

CHAPTER 4

HEALTH RECORDS AND FORMS

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CHAPTER FOUR – HEALTH RECORDS AND FORMS

A. Health Records.

1. Purpose and Background.

a. Introduction. The health record is the chronological medical and dental record of an individual while a member of the CG or the CG 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 CG 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.
 - (c) At time of separation.
- (3) To facilitate appraisal of the physical fitness or eligibility for benefits by making selected, necessary information contained in the health record available to CG 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.
- (6) To facilitate communication among health care providers, utilization managers, quality assurance and medical records personnel.

b. Value of accuracy. 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. Each member's health record shall consist of a Health Record Cover, CG-3443 with medical records and dental records arranged as follows:

a. SECTION I - HISTORY OF CARE. All forms in this Section shall be arranged in the following order, (1) being the top and (9) being the bottom.

Additionally, the forms should be grouped by date with the most recent on top. Do not separate corresponding Report of Medical Examination, Form DD-2808 and Report of Medical History, Form DD-2807-1.

- (1) Health Record Receipt, Form NAVMED 6150/7.
- (2) Adult Preventive and Chronic Care Flowsheet, Form DD-2766.
- (3) Consultation Sheet, Form SF-513, or Tricare Referral Authorization printout.
- (4) Pre-Deployment Health Assessment, Form DD-2795.*
- (5) Post-Deployment Health Assessment, Form DD-2796.*
- (6) Post-Deployment Health Reassessment (PDHRA), Form DD-2900.*
(Post-Deployment Health Reassessment (PDHRA), Form DD-2900 on top of the Post-Deployment Health Assessment, Form DD-2796 which is on top of the Pre-Deployment Health Assessment, Form DD-2795, most recent on top, see Chapter 6 of this Manual for details on when to fill out these forms).
- (7) Medical Recommendation for Flying Duty, Form CG-6020 (aviation personnel only)*. A copy of every Medical Recommendation for Flying Duty, Form CG-6020 completed for a member should be filed in the record with the most recent just below the Adult Preventive and Chronic Care Flowsheet, Form DD-2766.
- (8) Report of Medical Examination, Form DD-2808, and Report of Medical History, Form DD-2807-1.
- (9) History and Report of Occupational Medical Surveillance and Evaluation Program (OMSEP) Examination, Form CG-5447, and Periodic History and Report of OMSEP Examination, Form CG-5447A.
- (10) Medical Record, Form SF-507*. Attached to and filed after the form they continue.
- (11) Medical Board Report Cover Sheet, Form CG-5684*.

* Annotates when required

- b. SECTION II - RECORDS OF CARE. All forms in this Section (and their civilian equivalents) shall be arranged in the following order, (1) being the top and (3) being the bottom. Additionally, the forms should be grouped by date with the most recent on top.

- (1) Chronological Record of Medical Care, Form SF-600. Command Medical Referral Form, Form CG-6050 for weight evaluation shall be placed in chronological order with the Chronological Record of Medical Care, Form SF-600. See Coast Guard Weight and Body Fat Standards Program Manual, COMDTINST M1020.8 (series)
- (2) Emergency Care and Treatment, Form SF-558.

- (3) Emergency Medical Treatment Report, Form CG-5214.
- c. SECTION III - RADIOLOGICAL REPORTS. All forms in this Section (and their civilian equivalents) shall be arranged in the following order, (1) being the top (2) being the bottom. Additionally, the forms should be grouped by date with the most recent on top.
- (1) Radiographic Consultation Request/Report, Form SF-519A.
 - (2) Medical Record - Radiographic Reports, Form SF-519.
- d. SECTION IV - LABORATORY REPORTS AND ECG REPORTS. All forms in this Section (and their civilian equivalents) should be grouped by date with the most recent on top.
- e. SECTION V - MISCELLANEOUS. All forms in this Section shall be arranged in the following (1) being on top (11) being on the bottom. Additionally, the forms should be grouped by date with the most recent on top.
- (1) Request to Restrict Medical and Dental Information, Form DD-2871.
 - (2) Authorization for Disclosure of Medical or Dental Information, Form DD-2870.
 - (3) Eyewear Prescription, Form DD-771.
 - (4) Hearing Conservation Program microprocessor test result strips. Reference Audiogram, Form DD- 2215 and Hearing Conservation Data, Form DD-2216 will also be placed in Section V in sequential order.
 - (5) Request for Administration of Anesthesia and Performance of Operations and other Procedures, Form OF-522.*
 - (6) Serology Record, Form SF-602.*
 - (7) Occupational Health Surveillance Questionnaire, Form CG-5197.*
 - (8) Record of Occupational Exposure to Ionizing Radiation, Form DD-1141.*
 - (9) Special Duty Medical Abstract, Form NAVMED 6150/2.*
 - (10) Chronological Record of Service, Form CG-4057.*
- * Annotates when required
- f. SECTION VI - DENTAL RECORD AND INTERNATIONAL VACCINATION RECORD. All forms in this Section shall be arranged in the following (1) being the top and (2) being the bottom.
- (1) U.S. Coast Guard Dental Record, CG-3443-2. If needed a Sensitivity Sticker, CG-5266 shall be placed on outside of Dental Record. All forms in the Dental Record shall be arranged in the following order (a) being

the top and (d) being the bottom. Additionally, the forms should be grouped by date with the most recent on top.

(a) Dental Health Questionnaire, Form CG-5605.

(b) Health Record – Dental, Form SF-603.

(c) Health Record – Dental (Continuation), Form SF-603A.*

(d) Request for Administration of Anesthesia and Performance of Operations and other Procedures, Form OF-522.

(2) International Certificate of Vaccination, Form CDC-731 *(This form is optional).

* Annotates when required

- g. Filing forms. File forms of the same number in their assigned sequence, with the most recent on top of each previous form, e.g., Chronological Record of Care, Form SF-600 dated 94/02/15 is filed on top of Chronological Record of Care, Form SF-600 dated 94/02/14.
- h. Recording dates. Record all dates on the Health Record Cover, CG-3443 in the following sequence (all numerals): year/month/day (e.g., 51/02/07).
- i. Review reports before filing. Reports, including laboratory, X-ray, and consultations, shall be reviewed and initialed (electronically or pen and ink) by the responsible MO, DO, PA, or NP before they are filed in the health record. IDHS's are authorized and required to sign negative HIV results (electronically or pen and ink) before hard copies are placed in the Health Record.
- j. 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, typed, or electronically generated name and rank of the practitioner.
3. Custody of Health Records. The following are the general responsibilities for keeping health records.
- a. Security. Health records are the property of the Federal government and must be handled in accordance with the provisions of the HIPAA Regulations, the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information (FOIA) and Privacy Acts Manual, COMDTINST M5260.3 (series). Health record custody, privacy, confidentiality and security requirements are applicable to all documents and electronic files that contain protected 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 Information and Life Cycle Management Manual, COMDTINST M5212.12 (series).

- (1) Since health records contain personal information of a critical or sensitive nature, they are considered For Official Use Only requiring maximum security (high security locked cabinets or areas). All clinic personnel and all individuals who are designated as health record custodians are to ensure the protection of patients' SSN at all times. Health records that are not filed while the patient is awaiting care shall be protected, ensuring the SSN is not visible. When a patient signs out their health record, records shall be placed in a large envelope, sealed, and shall not be opened until given to the appropriate clinic personnel or health record custodian.
 - (2) Except as contained in HIPAA and The Coast Guard Freedom of Information (FOIA) and Privacy Acts Manual, COMDTINST M5260.3 (series) 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 written authorization of the individual to whom the record pertains. It is the requestor's responsibility to obtain the written authorization.
- b. Custody. Health records shall be retained in the custody of the Senior Health Services Officer 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 United States Coast Guard Regulations 1992, 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., Sectors). 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.
- c. Patient's right to examine record. Individuals may examine their own health record in the presence of a health services department representative, providing.
- (1) Such examination does not interrupt the unit's scheduled mission.
 - (2) 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.

- d. Disclosure of information. The protected health information necessary for fitness-for-duty determinations; status for deployment and special operational duty; separations from duty; convalescent leave recommendations; inpatient admission and casualty notifications; and other routine disclosures for the military mission; is subject to inspection by the Commanding Officer; their delegate designated in writing; duly appointed counsel in the case of formal hearings; or duly appointed CG 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 health information.
 - e. Signatures and stamps. 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.
 - f. Erroneous entry. If an erroneous hand-written 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. For electronic record erroneous entries, correction may be recorded by either amendment of the original entry or an addendum to the original entry, both of which are signed/dated electronically with closure of the document.
 - g. Responsibility of record. 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.
 - h. Member's authorization. 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 writing in accordance with procedures contained in the HIPAA Privacy Regulation and in Chapter 16 of the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).
4. Opening Health Records.
- a. General.
 - (1) A health record will be opened at the recruiting office for each individual upon entering the CG.
 - (2) A new health record will be opened upon reenlistment of personnel with prior CG 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 Department of Veteran Affairs (VA), Records Management Center, St. Louis, MO.
 - (3) Other specific occasions for opening a Health Record.

Figure 4-A-1

<u>OCCASION</u>	<u>OPENED BY</u>
Officer appointed from civilian status	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

5. Checking out the Health Record. Whenever a Health Record is checked out, the Health Record Receipt, Form NAVMED 6150/7 shall be used as a permanent record of receipt and disposition of health records which are maintained at CG health care treatment facilities. For each health record maintained at CG facilities, complete the first four lines of a Health Record Receipt form and place into the health record folder. 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. General Instructions for checking out the Health Record for appointments, Temporary Assigned Duty (TAD) and Permanent Change of Station (PCS) are as follows:
- a. Medical Appointments. When the member is permitted to hand carry their health record, the health record custodian shall:
- (1) Explain to the member their responsibility in the care of the Health Record as outlined in Chapter 4 Section A of this Manual. Make sure the member knows to return the record as soon as possible after the appointment.
 - (2) Fill out the Health Record Receipt, Form NAVMED 6150\7.
 - (3) Place the record in a sealed envelope.
 - (4) Attach the following information to the outside of the envelope:

**For Official Use Only
Information Enclosed**

In accordance with public law and the U.S. Coast Guard Medical Manual COMDTINST M6000.1 (series) the contents of medical records are considered For Official Use Only.

Health Care Professional

Please enclose copies of consultations, procedures, or case notes of care rendered to the patient.

Patient

The enclosed records remain the property of the United States Government. You must return the Health Record as soon as possible to your command's Health Record Custodian. If you wish to review the enclosed information you may do so only in the presence of a health department representative.

