall inform their respective MLC, and verify that they will operate within these guideline.

(2) All Coast Guard health care facilities shall make condoms available to beneficiaries even if they elect not to offer a nonprescription drug program. Condoms shall be made available to beneficiaries under 18 years of age unless specifically forbidden by law.

(3) Items available shall be limited to those specifically identified in the Nonprescription Medication Program section of the "Core" Formulary (COMDTINST 6570.2A) Units may elect not to offer every product from this list but shall not select products other than those listed.

(4) A beneficiary family shall be limited to a maximum of two items per week from the program. Occasionally, it may be necessary to extend this limit due to family size. Pharmacy and Therapeutics Committees ( if available) and collateral duty pharmacy officers shall provide guidance and monitor any such extensions.

(5) Items shall only be available during normal operating hours of the facility.

(6) Pharmacy or sick bay personnel shall monitor the program for perceived overuse. Individuals suspected of this shall be referred to a medical officer and may have their access to this privilege denied.

(7) All products must be dispensed in the Manufacturer's FDA approved packages with required instructions and warnings. Other locally packaged items are not authorized. Local Pharmacy and Therapeutics Committees may develop supplemental information on sheets to provide additional dosage or drug information to the patient.

(8) Nonprescription drug program items shall not be dispensed to pregnant patients or non active duty beneficiaries under 18 years of age. Local flight surgeons, via the Pharmacy and Therapeutics Committee, shall determine which products may be acquired by personnel on flight status.
(9) Facilities offering this service shall keep quarterly statistics as to the quantity of items dispensed and the dollar value expended. This figure shall be separated from regular pharmacy workload statistics and not be counted as a prescription number. Only those items which have been dispensed by a written prescription shall be counted in the facility prescription number totals.

(9) The Patients are responsible for providing an authorized identification card to verify their eligibility.

(10) To receive a nonprescription item, patients must sign a log request form which certifies the following:

(a) "I do not wish to see a physician or other health care provider for advise before receiving these medications. I understand that the medication is for minor illness or conditions and that if symptoms worsen or persist longer than 48 hours, the person for whom this medication is intended should be seen by a health care provider.

(b) "I am not pregnant or under 18 years of age (unless active duty). If on flight status, I understand that I am only authorized to receive over-the-counter items approved by the flight surgeon.

(11) Individuals suspected of returning for medication for a non-resolving problem shall be referred to a medical officer for evaluation.

(12) The log sheet or request form shall also contain the date, patient's name, and the name and quantity of the item(s) received.

(13) Beneficiaries requesting medical advice that, in the opinion of the pharmacy or sick bay personnel, is beyond their expertise, shall be referred to the medical officer.

(14) Funding for independent duty HS assigned units (vessel, groups, etc.) deciding to offer this service shall be from their unit's AFC-30 account.

i. When the pharmacy is closed, a medical or dental officer, or a person so authorized, may dispense medication from a locked cabinet or locker containing pre-packaged or limited supplies of after-hours medications. These drugs are dispensed under the same procedures required when the pharmacy is open, including appropriate labeling and complete as an entry in the health record.
Do not fill prescriptions from civilian prescribers from the after-hours locker except for emergency pain medications and/or antibiotics to treat acute infection.

j. Bulk items for use in the clinic may be issued on authorized prescription forms or locally approved requisition forms.

k. A sign shall be posted outside of the pharmacy in a highly visible location stating "Please inform our pharmacy staff if you are breast feeding or may be pregnant." Clinic pharmacies shall maintain a written drug information system (USP, CHCS, etc.) to provide information to patients when appropriate.

l. Coast Guard pharmacies staffed with one pharmacy technician or HS generally dispense an average of 75 prescriptions per day. Clinics with a pharmacy officer and HS can be expected to average 150 prescriptions per day. These workload expectations account for "background" clinic and pharmacy activities (collateral duties, OTC program, bulk issues, etc.).

m. Pharmacies shall adhere to applicable state laws governing generic dispensing of civilian prescriptions. Civilian prescribers may provide the facility with a written statement giving "blanket approval" to dispense generics for their prescriptions.

n. Dispense drug samples only through the pharmacy; they must have proper labeling and child-resistant containers. A system shall be maintained to recall sample products should such action become necessary.

7. Labeling.

a. A label will be prepared for each prescription dispensed to individuals and will be securely affixed to the container prior to dispensing. The label or appropriate auxiliary labeling will show as a minimum:

(1) facility identity, including pharmacy address and telephone number;

(2) consecutive identifying number;

(3) prescriber's name;

(4) definite, concise directions to the patient;

(5) drug name and strength, unless prescriber directs otherwise;

(6) amount dispensed;

(7) patient's first and last name;

(8) initials of person typing the prescription label;

(9) the legend "**KEEP OUT OF THE REACH OF CHILDREN**" on all prescription labels;

(10) date prescription filled;

(11) indication of refills;

(12) expiration date (for liquid antibiotics);

(13) the legend "**CAUTION: FEDERAL LAW PROHIBITS THE TRANSFER OF THIS DRUG TO ANY PERSON OTHER THAN THE PATIENT FOR WHOM IT WAS PRESCRIBED**" (for controlled substances only);

(14) any necessary supplemental or auxiliary labels.

b. If prescription contents are for external use only or require further preparation(s) for use (shaking, dilution, temperature adjustment, or other manipulation or process) include appropriate directions on the label or affix an additional label to the container. If liquid preparations for external use are poisonous, affix a "poison" label to the container. If medicines prescribed for internal use are poisonous, use sound judgment whether to label them "poison" based on the finished preparation's potency in each case.

c. Medicinal preparations compounded or packaged in the pharmacy for subsequent issue will be identified and labeled with the full generic name, except that trade or brand names may be used provided trade or brand name product actually is in the container. The manufacturer's name, lot number, and expiration date, if any, will be shown on the label.

d. Drug issued to clinics for subsequent reissue to outpatients shall be adequately labeled in the pharmacy.

e. All multiple dose injectable vials shall be dated upon opening. Expiration will normally be thirty days unless:

(1) the product is expensive and manufacturer's information guarantees the product is usable beyond 30 days, or

(2) product information indicates a shorter expiration date.

8. Drug Stock.

a. The person responsible for the pharmacy's daily operations must authorize all orders procuring medications. The clinic finance officer shall verify funds are available for all procurements. For prime vendor requisitions, verify funds availability before entering the "ZOA" document entry in the Automated Requisition Management System (ARMS), not prior to the order being submitted to the prime vendor.

b. The Defense Personnel Support Center is the primary source of medications for either the "Depot" system or prime vendor contracts. Use other Federal sources (Perry Point IHS Depot, Federal Supply Schedules, MLC-negotiated purchase agreements, etc.) may be used when, due to price or service advantages, it is

determined to be the most cost-effective procurement method to meet the needs of the unit. Drug procurement from retail sources shall be done only when absolutely required for urgent patient needs and when other, less costly, sources cannot meet this need.

c. Only those items that have been licensed and approved by the Food and Drug Administration (with the exception of vitamins with an established RDA) are authorized for use in Coast Guard health care facilities. Coast Guard health care facilities shall not purchase or dispense "herbal supplements" or "dietary supplements".

d. In storage, separate external use medications from internal use medications and ophthalmic and otic preparations. Caustic acids such as glacial acetic, sulfuric, nitric, concentrated hydrochloric, or oxalic acid shall not be issued to clinics, but shall be stored in separate lockers, clearly marked as to contents. Methyl alcohol shall not be stored, used, or dispensed by the pharmacy.

e. Store flammable drugs according to accepted fire safety regulations.

f. Use solid-core doors with 1-inch (minimum), throw key-operated, dead-bolt locks shall be used for all pharmacy and medical supply areas. On “Dutch” doors, both sections shall have this type lock.

g. Remove from stock drugs under testing in the FDA/DOD Shelf Life Extension Program; label them with the project number until results are received. While pending, use these items only in emergencies. Upon return of results, items should be destroyed or marked with new expiration dates and returned to stock. Oral contraceptives, opthalmics, otics, and inhaler medications should not be extended. These items may be used, while pending, results, to offset medical allowance list requirements.

h. The pharmacy shall maintain, in the pertinent clinic areas, an adequate supply of emergency medications, poison antidotes, and the poison control center telephone number. Containers for these items shall be closed with break-away seals to prevent the unreported removal of items. The outside of the container shall contain an inventory list containing the expiration dates of dated items.

i. Where feasible, pharmacies shall establish borrowing policies with local Government or civilian pharmacies to cover temporary supply shortfalls. The person responsible for the pharmacy shall maintain a log of items loaned or borrowed, and review and initial the log weekly to ensure prompt replacement of all items.

9. Pharmacy and Therapeutics Committee.

a. This is a mandatory advisory committee in all Coast Guard health service treatment facilities having assigned medical officers. It should meet regularly, but at least four times a year. The committee is composed of, but not limited to the following: at least one physician, one dental officer, a pharmacy officer (when available), and a

representative from medical administration. The chairman shall be a physician member. When a pharmacist is assigned, he or she is the secretary of this committee.

b. The committee is an advisory group on all matters relating to the acquisition and use of medications. Its recommendations are subject to the approval of the Chief, Health Services Division. The basic responsibilities of this committee are to:

(1) Use the Coast Guard Core Formulary as guidance to develop and maintain a clinic drug formulary; the group reviews new and deletes unnecessary items.

(2) Maintain a health service technician formulary selected from products authorized by the Coast Guard Standardized Health Services Technician Formulary;

(3) Ensure the unit formulary does not include items based primarily on civilian prescriber demand;

(4) Prevent unnecessary therapeutic duplications of formulary products;

(5) Conduct an ongoing review of all non-formulary items the pharmacy procures and dispenses. To accomplish this, the clinic and/or P&T committee lists:

(a) A list of all clinic formulary items not currently in the CG Core Formulary;

(b) A list of all special order items and the number of patients for whom procured (add special order items procured for seven or more patients to the unit formulary);

(6) Conduct an ongoing drug usage evaluation (DUE) program for selected medications;

(7) Monitor the facility's controlled drug prescribing and usage;

(8) Review pharmacy policies and procedures as necessary;

(9) Monitor the quality and accuracy of prescriptions and patient information the pharmacy provides and enacts any quality assurance measures it deems necessary (double checks, etc.) to ensure pharmacy quality and availability of services; and

(10) Reviews any adverse reaction or product quality reports (VAERS or MEDWATCH) before any drugs or vaccines are released.

c. Minutes shall be prepared for each meeting and approved by the Chief, Health Service Division.

FIGURE 10-A-1

NSN 7540-00-934-4178 500-108

| HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE |
|---|---|
| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry) |
| | NEW PRESCRIPTIONS (WITH CLAMS): |
| 08 Aug 91 | P:① Rxs : HCTZ 50 MG, #1 TAB QD, #90 MJ, RFx1 #1842 |
| 0930 | Clonidine 0.1 MG, #1 TAB BID, #180 #1843 MJ |
| | RF x 1 |
| | ② F/U 6 months |
| | CDR J. James M.D |
| | John James |
| | NEW PRESCRIPTIONS (WITHOUT CLAMS): |
| 08 Aug 91 0930 | P:① Rxs : HCTZ 50 mg, #1 Tab QD, #90, RFx1 #1842 Barr/624834/1/94 MJ |
| | Clonidine 0.1 mg, #1 Tab BID, #180, RFx1 #1843 BI/18A23/5/95 |
| | John James |
| | CDR JOHN JAMES M.D. |
| | REFILL PRESCRIPTIONS (WITH CLAMS): |
| 06 Nov 91 1415 | Rx Refill : Ref #1842 (HCTZ) #1843 (Clonidine) MJ |
| | |
| | |
| | REFILL PRESCRIPTIONS (WITHOUT CLAMS) |
| 06 Nov 91 1415 | Rx Refill : Rx #1842 (8-8-91) (HCTZ) #90, NR |
| | Barr / Exp 6/94 / Lot #624833 MJ |
| | Rx #1843 (Clonidine 0.1MG) #180, NR |
| | BI / Exp 6/95 / Lot #18A23 |
| | OVER |

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

| | |
|---|---|
| RECORDS MAINTAINED AT: | USCG Headquarters Clinic |
| PATIENT'S NAME (Last, First, Middle Initial) | Flyer, Joseph R. |
| SEX | M |
| RELATIONSHIP TO SPONSOR | |
| STATUS | A/D |
| RANK/GRADE | CDR |
| SPONSOR'S NAME | |
| ORGANIZATION | STA ALEXANDRIA |
| DEPART./SERVICE | CG |
| SSN/IDENTIFICATION NO. | 000-00-0000 |
| DATE OF BIRTH | 10 JAN 49 |

CHRONOLOGICAL RECORD OF MEDICAL CARE STANDARD FORM 600 (REV. 3-84) Prescribed by GSA and ICMR FPMR (41 CFR) 201-45.505

10-A-11

CH-10

FIGURE 10-A-1 (reverse)

| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)* |
|---|---|
| | **DENTAL PRESCRIPTIONS:** |
| 08 Aug 91 0830 Trans Point Clinic DOT Rm. 3403 2100 2nd St. S.W. Wash. D.C. 20593 | Dental Rx: ① Tylenol #3, 1-2 q 4-6h prn, #13, NR<br>② Amoxicillin 500mg, #3 caps 6 hrs ~~p~~ tx<br>#3, NR Rx #1822 / MJ |
| | **NOTE: Tylenol #3 IS A CONTROLLED SUBSTANCE AND MUST BE WRITTEN ON A REGULAR PRESCRIPTION FORM (DD 1289)** |
| | M. Fritz<br>M. Fritz DDS |

of U. Government Printing Office: 1990-262-081/20011

**FIGURE 10-A-2: PRESCRIBING GUIDELINES FOR EXPENSIVE MEDICATIONS**

| DRUGS INCLUDED | GUIDELINES |
|---|---|
| **1. Cholesterol and Lipid Lowering Agents** | |
| Lovastatin and other similar agents to reduce cholesterol and lipid levels | Patients prescribed these products shall have:<br>A. Documented hyperlipidemia confirmed by at least one of these baseline laboratory values:<br>1. Fasting Total Serum Cholesterol > 240 mg/dl<br>2. Fasting serum LDL > 160 mg/dl or > 130 mg/dl if risk factors present<br>3. Fasting HDL < 35 mg/dl<br>4. Fasting Serum Triglyceride Levels > 250 mg/dl |
| **2. Antibiotics** | |
| Amoxicillin and Potassium Clavulanate (Augmentin), Azithromycin (Zithromax), Cefaclor (Ceclor), Cefixime (Suprax), Cefuroxime (Ceftin), Ciprofloxacin (Cipro), Clarithromycin (Biaxin), Erythromycin/Sulfasoxazole (Pediazole) | Limit use of these and other more costly antibiotics to patients who have unsuccessfully taken more traditional, less expensive antibiotics or where culture and sensitivity testing confirms organism sensitivity. Use these drugs for initial therapy only if Sanford's *Guide to Antimicrobial Therapy* indicates they are the primary agent of choice. |
| **3. Smoking Cessation Aids** | |
| Nicotine gum and patches (any manufacturer), and other products used for smoking cessation | Behavioral modification is the primary method of smoking cessation; do not prescribe smoking cessation aids to patients without proof of ongoing participation in a "recognized" program that consists of regularly scheduled patient interaction with a smoking cessation facilitator. Do not prescribe smoking cessation products for anyone who continues to smoke after the initial two weeks of therapy. |
| **4. Antihistamines** | |
| Fexofenadine (Allegra), Loratadine (Claritin) | All patients prescribed these products shall have:<br>1. Previously documented failure to obtain relief of symptoms with at least one antihistamine or one antihistamine-and-decongestant combination or documented history of intolerance to antihistamines' sedative effects.<br>2. A consulting physician's prescription for unresolved allergy problems.<br>3. Current aircrew qualification with documented allergies. |

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Section B- Controlled Substances

1. General.

   a. Controlled substances, as used here, are defined as:

      (1) drugs or chemicals in DEA Schedules I-V: (for example, the manufacturers label for Acetaminophen with Codeine #3(30 mg.) carries the DEA symbol for Schedule III (C-III) and will be treated as a Schedule III by Coast Guard units.)

      (2) precious metals;

      (3) ethyl alcohol (excluding denatured);

      (4) other drugs or materials the local commanding officer or Pharmacy and Therapeutics Committee determine to have significant abuse potential.

   b. Coast Guard authorized uses for controlled substances are:

      (1) medicinal purposes;

      (2) retention as evidence in legal or disciplinary actions; or

      (3) other uses CG Regulations specifically authorize.

   c. Quantity Definitions. Due to the potential for abuse and associated audits required, Coast Guard units should strive to minimize the quantities of controlled substances used. Two types of quantities are recognized for controlled substances:

      (1) Working Stock. Working stock is defined as a 30 day supply (under routine conditions) of a controlled substance or limited amounts of emergency drug as might be required. For smaller facilities, with limited quantities of controlled substances, working stock may surpass the 30 day limit when quantities are less than 1000 dosage units (tablets, capsules, etc.). It is also acceptable for partial containers to temporarily surpass this 1000 dosage unit limit.

      (2) Bulk Stock. Bulk stock is defined as a larger quantity beyond the normal working stock quantity. Bulk stock should primarily be sealed in sealed manufacturer's containers.

2. Custody and Controlled Substance Audits.

   a. Controlled Substance Custodian (CSC).

      (1) Pharmacy officers, when assigned, shall be appointed in writing as the CSC by the commanding officer.

      (2) In the absence of a pharmacy officer, COs shall designate the clinic administrator as CSC.

      (3) Medical and dental officers may serve as alternate CSCs.

      (4) Temporarily assigned personnel shall not serve as CSCs or alternates.

      (5) Under Coast Guard Regulations, COMDTINST M5000.3A, Chapter 6-2-3-A.(6), the Executive Officer is directly responsible for medical matters if a

medical officer is not assigned. For sickbays, the CO shall designate a commissioned officer as the CSC.

(6) CSCs may permit Health Services Technicians to assume custody of a "working stock" quantity of controlled substances.

(7) An audit of all controlled substances (working and bulk stock) is required when the CSC is changed. The results of this inventory shall be filled in the command's permanent file and in the Health Services Log. All keys should be transferred and/or combination locks changed at the time of this inventory.

b. Unit Controlled Substance Audits.

(1) Controlled Substance Audit Boards (CSAB). Each unit procuring, storing, or dispensing controlled substances shall have a CSAB.

(a) Membership: The CSAB shall consist of two or more disinterested officers or, if unavailable, the CO shall appoint two senior petty officers (E-6 or above) in writing. When expeditious, commands may promulgate an annual letter designating all CSAB members and the term of their assignment. In no case may the custodian be a member of the CSAB.

(b) The CSAB shall conduct monthly audits of controlled substances at clinics (quarterly at ashore or afloat sickbays) and submit its report to the commanding officer within 5 working days after its audit. Commands shall maintain these reports for three years after which they may be destroyed.

(c) Monthly CSABs shall audit all working and bulk stock of C-II through C-V controlled substances, precious metals, ethyl alcohol, and drugs or other items locally designated as controlled substances due to abuse potential and report all quantities on CG-5353, Monthly Report for Narcotics and Other Controlled Drugs.

(d) During monthly audits, CSABs shall inspect controlled substances for expiration, deterioration, and inadequate or improper labeling. Expired products or those with other discrepancies shall be removed for disposal.

(e) The CSAB shall count required controlled substances; review a representative random sample of prescriptions, receipts, and issue documents; and report the results on Monthly Report for Narcotics and Other Controlled Drugs, CG-5353. For sealed containers, a bottle count is sufficient; for open containers an exact count is required. For open liquid containers, an estimate other than an exact volume measurement is adequate. CSABs may use tamper-proof seals on open containers to avoid future counting of partial quantities.

(2) DPSC Controlled Substance Reports. DPSC supplies Commandant (G-WKH-2) with monthly reports of controlled substance purchases. These reports are

reviewed to ensure that only authorized products are procured in appropriate quantities. Discrepancies are forwarded to the pertinent MLC (kqa) for follow-up.

(3) DEA Biennial Inventories. To comply with DEA requirements, all controlled substances shall be inventoried by the custodian during May of even-numbered years. This copy of the CG-5353 shall be maintained on file locally and labeled "FOR DEA BIENNIAL INVENTORY" at the top of the form.

c. Drug Enforcement Administration (DEA) Registration. DEA registration is required for those CG clinics with Prime Vender Ordering Officers. Purchase of controlled substances from commercial sources is prohibited unless approved and procured by pharmacy officers. Sickbays shall not register with the DEA unless in-house physician services are provided. The unit's Drug Enforcement Agency Registration Form (DEA-244A) shall be signed by the Commanding Officer. By direction signature is not authorized. Forward the signed form to the cognizant MLC (k) for signature as approver/exemptor. The MLC (k) shall forward the form (DEA-244A) to the DEA and provide a photostatic copy to the originating unit. The DEA will issue the registration to the unit.

d. Reporting Theft or Loss. Upon receipt of the CSAB or pharmacy officer monthly audit noting theft or loss of controlled substances, the command shall::

(1) Designate a command member to contact the cognizant MLC (k), discuss the circumstances of the discrepancy, and request guidance for further action. MLC will advise the command in writing or by E-mail of the guidance provided. Should MLC determine an investigation is warranted, the command shall: appoint one or more members of the command to investigate the discrepancy. The command shall not appoint CSAB members to investigate an incident they have reported.

(2) Review and send to the pertinent MLC (k) the findings of the investigation.

(3) The pertinent MLC (k) shall determine if the theft or loss warrants further action or DEA notification.

3. Procuring, Storing, Transferring, and Disposing of Controlled Substances.

a. Procurement.

(1) Clinics shall procure controlled substances from the DSCP prime vendor, or directly through DSCP, if items are available. Coast Guard vessels shall obtain authorized controlled substances through their collateral duty pharmacy officer.

(2) Documents relating to commercial procurement of controlled substances shall be endorsed by the CSC prior to processing.

(3) Schedule I controlled substances and alcoholic beverages shall not be procured or stocked in Coast Guard health care facilities.

(4) Upon receipt, controlled substances shall immediately be placed in the custody of the designated custodian. The invoice shall be checked against the

requisition to verify receipt of all quantities listed on the invoice. The custodian shall acknowledge receipt by signing the invoice. Controlled substance procurement documents shall be maintained in the pharmacy for three years.

b. Storage.

(1) Bulk stocks of controlled substances shall be stored in an all-purpose Class V safe or cabinet.

(2) Working stocks shall be stored in a locked cabinet in a secured area (pharmacy, etc.).

(3) The controlled substance custodian shall record and sign on the NAVMED 6710/5 all transfers of controlled substances from bulk.

(4) Afloat units may use existing "built in" containers to store bulk or working stocks of controlled substances.

c. Transfer.

(1) Controlled substances may be transferred between CG and other government facilities using the Requisition and Invoice/Shipping Document (DD-1149). When completed the document shall include:

(a) names of issuing and receiving facility or unit;

(b) name, strength, and quantity of each drug;

(c) date; and

(d) signatures of the issuing and receiving custodians.

(2) Both units shall adjust inventories as required and file copies of the DD-1149 for three years.

(3) When the transaction cannot be done in person, it may be done by registered mail. The Registered Mail Return Receipt (PS Form 3806) shall be maintained by the issuing unit until a signed copy of the DD-1149 is returned.

(4) A copy of the DD-1149 shall be sent to the pharmacy officer with collateral duty responsibility for the facility.

d. Disposal.

(1) Expired, contaminated, excessive, or inadequately labeled controlled substances shall be destroyed by the inventory board. CSAB reports shall include the drug name, quantity, reason for destruction, and mechanism of destruction. These shall be maintained on file for three years.

(2) Controlled substances identified for destruction must be disposed of in accordance with state law. The DEA may also be used to dispose of controlled substances. Contact your pharmacy officer for information on this procedure.

4. Prescribing Practices.

a. Authorized prescribers (see 10-A-2.a). are exempt from registration under provision of 21 CFR 1301.25. The officer's social security number shall be used in lieu of a DEA registration number. The exemption does not apply when the officer prescribes controlled substances outside of their official duties. In that case, the prescriber is required to register with the DEA, at their own expense, and comply with applicable state and federal laws.

b. Signatures.

(1) All prescriptions for controlled substances shall be signed by a medical or dental officer. If none is assigned, the prescription shall be signed by the senior health services department representative and countersigned by the executive officer.

(2) All schedule II controlled substance prescriptions by physician assistants or nurse practitioners shall be countersigned quarterly by their supervising medical officer.

(3) All controlled substance quantities used in the preparation of other products (compounding, etc.) shall be accounted for on a prescription form and be signed by the pharmacy officer or custodian.

(4) The back of all controlled substance prescriptions shall include the wording "received by," followed by the patient's signature, address, and the date dispensed.

c. Quantities and Refills.

(1) Controlled substances shall be prescribed in minimal quantities consistent with proper treatment of the patient's condition.

(2) Out-of-state controlled substance prescriptions may be dispensed if, in the professional judgment of the pharmacy staff, the prescription is legitimate. These prescriptions should invoke special scrutiny by pharmacy personnel.

(3) Schedule II prescriptions shall not be accepted more than seven days after the date the prescription was written. For other controlled substances, 30-days shall be the limit.

(4) Schedule II prescriptions shall be limited to a 30-day quantity and may not be refilled. The only exception shall be medication for Attention Deficit Disorder (ADD) where quantities may be dispensed in up to a 90 day supply with no refills.

(5) Schedule III, IV, and V prescriptions shall be limited to 30-day quantities with up to five refills authorized by prescriber. The only exception shall be for chronic seizure medications, which may be dispensed in up to 90-day quantities with one refill (six months' total supply). Civilian prescriptions for these medications shall only be honored for these quantities. Patients shall be

informed of this quantity/refill limit and be offered the opportunity to have the prescriptions filled elsewhere.

d. Filing Prescriptions.

(1) Controlled substance prescriptions shall be serially numbered and maintained in two files:

(a) File #1: All C-II, precious metals, and alcohol prescriptions.

(b) File #2: All C-III, C-IV, and C-V prescriptions.

(2) All prescriptions shall be maintained on file for three years after which they may be destroyed them by shredding or tearing each prescription in half.

(3) All prescriptions for C-II medications, precious metals, and alcohol shall be posted on NAVMED 6710/5 by the end of the workday. When this is done, a line shall be initialed by the pharmacy staff member completing the transaction.

Section C - Forms and Records

1. General. Records shall be maintained for certain procedures conducted within all Coast Guard Clinics. Among mandatory requirements for record keeping are the prescribing of drugs, handling of controlled substances, and quality control procedures. Standardized forms are available for all procedures except quality control.

2. Prescription Forms.

   a. The DOD prescription form (DD 1289) or polyprescription (NAVMED 6710/6) shall be used by Coast Guard prescribers when chart prescribing is not available.

   b. All prescriptions shall be filed in one of three files:

      (1) All non-controlled drug prescriptions;

      (2) Schedule II prescriptions; and

      (3) Schedule III, IV, and V prescriptions.

   c. Prescriptions in black or blue ink, indelible pencil, or typewritten must show the information:

      (1) Patient's full name;

      (2) Date the prescription was written;

      (3) Full generic name (or trade name with substitution instructions), dosage form desired, and dosage size or strength written in the metric system. The quantity dispensed shall be clearly specified numerically or spelled out in words ("one bottle" or "one package" are not acceptable). Standard pharmacy abbreviations may be used in writing dispensing and dosage instructions but not in specifying the drug to be dispensed.

      (4) Complete, explicit directions to the patient (expressions such as "take as directed," "label," etc. are not adequate directions and not allowed);

      (5) Prescriber's legible, legal signature (initials not permitted) with stamped name and professional discipline (MD, DO, DMD, DDS, PA, HS2, etc.);

      (6) All additional requirements when prescribing controlled substances:

         (a) Patient's complete address; and

         (b) Prescriber's SSN or DEA number.

         (c) NOTE: Alterations on prescriptions for controlled substances are prohibited unless initialed by the prescriber.

   d. Multiple prescription forms, such as NAVMED 6710/6 or 6710/10, which are intended for use when prescribing a number of non-controlled drugs for one patient, are authorized.

e. Maintain all prescriptions on file, including all "prescription logs" related to chart prescribing, for three (3) years, after which they may be destroyed by shredding or tearing each prescription in half.

f. The pharmacy shall have ready access to the patient's medical information including age, allergies, weight, etc., when preparing and dispensing prescriptions.

3. Quality Control Forms. Quality control is important for proper conformity and safety of drug products to be dispensed. The two main areas that benefit from quality control are compounding and prepackaging. A locally prepared form shall be used which will provide clearly definable material sources (manufacturer's name, lot numbers, and expiration dates), procedures used, intermediary and final checks by supervisory personnel, and sample labeling.

4. Controlled Drug Forms.

a. NAVMED 6710/4—24-Hour Narcotic and Controlled Drug Inventory. This record shall be maintained at Coast Guard facilities providing inpatient care.

(1) The NAVMED 6710/4 shall be signed by the senior health services technician on each watch after the drugs have been checked prior to relief. Where feasible and practical the drugs should checked concurrently by the HS reporting for duty as well as by the HS being relieved. Any discrepancies noted shall be reported immediately. The record is used for two (2) weeks, with a one (1) week period on each side. The night HS shall initiate the record.

(2) The serial numbers of new NAVMED 6710/1's received from the pharmacy during each watch shall be entered. The serial numbers of completed NAVMED 6710/1's returned to the pharmacy shall be entered and the pharmacist or authorized representative shall acknowledge receipt by initialing in the appropriate column.

(3) At the time specified in local instructions, the senior health services technician shall audit the clinic controlled substances supplies. After the audit the senior health services technician shall date and sign the NAVMED 6710/4.

b. NAVMED 6710/1—Narcotic and Controlled Drug Account Record.

(1) Upon receipt of a properly completed prescription requisition a separate Narcotic and Controlled Drug Account Record (NAVMED 6710/1) shall be prepared by the pharmacy for each schedule II through schedule V drug, and any other drug which, in the opinion of the commanding officer, requires control procedures.

(2) All NAVMED 6710/1's shall be kept in a controlled drug book.

(3) All entries shall be made in blue or black ink. Errors shall be corrected by drawing a line through the erroneous entry and having the person making the correction sign the entry. The correct entry shall be recorded on the following line, if necessary.

(4) If a new issue is received before the old issue is completely expended, the new NAVMED 6710/1 shall be inserted in back of the current record. The serial number of the new NAVMED 6710/1 shall be entered on the NAVMED 6710/4.

(5) The heading for each NAVMED 6710/1 shall be completed at the time of issue. The body shall be used for recording expenditures and balances only.

(6) Each time a drug is used, complete information shall be recorded: date, time, patient, doctor's name, by whom given, amount used, and balance remaining on hand (NAVMED 6710/1).

(a) Record all amounts in Arabic numerals. Where the unit of measure is a milliliter (ml) and the amount used is less than one ml, it shall be recorded as a decimal (e.g., 0.5 ml) rather than a fraction.

(b) When a fraction of the amount is expended to the patient , it shall be placed in parentheses before the amount recorded in the expended column; [e.g., an entry of (0.0005)1 on the morphine sulfate 16 mg/ml record indicates that one-half ml was expended and that 0.008 gm was administered].

(c) If a single dose of a controlled substance is accidentally damaged or contaminated during preparation for administration or the patient refuses after preparation, the dose shall be destroyed and a brief statement of the circumstances shall be entered on the NAVMED 6710/1. Such statements shall be signed as witnessed by a second health care provider.

(d) If multiple doses of a controlled substance are damaged, another senior HS shall record the disposition of the drug, including date, amount of drug, brief statement of disposition, and new balance. Both the senior and witnessing HS shall sign the NAVMED 6710/1.

(e) Deteriorated drugs shall be returned to the pharmacy for disposal.

(f) The completed NAVMED 6710/1, along with the counter-type dispenser, shall be returned to the pharmacy.

(g) Monthly, the pharmacy shall report all NAVMED 6710/1s still outstanding 30 days from date of issue. The report shall be verified and returned to the pharmacy for reconciliation. Discrepancies shall be reported to the commanding officer via the Controlled Substances Inventory Report.

c. Narcotic and Controlled Drug Book.

(1) Each activity drawing controlled substances from the pharmacy shall maintain a loose leaf notebook containing NAVMED 6710/4—24-Hour Narcotics and

Controlled Drug Inventory in the first section and individual NAVMED 6710/1—Narcotic and Controlled Account Records in the latter sections.

(2) The senior HS shall remove all filled NAVMED 6710/4's over three (3) months old from the Narcotic and Controlled Drug Book and return them to the pharmacy.

d. NAVMED 6710/5—Perpetual Inventory of Narcotics, Alcohol, and Controlled Drugs. Separate NAVMED 6710/5 forms are not required for each controlled substance (C-II through C-V) in bulk and working stock when electronic records or documentation are available via the Composite Health Care System (CHCS) or equivalent software programs. The requirement for hard copy report monthly substance audit board report (CG-5353) is still required, however the CHCS software prepares and automates controlled substance inventory reports which are acceptable and can be used as an equivalent to the CG-5353. If software is not available prepare a separate NAVMED 6710/5 for each controlled substance (C-II through C-V) in bulk and working stock; All boxes and columns below are self-explanatory except as noted:

(1) Drug Name. Enter generic or proprietary drug name as appropriate, e.g., "Codeine Sulfate."

(2) Strength. Express as gm, mg, etc.

(3) Unit. Enter dosage form as appropriate.

(4) Prescription or Requisition Number. Enter appropriate prescription or requisition (voucher) number. For issues returned to the pharmacy, enter the source.

(5) Recipient. Enter "pharmacy" for receipts. Enter clinic or patient name, as appropriate, for expenditures.

(6) NAVMED 6710/1 Returned. The date the NAVMED 6710/1 is returned to the pharmacy shall be entered on the appropriate line bearing the same serial number or prescription number.

5. Forms Availability.

a. Forms CG-5353, DD-1289, NAVMED 6710/1, NAVMED 6710/4, NAVMED 6710/5, and NAVMED 6710/6 are available from the Coast Guard Supply Center.

b. Obtain DEA forms from the nearest DEA office. Consult with a pharmacy officer for more information.

Section D - Drug Dispensing Without a Medical Officer.

HSs dispensing prescriptions without a medical officer's direct supervision, e.g., at independent duty shore stations or vessels, shall be conducted in accordance with provisions of this manual, except that these services shall be provided for active duty personnel only. HSs in these situations are encouraged to seek consultation with their assigned collateral duty pharmacy officer when necessary.

1. Child-Resistant Containers. Prepackaged OTC products should be issued in their original container. For vessels, limited quantities of prescription drugs may be issued in labeled plastic zip-lock bags while underway. These bags must be inserted in a child resistant container if they are removed from the vessel.

2. Controlled Substances.

   a. All drugs shall be dispensed under the supervision of a health services technician at activities where there are no officers of the health services department.

   b. An officer, designated by the commanding officer, shall keep in a separate locked compartment, all bulk un-issued controlled substances, alcohol, or items otherwise controlled. The keys or combination shall always be in the custody of an officer. The executive officer, or other designated officer, shall arrange for the care and safe custody of all keys and require strict compliance with instructions concerning the receipt, custody, and issue of controlled substances and alcohol as contained in the law, Coast Guar Regulations, and this manual.

   c. Custodians or their designated assistants shall retain the keys or combination to the working stock storage area while on duty. When relieved, they shall deliver the keys to their relief or to a responsible person designated by local instructions. A copy of the combination of a safe, if used, shall be sealed in an envelope and deposited with the commanding officer.

   d. Commanding officers may authorize temporary deviations from the controls established in this Chapter due to operational and/or emergency situations.

3. Formulary. Health Services Technicians on independent duty shall maintain drug formularies consisting of:

   a. Standardized Health Services Drug Formulary items;

   b. Health Services Allowance List requirements;

   c. Chronic medications prescribed by a physician for active duty members; and

   d. Other drugs the HS has agreed to stock for their active duty members for a local contract prescriber.

4. Non-prescription Medication Programs. Sickbays are encouraged to operate nonprescription medication programs as described in paragraph 10-A-6.h. of this manual.

# CHAPTER 11

# HEALTH CARE PROCUREMENT

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## CHAPTER 11. HEALTH CARE PROCUREMENT

Section A - Contracting For Health Care Services

1. General. Commandant (G-WK) has fiscal responsibility for health care for all Coast Guard beneficiaries. The necessary care can be obtained through contracts with private concerns and individuals and interagency and other agreements with military facilities. Commanding officers are responsible for obtaining the necessary services for each fiscal year, subject to MLC (k) review and approval. MLC (k) first authorizes all non-emergency, non-Federal health care. The MLC is responsible for all health services contracting in its area and shall comply with Federal Acquisition Regulations Part 37. The MLC (k) oversees all non-Federal care acquired and minimizes expenses by ensuring competitive contracting procedures take place.

2. Type of Services. The following services may be procured by contract as determined by MLC (k).

   a. Allergist;

   b. Dental Prosthetic Laboratory;

   c. Dentist, Dental Hygienist, or chairside Dental Assistant;

   d. General medicine (Physician or Midlevel Providers);

   e. Group Practice Hospital;

   f. Gynecologist;

   g. Medical Laboratory;

   h. Neurologist;

   i. Nurse (Registered or Licensed Practical);

   j. Obstetrician;

   k. Occupational Health Services (for OCCMED Physicals);

   l. Optometrist;

   m. Orthopedist;

   n. Pharmacist;

   o. Physical Therapist or Certified Athletic Trainer;

   p. Psychiatrist or Psychologist; and

q. Radiologist.

3. Eligibility For Contract Health Care Services. Eligibility for contract health care services is the same as described in Chapter 2.

a. The following persons are NOT eligible for health care services rendered by contract providers:

(1) Family members of Coast Guard personnel and retired and retired members of the Coast Guard (however, they may receive health care services when the contractor performs the service at a Coast Guard Clinic or sickbay and/or if the Coast Guard has contracted with a health care provider as a demonstration project).

(2) Active duty beneficiaries separated from the Service while undergoing treatment (eligibility for treatment terminates and becomes the member's responsibility).

(3) Coast Guard civilian employees except for required Occupational Medical Surveillance and Evaluation Program (OMSEP) physical examinations and required pre-appointment examinations, all funded using either MLC (k) or unit AFC-57 funds.

b. Dental laboratory fees for non-active duty beneficiaries:

(1) Retirees. Retirees are authorized to use private sector dental laboratories. Pay retirees' dental laboratory fees in the same manner as for active duty members.

(2) Dependents. The dependent receiving the treatment shall pay all private sector laboratory fees resulting from space-available treatment . A suggested way to handle such payments is to require dependents to submit a check or money order payable to the private sector laboratory before delivery of appliances. The attending dental officer then photocopies the check or money order, pays the laboratory, and retains the photocopy in the dental record.

4. Approval to Contract for Services.

a. Units shall submit letter requests for contract health care services through the appropriate chain of command to MLC (k). All requests must contain this information:

(1) Description of services required (e.g., general health care, pharmacy, lab, or specialty care such as OB/GYN, optometry, or psychiatry), including desired days and hours of availability;

(2) A justification of the need for the service;

(3) Estimated annual cost of the required services;

(4) A list of USMTFs within 40 miles of the unit and whether they could perform the desired service;

(5) A list of Coast Guard units benefiting from the services;

(6) The number of active duty members assigned to each unit;

(7) Either the names and mailing addresses of all interested, recommended providers or a justification of other than full, open competition (see paragraph 11-A-7, Pre-contract Award Actions, below);

(8) Preferred solicitation area and the rationale for it (e.g. "provider must be located within 20 miles of the unit", etc.);

(9) Estimated number of annual Coast Guard visits to the provider; and

(10) A list (by type) of any other approved or requested health care contracts.

b. Each request must be able to stand on its own merits and fulfill cost-to-benefit criteria. MLC (k) will analyze each request and provide written approval or disapproval (with alternative proposals) to the requesting unit through the chain of command. If approved, the MLC contracting officer will undertake procurement.

c. MLC will not renew existing contracts simply as a matter of convenience. Each contract must continue to prove its value annually on a cost-to-benefit basis before its renewal. MLC (k) will review each contract's current fiscal year activity. If the contract passes review, it may be renewed; if it does not, MLC (k) will so advise the unit receiving the contract services.

