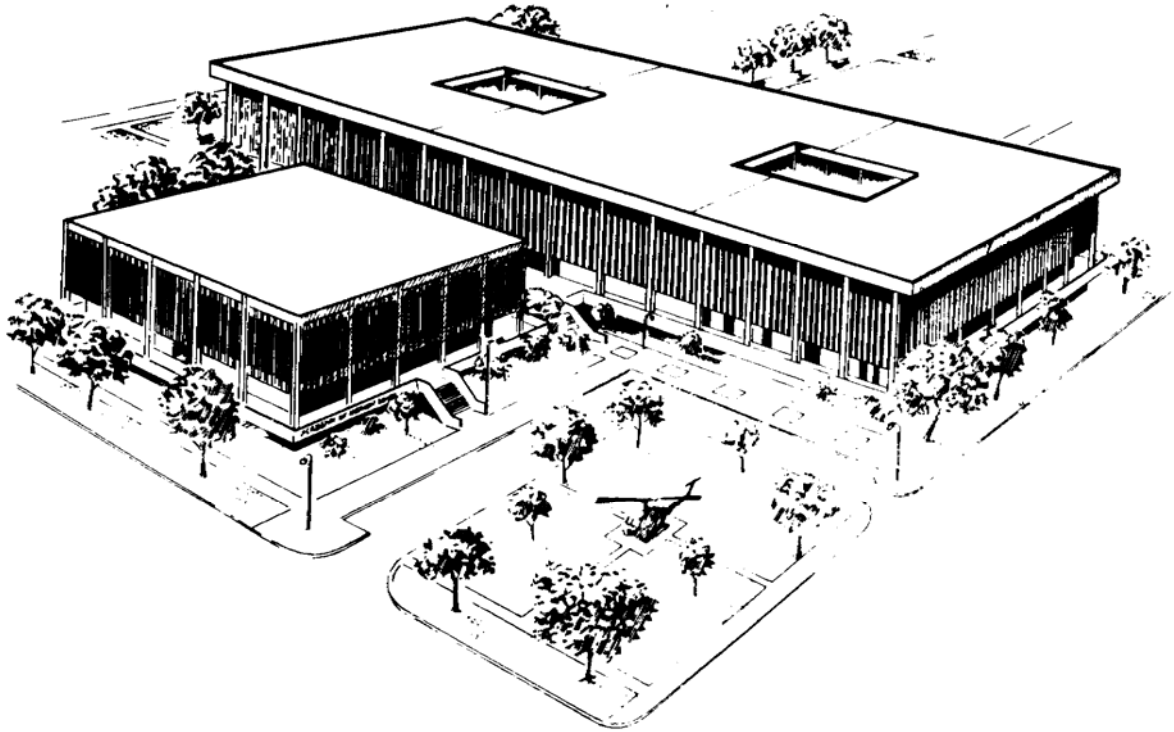


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**U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL  
FORT SAM HOUSTON, TEXAS 78234-6100**



# **MEDICAL RECORDS AND SICK CALL PROCEDURES**

**SUBCOURSE MD0920**

**EDITION 100**

## **DEVELOPMENT**

This subcourse is approved for resident and correspondence course instruction. It reflects the current thought of the Academy of Health Sciences and conforms to printed Department of the Army doctrine as closely as currently possible. Development and progress render such doctrine continuously subject to change.

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## **CLARIFICATION OF TRAINING LITERATURE TERMINOLOGY**

When used in this publication, words such as "he," "him," "his," and "men" are intended to include both the masculine and feminine genders, unless specifically stated otherwise or when obvious in context.

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## TABLE OF CONTENTS

Lesson		Paragraphs
	INTRODUCTION	
1	NURSING UNIT FORMS AND THE INPATIENT TREATMENT RECORD	1-1--1-19
	Exercises	
2	OUTPATIENT RECORDS	
	Section I. Clinics	2-1--2-2
	Section II. The Health Record	2-3--2-10
	Section III. The Outpatient Treatment Record	2-11--2-14
	Exercises	
3	TERMINAL DIGIT FILING SYSTEM	3-1--3-6
	Exercises	
4	FIELD MEDICAL CARD	4-1--4-9
	Exercises	
5	SICK CALL PROCEDURES	5-1--5-9
	Exercises	

**CORRESPONDENCE COURSE OF  
THE ACADEMY OF HEALTH SCIENCES, UNITED STATES ARMY**

**SUBCOURSE 920**

**MEDICAL RECORDS AND SICK CALL PROCEDURES**

**INTRODUCTION**

As a medical specialist assigned to an Army medical treatment facility or to a field unit, you want to do your best in providing care to your patients. One key to good patient care is communication. Many times this communication takes place through the use of forms, records, and reports. The physician and other health care providers rely upon the accuracy of the forms that you prepare in determining the treatment that the patient will receive. You rely upon forms completed by other personnel concerning instructions for patient care. An understanding of medical forms, records, and procedures is needed whether you are working on a nursing unit (ward) of a military hospital, in a clinic, or in a field unit.

**Subcourse Components:**

The subcourse instructional material consists of the following:

- Lesson 1, Nursing Unit Forms and the Inpatient Treatment Record.
- Lesson 2, Outpatient Records.
- Lesson 3, Terminal Digit Filing System.
- Lesson 4, Field Medical Card.
- Lesson 5, Sick Call Procedures

**Study Suggestions:**

Here are some suggestions that may be helpful to you in completing this subcourse:

- Read and study each lesson carefully.
- Complete the subcourse lesson by lesson. After completing each lesson, work the exercises at the end of the lesson, marking your answers in this booklet.
  
- After completing each set of lesson exercises, compare your answers with those on the solution sheet that follows the exercises. If you have answered an exercise incorrectly, check the reference cited after the answer on the solution sheet to determine why your response was not the correct one.

**Credit Awarded:**

To receive credit hours, you must be officially enrolled and complete an examination furnished by the Nonresident Instruction Branch at Fort Sam Houston, Texas. Upon successful completion of the examination for this subcourse, you will be awarded 8 credit hours.

You can enroll by going to the web site <http://www.train.army.mil> and enrolling under "Self Development" (School Code 555).

A listing of correspondence courses and subcourses available through the Nonresident Instruction Section is found in Chapter 4 of DA Pamphlet 350-59, Army Correspondence Course Program Catalog. The DA PAM is available at the following website: <http://www.usapa.army.mil/pdffiles/p350-59.pdf>.

## LESSON ASSIGNMENT

### LESSON 1

Nursing Unit Forms and the Inpatient Treatment Record.

### TEXT ASSIGNMENT

Paragraphs 1-1 through 1-19.

### LESSON OBJECTIVES

When you have completed this lesson, you should be able to:

- 1-1. Identify who should have an Inpatient Treatment Record.
- 1-2. Identify forms maintained in the Inpatient Treatment Record.
- 1-3. Identify information recorded on DA Form 3872, DA Form 3888, DA Form 3888-1, DA Form 3950, DA Form 4015, DA Form 4256, DA Form 4677, DD Form 792, SF 510, and SF 511.
- 1-4. Calculate fluid intake and output.
- 1-5. Enter information on DD Form 792.
- 1-6. Enter information on SF 510.
- 1-7. Enter information on SF 511.

### SUGGESTION

Work the lesson exercises at the end of this lesson before beginning the next lesson. These exercises will help you accomplish the lesson objectives.

## LESSON 1

### NURSING UNIT FORMS AND THE INPATIENT TREATMENT RECORD

#### 1-1. INPATIENTS AND OUTPATIENTS

Patients can be divided into two groups--inpatients and outpatients. Inpatients are those patients who are admitted to a military medical treatment facility (MTF), usually a United States Army (US Army) medical center (MEDCEN) hospital or a US Army community hospital (USACH) of a US Army medical department activity (MEDDAC). Outpatients are those patients who are treated at a MTF, usually a medical or dental clinic, but are not admitted to a MTF. Outpatients are sometimes referred to as ambulatory patients.

#### 1-2. MILITARY FORMS

Three general types of forms are discussed in this subcourse. Standard forms (SF) are those forms that have been approved for use by Federal agencies in general. Department of Defense (DD) forms are those forms that have been approved for use by the departments and agencies of the Department of Defense. Department of the Army (DA) forms are those forms which have been approved for use throughout the Department of the Army. If a question arises over whether a particular form is currently approved for use, Department of the Army Pamphlet 25-30, Consolidated Index of Army Publications and Blank Forms, should be consulted.

#### 1-3. THE INPATIENT (CLINICAL) TREATMENT RECORD

An MTF, sometimes called the Clinical Treatment Record, is prepared for every military and civilian patient admitted to the MTF (hospital, fixed health clinic, or convalescent center), for each live born infant delivered in the facility, for all North Atlantic Treaty Organization (NATO) personnel treated at the facility, and for carded-for-record- only (CRO) cases. A patient's MTF consists of all permanent forms prepared on the patient during his uninterrupted period of treatment. AR 40-66, Medical Record and Quality Assurance Administration, contains instructions for filing forms in the DA Form 3444-series file folder used to maintain MTFs Inpatient Treatment Record (ITR). Inpatient Treatment Records are filed using the terminal digit filing system discussed in Lesson 3.

a. **Transfer of Inpatient Treatment Record.** When an inpatient is transferred to another US military MTF, the patient's original MTF is sent with the patient and becomes part of the patient's MTF maintained at the receiving facility.

b. **Retirement of Inpatient Treatment Record.** When a patient is discharged (released from the facility, transferred to a nonmilitary MTF, or dies), the patient's MTF is completed in accordance with AR 40-66. An MTF Cover Sheet, DA Form 3647 or DA Form 3647-1, summarizing the treatment provided is filed in the patient's permanent

outpatient medical record (Health Record [HREC] or Outpatient Treatment Record [OTR]). The MTF is maintained by the facility for a specified time (usually 1 year for a USACH or 5 years for a MEDCEN) and then retired in accordance with AR 340-18, The Army Functional File System.

#### **1-4. PERMANENT AND TEMPORARY FORMS**

Some of the forms that a medical specialist may encounter while working on a hospital ward (unit) are discussed in this lesson. Some of these forms are permanent. That is, they become part of the patient's MTF. Other forms are temporary and can be destroyed once the information has been transferred to another form or when the form is no longer needed. Paragraphs 1-5 through 1-10 pertain to temporary forms and paragraphs 1-11 through 1-18 pertain to permanent records. Permanent forms are often kept in metal folders (charts) maintained on the ward. Each patient has a chart containing his SF 510, SF 511, DA Form 4256, and DA Form 4677. DA Forms 3888 and 3888-1 may be maintained in separate charts.

#### **1-5. NURSING SERVICE PERSONNEL TIME SCHEDULE (DA FORM 3872)**

The Nursing Service Personnel Time Schedule provides a roster of personnel, shows on-duty and off-duty time, and explains the absences of nursing personnel from the ward. The planning and preparation of the time schedule is the responsibility of the clinical head nurse or other person designated by the Chief, Department of Nursing. Time schedules are usually prepared and posted two weeks in advance. The processes for submitting schedules and making changes are determined by local policy. The form is retained as a reference for at least one month after the end of the period covered and may be retained longer if required. The time schedule is destroyed when it is no longer needed. Figure 1-1 shows an example of a time schedule. The symbols "D," "E," and "N" stand for day, evening, and night respectively. The numbers show how many professional (officer and civilian) and paraprofessional personnel (enlisted and civilian) nursing personnel are on the day, evening, and night shifts.

#### **1-6. NURSING CARE ASSIGNMENT**

The Nursing Care Assignment (DA FORM 4015) (figure 1-2) is a worksheet initiated by the clinical head nurse or other designated personnel showing the specific nursing care and related activities assigned to individual nursing personnel. It is prepared daily and distributed at the time of shift change. The form assists nursing personnel in organizing their work since each person knows the patients he has been assigned and any special nursing care that must be given.



NURSING SERVICE PERSONNEL TIME SCHEDULE				DATES (Inclusive) OF PERIOD COVERED						
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.				24 JUN 9X - 30 JUN 9X						
TITLE	LAST NAME	DUTY	DUTY TIME, CLASS TIME, OR OFF-DUTY STATUS							
			24 SUN.	25 MON.	26 TUE.	27 WED.	28 THURS.	29 FRI.	30 SAT.	
MAJ	SMITH	66H HN	DO	D	D	D	D	D	DO	
CPT	BLAIR	66H ASST HN	D	DO	D	DO	D	D	D	
1LT	MASON	66H CSN	E	E	E	E	E	DO	DO	
1LT	RAMIREZ	66H CSN	N	N	N	N	DO	DO	D	
2LT	EVANS	66J CSN	D	DO	DO	E	E	E	E	
2LT	MCNULTIE	66J CSN	N	N	DO	DO	N	N	N	
MRS	JOTE	GS-9 CSN	DO	D	D	D	LV	LV	DO	
			2/1/2	2/1/2	3/1/1	2/2/1	2/2/1	2/1/1	2/1/1	
SFC	ATKINS	91C40 WM	DO	D	D	D	D	D	DO	
SSG	CARTER	91C30 PN	D	D	D	D	DO	DO	D	
SGT	BANNER	91C20 PN	E	E	DO	DO	E	E	E	
SGT	LAWSON	91C20 PN	N	N	N	N	N	DO	DO	
SGT	TANNER	91A20 MED SP	DO	DO	E	E	E	E	E	
SPC	CANNINGER	91A10 MED SP	N	N	N	DO	DO	N	N	
SPC	NELSON	91A10 MED SP	LV	DO	DO	D	D	D	D	
PFC	DONALDSON	91A10 MED SP	D	D	DO	DO	D	D	D	
PFC	ZAPATA	91A10 MED SP	E	E	E	E	DO	DO	N	
MR	HARPER	GS-4 LVN	D	D	D	D	D	DO	DO	
			3/2/2	4/2/2	3/2/2	4/2/1	4/2/1	3/2/1	3/2/2	
SIGNATURE OF HEAD NURSE			<i>Henry K. Smith, MAJ, AN</i>						WARD 3-A	
<p><b>INSTRUCTIONS</b></p> <p>List professional personnel first and then nonprofessional. In column under "title" enter title, e.g., Maj., Capt., Lt., Sgt., Pvt., Mr., Mrs., Miss. Entries for "Duty" and for "Off-Duty Status" will be symbolized as follows:</p> <p><b>"Duty" symbols</b>  HN—Head nurse  ASST. HN—Asst. head nurse  GEN. DUTY—General duty  CL. T—Clinical technician  WM—Ward master</p> <p><b>"Off-Duty Status" symbols</b>  DO—Day off  LV—Leave  SK—Sick leave  HT—Holiday time</p>										

Figure 1-1. DA Form 3872, Nursing Service Personnel Time Schedule.