- b. TAD. When a member departs for a TAD assignment they will normally not carry any form of Health Record. If the member's TAD is such that they may require routine medical assistance (sick call) the medical representative shall complete an Adult Preventive and Chronic Care Flow sheet, Form DD-2766, and the member will take this. Types of assignments which may require this type of "Health Record" are TAD assignment aboard a cutter or deployment for contingency operations. The exception to this is when a member is going TAD to a facility that can provide additional medical support (example flight physicals) or is in receipt of orders to "A" school, the Chiefs Academy or Officer Candidate School. When a member departs to any of these assignments listed above, the member shall hand carry their health record as per 5.a. above; however, if hand carrying is not feasible, the members health record shall be sent via traceable means (e.g. DHS authorized Commercial Carriers FedEx or UPS), along with a Request for Medical/Dental Records or Information, Form DD-877 to the servicing clinic.
- c. PCS.
 - (1) Upon notification that an individual will be transferred, an Accuracy and Completeness Check will be performed and all identified deficiencies corrected. All required entries shall be made in MRRS. Both the detaching unit and the receiving unit shall inspect the health record for Accuracy and Completeness Check as per Chapter 4-A-9 of this Manual.

When a member is due to transfer, the Servicing Personnel Office (SPO) shall notify the medical custodian where to send the medical records as per Military Personnel Data Records (PDR) System, COMDTINST M1080.10 (series). (TO ENSURE THAT HEALTH RECORDS GET TO THE

RIGHT LOCATION IN A TIMELY MANNER IT IS IMPERATIVE THAT THE SPO AND MEDICAL WORK TOGETHER). At the discretion of the health record custodian the health record of the member may be transferred in two ways. The departing member may be permitted to hand carry their medical record to their new unit or the record can be mailed.

- (a) When the member is permitted to hand carry their health record, the health record custodian shall:
- [1] Fill out a Health Record Receipt, Form NAVMED 6150/7 with the date and where the members will be taking their record. Have the member sign the Health Record Receipt, Form NAVMED 6150/7. Cut the form at the double lines above the "INSTRUCTIONS" section and maintain the top section on file for two years.
 - [2] Place the record in a sealed envelope and instruct the member to give his health record to the health record custodian when they get to their new unit. Attach the same information to the outside of the envelope as you would in 5.a. (4) of this section.
 - [3] Inform the receiving unit via a Request for Medical/Dental Records or Information, Form DD-877 (this form can be e-mailed) that the member has departed with their health record and their estimated time of arrival. The new unit should inform the old unit that the record has been received via the Request for Medical/Dental Records or Information, Form DD-877 and perform an Accuracy and Completeness Check.
- (b) The records may also be sent via DHS authorized Commercial Carriers FedEx or UPS. The health record custodian will:
- [1] In accordance with Military Personnel Data Records (PDR) System, COMDTINST M1080.10 (series), the health record custodian will receive the Medical/Dental Disposition Instructions from the SPO. The health record custodian will follow the disposition instructions and send the health record via traceable means (e.g. DHS authorized Commercial Carriers FedEx or UPS).
 - [2] Inform the receiving unit via a Request for Medical/Dental Records or Information, Form DD-877 (this form can be e-mailed) that the member has departed with their health record and their estimated time of arrival. The new unit should inform the old unit that the record has been received via the Request for Medical/Dental Records or Information, Form DD-877 and perform an Accuracy and Completeness Check.

[3] Fill out a Health Record Receipt, Form NAVMED 6150/7 with the date and where the member's record will be mailed. Have the member sign the Health Record Receipt, Form NAVMED 6150/7. Cut the form at the double lines above the "INSTRUCTIONS" section and maintain the top section on file for two years.

6. Terminating Health Records.

- a. Discharge/Release from Active Duty (RELAD). Upon discharge, RELAD, 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. The health record custodian (in accordance with Military Personnel Data Records (PDR) System, COMDTINST M1080.10 (series)) will receive the Medical/Dental Disposition Instructions from the SPO. The health record custodian will follow the disposition instruction and mail the health record to the appropriate office via traceable means (e.g. DHS authorized Commercial Carriers FedEx or UPS); US Postal Service (USPS): 1) Express Mail or 2) Proof of Delivery using Extra Services which are either Certified, Delivery Confirmation, or Signature Confirmation. DO NOT GIVE THE ORIGINAL HEALTH RECORD TO THE MEMBER UPON FINAL SEPARATION. The member is entitled to a copy of the original health record. Cite the reason for separation on the reverse side of Chronological Record of Service, Form CG-4057 before mailing.
- b. 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 Chronological Record of Care, Form SF-600 in the health record. Do not terminate the health record until final disposition.
- c. Desertion. When an individual is officially declared a deserter, enter an explanatory note on a Chronological Record of Care, Form SF-600. As per Military Personnel Data Records (PDR) System, COMDTINST M1080.10 (series) the SPO will instruct the health record custodian where to send the health record. Once notified the health record custodian shall send the health record, via traceable means (e.g. DHS authorized Commercial Carriers FedEx or UPS), within 2 working days.

- d. Return of a deserter. Upon return of a deserter to his/her own command, a physical examination shall be performed and recorded on the Report Of Medical Examination, Form DD-2808. Retain the original for incorporation into the health record, and forward a copy to Commander (PSC) or Commander (PSC-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 CO will make arrangements for their physical examination, to be recorded on a Report of Medical Examination, Form DD-2808. 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 CG is physically and mentally qualified for discharge and is not in need of hospitalization. The unit will take the warden's statement, accompanied by the health record, and follow the disposition instruction and mail the health record to the appropriate office via traceable means (e.g. DHS authorized Commercial Carriers FedEx or UPS); US Postal Service (USPS): 1) Express Mail or 2) Proof of Delivery using Extra Services which are either Certified, Delivery Confirmation, or Signature Confirmation.
- 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 Report of Medical Examination, Form DD-2808 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 Report of Medical Examination, Form DD-2808 and the account of medical, dental, and first aid treatments supplied by the penal institution. The unit will terminate health record, include the Report of Medical Examination, Form DD-2808, follow the disposition instruction from the SPO and mail the health record to the appropriate site via traceable means (e.g. DHS authorized Commercial Carriers FedEx or UPS); US Postal Service (USPS): 1) Express Mail or 2) Proof of Delivery using Extra Services which are either Certified, Delivery Confirmation, or Signature Confirmation.
- g. Retired Personnel (Includes Temporary Retirement). Upon notification of retirement, make an entry on the Chronological Record of Service, Form CG-4057 under "Remarks" indicating place, date, and category under which retired. The command having custody of the health record will sign the Chronological Record of Service, Form CG-4057. The health record custodian will follow the instructions of the SPO and send the health record; via traceable means (e.g. DHS authorized Commercial Carriers FedEx or UPS).

- 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 the health record will be terminated. The health record custodian will follow the instructions of the SPO and mail the record to the appropriate office via traceable means (e.g. DHS authorized Commercial Carriers FedEx or UPS); US Postal Service (USPS): 1) Express Mail or 2) Proof of Delivery using Extra Services which are either Certified, Delivery Confirmation, or Signature Confirmation.
- j. Death. Upon notification of death, make an entry on a Chronological Record of Service, Form CG-4057 under "Remarks" indicating place, time, date, and a short explanation of the circumstances surrounding death. Verbal briefs are provided to those on a need to know basis (i.e. Commandant (CG-112), HSWL, etc.). CG Investigative Service (CGIS) may also inquire and request to review the health record. The health record shall be forwarded to the HSWL SC for a Quality Improvement (QI) review upon conclusion of local review(s). Findings of the review are forwarded to Commandant (CG-11) via Commandant (CG-112) to determine if additional investigation, process improvement, or adverse privileging action is warranted. The HSWL SC shall forward the original health record to Commander (PSC) .
- k. 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 court-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 (PSC).
- l. Separation from service. 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. The health record custodian will follow the

instructions of the Servicing Personnel Office and mail the record by traceable means to the appropriate office.

7. Creating an Additional Volume. 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. Procedures for creating a second volume are as follows:
 - a. Obtain a new Health Record Cover, CG-3443 and transcribe the information from the original jacket.
 - b. Write "VOLUME II" in bold print in the lower left corner of the new jacket cover. Insert forms required by this chapter.
 - c. Write "VOLUME I" in bold print in the lower left corner of the original jacket cover.
 - d. Transfer all documents pertaining to current or chronic illness to the new record.
 - e. Remove the most recent Chronological Record of Care, Form SF-600 from VOLUME I and place it in VOLUME II. Insert a blank Chronological Record of Care, Form 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.
 - f. Insert the most recent Report of Medical Examination, Form DD-2808 and the Report of Medical History, Form DD-2807-1 into VOLUME II.
 - g. Problem summary list. Place the original Adult Preventive and Chronic Care Flowsheet, Form DD-2766 into VOLUME II and a copy of this form in VOLUME I with the annotation, "CLOSED. NO FURTHER ENTRIES.", below the last entry.
 - h. Place the original Chronological Record of Service, Form CG-4057 in VOLUME II and a copy in VOLUME I.
8. Lost, Damaged, or Destroyed Health Records.
 - a. Lost or destroyed. 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. Illegible. 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 onto the Report of Medical Examination, Form DD-2808 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 a Chronological Record of Care, Form SF-600. Forward health records replaced by duplicate records to Commander (PSC).

9. Accuracy and Completeness Check. Upon notification that an individual will be transferred, the detaching unit shall conduct an Accuracy and Completeness Check and correct all identified deficiencies prior to transfer. The receiving unit shall inspect the health record for accuracy and completeness within 30 days of receiving the health record, in accordance with the following guidelines:
 - a. Immunizations. That all immunizations are up-to-date (See Immunizations and Chemoprophylaxis, COMDTINST 6230.4 (series)).
 - b. Tuberculin Skin Test (TST). That TST screening is current in accordance with Chapter 7 Section D of this Manual.
 - c. HIV. That HIV screening is current (every 2 years) in accordance with Chapter 3 Section C of this Manual.
 - d. Audiograms. That all required audiograms are completed, especially on personnel involved in the hearing conservation program.
 - e. Forms completed and in the right order. That required forms have been properly completed and are in the correct order.
 - f. Deficiencies corrected. 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.
 - g. That all OMSEP requirements are met.
 - h. That everything is properly recorded in the MRRS.

B. Health Record Forms.

1. Health Record Cover, CG-3443. Each patient's health record shall be maintained in a Health Record Cover, CG-3443. This health record cover 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.