5. Funding.

a. The MLC shall budget, review, and pay for all MLC (k)-authorized non-Federal health care obtained in its area. These documents contain detailed instructions:

(1) Maintenance and Logistics Command, Atlantic Standing Operating Procedures (MLCLANT SOP), Annex D; and

(2) Maintenance and Logistics Command, Pacific Instruction M6000.1 (series).

b. Charge all MLC (k)-authorized non-Federal health care expenditures to the MLC AFC-57 account. MLCs can find detailed object class and cost center information in the Accounting Manual, COMDTINST M7300.4 (series).

6. Pre-contract Award Actions.

a. The contracting officer issues solicitations to obtain supplies and services from industry on a competitive (more than 1 source) or non-competitive (1 source) basis. The Competition in Contracting Act of 1984 (PL-98-369) requires the Government to contract for supplies and services by means of full, open competition to the maximum extent possible. This means all responsible firms or individuals who can provide the supplies or services must be allowed to compete for a government contract. Contracting officers locate potential contractors by publishing the proposed procurement in the *Commerce Business Daily* as required by Federal Acquisition Regulation (FAR), Part 5.

(1) Non-competitive Procurements. Pre-awarding a firm a Government contract violates the Competition in Contracting Act of 1984. If it is claimed only one firm can provide the supplies or service, the purchasing office must justify in writing other than full, open competition, setting forth the facts and rationale (see FAR, Part 6) to support this claim. The justification must be certified that it is accurate and complete and send it with the purchase request when sending it to the contracting officer for procurement action.

(2) Competitive Procurements. The contracting officer also may require certain information before contracting on a competitive basis. The contracting officer may request the types of information below to determinate responsibility within the meaning of Federal Acquisition Regulation, Part 9.

(a) Organizational structure and plan to accomplish the service;

(b) Summary of experience in performing the same or similar work;

(c) Evidence of pertinent state and local licenses;

(d) Evidence of professional liability insurance, or that the offeror can obtain such insurance;

(e) Membership in professional organizations;

(f) Resume of key personnel with particular emphasis on academic achievements pertinent to the proposed services; and

(g) Information about the firm or its key individuals that reflects their status or professional recognition in their field, e.g., awards, published articles, and the like.

b. Subject to the contracting officer's approval, a visit may be made to the offeror's facility before the award (pre-award survey) to review some of the above data to reduce submitted data. The following paragraphs are examples of the information that may be required from an offeror.

(1) Brief description of the facility, how long established, where located relative to the required mile radius, daily operating hours, weekly operating hours (include holidays, Saturdays, and Sundays).

(2) Brief description of similar work performed under Government contracts including the government agency's name, contract number, contract price, and name and telephone number of the agency's contracting officer.

(3) A resume, X pages maximum, including education, past and present experience over the last X years, certificates, association membership, etc., of the key persons who will perform the work under the contract and their letter of intent indicating they intend to work for the offeror if it is awarded the medical services contract.

c. Minimum qualifications required to perform the contract may be stated; however, these qualification requirements must be justified. For example:

(1) Personnel.

(a) Physician. At a minimum, a X year degree in medicine from an accredited college, license to practice medicine in the location where the services will be performed, member of the AMA; X years' experience in practicing general medicine.

(b) Nurse. RN or LPN. B.S. degree (or equivalent) in nursing from an accredited college; ANA-certified or equivalent; X years' experience in handling patients, administering patient records, etc.

(c) Laboratory Technician. HHS certified, ASCP or eligible, X years' experience in all phases of laboratory work; e.g., x-rays, blood samples, etc.

(2) Facility.

(a) Within a X mile radius of the Coast Guard facility requiring the services.

(b) Capable of accommodating or rendering services for at least X patients simultaneously.

7. Award Evaluation Factors.

a. State the steps or procedures to be used to evaluate the proposals.

b. List the evaluation criteria in the descending order of relative importance and state whether one factor will have predominant consideration over another. For example:

(1) Personnel,

(2) Experience,

(3) Facility, and

(4) Price.

c. Establish the criteria to be used in evaluating the proposal. They must be the same as the evaluation factors for award the solicitation cited. The weights assigned to the factors may be in any form, e.g., adjective (acceptable, outstanding), numerical (50). Give this information to the contracting officer, preferably before he or she issues the solicitation, but in any event before receiving the proposals for evaluation.

8. Post-Contract Award Actions.

a. Referring for Contract Services. Before referring any person to a medical services contractor, the cognizant authority shall determine whether:

(1) The person is eligible;

(2) Services are available in-house;

(3) Services are available from a USMTF; and

(4) Services are available from another Federal facility, e.g., Department of Veterans Affairs, under an interagency support agreement.

b. Contracting Officer's Technical Representative. The contracting office that awarded the contract administers it. If the requiring office requests, a Contracting Officer's Technical Representative (COTR) may be assigned to the contract. The COTR is preferably a health services program manager or medical administration officer having jurisdiction in the contract services area. The contracting officer designates the contracting officer's technical representative in a written, signed letter of appointment describing the COTR's responsibilities and limitations. These responsibilities and limitations must strictly be adhered to avoid any conflicts with the contractor about changes to contract terms and conditions.

c. Health Care Invoices.

(1) Contractor Invoices.

(a) All invoices for health care services contractors by contractors shall be processed for payment under the applicable contract's terms and conditions. This Manual's Chapter 6-B-8 describes certifying and processing non-Federal health care invoices. The contracting officer is responsible for including the applicable invoice and payment clauses (e.g., Federal Acquisition Regulations 52.204-3, Taxpayer Identification, 52.232-25, Prompt Payment, etc.) in the contract. Ensure the contracting officer also includes these invoice requirements in the contract so the invoice is proper for payment:

1 An itemized, priced list of the services by contract or order line item number; and

2 Any additional information deemed necessary to process the invoice for payment.

(b) In addition to the invoice requirements above :Any invoice without the following supporting documentation will not be paid.

1 Services Rendered Under Non-Emergent Conditions. A referral slip or written confirmation of patient's eligibility from cognizant health services department representative.

2 Services Rendered Under Emergent Conditions. A written statement from the patient describing the emergent condition(s). The cognizant health services department representative must certify the patient's eligibility and emergent condition.

(c) If the eligible patient pays the contractor for services rendered under a contract and requests reimbursement, the reimbursement claim must be submitted to the appropriate accounting office on SF-1034, Public Voucher for Purchases or Services Other Than Personal. A patient's invoice cannot be reimbursed from funds obligated under a contract even though the contractor rendered the services. These documents must accompany the claim:

1 The contractor's itemized invoice,

2 A copy of the invoice and receipt showing payment to the contractor,

3 The patient's written statement of the circumstances justifying the claim, and

4 The cognizant health services department representative's approval of the claim.

(2) Invoices Outside the CONUS.

(a) The nearest Coast Guard facility having an authorized certifying officer shall process invoices for emergency health care civilian facilities furnish to Coast Guard members. The invoices and justification explaining the reasons for the emergency health care must be in duplicate and attached to SF-1166, Voucher and Schedule of Payments.

(b) Every attempt to pay for emergency health care should be made before departing from a foreign port to reduce paperwork and pay at the exchange rate. If payment before departure is not feasible, advise the facility rendering the service to send all invoices to the United States Embassy or appropriate consular office for the area.

Figure 11.A.1

**STATEMENT OF WORK**

1. Scope. Provide all labor, materials, and facilities necessary to perform the tasks herein.
2. Definitions.

   a. Patient. An eligible U.S. Coast Guard military member.

   b. Emergency. Treatment required to curtail the patient's undue suffering or loss of life or limb.

   c. Non-Elective Condition. A condition that, if untreated, would render the patient unfit for duty.

   d. Elective Procedure. Treatment the patient *desires*, e.g., vasectomy, tubal ligation, sterility test, contact lenses, orthodontics, etc.

   e. Duty Status. A determination of the patient's ability to perform the assigned tasks at the assigned work station. These statuses apply:

      (1) Fit for Full Duty (FFFD). Patient is not physically restricted or limited.

      (2) Fit for Limited Duty (FFLD). Patient is physically restricted or limited, e.g., office work only; no lifting, stooping, prolonged standing, walking, running, jumping, sea duty, etc.

      (3) Not Fit for Duty (NFFD). Patient cannot perform any assigned tasks at assigned work station.

3. The contractor shall perform these tasks:

   a. Task I. Eligibility Determination. Provide service to the Coast Guard military personnel listed below. Each patient must show the required authorizations before the Contractor renders service.

   b. Task II. Physical Examinations. Examine the patient according to Attachment (1) requirements. [Attach copy of appropriate section of Medical Manual, COMDTINST M6000.lA (series).]

   c. Task III. Immunization. Immunize the patient and document appropriately on Standard Form 601 (Immunization Record) or Public Health Form 731 (International Certificate of Vaccination) in the Coast Guard Health Record the patient presents the contractor. Record also any sensitivity reactions to the immunization. The contractor shall use only those immunizing agents approved by the Department of Health and Human Services. Immunize the patient at the time intervals Attachment 2 specifies. [Attach a copy of Immunization and Chemoprophylaxis, COMDTINST M6230.4D (series).]

d. Task IV. Emergency Hospitalization. Provide all necessary services to patient while he or she is hospitalized, to a maximum of seven days. If the patient requires hospitalization for eight or more days, the contractor shall notify the Coast Guard Point of Contact by telephone. If the Coast Guard elects to transfer the patient to a military hospital, the contractor shall complete all necessary documents the civilian hospital may require to effect the transfer.

e. Task V. Prosthetic and Orthopedic Appliances. The contractor shall provide prosthetic or orthopedic appliances to the patient only under emergency conditions (required immediately due to his or her condition). The contractor shall document the emergency condition on the Coast Guard Health Record. Under non-emergency conditions, the contractor shall refer the patient to a military hospital to obtain these appliances.

f. Task VI. Communicable Disease. The contractor shall report all communicable diseases and recommended control measures to the Coast Guard Point of Contact immediately after detecting the disease. The contractor also shall report to local authorities as required by local regulations.

g. Task VII. Notification. The contractor shall notify the Coast Guard Point of Contact if a patient is seriously ill, injured, or dies.

h. Task VIII. Records and Reports. For all patients the contractor shall maintain a record with this information:

(1) Outpatient Record. Record the name, rank or rating, Social Security Number, address, date of treatment, history of present illness, physical findings, diagnostic procedures including x-rays and laboratory, therapy provided, fitness for duty determination, duration and limitations if unfit or fit for limited duty, and the contractor's printed name and signature.

(2) Inpatient Report. On discharge from the hospital, furnish the patient's medical report written using diagnostic nomenclature (standard disease and operation nomenclature) to summarize the course of the case, laboratory and x-ray findings, surgeries and treatments, complications, current condition, final diagnosis, and a fitness for duty determination with duration and limitations if unfit or fit for limited duty.

i. Task IX. Certificate of Services. After rendering services to the patient, complete Attachment (3) and obtain the patient's signature before he or she departs from the contractor's facility or location where the services were rendered. [Attach copy of certification form.]

4. The contractor shall not execute any oral or written agreements with the patient to render a more expensive type of service than that described in the contract in which the patient pays the difference in price between the contract unit price and the price the contractor charges (for eyeglasses, see Section 8-E-3

5. The contractor must obtain written authority from the patient's Coast Guard unit before filling any prescriptions.
6. The contractor must obtain written authority from the patient's Coast Guard unit before performing any elective procedure.

| Personnel | Required Authorization |
|---|---|
| Active Duty | 1. Valid Green I.D. Card (DD Form 2CG (ACTIVE))<br>2. a referral slip signed by an authorized Coast Guard official |
| Reservists (Active Duty) | 3. Valid Green I.D. Card (DD Form 2CG (RESERVE))<br>4. copy of active duty orders<br>5. a referral slip signed by an authorized Coast Guard official |
| Reservists | 6. Valid Green I.D. Card (DD Form 2CG (RESERVE))<br>7. a copy of Inactive Duty letter signed by the Coast Guard Reserve unit's commanding officer<br>8. **or** CG-4671 and a letter signed by the Coast Guard unit's commanding officer |
| PHS Commissioned Officers on Coast Guard Active Duty | Valid Green I.D. Card (DD Form 2CG (ACTIVE)) |
| Prospective Coast Guard Recruit | A letter signed by an authorized official at the Coast Guard recruiting unit |
| The contractor shall not provide services under this contract to personnel who do not have the required authorizations listed above. | |

Section B - Health Care Services Invoice Review and Auditing

1. General.

   a. All health care invoices are subject to review and audit to ensure the Coast Guard pays only for necessary, appropriate health care for its beneficiaries.

      (1) The auditing process ensures the contractor's invoice charges for services provided at either reasonable fees or those in agreement with the contract.

      (2) The review process determines the appropriateness of care for the diagnosis.

   b. Personnel performing the review and audit functions must remember if they find discrepancies, they must give the care provider the opportunity to comment on the findings.

   c. The process of health care invoice auditing and review is complex and lends itself to errors; thus, most reviews and audit inquiries are not dismissed. Finding must be presented in a non-threatening manner, demonstrating the Coast Guard's willingness to cooperate with our health care providers in determining fair, equitable charges.

2. Invoices Subject to Review and Audit. These contract and non-contract health services invoices are subject to review and audit. The unit processing the invoice should review bills in these categories before paying them:

   a. All outpatient invoices contractors submit;

   b. All inpatient and outpatient supplemental care.

3. Review and Audit Procedures. The personnel processing health care invoices should perform these procedures:

   a. Review.

      (1) Is the diagnosis compatible with the prescribed care?

      (2) Are ancillary services (e.g., lab, x-ray, pharmacy, electrodiagnostic tests, etc.) prescribed appropriately in amount and frequency?

      (3) Is the length of care appropriate for the diagnosis?

   b. Audit. Does the contractor's invoice meet the contract definition of a proper invoice? If not, notify the contracting officer immediately.

      (1) Is the bill mathematically correct?

      (2) Does it bill only for authorized care and services?

      (3) Were services and billed care actually furnished?

      (4) Do the charges agree with the provider's regular fee schedule or the prices listed in the contract?

(5) Does the bill give credit for incomplete, canceled, or partial treatments?

(6) Do dates of care match the time period the patient received the care or services?

(7) Have previous audits of this provider demonstrated billing errors?

Section C - Claims Processing

1. General. The Maintenance and Logistics Command, Health and Safety Division (MLC (k)) is responsible for processing Federal and nonfederal health care claims in compliance with the Federal Law and CG Regulations.

2. Certification. Certification ensures that only authorized payment services to eligible beneficiaries receiving health care within their entitlements and the care and related charges are appropriate. Commanders, MLC (k) shall

   a. Administratively screen each claim and supporting documents according to paragraph 3 below. Claims submission procedures from field units are contained in COMDTINST 6010.20 and MLC (k) Standard Operating Procedures.

   b. Technically screen claims and supporting document according to paragraph 4. below.. In screening, perform these actions:

      (1) Refer claims that do not satisfy the Technical Screen criteria to a medical audit staff for Appropriateness Review and/or audit.

      (2) Enter information from these claims into the Non-Federal Invoice Processing System (NIPS) data base and approve them for payment in this manner:

         (a) Claims that satisfy Administrative and Technical Screen criteria (including Active Duty Claims Program (ADCP) claims coded through a TRICARE Fiscal Intermediary).

         (b) Claims referred for Appropriateness Review and/or audit recommended for payment.

   c. Transmit payment data electronically to the Coast Guard Finance Center.

   d. Certify batch transmissions.

   e. Correct batch errors.

   f. Update vendor files.

3. Administrative Screen.

   a. Administrative screening of a claim package determines the patient's authorization and eligibility to receive billed services and also ensures the package contains all appropriate, necessary documents. At a minimum, administrative screening includes:

      (1) Patient and unit certification to ensure CG-5534, Non-Federal Health Care Certification Form, is present and complete.

      (2) Public Voucher for Purchases and Services other than Personal (SF-1164) is completed for reimbursement requests.

(3) The claim is a complete, itemized original.

(4) A copy of CG-4899, Report of Potential Third Party Liability, is attached if a third party potentially is liable.

(5) Verification of pre-authorization number.

(6) Support documentation is complete for Reservists' bills.

(7) Claims for formal contracts have the contracting officer's signature and amount to be paid.

(8) Claims for clinic support contracts have a Coast Guard beneficiary breakdown.

b. Ensure that all claims that fail to satisfy the administrative screening are corrected by the unit through the most expeditious means possible.

4. Technical Screen.

a. Health care claims must be reviewed to ensure they comply with Federal regulations. Part of that process compares claim packages to standard criteria to withstand the scrutiny of Departmental Accounting and Financial Information System (DAFIS) for payment. Technical screening of claim packages includes:

(1) Comparing charges against contract fee schedules, pre-authorizations, blanket purchase agreements, or the geographic area's usual and customary fees; claims falling within ADCP guidelines are exempt from fee review;

(2) Entering relevant claim information into NIPS;

(3) Determining whether services were appropriate for the diagnosis; and

(4) Identifying claims requiring further review under these circumstances:

(a) Unrelated charges to the initial diagnosis or injury.

(b) Duplicate charges for services received on a given day.

(c) Care was unauthorized or unnecessary.

(d) Claims submitted by different providers for the same service (e.g., anesthesiology charges from more than one provider).

(e) NIPS "flagged" the claim.

(f) The reviewer "feels" a need for further review.

b. Claims a Technical Screen identifies for further review and/or audit require:

(1) Documentation of the problem, and

(2) A recommended course of action.

5. Appropriateness Review.

a. An appropriateness Review is performed under these circumstances:

(1) MLC (k) selects or NIPS flags a claim for further review and/or audit for a Technical Screen; and/or

(2) Periodically for quality assurance.

b. An Appropriateness Review requires:

(1) An itemized claim;

(2) A patient's signed "Request for Medical Records" as generated by the Clinic Automated Management System (CLAMS) or its equivalent to request medical records and other information about an individual's care; this is not needed if the beneficiary signed CG-5534; and/or

(3) Various records, which may include:

(a) Hospital records,

(b) Physician's orders,

(c) Physician and nursing progress notes,

(d) Lab and x-ray reports,

(e) Operative or endoscopic reports,

(f) Admission records (history and physical examinations), and

(g) Discharge summaries.

c. An Appropriateness Review process often involves these activities:

(1) Reviewing records to verify:

(a) The treatment or therapy was:

1 Appropriate for the diagnosis,

2 Consistent with currently accepted medical practice, and

3 Not duplicated unnecessarily.

(b) The length of inpatient hospitalization was appropriate for the diagnosis and course of care.

(c) The charges were reasonable; claims falling within ADCP guidelines are exempt from fee review.

(2) Obtaining additional documentation and/or correspondence from health care providers.

(3) Initially notifying health care providers of this information:

(a) Their claims are being reviewed and audited.

(b) The audit is a normal part of the Coast Guard's health care review process and does not indicate or allege the health care provider committed a offense; and

(c) If reviewing cases for longer than 30 days, periodically communicate with health care providers to inform them of claim status.

d. An Appropriateness Review may recommend:

(1) Full payment for services. Enter data into and process through NIPS.

(2) Partial payment for services. Attach decision documents; recommend the amount of payment; and enter data into NIPS. Initiate a reimbursement request if the claim initially was overpaid.

(3) Consulting a specialist for peer review.

(4) Referral to a contractor for further review or an on-site hospital audit.

(5) Closing the case with no further action.

e. An Appropriateness Review includes:

(1) Fully documenting the decision process,

(2) Initiating payment or the provider's reimbursement, and

(3) Drafting appropriate correspondence.

6. Peer Review.

a. A Peer Review will be performed under these circumstances:

(1) A health care provider objects to other reviews' findings, or

(2) An Appropriateness Review reveals the need for a more sophisticated evaluation of the diagnosis, prognosis, or specific medical procedures employed.

b. Send the case and health care provider's additional documentation (if any) to a qualified medical, pharmaceutical, or dental specialist for review. These services should be contracted if in-house specialists are not available

c. Peer Review may include these detailed examinations:

(1) Diagnosis;

(2) Prognosis;

(3) Appropriateness of the care provided;

(4) Claims submitted to a Fiscal Intermediary for pricing are exempt from fee review.

(5) Selection of the most cost-effective therapy.

d. Among other things a pharmacist's review of pharmaceutical bills and supporting documents may:

(1) Determine the efficacy of prescribed medication;

(2) Identify cost-effective choices; or

(3) Recommend stocking pharmaceuticals for future issuance.

7. Guidelines for Initial Appropriateness and Peer Reviews. These common health care services guidelines are not all-inclusive. Appropriateness and Peer Reviews should be used to assist reviewers in deciding whether in-hospital audits or contracted review services are required.

a. Trauma. Answer these questions:

(1) Does the level of care correspond to the diagnosis?

(2) Were appropriate facilities used?

(3) Were laboratory and x-ray procedures appropriate? Include justification for:

(a) Repeating procedures on a given day;

(b) Repeating normal procedures;

(c) Failing to follow up abnormal tests.

(4) Were iatrogenic complications were identified appropriately? Include:

(a) Sepsis,

(b) Wound dehiscence,

(c) Hemorrhage,

(d) Pulmonary complications,

(e) Cardiovascular complications (thrombophlebitis, etc.),

(f) Urinary tract infection,

(g) Anesthetic or other drug reactions (appropriate drug and dosage, known allergies), and

(h) Other associated injuries.

(5) The length of stay was appropriate for the diagnosis and indicated complications.

(6) The discharge diagnosis was compatible with admission diagnosis and the patient's history.

(7) The patient's physical status on discharge:

(a) Alive,

(b) Complications were controlled,

(c) Wound(s) condition was satisfactory,

(d) Required follow-up arrangements are listed, and/or

(e) Medications were prescribed.

(8) Follow-up care was appropriate, including:

(a) Therapy,

(b) Office visits, and

(c) Additional hospitalization was for a good reason, e.g., iatrogenic complications, continued therapy, or additional surgeries.

(9) Fees are usual and customary for the geographic area (claims falling within ADCP guidelines are exempt from fee review).

(10) The use of multiply providers is explained.

(11) Providers' and reviewers' differences in medical opinion (particularly involving altered treatment and length of hospital stay) are significant enough to warrant negotiation.

b. Laboratory Services. Answer these questions:

(1) Are tests related to or necessary for the diagnosis?

(2) Were ICU standing orders in effect?

(3) Were tests repeated excessively?

(4) Were charges duplicated for the same procedure on the same day?

(5) Were tests repeated due to equipment or operator error?

(6) Were tests repeated despite normal previous test(s) (justification is required)?

(7) Were there multiple charges for the same or similar tests?

(8) Were multiple tests performed in a logical sequence (i.e., the most invasive or sophisticated performed last)?

(9) Were fees usual and customary (claims falling within ADCP guidelines are exempt from fee review);

(10) For a laboratory under Coast Guard contract, were:

(a) Tests covered by the contract?

(b) Charges within fee schedule?

c. Radiology Services. Considerations:

(1) Was the examination required given the diagnosis?

(2) Were charges for portable radiology of an ambulatory patient?

(3) Were examinations repeated?

(4) Were bilateral x-rays appropriate (patients over 12 years of age)?

(5) Were charges or exams of the same anatomical part duplicated?

(6) Do examinations and in-patient dates coincide?

(7) Were examinations repeated despite normal findings in previous examinations?

d. Physical Therapy. Considerations:

(1) Was the injury or diagnosis properly documented? Did it include:

(a) Objective findings?

(b) Functional findings?

(c) Multiple provider discrepancies?

(d) Documentation of improvement?

(2) Did a physician prescribe treatment?

(3) Were injury management and treatments reasonable and necessary? Did they cover these:

(a) Was the treatment plan documented?

(b) Did objective findings permit the therapist and/or physician to monitor treatment results?

(c) Were changes in the treatment program due to unsuccessful results?

(d) Was treatment only for subjective complaints?

(e) Was the treatment related to diagnosis?

(f) Did the treatment follow standard procedures and protocols?

(g) Did the treatment plan include goals and objectives?

(4) Was the length or number of treatments excessive?

(5) Was treatment consistent or continuous or did patient attend sporadically?

(6) Did therapy continue after "Fit-For-Duty" status?

(7) Did therapy charges continue during stays in cardiac or intensive care units.

(8) Were charges duplicated for same-day, apparently inappropriate treatments?

(9) Was therapy frequency within accepted standards?

(10) Were same-day charges for three or more modalities during a single therapy session.?

(11) Were charges usual and customary (claims falling within ADCP guidelines are exempt from fee review).

e. Dentistry.

(1) For provider contract care, were:

(a) Services within the contract scope?

(b) Charges within fee schedules?

(2) For emergency care, were:

(a) Services within the scope of entitlements?

(b) Charges reasonable and customary?

(3) For care pre-authorized in Chapter 2-A-6, did any of these occur?

(a) Did the MLC assign a pre-authorization number?

(b) Were services within the authorized, standard treatment plan?

(c) Were treatments split to circumvent pre-authorization requirements?

(4) For all dental services, do any of these apply?

(a) Were services duplicated?

(b) Were billings for the same service duplicated?

(c) Were diagnosis charges consistent with services received?

(d) Were crowns constructed of precious metals?

(e) Are laboratory charges consistent with the service provided (bridges, crowns, partial or full dentures)?

f. Pharmacy.

(1) For contract providers, were services within the scope of the contract?

(2) For inpatient care, do any of these apply?

(a) Were billings duplicated?

(b) Was credit received for returned or unused medications?

(c) Did medication and in-patient dates coincide?

(d) Did medications' cost exceed 250 percent of Annual Pharmacists' Reference ("Red Book") average wholesale price (Note: This equals a 150 percent markup.)? Claims falling within ADCP guidelines are exempt from fee review.

# CHAPTER 12

# OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP)

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# CHAPTER 12. OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP)

## Section A - General Requirements.

1. Description.

   a. The work environment and occupational activities inherent to Coast Guard missions can expose personnel to health hazards with the potential for disease or injury. The Occupational Medical Surveillance and Evaluation Program (OMSEP) is designed to identify work related diseases or conditions, through baseline and periodic examinations, at a stage when modifying the exposure or providing medical intervention could potentially arrest disease progression or prevent recurrences. The fundamental purpose of this program is to identify pre-existing health conditions, provide risk specific periodic screenings, and monitor clinical laboratory tests and biologic functions suggestive of work related environmental exposures. All OMSEP enrollees receive periodic physical examinations, in accordance with Occupational Safety and Health Administration (OSHA) requirements, for the duration of their health hazard exposure or end of their employment. Individuals are released from active surveillance at the end of their exposure. In accordance with OSHA regulations, the OMSEP personnel tracking database containing the name, social security number, billet or occupation code, applicable examination protocols, and next physical examination due date remains active for an additional 30 years.

   b. The OMSEP is the physical examination process for the Coast Guard's Occupational Health Program. The guidance for this program is outlined in the Safety and Environmental Health Manual, COMDTINST M5100.47 (series). OMSEP replaces the present version of the physical exam process described in the SEH Manual as the Occupational Medical Monitoring Program (OMMP).

2. Enrollment**.**

   a. Coast Guard Medical Surveillance Action Level: The medical surveillance action level (MSAL) is the level of worker exposure, determined by workplace sampling, at or above which occupational medical surveillance examinations will be performed. The Coast Guard MSAL will be 50% of the most stringent of the current OSHA permissible exposure limit (PEL),or, the most current American Conference of Governmental Hygienists (ACGIH) Threshold Limit Value (TLV).

   b. Determination of Occupational Exposure.

      (1) An employee is considered occupationally exposed for OMSEP purposes if a noise exposure or hazardous condition is likely to occur **30 or more days per year**. Documentation of the exposure must meet the following criteria: quantitative work-site sampling measurements indicate hazard levels at or above the MSAL or that the exposure can reasonably be determined, in the absence of quantitative sampling, to exceed the MSAL.

      (2) Quantitative sampling is the primary and definitive means to characterize workplace health hazards, although personal sampling measurement is preferred to workplace sampling. Coast Guard Safety and Environmental Health Officers

(SEHOs) using guidance contained in the Safety and Environmental Health Manual, COMDTINST M5100.47 (series) will generally perform this function. SEHOs will normally characterize workplaces by frequency of exposure, type of exposure, and risk groups.

(3) Certain occupations or exposures may require surveillance by federal statutes, DOT regulations, or Safety and Environmental Health Manual, COMDTINST M5100.47 (series) without regard to the 30-day exposure threshold.

(4) Competent environmental health authority is considered to be the cognizant SEHO but the authority may be delegated to other recognized and approved personnel with the necessary technical training and abilities. Qualitative assessments must be based on expected type, frequency, mode, and duration of hazard exposure, and are considered temporary until validated by quantitative means.

c. Enrollment Criteria: Recommendations for enrollment are based on specific job assignments and the level of worker exposure. This process is initiated at the unit level and must be finalized by the IH or cognizant SEHO, with recommendations from the supervising medical officer (if necessary), before forwarding to Maintenance and Logistics Command (MLC (k)) for inclusion into the OMSEP database (see section 12-A-3-(a)-3). This centralized database will be maintained by MLC (k) and will be accessible to the commands in accordance with privacy act requirements. Personnel will be enrolled in the OMSEP if both of the following criteria are met:

(1) Personnel identified as occupationally at risk/exposed to hazardous chemicals or physical agents at levels documented or reasonably determined to be above the CG Medical Surveillance Action Level (MSAL) for that hazard,

(2) Personnel actively engaged for 30 or more days per calendar year in the following occupations will be enrolled in OMSEP, unless an IH investigation determines individuals are not exposed to toxic chemicals or physical hazards: resident inspectors, pollution investigators, marine safety (general), port safety (general), vessel inspectors or marine investigators; and fire fighters.

3. Reporting Requirements.

a. Examination Reports:

(1) Required forms: OMSEP physical examinations require completion of the most current version of CG Form 5447 (6-00) in addition to forms SF88 and 93. Other OMSEP specific forms and their uses are presented in Section 12-B (also see Table 12-B-1.) Uses of routine medical record forms are presented in Chapter 4 of this Manual.

(2) Record keeping: OMSEP personnel records will be handled in the same manner as other medical records (see Chapter 4 of this Manual) with the following exceptions: all x-ray, laboratory test, and related reports of examinations or procedures done for OMSEP purposes, as well as the medical record cover, shall be clearly labeled "OMSEP." All OMSEP examination reports, including all laboratory data, must be entered into the individual's health record and maintained in accordance with OSHA regulations. The member's medical record custodian will maintain all OMSEP medical records on file for the duration of employment. Upon separation or retirement, all records concurrently labeled "OMSEP" will be

maintained, for an additional 30 years, as required by OSHA regulations [29 CFR 1915.1120].

(3) OMSEP database: MLC (k)'s will maintain an electronic database of all OMSEP enrollees based on enrollment information provided by the local units. The OMSEP personnel tracking database should include, at a minimum, the member's name, social security number (SSN), billet or occupation code, applicable examination protocols, and next physical examination due date. The handling of all data in the OMSEP database will comply with Privacy Act requirements.

(4) Substitutions: OMSEP examination forms may **not** be substituted for other examination forms. If another examination is anticipated/required, (i.e. FLIGHT, RELAD) at the same time as the OMSEP examination the appropriate forms for each particular examination should be provided to the examiner so they may be completed at the same time. Duplicate laboratory tests are not required, so long as all specific tests and procedures required for each exam are completed and reported.

(5) Exposure data records: Any available exposure data, from workplace surveys, industrial hygiene personal or area monitoring, material safety data sheets, or assigned IH/SEHO other appropriate sources, will be provided by OMSEP coordinator to the examining medical officer as part of the examination packet. These data should be supplied by the local unit, in coordination with the supporting industrial hygienist, prior to the examination. The protocols in Section 12-C, in addition to OSHA regulations, specify what exposure surveillance data must be maintained and made available to the examining medical officer.

b. Tracking Report: Individual units, in coordination with the cognizant SEHO, are responsible for creating and managing a roster of all OMSEP enrollees and providing the designated medical officer advisor (DMOA)/clinic and MLC(k)'s with an updated report. Once fully implemented medical officers will be able to access this information through the OMSEP database. Updates to the tracking report will be possible by placing the information directly into the database. This will preclude the need for any additional written reports. The report should include all information cited in Section 12-A-3(a)(3) and will form the basis for the OMSEP database.

c. Sentinel Occupational Health Event Reporting: The occurrence of a new illness or disease, which is likely associated with an occupational exposure or condition, may be considered a "sentinel event." Such an event may serve as a warning signal that the quality of preventive measures may need to be improved. In order to facilitate timely intervention, the initial diagnosis of any such diseases must be reported IAW Section 7-B of this Manual. A complete list of reportable occupational diseases is found in Figure 7-B-2.

4. Medical Removal Protection. It is the responsibility of the commanding officer to assure a safe and healthy working environment. The finding of a work-related illness or injury, which could be further exacerbated by continued exposure to a workplace hazard or condition, requires immediate evaluation to determine whether the worker must be at least temporarily removed from further exposure. A recommendation to remove the member should be made by the examining medical officer and cognizant SEHO, in coordination with the unit's Commanding Officer. (See section 12-B-4-b).

5. Roles and Responsibilities**.** The OMSEP is part of a larger and more comprehensive surveillance process requiring the coordinated effort of various district units and local commands working to secure the safety and health of Coast Guard workers. Key personnel have been identified as essential in maintaining a sound occupational health prevention program. Following is a description of their expected roles and responsibilities in this process: NOTE: For the purposes of this Chapter all references to employees, workers, personnel will be assumed to be part of the ONE DOT/CG TEAM concept. Rules, regulations, and directives apply equally to ALL unless otherwise specified.

   a. Units/Commands: Each unit must appoint an OMSEP coordinator, usually the Safety Coordinator (SC) or the Safety and Occupational Health Coordinator (SOHC), or Independent Duty Corpsman. Even if units are under one servicing clinic, the unit is still required to appoint an OMSEP coordinator and manage their respective database. The OMSEP coordinator is responsible for updating the roster of OMSEP enrollees and maintaining the unit's OMSEP personnel tracking report, ensuring OMSEP examinations are completed in a timely fashion, and ensuring all available exposure data is available to the medical officer at the time of the OMSEP examination.

   b. MLC (k): MLC (k)'s will ensure that SEHO/IH work-site monitoring and reporting is completed and entered into the appropriate database. Additionally they will provide oversight to the local units ensuring the accuracy and completeness of the OMSEP personnel tracking report. The MLC (k)'s medical officers will provide oversight over the physical examination consultation and referral process. MLC (k)'s will also provide indicated guidance and or training to HS personnel on examination practices and procedures.

   c. SEHOs: SEHOs will be required to review all requested OMSEP enrollments from the unit OMSEP Coordinators. SEHOs will approve or disapprove requested enrollments through the on-line database. Disapprovals need to be explained to the requesting unit. To substantiate enrollments, SEHOs will be required to conduct and update quantitative and/or qualitative IH assessments of their units' workplace environment. SEHOs will be required to have these written assessments available to the medical officer for review, if requested, to determine the appropriate medical surveillance protocol to use. SEHOs will also be required to provide training and day-to-day consultation with their unit OMSEP Coordinators on database management.

   d. Commandant (G-WKS): Commandant (G-WKS) will provide planning, development, and expertise on occupational health issues. G-WKS is responsible for policy making, procedural decisions, and ensuring currency of Chapter 12 of the Medical Manual with OSHA standards. The G-WKS occupational medicine medical officer will provide support on physical examination problems and review all diagnosed occupational health related abnormalities encountered by the on-site provider. A yearly report, updating the status of the member's abnormalities, will be provided to onsite providers. G-WKS is the final authority on decisions of any OMSEP related problems.

   e. Medical Officer's Responsibilities:

      (1) Medical Diagnosis coding. The examining medical officer is responsible for explaining and/or following any abnormalities through to a resolution. All diagnoses made must be appropriately coded using ICD-9CM diagnostic coding,

or most current version. ICD codes should be noted in parentheses next to the diagnosis on the examination report and be reported to the fifth digit.

(2) Written assessment or opinion. Whenever a physical exam is performed, the examining medical officer must include the following information **in writing** as part of the record of each examination. This information should be included in the appropriate blocks.

(a) The occupationally pertinent results of the medical examination.

(b) An opinion about adequacy of the information available to support any diagnosed occupational disease(s), if appropriate.

(c) Any recommended limitations to the employee's assigned work.

(d) A statement that the employee has been informed about the results of the examination.

(e) Any additional written information required by the protocols listed in Section 12-C.

f. Medical Administrators:

(1) Support. Medical Administrators are responsible for providing administrative assistance on all OMSEP related matters. This support should extend to :

(a) All units within the designated AOR.

(b) Contracted medical providers and their respective facilities.

(c) IDT's.

(2) OMSEP report/worksite data. Medical Administrators should interact with OMSEP coordinators within their AOR to ensure currency of the roster of enrollees and ensure that work-site information is received in a timely matter. Worksite exposure information, reported history of past exposures and safety data sheets should precede the physical examination to give the medical officer ample time to reach an educated decision.

(3) Physical Examinations/Medical Records. The Medical Administrator is responsible for the following clinic functions in support of OMSEP:

(a) Timely scheduling of physicals.

(b) Providing qualified technicians to perform the indicated laboratory and radiological procedures.

(c) Ensuring proper calibration of equipment, and

(d) Compliance with quality assurance standards.

g. Civilian Employees: Civilian OMSEP enrollees may be entitled to services provided by Coast Guard medical facilities should a determination be made by a medical provider,

that an adverse health condition resulted from a work place exposure. Employees are expected to report and explain any illnesses or injuries resulting from exposure sources outside their primary duty station or from other non-occupational settings. Should a determination of an injury or illness, resulting from an exposure at the workplace, be made by a medical provider, civilian appropriated fund employees should contact their servicing civilian Command Staff Advisor (CSA) for assistance in making a claim with the Department of Labor. Non-appropriated fund employees (NAF) should contact their immediate supervisor and/or personnel liaison office. The services provided by the Coast Guard facilities will be only to establish an occupationally-related illness/injury. Further medical care should be provided by the civilian employee's health care provider.

h. Others: In the event of an emergency situation with heavy exposure (e.g., fire, spill), 24-hour assistance is available from the Agency for Toxic Substances Disease Registry (ATSDR) at the Centers for Disease Control and Prevention. Call 404-639-0615/6360

Disease Registry (ATSDR) at the Centers for Disease Control and Prevention. Call 404-639-0615-6360.

## LIST OF ABBREVIATIONS

| | |
|---|---|
| ACGIH | American Conference of Governmental Industrial Hygienists |
| ALT | Alanine aminotransferase |
| AST | Aspartate amino transferase |
| BUN | Blood urea nitrogen |
| CBC | Complete blood count |
| CNS | Central nervous system |
| CXR | Chest x-ray |
| DOT | Department of Transportation |
| EL | Excursion limit (OSHA mandated maximal "safe" airborne concentration of a substance) |
| FVC | Forced vital capacity |
| FEV-1 | Forced expiratory volume at one second |
| ICD-9 | International Classification of Diseases, 9th Revision (coding system for medical diagnoses.) |
| IH | Industrial hygiene or industrial hygienist |
| LDH | Lactic dehydrogenase |
| MCV | Mean corpuscular volume |
| MCH | Mean corpuscular hemoglobin |
| MCHC | Mean corpuscular hemoglobin concentration |
| MLC (k)/(kse) | Maintenance and Logistics Command: (k)-medical; ((kse)-safety & environmental health. |
| MO | Medical officer (physician, physician's assistant or nurse practitioner ) |
| MSAL | Medical surveillance action level (Defined in 12-A-3) |
| OMSEP | Occupational Medical Surveillance and Evaluation Program |
| OSHA | Occupational Safety and Health Administration |
| PEL | Permissible exposure limit (The OSHA mandated TWA airborne exposure limit) |
| PFTs | Pulmonary function tests |

LIST OF ABBREVIATIONS (continued)

| | |
|---|---|
| RBC | red blood cell |
| SC | Safety Coordinator |
| SEHO | Safety and Environmental Health Officer |
| SOHC | Safety and Occupational Health Coordinator |
| STEL | Short-term exposure limit (The maximal "safe" airborne concentration of a substance) |
| STEL/C | Short-term exposure limit/ceiling (maximal "safe" airborne concentration of a substance) |
| STS | Significant threshold shift |
| TB | Tuberculosis |
| TLV | Threshold limit value (ACGIH) (The TWA airborne concentration of a substance) |
| TST | tuberculin skin test (Mantoux) |
| TWA | time-weighted average |
| U/A | Urinalysis |

Section B - Administrative Procedures.