NURSING CARE ASSIGNMENT		HEAD NURSE	
For use of this form, see AR 40-407; the proponent agency is OTSG.		<i>S. Smith, CPT, AN</i>	
ASSIGNMENTS FOR (Nurse, Technician, Civilian attendant)			
<i>SPC R. Jones</i>			
WARD		DATE	
<i>2-B</i>		<i>28 May 199X</i>	
R/B	NAME OF PATIENT	BATH	TREATMENT AND CARE
<i>14-1</i>	<i>Sgt. Q Hans</i>	<i>bed</i>	<i>Back care with lotion Turn from side to side at 0800-1000-1200-1400</i>
<i>14-2</i>	<i>PFC Rable</i>	<i>assist</i>	<i>Assist in and out of bed. Elevate (R) foot on two pillows when in bed.</i>
<i>14-3</i>	<i>Mr. H. Ander</i>	<i>self</i>	<i>Refer to nursing care plan</i>
<i>14-4</i>	<i>MSG H. Smith</i>	<i>assist</i>	<i>Escort in wheel-chair to Neurology Clinic at 1300.</i>
SIGNATURE			
<i>SPC Ruth Jones</i>			
DA FORM 4015		REPLACES DA FORM 8-896, 1 JUL 87, WHICH MAY BE USED.	
		U.S.GPO:1979-0-865-041/162	

Figure 1-2. DA Form 4015, Nursing Care Assignment.

a. **Contents.** The assignment worksheet contains the name of the nursing team member who will perform the duties assigned, the date of the worksheet, and the locations and names of the patients assigned to the member. Instructions for patient bathing are listed in the "Bath" column. Common instructions include "assist," "self," "tub," and "shower." A check mark indicates that the nursing team member is to bathe the patient. Any special instructions are listed in the "Treatment and Care" column.

b. **Signatures.** The form is signed by the head nurse when it is given to the team member. Observations and special points of care performed by the team member are noted on the back of the form by the team member. After the assignments have been accomplished, the team member signs the form and returns it to the nurse.

### 1-7. TEMPERATURE, PULSE AND RESPIRATION RECORD (DA FORM 3950)

The Temperature, Pulse and Respiration Record (TPR) is a worksheet used to record the patients' vital signs TPR, as they are taken. This worksheet is usually destroyed after the readings have been transcribed to the Standard Forms 511 maintained on the individual patients.

a. **Initiate the Form.** Use either a pencil or pen to make entries on the TPR. Enter the ward number and the date in the upper right corner of the form. Enter the times the vital signs are to be taken (usually every 4 hours) in the column headings.

b. **Enter Vital Signs Readings.** Enter the patient's vital signs as they are taken. Enter a patient's blood pressure readings (in even whole numbers) if taken at the top of the block in systolic/diastolic format. Enter the patient's temperature (to the nearest two-tenths of a degree Fahrenheit), pulse rate (to the nearest even whole number), and respiration rate (even or odd whole number) in the bottom portion of the block in that order. If the patient's temperature is taken rectally, enter " R " after the temperature reading. If it is taken by the axillary method (under the arm), enter " A " after the reading. A temperature taken orally (by mouth) does not have a special symbol entered after the reading. Figure 1-3 shows an example of a TPR worksheet.



**1-8. TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET (DD FORM 792)**

The Twenty-Four Hour Patient Intake and Output Worksheet (figures 1-4 and 1-5) is used to record the amount of liquid that the patient takes into his body and the amount of liquid that the patient's body loses. In a normal healthy adult, the intake (the amount taken into the body) is about the same as the output (the amount lost by the body). This balance between liquid intake and liquid output is called the fluid balance. A physician may order that a Twenty-Four Hour Patient Intake and Output Worksheet (usually called the Intake and Output (I&O) Worksheet be maintained for a patient whom he suspects has had or will have an abnormal fluid loss or gain. Information from the I&O Worksheet may also be used in computing intravenous (IV) therapy. The form is kept by the patient's bed so I&O can be recorded conveniently. A "Measure Intake-Output" sign is usually attached to the patient's bed to remind personnel that all liquid I&O must be recorded. After receiving proper instructions, the patient and even visitors can assist nursing personnel by measuring and recording I&O data. The I&O Worksheet may be completed either in pencil or in pen. After the worksheet has been completed, the sums are recorded either on the patient's Vital Signs Record (SF 511) or in the Nursing Notes (SF 510). The worksheet is usually destroyed once the information has been transcribed to the proper form.

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET						FROM 0001 HOURS	TOTAL HOURS COVERED	DATE		
						TO 2400 HOURS	24	15 May 9X		
ORAL				INTAKE						
TIME	TYPE	AMOUNT	ACCUM TOTAL	INTRAVENOUS						
				TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL	
0615	Water	120	120	0001	300	D5W w/Multivitamins	300	0400	300	
0830	Coffee	160	280	0400	1000	D5W w/Multivitamin	1000	1630	1300	
1230	Tea	180	460	1630	1000	NS	600	2400	1900	
1500	Tea	120	580							
1830	Water	240	820							
2000	Tea	240	1060							
2200	Juice	120	1180							
2215	Water	120	1300							
				IRRIGATIONS (N/G, Bladder, etc.)						
				TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL			
				1300	NG/NS	45	45			
				1900	NG/NS	30	75			
				BLOOD/BLOOD DERIVATIVES						
TIME STARTED	PRODUCT (i.e. B1, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL	OTHER INTAKE					
					TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL		
				GRAND TOTAL INTAKE 3275						

Figure 1-4. DD Form 792, Twenty-Four Hour Patient Intake and Output Worksheet (top [intake] section).



## 1-9. DEFINITIONS OF INTAKE AND OUTPUT

a. **Intake.** Intake is any measurable fluid that goes into the patient's body. Intake includes fluids (such as water, soup, and fruit juice) and "solids" composed primarily of liquids (such as ice cream and gelatin) that are taken by mouth (orally), fluids that are introduced by IV, and fluids that are introduced by irrigation (through a tube).

b. **Output.** Output is any measurable fluid that comes from the body. Water given off in the form of perspiration and water vapor (exhaled breath) is also output, but it is not recorded on the DD Form 792, since it cannot be accurately measured. (An adult usually loses about 500 milliliters (ml) a day through perspiration and moisture exhaled in breathing.) The major forms of output recorded on the worksheet are urine, drainage, vomitus (matter vomited), and stools (fecal discharge from the bowels).

**NOTE:** Intake and output are measured in milliliters (ml) or cubic centimeters (cc). Since 1 milliliter is equal to 1 cubic centimeter, the terms milliliters and cubic centimeters will be interchangeable for the purpose of this subcourse. Conversion equivalents are found in Table 1-1 and in the "Intake Equivalents" section of DD Form 792.

## 1-10. COMPLETING THE TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

a. **Patient's Identification Section.** Enter the information in the lower left corner of the output section of the worksheet. The information may be typed, handwritten, or imprinted using an addressograph machine to imprint the patient's inpatient identification plate and the unit's ward plate.

(1) The normal format of the inpatient plate is as follows:

(a) Line 1. Patient's name (last, first, middle initial); rank or grade or status.

(b) Line 2. Hospital register number; family member prefix code and sponsor's social security number.

(c) Line 3. Patient's sex (M or F); patient's age.

(2) The ward plate normally contains the hospital's name, location, and Military Expense Performance Reporting System code (old Uniform Chart of Accounts code) on the first and second lines and the nursing unit (ward) on the third line.

b. **Heading.** Enter the time covered by the report, the number of hours covered, and the date in area to the right of the form title. The time span is usually for 24 hours from midnight to midnight (0001 hours to 2400 hours). If the worksheet is ordered for a patient to be begin at a time different from 0001, such as an order to begin the I&O Worksheet immediately for a patient admitted at 1400, then the patient's first worksheet covers the time (10 hours) from when the worksheet was begun (1400) to 2400. At 2400, the worksheet is completed and a second worksheet covering the next 24 hours (0001 to 2400) is begun.

<u>Measure</u> .....	<u>Approximate equivalent</u>
Cubic centimeter.....	1 ml
Teaspoon .....	5 ml
Tablespoon.....	15 ml
Ounce.....	30 ml
Medicine Glass (1 oz.).....	30 ml
Small Fruit Cup.....	120 ml
Coffee Cup .....	160 ml
Large Coffee Mug.....	180 ml
Plastic or Paper Juice Container .....	180 ml
Half-pint Milk.....	240 ml
Large Soup Bowl .....	240 ml
Large Water Glass.....	240 ml
Pint .....	480 ml
1/2 Liter .....	500 ml

Table 1-1. Converting to millimeters (or cubic centimeters).

c. **Oral Intake.** Fluids and solids composed primarily of liquids, which are consumed are recorded in the section labeled "Oral."

(1) Measure oral intake. Oral intake is usually determined by using a graduated cylinder to measure the amount of fluid that the patient did not consume and subtracting that amount from the original amount. For example, if a patient drank all but 80 ml of a half-pint of milk, the amount that the patient actually consumed can be determined by taking the original amount contained in a half-pint of milk (240 ml) and subtracting the amount not consumed (240 ml - 80 ml = 160 ml).

**NOTE:** If you are not certain as to whether the liquid was consumed by the patient or by a visitor--**ASK.**

(2) Record oral intake. Record oral intake as follows:

(a) Time. Enter the time that the intake occurred.

(b) Type. Describe what was consumed.



(c) Amount. Enter the amount consumed.

(d) Accumulative total. Enter the total oral intake for the patient by adding the amount consumed (amount block) to the total of consumed previously (previous entry in the accumulative total column).

d. **Intravenous Intake.** Record all fluids given by IV in the section labeled "Intravenous" with the exception of blood and blood derivatives. Record blood and blood derivatives in a similar manner in the section labeled "Blood/Blood Derivatives."

(1) Measure intravenous intake. Measuring intravenous intake does not require any additional equipment or tables of conversion since the IV bag or bottle itself is a type of graduated cylinder.

(a) An IV bag has a scale, which can be read when the bag is hung. If the bag is not empty, the amount of fluid which has entered the patient can be determined by grasping the top (empty) part of the bag, pulling it taut, and reading the scale. The number indicated by the top of the fluid level in the bag is the approximate amount of fluid, which the patient has received. (The scale is in hundreds of milliliters).

(b) An IV bottle has two scales--one scale that can be read when the bottle is turned upright and another scale that can be read when the bottle is turned upside down. The scale is read when the bottle is upright (neck up and bottom down) gives the amount of fluid that is in the bottle. The scale that is read when the bottle is upside down gives the amount of fluid which has gone into the patient. The amount of fluid that a patient has received may be measured without stopping the IV since the bottle must be hung upside down in order for the solution to flow into the patient's vein.

(2) Record intravenous intake. Record IV intake as follows:

(a) Time. Enter the time the IV was initiated.

(b) Amount. Enter the total amount of solution in the bag or bottle at the time the IV was started.

(c) Type. Record the solution being administered (normal saline (NS), five percent dextrose in water (D5W), Ringer's lactated solution (RL), and so forth.) Record any medications which are added to the solution.

(d) Amount received. Enter the amount of fluid that actually went into the patient.

(e) Time completed. Enter the time the IV was completed or stopped.

(f) Accumulative total. Enter the total amount that the patient has received by IV during the reporting period.

**NOTE:** If an IV is in progress at midnight (2400), it is recorded on the forms as though the IV is stopped at 2400 and restarted at 0001. (Of course, the IV is not really stopped at this time.) Suppose a patient is to be administered 1000 ml of Ringer's lactated solution starting at 2300 and the bag still contained 400 ml at 2400. The form ending at 2400 would read:

<b>OUTPUT WORKSHEET</b>		FROM <u>1600</u> HOURS	TOTAL HOURS COVERED <u>8</u>	DATE <u>24 May 9X</u>		
		TO <u>2400</u> HOURS				
<b>INTAKE</b>						
<b>INTRAVENOUS</b>						
AMOUNT	TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
	<u>2300</u>	<u>1000</u>	<u>RL</u>	<u>600</u>	<u>2400</u>	<u>600</u>

The new form beginning at 0001 would read:

<b>OUTPUT WORKSHEET</b>		FROM <u>0001</u> HOURS	TOTAL HOURS COVERED	DATE <u>25 May 9X</u>		
		TO _____ HOURS				
<b>INTAKE</b>						
<b>INTRAVENOUS</b>						
AMOUNT	TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
	<u>0001</u>	<u>400</u>	<u>RL</u>			

**NOTE:** Items (d), (e), and (f) are not completed until the I.V. bag or bottle has been replaced, the IV has been discontinued, or the time covered by the form has ended.

e. **Irrigation Intake.** Irrigation is the washing or flushing of a body cavity by a steady stream of liquid. Common examples are irrigation of the bladder using a Foley catheter and irrigation of the gastrointestinal (GI) tract using a nasogastric (NG) tube.

(1) Measure irrigation intake. Determine irrigation intake by subtracting the amount of fluid remaining in the container from the original fluid amount of the container.

(2) Record irrigation intake. Record irrigation intake as follows:

(a) Time. Enter the time the irrigation was begun.

(b) Type. Describe the type of irrigation performed and the type of solution used.

(c) **Amount.** Enter the total amount of irrigation fluid actually introduced into the patient's body.

(d) **Accumulative total.** Enter the total amount of irrigation fluid which the patient has received during the reporting period (amount plus previous accumulative total).

f. **Grand Total Intake.** At the end of the reporting period, add together the last figure in the accumulative total column from each input section and enter the sum in the "Grand Total Intake" section. This is the amount of fluid which the patient has received during the reporting period.

g. **Urine Output.** Urine output includes urine that is voided by the patient and urine that is drained using a catheter.

(1) Measure urine output. A bedpan or urinal is used for voiding so that the urine can be accurately measured. An empty IV bottle with an improvised paper funnel may be used to measure the amount of fluid voided if a wide-mouth graduated cylinder is not available. If the patient has a urinary catheter, the bag connected to the catheter will have markings for measuring the amount of urine in the bag.

(2) Record urine output. Record urine output as follows:

(a) **Time.** Enter the time that the patient voided.

(b) **Amount.** Enter the amount the patient voided.

(c) **Accumulative total.** Enter the total amount of urine output by the patient during the reporting period (amount plus previous accumulative total).

h. **Nasogastric Output.**

(1) Measure nasogastric output. Nasogastric output from nasogastric irrigation can be captured using a bottle that has markings for measuring liquid content. Otherwise, capture the output and pour it into a graduated cylinder to measure the output.

(2) Record nasogastric output. Record nasogastric output as follows:

(a) **Time.** Enter the time that the nasogastric drainage bottle was emptied.

(b) **Amount.** Enter the amount of drainage (obtained using the scale on the drainage bottle).

(c) Type. Enter a description of the drainage, such as green, yellow, or greenish-yellow.

(d) Accumulative total. Enter the total nasogastric output that has occurred during the reporting period (amount plus previous accumulative total).

**i. Chest Output.**

(1) Measure chest output. Drainage from the chest cavity is usually captured in an IV bottle or other device with markings for measuring the amount of liquid present.

(2) Record chest output. Record chest output as follows:

(a) Time. Enter the time that the chest drainage bottle was emptied.

(b) Amount. Enter the amount of drainage (obtained from drainage bottle).

(c) Accumulative total. Enter the total chest drainage that has occurred during the reporting period (amount plus previous accumulative total).