Smith	John	Joseph	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, and/or for the HIPAA Notice of Privacy Practices Acknowledgement sticker.
2. Drug Sensitivity Sticker, CG-5266.
- a. General. The Drug Sensitivity Sticker, 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 Adult Preventive and Chronic Care Flowsheet, Form DD-2766.
 - (3) Affix the Drug Sensitivity Sticker, CG-5266 vertically to the indicated location on the Health Record Cover, CG-3443 and vertically to the lower left corner on the front of the Dental Record Cover, CG-3443-2.
3. Adult Preventive and Chronic Care Flowsheet, Form DD-2766.
- a. General. The Adult Preventive and Chronic Care Flowsheet, Form DD-2766 shall be used as a temporary Health Record during TAD Deployments. It documents significant/chronic health problems, allergies, chronic medications, hospitalizations/surgeries, health counseling, immunizations, Purified Protein Derivative (PPD), DNA & HIV testing, (immunizations can be printed from Composite Health Care System (CHCS) data base and stapled in the form) placed in the screening (preventive medicine) exams, other medical readiness items (such as blood type, G6PD, sickle cell, glasses, dental exam, etc), and chart audits. It is advised that a copy of the completed Adult Preventive and Chronic Care Flowsheet, Form DD-2766 remain in the record when the member goes TAD. In-house training sessions should be conducted prior to the implementation of this form.
 - b. Detailed Instructions. The card-stock version Adult Preventive and Chronic Care Flowsheet, Form DD-2766 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 Adult Preventive and Chronic Care Flowsheet, Form DD-2766 as it is placed in the health record.
 - (2) If the patient is not allergic to any drugs, indicate NKDA (no known drug allergies), in block 1.a.
 - (3) Sections 8.a., 10.e. and 10.i. are not required to be completed.
 - (4) Use a pencil to darken the circles on Section 7, Screening Exam.
 - (5) The Medical Officer should enter the date and location of every deployment the member participates in Section 11, Pre/Post Deployment History. Pre and post deployment questionnaires are documented in Section 11 for participants in DOD deployment.
4. Consultation Sheet, SF-513.
- a. Purpose. A Consultation Sheet, Form SF-513 is used whenever a patient is referred to another facility for evaluation. Tricare authorizations for consultations contain additional detail compared to the Consultation Sheet, Form SF-513 and will be filed in place of the Consultation Sheet, Form SF-513 upon receipt.
 - 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. Completed Consultation Sheet, Form SF-513. 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 Consultation Sheet, Form SF-513.
 - (2) The Consultation Sheet, Form SF-513 shall then be filed in the appropriate dental or medical section of the health record.
 - (3) When consultation results are received in the form of professional correspondence, they will be filed in the appropriate dental or medical section of the health record, while the original Consultation Sheet, Form SF-513 (or Tricare authorization, as appropriate) is retained in the appropriate section of the health record.
5. Medical Record, Form SF-507. If received subsequent to the individual's discharge from the hospital, it shall be inserted in the health record immediately upon receipt. Medical Record, Form SF-507's are used for a variety of purposes, such as:
- a. Patient's hospitalization. To summarize the important facts about a patient's hospitalization.
 - b. Medical board. To summarize the findings of a medical board.
 - c. Board of Flight Surgeons. To report the results of a Board of Flight Surgeons.
6. Pre-Deployment Health Assessment, Form DD-2795. This form should be completed electronically using the Electronic Health Deployment Assessment (EDHA). The completed form should be printed out and placed in the health record. This form is used to assess the patient's health before possible deployment outside of the United States in support of military operations (and certain specified domestic deployments) and to assist military healthcare providers in identifying and providing present and future medical care. Directions for filling out this form can be found in Chapter 6. For questions concerning this form contact Operational Medicine at Commandant (CG-1121) <http://www.uscg.mil/hq/cg1/cg11/>.
7. Post-Deployment Health Assessment, Form DD-2796. This form should be completed electronically using the EDHA. The completed form should be printed out and placed in the health record. This form is used to assess the

patient's health after deployment outside of the United States in support of military operations (and certain specified domestic deployments) and to assist military healthcare providers in identifying and providing present and future medical care. Direction for filling out this form can be found in Chapter 6 of this Manual. For questions concerning this form contact Operational Medicine at Commandant (CG-1121) <http://www.uscg.mil/hq/cg1/cg11/>.

8. Post-Deployment Health Re-Assessment, Form DD-2900. This form should be completed electronically using the EDHA. The completed form should be printed out and placed in the health record. This form is designed to identify and address health concerns, with specific emphasis on mental health, that have emerged over time since deployment. Directions for filling out this form can be found in Chapter 6 of this Manual. For questions concerning this form contact Operational Medicine at Commandant (CG-1121) <http://www.uscg.mil/hq/cg1/cg11/>.
9. Medical Recommendation for Flying, Form CG-6020. Refer to the Aviation Medical Manual for instructions.
10. Report of Medical Examination, Form DD-2808.
 - a. Purpose. The Report of Medical Examination, Form DD-2808 is used to record physical examination results to determine whether an examinee does, or does not, meet the standards established for the type of physical examination administered (e.g., initial enlistment, officer programs, retention, release from active duty, diving, aviation, retirement, etc.). The Report of Medical Examination, SF-88 is no longer applicable.
 - b. Preparation.
 - (1) When Prepared. A Report of Medical Examination, Form DD-2808 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 Report of Medical Examination, Form DD-2808 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 17-42) which was not evaluated. For other items listed on the Report of Medical Examination, Form DD-2808 which were not required for a particular category of physical examination, an entry "NI" (Not Indicated) or "NA" (Not Applicable), shall be made in the appropriate space. Reference should be made to other provisions of Chapter 3, which

prescribe the nature and scope of each physical examination and indicate the applicability of items of the Report of Medical Examination, Form DD-2808 to the particular program. Unless otherwise indicated by such provisions, the minimum requirements for completing the Report of Medical Examination, Form DD-2808 are:

- (a) All Examinations. Items 1-44, 45-63, 66, and 71a, shall be completed for all physical examinations, if facilities are available. Item 41 shall be completed for all female personnel.
 - (b) Aviation Personnel. Refer to the CG AERO Guide and Aviation Medical Manual, COMDTINST M6410.3 (series) 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 Report of Medical Examination, Form DD-2808 for completeness and accuracy. Failure to do so reflects significantly on the examiner's clinical and/or administrative attention to detail. 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 the Report of Medical Examination, Form DD-2808.
- (1) Item 1: Date of Examination. Enter date in format - 02Aug15.
 - (2) Item 2: Social Security Number. Enter the nine digits of their SSN.
 - (3) Item 3: Last Name. 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 (e.g. Smith, Robert "T"). If the individual has no middle name, enter the letter "(n)" in parenthesis [e.g., Smith, Robert (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)."
 - (4) Item 4: Home Address. Enter the patient's present residence and not the home of record.
 - (5) Item 5: Home Telephone Number. NA.
 - (6) Item 6: Grade. Use official abbreviation of the current grade or rate. Example: HSCS; LTJG. If not a service member, enter "civilian."
 - (7) Item 7: Date of Birth. (e.g. 57Sep04).
 - (8) Item 8: Age. Enter age.
 - (9) Item 9: Sex. Mark one or the other of the boxes.

- (10) Item 10: Race. Mark the box next to the racial or ethnic group of which member belongs.
- (11) Item 11: Total Years of Government Service. Enter years and months (e.g., 06 yrs 04 mo's).
- (12) Item 12: Agency. Enter the OPFAC number of the unit to which the examinee is attached.
- (13) Item 13: Organization and UIC/Code. List name of ship or station to which the examinee is assigned. Initial entry into Service; enter recruiting office concerned.
- (14) Item 14a: Rating or Specialty. NA
- (15) Item 14b: Total Flying Time. Refer to the CG AERO Guide and Aviation Medical Manual, COMDTINST M6410.3 (series) for physical examinations of aviation personnel.
- (16) Item 14c: Last six months. Refer to the CG AERO Guide and Aviation Medical Manual, COMDTINST M6410.3 (series) for physical examinations of aviation personnel.
- (17) Item 15a: Service. Mark a box next to appropriate service.
- (18) Item 15b: Component. Mark a box next to appropriate component.
- (19) Item 15c: Purpose of Examination. Mark the box and corresponds to the appropriate purpose(s) of the examination. If not listed, mark "Other," and explain above the box such as: Medical Evaluation Board; Retirement; etc. Avoid nonstandard abbreviations. When necessary, continue under Item 73, Notes. For Diving and Aviation examinations, refer to the CG AERO Guide and Aviation Medical Manual, COMDTINST M6410.3 (series) for physical examinations of aviation personnel.
- (20) Item 16: Examining Facility or Examiner. For civilian or contract physician, enter the full name and address. For USMTF, enter only the facility name, city and state in which located.
- (21) Item 17-42: Clinical Evaluation. Check each item in appropriate column.
- (a) Item 35: Is continued on lower right side (Feet), circle appropriate category.
- (22) Item 43: Dental Defects and Disease. For an oral examination as part of an accession physical, record whether or not the applicant is 'Acceptable' or 'Not Acceptable'. Refer to the standards described in Chapter 3-D-5 Physical standards for enlistment, appointment, and induction. Enter disqualifying defects in detail in Item 73. Record the Dental Classification. Refer to Chapter 4- C-3-c for definitions of dental classes. For routine physical examinations, record only the

Dental Classification. When oral disease or dental defects are discovered on examination of active duty member personnel, suitable recommendations will be made for instituting corrective measures. A copy of the Dental Record, Form SF-603 does not need to be attached to the Report of Medical Examination, Form DD-2808.

(23) Item 44: Notes.

(a) Approving official will endorse (stamp is authorized) in this box (if no room is available place in Item #73 or add a separate endorsement) with the following information:

1. Date. This is the date that the member received their physical. For approved physicals this is also the date from which you will start counting to the next PE and the date of MRRS entry. (An unapproved physical shall not be entered into MRRS).
2. Does / Does Not meet physical standards.
3. Purpose of the examination.
4. Signature of approving authority and date. The signature is not necessary if the same person has signed in item 84. The date of the Approving authority should be no more than 60 days from the start of the physical, without written explanation for the delay.

Example: Date _____ Does / Does Not meet the physical standards for _____ as prescribed in Chapter 3 of CG Medical Manual, COMDTINST M6000.1 (series)

Signed _____ Date: _____

The disqualifying defects are:

(b) Describe every abnormality from Items 17-43 in detail. Enter pertinent item number before each comment. Continue in Item 73 and use a Continuation Sheet, Form SF-507 if necessary.

(24) Item 45: Laboratory Findings. Enter all laboratory results in quantitative values.

- (a) Urinalysis. Enter specific gravity and results of albumin, sugar and if required, microscopic tests in the indicated spaces.
- (b) Item 46: Urine HCG. If applicable.
- (c) Item 47: H/H. Enter either the hematocrit or the hemoglobin results.
- (d) Item 48: Blood Type. If applicable.

- (e) Item 49: HIV. Enter date drawn only in the results section.
 - (f) Item 50: Drugs Test Specimen ID Label. NA.
 - (g) Item 51: Alcohol. NA.
 - (h) Item 52: Other. Enter all other tests performed 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, Papanicolaou (PAP) test, Tuberculin Skin Test (TST), Electrocardiogram (EKG), Chest X-ray results, etc.). The results will be continued in Item 73 or on a Medical Record, Form 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 avoid vague terms such as "WNL" or other such qualitative forms.
- (25) Item 53: Height. Measure without shoes and record to the nearest one-half centimeter (one-half inch).
- (26) Item 54: Weight. Measure with the evaluatee in under garments and record results to the nearest kilogram (pound).
- (27) Item 55: Min Weight-Max weight, Max BF%. NA.
- (28) Item 56: Temperature.
- (29) Item 57: Pulse. Record the actual pulse rate.
- (30) Item 58: Blood Pressure. Record the actual value in numerals for both systolic and diastolic.
- (31) Item 59: Red/Green. NA
- (32) Item 60: Other Vision Test. If applicable.
- (33) Item 61: Distant Vision. Test and record using the Snellen scale. Record vision in the form of a fraction and in round numbers, such as 20/20, 20/40, not 20/20-2 or 20/40-3.
- (34) Item 62: Refraction. Enter the lens prescription when the evaluatee wears (or requires) lenses for correction of visual acuity. Do not enter the term "lenses".
- (35) Item 63: Near Vision. Test and record using the Snellen scale. (See item 61).
- (36) Item 64: Heterophoria. Enter when indicated.
- (37) Item 65: Accommodation. Enter when indicated.
- (38) Item 66: Color Vision. Enter the test used and the results.