**1.** General. All medical examinations and procedures required under the OMSEP shall be performed by or under the supervision of a licensed medical officer and an accredited laboratory shall perform all laboratory tests. Timely completion and monitoring of scheduled examinations is essential in identifying work related health hazards and any specific health effects. All tests required as part of an OMSEP examination should be completed prior to and the results made available to the health care provider at the time of the physical examination. This requirement may be waived if travel or time costs make separate visits impractical. **The provider is required to review, approve (sign), and explain any abnormalities. Any unexplained, examination finding, laboratory abnormality, or test result must be referred to a certified Occupational Health Clinic/provider for further evaluation.**

2. Examination Types.

a. Initial/baseline. Baseline examinations are required before placement in a specific job in order to assess whether the worker will be able to do the job safely, to meet any established physical standards, and to obtain baseline measurements for future comparison. Each baseline examination shall consist of all of the elements specified under the appropriate surveillance protocol(s) in Section 12-C. Table 12-B-1 also summarizes the required forms and tests for a baseline examination under each of the surveillance protocols. In the event that the employee is being monitored under more than one protocol, each unique form or test need only be completed once for a particular examination.

(1) An initial examination is required for all employees prior to employment. The employee may not be exposed to a potential health hazard until the physical examination is completed. In the event of scheduling delays, this requirement may be waived, if the employee completes ALL the necessary laboratory tests specified under the appropriate surveillance protocol(s). The physical examination must still be completed at the earliest possible date, but not beyond 30 days after the initial date of employment. Longer delays will require temporary removal. Workers who transfer from operational to administrative positions on a frequent basis during the same duty assignment may, with medical officer approval, receive a periodic physical vice a complete baseline examination upon re-entering the hazardous work site.

(2) All employees must have a physical examination prior to reassignment to any position with an occupational health hazard exposure as defined in Section 12-A-2-b. This requirement is subject to the stipulation described above in Section 12-B-2-a-1.

(3) Any employee actively monitored in the OMSEP, identified, as at risk of exposure to a new health hazard requiring additional protocols, should have an initial examination performed for the new potential exposure(s). The employee may not be placed at risk of exposure until the examination is completed. During such an examination, both the initial examination requirements for the additional protocol and the periodic examination requirements for the original protocol(s) should be met. This requirement is subject to the stipulation described above in Section 12-B-2-a-1.

b. Periodic.

(1) Once enrolled in the OMSEP, periodic examinations will be performed at the required interval for the duration of the health hazard exposure. Periodic examinations are generally provided at twelve-month intervals, though under some exposure protocols, the period between exams may vary. Each periodic examination shall consist of all of the elements specified under the appropriate surveillance protocol(s). See Section 12-C. and Table 12-B-1. If an employee is being monitored under more than one protocol, each form or test need only be completed once during a particular examination.

(2) Periodic laboratory monitoring may be required under certain protocols (e.g., lead, pesticides) or special situations. These examinations consist of the specified **laboratory tests only**, and are usually performed in accordance with the specific protocol or as often as deemed necessary by the medical provider.

c. Acute Exposure.

(1) An acute health hazard exposure examination is required, under some protocols, (e.g., benzene, hazardous waste, noise, solvents), when the applicable short-term exposure limit (STEL) ceiling limit of the substance(s) in question is exceeded. The requirement applies whether or not the employee exhibits any overt symptoms of acute exposure. Specific requirements, if any, for an acute exposure examination are found under the protocols in Section 12-C.

(2) An acute health hazard exposure examination is recommended if the employee exhibits any adverse effects following an acute exposure to a suspected hazardous substance. If the substance(s) is identified, an examination should be performed following the specific protocol(s) for that substance(s). In the event no specific substance is identified, an examination should be directed according to the "Unspecified" examination protocol and presenting symptoms. The Acute Chemical Exposure Information form (Figure 12-B-1) should be used to collect and organize information when an acute exposure occurs. The information on this form must accompany the employee to his/her examination.

(3) All HAZMAT response personnel with a documented exposure event, including Coast Guard Strike Team members and firefighters, must complete an Acute Chemical Exposure Information form (Figure 12-B-1) at the end of each HAZMAT response. Special attention must be provided to the type, duration and degree of toxicity of the agent(s) encountered as well as the type of contact (inhalation, skin absorption, ingestion). The type of PPE utilized, type of respirator (if any), and protective clothing worn should also be noted. This information is to be entered in the member's medical record.

d. Exit/Separation (Employment/Exposure). Exit exams are designed to assess pertinent aspects of the worker's health when the worker leaves employment or when exposure to a specific hazard has ceased. Results may be beneficial in assessing the relationship of any future medical problem to an exposure in the workplace. Exit physical examinations must be completed within 30 days of the last day of exposure or employment. The worker may not be re-assigned to a hazardous area once the examination is completed. In the event the worker is exposed to a hazardous substance, after completing the examination, ALL laboratory tests required by the specific protocol for that particular

substance must be repeated (see Table 12-B-1 and Section 12-C). The following conditions also apply:

(1) End of Exposure:

(a) OMSEP enrollees assigned to a non-hazardous work environment but likely to be assigned to a designated area later in their career.

(b) Workers who transfer from operational to administrative positions on a frequent basis may, with medical officer approval, receive an update to their periodic physical vice a complete exit (end of exposure) examination. This does not preclude a complete exit/separation examination upon the end of employment.

(c) Individuals enrolled in the OMSEP, with exposures to known carcinogens or agents with prolonged latency periods for disease development (e.g., asbestos, benzene), will receive an end of exposure exam upon reassignment to non-hazardous area and continue to receive updates to their periodic physicals according to the designated protocol(s). These individuals will be monitored for the duration of their Coast Guard career unless the responsible supervising medical officer or other cognizant medical authority determines such monitoring is not required.

(2) End of Employment:

(a) OMSEP enrollees permanently separating from Coast Guard employment should receive an end of employment examination.

(b) The member's permanent home of record and phone number must be secured for notification of any abnormalities.

(c) A copy of the member's occupational health history, including all potential exposure agents, severity and duration of exposure, and any recommendations on future protocol testing or examinations, must be placed in the member's medical record. A personal copy should also be provided to the member. (see Section 12-B-3-j).

e. Timing of next examination. The default interval between examinations is one year for all protocols except respirator wear and prior (not current) exposure to asbestos, in which case the default interval is **five years**. However, exams may be recommended as infrequently as biennially for employees monitored solely under the protocols for chromium compounds, hazardous waste, solvents, and unspecified exposures. **A medical officer may recommend for any individual patient a shorter interval between examinations than the default period, if such is medically indicated**. Any recommendation on the timing of the next examination should be included as part of the physician's written assessment.

3. Use of OMSEP Forms.

a. CG Form 5447 (6-00) (History and Report of OMSEP Examination).

(1) This form must be completed whenever an OMSEP physical examination is required, except when only annual hearing conservation program is needed. Ensure that the examinee and medical officer identifying information are accurately recorded, including phone numbers.

(2) For an initial examination, all history sections on the CG-5447 must be completed. For subsequent examinations, as an alternative to completing all the blocks in history Sections I through IV, the examinee may choose to initial the statement above each section noting that there have been no changes during the interval from the last examination.

(3) The CG-5447 (6-00) replaces the SF 88 and SF 93 continuation forms and incorporates CG-5197 and the existing CG-5447 (3-97). Previous editions are obsolete.

b. OSHA Respirator Medical Evaluation Questionnaire-(mandatory). This questionnaire is to be completed by any worker who is to be issued a respirator or assigned to a task that may require a respirator.

c. CG-5140 (Audiometric Biological Calibration Check). This form is to be used to record calibration of the audiometric equipment.

d. CG-5552 (Audiology History Questionnaire). This form provides a chronological record of audiologic symptoms and recreational noise exposure. It should be initiated at the time of enrollment in the hearing conservation program and OMSEP surveillance for occupational noise exposure. This form must be updated at each subsequent annual audiogram and reviewed by the responsible medical officer.

e. DD Form 2215 (Reference Audiogram). This form is used to record initial audiometric test results.

f. DD Form 2216 (Hearing Conservation Data). This form is used to record the results of periodic and follow-up audiometry for individuals routinely exposed to hazardous noise. This form should be preceded by a reference audiogram (DD Form 2215 or other record) already on file in the individual's health record.

g. Notification of Summary Results. A sample of this form is provided in Figure12-B-2. A photocopy or a locally generated form may be used to provide the required notification to the enrollee of the results of his/her OMSEP examination.

h. Acute Chemical Exposure Information Form. This form is used to record the results of any unexpected exposures and for verification of notification of the appropriate agencies. A sample of this form is provided in Figure 12-B-1.

i. Separation Letter. This letter serves as notification of the member's documented exposure(s) while serving in the US Coast Guard. It provides the nature and levels of exposure(s), if known, and the medical provider's comments and recommendations A copy is to be placed in the member's record and another provided directly to the member. A sample of the separation letter is provided as Figure 12-B-4.

j. Patient Notification. The medical officer is responsible for notifying the patient of any and all abnormalities found or diagnoses made, whether or not they are occupationally related or simply an incidental finding. Notification must be made within 30 days of completion of the examination and should be documented as a medical record entry (see Figure 12-B-2).

4. Medical Removal Standards.

a. The following abnormal laboratory findings during an OMSEP examination mandate immediate removal of the employee from further workplace exposure to the hazard listed, pending resolution of the abnormality or a determination that the abnormality is not due to a workplace exposure. The medical officer should coordinate all medical removal recommendations with the cognizant SEHO before forwarding to the commanding officer (CO).

(1) Benzene (**any** of the following):

(a) The hemoglobin/hematocrit falls below the laboratory's normal limit and/or these indices show a persistent downward trend from the individual's pre-exposure norms; provided these findings cannot be explained by other means.

(b) The thrombocyte (platelet) count varies more than 20% below the employee's most recent prior values or falls below the laboratory's normal limit.

(c) The leukocyte count is below 4,000 per mm3 or there is an abnormal differential count.

(2) Lead: A blood lead level at or above 40µg/100 ml of whole blood.

(3) Noise: A loss of hearing of $\geq$ 35 dB in either ear at one or more of the speech frequencies (500, 1,000, 2000, or 3000 Hz), compared with the **current** reference audiogram.

(4) Organophosphate pesticides: cholinesterase level at or below 50% of the pre-exposure baseline.

b. Pregnancy is not a reason for automatic medical removal from the workplace. A decision to remove or restrict a pregnant woman must be based on sound clinical judgment after careful consideration of the workplace environment and the woman's physical capabilities. The woman's pre-natal health care provider (obstetrician) should be apprised early of any/all potential hazards and safety precautions available.

5. Reporting of Examination Results.

a. Coast Guard medical officers will have 30 days from completion of the examination to meet all medical officer responsibilities in Section 12-B-4.

b. Contractual providers, IDTs, and other detached HSs/units must forward all OMSEP examination questions, problems, and any unresolved matters, with accompanying supporting information, to the assigned CG medical officer for review within 15 days of receipt (includes the examination and any additional testing or consultations).

c. All records must be forwarded to the record custodian upon compliance with Sections 12-B-6- (a) and 12-B-6 (b) above.

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TABLE 12-B-1

REQUIRED FORMS AND TESTS FOR VARIOUS OMSEP EXAMINATIONS AND PROTOCOLS

| Exam Type<br><br>Exposure Protocol | Initial/ Baseline | Periodic | Exit/Separation | Acute Exposure | Biological Monitoring |
|---|---|---|---|---|---|
| Asbestos | CG 5447<br>***OSHA Resp. Quest.**<br>SF88&93<br><br>Stool guaiac (a)*<br>PFTs<br>"B" reader CXR<br>CBC<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>Stool guaiac (a)*<br>PFTs<br>"B" reader CXR(b)*<br>CBC<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>Stool guaiac (a)*<br>PFTs<br>"B" reader CXR<br>CBC<br>Multichem panel<br>U/A w/ micro | N/A | N/A |
| Benzene | CG 5447<br>SF88&93<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>CBC w/diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br>Urinary phenol<br>CBC w/ diff<br>**Acute Exposure Form** | Only under special circumstances. Contact G-WKS-3. |
| Chromates | CG 5447<br>SF88&93<br><br>CXR<br>PFTs<br>CBC<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>PFTs<br>CBC<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>CXR<br>PFTs<br>CBC<br>Multichem panel<br>U/A w/ micro | N/A | N/A |

* OSHA Medical Evaluation Respiratory Questionnaire. Note: DD Forms 2493-1/2493-2 Asbestos Report may be required at medical DOD facilities.

TABLE 12-B-1 (Continued)

| Exam Type<br><br>Exposure Protocol | Initial/ Baseline | Periodic | Exit/Separation | Acute Exposure | Biological Monitoring |
|---|---|---|---|---|---|
| Hazardous Waste | CG 5447<br>SF88&93<br>vision screening<br>CXR<br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>vision screening<br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>vision screening<br>CXR<br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br>**Acute Exposure Form**<br><br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro<br>Heavy metal screen (c)* | Only under special circumstances. Contact G-WKS-3. |

NOTES: *(a) only if patient is age 35+ or otherwise clinically indicated.

*(b) B-reader chest x-rays will be done at periodic examinations according to the following schedule:

| Years since first exposure | Age of examinee 15 to 35 | 36 to 45 | over 45 |
|---|---|---|---|
| 0 to 10 | Every 5 yrs. | Every 5 yrs. | Every 5 yrs. |
| Over 10 | Every 5 yrs. | Every 2 yrs. | Annually |

*(c) Heavy metal screen includes blood lead, cadmium, mercury, and arsenic levels.

TABLE 12-B-1 (Continued)

| Exam Type<br><br>Exposure Protocol | Initial/ Baseline | Periodic | Exit/Separation | Acute Exposure | Biological Monitoring |
|---|---|---|---|---|---|
| Lead | CG 5447 SF88&93<br><br>Blood lead & ZPP<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>Blood lead & ZPP<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>Blood lead & ZPP<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br>**Acute Exposure Form**<br><br>Blood lead & ZPP<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | Blood lead, ZPP |
| Noise | CG-5552<br><br>DD Form 2215 * | CG-5552 (update)<br>DD Form 2216 * | CG-5552 (update)<br><br>DD Form 2216 * | CG-5447 (update)<br>DD Form 2216 * | N/A |
| Pesticides | CG 5447 SF88&93<br>Blood cholin-esterase, twice<br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>Blood cholin-esterase (d)*<br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>Blood cholin-esterase (d)*<br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br>**Acute Exposure Form**<br><br>Blood cholin-esterase (d)*<br>PFTs | Blood cholinester ase (c)* |

Note: DD Forms 2215/2216 remain active and are to be properly recorded and maintained in the member's medical record. DOD facilities continue to use these forms or an electronic equivalent.

CG facilities may continue to use these forms; an equivalent locally reproduced form or electronic version as long as they comply with regulations set forth in Chapter 4 of this Manual.
NOTES: *(d) Blood cholinesterase only required if exposure includes organophosphate and/or carbamate pesticides.

TABLE 12-B-1 (Continued)

| Exam Type<br><br>Exposure Protocol | Initial/ Baseline | Periodic | Exit/Separation | Acute Exposure | Biological Monitoring |
|---|---|---|---|---|---|
| Respiratory Sensitizers | CG 5447<br>SF 88&93<br><br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br>**Acute Exposure Form**<br><br>PFTs | N/A |
| Solvents | CG 5447<br>SF 88&93<br><br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro<br>Biological moni-toring (if possible) | CG 5447 (update)<br><br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br>**Acute Exposure Form**<br><br>Specific blood or urine tests for specific solvents. | Specific blood or urine tests for specific solvents. (See Section 12-C-11.d.) |
| Respirator wear only | CG 5447<br>** OSHA Resp Quest | **ORQ (update) | N/A | N/A | N/A |

* Respiratory: OSHA Respiratory Questionnaire, this form is provided at the unit level (worksite), (Reference Section 12-c-9.

TABLE 12-B-1 (Continued)

| Exam Type<br><br>Exposure Protocol | Initial/ Baseline | Periodic | Exit/Separation | Acute Exposure | Biological Monitoring |
|---|---|---|---|---|---|
| Tuberculosis | CG 5447<br>Sf 88&93<br><br>Mantoux skin test (e)* | Mantoux skin test (e)* | Mantoux skin test (e)* | Mantoux skin test (e)* | N/A |
| Unspecified | CG 5447<br>SF 88&93<br><br>CBC<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>CBC<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br><br>CBC<br>Multichem panel<br>U/A w/ micro | CG 5447 (update)<br>**Acute Exposure Form**<br><br>CBC<br>Multichem panel<br>U/A w/ micro | Only under special circumstances. Contact G-WKS-3. |

NOTES: *(e) Personnel with a history of reactive tuberculin skin tests should be monitored for development of symptoms of active TB. A CXR should be done **only** if the skin test is newly reactive.

FIGURE 12-B-1

## ACUTE CHEMICAL EXPOSURE INFORMATION

| **Last Name, First Name, M.I.** | | | **Rank/Rate** **SSN** |
|---|---|---|---|
| 1. Name(s) of chemical(s): | _____ | _____ | _____ |
| 2. CAS number(s), if known: | _____ | _____ | _____ |
| 3. Physical form: | ☐ Solid ☐ Liquid<br>☐ Gas/Vapor<br>☐ Aerosol | ☐ Solid ☐ Liquid<br>☐ Gas/Vapor<br>☐ Aerosol | ☐ Solid ☐ Liquid<br>☐ Gas/Vapor<br>☐ Aerosol |
| 4. Chemical form: | ☐ Acid ☐ Alkali<br>☐ Organic solvent | ☐ Acid ☐ Alkali<br>☐ Organic solvent | ☐ Acid ☐ Alkali<br>☐ Organic solvent |
| 5. Modes or routes of exposure: | ☐ Inhalation<br>☐ Ingestion ☐ Skin | ☐ Inhalation<br>☐ Ingestion ☐ Skin | ☐ Inhalation<br>☐ Ingestion ☐ Skin |
| 6. Exposure date, time & duration: | Date/time _____<br>Duration _____ minutes | Date/time _____<br>Duration _____ minutes | Date/time _____<br>Duration _____ minutes |

**7. Brief description of the incident**:

8. Observed symptoms: _____

9. Associated injuries: _____

10. Personal Protective Equipment Used:

**Notify District/ISC Safety & Environmental Health Officer, cognizant MLC (kse), and G-WKH-3.**

11 Further guidance received:

**Contact ATSDR emergency response line at 404-649-0615 to obtain further guidance.**

| 12. ATSDR guidance: | Prescribed tests: | Time limits for specimens | Other |
|---|---|---|---|

Attach Material Safety Data Sheet (MSDS) and shipping manifest to this form, if available.

*(Use reverse for continuation or reporting of additional information.)*

FIGURE 12-B-2

**OMSEP**

**NOTIFICATION OF SUMMARY RESULTS**

Date of Examination: _____
Patient: _____ SS#:_____

| Address: | Phone # |
|---|---|
| | |
| | |

Reference. (a) Medical Manual, COMDTINST M6000.1(series).

1) An environmental health evaluation has determined that you may have been exposed to the following health hazards at your workplace:

_____

_____

2) Your physical examination was conducted in accordance to reference (a).
There ***ARE*** / ARE ***NOT*** abnormalities in your physical examination and laboratory testing.

| NOTED ABNORMAL PHYSICAL FINDINGS OR LABORATORY TESTS | RESULT/INTERPRETATION |
|---|---|
| | |

3) Additional comments on your Occupational Medical Surveillance and Evaluation physical

_____

_____

_____

_____

Name and Title of Health Care Provider: _____

_____

Signature of Health Care Provider: _____
Date:_____

FIGURE 12-B-3

# HISTORY AND REPORT OF OMSEP EXAMINATION

| 1. Last Name, First Name, M.I. | 2. Grade/Rate/Rank | SSN | Date of Examination |
|---|---|---|---|
| 5. Home Address (apt#, street#, street name, city, state, zip) | 6. Work/duty phone ( ) | 8. Unit Name and Location (*city & state)* | |
| | 7. Home phone ( ) | 9. Unit OPFAC# | 10. Unit Zip Code |

| 11. Date of birth & age | 12. Sex (*M or F)* | 13. Race or Ethnicity | 14. Occupation or usual duties (describe) |
|---|---|---|---|
| 16. Examining facility name & location (*○city, state)* | | 17. Purpose of Examination<br>O Initial/Baseline O Periodic<br>O Acute exposure O Exit/Separation | 15. How many years have you worked in this occupation? |

**I. Occupational History** *(patient must complete)*

_____ Initial here if there have been **NO** changes to your occupational history since your last exam and go to section **II**.

18. Are you exposed to any of the following in your *present job,* yes or no?

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| | | Asbestos (fibers, dust) | | | Hazardous wastes (or spills) |
| | | Benzene (liquid or vapor) | | | Radiation (microwave |
| | | Lead (dust or fumes) | | | Loud noise |
| | | Liquid chemicals (various) | | | Vibration (jackhammer) |
| | | Chemical vapors or gases | | | Extreme heat |
| | | Dust (sawdust, blasting) | | | Extreme cold |
| | | Metals or metal fumes | | | Mental or emotional stress |
| | | Entry into closed spaces (tanks, voids) | | | Human bodily fluids, or infectious agents |

19. Do you wear any of the following on your present job, yes or no?

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| | | Earplugs or muffs | | | Safety glasses |
| | | Dust mask | | | Welding face-mask |
| | | Half-face respirator | | | Rubber gloves |
| | | Full-face respirator | | | Protective body suit |
| | | Air-line respirator | | | Other, list below: |

| Y | N | |
|---|---|---|
| | | 20. Have you had any difficulty wearing your protective clothing or equipment? (If you don't need to wear any, answer "no.") |
| | | 21. Have you had any work-related illness or injury? |
| | | 22. Have you been limited in your work for health reasons? |
| | | 23. Have you left or changed jobs due to health reasons? |
| | | 24. Have you had a work-related experience, which you believe may have affected your health or the health of fellow workers? |
| | | 25. Do you have any hobbies or outside activities, which would expose you to any of the hazards listed in 18, above? If Yes, explain: |

**II. Family History** *(patient must complete)*

_____Initial here if there have been **NO** changes in the answers to the following questions since your last exam and go to section **III**.

26. Have any of your blood relatives (mother, father, brother, sister, grandparents, aunts, uncles, children) had any of the following illnesses or problems, yes or no?

| Y | N | |
|---|---|---|
| | | Anemia, blood disease, or bleeding tendency |
| | | Asthma, hayfever, or allergies |
| | | Birth defects or multiple miscarriages |
| | | Cancer, leukemia, or other malignancy |
| | | Diabetes (high blood sugar) |
| | | Eye trouble or blindness |
| | | Epilepsy, fits, or convulsions |
| | | Hearing trouble or deafness |
| | | Heart trouble, high blood pressure, or stroke |
| | | Kidney trouble (stones or kidney failure) |
| | | Lung trouble (cystic fibrosis, bronchitis, emphysema) |
| | | Some other disease or condition which runs in your family, if so list: |

**III. Social History***(patient must complete)*

_____Initial here is there have been **NO** changes in the answers to the following questions since your last exam and go on to section IV.

27. Cigarette smoking history.

| Y | N | | |
|---|---|---|---|
| | | Do you smoke cigarettes now? | |
| | | If NO: Did you ever smoke cigarettes? | |
| | | If you smoked before, what year did you stop? | |
| | | How many years had you smoked? | |
| | | How many packs per day? | |
| | | If YES: How many years have you smoked? | |
| | | How many packs per day? | |

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**Section III. Social History (continued)**

28. Other smoking history:

| Y | N | |
|---|---|---|
| | | Do you smoke cigars or a pipe now? |
| | | If NO: Did you ever smoke cigars or a pipe? |
| | | If you smoked before, what year did you stop? |
| | | How many years had you smoked? |
| | | How many cigars or pouches per week? |
| | | If YES: How many years have you smoked? |
| | | How many cigars or pouches per week? |

29. Alcohol use history:

| Y | N | |
|---|---|---|
| | | Do you drink any alcoholic beverages (beer, wine, liquor)? |
| | | If YES: How many bottles/cans of beer per week? |
| | | How many glasses of wine per week? |
| | | How many ounces of liquor per week? |
| | | 30. Do you use any other recreational drugs? If so, list below. |

**IV. Personal Health History** *(patient must complete)*

_____ Initial here if the answers to the following questions are all "**NO**" and there have been no changes since your last exam, then go to item 32.

31. Have you *recently* had or do you *now have any* of the following symptoms or complaints, yes or no?

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Unexplained weight loss | | | Difficulty sleeping | | | Chest pain or angina | | | Birth defects in your children |
| | | Fever or chills | | | Red or irritated eyes | | | Palpitations or irregular heart | | | Pain or blood with urination |
| | | Skin rashes or ulcers | | | Visual disturbances or changes | | | Other heart trouble | | | Muscle pain or weakness |
| | | Lumps you can feel | | | Sinus trouble (pain, discharge) | | | Abdominal pain | | | Joint pain or swelling |
| | | Severe or recurrent headaches | | | Nosebleeds | | | Gastritis or peptic ulcers | | | Limitations of motion |
| | | Dizziness or vertigo | | | Sore throat, trouble swallowing | | | Jaundice or yellowing skin | | | Back pain |
| | | Fainting or passing out | | | Pain or swelling in neck | | | Nausea or vomiting | | | Numbness, tingling in extremities |
| | | Seizures or epilepsy | | | Frequent coughing | | | Constipation | | | Anemia ("low blood") |
| | | Trouble concentrating | | | Coughing phlegm or blood | | | Diarrhea or runny stools | | | Easy bruising or bleeding |
| | | Mood changes, irritability | | | Wheezing or asthma | | | Bloody or tarry stools | | | HIV/AIDS |
| | | Tiredness or fatigue | | | Shortness of breath | | | Infertility or miscarriages | | | Cancer or leukemia |

32. In general, would you say your health is (check one): Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

33. List any medications you are currently using, or state "none".

SAMPLE FORM

34. List any allergies you know you have, or state 'none".

35. Additional space for comments and explanations of your "yes" answers:

All information provided will be handled in accordance with Privacy Act requirements, and will not be otherwise disclosed.

| I hereby certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. | Signature of patient | Date |
|---|---|---|

FIGURE 12-B-3 (cont'd)

## Occupational Exposure History

| | |
|---|---|
| _____Patient initial here if there have been **NO** changes in the answers to the following questions since last exam and proceed to Part 2. | _____Medical Officer/SEHO initial here for verification of hazardous exposure and monitoring. |

**INSTRUCTIONS**: Please complete the following history beginning with present job or military assignment. Additional copies of this sheet may be added if necessary

36. List all known hazardous exposures:

| Agents(s) (noise-metals-solvents) | Date (from - to) | Location (work site) | Protective equipment used |
|---|---|---|---|
| | | | |
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SAMPLE FORM

All information provided will be handled in accordance with Privacy Act requirements, and will not be otherwise disclosed.

| | | |
|---|---|---|
| I hereby certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. | Signature of patient | Date |

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FIGURE 12-B-3 (cont'd)

## MEDICAL OFFICER'S SECTION

**Part 2**

| 1. Last Name, First Name, M.I. *(of patient)* | 2. Grade/Rate/Rank *(of patient)* | 3. SSN *(of patient)* | 4. Date of Examination |
|---|---|---|---|
| 5. Examining facility or examiner name and address: | | | 6. Facility phone number ( ) |

7. Surveillance protocols followed *(check all that apply)*

☐ Asbestos ☐ Chromium compounds ☐ Lead ☐ Pesticides ☐ Respiratory sensitizers ☐ Unspecified

☐ Benzene ☐ Hazardous waste ☐ Noise ☐ Respirator wear ☐ Solvents ☐ Other:____

8. Medical Officer Initial Here: _____ Verify completion of SF-93 & SF-88. Initial Baseline _____

9. General prevention counseling provided to patient 9check any that were addressed with patient)

☐ Tobacco cessation ☐ Physical activity ☐ Weight reduction ☐ HIV/STD's avoidance ☐ Injury prevention

☐ Alcohol or drug abuse ☐ Nutrition (low-fat/salt) ☐ Stress reduction ☐ Breast/testicular self exam ☐ Other:_____

10. List current diagnoses by ICD-9 code number and name: *(If no exactly corresponding ICD-9 code is available, use the closest code to the named diagnosis.)*

| ICD-9 | Diagnosis | ICD-9 | Diagnosis |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

11. In your opinion, was the information to you adequate to support any listed diagnoses of occupational disease? ☐ YES ☐ NO

12. Respirator wear This examinee ☐ Is medically approved for respirator wear. *(Comment on any restrictions or limitations)*
☐ Is not

13. CONCLUSIONS: This examinee ☐ Has medical conditions which limit his/her performance of duties. *(Specify any limitations)*
☐ Does not have

14. Next OMSEP examination should be in ☐ 12 mos. ☐ Other_____

15. Examinee was informed about the results of this examination_____(date).

SAMPLE FORM

| Printed or typed name (rank) and degree of examining medical officer | Signature of examining medical officer | Date |
|---|---|---|
| | | |

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FIGURE 12-B-4

**OMSEP**

**SEPARATION LETTER**

NAME: _____ SSN:_____
DATE:_____

You have been enrolled in the Coast Guard's OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP). During the past _____years you received periodic physical examinations based on Occupational Health Safety Organization (OSHA) protocols for the following known potentially hazardous exposures:

_____
_____
_____
_____

Your occupational (work-related) history also indicates suspected exposure to the following agents:

_____
_____
_____
_____
_____

At the time of your EXIT/SEPARATION medical examination you were found to be in good health with no evidence occupational induced disease. However, it is recommended that you continue to receive medical examinations on a periodic basis based on age indicated guidelines. In addition, the periodicity of the examination should be modified to allow for adequate detection and prompt intervention on disease processes resulting from the latent effects of occupational hazardous substances. Your medical provider should follow OSHA mandated recommendations, for the aforementioned hazardous substances, in determining the frequency and level of care you require. NOTE: if a member is found to have an occupational related disease process at the time of separation, indicated medical referral measures will be instituted.

Any questions relating to this member's occupational health history can be obtained by contacting the US Coast Guard's Office of Safety and Environmental Health at # 202-267-1883.

Medical officer signature

- This letter should printed on official Coast Guard Letterhead for inclusion in members official health record.

Section C - Medical Examination Protocols.

1. General.

   a. The following protocols follow the same format. Each contains a brief description of the hazard and its possible effects; the conditions required for an individual to be surveyed under that protocol; information which must be provided to the examining medical officer; specific requirements of the history and physical, including laboratory tests and special procedures; and any additional written requirements on the part of the examining medical officer. The protocols are summarized in Figures 12-C-1 through 12-C-12. Copies of these figures may be locally reproduced. The unit OMSEP coordinator should complete the information in the first eight blocks at the very top, and the appropriate protocol summary figure(s) should be provided to the examining medical officer with the examination packet.

   b. Multiple protocols for a single individual. In the event that an individual is being monitored on more than one protocol (e.g., asbestos and noise), the final examination packet must include each of the required items for each of the protocols. However, each required form or test need only be completed once.

   c. *Past* exposure. Personnel who have a documented history of workplace exposure to known carcinogens**,** but who are not currently exposed, shall be offered an annual medical examination, according to this protocol until end of employment. Undergoing this examination is strictly voluntary.

2. Asbestos (Figure 12-C-1).

   a. Exposure effects. Asbestos exposure can cause asbestosis, bronchogenic carcinomas, mesothelioma, and gastric carcinoma. It may also be associated with multiple myeloma and renal carcinoma. Disease risk is dose dependent. There is a synergistic effect between asbestos exposure and cigarette smoking, so that the risk of lung cancer is roughly ten times greater in asbestos-exposed workers who smoke as opposed to nonsmoking asbestos-exposed workers. The primary route of exposure is inhalation, though ingestion of fibers may also occur.

   b. Required surveillance.

      (1) All personnel with current employment exposure to airborne asbestos, who meet the MSAL criteria in Section 12-C-2- (4) below, shall undergo medical surveillance. These personnel shall be included in the OMSEP and be examined according to the protocol in Section 12-C-2.d below. Medical examinations shall be provided upon enrollment and at least annually thereafter, throughout the duration of exposure or until end of employment, whichever comes first. Under current Coast Guard policies for management of asbestos, very few non-shipyard workers should be currently exposed at or above the PEL or EL.

      (2) Construction worker standard. The OSHA standard for asbestos applies to, but is not limited to, workers who demolish, remove, alter, repair, maintain, install, clean up, transport, dispose of, or store asbestos containing materials.

      (3) The current MSALs are based on the OSHA exposure standard for shipyards [29 CFR 1915.1001].

(a) For other than shipyard and construction workers, medical surveillance is required for those employees who are or will be exposed at or above the PEL as an 8 hour time-weighted average, or above the EL averaged over 30 minutes, regardless of the number of days of exposure.

(b) For shipyard and construction workers, medical surveillance is required for those workers:

1 Who remove any asbestos-containing materials, or who perform repair and maintenance operations in which asbestos-containing materials are likely to be disturbed, is such work is performed for a combined total of 30 or more days per year, regardless of fiber levels;

2 Who are exposed at or above the PEL or EL for a combined total of 30 or more days per year; or

3 Who are required to wear positive pressure respirators while performing asbestos-related work, regardless of the number of days respirators are worn.

c. Information to medical officer. The following information must be provided to the examining medical officer, by the OMSEP coordinator, prior to the examination taking place:

(1) A copy of the OSHA asbestos standards [29 CFR 1915.1001], with appendices D and E.

(2) A description of the affected employee's duties as they relate to the employee's exposure.

(3) The employee's representative exposure level or anticipated exposure level.

(4) A description of any personal protective or respiratory equipment used or to be used.

d. Examination protocol.

(1) Each initial, periodic, and exit examination shall include, as a minimum:

(a) A medical and work history. Emphasis should be placed on the member's history of tobacco use (smoking), and associated symptoms of dyspnea on exertion, recurrent epigastric discomfort, pleuritic chest pains or unexplained cough.

(b) Completion of the OSHA Respiratory Medical Evaluation Questionnaire Appendix C to RP Standard 29CFR 1910.134. Note: additional information on asbestos reporting guidelines may be found at www.osha.gov.

(c) A complete physical examination of all systems, with emphasis on the respiratory system, the cardiovascular system, and digestive tract.

(d) A stool guaiac test, if the patient is age 35 or over.

(e) PFTs, including FVC and FEV1.

(f) Routine screening labs, including a CBC, multichemistry panel (including glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and U/A with microscopic.

(g) A postero-anterior (PA) CXR, in accordance with the schedule and interpretation requirements in Section 12-C-2-d(2) below;

(h) Any other tests or procedures deemed appropriate by the examining physician, including specialty consultations.

(2) Chest x-ray requirements:

(a) A PA CXR shall be performed at the initial examination and then according to the following schedule:

| Years since | Age of examinee | | |
|---|---|---|---|
| First exposure | 15 to 35 | 36 to 45 | over 45 |
| 0 to 10 | Every 5 yrs. | Every 5 yrs. | Every 5 yrs. |
| Over 10 | Every 5 yrs. | Every 2 yrs. | Annually |

(b) A PA chest-x-ray shall be performed at the exit examination.

(c) All CXRs shall be interpreted and classified in accordance with a professionally accepted classification system and recorded following the format of the CDC/NIOSH (M) 2.8 form. A B-reader or a board eligible/certified radiologist using the ILO-U/C International Classification of Radiographs for Pneumoconiosis references shall only do the interpretation.

(d) Assistance in obtaining the location of the nearest B-reader is available from MLC (k).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the examining physician must address the following in writing:

(1) Any detected medical conditions placing the employee at increased risk of health impairment from further asbestos exposure.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

(3) Employee notification of the results of the examination and any medical conditions resulting from asbestos exposure that might require follow-up.

(4) Employee notification of the increased risk of lung cancer attributable to the synergistic effects of asbestos and smoking.

3. Benzene (Figure 12-C-2).

a. Exposure effects. Benzene exposure can cause central nervous system depression, leukemia, aplastic anemia, and dermatitis. The primary route of exposure is inhalation

of vapors, though skin absorption may also occur. Within the Coast Guard, most benzene exposure occurs among marine inspectors and oil spill responders.

b. Required surveillance.

(1) The Coast Guard MSALs are based on the OSHA action level and PEL standards. Enrollment in the OMSEP is required for all personnel:

(a) who are or may be exposed to benzene at or above the current average exposure action level 30 or more days per year,

(b) who are or may be exposed to benzene at or above the current short-term exposure action level 10 or more days per year, or

(c) who served as resident inspectors, pollution investigators, marine safety officers, port safety officers, vessel inspectors, or marine investigators prior to 1990. These personnel are considered to have been exposed at/or above the MSAL unless otherwise documented.

(2) In addition to routine surveillance requirements above, if an employee is exposed to benzene in an emergency (fire, spill) situation, a urine specimen will be collected as soon as possible thereafter, but not later than 24 hrs. after the exposure, and an acute exposure examination will be performed within 72 hrs. of the exposure. Such an examination must contain a urinary phenol test on the collected urine specimen.

c. Information to medical officer. The following information must be provided to the examining physician, by the OMSEP coordinator, prior to the examination taking place:

(1) A description of the affected employee's duties as they relate to the employee's exposure.

(2) The employee's representative exposure level or anticipated exposure level.

(3) A description of any personal protective or respiratory equipment used or to be used.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed history which includes:

1 past occupational exposure to benzene or any other hematological toxins, at work or at home;

2 a family history of blood dyscrasias, including hematological neoplasms;

3 a personal history of blood dyscrasias, including genetic hemoglobin abnormalities, bleeding abnormalities, abnormal function of formed blood elements; and of renal or liver dysfunction;

4 history of exposure to ionizing radiation;

5 smoking history, alcohol usage history, and all medicinal drugs routinely taken;

6 any current history of headache, difficulty concentrating, decreased attention span, short-term memory loss, mood lability, fatigue, dry skin, abnormal bleeding, anemia, or weight loss.

(b) a complete physical examination, (Ensure the patient is examined for mental status changes, dermatitis, and pallor.);

(c) a CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC);

(d) a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and U/A with microscopic;

(e) any other tests or procedures deemed appropriate by the examining physician.

(2) Each acute exposure examination shall include, as a minimum:

(a) a brief summary of the nature of the exposure and investigation of any symptoms or complaints;

(b) a total urinary phenol level (mg/L) or a urinary phenol adjusted for urinary creatinine (mg/g creatinine), plus a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC).

(c) If either the total urinary phenol level is below 50 mg phenol/L of urine, or the urinary phenol adjusted for urinary creatinine is less than 250 mg/g creatinine, and the CBC is normal, no further testing is required. Otherwise, contact Commandant (G-WKS-3) for further requirements.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the following must be addressed in writing by the examining medical officer:

(1) Any detected medical conditions, which would place the employee's health at greater than normal risk of material impairment from exposure to benzene.

(2) The medical officer's recommended limitations upon the employee's exposure to benzene or upon the employee's use of protective clothing or equipment and respirators.

(3) A statement that the employee has been informed by the medical officer of the results of the examination and any medical conditions resulting from benzene exposure which require further explanation or treatment.

4. Chromium Compounds (Figure 12-C-3) .

a. Exposure effects. Hexavalent chromium compounds are known human carcinogens. They may also cause dermatitis, skin ulceration, occupational asthma, and nasal septum perforation. The primary routes of exposure are percutaneous absorption and inhalation. Chromates may be found in certain metal alloys, paints, and masonry cements. Within the Coast Guard, most chromate exposure is from the use of chromium containing paints.

b. Required surveillance. The Coast Guard MSALs are based on the ACGIH threshold limit values (TLVs). Medical surveillance is required for all personnel who are or may be exposed to chromium IV compounds at or above the current exposure action level 30 or more days per year.

c. Information to medical officer. The following information must be provided by the OMSEP coordinator to the examining physician prior to the examination taking place:

(1) A description of the affected employee's duties as they relate to the employee's exposure.