**j. Emesis (Vomiting) Output.**

(1) Measure vomitus. Vomitus is usually captured in a pan designed for this purpose. The vomitus is then poured into a graduated cylinder or other device and measured.

(2) Record vomitus output. Record vomitus output as follows:

(a) Time. Enter the time that the patient vomited.

(b) Amount. Measure and enter the amount of vomitus.

(c) Type. Enter a description of the vomitus, including color and content. Vomitus that has no content is referred to as "clear."

(d) Accumulative total. Enter the total vomitus output that has occurred during the reporting period (amount plus previous accumulative total).

**k. Stool Output.**

(1) Measure stool output. Stool (fecal) output can be liquid, semi-formed, or formed. The stool is captured in a bedpan. Liquid and semi-formed stools are considered to be fluid output and are measured by pouring the stool into a graduated cylinder or other measuring device. Formed stools are classified by observation and are not considered to contain fluid.

- (a) A "liquid" stool (diarrhea stool) is predominately water.
- (b) A "formed" stool is solid.
- (c) A "semi-formed" stool is composed of both liquid and formed stool.

This stool may also be called a "semi-liquid" stool.

(2) Record stool output. Record stool output as follows:

- (a) Time. Enter the time at which the patient passed the stool.
- (b) Color. Enter the color of the stool, such as dark brown, black, gray, or green.
- (c) Character. Enter a description of the stool's consistency (liquid, semi-formed, or formed).
- (d) Amount. Enter the size of the stool (small, moderate, or large) if the stool was formed or the amount in milliliters if the stool was liquid or semi-formed.
- (e) Accumulated total. Enter the total stool output that has occurred during the reporting period (amount plus previous accumulative total). Formed stools are counted as containing no fluid.

I. **Grand Total Output.** At the end of the reporting period, add together the last figure in the accumulative total column from each output section and enter the sum in the "Grand Total Output" section.

## 1-11. VITAL SIGNS RECORD (SF 511)

The Medical Record--Vital Signs Record (figure 1-6) is a form used to record the patient's vital signs. This form is also called the TPR graphic and the SF 511. All entries are made using permanent blue-black or black ink to ensure that good photostat or microfilm copies can be made of the form. Charting errors are corrected by drawing a single line through the incorrect entry, initialing above the drawn line, and making the correct entry. The entire form is usually recopied if the error appears too untidy. A partially completed SF 511 is shown in figure 1-7. The Vital Signs Record is kept in the patient's chart (a metal folder kept on the ward). The form is filed in the patient's MTF after the form has been filled or when the patient is dispositioned (released from the hospital, and so forth.).

## 1-12. COMPLETING THE VITAL SIGNS RECORD

Transfer the information from the TPR worksheet (DA Form 3950) to each patient's SF 511. The procedures for initiating and recording vital signs and other information follow.

a. **Patient's Identification Section.** Enter the patient identification information in the patient identification section located at the bottom of the SF 511. This information may be typed, hand printed, or imprinted with an addressograph machine. For example, Sergeant James J. Jones, age 25, SSN 223-23-3323, was admitted to US Army Community Hospital, Fort Splendid, Texas, at 0400 on 14 September 199X. He was given hospital register number 55574 and was assigned to Ward 5A. This data was recorded as follows:

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; rank; rate; hospital or medical facility)				REGISTER NO. 55574	WARD NO. 5A
111-112	JONES	James J	SGT	VITAL SIGNS RECORD	
	20	22323	3323	14 Sep 9X	
	M.	25		STANDARD FORM 611 (REV. 9-79)	
	USACH	FT Splendid TX		Prescribed by GSA and Interagency Committee on Medical Records FPMR (41 CFR) 101-11.606-8	

b. **Heading Entries.** Enter the hospital day, the post-op/partum day (if applicable), calendar date, and times that the vital signs are taken at the top of the SF 511.

(1) Hospital Day. The row of blocks horizontal to "Hospital Day" indicates the number of days the patient has been in the hospital. The day the patient enters the hospital (the day of admission) is referred to as "day 1." The following day is "day 2," and so forth.

(2) Post- Day. The row of blocks located under the hospital day row indicates the date the patient underwent an operation or, in the case of a female patient who has given birth, the date of delivery and the number of days which have passed since that day. If the patient did not undergo an operation or delivery, the row is left blank.

(a) Write "OP" after "POST-" if the patient had an operation. Write "PARTUM" after "POST-" if the patient had a delivery.

(b) Indicate the date of surgery (DOS) or date of delivery (DOD) by writing the appropriate abbreviation in the block of the "POST- DAY" row which corresponds to the calendar date of the event.

(c) Indicate the post-operation or post-partum date by writing the appropriate numeral in the column headings. The day following the date of surgery is post-op day 1; the day following the date of delivery is post-partum day 1. The following days would be post-op/post-partum day 2, post-op/post-partum day 3, and so forth.

MEDICAL RECORD				VITAL SIGNS RECORD													
HOSPITAL DAY																	
POST-		DAY															
MONTH-YEAR		DAY															
IS		HOUR															
PULSE (C)		TEMP. F (C)														TEMP. C	
		105°														40.6°	
180		104°														40.0°	
170		103°														39.4°	
160		102°														38.9°	
150		101°														38.3°	
140		100°														37.8°	
130		99°														37.2°	
120		98.6°														37.0°	
110		98°														36.7°	
100		97°														36.1°	
90		96°														35.6°	
80		95°														35.0°	
70																	
60																	
50																	
40																	
RESPIRATION RECORD																	
BLOOD PRESSURE																	
HEIGHT:      WEIGHT:																	
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; rank; rate; hospital or medical facility)																	
												REGISTER NO.		WARD NO.			

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)  
Prescribed by GSA and Interagency  
Committee on Medical Records  
FPMR (41 CFR) 101-11.606-8

Figure 1-6. SF 511, Vital Signs Record.

MEDICAL RECORD		VITAL SIGNS RECORD											
HOSPITAL DAY		1		2									
POST-	DAY												
MONTH-YEAR	DAY	14		15									
SEP 19	SEP 9X	HOUR - 6-10		2-6-10		2-6-10							
PULSE (C)	TEMP. F (°)	100	101	102	103	102	101	100	101	101			
	TEMP. C	37.8	38.3	38.9	39.4	38.9	38.3	37.8	38.3	38.3			
	180												
	170												
	160												
	150												
	140												
	130												
	120												
	110												
	100												
	90												
80													
70													
60													
50													
40													
RESPIRATION RECORD		1-1	1-1	1-1	1-1	1-1	1-2	1-1					
BLOOD PRESSURE		110/76	114/86	104/64	114/78								
HEIGHT: 71"		110/78	112/74	112/74	114/78								
WEIGHT: 165		112/78	114/68	120/84	110/72								
Fluid Intake				3450									
Output				2800									
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; rank; rate; hospital or medical facility)													
511-112		JONES James J SGT		20 22323 33 23		14 Sep 9X		M 25		USACH Ft Splendid TX		REGISTER NO. 55574 WARD NO. 5A	
												VITAL SIGNS RECORD	
												STANDARD FORM 511 (REV. 9-79) Prescribed by CSA and Interagency Committee on Medical Records FPMR (41 CFR) 101-11.806-8	

Figure 1-7. Partially completed SF 511.



(3) Month-Year/Day.

(a) Enter the month and year (the month and year of the first set of vital signs recorded in the first column of that side of the form) under the words "Month-Year."

(b) Enter the day of the month in the row of blocks horizontal to the words "Month-Year/Day" and under the "Post- Day" row.

(4) Hour. Enter the time that the patient's vital signs are taken (not recorded) under the calendar date row. The block under each calendar date is divided in half to represent the AM and PM hours. Each half is then divided into thirds by two dots. Since each "day" is divided into six columns and there are twenty-four hours in a day, this allows vital signs to be recorded once every four hours (the normal schedule).

(a) Use civilian time, not military time, in completing this section. For instance, a patient whose vital signs are to be taken at 0200, 0600, 1000, 1400, 1800, and 2200 would have "2:6:10" entered in the AM half of the block and would also have "2:6:10" entered in the PM half. This is referred to as a "2:6:10" schedule. Another version of the four hour interval schedule is the "4:8:12" schedule.

(b) Vital signs may be taken every four hours, less often, or more often depending upon the needs of the patient and the physician's orders. If a patient's vital signs are to be taken more often than every four hours, additional columns may be used. If vital signs are taken every two hours, for example, use one complete "day" column for the AM readings and another "day" column for the PM readings. Enter the appropriate times in the heading. The calendar and post-op/partum day entries must also appear in the appropriate blocks.

(5) Examples of headings. Sergeant Jones underwent surgery on 16 September 199X. His vital signs are taken on a 2:6:10 schedule.

(a) The heading on Sergeant Jones' SF 511 would be:

MEDICAL RECORD		VITAL SIGNS RECORD															
HOSPITAL DAY		1		2		3		4		5		6		7			
POST. OP DAY						DOS		1		2		3		4			
MONTH-YEAR		DAY		14		15		16		17		18		19		20	
SEP 199X		HOUR		6:10		2:6:10		2:6:10		2:6:10		2:6:10		2:6:10		2:6:10	
PULSE (C)		TEMP. F (C)		0400													
180		104°															
																TEMP. C	
																40.5°	
																40.0°	

**NOTE:** The actual time of the admission vital signs (0400) is entered vertically in the proper column.

(b) Both sides of the SF 511 are the same. When the front of the form is filled (such as a patient whose hospital stay is longer than seven days), the reverse side of the form is used. The numbering of the rows is continued consecutively. The reverse side of Sergeant Jones' TPR graphic would appear as follows:

MEDICAL RECORD			VITAL SIGNS RECORD							
HOSPITAL DAY			8	9	10	11	12	13	14	
POST-OP DAY			5	6	7	8	9	10	11	
MONTH-YEAR	DAY		21	22	23	24	25	26	27	
SEP 19 9X		HOUR	2-6:10	2-6:10	2-6:10	2-6:10	2-6:10	2-6:10	2-6:10	2-6:10
PULSE (O)	TEMP. F (O)									
	105°									
		TEMP. C								40.6°

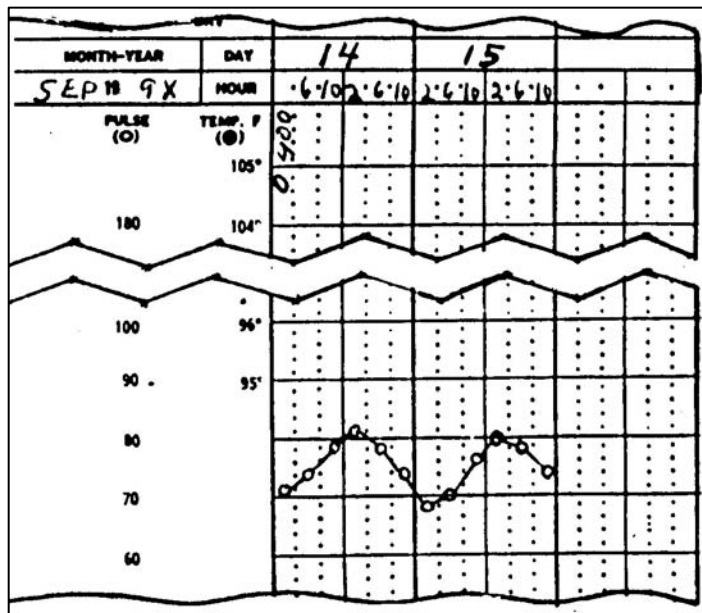
c. **Pulse Rate.** Enter the pulse symbol in the appropriate location in the time column. Connect the pulse symbols with a solid line to form a graph.

(1) The symbol used to graph the pulse rate is an open circle (o).

(2) There are two scales located along the left side of the SF 511. Use the scale under the word "PULSE" to graph the patient's pulse rate and blood pressure readings. Four dots lie vertically between the solid horizontal lines. Since the pulse scale indicates that the interval between the solid horizontal lines is 10 (a change in pulse rate of 10 beats per minute), then the distance between two dots represents two whole numbers (a change in pulse rate of two beats per minute). By convention, pulse rates are recorded in even whole numbers. Sergeant Jones' pulse rates and an illustration of how they were graphed on his SF 511 are shown below.

14 SEP 9X	
ADMISSION (0400) .....	72
0600 .....	74
1000 .....	78
1400 .....	82
1800 .....	78
2200 .....	74

15 SEP 9X	
0200 .....	68
0600 .....	70
1000 .....	76
1400 .....	80
1800 .....	78
2200 .....	74



d. **Blood Pressure.** Enter two blood symbols, one to indicate the systolic and another to indicate the diastolic, in the appropriate locations in the time column. Then connect the two symbols with a vertical line.

(1) The symbol used to graph blood pressure readings is an "X." The point at which the lines composing the "X" intersect indicates the numerical value being graphed.

(2) Use the pulse scale to graph the patient's blood pressure readings. Both the systolic (higher) and the diastolic (lower) pressures must be graphed. As with the pulse rate, the systolic and diastolic readings are recorded as even whole numbers. Although blood pressure readings are always graphed, they may also be written in the blocks horizontal to the words "BLOOD PRESSURE" in the lower section of the form. Sergeant Jones' blood pressure readings and an illustration of how they were graphed are shown on the following page.

14 SEP 9X

ADMISSION (0400) ..... 110/76  
 0600 ..... 110/70  
 1000 ..... 112/78  
 1400 ..... 114/86  
 1800 ..... 112/74  
 2200 ..... 110/68

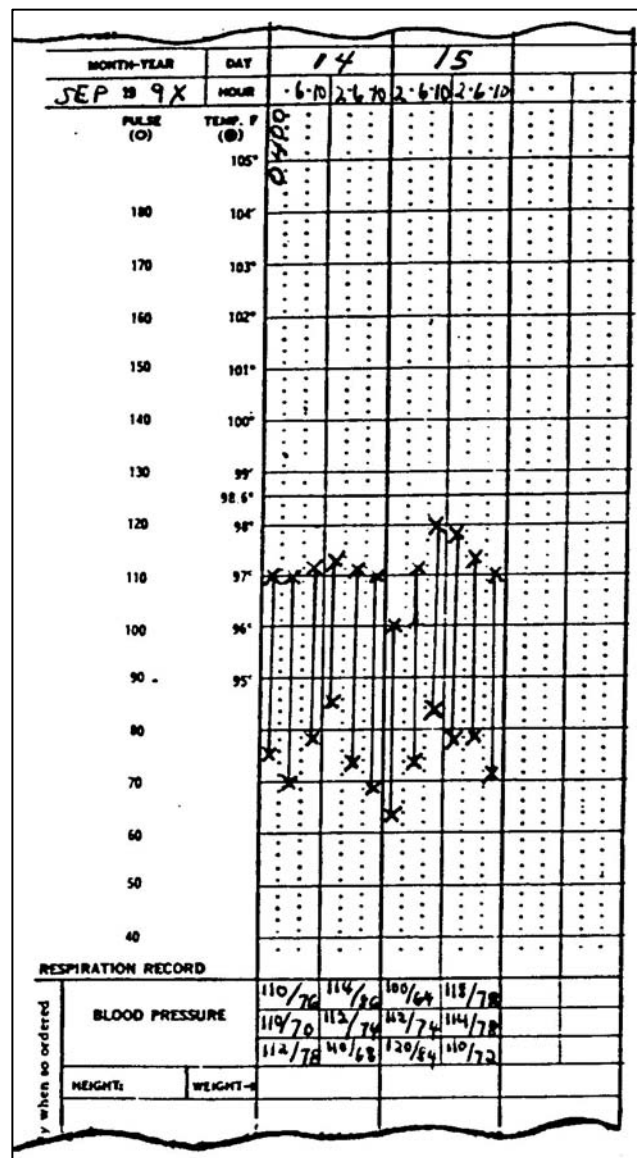
15 SEP 9X

0200 ..... 100/64  
 0600 ..... 112/74  
 1000 ..... 120/84  
 1400 ..... 118/78  
 1800 ..... 114/78  
 2200 ..... 110/72

**NOTE:** If a pulse symbol (open circle) is between the two Xs, do not draw the line through the pulse symbol. Leave the interior of the pulse symbol empty:



If a blood pressure and a pulse reading have the same numerical value, leave the interior of the pulse symbol empty:



e. **Temperature.** Enter the temperature symbol in the appropriate location in the time column. Connect the temperature symbols with a solid line to form a graph.