- (a) Farnsworth Lantern (FALANT). 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.
- (39) Item 67: Depth Perception. When indicated, enter test used in left portion of Item 67.
- (a) Armed Forces Vision Tester (AFVT). In the appropriate space in the right-hand portion of Item 65, 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.
- (40) Item 68: Field of Vision. Enter when indicated.
- (41) Item 69: Night Vision. Enter when indicated.
- (42) Item 70: Intraocular Tension. When indicated, enter the results in millimeters of mercury.
- (43) Item 71: Audiometer. Required on ALL physical examinations. Use ANSI 1969 standards; do not use ISO or ASA standards.
- (a) Item 71a: Current.
 - (b) Item 71b: If applicable.
- (44) Item 72a: Reading Aloud Test. If applicable.
- (45) Item 72b: Valsalva. When required, mark either satisfactory (SAT) or unsatisfactory (UNSAT).
- (46) Item 73: 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 Chapter 3-C-20-b(5) of this Manual).
 - (e) Date of TST and results.

- (47) Item 74a: 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 MEB, 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 74b: Physical profile. Leave blank.
- (49) Item 75: I have been advised of my disqualifying condition. If indicated, have evaluatee sign and date.
- (50) Item 76: Significant or Disqualifying Defects. Leave Blank
- (51) Item 77: Summary of Defects and Diagnoses. List ALL defects in order to protect both the Government, and evaluatee, 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)". Leave Profile Serial, RBJ, Qualified, and Waiver blocks blank.
- (52) Item 78: Recommendations. Indicate any medical or dental recommendations. Specify the particular type of further medical or dental specialist examination indicated (use a Continuation Sheet, SF-507 if necessary).
- (53) Item 79: Military Entrance Processing Station (MEPS) Workload. Leave Blank.
- (54) Item 80: Medical Inspection Date. Leave Blank.
- (55) Item 81-84: Names and Signature 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 number (both sides); however, indicate only the actual number of attached sheets in Item 87 on DD-2808.
- (56) Item 85: Administrative Review. Prior to submitting for approval, the person who reviews the examination for accuracy shall sign and date.
- (57) Item 86: Waiver Granted. Leave Blank.

(58) Item 87: Number of attached Sheets. Fill in with appropriate number of forms attached.

11. Report of Medical History, Form DD-2807-1.

- a. Purpose. Report of Medical History, Form DD-2807-1 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 Report of Medical History, Form DD-2807-1. Prepare and submit Report of Medical History, Form DD-2807-1 with all physical examinations except: Periodic OMSEP and Substitution/Overseas/Sea Duty Modified Physical Examination.
- c. Preparation Procedures. Report of Medical History, Form DD-2807-1 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 Report of Medical History, Form DD-2807-1 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 Report of Medical History, Form DD-2807-1 must be included in the member's health record. Entries must be hand printed in the examinee's and examiner's own handwriting using either ball-point pen or ink pen (black or dark blue) or electronically typed (for PDF versions). 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) Item 1: Last Name, First, Middle Name. Smith, Michael D. 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) Item 2: Social Security Number. Enter SSN.
 - (c) Item 3: Enter date format –year/month/day (ie 2001Sep04).

- (d) Item 4a: Home Address. Enter the patient's present residence and not the home of record.
- (e) Item 4b: Home Telephone. Enter home phone number.
- (f) Item 5: Examining Location and Address. For civilian or contract physician, enter the full name and address. For a Uniformed Services Military Treatment Facility (USMTF), enter only the facility name and the city and state in which located.
- (g) Item 6a: Service. Mark a box next to the appropriate service.
- (h) Item 6b: Component. Mark a box next to the appropriate component.
- (i) Item 6c: Purpose of Examination. Mark a box next to the appropriate purpose(s) of the examination. If not listed, mark "Other" and explain above the box such as: retirement; separation; etc. For a medical board, indicate whether it is an IMB (Initial Medical Board)/DMB (Disposition Medical Board), etc. Avoid nonstandard abbreviations.
- (j) Item 7a: Position. 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."
- (k) Item 7b: Usual Occupation. List current occupation.
- (l) Item 8: Current Medications. List all current medications including over the counter meds.
- (m) Item 9: Allergies. List any allergies to insect bites/stings, foods medicine or other substances.
- (n) Item 10 to 28. Check appropriate box.
- (o) Item 29: Explanation of "Yes" Answer(s). Describe all "yes" answers from section 10-28. Include date(s) of problems, name of doctor(s), and /or hospitals(s), treatment given and current medical status.

[1] Append Item 29 to include: The statement to present health and a list of medications presently being taken by the examinee. For individuals receiving examinations more frequently, there is often little change in the medical history from year to year.

[2] As an alternative to having the examinee complete Section 10-28 of the Report of Medical History, Form DD-2807-1 at a periodic examination, the following statement may be entered in Item 29 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).

(p) Item 30. Examiner’s Summary and Elaboration of all Pertinent Data. Prior to performing the physical examination, the examiner will review the completeness of the information furnished on the Report of Medical History, Form DD-2807-1. When this is done, summarize the medical history under (Item 30a. Comments) as outlined below and then sign the form. If additional space is needed, use Medical Record, Form SF-507.

(q) 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 CG, 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.

- (r) **Distribution.** Attach the original Report of Medical History, Form DD-2807-1 to the original Report of Medical Examination, Form DD-2808 and submit to reviewing authority (electronic submission via AERO for aviation and diving physicals is authorized). A copy of the Report of Medical History, Form DD-2807-1 and Report of Medical Examination, Form DD-2808 shall be kept on file at the unit pending the return of the approved Report of Medical History, Form DD-2807-1 and Report of Medical Examination, Form DD-2808. After review and endorsement, the reviewing authority shall forward the original Report of Medical History, Form DD-2807-1 and Report of Medical Examination, Form DD-2808 to the member's parent command for insertion into the member's health record.

12. History and Report of OMSEP Examination, Form CG-5447.

- a. Introduction. The History and Report of OMSEP Examination, Form CG-5447 is used to biennially update the Occupational Medical Surveillance and Evaluation Program. Demographic and identification information is vital to maintaining the database. The History and Report of OMSEP Examination, Form CG-5447 will allow better tracking of personnel currently enrolled in OMSEP. Complete the form as follows:
- (1) **Item 1: Last Name.** 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., BRUNNER, Glen "W"). If the individual has no middle name, enter the letter "(n)" in parenthesis [i.e., COFIELD, Bernie (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: Grade/Rate/Rank.** 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; SN, USCG (TEMPRET); ETCM, USCG (RET). If not a service member, enter "civilian."

- (3) Item 3: SSN. Enter the Social Security Number.
- (4) Item 4: Date of Exam. Enter date in format e.g.04Sept03.
- (5) Item 5: Home Address. Enter home address in full (where examinee presently resides).
- (6) Item 6: Work/duty phone. Enter phone number beginning with area code. Include extension (if any), e.g., (xxx)-xxx-xxxx, ext xxxx.
- (7) Item 7: Unit Name and location. Enter unit, ship or station to where examinee is assigned.
- (8) Item 8: Home phone. Enter phone number beginning with area code. Include extension (if any), e.g., (xxx)-xxx-xxxx, ext xxxx.
- (9) Item 9: Unit Operating Facility (OPFAC)#. Enter OPFAC number of unit to which examinee is attached.
- (10)Item 10: Unit Zip Code: Enter unit's 5-digit zip code, e.g., 20593.
- (11)Item 11: Date of Birth & Age. Enter date followed by age in parentheses, e.g., 3Mar48 (54).
- (12)Item 12: Sex. Enter appropriate letter: (M) male or (F) female.
- (13)Item 13: Race or Ethnicity. Enter a one character designator to identify the examinee's racial or ethnic group:
 - (a) 1-Black.
 - (b) 2-Hispanic (includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or other Spanish origin or culture regardless of race).
 - (c) 3-American Indian (including Alaskan Natives).
 - (d) 4-Asian (including Pacific Islanders).
 - (e) 5-All others (e.g., White/Caucasian, etc.).
- (14)Item 14: Occupational or usual duties. Describe all primary duties, positions or billet assignments, (e.g. inspector, electrician, ASM).
- (15)Item 15: Examining Facility Name & Location. 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 16. Purpose of Examination. Mark appropriate box. If uncertain ask for assistance.
- (17)Item 17. Years in Occupation. List number of years in present position or job title.
- (18)Item 18-24. (Part 1-Section 1-Occupational History). Mark appropriate box Yes (Y) or No (N) as indicated.

- (19) Item 25. (Part 1-Section 1-Occupational History). Explain all Yes (Y) answers to Questions 18-24 above.
- (20) Item 26. (Part 1-Section II-Family History). Mark appropriate Yes (Y) or No (N) as indicated.
- (21) Item 27. (Part 1-Section III-Social History). Mark appropriate box Yes (Y) or No (N) as indicated. Where indicated, please enter the number that best approximates the amount of tobacco products consumed/used by the examinee. If examinee does not consume tobacco products but is frequently exposed to second hand smoke (home; social group) please describe in Item 33 below.
- (22) Item 28. (Part 1-Section III-Social History). Mark appropriate box Yes (Y) or No (N) as indicated. Where indicated, please enter the number that best approximates the amount of alcoholic beverages consumed/used by the examinee.
- (23) Item 29. (Part 1-Section III-Social History). Mark appropriate box Yes (Y) or No (N) as indicated. Explain all YES answers.
- (24) Item 30. (Part 1-Section IV – Personal Health History). Mark appropriate box Yes (Y) or No (N) as indicated.
- (25) Item 31. (Part 1-Section IV – Personal Health History). Mark the one box that best describes the examinees present health status.
- (26) Item 32. (Part 1-Section IV – Personal Health History). Mark appropriate box Yes (Y) or No (N) as indicated.
- (27) Item 33. (Part 1-Section IV – Personal Health History). Enter comments and explain all Yes (Y) responses to questions 27-32.
- (28) Examinee must sign and date form.
- (29) Item 34. (Part 1-Occupational Exposure History).
- (a) Column 1 - In chronological order list all known/documented exposures, including those occurring in prior employments.
 - (b) Column 2 - Enter the date of the known exposure, e.g. year/day/month.
 - (c) Column 3 - Enter the name of the place where exposure is known to have occurred.
 - (d) Column 4 – List the type (if any) for protective equipment in use during the documented exposure.
- (30) Examinee must sign and date form.
- (31) Part 2 - Medical Officer Section.
- (a) Item 1-4. Same as Part 1 Items 1-4 first page. Provider must enter.