(2) The employee's representative exposure level or anticipated exposure level.

(3) A description of any personal protective or respiratory equipment used or to be used.

d. Examination protocols. Each routine initial, annual (periodic), and exit examination must include:

(1) A detailed history, which includes:

(a) Past and current occupational exposures to chromate, asbestos, or any other pulmonary carcinogens at work or at home;

(b) Smoking history and alcohol usage history;

(c) Any past or current history of dry skin, skin ulcers—usually painless, nosebleeds, asthma, shortness of breath, wheezing, or cough;

(2) A directed physical examination, with attention to the skin, mucous membranes, and respiratory tract, both upper and lower (ensure the patient is examined for erosion of the nasal mucosa and septum, respiratory rhonchi, dermatitis, and cutaneous ulcers);

(3) A CBC, multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a U/A with microscopic;

(4) PFTs (including FVC & $FEV_1$);

(5) A PA CXR **only** for an initial/baseline or exit examination, unless there is a current clinical indication (cough, shortness of breath, wheezing, etc.);

(6) Any other tests or procedures deemed appropriate by the examining physician.

e. Specific written requirements. Other than the general requirements specified in Section 12-B-4-b, the physician should address:

(1) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

5. Hazardous Waste (Figure 12-C-4).

a. Exposure effects. The OSHA medical surveillance protocol for hazardous waste operations and emergency response (HAZWOPER)[29 CFR 1910.120] involves medical surveillance for potential exposure to numerous metals and chemicals, usually in uncontrolled—spill, fire, disposal—situations. Therefore, there are no specific exposure effects to describe.

b. Required surveillance.

(1) Routine medical surveillance is required for employees involved in hazardous waste operations when any of the following conditions are met:

(a) Exposure or potential exposure to hazardous substances or health hazards at or above the MSAL for that substance (as defined in Section 12-A-4), without regard to the use of respirators or personal protective equipment, for 30 or more days per year.

(b) All hazardous waste operation employees who wear a respirator for 30 or more days per year or as required under Section 12-C-9.

(c) All employees who are injured, become ill, or develop signs or symptoms due to possible overexposure involving hazardous substances or health hazards from an emergency response or hazardous waste operation.

(d) Members of HAZMAT response teams, including all Coast Guard Strike Team members and firefighters.

(2) In addition to routine surveillance requirements above, if an employee is exposed to a hazardous substance above the Coast Guard MSAL in an emergency (fire, spill) situation, a urine specimen will be collected as soon as possible thereafter, but not later than 24 hrs. after the exposure, and an acute exposure examination will be performed within 72 hrs. of the exposure.

c. Information to medical officer. The examining medical officer shall be provided, by the OMSEP coordinator, one copy of the OSHA HAZWOPER standard [29 CFR 1910.120] and its appendices, plus the following specific information:

(1) A description of the employee's duties as they relate to the employee's exposures.

(2) The employee's exposure levels or anticipated exposure levels.

(3) A description of any personal protective equipment used or to be used, including any respirators.

(4) Information from previous medical examinations of the employee which is not readily available to the examining physician.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A medical and occupational history which includes:

1 past and current occupational exposure to hazardous chemicals, metals, dusts, fumes, and heat stress;

2 any history of heat illness, allergies, sensitivities, or physical abnormalities;

3 current medications, and immunization history;

4 smoking history, and alcohol usage history;

5 a complete review of organ systems.

(b) A complete physical examination with attention to the skin, eyes, nose, throat, and respiratory, cardiovascular, genitourinary, and neurologic systems;

(c) A CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC);

(d) A multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and U/A with microscopic;

(e) PFTs (including FVC & FEV1);

(f) Vision screening;

(g) A PA CXR only for an initial/baseline or exit examination, unless there is a current clinical indication (cough, shortness of breath, wheezing, etc.);

(h) Any other tests or procedures deemed appropriate by the examining physician. (Consider a stool guaiac and/or electrocardiogram, if indicated by age or physical findings).

(2) Each acute exposure examination shall include, as a minimum:

(a) A brief summary of the nature of the exposure and investigation of any symptoms or complaints;

(b) A CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC), a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and a U/A with microscopic;

(c) PFTs (including FVC & FEV1);

(d) Appropriate biological monitoring tests (e.g., blood metal screen) depending on the exposure in question. Contact Commandant (G-WKS-3) for further information and requirements.

e. Specific written requirements. Other than the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Whether the employee has any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from work in hazardous waste operations or emergency response, or from respirator use.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

(3) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

6. Lead (Figure 12-C-5).

a. Exposure effects. In adults, excessive lead exposure can cause hypertension, anemia, peripheral neuropathy, encephalopathy, spontaneous abortions in women, and decreased fertility in men. The primary route of exposure in adults is inhalation of lead containing dust or fumes. Most exposure in the Coast Guard occurs during removal of previously applied lead-based paint coatings, or during environmental recovery of previously discarded lead-acid batteries. Some welders may be exposed to lead fumes.

b. Required surveillance. The Coast Guard MSAL is based on the OSHA PEL standard for shipyards [29 CFR 1915.1025]. Enrollment in the OMSEP is required for all personnel who are or may be exposed to lead at or above the current exposure action level for 30 or more days per year.

c. Information to medical officer. The OMSEP coordinator shall provide the medical officer with one copy of the OSHA lead standard [29 CFR 1915.1025] and its appendices, plus the following specific information:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or anticipated exposure levels to lead and to any other toxic substance (if applicable).

(3) A description of any personal protective equipment used or to be used, including any respirators (if known).

(4) Prior blood lead determinations.

(5) Information from previous medical examinations of the employee which is not readily available to the examining physician. This includes all available prior written medical opinions concerning the employee.

d. Examination protocols.

(1) Biological monitoring or "blood lead only" examinations must be provided to each employee exposed at or above the OSHA action level (currently TWA of 30 µg/ $m^3$ air) **every six months**. Otherwise, only annual examinations must be

performed, unless an employee's blood lead level is found to be elevated at or above 40 µg/100 ml of whole blood.

(2) Each routine initial, periodic, exit, and acute exposure examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past lead exposure (occupational and non-occupational);

2 personal habits (smoking, handwashing after work and before eating);

3 past and current gastrointestinal, hematological, renal, cardiovascular, reproductive, and neurological problems.

(b) A complete physical examination with particular attention to:

1 occular fundi, teeth, gums, hematological, gastrointestinal, renal, cardiovascular, and neurological systems;

2 blood pressure (must be recorded);

3 pulmonary status should be evaluated if respiratory protection is to be used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC), plus examination of peripheral smear morphology;

2 blood lead level and zinc protoporphyrin (must be performed by a laboratory licensed by the CDC for proficiency in blood lead testing);

3 a multi-chemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase);

4 a U/A with microscopic examination; and,

5 PFTs (including FVC & FEV 1).

(d) Any other tests or procedures deemed appropriate by the examining physician (pregnancy testing, laboratory examination of male fertility).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from exposure from lead, or from respirator use.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

(3) The results of the blood lead determinations.

7. Noise (Figure 12-C-6)

a. Exposure effects. The primary effect of excessive noise is to cause loss of hearing. This hearing loss may be described by three "p-words:" painless, progressive, and permanent. Cumulative overexposures to hazardous noise levels cause millions of people to lose hearing during their working lives.

b. Required surveillance. The Coast Guard MSAL is based on DOD Instruction 6055.12, DOD Hearing Conservation Program, as well as OSHA guidance [29 CFR 1910.95]. Enrollment in the OMSEP is required for all personnel who are or may be exposed to hazardous noise at or above the current exposure action level for 30 or more days per year. However, personnel who infrequently or incidentally enter designated "hazardous noise areas" need not participate in the audiometric testing program.

(1) Enrollment is required in accordance with the following criteria:

(a) When the member is exposed to continuous and intermittent noise that has an 8-hour time-weighted average (TWA) noise level of >85 decibels A-weighted (dBA), or is exposed to impulse noise sound pressure levels (SPLs) of 140 decibels (dB) peak, or greater.

(b) When a threshold shift of > 35 dB is noted in the speech frequencies.

(2) Reference (baseline) audiograms:

(a) All personnel shall receive a reference audiogram prior to any Coast Guard occupational noise exposure or before they are assigned to duties in "hazardous noise areas".

(b) Every effort should be made to schedule the reference audiogram on civilian workers in order to avoid conflicts with assigned duties; military personnel shall receive their reference audiogram at initial entry training.

(c) Testing to establish a reference audiogram shall be preceded by at least 14 hours without exposure to workplace noise. Hearing protectors that attenuate workplace noise below a TWA of 85 dBA, may be used to meet this requirement, in place of exclusion from the noisy workplace.

(3) Exit audiograms: shall be conducted on all employees, previously enrolled in the "hearing conservation program", if it is determined the employee no longer works in a designated "hazardous noise area," unless that employee is moving to another Coast Guard position that also involves work in such areas. However, if the employee's audiogram shows hearing losses (compared to the reference audiogram) of greater than 35 dB in the speech frequencies (500 - 3000 Hz) the employee must continue to receive annual audiograms until end of employment.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with a description of the employee's duties as they relate to the employee's exposure, the dB level of the hazardous work area and a description of any personal protective equipment used or to be used (e.g., earplugs or earmuffs).

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include completion or updating of an Audiology History Questionnaire (CG 5552) and audiometric testing (audiogram). All audiometric testing shall:

(a) Be performed by a licensed or certified audiologist, otolaryngologist, or other physician; or by a technician who is certified by the Council for Accreditation in Occupational Hearing Conservation or who has completed CG HS "A" school. A technician who performs audiometric tests shall be responsible to an audiologist, otolaryngologist, or other physician. Standard instructions shall be given to individuals before testing.

(b) Be conducted in a testing environment with background octave band SPLs not greater than 27 dB at 500 Hz, 29 dB at 1000 Hz, 34 dB at 200 Hz, 39 dB at 4000 Hz, and 41 dB at 8000 Hz. The test environment shall be surveyed annually to ensure these levels are not exceeded.

(c) Include pure tone, air conduction, and hearing threshold examinations of each ear at the test frequencies of 500, 1000, 2000, 3000, 4000, and 6000 Hz.

(d) Be performed on audiometers conforming to the most current calibration specifications of the American National Standards Institute (ANSI). Audiometers currently in operation must receive annual electroacoustic calibration to maintain certification.

(e) Occur on audiometers that have received a functional operations check before each day's use for specifications in the OSHA Occupational Noise Exposure standard [29 CFR 1910.95]

(f) Be recorded on DD Form 2215 (Reference Audiogram), or DD Form 2216 (Hearing Conservation Data), or equivalent locally reproduced versions as appropriate.

(2) Significant Threshold Shift (STS). Transcribe the reference audiogram test results into the "Reference Audiogram" spaces on the DD Form 2216, Hearing Conservation Data. The reference levels are subtracted from the current levels at 2000, 3000, and 4000 Hz. The differences in hearing levels calculated at 2000, 3000, and 4000 Hz are added together and divided by three, for each ear. STS exists if the resulting average hearing loss in either ear is greater than or equal to $\pm$10 dB [29 CFR 1910.95]. Additionally, any change of $\pm$15 dB at 1000, 2000, 3000, or 4000 Hz in either ear shall constitute an STS. Results shall be recorded on DD Form 2216. Aging (presbycusis) can contribute to the change in hearing level. When determining whether an STS has occurred, note the following: The TRACOR microprocessor audiometer automatically corrects for aging. The National Institute for Occupational Safety and Health (NIOSH) age corrections shall **not** be applied when determining STS if a microprocessor audiometer is used for the test.

(3) A follow-up audiogram shall be conducted when an individual's audiogram shows an STS, in either ear, relative to the current reference audiogram. Medical evaluation is required to validate the existence of a permanent noise-induced threshold shift and/or to determine if further medical referral is required. An audiologist, otolaryngologist, or other knowledgeable physician shall perform the evaluation and determine if the noise-induced STS is/is not work-related or has/has not been aggravated by occupational noise exposure.

(4) When a negative STS (improvement in hearing threshold from the reference audiogram) is noted on the periodic audiogram, one 14-hour noise-free follow-up test is required. That may be administered on the same day as the periodic test. The results of the follow-up test may be used to create a re-established reference audiogram.

(5) When a positive STS (decrease in hearing threshold form the reference audiogram) is noted on the periodic audiogram, two consecutive 14-hour noise-free follow-up tests **must** be administered to confirm if the decrease in hearing is permanent. The follow-up exams may not be performed on the same day as the periodic audiogram. The results of the second follow-up test may be used to reestablish a reference audiogram. If the results of the first follow-up test do not indicate an STS, a second follow-up test is not required.

(6) A new reference audiogram shall replace the original reference audiogram when the medical evaluation confirms that the STS noted during the annual and follow-up audiograms is permanent. The original reference audiogram shall be retained in the patient's medical record.

(7) Acute exposure examinations (formerly called the Detailed Surveillance Program). These examinations are designed to observe any dynamic hearing loss, to identify those who demonstrate unusual noise sensitivity, or to monitor personnel acutely exposed to unprotected high levels of noise (impulse >140dba).

(a) The initial acute exposure examination shall consist of all elements described in Sections 12-C-7.d. (1)-(6), above. Additional follow-up audiograms will be performed at 30 and 90 days, or at more frequent intervals at the discretion of the medical officer.

(b) If any of the follow-up audiograms demonstrate an average loss of no more than 10 dB in 2000, 3000, and 4000 Hz in either ear, when compared to the revised reference audiogram, hearing may be considered stable. The reference audiogram (per Section 12-C-7-d (5) and (6)) remains the audiogram against which further testing is compared. The individual is returned to annual monitoring.

(c) If these reevaluation audiograms exhibit a loss greater than an average threshold of 10 dB in 2000, 3000, and 4000 Hz in either ear when compared to the revised reference audiogram, the individual must be referred to an otolaryngologist for a consultation. Final disposition will depend on the consultant's diagnosis and recommendations.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the medical officer must do the following:

(1) The employee shall be notified in writing within 21 days, when an audiologist or a physician confirms a positive threshold shift is permanent. Such determination must be entered in the employee's medical record.

(2) Supervisors shall be notified, in writing, that the worker has experienced a decrease in hearing. Release of medical information must conform to privacy act requirements.

(3) Document that the patient was counseled concerning the potential seriousness of repeated unprotected exposures to excessive noise and provided additional information on hearing protection and avoidance of hazardous noise exposures.

8. Pesticides (Figure 12-C-7)

a. Exposure effects. There are over 1,200 chemical compounds currently classified as pesticides. However, this surveillance protocol is primarily concerned with only two classes of pesticides: organophosphate and carbamate insecticides, and chlorophenoxyacetic acid herbicides. Organophosphates and carbamates are inhibitors of the enzyme acetylcholinesterase and they cause parasympathetic nervous system hyperactivity (miosis, urination, diarrhea, defecation, lacrimation, salivation), neuromuscular paralysis, CNS dysfunction (irritability, anxiety, impaired cognition, seizures, coma), peripheral neuropathy, and depression of RBC cholinesterase activity. Chlorophenoxyacetic acid herbicides cause skin, eye, and respiratory tract irritation, cough, nausea, vomiting, diarrhea, abdominal pain, and peripheral neuropathy. In the past, some chlorophenoxyacetic herbicides were contaminated with dioxins during manufacture.

b. Required surveillance. The Coast Guard MSALs for carbaryl, chlorpyrifos, malathion, parathion, 2,4, -D, and 2,4,5,-T are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified pesticide at or above the MSAL (as defined in Sect. 12-A-2) for 30 or more days per year.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or potential exposure level to any pesticides.

(3) A description of any personal protective equipment used or to be used, including any respirators.

d. Examination protocols.

(1) Biological monitoring or "RBC cholinesterase only" examinations must be provided at least **every six months** to each employee exposed to organophosphate or carbamate pesticides at or above the MSAL. If an employee's RBC cholinesterase activity is found on any testing to be less than 80% of the pre-exposure baseline, the frequency of biological monitoring will be increased to at least **every three months during the application season**. Non-seasonal, acute

exposures will be monitored at a frequency determined by the supervising medical officer based on exposure information data.

(2) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past and current exposure to pesticides or other chemicals (occupational and non-occupational);

2 smoking and alcohol use history;

3 any symptoms of eye, nose, or throat irritation; cough; nausea, vomiting, diarrhea, or abdominal pain; irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities; and

4 allergic skin conditions or dermatitis.

(b) A complete physical examination, with attention to the skin, respiratory, and nervous systems, including a mental status examination, should be performed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 A CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A;

2 An erythrocyte (RBC) cholinesterase level.

3 **Initial examination only—two RBC cholinesterase tests must be drawn at least 24 hrs. apart**. The results of these two tests will be averaged to provide the pre-exposure baseline for future reference, unless they differ by more than 15% from each other, in which case, additional testing must be performed until successive tests do not differ by more than 15%. The pre-exposure baseline blood tests must be drawn after a period of at least 60 days without known exposure to organophosphates.

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., cognitive function testing). Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.

(3) Each acute exposure examination shall include, as a minimum:

(a) A medical and work history with emphasis on any evidence of eye, nose, or throat irritation; cough; nausea, vomiting, diarrhea, or abdominal pain;

irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities.

(b) A complete physical examination with attention to any reported symptoms as well as the skin, respiratory, and nervous systems. A mental status examination must be performed.

(c) An erythrocyte (RBC) cholinesterase level.

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, cognitive function testing, urinary metabolites—if less than 24 hrs. post acute exposure). Pulmonary function testing should be performed at least every 4 years if the employee wears a respirator.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4, the physician should address:

(1) Any detected medical conditions, which would place the employee's health at increased risk from exposure to identified pesticides or from respiratory wear.

(2) Counseling on the possible increased risk of health impairment from working with certain pesticides, in the event that the employee was found to have skin disease, chronic lung disease, or abnormalities of the central or peripheral nervous system that could directly or indirectly be aggravated by such exposure.

9. Respirator Wear (Figure 12-C-8)

a. Exposure effects. The OSHA medical surveillance protocol for respirator wear is a means to assess the effectiveness of respiratory protection among exposed workers. Periodic examinations are required to assess continued fitness for duties and to assess whether the present respiratory protection program provides adequate protection against illness. Respirators are often extremely uncomfortable to wear for long periods. Workers with asthma, claustrophobia, angina, and other conditions may not be able to wear respirators effectively. The worker should be questioned for a history or symptoms of past and current exposures to hazardous chemicals; fumes and dusts; smoking and alcohol use histories; wheezing or abnormal breath sounds; clubbing; and cardiac arrhythmia.

b. Required surveillance.

(1) Initial Medical Determination. An initial/baseline examination will be performed at the time of assignment to a job requiring respirator wear. Before an employee may be issued a respirator or assigned to a task that may require a respirator, that worker must complete a mandatory OSHA Respirator Medical Evaluation Questionnaire. This questionnaire will be provided, at the local unit by the cognizant SEHO, to all workers expected to require the use of a respirator. This questionnaire serves as the initial medical examination. A health care professional (nurse, nurse practitioner, physician assistant, and physician) must review this questionnaire to determine if a follow- up medical examination is required. Independent duty technicians (IDT'S) are authorized to review the questionnaire but must refer any positive responses on questionnaire (or any other concerns) to

the supervising medical officer for further review. Any employee who gives a positive response to any questions among questions 1-8 in section two of the questionnaire shall be subject to a follow-up medical examination. This examination will determine whether the worker is physically and mentally capable of performing the work and using a respirator [29 CFR 1910.134].

(2) Additional Medical Evaluation and Medical Examination.

(a) Additional medical examinations are required to assess continued fitness for duties involving respirator wear. The following conditions will trigger the need for a follow-up evaluation:

1 The member reports signs and symptoms related to the ability to use a respirator;

2 The health care provider, supervisor, or respirator program coordinator informs the command of the need for re-evaluation;

3 Observations are made during fit testing, respirator use, or program evaluation that indicate the need for re-evaluation;

4 When changes in workplace conditions such as physical work effort, protective clothing or climate conditions result in substantial increase in physiological burden;

5 At the same time of the member's schedule quintennial physical examination.

(b) Periodic physical examinations will be provided at least once every five years. The periodic physical examination requires a review and update of the respirator questionnaire. A health care provider must review the questionnaire to determine the need for a follow-up examination. A follow-up medical examination is required for anyone with positive responses to questions 1-8 in section two of the questionnaire.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's respirator wear.

(2) The employee's exposures or potential exposures to any hazardous chemicals or physical agents.

(3) A description of the respirator(s) used or to be used.

d. Examination protocol. Each routine (non-acute exposure) initial and periodic examination shall include, as a minimum:

(1) A medical and work history, including:

(a) history of exposure to hazardous chemicals, fumes, and dusts;

(b) smoking and alcohol use history;

(c) any history of claustrophobia, asthma, angina, other respiratory or cardiovascular disease.

(2) A system specific physical examination, with attention to the pulmonary and cardiovascular systems.

(3) Any other tests or procedures deemed appropriate by the examining physician.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4, the physician should address:

(1) Any detected medical conditions that would place the employee at increased risk of material impairment of the employee's health from respirator use.

(2) Note: There currently exists no consensus standard by which physicians may assess a worker's ability to wear a respirator. As a general rule, however, anyone with documented respiratory impairment of moderate to severe degree ($FEV_1$ or FVC <70% of predicted) should not be routinely approved to wear a respirator. Asthmatics with normal or mildly impaired lung function should be evaluated based on the job requirements, but disapproval should be strongly considered for asthmatics that require regular medications to maintain airflow, or who have a history of airway reactivity or sensitization to extrinsic materials (dusts, fumes, vapors, or cold).

10. Respiratory Sensitizers (Figure 12-C-9)

a. Exposure effects. Respiratory sensitizers include numerous compounds which cause both occupational asthma and/or hypersensitivity pneumonitis (extrinsic allergic alveolitis). Respiratory sensitizers include vegetable dusts and woods, molds and spores, animal danders, metals (platinum, chromium, nickel, cobalt, vanadium), and chemicals (isocyanates, formaldehyde, trimellitic anhydride).

b. Required surveillance. The Coast Guard MSALs for formaldehyde, toluene diisocyanate, and vanadium, are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified respiratory sensitizer at or above the MSAL (as defined in Sect. 12-A-2) for 30 or more days per year. In the Coast Guard, exposure to respiratory sensitizers is primarily associated with industrial operations, though some marine inspection activities may also lead to exposures.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or anticipated exposure level to any respiratory sensitizers.

(3) A description of any personal protective equipment used or to be used, including any respirators.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past and current exposure to respiratory sensitizers (occupational and non-occupational);

2 smoking history;

3 any symptoms of eye, nose, or throat irritation;

4 chronic airway problems or hyperactive airway disease; and

5 allergic skin conditions or dermatitis.

(b) In the event that the employee is not required to wear a respirator and the history and routine laboratory tests are unremarkable, the medical officer may determine that a complete physical examination is not required. Otherwise, at a minimum, a system specific physical examination with attention to the respiratory system must be completed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 a CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A;

2 PFTs (including FVC & $FEV_1$).

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CXR, bronchial provocation tests).

(2) Each acute exposure examination shall include, as a minimum:

(a) A medical and work history with emphasis on any evidence of upper or lower respiratory problems, allergic conditions, skin reaction or hypersensitivity, and any evidence of eye, nose, or throat irritation.

(b) A directed physical examination with attention to the respiratory system.

(c) PFTs (including FVC & FEV1).

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, bronchial provocation tests).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from exposure to identified respiratory sensitizers, or from respirator use.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

11. Solvents (Figure 12-C-10)

a. Exposure effects. There are over 30,000 industrial solvents. This protocol is designed to survey for the most frequent health effects of solvents when considered as an admittedly broad group. These effects are skin disorders (acute irritant dermatitis, chronic eczema), acute CNS effects (headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, confusion, coma), and chronic CNS effects (chronic solvent intoxication, neurobehavioral abnormalities, cognitive dysfunction). Some other less frequent effects of solvents involve the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems. Most solvents are **not** carcinogenic to humans; benzene being a notable exception (see Section 12-C-3, above). In the Coast Guard, exposure to solvents is primarily associated with industrial and maintenance operations (e.g., painting).

b. Required surveillance. The Coast Guard MSALs for ethylene glycol, methyl ethyl ketone, VM & P naphtha, and xylene are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified hazardous solvent at or above the MSAL (as defined in Section 12-A-2) for 30 or more days per year. An acute exposure examination is required in the event of any documented overexposure (above the TLV or STEL) to a solvent or any presumed overexposure where symptoms are present. In the case of an acute overexposure, an appropriate urine or blood specimen should be collected as soon as possible after the overexposure incident.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or potential exposure level to any solvents.

(3) A description of any personal protective equipment used or to be used, including any respirators.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past and current exposure to solvents (occupational and non-occupational);

2 smoking history and alcohol use history;

3 any symptoms of dry skin, skin irritation, or dermatitis;

4 any CNS symptoms, including headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, difficulty concentrating, mood changes, or confusion;

5 a review of symptoms with attention to the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems.

(b) A system specific physical examination, with attention to the skin and nervous systems, including a mental status examination, should be performed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC); and

2 a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and a U/A with microscopic.

(d) Consideration should be given to biological monitoring tests for ongoing overexposure to certain solvents, if specimens can be obtained in a timely manner during the exposure period. For non-acute exposures, a timely manner generally implies that the specimen be obtained at the end of a work shift or the end of a workweek.

1 For toluene, measure urinary hippuric acid, at the end of a full work shift.

2 For xylene, measure urinary methyl-hippuric acid, at the end of a full work shift.

3 For methylethylketone (MEK), measure urinary MEK, at the end of a full work shift.

4 For trichloroethylene, measure urinary trichloroacetic acid, at the end of a full workweek.

(e) Any other tests or procedures deemed appropriate by the examining physician (e.g., cognitive function tests. Note that skin (patch) testing is generally of little value in solvent-induced dermatitis, since the pathophysiology is generally not allergic. Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.

(2) Each acute exposure examination shall include, as a minimum:

(a) A medical and work history with emphasis on any evidence of skin disorders or acute CNS effects (headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, confusion, coma).

(b) A system specific physical examination with attention to the skin and nervous systems.

(c) If at all possible, a biological monitoring test for overexposure to the solvent in question should be performed, if such a test is available and a specimen can be obtained in a timely manner. For acute exposures, a timely manner implies within the first half-life of the chemical within the human body, generally a matter of a few hours after the overexposure.

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, and bronchial provocation tests).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions, which would place the employee at increased risk of material impairment of the employee's health from any identified exposures to solvents, or from respirator use.

(2) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

12. Tuberculosis (Figure 12-C-11)

a. Exposure effects. Tuberculous droplet nuclei are coughed, spoken, or sneezed into the air by an individual with active pulmonary tuberculosis. Exposure to these airborne droplet nuclei may cause infection with the bacterium that causes tuberculosis.

b. Required surveillance. Employees who are occupationally exposed to active TB cases will be enrolled in the OMSEP and undergo annual screening for tuberculosis. See section 7-D-3 of this Manual, Tuberculosis Screening Program, for complete details. In the Coast Guard, medical personnel and personnel involved in alien migrant interdiction operations (AMIO) are at potential risk for exposure to active TB cases.

c. Information to medical personnel. In order to assess whether the employee should remain under active surveillance for TB exposure, the OMSEP coordinator must provide the examining medical officer with the following information:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or potential exposure level active TB cases.

(3) A description of any personal protective equipment used or to be used.

d. Examination protocols.

(1) Routine screening for exposed individuals is covered in section 7-D-3.

(a) Personnel with a history of non-reactive tuberculin skin tests will receive annual skin testing. Routine skin testing does not require an examination by a medical officer.

(b) Personnel with a history of reactive skin test(s) will be monitored for development of symptoms of active TB (cough, hemoptysis, fatigue, weight loss, night sweats) annually. A health services technician or a medical officer may complete such monitoring. Routine annual CXRs will not be done.

(2) Evaluation of personnel with newly reactive tuberculin skin tests or suspected active TB is covered in section 7-D-4. A medical officer shall perform a physical examination and obtain a complete medical history in such personnel. A CXR should be done.

e. Specific written requirements. Requirements for recording routine skin test results are covered in Section 7-D-3-c. In addition, medical personnel should make a written recommendation as to whether continued annual TB surveillance is required.

13. Unspecified (Figure 12-C-12)

a. Exposure effects. Individuals undergoing surveillance in this category have exposures to hazards, which are not included in any of the other protocols. Exposure effects will vary with the nature of the exposure, so there are no specific effects to describe.

b. Required surveillance. Enrollment in the OMSEP is required whenever an employee is exposed to an identified hazard, at or above the MSAL, for 30 or more days per year.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or anticipated exposure level to any hazardous chemicals or physical agents.

(3) A description of any personal protective equipment used or to be used.

d. Examination protocols. Each routine initial, periodic, and exit examination shall include, as a minimum:

(1) A medical and work history. Ensure the patient is questioned about past exposure to chemical and physical hazards, smoking history and alcohol use, a complete review of systems.

(2) A complete physical examination of all systems, with attention to any organ systems with a significant history or current symptoms. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(3) A CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A.

(4) Any other tests or procedures deemed appropriate by the examining physician. Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from any identified exposures to identified hazards, or from respirator use.

(2) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

FIGURE 12-C-1

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |

Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Other ___
Acute Exposure ☐

Examination Protocol for Exposure to

# ASBESTOS

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| Initial/Baseline | ____<br>____ | CG-5447 History and Report of OMSEP Examination / **SF 88 & 93** |
| | ____ | DD Form 2493-1 or OSHA Respiratory Disease Questionnaire (Part 1) (optional) |
| Periodic/Separation or **Acute Exposure** | ____<br>____ | DD Form 2493-2 or OSHA Respiratory Disease Questionnaire (Part 2) **(optional**)<br>**CG 5447** (update) |
| All types | ____ | Complete blood count (CBC); multichemistry panel (includes liver function tests, BUN, creatinine); urinalysis with microscopic (U/A). |
| All types | ____ | Pulmonary function tests (FVC & $FEV_1$). |
| Acute Exposure | ____ | *Acute Exposure Form* |
| All types | ____ | Chest x-ray (PA) with "B-reader" or board certified radiologist evaluation at initial exam then per table: |

| | *Years since first exposure* | | |
|---|---|---|---|
| | *Age 15-35* | *Age 36-45* | *Age >45* |
| 0-10 | Every 5 years | Every 5 years | Every 5 years |
| Over 10 | Every 5 years | Every 2 years | Every year |

| | | |
|---|---|---|
| All types | _____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.

Ensure that the patient is questioned about the following history or symptoms: **smoking history, dyspnea on exertion, cough, pleuritic pain, heartburn or epigastric pain.** (See OSHA Respiratory Disease Questionnaire.)

Ensure that the patient is examined for the following possible signs: **clubbing, basilar rales.**

You must address the following four items in writing: 1) whether the employee has any detected medical conditions placing him/her at increased risk of health impairment from further asbestos exposure; 2) any recommended limitations on use of personal protective equipment; 3) that the employee has been informed by you of the results of the examination and any medical conditions resulting from asbestos exposure that require follow-up; 4) that the employee has been informed of the increased risk of lung cancer attributable to the synergistic effects of asbestos and smoking.

Asbestos exposure can cause asbestosis, bronchogenic carcinomas, mesothelioma, and gastric carcinoma. It may also be associated with multiple myeloma and renal carcinoma. Disease risk is dose dependent.

Asbestos was used in shipbuilding until the 1970s. Exposure among OMSEP participants is mostly associated with repair and overhaul of vessels built prior to that time

If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-2

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |
| Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____ | | | |

Examination Protocol for Exposure to

# BENZENE

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| **Initial/Baseline** | ____<br>____ | CG-5447 History and Report of OMSEP Examination.<br>**SF 88 & 93** |
| All types | ____ | CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC). |
| Initial/Baseline, Periodic, or Separation | ____<br>____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, GTT, LDH, and alkaline phosphatase)<br>**U/A with microscopic** |
| Periodic /Separation/**Acute Exposure** | ____ | **CG 5447** (update) |
| Acute exposure | ____<br>____ | Urinary phenol. **(Only immediately after acute exposure.)**<br>Acute Exposure Form |
| All types | ____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: **smoking history, headache, difficulty concentrating, decreased attention span, short-term memory loss, mood lability, fatigue, dry skin, abnormal bleeding, anemia, weight loss**.
- Ensure that the patient is examined for the following signs: **mental status changes, dermatitis, pallor**.
- Benzene exposure causes CNS depression, leukemia, aplastic anemia, and dermatitis.
- The employee should be medically removed from the workplace if any of the following are noted on the exam:
  - The hemoglobin/hematocrit is below the laboratory's normal limit and/or these indices show a persistent downward trend from the individual's pre-exposure norms; provided these findings cannot be explained by other means.
  - The thrombocyte (platelet) count has dropped more than 20% below the employee's most recent prior values or falls below the laboratory's normal limit.
  - The leukocyte count is below 4,000 per $mm^3$ or there is an abnormal differential count.
- Benzene is commonly associated with petrochemical manufacturing. Exposure among OMSEP participants is generally related to marine vessel inspection or disaster response (oil spill, fire). Commercial gasoline is about 3% benzene.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-3

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |
| Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Other _____ Acute Exposure ☐ | | | |

Examination Protocol for Exposure to

# CHROMATES

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| **Initial/Baseline** | ____ ____ | CG-5447 History and Report of OMSEP Examination/ **SF 88 & 93** |
| Initial/Baseline or Separation | ____ | Chest x-ray (PA) |
| **Periodic/Separation/ Acute Exposure** | ____ | **CG 5447** (update) |
| All types | ____ | Pulmonary function tests (FVC & $FEV_1$). |
| All types | ____ | Complete blood count (CBC) |
| All types | ____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) |
| All types | ____ | U/A with microscopic |
| All types | ____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: **smoking history, shortness of breath, wheezing, cough, dry skin, skin ulcers.**
- Ensure that the patient is examined for the following signs: **erosion of nasal mucosa and septum, respiratory rhonchi, dermatitis, cutaneous ulcers.**
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- Chromium exposure causes lung cancer, dermatitis, skin ulcers, and nasal septum perforation.
- Chromic acid may cause acute burns or irritation to skin, eyes, and upper respiratory tract. Inhalation may cause acute epiglottitis, laryngospasm, pneumonitis, and pulmonary edema.
- Some chromium compounds cause occupational asthma.
- Chromium compounds are commonly associated with steel and chemical manufacturing. Exposure among OMSEP participants is generally related to working with chromium containing paints.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-4

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |
| Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____ | | | |

Examination Protocol for Exposure to

# Hazardous Waste

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| **Initial/Baseline** | ____<br>____ | CG-5447 History and Report of OMSEP Examination<br>**SF 88 & 93** |
| Initial/Baseline or Separation | ____ | Chest x-ray (PA) |
| **Periodic/Separation /Acute Exposure** | ____ | **CG 5447** (update) |
| All types except acute exposure | ____ | Vision screening (distant and near) |
| All types | ____ | Pulmonary function tests (FVC & $FEV_1$). |
| All types | ____ | CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC). |
| All types | ____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) |
| All types | ____ | U/A with microscopic |
| **Acute exposure** | ____ | Blood lead and/or heavy metal screen, **if indicated**. |
| All types | ____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: **smoking history, weight loss, headache, visual** disturbances**, difficulty concentrating, decreased attention span, short-term memory loss, confusion, mood lability, fatigue, ataxia, peripheral numbness or paresthesias, weakness, shortness of breath, anemia.**
- Ensure that the patient is examined for the following signs: **gingivitis, sialorrhea, tremor, mental status changes, decreased deep** tendon **reflexes, decreased vibratory sensation, respiratory rhonchi and hyperresonance, dermatitis, edema.**
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- The hazardous waste protocol involves medical surveillance for effects of exposure to a variety of heavy metals and chemical compounds. Neurotoxicity, pulmonary disease, dermatitis, and cancer are possible effects of excessive exposures to hazardous wastes.
- OMSEP participants monitored under this protocol are primarily members of HAZMAT and spill response teams, firefighters, and marine safety inspectors. Individual, specific exposure histories are often ill defined. If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-5

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |
| Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____ | | | |

Examination Protocol for Exposure to

# Lead

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| **Initial/Baseline** | ____<br>____ | CG-5447 History and Report of OMSEP Examination<br>**SF 88 & 93** |
| All types | ____ | Blood lead and zinc protoporphyrin (ZPP) |
| All types | ____ | CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC), plus examination of peripheral smear morphology. |
| **Periodic/Separation/Acute Exposure** | ____ | **CG 5447** (update) |
| All types | ____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase, and uric acid) |
| **Acute Exposure** | ____ | **Acute Exposure Form** |
| All types | ____ | U/A with microscopic |
| All types | ____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: **past lead exposure, smoking history, abdominal pain and cramping, joint and extremity pain, difficulty concentrating, irritability, short-term memory loss, confusion, mood lability, fatigue, ataxia, peripheral numbness or paresthesias, weakness, anemia, and infertility.**
- Ensure that the patient is examined for the following signs: **hypertension, papilledema, gum "lead lines", pallor, mental status changes, decreased deep tendon reflexes, decreased vibratory sensation, extensor motor weakness.**
- Lead exposure can cause fatigue, anemia, arthralgias and myalgias, peripheral motor neuropathy, neurobehavioral disturbances and encephalopathy, acute abdominal pain, gout and gouty nephropathy, acute and chronic renal failure, spontaneous abortions, and male infertility.
- If the blood lead level is greater than 40 µg/100 g of whole blood, the employee must be medically removed from any workplace exposure.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-6

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |
| Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____ | | | |

Examination Protocol for Exposure to

# Noise

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| **Initial/Baseline** | ____ | CG-5447 History and Report of OMSEP Examination |
| | ____ | SF 88 & 93 |
| | ____ | **CG-5552 Audiology History Questionnaire** |
| | ____ | **DD Form 2215 (optional) or equivalent locally reproduced version**. |
| Periodic, Separation, or Acute Exposure | ____ | DD Form 2216 (optional) or equivalent locally reproduced version. |
| All types | ____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Review and initial the CG-5552 Audiology History Questionnaire and the audiogram results.
- A significant threshold shift (STS) exists if the **average** change in hearing from the reference audiogram at, 2000, 3000, and 4000 Hz is greater than or equal to $\pm$10 dB in either ear.
- Additionally, any change of $\pm$15 dB at 1000, 2000, 3000, or 4000 Hz in either ear constitutes an STS.
- Do not apply the National Institute for Occupational Safety and Health (NIOSH) age corrections when determining STS.
- Follow-up audiograms must be conducted when an individual's audiogram shows an STS relative to the current reference audiogram in either ear. When a positive STS (decrease in hearing threshold) is noted, two 14-hour noise-free follow-up tests must be administered to confirm that the decrease in hearing is permanent. When a negative STS (improvement in hearing) is noted, one 14-hour noise-free follow-up tests must be administered.
- Medical evaluation is required to validate the existence of a permanent noise-induced threshold shift and/or to determine if further medical referral is required. That evaluation must be performed by an audiologist, and otolaryngologist, or other knowledgeable physician.
- If, compared with the **current** reference audiogram, a loss of hearing of $\geq$ 35 dB in either ear at one or more of the speech frequencies (500, 1,000, 2000, or 3000 Hz) is noted , the employee must be medically removed from further workplace exposure.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-7

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |
| Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____ | | | |