(1) The symbol used in graphing temperature readings is a large dot or filled-in circle (●).

(2) Use the scale to the right of the pulse scale to graph the patient's temperature in degrees Fahrenheit. The interval between two solid horizontal lines is equal to one degree Fahrenheit (1.0°F). Therefore, the distance between two dots is equal to two-tenths of a degree Fahrenheit (0.2°F). By convention, temperature readings are recorded to the nearest two-tenths of a degree. A patient's temperature is usually taken orally. If the temperature is taken using either the axillary (under the arm) or rectal method, enter a circled R (Ⓡ) for rectal or a circled A (ⓐ) for axillary next to the graphed symbol on the SF 511. No special symbol is needed for oral temperature readings. Sergeant Jones' oral temperature readings and an illustration of how they were charted are shown below.

14 SEP 9X

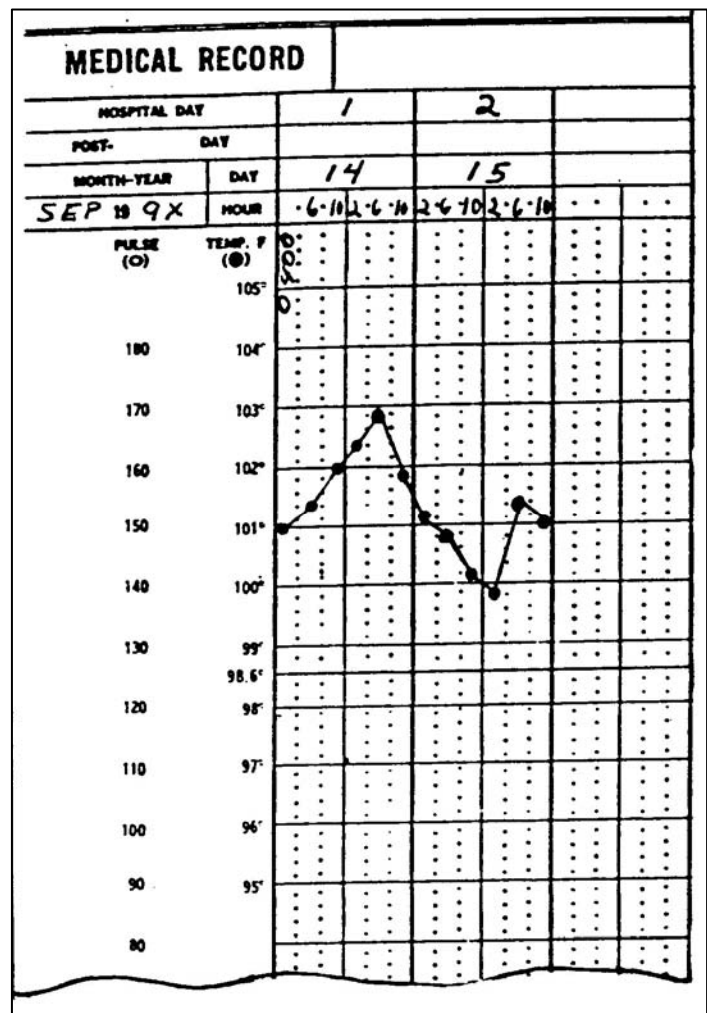
ADMISSION (0400) ..... 101.0°  
 0600..... 101.4°  
 1000..... 102.0°  
 1400..... 102.4°  
 1800..... 102.8°  
 2200..... 101.8°

15 SEP 9X

0200..... 101.2°  
 0600..... 100.8°  
 1000..... 100.2°  
 1400..... 99.8°  
 1800..... 101.4°  
 2200..... 101.0°

**NOTE:** The average normal body temperature, 98.6°F, is indicated by a solid horizontal line.

The patient's temperature in degrees Celsius (°C) can be determined using the "Temp C" scale on the far right of the form (see figure 1-7). For example, the average normal body temperature is 37°C. Read Celsius temperature to the nearest tenth of a degree (0.1°C).



f. **Respiration Rate.** Record the patient's respiration rate at the bottom of the appropriate time column. The respiration rate can be either an even whole number or an odd whole number. Since respiration rates are usually two digit numbers, one number can be written above the other for easier reading (tens digit on top, units digit below). Sergeant Jones' respiration rates and an illustration of how they were charted are shown below.

14 SEP 9X

ADMISSION (0400) ..... 18  
 0600..... 16  
 1000..... 18  
 1400..... 15  
 1800..... 16  
 2200..... 12

15 SEP 9X

0200..... 12  
 0600..... 14  
 1000..... 18  
 1400..... 18  
 1800..... 21  
 2200..... 13

**NOTE:** The patient's respiration rate is not graphed.

MEDICAL RECORD		1		2	
HOSPITAL DAY		14		15	
POST-	DAY	14		15	
MONTH-YEAR	DAY	14		15	
SEP 9X	HOUR	6:00	2:6:00	2:6:00	2:6:00
PULSE (○)	TEMP. F (●)	80	80	80	80
	105°				
	104°				
	103°				
	102°				
	101°				
	100°				
	99°				
	98.6°				
	98°				
	97°				
	96°				
	95°				
	80				
	70				
	60				
	50				
	40				
RESPIRATION RECORD		8 6 8	5 6 2	2 4 8	8 1 3
then so ordered	BLOOD PRESSURE				
	HEIGHT:      WEIGHT:				

**g. Height, Weight, and Special Data.** A patient's height and weight are measured and recorded upon admission to the hospital.

(1) Enter the patient's height (in inches) in the bottom left portion of the Vital Signs Record in the "HEIGHT" block.

(2) Enter the patient's weight (in pounds) in the "WEIGHT" row in the Hospital Day 1 column.

(3) A physician may order that the patient's weight be measured periodically (usually daily). If so, record the patient's weight in the "Weight" row beneath the appropriate calendar day.

(4) The remainder of the spaces at the bottom of the SF 511 may be used to record other special data, such as the 24-hour summary of the patient's fluid I&O for that day taken from his I&O worksheet.

(5) Sergeant Jones' height is 5 feet 11 inches. His weight was 165 pounds upon admission. The physician ordered that Sergeant Jones' fluid intake and output be monitored beginning 15 September. On that date, his intake was 3450 ml and his output was 2800 ml. The illustration below shows how the information was recorded.

50					
40					
<b>RESPIRATION RECORD</b>					
Record special data only when so ordered	<b>BLOOD PRESSURE</b>				
	HEIGHT: 71"	WEIGHT: 165			
	Fluid Intake		3450		
	Output		2800		
<b>PATIENT'S IDENTIFICATION</b> (For typed or written entries give: Nat; middle; rank; rate; hospital or medicine)					

**NOTE:** 5 feet 11 inches is equal to 71 inches.  $12 \times 5 = 60$   
 $60 + 11 = 71$

### **1-13. NURSING ASSESSMENT AND CARE PLAN (DA FORMS 3888 AND 3888-1)**

The Medical Record--Nursing Assessment and Care Plan (DA Form 3888) shown in figures 1-8 and 1-9 and the Medical Record--Nursing Assessment and Care Plan (Continuation) (DA Form 3888-1) shown in figures 1-10 and 1-11 document a baseline nursing history and assessment for the patient. They are also used to record identified problems and desired results of planned nursing intervention. DA Form 3888 consists of the nursing history and assessment information needed by the nurse to plan individual patient care. Additional information is recorded on DA Form 3888-1 as determined by the professional nurse. The reverse side of DA Form 3888-1 is used in conjunction with the DA Form 4677, Therapeutic Documentation Care Plan (Non-Medications). Although the professional nurse is responsible for the preparation of DA Forms 3888 and 3888-1, all persons involved in the patient's care contribute to the development of the care plan.

a. The forms are kept readily available to all members of the nursing care team for their review and input. The forms are kept in a metal folder separate from the one in which the patient's SF 510, SF 511, DA Form 4256, and DA Form 4677 are kept.

b. When the patient is dispositioned (other than transfer), the forms become a permanent part of the patient's MTF. In the event of transfer, they are sent with the patient to the next ward or MTF.

### **1-14. DOCTOR'S ORDER (DA FORM 4256)**

The Clinical Record--Doctor's Order form (figure 1-12) is a three-part carbonless form maintained in the patient's chart. All orders made by the physician are recorded on the Doctor's Order form. The original (white) copy remains with the chart while the second (pink) copy is sent to the pharmacy. The pharmacy receives a copy of all orders to ensure proper supervision of food-drug and laboratory- drug interactions. The third (yellow) copy is used to communicate all orders to the nursing staff. Additional uses may be made of the yellow copy as determined by local policy. The yellow copy is destroyed when no longer required. The original copy eventually becomes part of the patient's MTF.

### **1-15. THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATIONS) (DA FORM 4677)**

The Clinical Record--Therapeutic Documentation Care Plan (Non-Medications) form (figures 1-13 and 1-14) is printed on colored paper. The form is used to document accomplishment of tests, treatments, and nursing orders. Actions carried out on a recurring basis or on a one-time or p.r.n. (as needed) basis are also recorded. Medical orders from the Doctor's Orders form are transcribed onto this form. Nursing orders initiated by the professional nurse are written on this form and must be signed at the end of the order by the nurse initiating the order. This form is maintained in the patient's chart and becomes a permanent part of the patient's MTF.

<b>MEDICAL RECORD – NURSING ASSESSMENT AND CARE PLAN</b> <small>For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.</small>			
DEMOGRAPHIC DATA			
1. LOCAL ADDRESS	2. LOCAL TELEPHONE	3. LANGUAGE	
	4. RELIGION	5. OCCUPATION	
ADMISSION DATA			
6. DATE	7. TIME	8. NEXT OF KIN	
9. REASON FOR ADMISSION		10. INFORMANT	
NURSING HISTORY	YES	NO	INSTRUCTIONS: USE PATIENT'S OWN WORDS WHEN POSSIBLE. USE ITEM NUMBER FOR EACH RESPONSE.
11. What has the doctor told you about your illness?			
12. What plans does the doctor have for you?			
13. Have you been hospitalized before? If YES, describe most recent hospitalization.			
14. Do you have any other health problems? If YES, explain.			
15. Did you take any medications or treatments before your admission? If YES, name, frequency, reason, last time taken, meds brought to hospital.			
16. Do you have any allergies or sensitivities? If YES, explain and describe reaction.			
17. What is your usual eating pattern? Number of meals? Snacks? Diet restrictions?			
18. Do you have any trouble sleeping? If YES, explain. Aids used?			
PATIENT'S IDENTIFICATION		REGISTER NO.	WARD NO.

**DA** FORM 1 AUG 79 **3888**

EDITION OF 1 JUL 72 IS OBSOLETE.

(CONTINUE ON REVERSE)

Figure 1-8. DA Form 3888, Nursing Assessment and Care Plan (front).



NURSING HISTORY (Continued)	YES	NO
19. Do you have any problems with your bowels (diarrhea, constipation, or other)? Aids used? If YES, explain.		
20. Do you have any problems with urinating (frequency, burning, urgency or other)? If YES, explain.		
21. Do you need help with eating, bathing, dressing, or walking? If YES, explain.		
22. Do you have any difficulty with seeing, hearing, speaking? Any special aids used (glasses, hearing aid, crutches, cane, other)? If YES, explain.		
23. Do you have any particular likes and/or dislikes we should know about to provide care for you or any religious or cultural practices you would like us to respect? If YES, explain.		
24. Do you smoke? If YES, type and amount?		
25. Do you drink alcoholic beverages? If YES, amount and frequency?		
26. What do you normally do for hobbies, recreation, etc?		
27. How do you usually handle and react to situations which upset you?		
28. Do you have any special concerns or requests that will help us to make your hospital stay easier? If YES, explain.		
29. Who do you have to assist you when you are discharged?		
SIGNATURE (Nurse)	DATE	

U.S. G.P.O. 1984-421-646/8138

Figure 1-9. DA Form 3888, Nursing Assessment and Care Plan (reverse).

<b>MEDICAL RECORD NURSING ASSESSMENT AND CARE PLAN (Continuation)</b> <small>For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.</small>	
<b>ADDITIONAL ASSESSMENT DATA</b>	
SIGNATURE (Nurse)	DATE
PATIENT IDENTIFICATION	
<b>DA</b> <small>FORM 1 AUG 79</small> <b>3888-1</b> <span style="float: right;"><small>(CONTINUE ON REVERSE)</small></span>	

Figure 1-10. DA Form 3888-1, Nursing Assessment and Care Plan Continuation (front).









## 1-16. NURSING NOTES (SF 510)

The Clinical Record--Nursing Notes form (figure 1-15) is used to record objective observations of the patient's condition, including his physical and mental status, symptoms, response to diagnostic or therapeutic procedures, and changes noted in any of these aspects. The Nursing Notes reflect the response or status of the patient to all nursing care measures documented on the Nursing Assessment and Care Plan forms (DA Forms 3888 and 3888-1). All entries are significant and contain data relevant to nursing care. The administration and the effectiveness of all p.r.n. (as needed) and stat. (immediate) medications are recorded on the SF 510. The form is also used to document diagnostic procedures, therapeutic procedures, special nursing procedures, and unusual occurrences. In addition to aiding in diagnosis and treatment, information on the form can be used for research, teaching, and/or evidence in the event of litigation. When the front of the form is filled, the reverse side is used. Both sides of the form are the same except for the "Patient Identification" section which is located only on the front side. The Nursing Notes forms become a permanent part of the patient's MTF.