- (b) Item 5. Examining Facility Name & Location. 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.
- (c) Item 6. Enter the phone number of facility/medical provider performing the examination. Include area code and seven-digit number and extension, if indicated e.g. (xxx) xxx-xxxx extension xxx.
- (d) Item 7. Surveillance Protocols. Mark the indicated box for each of the examinee's documented exposure protocols for which an examination was performed. For a separation/termination examination, make sure to include ALL documented exposure protocols (past and present) for which surveillance was performed.
- (e) Item 8. Occupational related diagnosis. List ALL occupationally related diagnosis, e.g., asbestosis; leukemia, mesothelioma).
- (f) Item 9. Respirator Wear. Mark appropriate box.
- (g) Item 10. Conclusions. Mark appropriate box.
- (h) Item 11. Next Occupational Medical Surveillance and Evaluation Program (OMSEP) Examination. For a regular schedule exam at the default time mark the space for "12 months". You may enter any specific time interval (of less than 12 months) under space marked "Other".
- (i) Item 12. Enter appropriate date when examinee was notified of examination results. This is a mandatory requirement.
- (j) Item 13. Provider should utilize this space to expand on all aforementioned diagnosis, to provide recommendations on follow-up care, and advice on future testing or procedures.
- (k) Medical provider must print name, sign and date form in space provided. Signature must include name, rank, and professional discipline.

13. Periodic History and Report of OMSEP Examination, Form CG-5447A.

- a. Introduction. The Periodic History and Report of OMSEP Examination, Form CG-5447A, is to be used for all scheduled periodic examinations. The member should review the last/previous OMSEP examination prior to completing this form.
- b. Items 1-10. Follow the same guidelines for part 1, History and Report of OMSEP Examination, Form CG-5447, Chapter 4-B-12.
- c. Item 11. Follow the same guidelines in Item 15 part 1, History and Report of OMSEP Examination, Form CG-5447, Chapter 4-B-12.

- d. Item 12. Last OMSEP Exam. Enter date of last OMSEP Initial/periodic or separation examination on record.
- e. Item 13. Present Exposure Protocols. Enter all documented exposure protocols for which examinations are scheduled.
- (1) Any changes since the last examination should be listed and describe in the “comments” area indicated for each of the particular sections. If no changes have occurred the member need only check the “no change “ box, as indicated, for each of the particular sections.
 - Section 1- Occupational History
 - Section 2- Family History
 - Section 3- Social History
 - Section 4- Personal Health History
 - Section 5- Occupational Exposure
 - (2) Health Care Provider Review. The Medical Officer is responsible for reviewing the completed Periodic History and Report of OMSEP Examination, Form CG-5447A and accompanying laboratory and radiological study results (if any), as well as making any final recommendations. The Medical Officer MUST enter all appropriate comments in the “recommendations” space, including any additional studies, follow-up examinations or consultations. The medical provider MUST also initial the appropriate boxes indicating the review of any laboratory studies or radiological procedures performed as part of this examination.
 - (3) The Medical Officer MUST provide name and signature (to include name, rank, and professional discipline) as well as date the Periodic History and Report of OMSEP Examination, Form CG-5447A (in the spaces provided) indicating the examinee was notified of any results and recommendations. When finalized the Periodic History and Report of OMSEP Examination, Form CG-5447A is to be placed into the member’s medical record.
 - (4) Note: If no changes have been reported by the examinee since the last examination and laboratory studies or radiological procedures (if any) are all within normal parameters, the designated health services technician (HST) may review and initial (sign and stamp) the completed Periodic History and Report of OMSEP Examination, Form CG-5447A after discussing the results with the cognizant Medical Officer and obtaining approval. The HST must make the following notation: “discussed and approved by Medical Officer” below the signature block. This allowance is intended primarily for situations where the cognizant Medical Officer is geographically separated and travel to/from the units negatively impacts unit operations.

14. Medical Board Report Cover Sheet, Form CG-5684.
 - a. The Medical Board Report Cover Sheet, Form CG-5684 is used in preparing a medical board. A copy of the Medical Board Report Cover Sheet, Form CG-5684 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).

15. Chronological Record of Medical Care, Form SF-600.
 - a. General.
 - (1) This form provides a current, concise, and comprehensive record of a member's medical history. Properly maintained, the Chronological Record of Medical Care, Form 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 Chronological Record of Medical Care, Form 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 Chronological Record of Medical Care, Form SF-600 also serves as the patient's prescription from which pharmacy services are provided.
 - (2) When a new Chronological Record of Medical Care, Form 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 Chronological Record of Medical Care, Form SF-600's in Section II of the medical record with the most current Chronological Record of Medical Care, Form SF-600 on top.
 - (4) Enter sick call entries on Chronological Record of Medical Care, Form SF-600 in the following SOAP format:

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.
- sh: (Social History) any use of tobacco/alcohol/drugs, relationship status, social stressors.
- all: (Allergies) any known allergies to drugs/medications, etc.

O: (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/O (rule out) – describe rationale for diagnosis, considerations, factor in other related or impacting diagnoses.

Procedures: detailed description of any procedures performed for the stated diagnosis/es.

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 Chronological Record of Medical Care, Form 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:

- (a) Date.
 - (b) Transcribed From Official Records.
 - (c) Signature/Rate.
 - (d) Duty Station of Transcriber.
- (7) When an individual is required to carry the International Certificate of Vaccine PHS-731, enter a statement of acknowledgment on the Chronological Record of Medical Care, Form SF-600.
- (8) When an individual is diagnosed as having a Sexually Transmitted Infection (STI) 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.
 - (d) 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 Chronological Record of Medical Care, Form SF-600, placed in a sealed envelope labeled "Sensitive Medical Information – Confidential," and forwarded to the individual's duty station for inclusion in the health record.
16. Emergency Care and Treatment, Form SF-558. This form provides a comprehensive yet concise record of emergency health care. It shall be used whenever an individual receives emergency treatment which cannot be documented in the electronic health record on Chronological Record of Medical Care, Form SF-600, or when documentation of care must be provided upon transfer of the patient to a higher level of care. 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 Emergency Care and Treatment, Form SF-558 to Commandant (CG-1012). Note: Disregard Defense Instructional Technology Information System (DITIS) Report, Form DD-2568 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. The signature shall include name, rank, and professional discipline.
 - x. Codes. List all ICD-9 codes applicable to the patient.
 - y. Patients' Identification. Ensure all patient identification information is entered.
17. Emergency Medical Treatment Report, Form CG-5214.
- a. Purpose. Emergency Medical Treatment Report, Form CG-5214 provides a multiple copy record of all emergency medical care rendered by CG personnel outside of a clinic or sickbay. All care rendered by crews of CG emergency vehicles must be documented with a Emergency Medical Treatment Report, Form CG-5214. (Alternatively, compatible state-approved forms may be used in lieu of the Emergency Medical Treatment Report, Form CG-5214).
 - (1) Part 1, Copy to Patient. This copy shall be placed in the patients' health record in Section II behind the Emergency Care and Treatment, Form SF 558.
 - (2) Part 2, Copy to Receiving Unit. This copy shall be given to the hospital, clinic, or Emergency Medical Services (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.
 - b. Preparation and Submission of Emergency Medical Treatment Report, Form 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 Emergency Medical Treatment Report, Form 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).

18. Radiographic Reports, Form SF-519-A.

- a. This is a display form for mounting Radiographic Reports, Form SF-519-A. Attach the Radiographic Reports, Form SF-519-A to the indicated spaces, with the most recent report on top.
- b. Use Radiographic Reports, Form 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.

19. Laboratory Reports. Attach the laboratory reports to the indicated spaces with the most recent on top.

20. Eyewear Prescription, Form DD-771. Type Eyewear Prescription, Form DD-771 for clarity and to avoid errors in interpretation, using the following format:
- a. Date. Enter as follows, 22 JAN 87, etc.
 - b. Order Number. Enter unit identifying number, issued by the Naval Ophthalmic Support & Training Activity (NOSTRA), 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 HINSON, Frank 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 Eyewear Prescription, Form DD-771, or Chronological Record of Medical Care, Form 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 Eyewear Prescription, Form DD-771, or Chronological Record of Medical Care, Form 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 multi-vision lenses must be in "minus cylinder" form, (-0.50, -0.75, etc.).
 - (3) Axis. Copy directly from individual's prescription, previous Eyewear Prescription, Form DD-771, or Chronological Record of Medical Care, Form 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 Eyewear Prescription, Form DD-771, or Chronological Record of Medical Care, Form 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 a 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.
21. Serology Record, Form SF-602.
- a. Purpose. 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. Providers and patients responsibilities. 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 Serology Record, Form SF-602.
22. Request for Administration of Anesthesia and Performance of Operations and Other Procedures, Form OF-522. Complete a Request for Administration of Anesthesia and Performance of Operations and Other Procedures, Form OF-522 describing the general nature of the procedure and have the patient sign prior to administering anesthesia (local or general) except for dental anesthesia. A Request for Administration of Anesthesia and Performance of Operations and Other Procedures, Form OF- 522 is required for dental surgical procedures such as exodontia, root canal therapy, and periodontal surgery; a Request for Administration of Anesthesia and Performance of Operations and Other Procedures, Form OF-522 is not required for routine dental anesthesia. File the Request for Administration of Anesthesia and Performance of Operations and Other Procedures, Form OF-522 for dental procedures in Section VI of the Medical Record in chronological order behind the Dental, Form SF-603.
23. Record of Occupational Exposure to Ionizing Radiation, Form DD-1141.
- a. Requirements. The custodian of the medical records shall prepare and maintain as Record of Occupational Exposure to Ionizing Radiation, Form 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 Record of Occupational Exposure to Ionizing Radiation, Form 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 Record of Occupational Exposure to Ionizing Radiation, Form DD-1141 from the exposure records received from the Public Health Service Contractor.
 - (b) Maintain separate Record of Occupational Exposure to Ionizing Radiation, Form 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, HSI, 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 kilovolts peak (kVp) 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 certifies 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.
24. Audiogram Results. The Microprocessor will generate a legal archival test result strip which shall be filed chronologically in the health records.
25. Reference Audiogram, Form DD-2215. Place form in Section V of the Health Record.
26. Hearing Conservation Data, Form DD-2216. Place form in Section V of the Health Record.
27. Chronological Record of Service, Form CG-4057.
- a. Purpose. Use this form:
 - (1) As a statement of agreement or disagreement with the assumption of fitness for duty upon separation from the CG.
 - (2) To terminate the health record.
 - b. 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 the Chronological Record of Service,

Chronological Record of Service, Form CG-4057. They shall then proceed as indicated in Chapter 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.