Examination Protocol for Exposure to

# Pesticides

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| **Initial/baseline** | ____ | CG-5447 History and Report of OMSEP Examination |
| | ____ | **SF 88 & 93** |
| | ____ | Blood cholinesterase level, two specimens at least 24 hrs. apart |
| **Periodic/ Separation or Acute Exposure** | ____ | Blood cholinesterase level, **if current exposure involves organophosphate or carbamate pesticides** |
| | ____ | CG 5447 (update) |
| All types | ____ | Pulmonary function tests (FVC & $FEV_1$). |
| All types except acute exposure | ____ | CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC) |
| All types except acute exposure | ____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase) |
| All types except acute exposure | ____ | U/A with microscopic |
| **Acute Exposure** | ____ | **Acute Exposure Form** |
| All types | ____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: **past and current exposures to pesticides, smoking and alcohol use history; eye, nose or throat irritation; cough; nausea, vomiting, diarrhea or abdominal pain; irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities; allergic skin conditions or dermatitis.**
- Ensure the patient is examined for the following possible signs: **dermatitis, meiosis, rhinitis, mental status changes.** Pulmonary system must be examined if respiratory protection is used.
- If the cholinesterase level is at or below 50% of the pre-exposure baseline, the employee must be medically removed from any further workplace exposure.
- Organophosphates and carbamates are inhibitors of the enzyme acetylcholinesterase. They cause parasympathetic nervous system hyperactivity, neuromuscular paralysis, CNS dysfunction, peripheral neuropathy, and depression of RBC cholinesterase activity. Chlorophenoxyacetic acid herbicides cause skin, eye, and respiratory tract irritation, cough, nausea, vomiting, diarrhea, abdominal pain, and peripheral neuropathy.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-8

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |
| Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Other _____ | | | |

Examination Protocol for Exposure to

# Respirator Wear

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| **Initial/Baseline** | ____ | **OSHA Respiratory Medical Evaluation Questionnaire** |
| **Periodic/Exit/Separation** | ____ | **OSHA Respiratory Medical Evaluation Questionnaire (update).** |
| All types | ____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- This protocol applies to all employees required to wear a respirator in the course of their work.
- Ensure that the patient is questioned about the following history or symptoms: **past and current exposures to hazardous chemicals, fumes, and dusts; smoking and alcohol use history; any history of claustrophobia, asthma, angina, syncope, and other respiratory or cardiovascular disease.**
- Ensure the patient is examined for the following possible signs: **wheezing or other abnormal breath sounds, clubbing, and cardiac arrhythmias.**
- You must address whether the employee as any detected medical conditions which would place him or her at increased risk of material health impairment from the required respirator use. Consider whether the employee's health will allow him or her to tolerate respirator wear.
    - ∗ Note: There currently exists no consensus standard by which physicians may assess a worker's ability to wear a respirator. As a general rule, however, anyone with documented respiratory impairment of moderate to severe degree (FEV1 or FVC <70% of predicted) should not be **routinely** approved to wear a respirator. Asthmatics with normal or mildly impaired lung function should be evaluated based on the job requirements, but disapproval should be strongly considered for asthmatics that require regular medications to maintain airflow, or who have a history of airway reactivity or sensitization to extrinsic materials (dusts, fumes, vapors, or cold).
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-9

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |
| Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____ | | | |

Examination Protocol for Exposure to

# Respiratory Sensitizers

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| **Initial/Baseline** | ____<br>____ | CG-5447 History and Report of OMSEP Examination<br>**SF 88 & 93** |
| **Periodic/Exit/Acute Exposure** | ____ | **CG 5447** (update) |
| All types | ____ | Pulmonary function tests (FVC & $FEV_1$). |
| All types except acute exposure | ____ | CBC (complete blood count) |
| All types except acute exposure | ____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase) |
| All types except acute exposure | ____ | U/A (dipstick sufficient) |
| **Acute Exposure** | ____ | **Acute Exposure Form** |
| All types | ____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: **past and current exposures to respiratory sensitizers, smoking history; eye, nose or throat irritation; cough; asthma or other chronic airway problems; allergic skin conditions or dermatitis.**
- In the event that the employee is not required to wear a respirator, and the history and routine laboratory tests are unremarkable, the medical officer may determine that a complete physical examination is not required. Otherwise, at a minimum, a directed physical examination with attention to the respiratory system must be completed. Pulmonary status must be evaluated if respiratory protection is used.
- Respiratory sensitizers include numerous compounds which cause both occupational asthma and/or hypersensitivity pneumonitis (extrinsic allergic alveolitis). Respiratory sensitizers include vegetable dusts and woods, molds and spores, animal danders, metals (platinum, chromium, nickel, cobalt, vanadium), and chemicals (isocyanates, formaldehyde, trimellitic anhydride).
- In the Coast Guard, exposure to respiratory sensitizers is primarily associated with industrial operations, though some marine inspection activities may also lead to exposures.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-10

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |
| Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____ | | | |

Examination Protocol for Exposure to

# Solvents

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| **Initial/Baseline** | ____<br>____ | CG-5447 History and Report of OMSEP Examination<br>**SF 88 & 93** |
| All types | ____ | Pulmonary function tests (FVC & $FEV_1$). |
| All types except acute exposure | ____ | CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC) |
| **Periodic/Exit/Acute Exposure** | ____ | **CG 5447** (update) |
| All types except acute exposure | ____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase) |
| All types except acute exposure | ____ | U/A with microscopic |
| **Acute exposure** | ____ | **Acute Exposure Form** |
| All types | ____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: **past and current exposures to solvents, smoking and alcohol use history; allergic skin conditions, dry skin, or dermatitis ; eye, nose or throat irritation; headache, nausea, vomiting, dizziness, vertigo; fatigue, weakness, irritability, depression, difficulty concentrating, or impaired short-term memory; and numbness, tingling, or weakness in the extremities.**
- Ensure the patient is examined for the following possible signs: **dermatitis, peripheral neuropathy, cognitive dysfunction, and mental status changes.**
- If the particular solvent exposure is well characterized and specific laboratory tests are available, biological monitoring should be considered.
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- There are over 30,000 industrial solvents. This protocol is designed to survey for the most frequent health effects of solvents when taken as a broad group. These effects are skin disorders, and acute and chronic CNS effects. Some other less frequent effects of solvents involve the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems. Most solvents are **not** carcinogenic in humans; benzene being a notable exception.
- In the Coast Guard, exposure to solvents is primarily associated with industrial and maintenance operations (e.g., painting).
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-11

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |
| Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____ | | | |

Examination Protocol for Exposure to

# Tuberculosis

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| **Initial/Baseline** | ____<br>____ | CG-5447 History and report of OMSEP Examination<br>**SF 88 & 93** |
| All types, **no** history of prior reactive skin test | ____ | Mantoux tuberculin skin test (TST)<br>Enter results on SF 601 and PHS 731 |
| All types, **history of prior reactive skin test** | ____ | SF 600 entry |
| Follow-up on newly reactive TST | ____<br>____ | CG-5447 (update)<br>CXR (**only if TST is newly reactive**) |
| All types | ____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- **For personnel with a prior history of a reactive TST**, ensure the patient is questioned about the following symptoms of active TB: **fever, night sweats, weight loss, cough, and hemoptysis.** This questioning may be completed by a nurse or health services technician.
- See section 7-D of the Medical Manual for full information on the tuberculosis control program.
- Forward a copy of all test results to the unit OMSEP coordinator.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-12

| Date: | Unit: | OPFAC: | Unit POC: |
|---|---|---|---|
| Patient name: | | SSN: | Unit Phone: |
| Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____ | | | |

Examination Protocol for Exposure to

# Unspecified

| IF EXAM TYPE IS | ✓ | DO or COMPLETE THESE ITEMS |
|---|---|---|
| **Initial/Baseline** | ____<br>____ | CG-5447 History and Report of OMSEP Examination<br>**SF-88 & 93** |
| All types | ____ | CBC (complete blood count) |
| All types | ____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase) |
| **Periodic/Exit/Acute Exposure** | ____ | **CG 5447** (update) |
| All types | ____ | U/A (dipstick) |
| **Acute exposure** | ____ | **Acute Exposure Form** |
| All types | ____ | Physician's notification regarding examination results. (Final action.) |

**To the examining medical officer:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about his or her general medical and work history, including: **past and current exposure to chemical and physical hazards, smoking history and alcohol use, and a complete review of systems.**
- Ensure the patient is receives a complete physical examination of all systems, **with attention to any organ systems with a significant history or current systems**.
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- Individuals under going surveillance in this protocol have exposures to hazards which are not included in any of the other protocols.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

## CHAPTER 13

## QUALITY ASSURANCE


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## CHAPTER 13. QUALITY ASSURANCE

Section A - Quality Assurance Plan

1. Purpose. The Commandant and Chief, Office of Health and Safety are committed to providing the highest quality health care to Coast Guard beneficiaries. The Health Services Quality Assurance Program (QAP) described here establishes policy, prescribes procedures, and assigns responsibility for Quality Assurance (QA) activities at Coast Guard health services facilities. It is intended to function as an integral component in a Total Quality Management (TQM) system aimed at achieving patient satisfaction by using quantitative methods to continuously improve the health services program. It is essential that the QAP integrates into the Coast Guard's overall TQM concept to improve the health care delivery system at all organizational levels. The Office of Health and Safety, Maintenance and Logistics Commands, unit commanding officers, health care providers, and patients must cooperate to ensure successful implementation of the TQM concept in the health care arena.

2. Background. Health care QA includes monitoring and evaluating performance against generally accepted medical and dental standards to improve performance. For QA activities to be successful, health care providers and managers must directly involve themselves in the on-going process of monitoring, evaluating, and reviewing records, etc., to allow effective adjustments at the local level. For many years, Coast Guard health care facilities have conducted QA activities, usually as a normal outgrowth of conforming with this Manual's directives and the consequence of Coast Guard practitioners' good medical and dental practices. However, until 1988, no attempts were made to standardize QA activities among all Coast Guard health care facilities to ensure consistently high-quality performance. Formal QA mechanisms were lacking and documentation was sketchy. Since Maintenance and Logistics Commands were established in 1987 and the Quality Assurance Branch was reorganized in 1989 in the Office of Health and Safety, a concerted effort has been made to develop a Coast Guard-wide QA program designed to address quality-of-care issues at our facilities. The program has been tailored the program to Coast Guard medical and dental practices and incrementally phased it in over an extended time period. This dynamic program continues to evolve in an ever-changing health care environment. Directives will be amend as necessary.

3. Applicability and Scope. All Coast Guard health care facilities with medical or dental officers assigned shall have a QAP to organize efforts to achieve and document quality health care for eligible beneficiaries. The QAP described here contains the essential elements required at all Coast Guard facilities and assigns responsibilities for program initiatives. All active duty, reserve, and civilian health care providers treating patients at Coast Guard clinics must participate in on-going monitoring and evaluation processes designed to assess the quality and appropriateness of the services they provide.

4. QAP Objectives.

   a. Communicate important QA information to enable sound clinical and management decision-making at all organizational levels.

b. Review credentials; approve privileges.

c. Establish criteria to certify clinics and ensure facilities attain and sustain compliance with established standards.

d. Systematically monitor health services to identify opportunities to improve patient care, implement corrective actions when required.

e. Integrate, track, and analyze QA information to identify significant patterns that may require additional review or intervention.

f. Identify and justify resources required to maintain acceptable patient care standards.

g. Conduct safety and infection control surveillance.

h. Identify, assess, and decrease risk to patients and staff, thereby reducing liability exposure.

i. Identify educational and training requirements and assure satisfactory education and training standards are established and maintained.

j. Establish and maintain adequate systems to monitor and assess patient satisfaction; respond to patient and command concerns about access and quality of care.

5. Definitions.

a. Quality. The desired level of performance as measured against generally accepted health care standards.

b. Quality Health Care. According to the Joint Commission on Accreditation of Healthcare Organizations, quality is the prompt, well-documented, effective, efficient, and appropriate organization and delivery of care which maximizes the probability of positive outcomes and minimizes the probability of negative outcomes. Additionally, Coast Guard health care also must meet these criteria:

(1) Consistent with Coast Guard policies, guidance, and Medical Manual directives;

(2) Consonant with practices in the applicable professional community; and

(3) Perceived by beneficiaries as caring, competent, and effective.

c. Quality Assurance. Those functions which attempt to ensure the desired level of performance by systematically documenting, monitoring, evaluating, and, where necessary, adjusting health care activities. These functions' goal is to improve clinical performance and patient care by striving to meet established high standards.

d. Professional Oversight. Monitoring and evaluating services provided by Coast Guard health care personnel and non-Federal providers, including, among others, technical guidance and assistance, peer review, resource utilization review and QA site surveys

conducted by Maintenance and Logistics Commands to ensure compliance with the Coast Guard Health Care QAP.

e. Governing Body. The agency that has ultimate authority and responsibility for establishing policy, maintaining quality patient care, and providing organizational management and planning.

6. Organizational Responsibilities. See Figure 13-A-1.

a. Chief, Office of Health and Safety.

(1) Establish at all Coast Guard health care facilities a comprehensive QAP which meets industry standards such as those published by the Joint Commission on the Accreditation of Health Care Organizations or similar independent accrediting organizations (the MLC implements the QAP);

(2) Govern Coast Guard health care facilities, with delegated responsibilities to the Chief, Health Services Division at each facility.

(3) Establish and promulgate health care policy, including professional performance standards against which quality can be measured;

(4) Establish and promulgate productivity and staffing standards for the health services program;

(5) Conduct periodic Quality Assurance Meetings for Headquarters and MLC QA staffs to coordinate and implement program policy at all organizational levels;

(6) Review credentials and grant privileges for all Coast Guard medical and dental officers;

(7) Establish criteria for Coast Guard clinic certification and, based on MLC site surveys, certify those facilities meeting established standards;

(8) Develop and promulgate the Quality Assurance Implementation Guide; and

(9) Identify education and training requirements and assure satisfactory standards are established and maintained. Coordinate and fund continuing professional education for all health services personnel.

b. Maintenance and Logistics Commands.

(1) Ensure the Commandant's Health Care QA Program is executed at the field level;

(2) Periodically conduct QA site surveys of all health services facilities in their area in accordance with Section 13.F. provisions. Based on survey findings, recommend clinic certification status to Commandant (G-WK) in accordance with Section 13.G. provisions; pay customer assistance visits when necessary;

(3) Develop and maintain standard operating procedure manuals and/or health services support program guides necessary to provide operational guidance for clinic activities;

(4) Develop and maintain Quality Assurance Checklists for QA site surveys;

(5) Perform utilization review of clinic expenditures, staffing, equipment, supplies, and facilities; review and process all requests for non-Federal medical care from units in its jurisdiction; and

(6) Provide technical and professional advice regarding health services to units, as required.

c. Commanding Officers.

(1) Ensure the unit actively pursues health services QAP standards;

(2) Appoint in writing an individual to serve as Health Services Quality Assurance Coordinator in accordance with Paragraph 13.A.6.e.;

(3) Appoint health services staff members to serve on a Health Services Quality Assurance Focus Group in accordance with Paragraph 13.A.6.f.; and

(4) Send copies of QA Focus Group meeting minutes to cognizant MLC (K).

d. Chief, Health Services Division. Represents the Governing Body locally for Quality Assurance and related activities.

e. Health Services QA Coordinator.

(1) The Health Services QA Coordinator should be a senior health services staff member with these characteristics:

(a) demonstrates the ability and motivation to provide and ensure quality health care;

(b) knows the requirements of the Medical Manual, COMDTINST M6000.1 (series);

(c) communicates well both in writing and orally;

(d) well versed in delivering Coast Guard health care and supports the goals of health care quality assurance; and

(e) is an E-6 or above.

(2) The Health Care QA Coordinator fulfills these responsibilities:

(a) Directs Health Services QA Focus Group activities;

(b) Implements the health care QA program locally by identifying and coordinating resolution of health care QA problems;

(c) Develops and promulgates an annual QA calendar which sets the agenda for all QA activities at the unit, including among other activities QA Focus Group meetings and all monitoring and evaluation functions; and

(d) Other health care QA functions as necessary.

(3) The Chief, Health Services Division or Clinic Administrator may be appointed as the Health Services QA Coordinator.. However, this is not recommended in larger clinics since these two individuals are expected to provide necessary management expertise and clinical guidance in conducting the health care QA program and effecting any required program adjustments. The Health Services QA Coordinator's relationship to the Chief, Health Services Division is advisory.

f. Health Services QA Focus Group.

(1) The Health Services QA Focus Group shall consist of three to 15 members, depending on unit size, including both enlisted members and officers who broadly represent the health care services provided at that unit.

(2) Members will include at least a medical or dental officer, a clinic supervisor, and department representatives, e.g., pharmacy, physical therapy, x-ray, laboratory, etc. If desired, the Health Care QA Focus Group at small units may operate as a "Committee of the Whole" of all staff members.

(3) The Health Services QA Focus Group advises the Chief, Health Services Division about the quality of the facility's health care and performs these functions:

(a) Identifies and resolves problems which affect the quality of health care delivery at the facility (The Chief Health Services Division may delegate investigating and resolving a particular QA problem to the staff member responsible for the clinical area where the problem has been identified, e.g., laboratory, patient reception, etc.).

(b) Ensures all required health services committee meetings are held according to the provisions of the Coast Guard Medical Manual, MLC standard operating procedures and operational guides, and local instructions, including, among others, the Pharmacy and Therapeutics Committee (see Paragraph 10.A.8.) and Patient Advisory Committee (see Paragraph 13-N-2)

(c) Uses existing USCG standards, MLC QA checklists, and monitoring and evaluation exercises to monitor and evaluate the quality of services delivered both in-house and by contract providers.

(d) Performs systematic, documented reviews of health records for compliance and adherence to Medical Manual standards and MLC standard operating procedures, health and safety support program guides, and QA checklists.

(e) Solicits and monitors patient perceptions and satisfaction by surveys and questionnaires.

(f) The Health Care QA Focus Group shall meet at least quarterly and more often as local needs dictate. The MTF will maintain these meetings' original minutes; forwarding copies of the minutes along with monitoring and evaluation reports through the chain of command for the cognizant MLC (K) and Commandant (G-WKH) to review.

7. Confidentiality Statement. All documents created under authority of this instruction are health services quality assurance records and part of the Coast Guard's QAP. They are confidential and privileged under 14 USC 645 provisions. Releasing health services QA documents is expressly prohibited except in limited circumstances listed in 14 USC 645.

8. QAP Review and Evaluation. The Chief, Office of Health and Safety will annually review and evaluate the QAP. The review will reappraise the QA Plan and incorporate comments from the Commanders of the Maintenance and Logistics Commands on implementation activities at field units during the preceding year.

   a. By 30 November annually MLC Commanders shall provide to Commandant (G-WK)a written QA Review and Evaluation Report addressing these topics during the previous fiscal year:

      (1) Summary of clinical certifications and accreditations;

      (2) Summary of significant clinical problems identified;

      (3) Summary of peer review activities;

      (4) Recommended QAP modifications; and

      (5) MLC QA Plan for upcoming calendar year.

   b. By 31 January annually the Chief, Office of Health and Safety will issue to all units a written QA report addressing these topics:

      (1) Summary of clinical certifications and accreditations during past fiscal year;

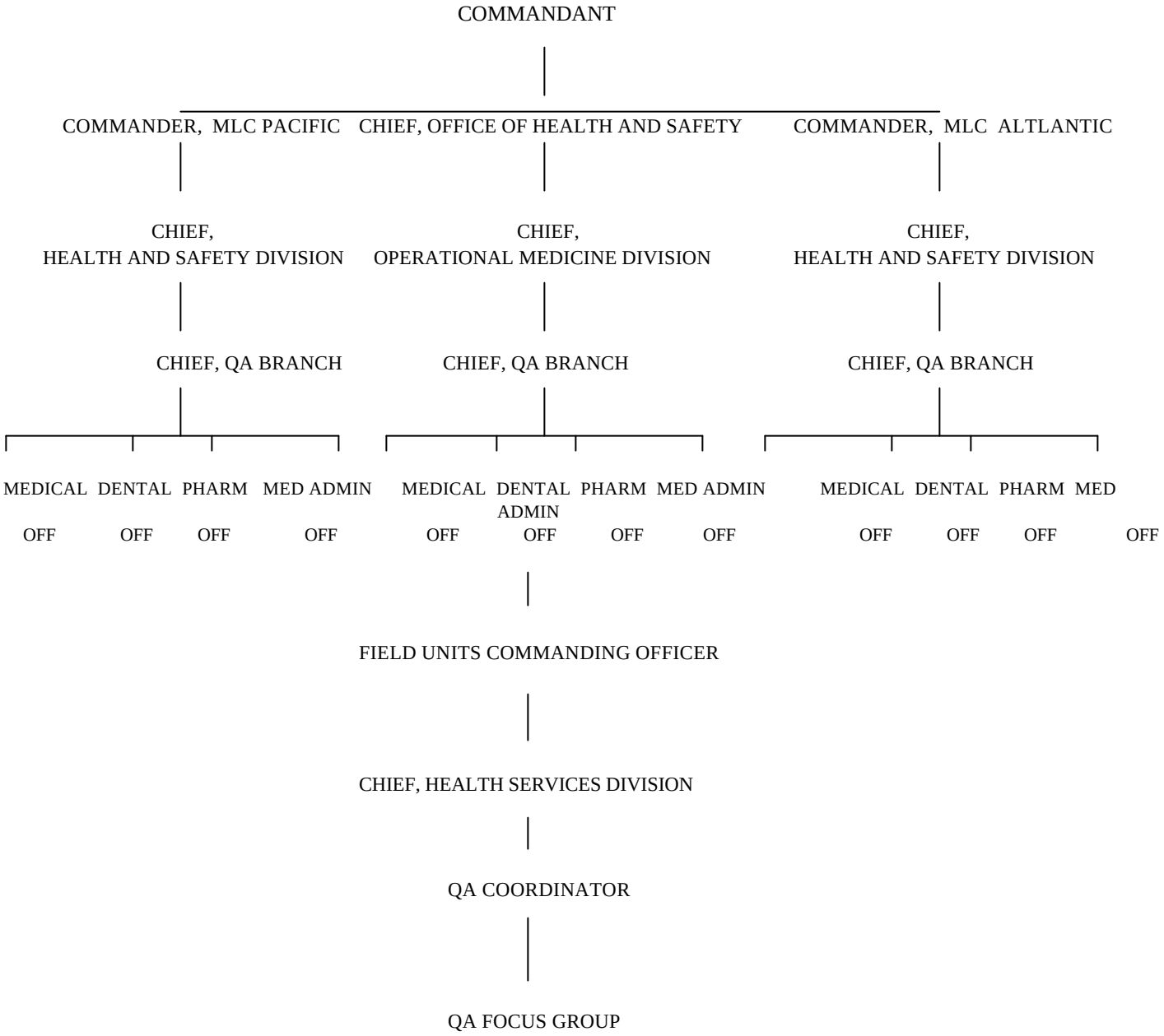
      (2) Summary of significant clinical problems identified during past year;

      (3) QAP modifications for the current fiscal year; and

      (4) QA Plan for the current fiscal year.

FIGURE 13-A-1

ORGANIZATIONAL CHART FOR QUALITY ASSURANCE PROGRAM



Section B – Credentials Maintenance and Review

1. Background. Commandant (G-WK) is responsible for ensuring health care providers in Coast Guard facilities are competent and capable. Verifying medical or dental officer qualifications is essential to assure providers are prepared for the scope of practice for which they are employed. To maintain quality health care the credentials review process must be effective. Primary sources must certify as valid certain credentials, including qualifying professional degree(s), license(s), graduate training, and references before a provider may practice independently in Coast Guard health care facilities. All candidates for USCG employment, USCG civil service employees, assigned USPHS commissioned corps officers, and contract providers who provide direct patient care in Coast Guard health care facilities will comply with this chapter's provisions as applicable. The credentials shall be reviewed for each medical or dental officer appointed to a position providing patient care. Clinical responsibilities will be assigned based on this review.

2. Definitions.

   a. Contract Provider. An individual physician, dentist, physician assistant or nurse practitioner, other than uniformed services personnel, who provides care in a Coast Guard health services facility under a contractual agreement with the Coast Guard.

   b. Credentials. Documents constituting evidence of education, clinical training, licensure, experience, clinical competence and ethical behavior.

   c. Credentials Maintenance. Filing, updating, modifying or completing files or documents about practitioner credentials.

   d. Credentials Review. The process of checking a practitioner's verified credentials and other supporting documents to evaluate potential assignments, assign or rescind clinical privileges, or take administrative or personnel actions.

   e. Dental Officer. A U.S. Public Health Service (USPHS) commissioned officer assigned to the Coast Guard, who is a graduate of an accredited school of dentistry and holds a valid, current state license to practice dentistry.

   f. Intake Credentials Verification. The process of verifying a practitioner's license, education, training, and competence before initial assignment or employment.

   g. License (Current, Valid). A certificate issued by one of the 50 states, District of Columbia or U.S. Territories (Guam, Puerto Rico, Virgin Islands) that permits a person to practice medicine, dentistry, or other allied health profession.

   h. Medical Officer. A commissioned USCG or USPHS officer assigned to the Coast Guard who has graduated from an accredited educational institution and is currently licensed as a physician or nurse practitioner; or a physician assistant holding valid certification from the National Association on Certification of Physician Assistants.

i. Primary Source Verification. Verification of a credential with an individual or institution possessing direct knowledge of the validity or authenticity of the particular credential.

j. Provider. A person granted individual clinical privileges to diagnose and treat diseases and conditions, including physicians, dentists, physician assistants, nurse practitioners, podiatrists, optometrists, and clinical psychologists.

3. Pre-selection Credentials Review.

a. Commandant (G-WKH) PHS liaison officer in cooperation with the PHS Division of Commissioned Personnel (DCP) shall perform a pre-employment review and verify minimum standards before appointing Commissioned personnel. The DCP also screens individuals and certain credentials as part of the commissioning process. Coast Guard procedures are designed to complement the DCP's; the Coast Guard may alter its policies as DCP modifies them.

b. The cognizant MLC or local command by direction shall perform a pre-employment review of and verify Civil Service employees, contractors providing care in Coast Guard health care facilities, and students.

c. To review and verify student credentials, obtain a letter from the school stating the student is in good academic standing. Document malpractice coverage arrangements through an appropriate affiliation agreement. (Student Extern Programs, COMDTINST 6400.1 (series).

4. Practitioner Credentials File (PCF). Commandant (G-WKH-2) shall initiate and maintain PCFs for all Civil Service and Uniformed Service licensed practitioners for the entire length of their employment or service. Persons unable or unwilling to provide required information may be disqualified for employment or accession. These files must contain this information:

a. A current curriculum vitae accounting for all time since the qualifying degree was received.

b. Copies of qualifying educational degrees (diploma, certificate) needed to perform clinical duties with the documents' primary source verification; see Section 13-B-6.

c. Copies of required postgraduate training certificates for the area of work; for example, internship, residency, fellowship, nurse practitioner or physician assistant training, and primary source verification of these documents' authenticity.

d. Copies of state licenses for all states in which the practitioner is licensed (active or inactive), current renewal certificates, and Educational Commission for Foreign Medical Graduates (ECFMG) certification if the practitioner graduated from a medical school not in the Continental U. S., Hawaii, Alaska, or from a medical school not accredited by the American Association Liaison Committee on Medical Education in Puerto Rico. The practitioner must attach a statement of explanation for lapsed state licenses or those subject to disciplinary action. The primary source must verify all licenses or renewal certificates.

e. Copies of specialty board and fellowship certificates with primary source verification of these documents.

f. Proof of current (within one year) competence, i.e., reference letters and a description of recent clinical privileges held (practitioner's supervisor must note concurrence with and approval of privilege performance).

g. A statement explaining any involvement in malpractice cases and claims, including a brief review of the facts about the practitioner's involvement.

h. A statement about any hospitals', licensing boards', or other agencies' disciplinary action.

i. A copy of current certification in Cardiopulmonary Resuscitation from the American Heart Association or American Red Cross.

j. Copies of all current and prior Drug Enforcement Agency (DEA) registration, as appropriate.

k. National Practitioner Data Bank (NPDB) query.

5. Documentation.

a. Documents will be placed into a U. S. Coast Guard Training Record (CG-5285) folder. Commandant (G-WKH-2) will maintain files in a locked cabinet. PCFs and their contents are Class III (maximum security) records and protected from disclosure under the Privacy Act. Do not release documents in the PCF to any other individual or entity unless the provider has given express written permission.

b. Place documents in the six-section folder are as follows:

(1) Section One: Coast Guard clinical privilege documents.

(2) Section Two: Reference letters.

(3) Section Three: Adverse actions, malpractice documents, proof of malpractice coverage, statements about adverse information or malpractice claims.

(4) Section Four: Copies of CPR certification cards, continuing education certificates (CME), other military or civilian courses other than initial qualifying degree.

(5) Section Five: JCAHO-accredited hospital letter on admitting privileges, privileges granted by other or previous institutions, curriculum vitae.

(6) Section Six: Copies of license(s), diploma(s) or degree certificates, ECFMG certificate (if applicable), Internship certificate, Residency Certificate, Fellowship documents, and Board Certification. Primary sources must verify all documents in Section Six.

c. See Figure 13-B-1 for a list of required documents by provider category.

6. Verification.

   a. To verify education, training, licensure or registration, certification, ECFMG and board certification, obtain either an original letter from the educational institution or certifying body attesting to successful completion of specialty training, or verify by telephone call between the Coast Guard representative and educational institution or specialty board. Record telephone verification on the document itself and on official letterhead signed and dated by the person making the call. Place all verification documents with their source documents in PCF Section Six.

   b. Commandant (G-WKH) will verify uniformed services persons before appointment.

   c. Before selection of Civil Service and contract providers, there will be a verification of education, training, licensure, experience, certification or registration, and current competence.

   d. To verify experience and current competence requires at least two recommendation letters from appropriate sources as listed below. Commandant (G-WKH-2) or the appropriate MLC shall receive direct letters from the person providing the reference. Verify descriptions of recent clinical privileges as above.

      (1) A letter either from the hospital chief of staff, clinic administrator, professional head, or department head if the individual has professional or clinical privileges or is associated with a hospital or clinic; or

      (2) A letter from the director or a faculty member of the individual's training program if he or she has been in a training program in the previous two years; or

      (3) A letter from a practitioner in the appointee's discipline who is in a position to evaluate the appointee's peer and a professional association or society association (mandatory if the appointee is self-employed).

7. Contract Provider Credentials Review.

   a. All contract providers who perform any part of their work in a Coast Guard health care facility will submit credentials documents to the appropriate MLC per Paragraph 13.B.6. above and MLC SOPs.

   b. The contracting officer will verify documents.

   c. At the contracting officer's request, MLC (K) will perform a technical review of the providers' credentials.

8. Reverification.

   a. These credentials are renewable and will be primary source on renewal: License, PA certification, Board certification, and contract providers' malpractice coverage. Reverify contract providers' credentials at contract renewal.

   b. Reverify these credentials by original letter or telephone contact. The person making the call will record telephone contact on the document and by a separate, signed memorandum.

9. National Practitioner Data Bank.

   a. Commandant (G-WK) possesses sole authority to report to the National Practitioner Data Bank. Commandant (G-WKH-2) is designated as the appropriate entity for National Practitioner Data Bank queries. Coordinate all queries for patient care providers through this branch.

   b. A reply from the NPDB is not required before the practitioner begins providing services. However, any provider whose credential verification is not fully completed will be considered to have a conditional appointment until all credentials are verified as required.

FIGURE 13-B-1

REQUIRED CREDENTIALS BY PROVIDER CATEGORY

| | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Physicians | X | X | X | X | X | X | X | X | X | X | X |
| General Practice Physicians* | X | X | X | X | | X | X | X | X | X | X |
| Dentists | X | X | X | X | | | X | X | X | X | X |
| Physician Assistants | X | X | X | X | | | X | X | X | | X |
| Nurse Practitioners | X | X | X | X | | | X | X | X | | X |
| Optometrists | X | X | | X | | | X | X | X | | X |
| Physical Therapists | X | X | X | X | | | X | X | X | | X |
| Dental Hygienists | X | X | | X | | | X | X | X | | X |

A. Current curriculum vitae

B. Copies of qualifying educational degrees

C. Copies of required postgraduate training certificates for the area of work; for example, internship, residency, fellowship, nurse practitioner or physician assistant schooling

D. Copies of state license(s)

E. Copies of specialty board certification and fellowship certificates

F. Proof of current competence, recent clinical privileges

G. Proof of malpractice coverage (contractors only)

H. Statement explaining malpractice claims, other adverse actions

I. CPR certification

J. DEA certification

K. NPDB query

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* General Practitioners. Physicians who have completed one year of Graduate Medical Education (Internship) and have not completed a full residency in a medical specialty.

Section C – Clinical Privileges

1. Purpose. Granting individual clinical privileges to independent practitioners providing services in health care organizations is an essential component of quality assurance. Clinical privilege granting and rescinding activities define the organization's scope of care and services available to patients. The privileging process is directed solely and specifically at providing quality patient care; it is not a disciplinary or personnel management system. However, privileging actions may accompany administrative or judicial actions or engender them. Granting and rescinding clinical privileges is highly confidential, and must be conducted according to strict rules to prevent improper or prejudiced actions. This section establishes processes and procedures to grant and rescind clinical privileges. These provisions fall outside the scope of Administrative Investigations Manual, COMDTINST M5830.1 (series).

2. Background. Commandant (G-WK) is responsible for planning, developing, and administering a comprehensive, high-quality health care program which must ensure the persons providing care have appropriate, verified licenses, education, and training. Coast Guard health care practitioners must adhere to commonly accepted standards for treatment and therapeutic modalities. In the Coast Guard, adherence to accepted standards is achieved by rigorous quality assurance (QA) and providers' peer reviews.

3. Definitions.

   a. Abeyance. Temporarily assigning a provider to non-clinical duties while an internal (focused) or external review or investigation is conducted.

   b. Clinical Privileges. Type of practice activities authorized to be performed in the facility, within defined limits, based on the providers' education, professional license as appropriate, experience, current competence, ability, judgment, and health status.

   c. External Review. Administrative, non-judicial, or criminal investigations initiated by entities other than the Coast Guard health services program.

   d. Focused Review. An internal administrative mechanism to evaluate information about clinical care or practice. Coast Guard health services officers conduct focused reviews as part of the quality assurance program.

   e. Full Staff Privileges. Unrestricted privileges as defined by "Clinical Privileges" above, reevaluated and renewed every two years.

   f. Peer Review. Review by an individual (or individuals) who possesses relevant professional knowledge or experience, usually in the same discipline as the individual under review.

   g. Privileging. The process through which providers are given the authority and responsibility to make independent decisions to diagnose illnesses and/or initiate, alter, or terminate a regimen of medical or dental care.

h. Professional Review Committee. A committee appointed by Commandant (G-WK), composed of the Deputy Director of Health and Safety (G-WKd) and the Chiefs of the Operational Medicine Division (G-WKH), Operational and Clinical Medicine (G-WKH-1), and Quality Assurance Branch (G-WKH-2) or their designees. At least two physicians and one dentist shall be members.

i. Provider. For this chapter, an individual granted clinical privileges to independently diagnose and treat diseases and conditions. Physicians, dentists, physician assistants, nurse practitioners, podiatrists, optometrists, and clinical psychologists are provider disciplines within the Coast Guard health services program.

j. Provisional Clinical Privileges. Initial privileges, generally effective 365 days from issue date, Commandant (G-WK) grants providers when they begin practice in the Coast Guard health services program or earn a new or changed clinical privilege. New Coast Guard providers are eligible for full staff privileges after successfully completing one year of provisional privileges.

k. Expiration of Credentials. It is ultimately the responsibility of the provider to ensure that all credentials required for clinical privileges are renewed prior to their expiration dates. If any credential required for clinical privileges is allowed to expire, the provider may have clinical privileges suspended or terminated. This will remove the provider from direct patient care and may also render the provider ineligible to receive any special pay for clinical duties while the provider is in this status.

4. Applicability and Scope. All military and salaried civilian, and contract civilian Coast Guard health care providers shall have clinical privileges assigned. Health services personnel (other than providers) who function under a standard job or position description or standard protocol, policies, and procedures, or who must consult with another provider before or during medical or dental treatment will not receive clinical privileges.

5. Clinical Privileges.

a. General.

(1) Commandant (G-WK) will grant clinical privileges based on education, specific training, experience, license or certification status, and current competence. He or she shall consider facility, support staff, equipment capability, etc. limitations which may prevent a provider from conducting certain activities. Commandant (G-WK) shall assign or require providers to perform professional duties *only* if their education, training, and experience qualifies them to perform such duties. Commandant (G-WK) also shall consider the provider's health status and ability to treat coworkers and patients with dignity and respect (i.e., the presence or absence of good interpersonal skills and "bedside manner") when granting privileges.

(2) At defined intervals the provider shall use form CG-5575, Request for Clinical Privileges, to initiate a request for clinical privileges. Chief, Health Services Division (HSD) shall recommend whether to approve or disapprove clinical privileges and submit the recommendation to Commandant (G-WK) through MLC (K). The Professional Review Committee shall review the privileges requested and recommend a response to Commandant (G-WK). The actions of the Professional Review Committee actions will not be considered final until Commandant (G-WK) approves them.

(3) Absence of clinical privileges must not delay treatment in an emergency—a situation in which failure to provide treatment or hospitalization would result in undue suffering or endanger life or limb. In such cases the providers are expected to do everything in their power to save the patient's life or treat the condition.

(4) On transfer, the gaining Chief, Health Services Division shall evaluate the provider's clinical privileges to determine whether to continue all previously granted privileges, or whether the facility, patient population, or other factors require adjusting privileges. If a change is indicated, the provider shall submit a revised request for privileges form as delineated below for the Professional Review Committee's review and approval.

(5) (5) When providers in the Coast Guard are assigned TAD, Commandant (G-WKH-2) shall transmit a copy of the provider's clinical privileges to the host SMO/SDO who will evaluate the privileges and advise the provider which if any privileges will be restricted at that site. When assigned TAD to a clinic that is accredited by JCAHO, AAAHC or other external accrediting agencies, Commandant (G-WKH-2) will also transmit a credentials transfer brief (CTB) to the host command.

(6) (6) When providers from DoD are assigned TAD to Coast Guard clinics, their parent command shall transmit a copy of their clinical privileges as well as a CTB to the host command prior to their arrival. The SMO/SDO will determine if any of the privileges will be restricted.

b. Procedures.

(1) Commandant (G-WKH) will inform new Coast Guard providers they must request provisional clinical privileges in writing before accession to active duty or formal employment. New Coast Guard providers shall send written requests for provisional clinical privileges to Commandant (G-WKH) by facsimile or mail at least 45 days before accession. Privilege requests for persons already employed by or assigned to the Coast Guard shall be forwarded by mail for facsimile (FAX) to Commandant (G-WKH) through the cognizant MLC (k) for Professional Review Committee action.

(2) Providers do not require Professional Review Committee approval before reporting for duty. Until credentials review is completed and privileges are granted, new providers may deliver care under supervision, i.e., peers shall oversee the provider's

work by reviewing monthly a random sample of at least 5% of the provider's charts. Any problems detected during this review will be documented in writing and copies given to the provider. Providers who fail to have the deficiencies corrected in 60 days may have their privileges restricted.

(3) Provisional clinical privileges are effective for one year. When granting provisional privileges, the risks associated with the activities for which a new provider seeks privileges and the frequency with which he or she performs the procedures shall be considered.

(4) Privilege request documents, Professional Review Committee actions, and any other documents relating to the granting, maintaining, reviewing or rescinding clinical privileges will be maintained in the individual provider's credentials file.

(5) The Chief, HSD shall evaluate the provider's provisional privileges after one year. Providers may apply for full staff privileges after one year of successful performance.

(6) The Professional Review Committee will evaluate full staff privileges every two years. Providers will submit written privilege requests to Commandant (G-WKH) through MLC(kqa) 90 days before privileges are due for renewal.

c. Routine Operations of the Professional Review Committee (PRC)

(1) The Quality Assurance (QA) Division, Commandant (G-WKH-2) will have the responsibility of monitoring and administering the granting of clinical privileges for all health care workers (HCW'S) in the Health and Safety Program that require the formal granting of clinical privileges in order to perform their duties.

(a) Commandant (G-WKH-2) will maintain a Practitioner Credentials File (PCF) for HCW's in the CG Health and Safety Program that will be used for granting clinical privileges.

(b) The local QA Coordinator at each field unit will have the responsibility of maintaining a list of the expiration dates of all significant documents required to grant clinical privileges as stipulated in Section 13-B and will notify the HCW when these documents are within 90 days of expiration.