## 1-17. MAKING ENTRIES ON THE NURSING NOTES

a. **Patient Identification.** If a new form is being initiated, print the identification information in the Patient Identification block in ink or imprinted the information using an addressograph, the inpatient plate, and the ward plate. If the information is imprinted, all new pages must be imprinted exactly as the original. In figure 1-16, the local SOP includes the admission date on the inpatient plate.

b. **Date/Hour.** For each separate entry made, enter the day, month, and year in the Date column and the time of the entry (in military time) in the appropriate Hour column (AM or PM). If another entry is made on the same date, you must enter the date and time again. Ditto marks are not acceptable.

c. **Observations.** Write (chart) all entries on the Nursing Notes with black or blue-black ink. The entry can be either printed or in cursive writing, but it must be legible. Do not skip lines or write between lines. Begin each entry with a capital letter. Make the entry objective (who, what, where, when), clear, and concise. Use the term "appears" when recording your observations, and record specific data such as time, severity, location, duration, amount, size, frequency, and type. Use only standard, approved abbreviations (AR 40-66). Use only present tense or past tense verbs. Make your entry as soon as possible after the event since you may forget to record pertinent information if you delay too long.





CLINICAL RECORD			NURSING NOTES <i>(Sign all notes)</i>	
DATE	HOUR		OBSERVATIONS <small>Include medication and treatment when indicated</small>	
	A M	P M		
24 Jun 9X		1430	<p>5: 32 y.o. black male % severe lower back pain and nausea. Denies any allergies.</p> <p>O: Admitted to ward via w/c from urology clinic's diagnosis of (R) renal calculi. T 99° P 102 R 24 BP 140/88. Pt is diaphoretic, extremely restless, and unable to stand in an upright position. Pt appears to be in severe pain. Lab work and X-rays done en route to ward. —</p> <p>A: Severe (R) flank pain and nausea secondary to (R) renal calculi. —</p> <p>P: Administer Demerol 75 mg and Phenergan 25 mg I.M. Instruct pt to strain all urine. Continue to monitor urine output and effectiveness of analgesic. —</p> <p>Robert E. Greene, CPT, AN</p>	
			<small>Continue on reverse side</small>	
<small>PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first middle; grade; date; hospital or medical facility)</small> WILSON CHARLES P SSG 0175036 20 77765 23 39 M 23 24 JUN 9X USACH FT MCINTOSH TX ZZWX 3A			REGISTER NO	WARD NO
			<small>NURSING NOTES Standard Form 510 General Services Administration and Interagency Committee on Medical Records FPMR 101-11.806-8—October 1975 510-109</small>	

Figure 1-16. SF 510, Nursing Notes, showing an admitting entry.

d. **Recording Special Procedures.** Always document diagnostic, therapeutic, and nursing procedures and the patient's condition before, during, and after the procedure. Record the name of the procedure, the time that the procedure was performed, the name of the person performing the procedure, any information or instructions given to the patient, a description of what was done, and any laboratory data, x-ray reports, or other records pertinent to the procedure.

e. **Recording Other Information.** Record all medications and treatments given to the patient. Record the patient's vital signs (TPR/blood pressure (BP) and, if applicable, daily intake and output. Record any unusual occurrences, especially any falls or similar happenings. When possible, use laboratory data to verify observations recorded on the Nursing Notes.

f. **Correcting Entries.** If an error is made on the form, do not erase the mistake or blot out the mistake to make it illegible. Instead, draw a single line through the error (the error must remain readable), enter your initials above the lined-out entry, and enter the correct information following the lined-out entry.

(NOTE: The same procedure is used for correcting any entry on any permanent medical record form.)

g. **Signing Entries.** Each entry in the Observations section of the Nursing Notes form must be signed by the person making the entry. If you make an entry in the Nursing Notes, write your payroll signature, rank, and status (MOS, corps, and so forth) after the entry without skipping a line. Draw a single line through any blank space preceding or following your signature block to prevent another person from including any other information in your entry.

## 1-18. MAKING SPECIAL ENTRIES ON THE NURSING NOTES

a. **Subjective Objective Assessment Planning Format.** Some facilities use the subjective, objective, assessment, and planning (SOAP) format when charting pertinent information. Information is arranged according to type (subjective, objective, assessment, and planning). Each section of the entry is preceded by the appropriate letter (S, O, A, or P) to make referencing easier. Medical specialists will usually only make subjective and objective type entries. Assessment and planning type entries are usually made by a physician, nurse, or physician assistant.

(1) Subjective ("S") information is information obtained from the patient, relative, or similar source. When making an "S" entry, use the patient's own words when possible. For example, "Patient states, 'I am having pain in my right calf.'"

(2) Objective ("O") information is based upon your observations of the patient or upon diagnostic or laboratory tests (you observe the test data). Basically, objective entries are what you see, feel, and hear. Vital signs are recorded in this section.

(3) Assessment ("A") entries document the writer's analysis of the patient's problem (the writer's evaluation of what he observed).

(4) Planning ("P") entries document the plan of action to be taken to resolve the patient's problems.

b. **Admitting Entry.** When the Nursing Notes is initiated on a patient newly admitted to the MTF, the first entry documents certain admitting information. This initial admitting entry usually includes the date and time of admission, the manner in which the patient arrived (ambulatory, wheelchair, litter, and so forth), any wounds (including sores and decubitus ulcers) present, any prostheses (dentures, artificial limbs, and so forth), reason for admission, TPR (temperature, pulse, and respiration) and BP upon admittance, height, weight, known allergies (usually obtained from patient), patient's level of consciousness (LOC), and any medications and/or treatments which the patient is taking. An admitting entry in SOAP format is shown in figure 1-16.

c. **Discharge Note.** When a patient is transferred or discharged, a final entry is made in the patient's Nursing Notes. The entry usually includes the date and time the patient was discharged (or transferred), the manner in which the patient left (ambulatory, wheelchair, or stretcher), the name of the person or persons (parents, ward personnel, and so forth) who accompanied the patient, any medications or schedules given to the patient, discharge information and instructions given the patient, and a note of any follow-up visits to be made. When appropriate, the entry should contain a statement indicating the patient acknowledges and understands all instructions (for example, "Patient states he has a good understanding of all discharge instructions given.")

## 1-19. CONFIDENTIALITY

Treat the information contained on the forms in the patient's chart, including Nursing Notes, as confidential. Do not discuss the patient's chart with another patient, within hearing range of patients, or in the presence of unauthorized personnel. Record information away from the patient and do not let the patient see or hear what you record since the patient may misunderstand the information or become unduly upset. If a patient asks medical questions or asks about information on his chart, refer the patient to the physician or nurse who can best answer his questions. Do not make entries in the patient's chart for someone else. Do not have someone else chart your entries.

**Continue with Exercises**

## EXERCISES: LESSON 1

**INSTRUCTIONS:** For each question or incomplete statement, write the appropriate term in the space provided or circle the letter of the response, which BEST answers the question or BEST completes the statement. Use the form provided on the following page to accomplish Exercise One. After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers. For each exercise answered incorrectly, reread the material referenced after the solution.

1. Record the following information on the Standard Form 511 on the following page. Blood pressure readings are to be written and graphed.

Data upon admission (2300 on 18 December 199X):

Height: 6'2"  
Weight: 210 lbs.  
Blood pressure: 160/100  
Temperature: 103.6°F (oral)  
Pulse: 88  
Respiration: 26

At 0200 the next day, his readings were:

Blood pressure: 140/94  
Temperature: 102.6°F (rectal)  
Pulse: 80  
Respiration: 25

At 0600, his readings were:

Blood pressure: 126/88  
Temperature: 99.2°F (oral)  
Pulse: 64  
Respiration: 16

At 1000, his readings were the same as the 0600 set of readings.

The physician wishes to check for weight loss. His weight at 1000 was 209 pounds.

At 1300, the patient was sent to surgery.

<b>MEDICAL RECORD</b>	<b>VITAL SIGNS RECORD</b>
-----------------------	---------------------------

HOSPITAL DAY															
POST-	DAY														
MONTH-YEAR	DAY														
19	HOUR														
PULSE (O)	TEMP. F (●)													TEMP. C	
	105°													40.6°	
180	104°													40.0°	
170	103°													39.4°	
160	102°													38.9°	
150	101°													38.3°	
140	100°													37.8°	
130	99°													37.2°	
120	98.6°													37.0°	
110	98°													36.7°	
100	97°													36.1°	
90	96°													35.6°	
80	95°													35.0°	
70															
60															
50															
40															

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD													
BLOOD PRESSURE													
HEIGHT:	WEIGHT:												

**PATIENT'S IDENTIFICATION** (For typed or written entries give: Name—last, first, middle; rank; rate; hospital or medical facility)

**REGISTER NO.** \_\_\_\_\_ **WARD NO.** \_\_\_\_\_

511-112

**VITAL SIGNS RECORD**  
**STANDARD FORM 511 (REV. 9-79)**  
 Prescribed by GSA and Interagency  
 Committee on Medical Records  
 FPMR (41 CFR) 101-11.806-8  
 USGPO 1981-381-646/8699

2. The Temperature, Pulse and Respiration Record is usually:
  - a. Filed in the patient's Inpatient Treatment Record.
  - b. Filed in the patient's Health Record.
  - c. Destroyed after the information has been transferred to the Standard Form 511.
  - d. Destroyed after the information has been transferred to a DA Form 3872.
  
3. The number recorded in the "Amount" column of the intravenous section of the Intake and Output Worksheet indicates:
  - a. The amount of fluid in the bag or bottle before the I.V. is started.
  - b. The amount of fluid remaining in the bag or bottle after the I.V. is discontinued.
  - c. The amount of fluid that the patient has received intravenously.
  - d. The amount of intravenous fluid ordered by the physician.
  - e. The accumulated total amount of fluid the patient has received intravenously since the Intake and Output Worksheet began.
  
4. A patient consumes a small fruit cup size serving of strawberry flavored gelatin. How is this recorded on the Intake and Output Worksheet?
  - a. As an oral intake of 120 milliliters.
  - b. As an oral intake of 160 milliliters.
  - c. As an oral intake of 180 milliliters.
  - d. As an oral intake of 240 milliliters.
  - e. None of the above. The intake of solid food is not recorded on the worksheet.

5. According to the Twenty-Four Hour Patient Intake and Output Worksheet, a patient's grand total intake was 3000 ml and his grand total output was 2550 ml. What would be a logical conclusion about the patient's fluid balance?
- a. The patient's actual fluid intake was several hundred milliliters greater than his actual fluid output.
  - b. The patient's actual fluid output was several hundred milliliters greater than his actual fluid intake.
  - c. The patient's fluid intake and fluid output were about equal since not all output is recorded on the form.
6. Vomitus which has no solid content is referred to as:
- a. Clean.
  - b. Clear.
  - c. Transparent.
  - d. Unclouded.
  - e. White.
7. Which one of the following is a correct procedure for handling the Intake and Output Worksheet after it has been completed?
- a. The worksheet is made a permanent part of the patient's Inpatient Treatment Record.
  - b. The worksheet is made a permanent part of the patient's Health Record.
  - c. The information from the worksheet is entered in the Doctor's Orders and destroyed.
  - d. The information from the worksheet is entered in the patient's SF 510 or SF 511 and then destroyed.

8. Entries are made on a patient's SF 511 at 0600 and 1000. Which one of the following, if any, is an incorrect graphing procedure?
- a. The 0600 diastolic reading is connected to the 1000 diastolic reading.
  - b. The 0600 pulse reading is connected to the 1000 pulse reading.
  - c. The 0600 temperature reading is connected to the 1000 temperature reading.
  - d. All of the above are correct graphing procedures.
9. The patient's temperature is taken rectally. What symbol will you use when recording his temperature?
- \_\_\_\_\_
10. Which of the following statements is/are true?
- a. Temperature readings are recorded in even whole numbers only.
  - b. Pulse readings are rounded off to the nearest odd number.
  - c. Respiration rates may be recorded either as even or odd numbers.
  - d. Blood pressure readings may be recorded either as even or odd numbers.
  - e. All of the above are true.
11. Identify the meaning of each of the following symbols when they appear on the graphic portion of an SF 511.
- a. X \_\_\_\_\_
  - b. o \_\_\_\_\_
  - c. M \_\_\_\_\_



12. A patient asks you about the medication that her physician has prescribed. The physician's reason for prescribing the medication is contained in the patient's medical forms in his chart. What should you do?

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13. The Nursing Notes form is used to record:
- a. Any "stat." medications that have been administered to a patient.
  - b. Observations of the patient's mental condition.
  - c. The patient's response to therapeutic procedures.
  - d. All of the above.
14. A medication that is given p.r.n. is:
- a. Given as needed.
  - b. Given as soon as possible.
  - c. Given by mouth.
  - d. Not given by mouth.
  - e. Prescribed by a registered nurse.
15. The SOAP method is being to record information on a patient's Nursing Notes. Vital signs are recorded in the \_\_\_\_\_ section.
- a. "S."
  - b. "O."
  - c. "A."
  - d. "P."

16. When correcting an error in an entry on a permanent medical record form, you should:
- a. Draw one line through the incorrect entry and initial.
  - b. Draw three lines through the incorrect entry and initial.
  - c. White out the incorrect entry.
  - d. Mark through the incorrect entry with a wide-tipped felt pen so the entry can no longer be read and initial.

**Check Your Answers on Next Page**



2. c (para 1-7)
3. a (para 1-10d(2)(b))
4. a (para 1-9a, Table 1-1)
5. c (para 1-9b)
6. b (para 1-10j(2)(c))
7. d (para 1-8)
8. a (para 1-12d, NOTE and illustration)
9. R (para 1-12e(2))
10. c (paras 1-12c(2), d(2), e(2), f; 1-7b)
11.
  - a. Blood pressure (systolic or diastolic).
  - b. Pulse rate.
  - c. Temperature. (paras 1-12c(1), d(1), e(1))
12. Refer the patient to a physician or nurse who can answer his questions.  
(para 1-19)
13. d (para 1-16)
14. a (para 1-16)
15. b (para 1-18a(2))
16. a (paras 1-17f, 1-11)

End of Lesson 1

## **LESSON ASSIGNMENT**

### **LESSON 2**

Outpatient Records.

### **TEXT ASSIGNMENT**

Paragraphs 2-1 through 2-14.

### **LESSON OBJECTIVES**

When you have completed this lesson, you should be able to:

- 2-1. Identify who should have a Health Record.
- 2-2. Identify who should have an Outpatient Treatment Record.
- 2-3. Identify forms maintained in the Health Record.
- 2-4. Identify forms maintained in the Outpatient Treatment Record.
- 2-5. Identify information recorded on an SF 600.
- 2-6. Identify who can have access to Health Records.
- 2-7. Identify transfer and disposition procedures for Health Records and Outpatient Treatment Records.

### **SUGGESTION**

Work the lesson exercises at the end of this lesson before beginning the next lesson. These exercises will help you to accomplish the lesson objectives.

## LESSON 2

### OUTPATIENT RECORDS

#### Section I. CLINICS

##### 2-1. GENERAL

As a medical specialist, you will probably come into contact with military and civilian outpatient records while serving in an Army clinic.