- c. 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 Special Duty Medical Abstract, Form NAVMED 6150/2, a copy of separation examination if done (either Report of Medical Examination, Form DD-2808 or Chronological Record of Medical Care, Form SF-600 entry), a signed copy of the Chronological Record of Service, Chronological Record of Service, Form CG-4057, and the International Certificate of Vaccination PHS-731 (if available) shall be made in the Remarks section of the Chronological Record of Service, Chronological Record of Service, Form CG-4057.
 - d. Notification of benefits. 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.
 - e. Chronological Record of Service, Form CG-4057 is filled. If either side of the Chronological Record of Service, Form CG-4057 is filled, the reverse side shall have a line drawn diagonally through it in red and a second Chronological Record of Service, Form CG-4057, marked "Supplement started this date" at the top.
28. Authorization for Disclosure of Medical or Dental Information, Form DD-2870. In order to use or disclose patient health information for purposes beyond the treatment, payment and health care operations and other purposes described in the MHS Notice of Privacy Practices, written authorization from the patient must be obtained on form Authorization for Disclosure of Medical or Dental Information, Form DD-2870.
29. Request to Restrict Medical or Dental Information, Form DD-2871. Individuals have the right to request restrictions on the use or disclosure of their health information. Requests must be made in writing on form Request to Restrict Medical or Dental Information, Form DD-2871. Requests for restriction may be denied upon review by the clinic HIPAA Privacy/Security Official, or the CG HIPAA Privacy/Security Official.

30. International Certificate of Vaccination, CDC-731.a. General.

- (1) When required, prepare an International Certificate of Vaccination PHS-731 for each member of the CG (for reserve personnel when ordered to Active Duty for Training). This form shall be carried only when required for performing international travel.
- (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 an International Certificate of Vaccination PHS-731 for this purpose. The reservist shall return the International Certificate of Vaccination PHS-731 to the district commander (r) when travel is completed.
- (3) When properly completed and authenticated, the International Certificate of Vaccination 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 CG cognizance shall be immunized in accordance with Commandant Instruction 6230.4 (series) and shall have in their possession a properly completed and authenticated International Certificate of Vaccination PHS-731, if required by the host country.

b. Detailed Instructions.

- (1) Stamp or type the following address on the front of PHS-731:

COMMANDANT (CG-11)
ATTN HEALTH SAFETY AND WORKLIFE
US COAST GUARD
2100 2ND ST SW STOP 7902
WASHINGTON DC 20593-7902

- (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. International Certificate of Vaccination, CDC-731. Remove the International Certificate of Vaccination CDC-731 from the health record and give it to the individual upon separation from the Service.

31. Tissue Examination, Form SF-515.
 - a. Prepare a Tissue Examination, Form SF-515 or use the contract lab form whenever a tissue specimen is forwarded to a laboratory for examination.
 - b. Ensure patient's identification information is completed.

32. Request for Medical/Dental Records or Information, Form DD-877.
 - a. Purpose. The Request for Medical/Dental Records or Information, Request for Medical/Dental Records or Information, Form DD-877 is a form used to track health records between clinics and units as well as to request records from clinics, units, or MTFs.
 - b. General. This form shall be initiated and included with health and clinical records as directed in this Manual.
 - c. Detailed Instruction.
 - (1) Each Request for Medical/Dental Records or Information, Form DD-877 must have all boxes completed.
 - (2) In all instances when a Request for Medical/Dental Records or Information, Form DD-877 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 Request for Medical/Dental Records or Information, Form DD-877 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 Individual Ready Reserve, (IRR) follow the instructions given by the Servicing Personnel Office as per the Military Personnel Data Records (PDR) System, COMDTINST M1080.10 (series).
 - (4) A copy of the Request for Medical/Dental Records or Information, Form DD-877 will be retained at the unit sending the record for 6 months after the record is mailed, and then may be discarded.

33. Modified Screening For: Overseas Assignment and/or Sea Duty Health Screening, Form CG-6100.
 - a. General. Refer to Chapter 3 of this Manual for the completion of this form.

34. Bloodborne Pathogens Exposure Guidelines, Form CG-6201.
 - a. General. Refer to Chapter 13 of this Manual for the completion of this form.

35. Examination Protocol for Exposure to: CHROMIUM COMPOUNDS, Form CG-6202.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.
36. Examination Protocol for Exposure to: ASBESTOS, Form CG-6203.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.
37. Examination Protocol for Exposure to: BENZENE, Form CG-6204.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.
38. Examination Protocol for Exposure to: NOISE, Form CG-6205.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.
39. Examination Protocol for Exposure to: HAZARDOUS WASTE, Form CG-6202.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.
40. Examination Protocol for Exposure to: LEAD, Form CG-6207.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.
41. Examination Protocol for Exposure to: RESPIRATOR WEAR, Form CG-6208.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.
42. Examination Protocol for Exposure to: PESTICIDES, Form CG-6209.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.
43. Examination Protocol for Exposure to: RESPIRATORY SENSITIZERS, Form CG-6210.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.
44. Examination Protocol for Exposure to: BLOODBORNE PATHOGENS, Form CG-6211.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.

45. Examination Protocol for Exposure to: TUBERCULOSIS, Form CG-6212.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.

46. Examination Protocol for Exposure to: SOLVENTS, Form CG-6213.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.

47. Examination Protocol for Exposure to: RADIATION, Form CG-6214.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.

48. How to Calculate a Significant Threshold Shift, Form CG-6215.
 - a. General. Refer to Chapter 12 of this Manual for the completion of this form.

C. Dental Record Forms, Classification, and Treatment Priority.1. Dental Record Cover, CG-3443-2.

a. Open a Dental Record Cover, CG-3443-2 for each individual upon arrival at a training center or initial entry into the CG or CG 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. The dental record shall be kept in the Health Record Cover, CG-3443 of each individual.

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.

(9) Dental Radiographs. 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 **front** side of the card.

2. Dental Health Questionnaire, NAVMED 6600/3.

- a. General. The Dental Health Questionnaire, Form NAVMED 6600-3 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 Dental Health Questionnaire, Form NAVMED 6600-3 and the Dental Continuation, Form SF-603-A.
- b. Detailed Instructions. Insert the Dental Health Questionnaire, Form NAVMED 6600-3 as the first page of the dental record. Patients shall fill out a new Dental Health Questionnaire, Form NAVMED 6600-3 at least annually, or when information changes. Maintain the two most recent forms in the dental record with the current Dental Health Questionnaire, Form NAVMED 6600-3 on top.
 - (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. Dental Record, Form SF-603.

- 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) Use the following numbering system for permanent dentition starting with the maxillary right third permanent molar as tooth #1:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

- (2) Use the following numbering system for deciduous dentition starting with the maxillary right second deciduous molar as tooth A:

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

- (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 Dental Record, Form SF-603 in SECTION I, Part 5 (Diseases, Abnormalities, and Radiographs) and enter a statement in the remarks section of Section 5.

c. SECTION 1. DENTAL EXAMINATION.

- (1) Purpose of Examination. To assess the oral health status of cadets, officer candidates and enlisted recruits upon initial entry into the CG, 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 CG. 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 shall include: oral cancer screening examination; mouth-mirror, explorer, and periodontal probe examination; adequate natural or artificial illumination; panoramic 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 plans 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). Shall include hard and soft tissue examination, which shall include: oral cancer screening examination; mouth mirror and explorer examination include Periodontal Screening and Recording™ (PSR) with sextant scores; appropriate panoramic 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 and follow-up exams for previously rendered treatment.
 - (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, Form NAVMED 6600-2 (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 (Oral Health). Patients with a current dental examination, who do not require dental treatment or reevaluation. Class 1 patients are worldwide deployable.
 - (b) Class 2. Patients with a current dental examination, who require non-urgent dental treatment or reevaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Class 2 are worldwide deployable. Patients in dental class 2 may exhibit the following:
 - [1] Treatment or follow-up indicated for dental caries or minor defective restorations that can be maintained by the patient.
 - [2] Interim restorations or prostheses that can be maintained for a 12-month period. This includes teeth that have been restored with permanent restorative materials for which protective cuspal coverage is indicated.

- [3] Edentulous areas requiring prostheses but not on an immediate basis.
 - [4] Periodontium that:
 - [a] Requires oral prophylaxis.
 - [b] Requires maintenance therapy.
 - [c] Requires treatment for slight to moderate periodontitis and stable cases of more advanced periodontitis.
 - [d] Requires removal of supragingival or mild to moderate sub-gingival calculus.
 - [5] Unerupted, partially erupted, or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis, but which are recommended for prophylactic removal.
 - [6] Active orthodontic treatment. The provider should consider placing the patient in passive appliances for deployment up to six months. For longer periods of deployment, the provider should consider removing active appliances and placing the patient in passive retention.
 - [7] Temporomandibular disorder patients in remission. The provider anticipates patient can perform duties while deployed without ongoing care and any medications or appliances required for maintenance will not interfere with duties.
- (c) Class 3. Patients who require urgent or emergent dental treatment. Class 3 patients normally are not considered to be worldwide deployable.
- [1] Treatment or follow-up indicated for dental caries, symptomatic tooth fracture or defective restorations that cannot be maintained by the patient.
 - [2] Interim restorations or prostheses that cannot be maintained for a 12-month period.
 - [3] Patients requiring treatment for the following periodontal conditions that may result in dental emergencies within the next 12 months.
 - [a] Acute gingivitis or pericoronitis.
 - [b] Active progressive moderate or advanced periodontitis.
 - [c] Periodontal abscess.

- [d] Progressive mucogingival condition.
 - [e] Periodontal manifestations of systemic disease or hormonal disturbances.
 - [f] Heavy subgingival calculus.
 - [g] Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate mastication or communication, or acceptable esthetics.
 - [h] Unerupted, partially erupted, or malposed teeth with historical, clinical or radiographic signs or symptoms of pathosis that are recommended for removal.
 - [i] Chronic oral infections or other pathologic lesions.
 - [j] Pulpal, periapical, or resorptive pathology requiring treatment.
 - [k] Lesions requiring biopsy or awaiting biopsy report.
 - [l] Emergency situations requiring therapy to relieve pain, treat trauma, treat acute oral infections, or provide timely follow-up care (e.g., drain or suture removal) until resolved.
 - [m] Acute Temporomandibular disorders requiring active treatment that may interfere with duties.
- (d) Class 4: Patients who require periodic dental examinations or patients with unknown dental classifications. Class 4 patients normally are not considered to be worldwide deployable.
- (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. CG active duty personnel in receipt of orders to sea, overseas, or combat duty.
 - (b) Group 2. CG active duty personnel upon return from sea, overseas, or combat duty.
 - (c) Group 3. Other CG personnel.
 - (d) Group 4. Active duty personnel of other Services assigned to duty with the CG.
 - (e) Group 5. Active duty personnel of other Services.
- (5) Missing Teeth and Existing Restorations.
- (a) 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 ceramics and resins). 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, Amalgam Restorations, above.
 - [8] Porcelain and Acrylic Post Crowns. Outline the crown and approximate size and position of the post(s).
 - [9] Porcelain Veneers. Outline each aspect.
 - [10] Acrylic Resin Jacket Crowns. Outline each aspect.
 - [11] Fixed Bridges. Outline each, showing overall size, location, teeth involved and shape by the inscription of diagonal lines in abutments and pontics.
 - [12] Removable Appliances. Place an "X" through the missing tooth, place a line over replaced teeth and describe briefly in "Remarks."
 - [13] Root Canal Fillings. Outline canal filled and black in solidly.
 - [14] Apicoectomy. Draw a small triangle apex of the root of the tooth involved, the base line to show the approximate level of root amputation.
 - [15] 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.
- (b) 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).