(c) It is ultimately the responsibility of the HCW to take appropriate actions to prevent these documents from expiring and to ensure that current documents are entered in the PCF.

(d) Commandant (G-WKH-2) will also monitor the expiration dates on these documents and will coordinate through the local QA coordinators.

(e) The Professional Review Committee (PRC) will make recommendations to Commandant (G-WK) on the granting of clinical privileges.

(f) The PRC will routinely review requests for clinical privileges for HCWs upon reporting to new CG duty stations and every 2 calendar years.

(g) The PRC can also be convened by Commandant (G-WK) to review PCF's for situations other than the routine review of clinical privileges. This is described further in section 13-C-5-d.

(2) Commandant (G-WKH-2) will conduct a preliminary review of the requests for clinical privileges as well the entire PCF'S selected to be presented before the PRC.

(3) Commandant (G-WKH-2) will forward requests for clinical privileges as well as the PCF'S to the cognizant Program Coordinators who will evaluate the PCF'S and decide if they should be presented before the PRC or if further information or action is required before being submitted before the PRC.

(4) After Commandant (G-WK-2) and Program Coordinators have decided which records will be presented to the PRC, Commandant (G-WKH-2) will prepare an agenda and will schedule a PRC meeting.

(5) The PRC will included:

(a) Commandant (G-WKd) as President of the PRC

(b) At least 2 physicians

(c) At least 1 dentist

(d) At least 1 PA or NP

(e) 1 member of Commandant(G-WKH-2), non-voting, to act as recorder

(f) Other members of Commandant (G-WKH-2)

(6) The PRC will evaluate each PCF and can recommend any of the following actions for each case:

(a) Grant all requested privileges.

(b) Revoke all current privileges or certain specific privileges.

(c) Restrict all current privileges or certain specific privileges.

(d) Suspend all current privileges or certain specific privileges.

(e) Hold in abeyance all current privileges or certain specific privileges.

(f) Monitor or supervise of performance of clinical privileges.

(g) Request that any decision regarding privileges be deferred until more information is submitted to the PRC.

(h) Maintain or modify current privileges while more information is forthcoming or an investigation is being conducted.

(i) Request a document focused review or other type of internal investigation.

(j) Request an external review or investigation.

(k) Other actions as dictated by circumstances.

(7) In accordance with the terminology adopted by the National Practitioner Data Bank (NPDB) and Federal Credentialing Program (FCP), an adverse privileging action is considered to be any action that revokes, restricts or suspends current privileges for over 30 days.

(8) The PRC will vote on each case but the decision to approve or reject a recommendation for a privileging action will be made by WKd..

(9) The PRC will forward its recommendations for privileging actions in the minutes of the meeting to Commandant (G-WK) via: Commandant (G-WKH-2), Commandant(G-WKH), and Commandant (G-WKH), and Commandant (G-WKd)

(a) Commandant (G-WK) will prepare the minutes for each meeting of the PRC.

(b) The minutes will specific the privileging action recommended.

(c) In the case of a recommendation by the PRC for an adverse privileging action or any privileging action less than granting full privileges requested, the minutes will specify the reasons or justification for that recommendation.

(10) After Commandant (G-WK) receives the minutes, Commandant (G-WK) will make a decision on how to act on the recommendations of the PRC.

(a) In cases where the PRC has recommended the granting of full privileges and Commandant (G-WKd) concurs, the request for Clinical Privileges will be submitted to Commandant (G-WK) for final approval.

(b) In cases where the PRC has recommended an adverse privileging action or a status less than the granting of all clinical privileges requested and Command (G-WK) may forward the case to General Legal Counsel, Commandant (G-LGL) for a legal opinion prior to taking action.

(11) In cases that have been forward to Commandant (G-LGL) for a legal opinion regarding the intended privileging action, Commandant (G-WK) will have 3 working

days to make the final decision on how to act after receiving the results of the legal opinion.

(a) Commandant (G-WK) will attempt to contact the HCW by telephone and inform about the action.

(b) Commandant (G-WK) will forward a letter to the HCW by mail.

(c) Commandant (G-WK) will inform the relevant MLC(k) or MLC(m) by letter.

(d) MLC will notify the local command and the Chief, Health Services Division,

(12) In cases where Commandant (G-WK) requests a document or focused review or investigation prior to acting on the recommendations of the PRC, MLC will have the responsibility of organizing and funding this activity and coordinating with the local command.

(a) The officer or team conducting the inquiry will be convened within 10 working days after MLC has received written notification from Commandant (G-WK)

(b) Within 5 working days after MLC has received written notification from Commandant (G-WK), the local Commanding Officer and the Chief, Health Services Division will be notified of the identity of the officer or team conducting the inquiry.

(c) The inquiry will be completed within 3 working days after it has been initiated.

(d) Before departing, the officer or team will brief the local Commanding Officer and the Chief, Health Services Division on the findings and recommendations.

(e) When the review or investigation has been completed, the officer or team conducting the inquiry will forward a written report of their findings and recommendations to MLC within 10 working days.

(f) MLC will forward the results to Commandant (G-WK) within 5 working days After receiving it.

(13) After receiving written notification from Commandant (G-WK) of the enactment of an adverse privileging action that does not grant full privileges, if the HCW has 30 calendar days to contact Commandant (G-WK) in writing to request a hearing

(14) After receiving written notification from Commandant ( G-WK) of the enactment of an adverse privileging action or a privileging action that does not grant full privileges, if the HCW does not request a hearing within 30 calendar days, it will be presumed that the HCW accepts and will comply with the privileging action.

Commandant (G-WK) will make the decision to notify the NPDB in the case of an adverse privileging action.

(a) The Coast Guard Health and Safety Program is considered a health care entity under the Health Care Quality Improvement Act of 1987.

1 Health care entities are requires to report any adverse privileging action that is enacted for over 30 calendar days for all physicians and dentists.

2 Health care entities are not required to report adverse privileging actions for other HCW'S

(b) Commander (G-WK) will make the final decision to report adverse privileging actions

(c) Commandant (G-WKH-2) will submit the report to the NPBD when directed by Commandant (G-WK) in accordance with current NPDB

d. Non-Routine Privileging Actions.

(1) The objective of a non -routine privileging action is to affect a change in clinical privileging that is motivated by an urgent set of circumstances that precludes waiting for the routinely schedule evaluation for clinical privileges by the PRC.

(2) In these cases, the local command will normally initiate a request for modification or termination of clinical privileges based on events at the local field unit level.

(a) The request will be in the form of a letter from the local command MLC(k).

(3) The letter must describe in detail the exact circumstances leading up to the decision to request a modification or termination of clinical privileges.

(4) The letter must identify the individuals who initiated the complaint or action and every member of the staff and chain of command who had any involvement in the case.

(a) In extreme cases, the local command may elect to communicate immediately with MLC(k) by telephone. However this must be followed by the issuance of a letter

(b) Local commanding officers may have questions or concerns about providers and under what circumstances requests for restrictive actions should be made.

(5) The local command should use the cognizant MLC(k) as the POC for these queries.

(6) Requests for information guidance can be made via telephone, electronic or written correspondence.

(7) MLC(k) will evaluate the request from the local command and will have up to 5 working days to determine what action will be taken including:

(a) No action.

(b) Request more information from the local command.

(c) Immediate action such as placing the HCW in abeyance.

1 Normally Commandant (G-WK) will make the decision to hold the privileges of the HCW in abeyance.

2 Incases where circumstances are extreme MLC(k) may temporarily hold the privileges in abeyance and then contact Commandant (G-WK) as soon as possible.

(d) Convening a document or focused review.

(e) Submitting the case for disposition to Commandant (G-WK).

(8) If MLC (K) determines that a document or focused review is indicated, an officer or team will be on site within 10 working days if the decision.

(a) The HCW will notified of the decision as soon as possible by telephone and this will be followed by a letter from MLC (k) to the HCW describing the circumstances that led to this action.

(b) The local Commanding Officer and Chief, Health Service Division will be appraised of the identity of the officer or team that will be convened for the document or focused review within 5 working days after the decision to convene has been made.

(c) The review will be completed within 3 working days after it has been initiated.

(d) The officer or team will brief the local a Commanding Officer as well as the Chief, Health Services Division on the findings and recommendations.

(e) The officer or team will forward a written report on the findings and recommendations to MLC(k) within 10 working days after the review has been concluded.

(9) MLC(k) will review the findings and recommendations of the document or focused review and will determine what action to take within 5 working days including:

(a) No action.

(b) Request more information from the local command.

(c) Forward the written report from the document or focused review to Commandant (G-WK) for disposition with recommendations from MLC(k)

(10) After receiving the written report if the document or focused review and the recommendations from MLC(k), Commandant (G-WK) will decide what action to take within 5 working days including:

(a) No action.

(b) Request for more information.

(c) Forward the report from the document or focused review with recommendations from the MLC(k) to the PRC and convene an impromptu meeting with instructions to make recommendations to Commandant (G-WK) on the issue of privileging for this particular case.

1 The PRC will convene within 5 working days.

2 The PRC will vote on the case but the decision to enact a privileging action will made by WKd.

3 The PRC will forward its recommendations to Commandant (G-WK) within 3 working days.

(d) Summary adverse privileging action or grant less than full privileges

(11) In the event that Commandant (G-WK) decides to enact an adverse privileging action or not grant full privileges either as a summary action or on the basis of recommendations from the PRC, the following actions will be taken by Commandant(G-WK):

(a) Commandant (G-WK) will attempt to contact the HCW by telephone to inform.

(b) Commandant (G-WK) will forward a letter describing the privileging action and justification to the HCW.

(c) Commandant (G-WK) will forward a letter to MLC informing of the privileging action.

(d) MLC will forward the letter to the local command and Chief, Health Services Division.

(12) After receiving written notification from Commandant (G-WK) of the enactment of an adverse privileging action or a privileging action that does not grant full privileges, the HCW has 30 calendar days to contact Commandant (G-WK) in writing to request a hearing.

(13) After receiving written notification from Commandant (G-WK) of the enactment of an adverse privileging action or a privileging action that does not grant full privileges, if the HCW does not request a hearing within 30 calendar days, it will be presumed that the HCW accepts and will comply with the privileging action.

(14) Commandant (G-WK) will make the decision to notify the NPDB in the case of an adverse privileging action.

(a) The Coast Guard Health and Safety Program is considered a health care entity under the Health Care Quality Improvement Act of 1986.

1 Health care entities are required to report any adverse privileging action that is enacted for over 30 calendar days for all physicians and dentists.

2 Health care entities are not required to report adverse privileging actions for other HCW'S.

(b) Commandant (G-WK) will submit make the final decision to report adverse privileging actions.

(c) Commandant (G-WKH-2) will submit the report to the NPDB when directed by Commandant (G-WK) in accordance with current NPDB protocols.

e. Hearing Process

(1) After receiving written notification from Commandant (G-WK) of the enactment of an adverse privileging action or a privileging action that does not grant full privileges, the HCW has 30 calendar days to contact Commandant (G-WK) in writing to request a hearing.

(2) Commandant (G-WK) has 10 working days to convene a hearing committee after receiving request from the HCW for a hearing.

(a) Commandant (G-WK) will notify MLC that a hearing has been requested.

(b) Normally hearings will be schedule at Commandant (G-WK) unless otherwise specified.

(3) A hearing committee will consist of at least three Coast Guard Public Health Service (CG/PHS) officers with the rank of Lieutenant Commander or above and a representative Commandant (G-LGL) to act as legal advisor. At least two of the CGPHS officers on the hearing committee will have board specialties the same as the provider requesting the hearing. Each (CGPHS) officer will have one vote.

(a) The HCW will bear all expenses of transporting witnesses or legal advisors.

(b) The HCW has the right to:

(c) Have an attorney or legal advisor present who can provide legal advice to the HCW. The legal advisor will not participate directly in the proceedings.

(d) To record of the proceedings.

(e) To call and cross-examine witnesses.

(f) To present relevant written evidence.

(g) To submit a written statement at the conclusion of the hearing.

(4) The hearing committee will convey its findings in a written report within 3 working days after the conclusion of the hearing to Commandant (G-WK).

(5) Commandant (G-WK) will have 3 working days to act on the findings of the hearing.

(a) Commandant (G-WK) will attempt to contact the HCW by telephone and inform about the results of the hearing and the action to be taken

(b) Commandant (G-WK) will forward a letter to the HCW by mail.

(c) Commandant (G-WK) will inform the relevant MLC(k) or MLC(m) by letter.

(d) MLC will notify the local command and Chief, Health Services Division.

Section D - Quality Assurance Checklists.

1. Background. The MLC Health and Safety Divisions develop and maintain Quality Assurance Checklists, which detail in question-and-answer format the essential criteria against which to assess the quality of health services. These criteria are derived from primarily from the Coast Guard Medical Manual and MLC Standard Operating Procedures and Health and Safety Support Program Guide. MLC commanders will make every effort to ensure uniformity among MLC Checklists to the extent permitted by regional command policies.

2. Usage. QA Checklists will be used primarily to assess compliance with quality assurance standards, which may focus on structure, process, or outcome measures of quality care. Their design will allow clinics and sick bays to self-assess performance by answering the series of questions the checklist poses. Compliance with checklist standards will be scored on a percentage basis. Resulting scores will determine each clinic's certification status.

   a. Key Elements. Because of their critical nature and importance governing quality of care, certain clinic checklist items will be designated "key elements." Complying with key elements is essential for clinic success. A high degree of conformity with key elements will be required to certify a clinic.

   b. Elements. “Elements” are certain other checklist items of a less critical (but still important) nature than key elements. Required compliance for clinic certification is lower for elements than for key elements.

   c. Information Items. The checklist also contains a number of questions included for informational purposes only and not scored for certification.

3. Amendments. The MLC is responsible for Checklist amendments and may amend its Checklist at any time based on policy changes, program requirements, or suggestions and recommendations from clinic personnel or Commandant (G-WK). QA checklists are "living documents" and expected to change regularly to reflect changes in clinic operations and policy. Therefore, clinics will be given updated checklist copies long before QA site surveys.

Section E – Quality Assurance Implementation Guide (QAIG)

1. Background. The QAIG is a series of exercises designed to assist commands to meet Health Services QA Program requirements. Serving as a guideline, the QAIG minimizes the QA program administrative requirements by providing direction and, in many cases, templates for addressing critical QA issues. The exercises often eliminate the need for each clinic to develop its own policies and procedures by providing generic frameworks clinics can adapt to local conditions. In some cases, clinics may be required to submit evidence of completing an exercise to the MLC Health and Safety Division for data evaluation purposes.

2. Responsibilities.

   a. COMMANDANT (G-WKH) develops as many as 10 exercises per year on critical QA issues for inclusion in the QAIG. The MLCs distribute the exercises.

   b. COMMANDER, MLC (K) ensures exercises are distributed to appropriate commands for clinic personnel to complete and also reviews each facility's QAIG during quality assurance site surveys.

   c. Unit QA Coordinators ensure staff promptly complete all QAIG exercises and maintain a complete, up-to-date QAIG.

Section F- Quality Assurance Site Survey.

1. Procedures. All Coast Guard health care facilities are subject to periodic QA site surveys designed to assess compliance with QA checklist elements, and in the case of clinics, to attain Commandant (G-WK) certification; see Section 13-G. MLC Health and Safety Divisions conduct clinic site surveys in accordance with Coast Guard Clinic Certification Program requirements. MLCs survey independent duty sick bays according to schedules promulgated by the MLC. Facilities will be given notice at least eight weeks before the scheduled survey date regarding survey format and schedule and include with the notice the current QA Checklist against which performance is to be evaluated. MLCs will make every effort to schedule QA site surveys during time periods that allow maximum clinic staff participation.

2. Survey Format. The MLC site survey team will conduct all surveys according to this format:

   a. On arrival brief the Commanding Officer.

   b. Review on-site clinic or sick-bay procedures and spaces according to QA checklist.

   c. Health Records Review.

      (1) Review selected records for documentation as required by QA checklist and verify accuracy of clinic data collection.

      (2) Review selected records for pertinent diagnosis and care (see Section 13.I., Peer Review).

   d. Review clinical monitoring and evaluation program.

   e. Clinic All-Hands Meeting to review the QA site survey team's preliminary findings and solicit clinic staff's suggestions and recommendations for improvement. Feedback from the staff is encouraged on the Quality Assurance Program and the staff may present problems for troubleshooting with MLC QA Staff. A training component focusing on Quality Assurance and its incorporation into the Coast Guard's total quality management philosophy may be included

   f. Clinical services review with branch heads (e.g., medical services, dental services, pharmacy, etc.).

   g. Brief Senior Medical Officer, Senior Dental Officer, and Medical Administrative Officer.

   h. Brief Commanding Officer.

3. Survey Report. Commander, MLC (k) will provide a written QA site survey report to the Commanding Officer within six weeks after the completed survey. Clinics which are determined to be performing at a level below that required for certification will receive the survey report or interim action report within two weeks of the site survey and will be re-survey within 180 days according to Section 13-G provisions. The report will consist of an executive summary of major survey findings, an itemized account of facility performance measured

against QA checklist elements, corrective actions required, and for clinics, certification status based on parameters described in the clinic certification program in Section 13-G. Commanding Officers must provide a written plan for corrective action to Commander, MLC (k), within 45 days of receiving the written evaluation. MLC (k) personnel will be available to assist all facilities in meeting program requirements.

4. Customer Assistance Visits. Customer assistance visits are interim, abbreviated visits by MLC (kqa) staff members. Units may request or MLC (k) initiate them to review compliance with applicable clinic regulations and offer assistance in meeting regulatory requirements.

Section G - Coast Guard Clinic Certification and Accreditation

1. Clinic Certification Program.

   a. Background. Commandant G-WK must certify all Coast Guard clinics with assigned medical and dental officers to provide health services. Clinic certification is based on complying with standards set forth in the U.S. Coast Guard Medical Manual, COMDTINST M6000.1 (series), and MLC Quality Assurance (QA) Checklists. Commandant G-WK certifies facilities based on the results of Quality Assurance site surveys conducted by Maintenance and Logistics Commands.

   b. Responsibility.

      (1) Unit. The unit commanding officer is responsible for ensuring the command's health care facility complies with standards set forth in the Coast Guard Medical Manual and MLC QA Checklists and for meeting the minimum requirements set forth for clinic certification.

      (2) Maintenance and Logistics Command. Chief, Health and Safety Division is responsible for developing and coordinating QA Checklists and periodically conducting Quality Assurance Site Surveys at facilities in their area of responsibility. These surveys will assess compliance with existing directives and recommend the facility's certification status based on survey results.

      (3) Headquarters. Chief, Office of Health and Safety coordinates and directs the certification program, issues certificates to certified clinics, adjudicates appeals, and promulgates appropriate standards governing Coast Guard providers' delivery of health care and policies on managing and operating Coast Guard health care facilities.

   c. Certification Standards.

      (1) Certified. Commandant G-WK will certify clinics complying with at least 90% of both key elements and all other elements on the QA Checklist. Clinics must earn re-certification every three years.

      (2) Provisionally Certified. Commandant G-WK will provisionally certify clinics complying with at least 80% of key elements and at least 80% of all other elements on the QA Checklist. MLC Health and Safety Divisions will annually re-survey provisionally certified facilities until they attain full certification.

      (3) Not Certified. A facility failing to achieve either certification or provisional certification under this Section's provisions will be subject to a follow-up MLC QA site survey within 180 days after notice of non-certification. During this remedial period, the MLC will assist the facility to promptly address QA survey discrepancies and may impose restrictions limiting the scope of services the facility can provide.

The facility must request a follow-up survey during this period. If the facility does not receive at least provisional certification

(4) MLC will notify the Commanding Officer the health care facility is not certified by letter through the chain of command and detail appropriate specific restrictions on care delivery in that facility.

(a) The Commanding Officer shall submit weekly message reports of progress attained in eliminating disqualifying discrepancies to the cognizant MLC (k), with an information copy to Commandant (G-WKH), through the chain of command.

d. Notice of Certification Status. The Maintenance and Logistics Command will send each surveyed facility a copy of the survey report and recommendations for corrective action within 6 weeks of the site survey. If a facility is not certified, the MLC(k) will send the survey report or an interim action report within two weeks of the site survey. Certified and provisionally certified facilities will receive certificates which they are to display prominently within.

e. Appeal of Certification Status. A Unit Commanding Officer (CO) may appeal the certification status awarded as a result of the MLC Quality Assurance site survey within 30 days of the site survey report date. The Commanding Officer appeals in writing to Commandant (G-WK) through the chain of command; the appeal must specify the particular disputed QA checklist elements and reasons for the appeal. The CO must not base the appeal on corrective actions taken after the QA site survey or local misinterpretation of QA checklist elements or Medical Manual guidelines. Commandant (G-WK) will consider the appeal and render a final verdict on certification status within 30 days of receiving the appeal.

2. Clinic Accreditation Program.

a. All Coast Guard-certified health care facilities with four or more medical officers assigned are expected to pursue accreditation from an external accrediting organization such as the Joint Commission on Accreditation of Health Care Organizations. The cognizant MLC and G-WKH must approve pursuit of this accreditation. Once a clinic achieves full or provisional external accreditation, that facility will automatically receive Coast Guard certification and be required to maintain external accreditation. A non-scored MLC QA survey will also be performed to ensure compliance with Coast Guard regulations and compliance with G-WK quality assurance program standards.

b. The respective Maintenance and Logistics Command will provide any technical and professional assistance the health care facility requires to prepare for external accreditation. On the command's letter request, Commandant G-WK will provide funding for external accreditation surveys through the respective MLC (K).

3. Laboratory Certification. All ashore medical facilities that test human specimens to provide information to diagnose, prevent, and/or treat any disease or assess a human being's health must comply with the regulations for laboratory testing as stated in the Clinical Laboratory Improvement Amendments of 1988 (CLIA), administered by the Department of Health and Human Services.

Section H- Monitoring and Evaluation Program

1. Background. Monitoring and Evaluation (M&E) is an on-going program that examines important areas of clinical care and assesses how well the facility provides that care. The Joint Commission of the Accreditation of Health Care Organizations describes M&E as the "heart" of quality assurance, a process of continuously seeking areas of potential improvement in the health care delivery system. Participants identify areas of care needing improvement, implement actions to improve care, and continually monitor these areas to ensure the improvements are effective and the quality of care satisfactory.

2. Responsibilities.

   a. Commandant (G-WKH-2) will monitor and update the M&E program as appropriate.

   b. Commander, Maintenance and Logistics Commands (k) shall review each facility's M&E log during Quality Assurance site surveys.

   c. Unit QA Coordinators shall ensure the Quality Assurance Focus Group (QAFG) performs on-going M&E according to schedule. They shall retain logs or their equivalent on file for three years for MLC QA site survey teams to review.

3. Implementation. The Monitoring and Evaluation Report Form (Figures 13-H-2 through 13-H-31) is the basic instrument documenting Coast Guard clinics' M&E. Each clinic will complete a separate form for each aspect of care monitored. M&E Reports and the M&E Data Collection Log, CG-5544 (Figure 13-H-32), are the only forms required to document M&E activity.

4. Using the Monitoring and Evaluation Schedule and Clinical Aspects of Care Listing.

   a. Monitoring. M&E exercises for each category—medical (MED), dental (DEN) and drug utilization review (DUR)—are numbered, e.g., MED-1 to MED-9. Units may select any appropriate exercise from the designated category each quarter; choose optional exercises from any category, or develop their own exercises to address unit-specific issues. Units must record exercises they developed on Figures 13-H-30 and 13-H-31 and obtain cognizant MLC (k) approval. All selected exercises must address high-risk, high-volume, or problem-prone clinic procedures.

   b. Submit M&E Reports to the QAFG prior to the last work day of each quarter. Therefore, start collecting data for each exercise at the beginning of each quarter.

   c. Follow-Up Reports.

      (1) Studies Meeting Thresholds. The facility must follow up each initial M&E Report in 6 months with a follow-up report (Figure 13-H-31).

(2) Studies Not Meeting Thresholds. The facility must produce a follow-up report 3 months after the initial report, and every 3 months thereafter until it meets that threshold(s).

d. Use the M&E Data Collection Log, CG-5544 (Figure 13-H-32), to evaluate health records or other information sources for compliance with the indicator criteria. Record each record reviewed as meeting or not meeting the indicator. Retain completed logs on file for three years for MLC QA site survey teams to review.

5. Monitoring and Evaluation Report Forms (Figure 13-H-2 through 31). M&E report forms contain ten (10) sections: Sections 1 through 7 on the front (Figures 13-H-2 through 30) and Sections 8 through 10 on the back (figure 13-H-31).

a. Aspect of Care (Section 1). If the M&E program is to be meaningful, it must focus on clinical issues that have the greatest potential to affect our patients: high-volume, high-risk, or problem-prone aspects of care.

b. Clinical Indicator (Section 2). A component of care which shall be measured to determine compliance with standards. Commandant (G-WKH-2) establishes clinical indicators with suggestions from MLCs (k) and the professional staff at all clinics.

c. Thresholds for Evaluation (Section 3). Evaluate compliance with indicator criteria. If the evaluation does not meet a threshold, then the QAFG or its designee(s) must investigate the aspects of care and recommend specific action(s) for improvement.

d. Data Collection Methodology (Section 4). M&E exercises' data collection processes are designed to be simple. Any staff member can collect the data. One method is to review clinical records for specific indicator criteria, which are assessed as either "met" or "not met" and recorded accordingly. The "not met" column on the Data Collection Log allows the data collector to identify the specific unmet criteria, so follow-up action can be started.

e. Evaluation Report (Section 5). Calculate the percentage of reviewed cases that meet and do not meet the indicator criteria and enter results

f. Recommended Action (Section 7). The QAFG must act on completed M&E Reports. If the M&E does not meet a threshold, its QAFG must recommend action(s) to improve this aspect of care.

g. Follow-Up Reports (Sections 8-10). Generate either 3 or 6 months after the initial report by completing Section 8 on the M&E Report Form reverse. If possible, the same person responsible for the initial report should prepare the follow-up report. In some cases, a clinic may need to continue a quarterly M&E of a particular aspect of care indefinitely. Use Form Sections 9 and 10 for this purpose.

h. Figure 13-H-33 depicts an M&E flow chart.

Figure 13-H-1

| ANNUAL MONITORING AND EVALUATION SCHEDULE | | | | |
|---|---|---|---|---|
| QUARTER | 1st | 2nd | 3rd | 4th |
| INITIAL | MED | DENT | DUR | OPTIONAL |
| *FOLLOW-UP | DUR | OPTIONAL | MED | DENT |

| CLINICAL ASPECTS OF CARE FOR MONITORING AND EVALUATION | |
|---|---|
| MED | 1. Strep Throat<br>2. Urinary Tract Infection<br>3. Gastroenteritis<br>4. Hypertension<br>5. Non-specific Vaginitis<br>6. Otitis Externa<br>7. Preventive Health Activities (Healthy Lifestyle Assessment)<br>8. Diagnosis of Acute Minor Illness: Acute Contact Dermatitis<br>9. Diagnosis of Acute Minor Illness: Herpes Zoster (Shingles) |
| DENT | 1. Exodontia Informed Consent<br>2. Annual Dental Examinations<br>3. Dental Emergencies<br>4. Post-operative Infections<br>5. Restoration Replacements<br>6. Biopsies<br>7. Cast Restorations<br>8. Dental Radiographs<br>9. Endodontics<br>10. Dental Radiology<br>11. Periodontics |
| DUR | 1. NSAID Therapy<br>2. Antibiotic Therapy<br>3. Antihistamine Therapy<br>4. Antilipemic Therapy<br>5. Intranasal Steroid Therapy<br>6. Oral Contraceptive Therapy<br>7. Smoking Cessation Aids<br>8. Oral Histamine $H_2$ Antagonists |

Figure 13-H-1 (continued)

USING THE MONITORING AND EVALUATION SCHEDULE AND CLINICAL ASPECTS OF CARE LISTING

Each clinic shall monitor at least **one** clinical aspect of care each quarter. The schedule above determines the required category examined in each quarter. Clinics shall select an aspect of care from the menu below the specified category. For example, each year in the first quarter, M&E must be performed for a Medical (MED) aspect of care on the category menu (e.g., Strep Throat).

Submit completed M&E reports to the Quality Assurance Focus Group (QAFG) before the last work day of each quarter. Data collection for each exercise should begin on the first day of each quarter to allow time to collect and evaluate a representative data sample before the end of the quarter. It is recommended that the QAFG assign responsibility for each exercise before the start of each quarter, so that person may collect data promptly. Whenever possible, the same person responsible for the initial M&E report also should generate follow-up reports.

FOLLOW-UP REPORTS

For studies that meet thresholds:

Each initial M&E report must be followed six months later by a follow-up report.

For studies that do not meet thresholds:

A follow-up report is required three months after the initial report and every three months after that, until the evaluation meets thresholds.

Record follow-up reports on the M&E Report Form reverse in Sections 8, 9, and 10.

USING THE M&E DATA COLLECTION LOG, CG-5544

Use this form or a locally produced equivalent to evaluate health records or other information sources for compliance with the indicator criteria. Record each health record reviewed as meeting or not meeting the indicator. M&E Report Section 2 lists indicator criteria, signify unmet indicator criteria by marking the log's appropriate column (e.g., (a), (b), etc.).

Retain completed logs or equivalent on file for three years for MLC QA site survey teams' review.

Figure 13-H-2

MED-1

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Diagnosis of acute minor illnesses: Strep throat. |
| 2. Indicator | All patients diagnosed with strep throat have these documents in their health record (SF-600) (record must meet all three criteria):<br>a. A positive either throat culture or "Rapid Strep;" or a documented history of two of these three findings: Fever, purulent tonsils, or lympadenophathy; and<br>b. A temperature was taken and recorded; and<br>c. A description of the condition of the tonsils and/or oropharynx |
| 3. Threshold | 90% of the records reviewed shall meet the criteria contained in the indicator. |
| 4. Data Collection Methodology | a. Use CLAMS and/or a review of patient records and/or a review of lab records to retrospectively identify all patients with a diagnosis of "strep throat," up to a maximum random sample size of 25 patients.<br>b. The QAFG or its designee will review all identified patients' health records to determine whether they meet the indicator criteria. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-3

MED-2

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Diagnosis of acute minor illnesses: Urinary Tract Infection. |
| 2. Indicator | All patients diagnosed with Urinary Tract Infection must have these documents in their health record (SF-600) (record must meet all three criteria):<br>a. Temperature recorded,<br>b. Documented exam (positive or negative) for cva/flank tenderness; and<br>c. Urinalysis results. |
| 3. Threshold | 90% of the records reviewed shall meet the criteria contained in the indicator. |
| 4. Data Collection Methodology | a. Use CLAMS and/or a review of patient records and/or a review of lab records to retrospectively identify all patients with a diagnosis of "urinary tract infection," up to a maximum random sample size of 25 patients.<br>b. The QAFG or its designee will review all identified patients' health records to determine whether they meet the indicator criteria. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-4

MED-3

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Diagnosis of acute minor illnesses: Acute Gastroenteritis. |
| 2. Indicator | All patients diagnosed with Acute Gastroenteritis must have these documents in their health record (SF-600) (record must meet all five criteria):<br>a. History (presence or absence) of nausea or vomiting, and/or diarrhea (if present, number of stools in past 24 hours,<br>b. Temperature recorded,<br>c. History (positive or negative) of blood in stools.<br>d. Abdominal exam, and<br>e. Current weight of children 11 and younger. |
| 3. Threshold | 90% of the records reviewed shall meet the criteria contained in the indicator. |
| 4. Data Collection Methodology | a. Use CLAMS and/or a review of patient records and/or a review of lab records to retrospectively identify all patients with a diagnosis of "acute gastroenteritis," up to a maximum random sample size of 25 patients.<br>b. The QAFG or its designee will review all identified patients' health records to determine whether they meet the indicator criteria. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-5

MED-4

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Out-patient management of chronic illnesses: Hypertension. |
| 2. Indicator | All patients diagnosed as hypertensive must have these documents in their health record (SF-600) (record must meet all four criteria):<br>a. A treatment plan as evidenced in a "SOAP" entry on the SF-600,<br>b. Blood pressure recorded at least once in preceding six months,<br>c. Documented evaluation of EKG, electrolytes, BUN or creatinine, and<br>d. A recommended follow-up visit. |
| 3. Threshold | 90% of the records reviewed shall meet the criteria contained in the indicator. |
| 4. Data Collection Methodology | a. Use CLAMS or a review of the hypertensive prescription files to retrospectively identify all patients diagnosed as hypertensive during a six-month period which begins one year before the date the M&E exercise begins..<br>b. The QAFG or its designee will review all identified patients' health records to determine whether they meet the indicator criteria. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-6

MED-5

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Diagnosis of acute minor illnesses: Non-specific Vaginitis. |
| 2. Indicator | All patients diagnosed with Non-specific Vaginitis must have these documents in their health record (SF-600) (record must meet five out of six criteria):<br>a. History of present illness, including sexual behavior;<br>b. Past medical history;<br>c. Medication history;<br>d. Temperature recorded;<br>e. Documented pelvic examination (positive or negative), including description of vaginal discharge; and<br>f. Microscopic examination of discharge, including KOH prep (yeast), wet prep (clue cells), and testing for chlamydia and GC. |
| 3. Threshold | 90% of the records reviewed shall meet five criteria contained in the indicator. |
| 4. Data Collection Methodology | a. Use CLAMS and/or a review of patient records and/or a review of lab records to retrospectively identify all patients with a diagnosis of "non-specific vaginitis," up to a maximum random sample size of 25 patients.<br>b. The QAFG or its designee will review all identified patients' health records to determine whether they meet the indicator criteria. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-7

MED-6

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Diagnosis of Acute External Otitis (Otitis Externa) |
| 2. Indicator | All patients diagnosed with Acute External Otitis must have these documents in their health record (SF-600) (record must meet three out of four criteria):<br>a. History of present illness;<br>b. Past medical history;<br>c. Temperature recorded;<br>d. Physical examination of the external ear, including:<br>1. Movement of the tragus or auricle to elicit pain;.<br>2. Description of the external ear canal, and<br>3. Description of any discharge found in the canal or external ear. |
| 3. Threshold | 90% of the records reviewed shall meet three criteria contained in the indicator. |
| 4. Data Collection Methodology | a. Use CLAMS and/or a review of patient records and/or a review of lab records to retrospectively identify all patients with a diagnosis of "Acute External Otitis," up to a maximum random sample size of 25 patients.<br>b. The QAFG or its designee will review all identified patients' health records to determine whether they meet the indicator criteria. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-8

MED-7

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Preventive Health Activities (Healthy Lifestyle Assessment) |
| 2. Indicator | Adult patients' health records should assess annually these factors with health education and counseling as needed::<br>a. Diet;<br>b. Tobacco use (cigarettes, smokeless tobacco, pipes, cigars);<br>c. Alcohol use;<br>d. Seat belt use;<br>e. Exercise type and frequency;<br>f. Stress identification and reduction;<br>g. TSE/BSE; and<br>h. Immunizations. |
| 3. Threshold | 60% of the random sample of patients seen in the study time frame should have had a health assessment performed. |
| 4. Data Collection Methodology | a. Use CLAMS or the patient appointment log to identify a random selection of adult patients who present for non-emergent conditions and/or physical exams during the study time frame.<br>b. The QAFG or its designee will review all identified patients' health records to determine whether they meet the indicator criteria. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-9

MED-8

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Diagnosis of acute minor illness: Acute Contact Dermatitis |
| 2. Indicator | All patients diagnosed with Contact Dermatitis must have these documents in their health record (SF-600) (record must meet all criteria)<br>a. History of present illness, including any recent changes in habits, detergents, soaps, lotions, topical medications, and known contact substance cause;<br>b. Problem-focused medical history;<br>c. Physical examination, including the description and distribution of lesion(s) (rash). |
| 3. Threshold | 90% of the records reviewed shall meet all criteria contained in the indicator. |
| 4. Data Collection Methodology | a. Use CLAMS and/or a review of patient records to retrospectively identify all patients with a diagnosis of "contact dermatitis," "industrial dermatitis," or "poison ivy." Select a random sample of 25 patients.<br>b. The QAFG or its designee will review all identified patients' health records to determine whether they meet the indicator criteria. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-10

MED-9

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Diagnosis of acute minor illness: Herpes Zoster (Shingles) |
| 2. Indicator | All patients diagnosed with herpes zoster or shingles must have these documents in their health record (SF-600):<br>a. History of present illness, including:<br>1. Course of illness and constitutional symptoms, if any, such as low grade temperature and malaise; and<br>2. 2 subjective complaints, such as pain;<br>b. Problem-focused medical history;<br>c. Temperature recorded;<br>d. Physical examination, including these symptoms:<br>1. Description and distribution of primary lesions; and<br>2. Description and distribution of secondary lesions (if present). |
| 3. Threshold | 90% of the records reviewed shall meet all criteria contained in the indicator. |
| 4. Data Collection Methodology | a. Use CLAMS and/or a review of patient records to retrospectively identify all patients with diagnoses including "herpes zoster," "herpes," or "shingles." Select a random sample of 25 patients.<br>b. The QAFG or its designee will review all identified patients' health records to determine whether they meet the indicator criteria. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-11

DENT-1

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Patient Education: Informed Consent for Dental Procedures. |
| 2. Indicator | The dental record documents informed consent before all exodontia procedures, evidenced by the presence of a dated informed consent document (e.g., SF-522) describing the procedure, associated risks, and alternatives; the dentist, a witness, and the patient have signed the form. |
| 3. Threshold | 100% of the records reviewed shall meet the indicator criteria. |
| 4. Data Collection Methodology | a. Use CLAMS and/or a review of patient records to retrospectively identify all patients who have undergone exodontia procedures, up to a maximum random sample of 25 patients.<br>b. The QAFG or its designee will review all identified patients' health records to determine whether they meet the indicator criteria. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-12

DENT-2

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Preventive Dentistry: Annual Type II Dental Examination for Active Duty USCG Personnel. |
| 2. Indicator | Active duty USCG members' dental record (SF-603) contains documentation of a Type II dental examination within the past 12 months. |
| 3. Threshold | 90% of the records reviewed shall meet the indicator criteria. |
| 4. Data Collection Methodology | a. The QAFG or its designee will randomly select 50 active duty members' dental records.<br>b. The QAFG or its designee will review each record (SF-603) to determine whether a dental officer performed a documented Type II dental examination during the past 12 months. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-13

DENT-3

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Treatment of Dental Emergencies.. |
| 2. Indicator | Patients treated for dental emergencies make unscheduled return visits with the same complaint within 72 hours of the original sick call visit. |
| 3. Threshold | 90% of the patients seen for a dental emergency or sick call visit do *NOT* return for an *unscheduled* visit for the same complaint within 72 hours.. |
| 4. Data Collection Methodology | a. Maintain a daily log of all patients reporting to the clinic for dental emergencies or sick call during a 60-day period. Be sure each patient is logged and note the date.<br>b. After this 60-day period, the QAFG or its designee will review the emergency or sick call log and screen the records of all emergencies or sick call visits to identify any patients paying a return visit for the same complaint within 72 hours of the first visit. The QAFG or its designee will review these records to determine whether they meet the indicator criteria. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records do not meet the threshold, the QAFG shall review all cases which do not meet the criteria before recommending improvement in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-14

DENT-4

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Post-Operative Infections |
| 2. Indicator | Note surgical sites that develop infections after oral surgery on SF-603/603A and on CLAMS forms with an audit code. Post-operative inflections display these characteristics:<br>a. Elevated oral temperature (>100° F.) in the absence of other disease; and<br>b. Increase in purulent drainage from the surgical site; and<br>c. Increased inflammatory signs and symptoms. |
| 3. Threshold | Fewer than 10% of the surgical site(s) will develop post-operative infections. |
| 4. Data Collection Methodology | a. Use CLAMS or a log to determine the number of surgical procedures performed in a month to a maximum of 30 cases.<br>b. Use a record review, a log, or a CLAMS audit code to determine the number of surgical procedures performed which resulted in post-operative infections.<br>c. The QAFG or its designee will review these records to determine whether they exceed the threshold.<br>d. If the records exceed the threshold, the QAFG shall review all post-operative infection and recommend action to the SDO. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-15