##### 2-2. ARMY CLINICS

An Army clinic is a self-contained operating facility organized for the express purpose of providing outpatient (ambulatory) health and dental care services to eligible personnel.

a. **United States Army Medical Clinics.** United States (US) Army medical clinics provide ambulatory medical health care services. Medical clinics are assigned to an appropriate MEDCEN (Medical Center) or MEDDAC (Medical Department Activity). The three types of US Army medical clinics are discussed below.

(1) United States Army troop medical clinic. A US Army troop medical clinic (TMC) provides care to active duty military personnel only. The clinic is designed to accomplish sick call, provide limited medical treatment, and provide referral to an Army health clinic, dental clinic, or hospital, as needed. The TMC normally provides immunization, medical examination, physical profiling, and limited pharmacy dispensing services.

(2) United States Army health clinic. A US Army health clinic (AHC) provides ambulatory medical services to personnel authorized care in Army MTF. It may also provide civilian employee health services. The health clinic normally has general radiology, laboratory, and pharmacy capabilities and may offer care in one or more subspecialties of medicine, surgery, and/or psychiatry. Although this clinic is not designed or staffed to be an inpatient MTF, it may be equipped with beds (normally less than 25) for observing patients awaiting transfer to a hospital. The beds may also be used for patients who cannot be cared for on a strictly outpatient basis, but who do not need to be hospitalized. Normally, patients will occupy a bed at an AHC for less than 72 hours.

(3) United States Army civilian employee health clinic. A US Army civilian employee health clinic (CEHC) provides emergency treatment for on-the-job injuries or illnesses, work-related medical examinations, and referrals to private health care practitioners for civilian employees of the Federal government. Whenever possible, the

functions of this clinic are performed by the MEDCEN or MEDDAC hospital or by the US Army health clinic, thus eliminating the need for a separate civilian employee health clinic.

b. United States Army Dental Clinic. A US Army dental clinic is the primary health care delivery organizational element of the Dental Activity (DENTAC). The clinic provides diagnostic, preventive, and therapeutic outpatient dental services.

## **Section II. THE HEALTH RECORD**

### **2-3. PURPOSE OF THE HEALTH RECORD**

The Health Record (HREC) is a permanent, continuous, and locally available file that documents the medical and dental care a service member has received. The primary purpose of the HREC is to ensure that, except during active combat, a concise and comprehensive medical history of each individual on active duty or in a Reserve Component is constantly available to Army Medical Department (AMEDD) personnel. The HREC is designed to minimize repetition of diagnostic procedures and reduce the correspondence necessary to obtain records of previous treatments. It also assists medical officers in advising commanders concerning the retention and utilization of personnel. Similarly, the HREC is of interest to physical evaluation boards appraising the physical fitness or eligibility for benefits of Army personnel. The HREC can also provide data used to settling claims, in medical research, and in identifying deceased persons when other methods are not adequate. The Army prepares and/or maintains HREC on the following personnel:

- a. Army personnel on active duty.
- b. United States Army Reserve (USAR) and Army National Guard (ARNG) personnel.
- c. Members of the US Navy/Marine and the United States Air Force (USAF) when such records are transferred to Army custody.
- d. Cadets of the US Military Academy.
- e. Military prisoners confined in US military facilities.

### **2-4. HEALTH RECORD COMPONENTS**

The HREC consists of two components. The primary (health) component of the HREC is maintained by the MTF providing primary medical care (usually a US Army troop medical clinic). The other (dental) component of the HREC is maintained by the dental treatment facility providing dental care (usually a US Army dental clinic). When a soldier on active duty is engaged in active combat, his HREC is maintained by a military personnel officer unless the HREC has been requested by a fixed hospital treating the soldier.

## **2-5. INITIATING A HEALTH RECORD**

A HREC is initiated when an individual enters the military service. At that time, a HREC file folder (DA Form 3444- series) is prepared. There are 10 different folders and each is a different color. The folder selected is determined from the soldier's social security number as explained in Lesson 3. The soldier reads, signs, and dates the Privacy Act Statement imprinted on the right inside corner of the folder. The results of the soldier's first physical examination is documented on SF 88, Report of Medical Examination; his medical history is documented on SF 93, Report of Medical History; and the administration of the initial immunizations are documented on SF 601, HREC--Immunization Records. These forms are then filed in the soldier's HREC. Thereafter, each contact that the individual has with the AMEDD as a patient throughout his military career is documented and filed in the soldier's HREC. Outpatient care is documented on SF 600, HREC--Chronological Record of Medical Care (paragraph 2-10). Inpatient care is summarized and documented on DA Form 3647 or DA Form 3647-1, Inpatient Treatment Record Cover Sheet (paragraph 1-3b).

## **2-6. CONTENTS OF HEALTH RECORDS**

Forms are filed in the primary (health) component of the HREC in the following order (top to bottom). If more than one of the same form is present, they are filed in chronological order with the most recent form on top. Forms are filed on the inside of the left side of the folder or on the inside of the right side of the folder. Holes are punched in the forms if the forms do not already have holes prepunched. The metal prongs of the paper fasteners are then inserted through the holes and secured. Refer to AR 40-66, Medical Record and Quality Assurance Administration, for additional instructions for filing forms in medical records. Most HRECs will not have all of the forms.

**NOTE:** If a soldier's HREC is old, the forms may be in a DD Form 722 folder instead of a DA Form 3444-series folder.)

### **a. Left Side of File Folder.**

- (1) DA Form 4186, Medical Recommendation for Flying Duty.
- (2) DA Form 3180/3180A, Personnel Screening and Evaluation Record (form must be included in all HRECs).
- (3) DA Form 5571, Master Problem List.
- (4) DA Form 2482, Venom Extract Prescription.



(5) SF 601, HREC--Immunization Record (form must be included in all HRECs).

(6) DA Form 4970, Medical Screening Summary--Over 40.

(7) DD Form 1141, Record of Occupational Exposure to Ionizing Radiation, or Automated Dosimetry Record.

(8) SF 545, Laboratory Report Display (form must be included in all HRECs; original copies of laboratory and radiographic reports, SF 546 through SF 557, are mounted on this form).

(9) SF 519/519A, Medical Record--Radiographic Report (form must be included in all HRECs).

(10) SF 519B, Radiologic Consultation Request/Report.

(11) SF 520, Clinical Record--Electrocardiographic Record (reports of electrocardiograph examinations with representative tracings are attached to the back of the form or on an attached sheet of paper).

(12) SF 560, Medical Record--Electroencephalogram Request and History.

(13) DA Form 2631-R, Medical Care--Third Party Liability Notification.

(14) DA Form 3647 or 3647-1, Inpatient Treatment Record Cover Sheet (copies of SF 502, SG Form 84, AF Form 565, NAVMED 6300.5, DD Form 1380, and/or other narrative summaries pertaining to the hospitalization are filed with the appropriate DA Form 3647/3647-1).

(15) DA Form 5006-R, Medical Record--Authorization for Disclosure of Information.

(16) DA Form 5303-R, Volunteer Agreement Affidavit.

(17) DA Form 3365, Authorization for Medical Warning Tag.

**b. Right Side of File Folder.**

(1) DA Form 4515, Personnel Reliability Program Record Identifier.

(2) SF 600, HREC--Chronological Record of Medical Care (form must be included in all HRECs; also file other basic chronological medical care records such as SF 558, DA Forms 5181-R, and AMOSIST Encounter Forms with SF 600s).

- (3) DA Form 3763, Community Health Nursing--Case Referral.
- (4) DA Form 5569-R, Isoniazid (INH) Clinic Flow Sheet.
- (5) State ambulance forms.
- (6) SF 602, HREC--Syphilis Record.
- (7) DA Form 199, Physical Evaluation Board Proceedings.
- (8) DA Form 2173, Statement of Medical Examination and Duty Status.
- (9) DA Form 3349, Physical Profile.
- (10) DA Form 3947, Medical Evaluation Board Proceedings.
- (11) DA Form 4060, Record of Optometric Examination (form is no longer used).
- (12) DA Form 4530, Electroencephalogram Request and History.
- (13) DA Form 4700, Medical Record--Supplemental Medical Data.
- (14) DA Form 5008, Telephone Medical Advice Consultation Record.
- (15) DA Form 5551-R, Spirometry Flow Sheet.
- (16) SF 88, Report of Medical Examination (form must be included in all HRECs; also file DA Forms 4497-R and FAA Forms 8500-8 with SF 88).
- (17) SF 93, Report of Medical History (form must be included in all HRECs; also file any other medical history forms with SF 93).
- (18) SF 513, Medical Record--Consultation Sheet (also file DD Form 2161, Referral for Civilian Medical Care, with SF 513).
- (19) SF 522, Medical Record--Request for Administration of Anesthesia and for Performance of Operations and Other Procedures.
- (20) SF 559, Medical Record--Allergen Extract Prescription-New and Refill.
- (21) DA Form 5007-R, Record of Hyposensitization.
- (22) Other SF 500-series forms (file in numerical sequence).

(23) DD Form 741, Eye Consultation.

(24) DD Form 771, Eyewear Prescription.

(25) DD Form 2215, Reference Audiogram.

(26) DD Form 2216, Hearing Conservation Data (also file supporting documents with DD Form 2216).

(27) DA Form 4465, ADAPCP Client Intake Record with Privacy Act Statement (also file authorized alcohol and drug forms with DA Form 4465).

(28) DA Form 4410-R, Disclosure Accounting Record (form must be included if DA Form 3444-series folder is not used).

(29) DD Form 2005, Privacy Act Statement--Health Care Records (form must be included if DA Form 3444-series folder is not used).

## **2-7. ACCESS TO HEALTH RECORDS**

The personnel listed below may be authorized access to HRECs. All personnel having access to HRECs or other medical records must protect the privacy of the medical information contained in the records.

a. **Medical Personnel.** Army medical personnel are authorized direct access to the contents of HRECs for purposes such as a diagnosis, treatment, and medical research.

b. **Member to Whom the Health Record Pertains.** Information from the HREC or copies of the documents contained in the HREC may be furnished to the soldier.

c. **Inspectors.** Personnel engaged in inspections of MTF, dental activity, or USAR records are authorized direct access to HRECs for the purpose of evaluating compliance with regulations.

d. **Graves Registration Personnel.** Graves registration personnel are allowed direct access to the HRECs of personnel killed in action or missing and can extract the medical and dental information needed by their service.

e. **Other Nonmedical Personnel.** Nonmedical personnel (such as the individual's unit commander, Inspectors General, officers of the Judge Advocate General's Corps, military personnel officers, and members of the US Army Criminal Investigation Command or military police personnel performing official investigations) may require information from an individual's HREC for official reasons. When officially required, information from the HREC or copies of documents contained in the HREC are furnished by the hospital commander, the patient administrator, or the Reserve Component record custodian. In such instances, the information provided should contain the minimal amount of personal information necessary to satisfy the need-to-know requirement. Copies of documents should not be provided when the information itself will suffice.

## **2-8. FILING, TRANSFER, AND DISPOSITION OF HEALTH RECORDS**

a. **Filing.** Health Records are normally filed alphabetically according to the patients' names without regard to rank or organizational unit. The HRECs can be filed according to the terminal digit filing system (TDFS) when authorized by the commander. The TDFS is discussed in Lesson 3.

b. **Transfer.** During transfer, an individual usually carries his HREC whenever he carries his Military Personnel Records Jacket (MPRJ). If the custodian of the HREC feels that an individual should not be allowed to carry his own HREC, it may be forwarded directly to the commander of the MTF responsible for providing care for the individual at his new assignment. When a HREC is transferred, it is sealed in an envelope with the individual's name, rank, social security number (SSN), and the type of record (Health-Dental) printed on the envelope.

c. **Disposition.** When an individual retires, is separated from service, dies, or transfers from the US Army Reserve (USAR) to the Army National Guard (ARNG), his HREC is dispositioned in accordance with AR 640-10, Individual Military Personnel Records. Army National Guard HRECs are dispositioned in accordance with NGR 640-100 (officers and warrant officers) or NGR 600-200 (enlisted personnel).

## **2-9. TEMPORARY AND NEW HEALTH RECORDS**

a. **Temporary Health Records.** If a person's HREC is not received with his Military Personnel Records Jacket (record delayed or "lost"), medical personnel initiate a temporary HREC. Forms and other documentation on the person's medical care are maintained in manila folders (one at the troop medical clinic and one at the dental clinic). The date the temporary record (health or dental) was initiated is printed on the folder. When a delayed HREC is received, the forms in the temporary records are filed in the permanent HREC.

b. **New Health Records.** If the original HREC is not received within 60 days after a temporary HREC is initiated or if official notification is received stating the original HREC has been destroyed, a new permanent HREC is prepared. If the lost HREC is received after the new HREC has been initiated, the forms from the new record are transferred to the original HREC.

## **2-10. CHRONOLOGICAL RECORD OF MEDICAL CARE (SF 600)**

The HREC--Chronological Record of Medical Care (figure 2-1), is the basic form of the HREC and of the OTR. It provides a record of each incident of outpatient medical care provided a soldier during his military career. Make entries on the form using the general rules described below.

a. Complete the patient identification section using the patient's recording card, clinic identification plate, and an addressograph, if available.

(1) The patient's recording card is prepared when a soldier is first examined or treated at the clinic. The card usually contains the following information.

(a) Line 1. Family member prefix and sponsor's social security number.

(b) Line 2. Blank.

(c) Line 3. Patient's name (last, first, middle initial).

(d) Line 4. Year of birth; sex (M or F); status of the patient or of the sponsor if the patient is a dependent, such as AD (active duty), RET (retired), or CIV (civilian); department of the patient or sponsor, such as DA (Department of the Army).

(e) Line 5. Rank or grade of the patient or of the sponsor if the patient is a dependent; sponsor's name if the patient is a dependent.

(2) The clinic plate normally contains the hospital's name, location, and Uniform Chart of Account (UCA) code on the first and second lines and the name of the clinic on the third line.

b. Type and/or handwrite entries in black or blue-black ink.

c. Enter the date and time of the visit for each separate entry. The name of the MTF visited must also appear on the form. The facility identification does not have to be repeated in recording subsequent visits to the same facility on the same form unless the sequence has been interrupted by treatment at another facility.

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION ( <i>Sign each entry</i> )

PATIENT'S IDENTIFICATION (*Use this space for Mechanical Imprint*)

RECORDS MAINTAINED AT:		
PATIENT'S NAME ( <i>Last, First, Middle initial</i> )		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-64)  
Prescribed by GSA and ICMR  
FIRM (41 CFR) 201-45.505

Figure 2-1. SF 600, Chronological Record of Medical Care.

d. Make each entry concise, complete, and legible. Include a description of the nature and history of the patient's chief complaint or condition, the findings of any examination or test, the diagnosis if one was made, any treatment rendered, any drugs prescribed, the disposition of the patient, and any instructions given to the patient for subsequent or follow-up care. Enter descriptions of injuries in a "how-when-where-leave status" format. An entry for an emergency patient must include the means by which the patient arrived and the condition of the patient at the time of disposition.

e. If you make an error on the form, draw a single line through the error (the error must remain readable), enter your initials above the lined-out entry, and enter the correct information following the lined-out entry. Do not erase the mistake or mark through the mistake so as to make the error illegible.

f. Record the patient's complaint even if the patient is returned to duty (RTD) without treatment. If the patient departs prior to being seen by medical personnel, record this fact also.

g. If a patient is assigned to quarters, include an estimate of the length of time the patient will remain in this status.

h. Sign or initial each entry you make on the form. When a person makes his first entry on the page, he must write his full signature block (name, rank, corps/status). Later entries made by the same person on the same page can be initialed. The signature block of the person making the entry may be stamped onto the form, but the person making the entry must still sign or initial the entry.

i. When there is no more space left on a patient's SF 600, initiate another SF 600 and continue the entry, if appropriate.

j. File Chronological Record of Medical Care forms with the more recent form on top.