- (c) The examining Dental Officer shall sign, date, and record the place of examination where indicated.
- (6) 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) Abscess. 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 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 Dental Record, Form SF 603 are used to record findings of initial and replacement examinations. These charts shall not be altered thereafter.
- (7) SECTION 2. PATIENT DATA. Complete Items 6 through 14 as indicated.

- (8) SECTION 3. ATTENDANCE RECORD. 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, composite resin 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 CG 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 CG 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 CG 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".
- (9) 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).
- (10) 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, all dental materials used intraorally shall be identified. 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 Subjective. Objective. Assessment. Plan. (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 Dental Record, Form SF-603/Dental Record, Form 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 "in the words of the patient") 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 post-operative 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)	O
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.
Amalgam	Am.
Anesthesia	Anes.
Apicectomy	Apico.
Bridge (denotes fixed unless otherwise noted)	Br.
Calcium Hydroxide	CaOH
Calculus	Calc.
Cavity Varnish	C.Var.
Cement	Cem.
Complete Denture (full unless otherwise noted)	CD.
Composite Resins	Comp. Res.
Crown	Cr.

Deciduous	Decid.
Defective	Def.
Drain.	Drn.
Equilibrate (action)	Equil.
Eugenol	Eug.
Extraction	Ext.
Fluoride	Fl.
Fracture(s)	Frac.
General	Gen.
Gingival (itis) (state type in parenthesis)	Ging.
Gutta percha	G.P.
Impacted (ion)	Imp.
Impression	Impr.
Maxillary	Max.
Mandibular	Mand.
Periapical	PA.
Pericoronitis	P-Cor.
Periodontitis	Perio.
Porcelain	Porc.
Post Operative Instructions Given	POIG.
Post Operative Treatment	POT.
Prepared (ation)	Prep.
Prophylaxis	Prophy.
Reappoint (ment)	Reappt.
Recement (ed)	Recem.
Reduce (d)	Red.
Removable Partial Denture	RPD.
Sedative (ation)	Sed.
Sequestrum	Seq.
Surgical	Surg.
Suture (s)(d)	Su.
Treatment (ed)	Tx.
Zinc Chloride	ZnCl.

(11) Space is provided in the lower right margin under Section 3 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. Dental Continuation, Form SF-603-A.

a. General. Use a Dental Record, Form SF-603-A whenever the original Dental Record, Form 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 backside of the form.
- (2) Number the continuation sheet in the upper right corner following the phrase "DENTAL-Continuation." Thus, the earliest Dental Continuation, Form SF-603-A is labeled "DENTAL-Continuation #1" and subsequent sheets are labeled "DENTAL-Continuation #2", "DENTAL-Continuation #3", etc.
- (3) File the Dental Continuation, Form SF-603-A forms on top of the Dental Record, Form SF-603 form in reverse chronological order, i.e., the most recent on top.

5. Consultation Sheet, Form SF-513.

a. Purpose. The Consultation Sheet, Form 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 Commander PSC-adm-3 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 Dental Record, Form SF-603 "REPLACEMENT." Request the old Dental Record from the individual's last unit or Commander PSC-adm-3.

c. In case a lost Dental Record is recovered, incorporate the replacement record into the original record.

7. Special Dental Records Entries. When dental treatment is refused, make an appropriate entry on the Dental Record, Form SF-603 or Dental Continuation, Form SF-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 Dental Record, Form 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 palatinus and torus mandibularis, tattoos, piercings, 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 Dental Record, Form 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, Dental Record, Form 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 Dental Record, Form SF-603/Dental Continuation, Form SF-603-A, including PSR scores.
 - e. For all patients 16 years of age or older, blood pressure readings shall be taken and recorded on the Dental Health Questionnaire, Form CG-5605 and the Dental Record, Form SF-603/Dental Continuation, Form SF-603-A at initial and subsequent dental examinations.
9. Recording of Dental Treatments on a Chronological Record of Care, Form SF-600. Make entries of dental treatment on the Chronological Record of Care, Form 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.

D. Clinical Records (Dependent/Retiree).

1. Purpose and Background. The Clinical Record, CG-3443-1 is the chronological medical and dental record of a non-active duty beneficiary (dependent or retiree) eligible for health care at a CG facility. The Clinical Record Cover is used whenever a Clinical Record is opened on dependents or retirees. The primary reasons for compiling a clinical record are:

a. Purpose. 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. CG clinics are Primary Care Managers (PCM) for active duty members only. The family member may be given a copy of the clinical record contents to carry with them when the family will no longer receive care at the CG clinic. Inactive health records of dependents will be forwarded to the National Personnel Records Center in St. Louis, MO.

b. Uses. 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.
- (7) To evaluate personnel and facilities for professional certification and accreditation.
- (8) To facilitate communication among health care providers, utilization managers, quality assurance and medical records personnel.

c. To aid in identifying deceased persons when other means may be inadequate.

d. Detailed Instructions.

(1) Last Name. Record the last name in all capital letters.

SMITH

(2) 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

- (3) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 3 FEB 77.
- (4) Social Security Number. Enter sponsor's SSN.
- (5) Status. Check the appropriate block; i.e., Retiree USCG, Dependent USPHS, etc.
- (6) Other. Use this block to indicate special status or other information useful for either proper monitoring of the patient or for aid in identifying the patient or record.
- (7) Occupational Monitoring. Indicate the reason for occupational monitoring if monitoring is required.
- (8) 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 Adult Preventive and Chronic Care Flowsheet, Form DD-2766.

2. Contents of Clinical Records.

- a. Contents. Each clinical record shall consist of CG-3443-1 with dental and medical records arranged in the following bottom to top sequence: (Notes * when required)
 - (1) Left Side - Dental: CG-3443-2 Dental Record Cover* with Drug Sensitivity Sticker, CG-5266*, containing the following:
 - (a) Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures, Form OF-522*.
 - (b) Consultation Sheet, Form SF-513 (to be replaced by Tricare authorization document upon receipt).
 - (c) Dental Record, Form SF-603 *.
 - (d) Dental Record Continuation, Form SF-603A*.
 - (e) Dental Health Questionnaire, Form CG-5605*.
 - (2) Right Side - Medical:
 - (a) International Certificate of Vaccination, Form PHS-731* (Attached to the lower right corner of the inside of the Clinical Record Cover.)
 - (b) Record of Occupational Exposure to Ionizing Radiation, Form DD-1141.*
 - (c) Medical Record, Form SF-507.*
 - (d) Serology Record, Form SF-602.*

- (e) Immunization Record, Form SF-601.*
- (f) Eye Wear Prescription, Form DD-771.*
- (g) Electrocardiographic Report.*
- (h) Radiologic Consultation Request/Report (Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations), Form SF-519.
- (i) Laboratory Reports.
- (j) Gynecologic Cytology, Form SF-541.*
- (k) Tissue Examination, Form SF-515.*
- (l) Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures, Form OF-522.*
- (m) Consultation Sheet, Form SF-513.*
- (n) Medical Record, Form SF-507*
- (o) Occupational Medical Surveillance and Evaluation Program, Form CG-5447.*
- (p) Report of Medical History, Form DD-2807-1.*
- (q) Report of Medical Examination, Form DD-2808.*
- (r) Emergency Care and Treatment, Form SF-558.
- (s) Chronological Record of Medical Care, Form SF-600.
- (t) Adult Preventive and Chronic Care Flowsheet, Form DD-2766.
- (u) Drug Sensitivity Sticker, CG-5266.*
- (v) Authorization for Disclosure of Medical or Dental Information, Form DD-2870.
- (w) Request to Restriction Medical and Dental Information, Form DD-2871.

* Annotates when required

- b. Filing system. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file Chronological Record of Care, Form SF-600 dated 3 AUG 89 on top of Chronological Record of Care, Form SF-600 dated 20 MAY 86.
 - c. Dates. 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 CG 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 Chronological Record of Care, Form SF-600 explaining the circumstances under which the record was terminated. Forward the record, placed in a sealed envelope labeled “Sensitive Medical Information – Confidential,” to:

Dependant/Retirees:

NPRC-ANNEX
1411 BOULDER BLVD
VALMEYER, IL 62295

Military Records:

VA RECORDS MANAGEMENT CENTER
4300 GOODFELLOW BLVD BLDG 104
ST LOUIS MO 63115-1703

6. Custody of Clinical Records.
 - a. Custody. Clinical Records shall be retained in the custody of the Senior Health Services Officer 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. Entries. 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. Erroneous entry. 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. Completeness. 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. Removal of material. 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).
 - a. Security class. Since Clinical Records contain personal information of an extremely critical or sensitive nature, they are For Official Use Only requiring maximum security (high security locked cabinets or areas).
 - b. Disclosure. Except as contained in 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 Clinical Records.

- a. Dependents. When dependents of active duty personnel accompany their sponsor to a new duty station, the Senior Health Services Officer, 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 4-A of this Manual.
- b. Request for Medical/Dental Records or Information, DD-877. A Request for Medical/Dental Records or Information, Form DD-877, shall be initiated for each record transferred. Send the health record, via traceable means (e.g. DHS authorized Commercial Carriers FedEx or UPS). In instances where the family member will not be located near a CG Clinic, the record may be sent to the appropriate MTF.
- c. CG Clinics are Primary Care Managers for Active Duty Members Only. The family member may be given a copy of the clinical record contents to carry with them when the family will no longer receive care at the CG clinic. Inactive health records of dependents will be forwarded to the National Personnel Records Center in St. Louis, MO.
- d. Request for copies. 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. Concern about potential loss. 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 Health Services Administrator or the Senior Health Services Officer shall direct that copies of parts or all of the clinical record shall be made and retained at the clinic.
- f. Originals and copies. Originals and copies of clinical records shall be retained and subsequently archived in accordance with directions contained in the Information and Life Cycle Management Manual, COMDTINST M5212.12 (series).

9. Lost, Damaged, or Destroyed Clinical Records.

- a. Lost or destroyed. 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. Illegible. 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 Chronological Record of Medical Care, Form SF-600. Forward Clinical Records replaced by duplicate records to the National Personnel Records Center.