DENT-5

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Replacing Dental Restorations |
| 2. Indicator | Note either in a log or with a CLAMS audit code all dental restorations performed to replace a restoration that has failed within one year of placement. Characteristics of failed restorations include:<br>a. Caries;<br>b. Lost tooth structure, including fractures;<br>c. Fractured or displaced restoration; and<br>d. Open contact or margin. |
| 3. Threshold | Fewer than 10% of restorations placed will need replacing within one year. |
| 4. Data Collection Methodology | a. Use CLAMS to record the number of restorations each dental officer places in one month.<br>b. Use a CLAMS audit code or a log to record the number of each dental officer's replacement restorations required fewer than 12 months after original placement.<br>c. The QAFG or its designee will review these records to determine whether they exceed the threshold.<br>d. If the records exceed the threshold, the QAFG shall review all premature that specific dental officer's restorative failures and recommend action to the SDO. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-16

DENT-6

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Biopsies |
| 2. Indicator | Biopsies are submitted properly:<br>a. Specimens are properly prepared and shipped them according to USN SF-515 guidelines; and<br>b. Adequate amounts of tissues are submitted. |
| 3. Threshold | Fewer than 10% of biopsies submitted have SF-515 forms returned with notes indicating inadequate tissue sampling or improper preparation and shipping.. |
| 4. Data Collection Methodology | a. Use CLAMS or a log to identify the number biopsy procedures performed each month, to a maximum of 10 cases.<br>b. Perform a record review of all biopsy cases (up to 10) to determine the number of cases returned with improper samples, tissue preparation, or shipping.<br>c. The QAFG or its designee will review these records to determine whether they exceed the threshold.<br>d. If the records exceed the threshold, the QAFG shall review all premature that specific dental officer's restorative failures and recommend action to the SDO. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-17

DENT-7

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Cast Restorations |
| 2. Indicator | Treatment is properly planned.<br>a. Periapical radiographs and periodontal probings are evaluated before preparing the teeth, and<br>b. Provisional (temporary) restorations are placed. |
| 3. Threshold | More than 90% of castings show a record of recent (<6 months) evaluation of periapical radiographs and periodontal probings and more than 90% of prepared teeth show a record of a successful provisional restoration. |
| 4. Data Collection Methodology | a. Use CLAMS or a log to identify the number of castings performed each month, to a maximum of 10 cases.<br>b. Perform a record review of all casting cases (up to 10) to determine the number without pre-operative radiographs and probings or successful provisional restorations. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-18

DENT-8

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Dental Radiographs |
| 2. Indicator | Radiographs are of diagnostic quality and display these characteristics:<br>a. Apices of subject teeth visible on PA films;<br>b. Open interproximals on BW films;<br>c. Films are appropriately developed and fixed; and<br>d. Films exhibit appropriate contrast |
| 3. Threshold | More than 90% of films will display appropriate technique and development. |
| 4. Data Collection Methodology | a. Review all recent (i.e., < 1 year old) dental radiographs in 50 randomly selected records, recording the number of films with technical and developing errors.<br>b. The QAFG or its designee will review these records to determine whether they exceed the threshold.<br>c. If the records exceed the threshold, the QAFG shall recommend action to the SDO. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-19

DENT-9

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Endodontics |
| 2. Indicator | Appropriate radiographs have been obtained. |
| 3. Threshold | More than 90% of cases include annotated pre- *and* post-operative radiographs. |
| 4. Data Collection Methodology | a. Identify endodontic cases with a CLAMS audit code; select 10 cases at random; review those 10 records' films; note the number of records with missing pre- or post-operative films.<br>b. The QAFG or its designee will review these records to determine whether they exceed the threshold.<br>c. If the records exceed the threshold, the QAFG shall recommend action to the SDO. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-20

DENT-10

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Dental Radiology |
| 2. Indicator | Radiographs are appropriately ordered and correctly interpreted. |
| 3. Threshold | Appropriate radiographs are ordered in 85% of cases and noted pertinent radiographic finds in 85% of cases. |
| 4. Data Collection Methodology | a. Select 25 dental records at random; review films and forms SF-603/603A for all 25; record the number of inappropriate orders and flawed interpretations.<br>b. The QAFG or its designee will review these records to determine whether they exceed the threshold.<br>c. If the records exceed the threshold, the QAFG shall recommend action to the SDO. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-21

DENT-11

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Periodontics |
| 2. Indicator | PSR recorded and treated appropriately. |
| 3. Threshold | More than 90% of records indicate PSRs within the last 12 months and appropriate follow-up in sextants with PSR of 3 or greater. |
| 4. Data Collection Methodology | a. Select 50 dental records at random; review forms SF-603/603A for all 50; note the number of records with absent or elevated and untreated PSRs.<br>b. The QAFG or its designee will review these records to determine whether they exceed the threshold.<br>c. If the records exceed the threshold, the QAFG shall recommend action to the SDO. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-22

DUR-1

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Drug Utilization: Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) |
| 2. Indicator | If treated with NSAIDs other than Aspirin, Indomethacin, and Ibuprofen, adults (>18 years old) with soft tissue injuries, musculo-skeletal disorders, and dental conditions must meet these criteria:<br>a. The patient's health record documents a history of hypersensitivity, adverse reaction, or specific contraindication to using Aspirin and either Indomethacin and Ibuprofen, OR<br>b. The patient has a documented failure with Aspirin and Indomethacin and Ibuprofen when used at appropriate therapeutic dosages (see below) for the indication for which currently prescribed, OR<br>c. The record documents a specialist prescribed or recommended the NSAID.<br>Therapeutic Dosage Ranges Aspirin 325-650 mg every four hours<br>Indomethacin Up to 150 mg/day<br>Ibuprofen Up to 3.2 gram/day, divided doses |
| 3. Threshold | 90% of cases of records reviewed meet one of the criteria contained in the indicator. |
| 4. Data Collection Methodology | a. Use CLAMS or review prescription files to retrospectively identify all patients receiving NSAIDs prescriptions except Aspirin, Indomethacin, and Ibuprofen during a one-month period. Then use CLAMS or review these records to identify patients who received the NSAIDs for the indicated conditions.<br>b. The QAFG or its designee will review these records to determine whether they meet the criteria in the indicator. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records exceed the threshold, the QAFG or its designee shall review all cases which do not meet the criteria and recommend action in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13.H.23

DUR-2

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Drug Utilization: Antibiotics |
| 2. Indicator | Health records document patients diagnosed with Otitis Media (OM) receive prescriptions from a clinic practitioner for Amoxicillin, Penicillin, or Septra UNLESS (record may meet any one of these criteria):<br>a. Current episode's symptoms or signs persisted after an initial regimen of listed antibiotics at therapeutic doses, OR<br>b. The diagnosis is expanded to recurrent OM (3 or more document OM episodes in the last 6 months), OR<br>c. The patient has a documented allergy to Amoxicillin, Penicillin, or Septra, OR<br>d. Resistant strains are so prevalent in the community using listed antibiotics is contraindicated. |
| 3. Threshold | 90% of records reviewed meet one of the four criteria in the indicator. |
| 4. Data Collection Methodology | a. Use CLAMS or keep a log book to identify all patients with a reported OM diagnosis in a one-month period. Then use CLAMS, review patient records, or audit the prescription files to retrospectively identify which patients received prescriptions for antibiotics other than the three listed.<br>b. The QAFG or its designee (e.g., Pharmacy and Therapeutics Committee) will review these patients' records to determine whether they meet the criteria in the indicator. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records exceed the threshold, the QAFG shall review all cases which do not meet the criteria before recommending corrective action. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Figure 13-H-24

DUR-3

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Appropriate use of Antihistamines: Terfenadine (Seldane) and Astemizole (Hismanal) |
| 2. Indicator | Health records document patients prescribed these products have:<br>a. Previously documented unsuccessful trial with at least one other antihistamine or documented history of intolerance to the sedative effects of antihistamines;<br>b. No concurrent therapy with ketoconazole and/or macrolide antibiotics (Terfenadine only), and<br>c. No evidence of impaired hepatic function or disease (see Problem Summary List). |
| 3. Threshold | 95% of all records reviewed meet the indicator criteria. |
| 4. Data Collection Methodology | a. Use CLAMS or review the prescription files to retrospectively identify all patients receiving prescriptions for Terfenadine and/or Astemizole.<br>b. The QAFG will review these patients' records to determine whether they meet the criteria in the indicator. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records exceed the threshold, QAFG or its designee shall review all cases which do not meet the criteria, evaluate, and recommend action in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-25

DUR-4

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Antilipemic agent therapy (HMG-CoA Reductase inhibitors, Gemfibrozil) |
| 2. Indicator | Patients placed on therapy with the above agents have documented hyperlipidemia confirmed by at least one of these baseline laboratory values:<br>a. Fasting total serum cholesterol ≥ 240 mg/dl<br>b. Fasting serum LDL ≥ 160 mg/dl<br>c. Fasting serum HDL ≤ 35 mg/dl<br>d. Fasting serum triglyceride levels ≥ 250 mg/dl<br>Note: In borderline cases, additional laboratory values should be sought before initiating drug therapy. |
| 3. Threshold | 80% of all records reviewed meet the indicator criteria. |
| 4. Data Collection Methodology | a. Use CLAMS to review the prescription files to retrospectively identify all patients receiving prescriptions for these medications.<br>b. The QAFG or its designee will review these patients' records to determine whether they meet the criteria in the indicator. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records exceed the threshold, QAFG or its designee shall review all cases which do not meet the criteria, evaluate, and recommend action in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-26

DUR-5

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Appropriate use of intranasal steroids (Flunisolide, Beclomethasone, Dexamthasone, Triamcinone, etc.) in seasonal and vasomotor rhinitis |
| 2. Indicator | All patients prescribed these medications will have:<br>a. Documented histories of seasonal or vasomotor rhinitis (characterized by moderate to severe symptoms lasting 4 or more weeks per episode) combined with a history of unsuccessful treatment with conventional therapy including antihistamines, decongestants, or combination product therapy, and<br>b. Administration dosage and frequency within the product manufacturer's and FDA's approved guidelines; and<br>c. Documented evidence instruction is provided in using these medications properly. |
| 3. Threshold | 95% of all records reviewed meet the indicator criteria. |
| 4. Data Collection Methodology | a. Use CLAMS to review the prescription files to retrospectively identify all patients receiving prescriptions for intranasal steroids.<br>b. The QAFG or its designee will review these patients' records to determine whether they meet the criteria in the indicator. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records exceed the threshold, QAFG or its designee shall review all cases which do not meet the criteria, evaluate, and recommend action in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-27

DUR-6

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Appropriate use of oral contraceptive medications |
| 2. Indicator | All patients prescribed these medications will have:<br>a. Documented history of physical exams within the past year including personal and family medical history, pelvic exam (including pap smear), breast exam, and vital signs, and<br>b. Documented evidence of instruction in the proper use of these medications, including an explanation of side effects, missed doses, increased risk factors (smoking, etc.), and drug interactions (antibiotics, etc.). |
| 3. Threshold | 95% of all records reviewed meet the indicator criteria. |
| 4. Data Collection Methodology | a. Use CLAMS to review the prescription files to retrospectively identify all patients receiving prescriptions for oral contraceptives.<br>b. The QAFG or its designee will review these patients' records to determine whether they meet the criteria in the indicator. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records exceed the threshold, QAFG or its designee shall review all cases which do not meet the criteria, evaluate, and recommend action in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-28

DUR-7

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Appropriate use of smoking cessation aids (nicotine patches or gum) |
| 2. Indicator | All patients prescribed these medications will have:<br>a. Documented enrollment in a recognized smoking cessation behavioral modification program advocating using nicotine products as adjunct therapy.<br>b. Health record documentation of counseling about using this medication properly, its side effects, and the member shall not smoke while undergoing this therapy.<br>c. Documentation therapy has been 12 or fewer weeks in duration. |
| 3. Threshold | 95% of all records reviewed meet the indicator criteria. |
| 4. Data Collection Methodology | a. Use CLAMS to review the prescription files to retrospectively identify all patients receiving prescriptions for smoking cessation aids.<br>b. The QAFG or its designee will review these patients' records to determine whether they meet the criteria in the indicator. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records exceed the threshold, QAFG or its designee shall review all cases which do not meet the criteria, evaluate, and recommend action in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-29

DUR-8

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | Appropriate use of oral histamine $H_2$ antagonist medications (Cimetidine, Ranitidine, etc.) |
| 2. Indicator | All patients prescribed these medications will have:<br>a. Documented diagnosis of duodenal or gastric ulcer, a hypersecretory condition, gastroesophageal reflux disease, or another appropriate indication before initiating therapy as listed in the current *Facts and Comparisons*.<br>b. Documented case review within 4-6 weeks and shift to maintenance dose regimen unless active disease still is present (except reflux esophagitis).<br>c. Documented monitoring of phenytoin serum levels (for cimetidine only) and prothrombin times (all warfarin patients) for patients taking these drugs.<br>d. Documented counseling on lifestyle modification (smoking cessation, dietary habits). |
| 3. Threshold | 95% of all records reviewed meet the indicator criteria. |
| 4. Data Collection Methodology | a. Use CLAMS to review the prescription files to retrospectively identify all patients receiving prescriptions for oral histamine $H_2$ antagonist medications.<br>b. The QAFG or its designee will review these patients' records to determine whether they meet the criteria in the indicator. Record the result on the M&E Data Log for each case before reporting results in Section 5.<br>c. If the records exceed the threshold, QAFG or its designee shall review all cases which do not meet the criteria, evaluate, and recommend action in Section 7. |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-30

OPTIONAL

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | |
| 2. Indicator | |
| 3. Threshold | |
| 4. Data Collection Methodology | |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-30

OPTIONAL

**MONITORING AND EVALUATION REPORT**

Facility_____ QA Coordinator_____

| | |
|---|---|
| 1. Aspect of Care | |
| 2. Indicator | |
| 3. Threshold | |
| 4. Data Collection Methodology | |
| 5. Evaluation Report | % Meeting _____ % Not Meeting Indicator Criteria _____ |
| 6. Evaluator | Name: _____ Date Evaluated _____ |
| 7. Recommended Action | _____ / _____<br>Signature Date |

Continued on Reverse

Figure 13-H-31

| | |
|---|---|
| 8. 3 to 6-Month Follow-up Report | Evaluation Criteria: _____ % Meeting _____ % Not Meeting<br>_____Continue M&E _____ Discontinue M&E<br>Recommended Action:<br>_____ / _____<br>Signature Date |
| 9. 3 to 6-Month Follow-up Report | Evaluation Criteria: _____ % Meeting _____ % Not Meeting<br>_____Continue M&E _____ Discontinue M&E<br>Recommended Action:<br>_____ / _____<br>Signature Date |
| 10 3 to 6-Month Follow-up Report | Evaluation Criteria: _____ % Meeting _____ % Not Meeting<br>_____Continue M&E _____ Discontinue M&E<br>Recommended Action:<br>_____ / _____<br>Signature Date |

Facility _____
Aspect of Care _____
Data Collector _____ Date _____

**M & E DATA COLLECTION LOG**

[Ed. Note: Not reviewed.]

SECTION I PEER REVIEW PROGRAM.

[Ed. Note: Text to come.]

SECTION J UTILIZATION REVIEW PROGRAM.

[Ed. Note: Text to come.]

Section K - Infection Control Program (exposure control plan).

1. Background.

   a. A standard set of infection control strategies is essential to prevent transmitting infectious diseases. Because history, physical examination, and/or readily available laboratory tests cannot identify all infected patients, use these procedures when providing health care to any patient to prevent transmitting infectious agents.

   b. Health services personnel (officers, enlisted, and civilian) and emergency medical technicians (EMTs) may be exposed to infection through direct contact, droplets, or aerosols from a wide variety of microorganisms in their patients' blood, secretions, excretions, and other body fluids. Direct contact may transmit infection by contaminated instruments (e.g.; needle sticks). Everyone has the potential to transmit infectious diseases to others. All health services personnel and emergency medical technicians must know how infectious diseases spread and take appropriate precautions.

   c. While Coast Guard health services personnel and emergency medical technicians must be seriously concerned with the risk of exposure to human immunodeficiency virus (HIV), the risk of contracting other infectious diseases, such as hepatitis B virus (HBV), is much greater. HBV infection can result in serious physical debilitation and adversely affect a practitioner's ability to provide health care. Once infected, a person also poses a potential risk to future patients as an HBV infection "carrier." Infection control practices that prevent HVB transmission also prevent HIV transmission. Since 1982 a safe, effective vaccine to prevent Hepatitis B has been available; it stimulate active immunity against HBV infection and provides over 90% protection against the virus for 7 or more years after vaccination.

2. Policy.

   a. Health services personnel will adhere to infection-control principles, general hygiene measures, and the Center for Disease Control and Prevention's (CDC's) "universal precautions" to prevent transmitting infectious disease between themselves and their patients.

   b. Hepatitis B vaccination is mandatory for all Coast Guard health services personnel and recommended for emergency medical technicians. Civilian administrative staff and E-8 and E-9 Health Services Technicians filling administrative positions are exempt; however, these personnel are encouraged to receive Hepatitis B vaccination. EMTs and clinic administrative personnel declining to receive HBV vaccination must sign this statement on an SF-600, and it shall be retain in the individual's health record:

      > I understand due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated **free** with Hepatitis B vaccine. However, I now decline Hepatitis B vaccination. I understand by declining this vaccine, I continue to risk acquiring Hepatitis B, a

serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series free.

c. Emergency medical technicians will adhere to the "universal precautions" described in Chapter 13-K-3.

d. Under the OSHA Blood-Borne Pathogen (BBP) Standard, all health services administrative and clinical personnel are occupationally exposed. All clinics shall provide the health care professional responsible for vaccinating employees with Hepatitis B vaccine a copy of the OSHA BBP Standard.

3. Universal Precautions.

a. Since medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, care providers must consistently use blood and body-fluid precautions with all patients, including those in emergency care settings in which the risk of blood exposure is greater and the patient's infectious status usually is unknown. CDC currently recommends the "universal blood and body-fluid precautions" approach or "universal precautions."

(1) All health care workers will routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when anticipating contact with any patient's blood or other body fluids. Personnel will wear gloves to touch patients' blood and body fluids, mucous membranes, or broken skin; to handle items or surfaces soiled with blood or body fluids; and to perform venipuncture and other vascular access procedures. Personnel will change gloves after contact with each patient. Personnel will wear masks and protective eyewear or face shields during procedures likely to generate blood droplets or other body fluids to prevent exposure to oral, nasal, or optic mucous membranes. Personnel will wear gowns or aprons during procedures likely to generate blood splashes or other body fluids.

(2) If contaminated with blood or other body fluids, personnel immediately will wash hands and other skin surfaces thoroughly. All persons shall wash their hands after completing activities likely to expose them to BBPs and remove protective clothing before leaving the work area.

(3) All health care workers will take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures or when cleaning used instruments, disposing of used needles, and handling sharp instruments after procedures. To prevent needle stick injuries, personnel will not by hand directly recap needles, purposely bend or break them, remove them from disposable syringes, or otherwise manipulate them. After using disposable syringes and needles, scalpel blades, and other sharp items, personnel will dispose of them by placing them in puncture-resistant containers located as close to the use area as practical. The Coast Guard does not authorize using reusable needles.

(4) Although research has not definitively implicated saliva in HIV transmission, it is prudent to use mouthpieces, resuscitation bags, or other ventilation devices instead of mouth-to-mouth resuscitation. These devices must be available for use in areas where the need for resuscitation is predictable.

(5) Health care workers who have exuding lesions or weeping dermatitis will not provide any direct patient care or handle patient care equipment until the condition resolves.

(6) Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas with a reasonable likelihood of occupational exposure to BBPs.

(7) Personnel shall not keep food and drink in refrigerators, freezers, shelves, drug storage areas, or cabinets or on countertops or benchtops where blood or other potentially infectious materials are present.

(8) Personnel shall perform all procedures involving blood or other potentially infectious materials in a manner that prevents droplets of these substances from splashing, spraying, splattering, and generating.

(9) Pregnant health care workers apparently do not face greater risk of contracting HIV infection than non-pregnant health care workers; however, if a health care worker develops HIV infection during pregnancy, the infant risks infection due to prenatal or perinatal transmission. Therefore, pregnant health care workers will thoroughly learn and strictly adhere to universal precautions to minimize the risk of HIV transmission.

b. Implementing universal blood and body fluid precautions for all patients eliminates the need for the "Blood and Body Fluid Precautions" isolation category CDC previously recommended for patients known or suspected to be infected with blood-borne pathogens. Personnel will use isolation precautions as necessary if they diagnose or suspect associated conditions, such as infectious diarrhea or tuberculosis.

4. Precautions for Invasive Procedures. The universal blood and body fluid precautions listed above and those listed below shall be the minimum precautions for all invasive procedures, defined as surgical entry into tissues, cavities, or organs; repair of major traumatic injuries in an operating or delivery room, emergency department, or out-patient setting, including both physicians' and dentists' offices; a vaginal delivery; manipulating, cutting, or removing any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.

a. All health care workers who participate in invasive procedures routinely shall take appropriate barrier precautions to prevent skin and mucous membrane contact with all patients' blood and other body fluids. Personnel shall wear gloves and surgical masks for procedures that commonly generate droplets, splash blood or other body fluids, or generate bone chips, such as those using rotary dental instrumentation. Personnel shall wear gowns or aprons made of materials that provide an effective barrier during invasive procedures likely to splash blood or other body fluids. All health care workers who perform or assist in vaginal deliveries shall wear gloves and gowns when handling the

placenta or infant until after they remove blood and amniotic fluid from the infant's skin and during post-delivery care of the umbilical cord.

b. If a glove is torn, cut, or punctured, the wearer will remove it, re-scrub, and put on a new glove as promptly as patient safety permits. The needle or instrument involved in the incident shall also be remove from the sterile field.

5. Precautions for Medical Laboratories. Blood and other body fluids from all patients will be considered infectious. To supplement the universal blood and body fluid precautions listed above, these following precautions are recommended for health care workers in clinical laboratories.

   a. All blood and body fluid specimens shall be placed in a well-constructed, labeled container with a secure lid to prevent leaking during transport, taking care when collecting each specimen to avoid contaminating the container's exterior or the laboratory form accompanying the specimen.

   b. All persons obtaining or processing blood and body fluid specimens (e.g., removing tops from vacuum tubes) shall wear gloves. Personnel shall wear masks and protective eyewear if they anticipate contact with mucous membrane with blood or body fluids, change gloves, and wash hands after completing specimen processing.

   c. For routine procedures such as histologic and pathologic studies or microbiologic culturing, a biological safety cabinet is not necessary. However, personnel shall use biological safety cabinets (Class I or II) whenever performing procedures with a high potential for generating droplets, including activities such as blending, sonicating, and vigorous mixing.

   d. Use mechanical pipetting devices to manipulate all liquids in the laboratory. *Never pipette by mouth.*

   e. Use needles and syringes only in situations in which no alternative exists. Personnel will follow the *recommended* universal precautions to prevent needle injuries.

   f. Decontaminate laboratory work surfaces with an appropriate chemical germicide after spilling blood or other body fluids and completing work activities.

   g. Decontaminate contaminated materials (including gauze pads) used in laboratory tests before reprocessing or place such materials in bags and dispose of them according to institutional policies for disposing of infectious waste.

   h. Decontaminate scientific equipment contaminated with blood or other body fluids with an appropriate chemical germicide and clean such equipment before repairing it in the laboratory or transporting it to the manufacturer.

   i. All persons shall wash their hands after completing laboratory activities and remove protective clothing before leaving the laboratory.

6. Handling Biopsy Specimens. Generally, personnel must put each specimen in a sturdy container with a secure lid to prevent leaking during transport and take care when collecting specimens to avoid contaminating the container's exterior. If the outside of the container is visibly contaminated, clean and disinfect it or place it in an impervious bag before delivery to the appropriate destination for examination

7. Using and Caring for Sharp Instruments and Needles.

   a. Personnel will consider sharp items (needles, scalpel blades, dental burs, and other sharp instruments) potentially infectious and handle them with extreme care to prevent unintentional injuries.

   b. Personnel must place disposable syringes and needles, scalpel blades, anesthetic carpules and other sharp items in closable, leak-proof, puncture-resistant containers. Cardboard containers are not appropriate for this purpose. To prevent unintentional needle stick injuries, personnel will not by hand directly recap disposable needles, purposefully bend or break them, remove them from disposable syringes, or otherwise manipulate them after use.

   c. If multiple injections of anesthetic or other medications from a single syringe are required, personnel may use these techniques in lieu of directly recapping by hand:

      (1) Use an approved shielding device specifically designed to recap safely (e.g., "On-Guard").

      (2) Use the "scoop" recapping technique. Affix the empty needle sheath to a flat surface and "scoop" it onto the exposed needle. A hand does not touch the sheath until the needle is securely inside.

      (3) Use a hemostat to recap by securing the empty sheath well away from the health care worker's hand.

   d. All Coast Guard Health Care Units shall establish a needle stick protocol; see Section 13-K-13. If a needle stick occurs, the affected person shall report the accident to his or her immediate supervisor, who will document the incident in a memorandum to the Chief, Health Services Division or health services department head, with a copy to the affected person. The memorandum will detail the needle stick's time, date, and circumstances and any medical treatment received. The Chief, Health Services Division or health services department head shall ensure the established needle stick protocol is observed in all cases.

8. Infection Control Procedures for Minor Surgery Areas and Dental Operatories.

   a. Medical History. Always obtain a thorough medical history. For dental procedures, have the patient complete a Dental Health Questionnaire, NAVMED 6600/3, as Section 4-C requires. Amplify this information by asking the patient specific questions about medications, current illnesses, hepatitis, recurrent illness, unintentional weight loss, lymphadenopathy, oral soft tissue lesions, results of last HIV test, or other infections.

Completely review the individual's health record or consult with a physician if the history reveals active infection or systemic disease.

b. Using Protective Attire and Barrier Techniques.

(1) Health care workers will consider all patients' blood, saliva, and other body fluids infectious. To protect themselves and patients, personnel must always wear gloves when touching:

(a) blood;

(b) saliva;

(c) body fluids or secretions;

(d) items or surfaces contaminated by the above; and

(e) mucous membranes.

(2) Further, personnel must completely treat one patient, if possible, and wash and re-glove hands before performing procedures on another patient. Repeatedly using a single pair of gloves is not allowed; such use can produce defects in the glove material which reduce its effectiveness as a barrier to microorganisms. Additionally, when gloves are torn, cut, or punctured, the wearer immediately must remove them, thoroughly wash his or her hands, and put on new gloves before completing minor surgical or dental procedures.

(3) Personnel shall wear surgical masks and protective eyewear or a chin-length plastic face shield. Personnel shall change masks after lengthy examinations or procedures, most especially after any which produce spatter. Patient protective eyewear shall be provide during all treatment procedures likely to splash or spatter blood, saliva, gingival fluids, or foreign objects. Personnel will use rubber dams, pre-procedural mouth rinsing, high-speed evacuation, and proper patient positioning, when appropriate, to minimize droplet generation and spatter in the dental operatory.

(4) When examining or treating any patient personnel must wear smocks, gowns, or laboratory coats. If wearing a reusable gown, personnel shall wash it using a normal laundry cycle. Personnel shall change gowns at least daily, when visibly soiled, or after any surgical procedure. All treatment team members must wear long-sleeved gowns or smocks during all surgical procedures employing rotary instrumentation.

c. Washing and Caring for Hands.

(1) Personnel must always wash hands after removing gloves between patient treatment contacts, after touching inanimate objects blood or saliva likely has contaminated, and before leaving the minor surgery area or dental operatory because gloves knowingly or unknowingly may become perforated during use. These perforations allow bacteria to enter and multiply rapidly beneath the glove material.

(2) Whenever possible wash hands at sinks that provide hot and cold water through a single mixing valve and preferably readily accessible to the treatment room or operatory. After scrubbing, rinse hands in cool water to reduce the likelihood and severity of latex reactions.

(3) For certain routine dental procedures, such as examinations and non-surgical techniques, hand-washing with plain soap is adequate, since soap and water will remove transient microorganisms. For surgical procedures, personnel must use an antimicrobial surgical hand scrub. Clinics may need to stock non-allergenic soap for allergic individuals.

(4) Health services personnel who have exuding lesions or weeping dermatitis must refrain from all direct patient care and handling patient-care equipment until the condition resolves.

d. Sterilizing and Disinfecting Dental Hand Pieces, Ultrasonic Scalers, and Dental Units.

(1) After each use with each patient, personnel will sterilize dental hand pieces (including high-speed, low-speed components used intraorally and ultrasonic scalers) because the device may aspirate a patient's blood, saliva, or gingival fluid into the hand piece or waterline. Clinics should purchase sufficient numbers of autoclavable hand pieces to meet this requirement. Dry heat is the recommended method of sterilizing dental burs.

(2) Because water retraction valves within dental units may aspirate infectious materials back into the hand piece and water line, check valves must be installed to reduce the risk of transferring infectious material. To physically flush out contaminants run high-speed hand pieces and discharge the water into a sink or container for 3 minutes at the beginning of each day and 30 seconds between patients. Additionally, flush high-speed hand pieces with a 1:10 hypochlorite solution for 3 minutes at the end of each week.

(3) Disinfect all dental unit surfaces with a suitable chemical germicide between patients or cover such surfaces during use. Use impervious backed paper, aluminum foil, or clear plastic wrap to cover surfaces difficult or impossible to disinfect (e.g., light handles or x-ray tube heads). Remove the covering while gloved, discard the covering, remove used and don fresh gloves, and then recover with clean material after each patient.

(4) Dental laboratory personnel will observe infection control protocols. They will thoroughly, carefully clean blood and saliva from material used in the mouth (e.g., impression materials, occlusal registrations), especially before polishing and grinding intra-oral devices. They will clean and disinfect contaminated materials, impressions, and intra-oral devices before handling them in the dental laboratory and before putting them in a patient's mouth. They will disinfect laboratory instruments (e.g. spatulas, knives, and wax carvers), plastic benches, chucks, handles, switches, tubing, air hoses, and lab hand pieces every day. Rubber mixing bowls require

overnight immersion to disinfect. Workstations, including exposed equipment, drawers, work surfaces, and sinks, require weekly surface disinfecting. Because of the increasing variety of dental materials used intra-orally, dental providers should consult with manufacturers about specific materials' stability in disinfecting procedures.

(5) Use sterile saline or sterile water as a coolant or irrigator when performing surgical procedures involving cutting soft tissue or bone.

e. Dental Radiology Sterilization and Disinfecting Procedures.

(1) Film-Holding and –Aiming Devices. When practical, heat-sterilize film-holding and –aiming devices between patients. For those items unable to withstand heat sterilization, use a chemical sterilant. Immerse for 6 to 10 hours depending on the sterilant manufacturer's instructions. If sterilization is not practical, immerse these items in chemical disinfectant between patients according to manufacturer's instructions.

(2) Panoramic Unit Bite Blocks. Use disposable bite block covers between patients. If disposable covers are not available, treat bite blocks similarly to film-holding devices.

(3) Handling Intra-oral Film Packets. Place intra-oral film removed from a patient's mouth directly into a disposable container such as a paper cup or towel for transfer to the darkroom. Discard wrappers directly into a refuse container or into a disposable towel to prevent contaminating the darkroom counter.

(4) X-ray Chair. Between patients wipe arm- and headrests with a chemical surface disinfecting solution. If using paper or plastic headrest covers, replace them after each patient.

(5) Intra-oral X-ray Tubehead and Exposure Buttons. Wipe these items with a surface disinfectant or cover them after each patient visit. Do not allow disinfectant liquid to leak into the tubehead seams or the exposure button switch.

9. Sterilizing and Disinfecting.

a. Instrument Categories (Spaulding Classification). The Spaulding Classification defines as critical instruments that normally penetrate soft tissue, teeth, or bone (e.g., forceps, scalpels, bone chisels, scalers, surgical burs, etc.). They must be heat-sterilized after each use. Instruments not intended to penetrate soft or hard tissues (e.g., amalgam carvers, plastic instruments, etc.) but which may come into contact with tissues are semi-critical and also should be heat-sterilized after each use. If heat sterilization is not possible, semi-critical instruments must receive chemical sterilization. Non-critical instruments never contact tissue. Sterilization is recommended for non-critical instruments, but high-level disinfection is acceptable.

b. Instrument Preparation.

(6) Initially Storing Contaminated Instruments. Immerse contaminated instruments in a container of soapy water immediately after use or completing the patient visit.

(7) Cleansing Instruments. Instruments must be cleansed for sterilization to be effective. Cleanse them using an ultrasonic cleaner according to the manufacturer's instructions. Hand-scrubbing instruments is prohibited. Persons who cleanse instruments must wear heavy-duty ("Nitrile") rubber utility gloves to reduce the risk of injury. Inspect instruments for cleanliness before preparing them for packaging.

(8) Packaging and Wrapping Instruments. Depending on intended use, wrap or package most instruments individually or in sets. Packaging in metal or plastic trays reduces set-up time; instruments and other materials arranged systematically are more convenient. Package size and sterilization method generally determine the best wrapping material, most commonly paper, plastic, nylon, cloth, or combinations of these materials. Seal packages by heat, tape, and self-sealing methods. Wrap instruments loosely to allow the sterilizing agent to circulate freely throughout the pack. Pack scissors, hemostats, and hinged instruments in the open position so the sterilizing agent can reach all parts. When wrapping in an easily punctured material, cover the tips of sharp instruments with 2 x 2 gauze or cotton roll. If using plastic or nylon sterilization tubing, the pack should be approximately 20% larger than the longest instrument to allow the inside air to expand when heated. Clear tubing is relatively puncture-resistant and enables rapid identification of contents. When using cloth to wrap critical items, use a double thickness. Date all packs.

c. Heat Sterilization.

(1) The best way to minimize cross-contamination is to sterilize all instruments that can withstand sterilizing conditions. The most practical, dependable sterilization method, heat, when appropriate, is preferable to chemical means. These are the most common heat sterilization techniques:

(a) Steam Vapor Under Pressure Sterilizer (Autoclave). Steam vapor under pressure is an excellent sterilization method. Moist heat kills the bacteria by causing their proteins to denature and coagulate within the microbial cell. The steam's high temperature, not the pressure, kills the microorganisms. Steam can rust cutting edges made of carbon steel; however, antirust agents reduce this process.

(b) Chemical Vapor Under Pressure Sterilizer (Chemiclave). This sterilizer uses chemical vapor under pressure and kills bacteria in much the same manner as the steam sterilizer. It is an excellent sterilization method. Because chemical vapors are less corrosive than steam, they do not dull sharpened instruments. Chemical vapor sterilizers use a specific mixture of formaldehyde, alcohols, ketone, acetone, and water. If the manufacturer's recommended chemical solution is not available, distilled water may be used for a short time Use chemical solutions only once. A disadvantage of the chemical vapor sterilizer

is the residual chemical vapor that escapes into the air when the chamber door is opened. While non-toxic and non-mutagenic, its odor can be objectionable. Allowing the sterilizer to cool for at least 20 minutes before opening will significantly reduce the residual vapor level. A commercial purging system that reduces residual vapor levels is available.

(c) Dry Heat Sterilizer. Dry heat kills bacteria by an oxidation process. Dry heat sterilization will not corrode instruments, but dry heat sterilizers can destroy metal instruments' temper and melt solder joints if not monitored properly. Some dry heat units are not able to sterilize large trays and require special wrapping and bagging materials. For these reasons, dry heat sterilization is not recommended for critical instruments, and should be monitored carefully and used judiciously with semi-critical and non-critical instruments. Because sterility is destroyed as soon as items are touched or left open to the environment, do not place loose instruments in dry heat sterilizers. Wrap and bag all instruments; they must remain wrapped or bagged until used.

d. Sterilization Monitoring.

(1) Chemical Indicators. External and internal chemical indictors provide a quick visual check to verify instruments have been exposed to elevated temperatures. They do not guarantee the instruments are sterile. External chemical indicators (autoclave tape or sterilizing bags with heat-sensitive printing) identify at a glance which instruments have been processed but show only the outside of the pack was exposed to an elevated temperature. An external chemical indicator must be on every pack processed. If using see-through packages, a chemical indicator placed inside the pouch is acceptable. Internal chemical indicators, available in strips, cards, or labels, react to time/temperature/ sterilizing agent combinations.

(2) Biological Spore Monitors (BSM). Bacterial spores resist heat destruction better than do vegetative forms of bacteria and viruses. Therefore, the spores are used to verify a sterilizer's effectiveness. Place them in the most challenging area of the load being tested and wrap the pack in the usual fashion. Monitor all chemical vapor, water vapor, and dry heat sterilizers with a spore test either weekly or each cycle, whichever is less frequent.

(a) These systems require a either medical laboratory service or an in-house incubator to incubate the test spore. Dry heat sterilizers require an alternate system using a glassine envelope with enclosed spore strips. Regardless of the system used, document spore monitoring, including identification test date, test results, and operator, and maintain the records for two years.

(b) If a spore monitor tests positive (spores are still alive), check the sterilizer for proper use and function and repeat the spore test. Items need not be recalled because of a single positive spore test. However, do not routinely use the unit in question until after obtaining a second test. If the second test also is

positive, the unit requires service or repair. When the unit is returned to use, perform a spore test to ensure the unit is in proper operating condition.

(3) Storage and Shelf Life. Store sterile instruments and packs in a cabinet or drawer to reduce contact with aerosols and dust. Handle them as little as possible before using them. Instrument pack life varies according to wrapping material as follows:

| | |
|---|---|
| Metal or Plastic Container | 30 days |
| Paper Wrap | 30 days |
| Cloth (Double Thickness) | 2 months |
| Nylon, Plastic, or Plastic-Paper Combination (Tape Sealed) | 6 months |
| Nylon, Plastic, or Plastic-Paper Combination (Heat Sealed) | 12 months |

Rewrap and resterilize outdated packs or packs suspected of being contaminated. Rotate packs to use the oldest ones first. Keep loose (unwrapped or unpacked) instruments to an absolute minimum as their sterility cannot be ensured. Recycle loose reusable instruments through a sterilizer at least once every two weeks. Disinfect drawers and instrument holders containing loose instruments monthly.

e. Chemical Sterilization and High-Level Disinfection. Although heat is the preferred sterilization method, certain instruments and plastics will not tolerate heat sterilization and require chemical sterilization or high-level disinfection. These disinfectants destroy microorganisms by damaging their proteins and nucleic acids. Most formulae contain 2% glutaraldehyde and come in two containers. Mixing the proper amounts from each container activates the solution. Sterilization monitors cannot verify glutaraldehyde sterilization. The solution is caustic to the skin, so use forceps or rubber gloves to handle instruments immersed in glutaraldehyde and *always* follow manufacturer's directions *carefully*. Label each container of fresh solution with an expiration date. Uninterrupted immersion for 7 to 10 hours in a fresh glutaraldehyde solution usually will achieve sterilization; uninterrupted immersion for 10 minutes will kill most pathogenic organisms, but not spores. Heavily soiled or contaminated instruments render glutaraldehydes ineffective. Debride instruments thoroughly to disinfect effectively. Glutaraldehydes are not recommended for surface disinfection.

f. Surface Disinfection.

(1) Extraordinary efforts to disinfect or sterilize environmental surfaces such as walls, floors, and ceilings generally are not required because these surfaces generally do not transmit infections to patients or health care workers. However, routinely clean and remove soil from them.

(2) After contamination, wipe all other treatment room surfaces such as countertops, dental chairs, light units, exam tables, and non-sterile objects in the operating field with absorbent toweling to remove any extraneous organic material, and then disinfect them with a suitable chemical germicide. Personnel shall wear heavy-duty ("Nitrile") rubber utility gloves when applying surface disinfectants. Many different chemical disinfectants possessing varying degrees of effectiveness are available. The following three surface disinfectants are recommended.