### **Section III. THE OUTPATIENT TREATMENT RECORD**

#### **2-11. GENERAL**

A record is maintained for each individual who has received outpatient treatment at a military medical or dental treatment facility. Usually, this record is the HREC. Records, however, must also be kept on people for whom a HREC is not authorized (military dependents, civilian employees of the Federal Government, etc.) or whose HRECs are no longer active (retired military personnel). An OTR is prepared for these categories of patients. The health component of the OTR is maintained at the facility providing primary health care (US Army health clinic). The dental component is maintained at the facility providing primary dental care (US Army dental clinic). Upon request, the patient may be given a copy of the permanent parts of his OTR.

## **2-12. CONTENTS OF OUTPATIENT TREATMENT RECORDS**

The basic form contained in the OTR is the SF 600, HREC--Chronological Record of Medical Care. The SF 600 is completed in the same general manner as given in paragraph 2-10. Forms are filed in the OTR in the following order (top to bottom). If more than one of the same form is present, they are filed in chronological order with the most recent form first. Additional information concerning the OTR can be found in AR 40-66, Medical Record and Quality Assurance Administration. Most OTRs will not have all of the listed forms.

### **a. Left Side of File Folder.**

- (1) DA Form 4186, Medical Recommendation for Flying Duty.
- (2) DA Form 3180/3180A, Personnel Screening and Evaluation Record.
- (3) Pediatric growth charts from civilian sources.
- (4) DA Form 5571, Master Problem List.
- (5) DA Form 5510-R, Exceptional Family Member Program Coding Summary.
- (6) SF 601, HREC--Immunization Record (form must be included in all OTRs).
- (7) SF 545, Laboratory Report Display (form must be included in all OTRs; original copies of laboratory and radiographic reports, SF 546 through SF 557, are mounted on the form).
- (8) SF 519/519A, Medical Record--Radiographic Report (form must be included in all OTRs).
- (9) SF 519B, Radiologic Consultation Request/Report.
- (10) SF 520, Clinical Record--Electrocardiographic Record (reports of electrocardiograph examinations with representative tracings are attached to the back of the form or to an attached sheet of paper).
- (11) SF 560, Medical Record--Electroencephalogram Request and History.
- (12) DA Form 3647/3647-1, Inpatient Treatment Record Cover Sheet (copies of SF 502, SG Form 84, AF Form 565, NAVMED 6300.5, DD Form 1380, and/or other narrative summaries pertaining to the hospitalization are filed with the appropriate DA Form 3647 or 3647-1).



(13) DA Form 5006-R, Medical Record--Authorization for Disclosure of Information.

(14) DA Form 5303-R, Volunteer Agreement Affidavit.

(15) DA Form 3365, Authorization for Medical Warning Tag.

(16) Administrative documents and other correspondence.

**b. Right Side of File Folder.**

(1) DA Form 4515, Personnel Reliability Program Record Identifier.

(2) SF 600, HREC--Chronological Record of Medical Care (form must be included in all OTRs; also file other basic chronological medical care records such as SF 558 and AMOSIST Encounter Forms with SF 600).

(3) State ambulance forms.

(4) DA Form 5568-R, Chronological Record of Well-Baby Care.

(5) DA Form 3763, Community Health Nursing--Case Referral.

(6) DA Form 5569-R, Isoniazid (INH) Clinic Flow Sheet.

(7) DA Form 4530, Electroencephalogram Request and History.

(8) DA Form 4700, Medical Record--Supplemental Medical Data.

(9) DA Form 5008, Telephone Medical Advice/Consultation Record.

(10) SF 513, Medical Record--Consultation Sheet (also file DD Form 2161, Referral for Civilian Medical Care, with form).

(11) SF 522, Medical Record--Request for Administration of Anesthesia and for Performance of Operations and Other Procedures.

(12) SF 559, Medical Record--Allergen Extract Prescription-New and Refill.

(13) DD Form 2482, Venom Extract Prescription.

(14) DA Form 5007-R, Record of Hyposensitization.

(15) Other SF 500-series forms (filed in numerical sequence).

(16) DD Form 741, Eye Consultation.

(17) DD Form 771, Eyewear Prescription (also DD Form 771-1, Eyewear Prescription--Plastic Lenses).

(18) Reports or certificates prepared by neuropsychiatric consultation services.

(19) Correspondence on hearing aids.

(20) Medical documents from civilian sources.

(21) DA Form 4410-R, Disclosure Accounting Record (form must be included if preprinted DA Form 3444-series folder is not used).

(22) DD Form 2005, Privacy Act Statement--Health Care Records (form must be included if preprinted DA Form 3444-series folder is not used).

### **2-13. FILING PROCEDURES**

Outpatient Treatment Records are filed using the terminal digit filing system discussed in Lesson 3. A nominal card index file serving as a cross-reference between the person's name and the sponsor's SSN is maintained at the facilities where the records are normally kept.

### **2-14. TRANSFER AND RETIREMENT PROCEDURES**

When the responsibility for providing primary outpatient care for an individual is transferred to another MTF (for example, a military dependent whose sponsor is transferred to another military post), the person's OTR is completed and transferred (hand-carried or mailed) to the appropriate receiving MTF. Outpatient Treatment Records are retired in accordance with AR 340-18.

**Continue with Exercises**

## EXERCISES: LESSON 2

**INSTRUCTIONS:** For each question or incomplete statement followed by a group of lettered responses, circle the letter of the response that BEST answers the question or BEST completes the statement. After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers. For each exercise answered incorrectly, reread the material referenced after the solution.

1. Which of the following is not classified as a US Army medical clinic?
  - a. US Army Civilian Employee Health Clinic.
  - b. US Army Dental Clinic.
  - c. US Army Health Clinic.
  - d. US Army Troop Medical Clinic.
  - e. All of the above are classified as US Army medical clinics.
  
2. A civilian employee of the Federal government has suffered an on-the-job injury. Assuming that all of the clinics below are established on post, he would probably receive treatment at:
  - a. The US Army civilian employee health clinic.
  - b. The US Army health clinic.
  - c. The US Army troop medical clinic.
  - d. Any of the above.
  
3. The Army may maintain HRECs on:
  - a. Air Force personnel.
  - b. Army Reserve personnel.
  - c. Cadets of the United States Military Academy.
  - d. Military prisoners.
  - e. All of the above.

4. A HREC is started on an individual when the individual:
  - a. Enters the military service.
  - b. Completes basic training.
  - c. Is admitted to a military hospital for the first time.
  - d. Leaves the military service.
  - e. Dies.
  
5. Which of the following is/are functions of HRECs?
  - a. Minimize repetition of diagnostic procedures.
  - b. Provide information used in identifying deceased persons.
  - c. Provide information used in medical research.
  - d. Provide information used in settling claims.
  - e. All of the above.
  
6. Which of the following is the name of the medical record file commonly found at a troop medical clinic?
  - a. The Chronological Record of Outpatient Treatment Medical Care.
  - b. The ITR.
  - c. The OTR.
  - d. The HREC.
  - e. Both c and d above.

7. The form that documents each incident of the outpatient medical care provided the individual during his military career is the:
  - a. Chronological Record of Medical Care.
  - b. Immunization Record.
  - c. Nuclear Duty Position Screening Evaluation.
  - d. Report of Medical Examination.
  - e. Report of Medical History.
  
8. Who normally functions as the custodian of the HREC for an individual engaged in combat?
  - a. The battalion commander.
  - b. A medical specialist assigned to a nearby aid station.
  - c. The senior medical officer assigned to a nearby aid station.
  - d. A military personnel officer.
  - e. The patient administrator of the nearest combat support hospital.
  
9. Health Records are usually filed:
  - a. Alphabetically by name.
  - b. In chronological order based upon date of birth.
  - c. Under the name of the treating physician.
  - d. In chronological order based upon the date the person entered military service.
  
10. In a HREC, the patient's immunization record is located:
  - a. On the left side of the file folder.
  - b. On the right side of the file folder.

11. In an OTR, the patient's prescription for plastic lenses is located:
  - a. On the left side of the file folder.
  - b. On the right side of the file folder.
  - c. Neither; plastic lenses are not authorized.
  
12. Which of the following is correct when completing an entry on an SF 600?
  - a. Stamped signature blocks cannot be used.
  - b. If a signature block is stamped on the form, no additional signature is needed.
  - c. If a signature block is stamped on the form, the person making the entry must sign or initial the entry.
  - d. If a signature block is stamped on the form, anyone can sign or initial the entry.
  
13. If you wish to obtain additional information about military medical records, you should consult:
  - a. AR 10-1.
  - b. AR 40-66.
  - c. STP 21-1-SMCT.
  - d. Uniform Code of Military Justice and Geneva Conventions
  
14. A HREC has two components. What are they?
  - a. The inpatient and the outpatient components.
  - b. The surgical and the medical components.
  - c. The health and the dental components.
  - d. The current records and the retired records components.

**Check Your Answers on Next Page**

## **SOLUTIONS TO EXERCISES: LESSON 2**

1. b (paras 2-2a, b)
2. a (para 2-2a(3))
3. e (para 2-3)
4. a (para 2-5)
5. e (para 2-3)
6. d (paras 2-4, 2-11)
7. a (para 2-10)
8. d (para 2-4)
9. a (para 2-8a)
10. a (para 2-6a(5))
11. b (para 2-12b(17))
12. c (para 2-10h)
13. b (paras 2-6, 2-12)
14. c (para 2-4)

**End of Lesson 2**

## LESSON ASSIGNMENT

### LESSON 3

Terminal Digit Filing System.

### TEXT ASSIGNMENT

Paragraphs 3-1 through 3-6.

### LESSON OBJECTIVES

When you have completed this lesson, you should be able to:

- 3-1. Determine a person's TDFS code.
- 3-2. Determine the sequence in which records should be filed using TDFS.
- 3-3. Identify the proper DA Form 3444- series file folder given a patient's SSN.
- 3-4. Identify information recorded on DA Form 3444-series file folders.
- 3-5. Identify which records are filed using the TDFS.

### SUGGESTION

Work the lesson exercises at the end of this lesson before beginning the next lesson. These exercises will help you to accomplish the lesson objectives.



## LESSON 3

### TERMINAL DIGIT FILING SYSTEM

#### 3-1. PURPOSE OF THE TERMINAL DIGIT FILING SYSTEM

The TDFS is used to file ITR, OTR, and X-ray film negatives. The system may also be used to file HREC when authorized by the MTF commander.

#### 3-2. TERMINAL DIGIT FILING SYSTEM CODES

The principle characteristic of the TDFS is the use of the SSN of the service member involved to file records regardless of whether he is the actual patient or is serving as sponsor for a dependent family member who is the patient. Records are filed numerically based upon an 11-digit number obtained from the patient's family member prefix code and the sponsor's SSN.

a. **Sponsor's Social Security Number.** The SSN of the service member (sponsor) is broken into three groupings.

- (1) The first five digits are called the tertiary group.
- (2) The second two number are called the secondary group.
- (3) The last two numbers are called the primary group.

(4) If a soldier's SSN is 123-45-6789, for example, then his primary group is 89, his secondary group is 67, and his tertiary group is 12345.

b. **Family Member Prefix Code.** The family member prefix (FMP) code is a two-digit code placed before the sponsor's social security number to indicate the patient's relationship to the sponsoring service member. The FMP codes are explained in Table 3-1.

<b>Family Member Prefix Code</b>	<b>Relationship of Patient to Sponsor</b>
20	The patient is the service member.
30	The patient is the service member's spouse or former spouse. FMP 31 through 39 indicates subsequent spouses.
01 through 19	The patient is the service member's child. FMP 01 denotes the oldest child, FMP 02 denotes the next oldest, and so forth. Adopted or other dependent children are assigned codes as they become eligible.
40	The patient is the service member's mother.
45	The patient is the service member's father.
50	The patient is the service member's mother-in-law.
55	The patient is the service member's father-in-law.
60 through 97	The patient is related to the service member, but different from the above categories.
98	The patient is a civilian brought into the MTF as an emergency. (The patient's own social security number is used.)
99	The patient does not fit into any of the above categories. Stillborns who are carded-for-record- only are given an FMP of 99.
00	The SSN of the patient is unknown or the patient has no SSN. The hospital assigns the patient a nine-digit number which is used as though it were a SSN. The primary and secondary groups are both "00" with the tertiary group containing in the identifying number. The first such patient would be 00 00001 00 00 using the FMP/tertiary/secondary/ primary format. The second such patient would be assigned the number 00 00002 00 00, and so forth.

Table 3-1. Family member prefix codes.

### **3-3. FILING SEQUENCE**

a. Records maintained using the TDFS are filed in the following sequence.

(1) Primary group. When records are filed using TDFS, folders are first arranged in numerical order using the primary groups only (eighth and ninth digits of sponsor's SSN).

(2) Secondary group. The folders in each primary group are then arranged in numerical order using the secondary group (sixth and seventh digits of sponsor's SSN).

(3) Tertiary group. The folders in each secondary group are then arranged in numerical order according to their tertiary group (first five digits of sponsor's SSN).

(4) Family member prefix. If two or more folders have the same SSN (a soldier and his dependent wife, for example), the folders are then arranged in numerical order using the family prefix code.

b. As an example, suppose PFC Smith's SSN is 123-45-6789. His primary group is 89, his secondary group is 67, his tertiary group is 12345, and his family member prefix code is 20. When looking for his record, it would be as though the records were filed in numerical order and his record was number 89671234520.

(1) If the soldier has a dependent wife, her records are filed as though her number were 89671234530.

(2) If the soldier has a wife that is also in the military, her records are filed under her SSN and her FMP is 20, since she is her own sponsor.

### **3-4. PURPOSE OF DA FORM 3444-SERIES**

DA Form 3444-series, Alphabetical and Terminal Digit File for Treatment Record, file folders are designed to make filing and retrieving health and dental records easier when the TDFS is used. Although the file folder is designed with the TDFS in mind, it can also be filed alphabetically when required.

### **3-5. IDENTIFYING FORM 3444-SERIES FOLDERS**

There are 10 folders in the series (DA Form 3444 through DA Form 3444-9). DA Form 3444-series forms are color-coded to help prevent misfiling. The proper form is selected based upon the eighth digit of the sponsor's SSN. Table 3-2 shows the relationship of the sponsor's primary group to the form number and the color of the form.