E. Employee Medical Folders.

1. Purpose and Background. The Employee Medical Folder, SF-66D is the chronological medical record of Federal employees eligible for health care at CG facilities. These are the primary reasons for compiling an Employee Medical Folder, SF-66D.
 - a. Documentation. 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. Provide quality health care. The information in the Employee Medical Folder, SF-66D 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 Folder, SF-66D.
 - a. Privacy. Employee Medical Folder, SF-66D 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 Employee Medical Folder, SF-66D contain personal information of extremely critical or sensitive nature, they are considered For Official Use Only records according to the CG 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 Employee Medical Folder, SF-66D 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. Custody. Employee Medical Folder, SF-66D 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. Individual's rights. Individuals may examine their Employee Medical Folder, SF-66D 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. Entries. Health services personnel making entries in Employee Medical Folder, SF-66D 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. Erroneous entry. If an erroneous hand-written 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. For electronic record erroneous entries, correction may be recorded by either amendment of the original entry or an addendum to the original entry, both of which are signed/dated electronically with closure of the document.
 - f. Completeness. Health services personnel are responsible for the completeness of the entries made on any form while the Employee Medical Folder, SF-66D is in their custody. No sheet shall be removed from the Employee Medical Folder, SF-66D except under conditions specified in this Manual.
 - g. Storage. Health services personnel shall ensure that, if Employee Medical Folder, SF-66D 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 Folder, SF-66D.
- a. Employee Medical Folder. Each medical folder shall consist of Employee Medical Folder, SF-66D with medical records arranged in the following bottom to top sequence:
 - (1) Left Side Dental: Leave blank.
 - (2) Right Side - Medical:
 - (a) International Certificate of Vaccination, Form PHS-731*
(Attached to the lower right corner of the inside of the Employee Medical Folder. This form is optional.)
 - (b) Record of Occupational Exposure to Ionizing Radiation, Form DD-1141*
 - (c) Medical Record, Form SF-507 **
 - (d) Occupational Medical Surveillance and Evaluation Program, Form CG-5447*
 - (e) Serology Record, Form SF-602*
 - (f) Immunization Record, Form SF-601*
 - (g) Eyewear Prescription, Form DD-771*

- (h) Electrocardiographic Report*
- (i) Radiologic Consultation Request/Report (Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations), Form SF-519
- (j) Laboratory Reports
- (k) Gynecologic Cytology, Form SF-541*
- (l) Tissue Examination, Form SF-515*
- (m) Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures, Form OF-522*
- (n) Consultation Sheet, Form SF-513 (to be replaced by Tricare authorization document upon receipt)*
- (o) Report of Medical History, Form DD-2807-1*
- (p) Report of Medical Examination, Form DD-2808*
- (q) Emergency Care and Treatment, Form SF-558*
- (r) Chronological Record of Medical Care, Form SF-600
- (s) Adult Preventive and Chronic Care Flowsheet, Form DD-2766
- (t) Drug Sensitivity Sticker, CG-5266 *
- (u) Authorization for Disclosure of Medical or Dental Information, Form DD-2870
- (v) Request to Restriction Medical or Dental Information, Form DD-2871

* Annotates when required

** Medical Record, Form SF-507 are attached to and filed after the form is continued.

- b. Sequence. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file Chronological Record of Care, Form SF-600 dated 3 AUG 87 on top of the Chronological Record of Care, Form SF-600 dated 20 MAY 86.
 - c. Dates. Enter all dates in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.
4. Accountability of Disclosures. The accountability of disclosure of records, as required by the HIPAA Privacy Regulation and the Privacy Act of 1974, will be maintained in accordance with Chapter 8, of The Coast Guard Freedom of Information (FOIA) and Privacy Acts Manual, COMDTINST M5260.3 (series), in the Protected Health Information Management Tool (PHIMT); see Chapter 14

Section B.2.e of this Manual. The information will be retained for six years after the last disclosure or for the life of the record, whichever is longer.

5. Opening Employee Medical Folder, SF-66D. Open an Employee Medical Folder, SF-66D when an eligible Federal employee initially reports for treatment.
6. Terminating Employee Medical Folder, SF-66D. Terminate the Employee Medical Folder, SF-66D in accordance with the Information and Life Cycle Management Manual, COMDTINST 5212.12 (series). Make an entry on the Chronological Record of Care, Form SF-600 explaining the circumstances under which the folder was terminated.
7. Transferring to Other Government Agencies. When transferring an Employee Medical Folder, SF-66D to other agencies, complete a Request for Medical/Dental Records or Information, Form DD-877.
8. Lost, Damaged, or Destroyed Employee Medical Folder, SF-66D.

Lost or destroyed. If an Employee Medical Folder, SF-66D is lost or destroyed, the unit which held the record shall open a complete new Employee Medical Folder, SF-66D. 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.

- a. Illegible. Employee Medical Folder, SF-66D 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 a Chronological Record of Care, Form SF-600. Forward Employee Medical Folder, SF-66D replaced by duplicate records to the National Personnel Records Center.
9. Employee Medical Folder, SF-66D.
 - a. Last Name. Record the last name in all capital letters.

BROOKS

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

- b. Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 8 JUN 62.
- c. Social Security Number. Enter SSN.

F. Inpatient Medical Records.1. Purpose and Background.

- a. Overnight care. Certain CG 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.
 - (2) Doctor's Orders, Form SF-508 (most recent on top).
 - (3) Physical Examination, Form SF-506.
 - (4) Medical Record, Form SF-507.
 - (5) Doctor's Progress Notes, Form SF-509 (most recent on top).
 - (6) Vital Signs Record, Form SF-511.
 - (7) Laboratory Report Display.
 - (8) Radiologic Consultation Request/Report (Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations), Form SF-519.
 - (9) Patient Care Kardex.
 - (10) Medication Kardex.
 - (11) Consultation Sheet, Form SF-513.
 - (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, an Abbreviated Medical Record, Form DD-2770, Radiologic Consultation Request/Report (Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations), Form SF-519, 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. Organizing the IMR. 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, confidentiality and security 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. Patients release. 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, radiology and consultation forms shall also be included in the IMR within 48 hours of the patient's release from overnight care.
 - f. Dictated entries. 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. Storage. After all notations, lab reports, radiology reports and consultations have been entered into the IMR, the IMR forms shall be placed in a bi-fold Clinical Record, 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 HIPAA Regulations, the Privacy Act of 1974 and the Freedom of Information Act. Guidance concerning these acts is contained in the CG 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. Security. Since IMRs contain personal information of an extremely critical or sensitive nature, they are considered For Official Use Only 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. Retention of records. IMRs will be retained at the creating health care facility for six years after the date the patient is released from overnight care.

3. Disposition of Inpatient Medical Record (IMR). The IMR will be forwarded to the National Personnel Records Center (NPRC) as described in Information and Life Cycle Management Manual, COMDTINST M5212.12 (series), six 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. Accession number. Print the accession number on each box, starting in the upper left hand corner. Mark the front of the box only. The accession number consists of the RG, which is always 26 for the CG, the current FY in which the records are being shipped, and a four digit number assigned by NPRC (see Chapter 4-F-3.j. for Records Transmittal and Receipt, Form 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.
 - 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.
 - f. Enclose in the first box of each accession one copy of the Records Transmittal and Receipt, Form 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.
 - 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 Records Transmittal and Receipt, Form 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 CG, the current FY during which the record is shipped, and the 4 digit sequential number assigned by NPRC. Also include the date sent. Complete a Records Transmittal and Receipt, Form SF-135 preparation and submission instructions are contained in the Information and Life Cycle Management Manual, COMDTINST M5212.12 (series).

4. Inpatient Medical Record Forms and Required Entries.

a. Doctor's Orders, Form SF-508.

(1) Purpose. Doctor's Orders, Form SF-508 are 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.

(a) When Prepared. Doctor's Orders, Form SF-508 shall be used to communicate doctor's orders for all persons admitted to the medical facility inpatient area.

[1] Required Entries.

[2] Patient identification information may be written in or overprinted using a patient identification card.

[3] 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.

[4] Certain orders may be defined as time limited, e.g., complete bed rest 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.

[5] 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. Clinical Record/Physical Exam, Form SF-506.

(1) Purpose. The Clinical Record/Physical Exam, Form SF-506 is part of the inpatient medical record. It is used to record information obtained from physical examinations.

(2) Preparation. When Prepared. Clinical Record/Physical Exam, Form SF-506 shall be prepared when a patient is admitted to the medical facility.

(a) 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. Progress Notes, Form SF-509.

(1) Purpose. The Progress Notes, Form 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.

- (a) When Prepared. The Progress Note, Form 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 Chapter 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. Vital Signs Record, Form SF-511.
 - (1) Purpose. Vital Signs Record, Form 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.
 - (a) When Prepared. Vital Signs Record, Form 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. 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.
 - [3] 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.
 - [4] 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.
 - [5] 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.

- [6] 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.
- [7] 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 diastolic measurements corresponding to the scale for pulse measurements.
- [8] 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.
- [9] 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. Laboratory Reports. Laboratory Reports are part of the inpatient medical record.
- f. Radiologic Consultation Reports, Form SF-519 (no longer used).
- (1) Purpose. Radiologic Consultation Reports, Form SF-519 is part of the inpatient medical record.
- g. Abbreviated Medical Record, Form DD-2770.
- (1) Purpose. Abbreviated Medical Record, Form 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.
- (a) When prepared, Abbreviated Medical Record, Form 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 Abbreviated Medical Record, Form 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 be 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 examinations 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.

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 a Chronological Record of Care, Form SF-600, Consultation Sheet, Form SF-513, IMB, DMB, or typed psychiatric evaluation forms as appropriate. Active duty episodic visits and routine appointments will be recorded on a Chronological Record of Care, Form SF-600 in SOAP format. The Objective (“O”) section shall include mental status observations and any other pertinent findings. Records of active duty mental health assessments and visits will be kept in the CG Health Record, CG-3443. An additional separate mental health record may be created and maintained in a system of records approved by the local QI Committee and kept secure in the mental health practitioner’s office. New patients shall be evaluated in accordance with traditional psychiatric evaluation processes.
2. Non-Active Duty. Separate records of mental health care may be created and maintained in a system of records approved by the local QI 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’s or retiree’s primary Clinical Record, CG-3443-1. Should the practitioner elect to maintain a separate office based record for non-active duty patients, the primary record must include at a minimum, the diagnosis on the problem summary list, current psychiatric medications on a Chronological Record of Care, Form SF-600, and laboratory analysis ordered by the mental health care provider. New patients shall be evaluated in accordance with traditional psychiatric evaluation processes. Episodic and follow-up visits shall be recorded in 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, chronic illnesses; surgical procedures, current medications; allergies; and alcohol and drug history); personal history, family history; mental status exam; assessment (DSM-IV); prognosis; and plan. Included in all assessments and other visits, as appropriate, an estimation of potential 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 USCG and copies should be made available to other practitioner’s or agencies at the patient’s request. These records should also be made available to other CG providers as part of an official records review process and as directed by Chapter 4-A-3 of this Manual.