(a) Iodophor. Iodophor compounds contain 0.05 to 1.6% iodine and surface-active agents, usually detergents, which carry and release free iodine. Iodophor's antimicrobial activity is greater than that of iodine alone: 10 to 30 minutes of contact produces intermediate levels of disinfection. Iodophors are EPA-approved as effective when diluted 1:213 with water. Because iodine's vapor pressure is reduced in iodophor, its odor is not as offensive. In addition, iodophors do not stain as readily as iodine.

(b) Phenolics. In high concentrations, phenolic compounds are protoplasmic poisons. In low concentrations, they deactivate essential enzyme systems. As disinfectants, phenolics are usually combined with a detergent; 10 to 20 minutes of contact produces disinfection. Phenolics are less corrosive to treated surfaces.

(c) Sodium Hypochlorite. Sodium hypochlorite is thought to oxidize microbial enzymes and cell wall components. A 1:10 dilution of 5.25% sodium hypochlorite in water produces a solution which disinfects at an intermediate level in 10 minutes. Sodium hypochlorite solution tends to be unstable, so prepare a fresh solution daily. It possesses a strong odor and can harm eyes, skin, clothing, upholstery, and metals (especially aluminum

(3) Chemical Disinfectants Not Recommended For Use.

(a) Alcohol. Alcohol is bacteriocidal against bacterial vegetative forms by denaturing cellular proteins. Diluted in water, a 70 to 90% solution is more effective than a more concentrated solution. Alcohol's disadvantages are: (1) rapid evaporation, (2) lack of sporicidal or viricidal activity, and (3) rapid inactivation by organic material. Since alcohol interferes with proper surface cleansing, it has no place in the disinfection protocol.

(b) Quaternary Ammonium Compounds. In the past, benzalkonium chlorides and other "quats" were used as disinfectants because they were thought to be safe and inexpensive and have low surface tension. Their biocidal activity breaks down the bacterial cell membrane, producing an altered cellular permeability. As a group, these compounds have serious deficiencies. Being positively charged, they are attracted to not only bacteria but also to glass, cotton, and proteins, which decrease their biocidal activity. Common cleaners', soaps',

and other compounds' negatively charged ions neutralize "quats." Research has shown some "quats" support the growth of gram-negative organisms. Quats are ineffective against most spore formers, the Hepatitis B virus, and the tubercle bacillus.

10. Laundry. Although research has identified soiled linens as a source of large numbers of certain pathogenic microorganisms, the risk of linens actually transmitting disease is negligible. Rather than rigid procedures and specifications, hygienic and common-sense storage and processing of clean and soiled linen are recommended. Wearing gloves while handling soiled linen is recommended. Handle it as little as possible and with minimum agitation to prevent gross microbial contamination of the air and persons handling the linen. Carefully check linen for sharps objects and remove them before washing. Bag all soiled linen where used; do not sort or rinse it in patient care areas. Place and transport linen soiled with blood or body fluids in bags that prevent leakage. Use normal laundry cycles according to the washer and detergent manufacturers' recommendations.

11. Cleaning and Decontaminating Blood or Other Body Fluid Spills. Use an EPA-approved germicide or recommended surface disinfectant agent to promptly clean all blood and blood-contaminated fluid spills. Health care workers must wear gloves. First remove visible material with disposable towels or other appropriate means that prevent direct contact with blood. If anticipating splashing, wear protective eyewear and an impervious gown or apron that provides an effective barrier to splashes. Next decontaminate the area with disinfectant solution or an appropriate EPA-approved germicide. Clean and decontaminate soiled cleaning equipment or put it in an appropriate container and dispose of it according to clinic policy. Use plastic bags clearly labeled as containing infectious waste to remove contaminated items from the spill site. Remove gloves; then wash hands.

12. Infectious Waste.

    a. Epidemiological evidence does not suggest most clinic waste is any more infectious than residential waste. However, public concern about the risk of medical wastes must not be ignored. Identifying wastes for which special precautions are necessary include those wastes which potentially cause infection during handling and disposal and for which special precautions appear prudent, including sharps, microbiology laboratory waste, pathology waste, and blood specimens or products. While any item that has touched blood, exudates, or secretions potentially may be infectious, it is usually not considered practical or necessary to treat all such waste as infectious. Materials containing small amounts of blood, saliva, or other secretions such as tainted gauze pads, sanitary napkins, or facial tissues are not considered infectious waste. Generally, autoclave or incinerate infectious waste before disposing of it in a sanitary landfill. Infectious waste autoclaving standards are different from normal sterilization standards. Carefully pour bulk blood, suctioned fluids, excretions, and secretions down a drain connected to a sanitary sewer. Or for materials capable of it, grind and flush such items into sanitary sewers (some states prohibit this practice).

b. The Environmental Protection Agency classifies health care facilities as generators of infectious waste based on the weight of waste generated. Coast Guard classification is based on facility type. All Coast Guard clinics are considered generators. Each Coast Guard health care facility must have a written infectious waste management protocol consistent with state and local regulations in the unit's area.

c. Biohazard warning labels shall be affixed to regulated waste containers; refrigerators, and freezers containing blood or other potentially infectious material; and other containers used to store, transport, or ship blood or other potentially infectious materials with these exceptions:

(1) Substitute red bags for labels on regulated waste bags or containers. OSHA believes red bags protect personnel because they must comply with OSHA BBP Standard Paragraph (g)(2)(iv)(M), which requires training personnel to understand the meaning of all color coding.

(2) Individual containers of blood or other potentially infectious materials placed in a labeled container during storage, transport, shipment or disposal.

13. Managing Exposures (Needle Stick Protocol)

a. Exposure.

(1) An exposure occurs if a health care worker comes in contact with blood or other body fluids in one of these ways:

(a) Parenteral—through a needle stick or cut;

(b) Mucous membrane—from a splash to the eye or mouth;

(c) Cutaneous—contact with large amounts of blood or prolonged contact with blood when the health care worker's exposed skin is chapped, abraded, or afflicted with dermatitis.

(2) All individuals so exposed shall report the exposure to their immediate supervisor, who will document the incident in a memorandum detailing the exposure's time, date, and circumstances and any medical treatment received to the Chief, Health Services Division or health services department head, with a copy to the exposed person. The QA coordinator or his or her designee also will retain a copy and ensure all required follow-up treatment and testing is documented. The Chief, Health Services Division or health services department head shall ensure that the following this management protocol is adhered.

(3) After an exposure, obtain the source person's consent, making sure to follow local laws governing consent for testing non-active duty source persons and incompetent or unconscious persons. At a location where appropriate pre-test counseling is available for the source person, draw a blood sample and test it for Hepatitis B Surface Antigen (HbsAg) and Human Immunodeficiency Virus (HIV) antibody.

Provide the source person post-test counseling and treatment referrals. Inform the exposed person of the source person's test results and applicable laws and regulations on disclosing the source person's identity and infectious status. It is extremely important all persons who seek consultation for any HIV-related concerns receive appropriate counseling from a USMTF or other medical facility capable of providing this service.

(4) All clinics shall ensure the health care professional evaluating an employee after an exposure incident has this information:

(a) A copy of the OSHA BBP Standard,

(b) A description of the exposed employee's duties as they relate to the exposure incident,

(c) Documentation of the route(s) of exposure and circumstances under which exposure occurred,

(d) Results of the source individual's blood tests, if available; and all records on the employee's appropriate treatment, including vaccination.

(5) The SMO shall obtain and give the exposed person a copy of the evaluating health care professional's written opinion within 15 days after the evaluation is complete.

(6) Figure 13-K-1 presents a sample needle stick injury flow sheet.

b. Hepatitis B Virus Post-exposure Management.

(1) For a worker exposed to a source individual found to be positive for HbsAg:

(a) The exposed worker who has not previously received Hepatitis B vaccine will receive the vaccine series. A single dose of Hepatitis B immune globulin (HBIG) if it can be given within 7 days of exposure is also recommended.

(b) Test the exposed worker who has previously received Hepatitis B vaccine for antibody to Hepatitis B surface antigen (anti-HBs). If the antibody level in the worker's blood sample is inadequate (i.e., less than 10 SRU by RIA, negative by EIA) give the exposed employee one dose of vaccine and one dose of HBIG.

(2) If the source individual is negative for HbsAg and the worker has not been vaccinated, the worker shall receive Hepatitis B vaccination.

(3) If the source individual refuses testing or cannot be identified, the unvaccinated worker should receive the Hepatitis B vaccine series. Consider administering HBIG on an individual basis if the source individual is known or suspected to be at high risk of HBV infection. At his or her discretion the responsible medical officer will manage and treat as needed previously vaccinated workers who are exposed to a source who refuses testing or is not identifiable.

c. Human Immunodeficiency Virus Post-exposure Management.

(1) If a worker is exposed to a source individual found positive for HIV infection or who refuses testing, counsel the exposed worker about the risk of infection and evaluate him or her clinically and serologically for evidence of HIV infection as soon as possible after the exposure. In view of the evolving nature of HIV post-exposure management, the health care provider must be well informed of current Centers for Disease Control (CDC) guidelines on this subject.

(a) Advise the exposed worker to report and seek medical evaluation for any acute febrile illness occurring within 12 weeks after exposure. Such an illness, particularly one characterized by fever, rash, or lymphadenopathy, may indicate recent HIV infection.

(b) After the initial test at the time of exposure, retest seronegative workers 6 weeks, 12 weeks, and 6 months after exposure to determine whether HIV transmission has occurred. During this follow-up period (especially the first 6 to 12 weeks after exposure, when most infected persons seroconvert), exposed workers must follow CDC recommendations to prevent transmitting HIV, including refraining from blood donation, informing health care workers rendering treatment of his or her status, and using appropriate protection during sexual intercourse. During all phases of follow-up, it is vital to protect worker confidentiality.

(2) If the source individual's tests are seronegative, perform a baseline testing of the exposed worker with optional follow-up testing 12 weeks later if the worker desires or the health care provider recommends it. After the initial test at the time of exposure, at the responsible medical officer's discretion, retest consenting seronegative source individuals at 12 weeks and 6 months afterward.

(3) If the source individual cannot be identified, decide appropriate follow-up on an individual basis. All workers concerned they have been infected with HIV through an occupational exposure should undergo serologic testing

(4) Follow CDC recommendations for preventing HIV and HBV transmission to patients during exposure-prone procedures, defined as those invasive procedures with a recognized risk of percutaneous injury to health care workers.

(a) All health care workers shall adhere to universal precautions. Health care workers with exuding lesions or weeping dermatitis shall refrain from all direct patient care. Health care workers shall comply with current CDC guidelines for disinfecting and sterilizing equipment and supplies.

(b) All health care workers performing exposure-prone procedures shall know their HIV and HBV status.

(c) All health care workers who are HIV or HBV positive shall refrain from performing exposure-prone procedures.

14. Training Personnel For Occupational Exposure. All Health Services Divisions or Branches will inform and train personnel in occupational exposure initially on assignment and annually thereafter. Personnel who have taken appropriate training within the past year need receive additional training only on subjects not previously covered. The training program shall contain at least these elements:

a. An accessible copy and explanation of the regulatory text of this standard (Federal Register 56 (235):64175, December 6, 1991 [29 USC 1910.1030]).

b. A general explanation of the epidemiology and symptoms of bloodborne diseases.

c. An explanation of bloodborne pathogen transmission modes.

d. An explanation of the exposure control plan outlined in Section 13-K.

e. An explanation of the appropriate methods to recognize tasks and other activities that may involve exposure to blood and other potentially infectious materials.

f. An explanation of methods to reduce or prevent exposure, such as barrier techniques, and their limitations.

g. Information on the types and properly using, locating, removing, handling, decontaminating, and disposing of personal protective equipment.

h. An explanation of the basis for selecting personal protective equipment.

i. Information on the Hepatitis B vaccine, including efficacy, safety, administration, and benefits. This vaccination is mandatory for all Health Services Technicians except E-8 and E-9 personnel in administrative positions. It is recommended and available for EMTs and E-8 and E-9 Health Services Technicians in administrative positions.

j. Information on appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.

k. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and available medical follow-up described in Section 13-K-13.

l. Information on the post-exposure evaluation and follow-up the SMO or designee is required to provide for the employee after an exposure incident.

m. An explanation of the signs, labels, and/or color coding required for sharps and biohazardous materials.

n. A question-and-answer period with the person conducting the training session.

Figure 13-K-1

SAMPLE NEEDLESTICK INJURY FLOWSHEET
(CONFIDENTIAL)

Health Care Worker's Name: _____

Source's name, status, and contact information (if known): _____
_____
_____
_____

Date of Incident: _____

Type of Exposure (check one)

- ❑ Needle stick, cut, or puncture wound with contaminated instrument
- ❑ Splash to the eye or mouth
- ❑ Contact with large amounts of blood when the exposed skin is chapped, abraded, or afflicted with dermatitis
- ❑ Other: _____

| | No | Yes |
|---|---|---|
| Have consent to test and pretest information been given? | ❑ | ❑ |
| Is source test positive for HBV? | ❑ (2) | ❑ (next) |
| Is Health Care Worker (HCW) vaccinated for hepatitis? | ❑ (2) | ❑ (next) |
| HCW Hepatitis B surface antigen (anti-HBs) adequate (i.e., more than 10 SRU by RIA, positive by EIA)? | ❑ (3) | ❑ (next) |
| Less than 7 days since exposure? | ❑ (7) | ❑ (4) |
| Is source test positive for HIV? | ❑ (5) | ❑ (1, 6) |

ACTION TAKEN

1. Post exposure counseling
2. Initiate and complete HBV vaccination series
3. Give one dose of HBV vaccine
4. Give one dose of HBIG
5. HIV testing (baseline, optional 12 weeks )
6. HIV Testing (baseline, 6 weeks, 12 weeks, 6 months)
7. No action required

SENT TO QA COMMITTEE:_____

Section L - Risk Management Program

1. Purpose. The risk management program supports quality medical care by identifying, analyzing, and preventing actual and potential risks to patients and staff. The program provides mechanisms to detect and prevent accidents and injuries and reduces the cost of claims and loss of other resources.

2. Background. Risk management programs are most effective if they are prospective, preventive, and comprehensive. All staff members, beneficiaries, contract providers, and volunteers shall be aware of risks in the clinical environment and act safely and responsibly to implement program requirements. Risk management activities are not limited to claims activities but examine all instances of actual and potential risk or loss.

3. Definitions.

   a. Medical Incident: An adverse or unexpected medical outcome resulting in death or significant morbidity.

   b. Occurrence: Any event or situation in which there is an actual or potential injury or patients or staff raise a significant complaint or concern about treatment delivered.

4. Informed Consent.

   c. Background. Every person, with a few exceptions, has the right to be examined and treated only in the manner they authorize. This individual prerogative is based on the concept a competent patient has the right to make informed decisions about health care. Consent for health care must be informed, voluntary, competent, and specific, and is clearly an important issue in quality patient care. The objective of informed consent is improved patient-provider communication in non-emergent situations, which should result in patients' realistic expectations about the nature of treatment and the expected outcome, and reduced liability for the government. Clear documentation demonstrating the patient was properly informed is necessary to protect the patient, the provider, and the government. Although patients must be informed of treatment options, military members who refuse treatment necessary to render them fit for duty (including immunization) are subject to separation and/or disciplinary action (see Chapter 2-A-4-b.).

   d. Responsibilities.

      (1) Chief, Health Services Division (CHSD): The CHSD must publish facility-specific implementing instructions that ensure providers carry out the spirit and intent of this Section. The CHSD and cognizant MLC should monitor compliance with consent policies and procedures as a regular part of medical and dental records review.

(2) Health Care Providers: Responsible health care providers must counsel patients before treatment and document receiving the patient's informed consent.

e. Types of Consent. Consent may be expressed or implied.

(1) Expressed Consent: This type of consent is obtained by open discussion between the provider and patient and must include a statement the patient consents to the proposed procedure. Expressed consent may be oral or written.

(a) Oral Consent. Except where this regulation specifically requires written consent, oral consent is sufficient authorization for treatment. However, oral consent is difficult to prove. If a health care provider receives oral consent to treatment, he or she must document it by an entry in the treatment record. Consent received from competent authority by telephone is a form of oral expressed consent; a person not directly involved in the patient's care should witness such consent; and it must be document it by an entry in the treatment record.

(b) Conditions Requiring Written Consent. Document written consent by having the patient sign forms authorizing treatment and including an entry in the treatment record that discusses the requirements outlined in Paragraph 13-L-4. Except in emergencies, written consent is required for these situations:

1 All surgical procedures (including, among others, placing sutures, incision and drainage, removing a foreign body(s), cauterizing, removing wart(s), injecting medications into a joint(s), etc.)

2 Invasive tests and procedures to diagnose and treat disease or remove tissue specimens (e.g., biopsies), except routine phlebotomy.

3 Anesthesia, except local dental anesthesia.

4 Dental procedures other than routine restorative dentistry.

5 Genitourinary procedures including vasectomies, IUD insertion or removal, etc.

(2) Implied Consent. Implied consent is derived from the patient's conduct even if he or she does not communicate specific words of consent. Assume implied consent only if one can reasonably presume the patient knows the risks, benefits, and alternatives to treatment. For example, a patient's presence at dental sick call is implied consent for a dental exam. Never accept implied consent to treatment involving surgical therapy or invasive diagnostic procedures except in emergencies.

f. Emergencies. Consent before treatment is not necessary when immediate treatment is required to preserve life or prevent deterioration of the patient's condition. The provider will document the existence and scope of the emergency and describe the events precluding obtaining consent.

g. Who May Consent. Generally, competent adult patients who have the capacity to manage their own affairs who present themselves for treatment have the authority to consent. If a patient is incompetent due either to statutory incompetence (e.g., a minor) or mental impairment, then it must determined who the individual with legal capacity to consent and obtain his or her consent before examining or treating the patient. Laws defining minors and to what they may legally consent differ by state. The law of the state where the facility is located governs legal capacity to consent. Each clinic will develop a policy for treating minors.

h. Information To Provide. The provider must advise the patient of the nature of his or her condition; describe the proposed treatment in terms the patient can understand; and explain the material risks and expected benefits of the proposed treatment course, available alternative health care options, and the option of non-treatment. A material risk is one a reasonable person likely would consider significant in deciding whether to undertake therapy and is a function of the likelihood of occurrence, the severity of the injury it threatens to cause, and existing reasonable alternatives. A provider is not required to explain risk that are considered extremely remote unless the patient requests an explanation or the potential adverse consequences are so grave a reasonable person in the patient's particular circumstances would consider the risk important.

i. Informing the Patient. Health care providers will provide information in a manner that allows a patient of ordinary understanding to intelligently weigh the risks and benefits when faced with the choice of selecting among the alternatives or refusing treatment altogether. Health care providers must communicate in language one can reasonably expect the patient to understand. Although open discussions between the responsible health care provider and the patient should be the standard, each department may develop internal methods to acquaint patients with the benefits, risks, and alternatives to procedures requiring consent. In some departments, prepared pamphlets or information sheets may be desirable.

j. Documentation. Regardless of the method used to inform the patient or the form of consent (oral or written), the provider must document the disclosure and the patient's reactions in the medical or dental record. It is highly recommended progress notes even if the patient has signed a preprinted "consent" form. Progress notes written to document disclosing information to the patient will be specific about the information provided. The notes must specifically enumerate risks, alternative forms of treatment, and expected benefits the provider discussed with the patient. Use SF 522, "Request for Administration of Anesthesia and for Performance of Operations and Other Procedures," to document consent in all surgical, anesthetic and reproductive procedures other than local dental anesthesia and routine restorative dentistry.

k. Witness to Consent. All consent forms require a witness's signature. The witness may be a health care facility member who is not participating in the procedure or treatment. Patients' relatives are not acceptable as witnesses. The witness confirms the patient signed the form, not that he or she received all relevant information.

l. Duration of Consent. Consent is valid as long as no material change in circumstances occurs between the date the patient consented and the procedure or treatment date. Obtain new consent if a material change in circumstances occurs, for example the provisional diagnosis changes. If more than seven (7) days elapse between the date the patient signed the consent and the date treatment begins, provider and patient must re-sign, re-initial, and re-date the consent form. A new consent is not required for each stage in a series of treatments for a specific medical condition, e.g., repeated application of liquid nitrogen to warts.

5. Occurrence Monitoring and Reporting. (To be developed).

6. Medical Incident Monitoring and Reporting.

a. Definition. In the Coast Guard's Health Services Program, a medical incident is an event involving an unexpected death or permanent disability of a patient to whom Coast Guard health services personnel have rendered health care. The event is not reviewed to place blame or discipline those involved, but rather to assess the health care process(es) involved and identify potential areas for improvement. The Coast Guard uses the resulting recommendations to determine health care policy, personnel, equipment, and training needs to prevent future adverse health care outcomes. A single event may result in initiating a Mishap Board as the Safety and Environmental Health Manual, COMDTINST M5100.47 (series), requires and a legal investigation conducted concurrently with a medical incident review of the same event (e.g., a vessel collision with injuries). In most cases however, a medical incident review will occur solely within a Coast Guard health care facility or with medical or dental services rendered its only issue.

b. Reporting Procedure. Within 24 hours after a medical incident occurs, the command shall submit copy(s) of SF-558, Emergency Care and Treatment Report , and/or SF-600 for events occurring within the clinic and/or CG-5214, Emergency Medical Treatment Report, for events occurring outside the clinic to the appropriate MLC (k). Clearly mark "Incident Report" in large print across the top of these forms. Stamp or print this statement on the top of each document: "This is a medical quality assurance document. It is protected by Federal law (14 USC 645)." MLC (k) shall send copies of the documents to Commandant (G-WKH) within three days of receipt.

c. Review Procedure. On receiving one of the three forms, MLC (k) or Commandant (G-WKH), if appropriate, shall review the document(s); verify the event meets the Paragraph 13-L-6-a criteria for an incident; determine whether an on-site medical review shall be conducted; and designate a single point of contact at MLC (k) or Commandant (G-WKH).

(1) If MLC (k), or Commandant (G-WKH), determines a medical incident review is unnecessary, they shall notify the command by letter within 10 working days of the event and send a copy of the letter to Commandant (G-WKH).

(2) If conducting an on-site medical incident review, MLC (k) or Commandant (G-WKH), as appropriate, shall notify the involved command as soon as possible and designate an officer to conduct a review or convene a panel of qualified professional staff, including a member of the involved facility, to review all aspects of the incident. To ensure confidentiality, the panel shall consist of only the designated facility point of contact and the persons MLC (k) or Commandant (G-WKH) appoint.

d. The incident review officer or panel shall request and review all relevant documents and reports, interview personnel as required, and when the review is complete, submit a written letter report with this information on the incident to Commandant (G-WKH) through the cognizant MLC (k) (see Paragraph 13-L-6-e below):

(1) Synopsis. A brief summary of the incident and injuries and/or fatalities involved.

(2) Factual Information. Factual information and data about the incident and personnel involved shall consist of at least these topics:

(a) History. The chronological order of any significant events preceding, during, and after the incident, including any written logs or transcripts of radio logs substantiating this chronology, such as the SF-558, CG-5214, or SF-600.

(b) Injuries. Describe each injury, or in the case of fatalities, the cause of death. Include autopsy findings when available.

(c) Professional qualifications of all persons who delivered health care, including all recent applicable training and certificates (e.g., ACLS, BLS, EMT, HS, etc.).

(d) Equipment Performance. List all pertinent medical equipment used during the incident and any failures due to mechanical malfunction, operator error, inadequate training, or other factors. Describe whether equipment involved was maintained or serviced according to manufacturers' specifications.

(3) Analysis and Conclusions. The individual's or panel's hypothesis of the circumstances surrounding the event, emphasizing the health care aspect, developed using all available information and including a brief conclusion about the health care rendered and how it contributed to the event’s outcome.

(4) Recommendations. Recommended modifications to policy, personnel staffing, equipment, training, or any other health care delivery system aspect which might improve to avoid similar incidents in the future.

e. Routing Incident Review Reports. The cognizant MLC (k) shall send the completed report to Commandant (G-WKH) for review and appropriate action.

Section M - Training and Education

1. Definitions.

   a. ACLS (Advanced Cardiac Life Support): Sponsored by the American Heart Association (AHA), this 16-hour program (8 hours for recertification) emphasizes cardiac-related diagnostic and therapeutic techniques and grants a completion certificate valid for two years on completion. An ACLS certificate of completion recognizes a person completed the course and does not in any way authorize him or her to perform skills taught there. ACLS also sometimes refers to the cardiac component of Advanced Life Support.

   b. Advanced Life Support (ALS): A general term applied to pre-hospital skills beyond the basic life support level including, among others, EKG interpretation, medication administration, and advanced airway techniques.

   c. Basic Life Support (BLS): Rudimentary pre-hospital skills including CPR, bleeding control, splinting, patient assessment, oxygen administration, etc., associated with the basic level emergency medical technician.

   d. Cardio-Pulmonary Resuscitation(CPR): A program sponsored by the AHA and American Red Cross which, on completion, grants certificates of completion for 1 to 2 years. The course curriculum includes basic skills (airway maintenance and cardiac compression) necessary to sustain heart and brain function until advanced skills can be administered.

   e. Emergency Medical Technician (EMT): A general term referring to the certification of pre-hospital care providers routinely recognizes at three skill levels (EMT-Basic, EMT-Intermediate, EMT-Paramedic), but functions performed at each level vary significantly by jurisdiction. When the term EMT is used alone, assumes it refers to the EMT-Basic level, which performs BLS skills.

   f. Paramedic: An individual certified by the National Registry of Emergency Medical Technicians as an Emergency Medical Technician-Paramedic (NREMTP) or certified by a local governing body to perform ALS procedures under a physician's license.

2. Unit Health Services Training Plan (In-Service Training).

   a. Clinics, sickbays, and independent duty health services technicians must have an on-going in-service training program aimed at all providers with emphasis on the Health Services Technicians' professional development. It is expected of clinic staff members attending outside training to share new information with other staff members. In-service training sessions allow clinics to ensure issues of clinical significance are presented to their staff.

   b. In-service training must include these topics, among others:

      (1) Quality Assurance Implementation Guide Exercises;

(2) Annual review of clinic protocols on suicide, sexual assault, and family violence;

(3) Patient satisfaction issues;

(4) Patient sensitivity;

(5) Emergency I.V. therapy;

(6) Pneumatic anti-shock garment (MAST) review;

(7) Emergency airway management;

(8) Cardiac monitor and defibrillator familiarization;

(9) Cervical spine immobilization and patient transport equipment;

(10) Emergency vehicle operator's training (where operated);

(11) Section 13-K infection control policy and procedures.

c. The Chief, Health Services Division, must designate in writing a Health Services Training Coordinator (HSTC) who coordinates clinic in-service training, distributes a quarterly training schedule, and maintains the unit's health services training record. The HSTC's responsibilities include these:

(1) Establishes and maintains a Health Services Training Record to document all training conducted within the clinic. Records should include presentation outline, title, program date, name of presenter, and list of attendees. Maintain training records for 3 years from the date on which training occurred.

(2) Ensures all emergency medical training is documented in the individual's Coast Guard Training Record (CG-5285) for credit toward the 48-hour National Registry EMT continuing education requirement.

(3) Maintains a Training Record section that records personnel certifications including CPR, ACLS, EMT, and flight qualifications, including expiration dates and copies of the current certificate. The HSTC should ensure assigned personnel obtain recertification before current certificates expire.

(4) Monitors satisfactory completion of the Health Services Technician Practicum Guide for all personnel assigned to the clinic directly on graduation from HS "A" School. Maintain these guides on file for 3 years after the HS graduates from HS "A" School for review during MLC QA Site Surveys. If the HS transfers to another unit within 3 years, send the Practicum Guide to that unit.

3. Emergency Medical Training Requirements.

a. All active duty, civilian, and contract civilian personnel working in Coast Guard clinics and sick bays shall maintain current CPR certification at the health care provider level (AHA "C" Course or equivalent).

b. Every Health Services Technician who participates in SAR or MEDEVAC operations must be a currently certified EMT. At least one currently certified EMT will staff Coast

Guard emergency vehicles. Unit commanding officers shall ensure HSs are trained in sufficient numbers under Section 13-M-3.h to meet this requirement.

c. At least one medical officer per clinic will maintain current ACLS certification.

d. Only licensed or certified physicians, nurse practitioners, physician assistants, or Nationally Registered advanced life support providers (EMT-P and EMT-I) will perform ALS procedures, except as Section 13-M-3.e stipulates. Paramedics may perform functions authorized by their certifying jurisdiction's protocols with written medical officer authority.

e. Other than those permitted in the Standardized Health Services Technician Formulary, (COMDTINST 6570.1), an HS in SAR or MEDEVAC situations may provide ALS procedures and medications only if his or her supervising medical officer authorizes such provision in writing and assumes responsibility for those procedures and medications. In emergencies, the supervising medical officer may so authorize by radio.

f. Other than those described in Sections 13-M-3.d and 13-M-3.e, persons who have completed an ACLS course should note certification means only they have completed the course and does not convey a license to perform any skill. Individuals completing ACLS courses shall serve as a clinic resource on current standards for pre-hospital care in training and equipment areas.

g. Emergency vehicles shall be equipped to provide basic life support (BLS) only. The clinic shall maintain equipment (monitor-defibrillator, advanced airway kit etc.) and medications to provide ALS services at in a reserve status and add them when necessary if authorized ALS providers are available.

h. To obtain required EMT training (basic course or recertification), commands shall use local military sources if available. Usually most public service training agencies or community colleges offering training can accept Coast Guard personnel. If the required training is not available from a civilian or military source within a 50-mile radius, commands may use other cost-effective training sources. Submit requests through the chain of command to Commandant (G-WKH) with these items:

(1) CG-5223, Short-Term Resident Training Request;

(2) SF-182, Request, Authorization, Agreement and Certification of Training;

(3) Requests for training outside a 50-mile radius which incur per diem expense require the unit commanding officer's or officer-in-charge's statement local training sources are unavailable.

4. Health Services Technician "A" School.

a. The Office of Personnel and Training operates the 20-week introductory course for Health Services Technicians, including the Emergency Medical Technician (EMT) course, at TRACEN Petaluma. As program manager, Commandant (G-WKH) provides

professional comments to the TRACEN on curriculum and qualifying requirements. Commandant (G-PRF) controls HS "A" School personnel quotas. The Training and Education Manual, COMDTINST M1500.1 (series), outlines selection requirements and procedures.

5. Health Services Technician "C" Schools.

   a. Due to the specialized nature of health care, the Coast Guard requires health services technicians to complete training in medical specialty fields such as aviation medicine, preventive medicine, medical and dental equipment repair, physical therapy, eye specialist, laboratory, radiology, pharmacy, and independent-duty specialties. The usual sources are Department of Defense training programs.

   b. Selection for HS "C" Schools is based on qualification code requirements for HS billets at clinics and independent duty sites as specified in personnel allowance lists. Secondary selection criteria include command requests, personnel requests, and deficiencies noted on MLC Quality Assurance Site Surveys.

   c. HS personnel should submit a CG-5223, Short-Term Resident Training Request, with Command endorsement to Commandant (G-WKH) through the appropriate chain of command. Commandant (G-WKH) must receive this request at least 45 days before the training convening date.

   d. HS personnel wishing to pursue "C" school training in courses of 20 weeks or longer require a permanent change of duty station coordinated by Military Personnel Command (CGPC). Submit requests on CG-3698A, Assignment Data Form, to Military Personnel Command (CGPC-emp).

6. Continuing Education Programs.

   a. All U.S. Public Health Service Officers and Coast Guard physician assistants must maintain active professional licenses and/or certification to practice their professional specialty while assigned to the Coast Guard. Licensing and/or recertification requirements often demand continuing professional education, which enhances the practitioner's skills and professional credentials.

   b. The Office of Health and Safety attempts to fund one continuing education course annually for all licensed health services professionals. The program coordinator for an applicant's professional specialty must approve all training requests. Generally training should provide at least six documentable continuing education credits per day pertinent to the applicant's Coast Guard billet. Personnel should obtain training at the nearest possible geographic location.

   c. Medical and dental officers' licensing and certification exams will not be funded as continuing education. Coast Guard-sponsored Physician Assistant (PA) programs' graduates may request funding for examination fees (primary care only), travel to the testing

site nearest their current duty station, and per diem associated with obtaining initial certification from the National Commission on Certification of Physician Assistants. The Coast Guard funds this one-time exception because it sponsors the PA training program and requires certification for employment. PAs may take the recertification examination in conjunction with the annual physician assistant conference. Travel and per diem will be authorized as annual CME. The member pays recertification examination fees.

d. Except for Health Service Technician "C" School applicants, Health and Safety Program personnel requesting continuing education must follow these procedures:

(1) Each person requesting training must complete CG-5223, Short-Term Resident Training Request, with proper endorsements.

(2) Accompany each training request with course literature (e.g., a descriptive brochure) or a brief written description.

(3) Submit SF 182, Request, Authorization, Agreement and Certification of Training (10 parts) with proper endorsements if using a government purchase order to pay tuition or fees.

(4) Send all completed forms to Commandant (G-WKH) for processing. Send one information copy of the Short Term Training Request to the appropriate Maintenance and Logistics Command, Quality Assurance Branch.

(5) Training requests must arrive at Commandant (G-WKH) *8 weeks* before the anticipated training convening date. Coast Guard Training Quota Management Center (TQC), Portsmouth, VA, processes approved requests and issues orders.

7. Long-Term Training Programs.

a. Long-Term Post-graduate Training for Medical Officers (Physicians, Physician Assistants, and Nurse Practitioners). This 1- to 2-year program for medical officers principally emphasizes primary care (family practice, general internal medicine, and pediatrics). Consideration may be given for non-primary care specialties such as occupational health, public health, and preventive medicine. Training in orthopedics is a potential option for mid-level practitioners only. The Health Services Program Manager will consider non-primary care post-graduate medical training only when needed. Applicants also must have applied to their chosen training program and meet its requirements before requesting training. Applicants should have served with the Coast Guard Health Services Program for at least 2 years for each year of training received. For physician applicants, highest consideration will be given first to those who have not completed an initial medical residency. Commandant (G-WKH) has more information.

b. Advanced Dental Training Programs. This 2-year program provides dental officers advanced training in general dentistry, enabling them to give more effective, comprehensive dental care to Coast Guard beneficiaries. The Department of the Navy, Naval Medical Command, Bethesda, MD, conducts the training, designed to qualify dental officers to meet the American Dental Association and Federal Services Board of General Dentistry

requirements for specialty board examination. Dental officers chosen for this program are expected to pursue board certification. For program prerequisites and applications procedures, see the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series).

c. Health Services Administration. This program provides instruction in facility and personnel management, program planning, cost containment, quality assurance, third-party payment and liability, and medical-legal issues. The program provides training at the undergraduate (bachelor's degree) level for Chief Warrant Officers and senior enlisted HS personnel (Medical Administrators) and post-graduate (master's degree) level for officers in grades O-2, O-3, and O-4. See the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series) for eligibility requirements, prerequisites, and application procedures.

d. Physician Assistant Program. Conducted at the U.S. Intra-service Physician Assistant Program, Fort Sam Houston TX, this program trains Coast Guard personnel interested in becoming Physician Assistants. Program graduates receive a baccalaureate degree from the University of Nebraska. If they meet eligibility requirements, graduates are offered a direct commissions as ensigns as described in the Personnel Manual, COMDTINST M1000.6 (series), Article 1.A.7. Each year three Coast Guard students are selected for training based on Service needs. Training at other institutions is not authorized. See the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series) for eligibility requirements, prerequisites, and application procedures.

Section N - Patient Affairs Program

1. Patient Sensitivity.

   a. The Coast Guard considers patient sensitivity issues of paramount importance in delivering health care. Important issues in this area include medical record confidentiality, privacy during medical examination and treatment, respect for patient concerns, and enhancing the patient's perception of the quality of services delivered.

   b. All clinics shall conduct continuing patient sensitivity training. The "Treat Everyone As Myself" (TEAM) Program, developed by the U.S. Navy and Service Quality Institute available through each MLC Health and Safety Division, is the recommended course. It provides the structure for an internal review of patient-provider interaction and suggestions on ways to improve this relationship.

2. Patient Advisory Committee (PAC).

   a. The Coast Guard's health services program provides primary health care to a wide array of beneficiaries authorized by law and regulation. Medical Treatment Facilities (MTFs) often are unaware of their population's health problems until patients voice complaints or criticisms to the command. To enable beneficiaries to express their concerns, a PAC must be available to open lines of communication between health care providers and care recipients.

   b. Each Coast Guard MTF shall establish a PAC and specify criteria for committee functions. PACs shall include one officer and one enlisted member not assigned to the clinic; an active duty representative from each Coast Guard command in the clinic's service area; an active duty representative from each of the other uniformed services using the MTF; a retired representative; and an active duty dependent representative from both officer and enlisted communities.

   c. MTF shall conduct PAC meetings at least quarterly.

   d. The Chief, Health Services Division or his or her designee shall chair the meeting. Meeting minutes shall include recommended actions and an attendance list; and will be forwarded to the commanding officer with a copy to each PAC member. Specific PAC objectives include:

      (1) Advise the Chief, Health Services Division on the range of services the beneficiary population requires;

      (2) Serve as a communications link between the MTF and the beneficiaries the members represent;

(3) Serve as a patient advocacy group to assure all patients are accorded their rights as described in the Commandant's Patient Bill of Rights and Responsibilities;

(4) Assist the Chief, Health Services Division in advising patients of their responsibilities as described in the Commandant's Patient Bill of Rights and Responsibilities;

(5) Assist the Chief, Health Services Division in establishing patient education programs; and

(6) Advise the Chief, Health Services Division on the acceptability and convenience of the services provided.

3. Patient Satisfaction Assessment.

a. Assessing patient satisfaction through patient satisfaction surveys has become an effective, efficient method to investigate and measure the quality of the Coast Guard health care delivery system from the patient's perspective.

b. A patient satisfaction survey form shall be available to every patient who receives care at a Coast Guard facility.

c. Satisfaction surveys will be conducted annually for all patient visits during a randomly selected one-week period.

d. Locally prepared patient satisfaction surveys are authorized for use.

e. Patient satisfaction survey results shall be provided to the quality assurance focus group for discussion and action and documented in meeting minutes. Survey results shall report and recommended actions to the unit commanding officer.

f. Persons distant from a Coast Guard clinic can comment about care received from civilian providers by sending a mail-in Maintenance and Logistics Command survey form available from unit Health Services Technicians.

4. Patient Grievance Protocol.

a. The Coast Guard expects health services personnel to maintain a professional attitude at all times. Our goal to provide the highest quality health care within allotted resources to all beneficiaries with the least personal inconvenience. Despite our best efforts, occasionally a patient will be dissatisfied with the care received.

b. Whenever possible individuals with grievances should seek out or be referred to the clinic supervisor, health benefits advisor (HBA), or clinic administrator (CA) for complaint resolution before leaving the clinic. Refer written or telephone complaints to the appropriate clinic staff member. At a minimum, the complainant shall be given the name of his or her unit Patient Advisory Committee representative and advise the complainant of the time and place of the next PAC meeting.

c. If the clinic supervisor, HBA, or CA cannot resolve the complaint, he or she shall refer the complainant to the senior medical or dental officer as appropriate.

d. Refer the complainant to the commanding officer or higher authority only if the patient believes the clinic or PAC has not resolved the complaint.

e. MLC (kqa) shall review concerns reported on forms mailed to the Maintenance and Logistics Command for quality assurance purposes, action, or referral to an appropriate level for resolution and follow up.

5. Congressional Inquiries.

a. Occasionally, circumstances arise in which beneficiaries exercise their right to solicit assistance from their elected Congressional Representative to resolve their complaint with the Coast Guard health care system.

b. The Coast Guard maintains a Congressional liaison staff to direct inquiries to the appropriate Headquarters office that can best address the issue and respond satisfactorily. Normally Commandant (G-WK) replies to health care problems.

c. Congressional inquiries require a complete investigation of the circumstances surrounding the issues the beneficiary addresses. To this end, the command, health care facility, and individuals involved must supply supporting documentation and/or statements to assist in the investigation.

6. Patient Bill of Rights and Responsibilities. Each Coast Guard health care facility shall conspicuously display the Commandant's "Patient Bill of Rights and Responsibilities."