Primary Group	DA Form	Color of Folder
00 through 09	3444	Orange
10 through 19	3444-1	Light green
20 through 29	3444-2	Yellow
30 through 39	3444-3	Gray
40 through 49	3444-4	Tan
50 through 59	3444-5	Light blue
60 through 69	3444-6	White
70 through 79	3444-7	Brown
80 through 89	3444-8	Pink
90 through 99	3444-9	Red

Table 3-2. Identification of DA Form 3444-series file folders.

### 3-6. INITIATING A DA FORM 3444-SERIES FOLDER

Use the following instructions to initiate a DA Form 3444-series file folder. Figure 3-1 shows a form initiated for an ITR. The front of the folder is smaller than the back. The top and right side of the back of the folder can be seen when the folder is closed. The name section, blocks 0 through S (horizontal), circles for the FMP, and blocks for the sponsor's SSN are on the top of the back of the folder; blocks 0 through S (vertical) are on the far right of the back of the folder.

- a. Select the proper folder using the eighth digit of the sponsor's SSN (Table 3-2).
- b. Mechanically imprint the patient's recording card onto a label and place the label in the identification section (upper right corner of the front of the folder).
  - (1) If the patient's recording card or mechanical imprinting is not available and the folder is to be used as an ITR or OTR, prepare a label [patient's family member prefix and sponsor's SSN on the first line and the patient's name (last name, first name, middle initial) underneath] and place the label in the identification section.
  - (2) If the folder is to be used as an ITR, you may stamp the folder using the patient's admitting plate rather than preparing the label.

0 1 2 3 4 5 6 7 8 9 | R | S | 2

LAST NAME FIRST MI

ALPHABETICAL AND TERMINAL DIGIT FILE FOR

PATIENT IDENTIFICATION

# TREATMENT RECORD

For use of this form, see AR 40-86, the proponent agency is TAG.

**NOTE TO PHYSICIAN:**

- MEDICAL CONDITION (Medical Warning Tag)
- PERSONNEL RELIABILITY PROGRAM (SCREENING)
- RADIATION SCREENING PROGRAM
- FLIGHT STATUS
- MEDICAL REGISTRIES
- BLOOD TYPE

**TYPE OF RECORD:**

- INPATIENT (CLINICAL)
- OUTPATIENT TREATMENT
- HEALTH
- HEALTH-DENTAL
- DENTAL (NON-MILITARY)

IF FOUND RETURN TO:  
ANY US POST OFFICE

POSTMASTER - FORWARD TO:  
HQ, Department of Army  
Washington, DC 20310

DA FORM 3444-2, 1 JAN 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

0  
1  
2  
3  
4  
5  
6  
7  
8  
9  
R  
S

Figure 3-1. DA Form 3444-series file folder (DA Form 3444-2).

c. Print the individual's name (last name, first name, middle initial) in the upper left corner (back portion of folder) as indicated.

**NOTE:** Use a felt-tip marker or similar marking device to make written entries on the folder. Do not use a pencil. Write so the entries can be read easily.

d. Write the patient's FMP (Table 3-1) in the two circles to the right of the name area (back portion of folder). Enter one digit in each circle.

e. Write the sponsor's SSN in the nine blocks to the right of the FMP (back portion of folder). The SSN is written in normal sequence (123-45-6789). The eighth digit is preprinted in the proper block.

f. Place a piece of black tape over the number on the top (back portion) and far right (back portion) of the folder that corresponds to the ninth digit of the sponsor's SSN (the second digit of the primary group). This marking, in addition to the color coding, helps to quickly locate records which have been misfiled. Figure 3-2 shows such a misfiled folder.

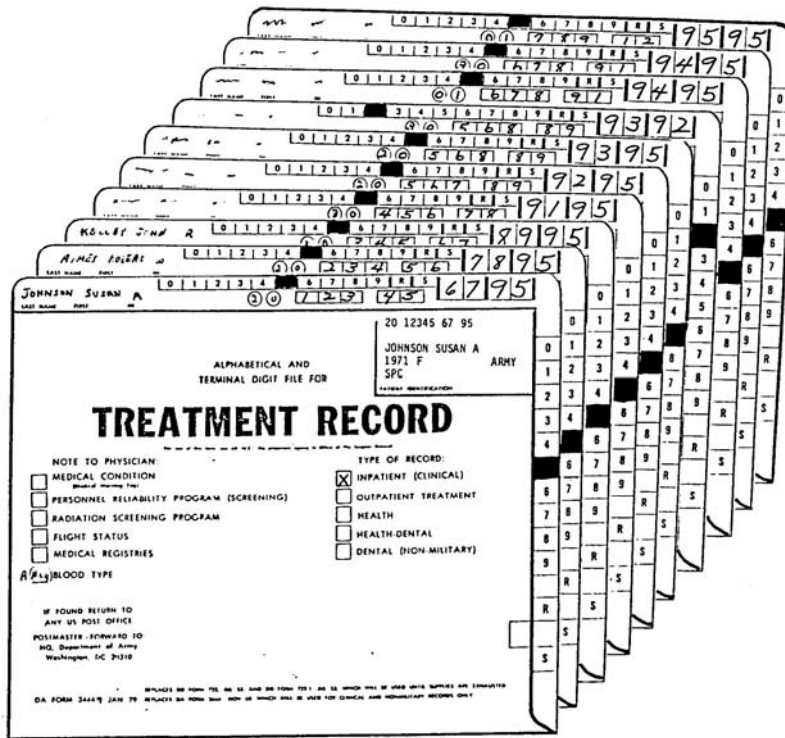


Figure 3-2. Series of DA Form 3444-series records showing a misfiled record.

g. If the file is an ITR or OTR, place a piece of colored tape over the "R" block (front and back of the back portion of the folder) to indicate the year the record is to be retired (Table 3-3). If the retirement year changes, another piece of colored tape is placed over the block.

Year ITR Is To Be Retired	Color of Tape
1990 1997	Green
1991 1998	Yellow
1992 1999	Silver or White
1993 2000	Black
1994 2001	Orange
1995 2002	Red
1996 2003	Blue

Table 3-3. Tape color codes for retirement dates.

(1) Retire an OTR three years after the end of the year in which the last medical treatment was given.

(2) ITRs are retired according to the schedule given in AR 340-18, The Army Functional Files System.

(a) Nonfixed medical facilities. Retire completed ITR at the end of the month in which the patient was released.

(b) United States Military Academy. Retire ITR three years after the end of the year in which the last medical treatment was given.

(c) Five year clinical medical libraries. Retire ITR five years after the end of the year in which the last medical treatment was given.

(d) Other medical facilities. Retire ITR one year after the end of the year in which the last medical treatment was given.

h. Place a piece of colored tape over the "S" block (front and back of the back portion of the folder) to indicate the status of the patient.

(1) Red. Active duty military or the medical record is an ITR.

(2) Green. United States. military other than active duty.

(3) Silver or white. North Atlantic Treaty Organization (NATO) and foreign nationals.

(4) Black. All others.

i. Mark an "X" in the appropriate block on the right half of the front portion of the folder to indicate the type of record being created (ITR, OTR--health component, HREC--health component, HREC--dental component, or OTR--dental component).

j. Enter an "X" in any category in the "Note to Physician" section which pertains to the patient. If the patient has an allergic reaction to medication, mark an "X" the "Medical Condition" block and affix a DA Label 162, Emergency Medical Identification Label, to the front of the file.

k. Enter the patient's blood type in the blank preceding "Blood Type" on the left half of the front portion of the folder. The Rh factor should be denoted by "(Pos)" or "(Neg)" rather than "+" or "-." For example, "A (Pos)" rather than "A+."

**Continue with Exercises**

### EXERCISES: LESSON 3

**INSTRUCTIONS:** For each question or incomplete statement, write the appropriate term in the space provided or circle the letter of the response which BEST answers the question or BEST completes the statement. After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers. For each exercise answered incorrectly, reread the material referenced after the solution.

1. Which of the following, if any, do not have to be filed using the terminal digit filing system?
  - a. Health Records.
  - b. Inpatient Treatment Records.
  - c. Outpatient Treatment Records.
  - d. X-ray film negatives.
  - e. All of the above must be filed using TDFS.
  
2. PFC John Doe's social security number is 454-66-7780. Give the following information for the TDFS.
  - a. His primary group is \_\_\_\_\_.
  - b. His secondary group is \_\_\_\_\_.
  - c. His tertiary group is \_\_\_\_\_.
  - d. His FMP is \_\_\_\_\_.



3. PFC John Doe's social security number is 454-66-7780. PFC Doe's DA Form 3444-series Inpatient Treatment Record file folder should be colored:
  - a. Brown.
  - b. Orange.
  - c. Pink.
  - d. Tan.
  - e. White.
  
4. Sergeant Bill Adam's social security number is 223-55-9876. His dependent wife's social security number is 232-44-3456. Give the following information for filing his wife's medical records using TDFS.
  - a. Her primary group is \_\_\_\_\_.
  - b. Her secondary group is \_\_\_\_\_.
  - c. Her tertiary group is \_\_\_\_\_.
  - d. Her FMP is \_\_\_\_\_.
  
5. SFC Mary Smith's social security number is 882-58-7431. Her son (age 12 and the oldest of three children) has a social security number of 111-22-3454. Give the following information for filing her son's medical records using TDFS.
  - a. His primary group is \_\_\_\_\_.
  - b. His secondary group is \_\_\_\_\_.
  - c. His tertiary group is \_\_\_\_\_.
  - d. His FMP is \_\_\_\_\_.

6. Sergeant Brown (SSN 349-54-6675), Sergeant Smith (SSN 494-66-5680), and Sergeant Hill (SSN 599-21-9202) has records filed under the TDFS. In which order should you find their records. (Begin with the first.)
  - a. Hill, Brown, Smith.
  - b. Smith, Hill, Brown.
  - c. Brown, Smith, Hill.
  - d. Smith, Brown, Hill.
  
7. You are preparing a DA Form 3444-series file folder for PFC Robert James, SSN 490-76 3807, whose blood type is A+.
  - a. Which form (number) do you select? \_\_\_\_\_.
  - b. What number on the top and side borders of the form do you cover with black tape? \_\_\_\_\_.
  - c. What do you enter in the "Blood Type" blank on the folder?  
\_\_\_\_\_.
  
8. You are preparing an ITR for a patient admitted to a nonfixed medical treatment facility. What color of tape should you place over the "S" block of the DA Form 3444-series folder?
  - a. Silver or White.
  - b. Black.
  - c. Orange.
  - d. Red.
  - e. Blue.
  - f. Green.
  - g. Yellow.
  - h. Cannot be determined until the record is completed and the patient dismissed.
  - i. Cannot be determined without the sponsor's social security number.

**Check Your Answers on Next Page**

### SOLUTIONS TO EXERCISES: LESSON 3

1. a (paras 3-1, 2-8a)
2. a. 80  
b. 77  
c. 45466  
d. 20 (para 3-2, Table 3-1)
3. c (table 3-2)
4. a. 76  
b. 98  
c. 22355  
d. 30 (para 3-2, Table 3-1)
5. a. 31  
b. 74  
c. 88258  
d. 01 (para 3-2, Table 3-1)
6. a (para 3-2) Hill 02/92/59921/20  
Brown 75/66/34954/20  
Smith 80/56/49466/20
7. a. DA Form 3444  
b. 7  
c. A (Pos) (paras 3-6a, f, k; Table 3-2)
8. d (para 3-6h(1))

**End of Lesson 3**

## **LESSON ASSIGNMENT**

### **LESSON 4**

Field Medical Card.

### **TEXT ASSIGNMENT**

Paragraphs 4-1 through 4-9.

### **LESSON OBJECTIVES**

When you have completed this lesson, you should be able to:

- 4-1. Identify the purpose of the DD Form 1380, US Field Medical Card.
- 4-2. Identify the information recorded on the field medical card.
- 4-3. Identify the procedures for entering information on the field medical card.
- 4-4. Identify the appropriate disposition for a field medical card.

### **SUGGESTION**

Work the lesson exercises at the end of this lesson before beginning the next lesson. These exercises will help you to accomplish the lesson objectives.

## LESSON 4

### FIELD MEDICAL CARD

#### 4-1. PURPOSE OF THE UNITED STATES FIELD MEDICAL CARD, DD FORM 1380

a. DD Form 1380, US Field Medical Card or field medical card (FMC), is used to record medical information when the patient's HREC is not available. The FMC is used by aid stations, clearing stations, treatment stations, and nonfixed troop or health clinics working overseas, on maneuvers, or attached to commands moving between stations. It can also be used to record outpatient visits at fixed medical facilities when needed (for example, a soldier on leave receiving treatment at a military medical clinic located on a post other than the post to which he is assigned) and certain CRO cases.

b. The field medical card was designed to be used in forward combat areas by NATO troops; therefore, the printed instructions on the form are in French as well as in English. The FMC provides medical officers who see the casualty during evacuation with essential information about the casualty's injury or disease and the treatment already given. When a MTF initiates a medical record on the casualty, the FMC becomes part of the record.

#### 4-2. DESCRIPTION OF THE FIELD MEDICAL CARD

Field medical cards are issued in a "book" containing 20 two-part sets. A set consists of a sturdy card with attached wire, a sheet of carbon paper, a carbon protective sheet, and a duplicate paper form. The front side of the card has spaces for the casualty's identification, a description of the injury or illness, treatment rendered, and the signature of the medical officer. The reverse side of the card has space for additional entries when needed. Figure 4-1 shows both sides of an initiated FMC.

#### 4-3. INITIATING A FIELD MEDICAL CARD

The FMC is initiated when the casualty receives medical treatment from medical personnel. The form is usually initiated by the combat medic (medical specialist MOS 91W) after he treats the casualty on the battlefield. If a casualty arrives at a battalion aid station or other MTF without a FMC (for example, the casualty reached the facility on his own or was evacuated by fellow soldiers [buddy-aid] without being evaluated by a combat medic), the form is initiated at the facility.

a. Remove and discard the carbon protective sheet. This allows the information written on the front of the form to also be recorded on the paper duplicate.

**NOTE:** If you accidentally remove the carbon paper, reinsert the carbon paper between the card, and the duplicate with the carbon side toward the duplicate.

FRONT

1. NAME (Last-First-Middle Initial) / NOM, PRENOMS <b>SMITH JOHN R</b>		3. SERVICE NUMBER / NUMERO MATRICULE <b>779 76 5110</b>	4. GRADE / GRADE <b>SGT</b>	5. NATION / NATION (e.g. Great Britain)
6. FORCE / ARMEE	8. BRANCH AND TRADE / ARME (e.g. Infantry)	7. UNIT / UNITE		9. SERVICE (Type) / DUREE DES SERVICES (e.g. 1 1/11)
10. AGE / AGE	11. RACE / RACE	12. RELIGION / RELIGION	13. FACILITY WHERE TAGGED / LIEU D'ETABLISSEMENT DE LA FICHE	14. DATE AND HOUR TAGGED / DATE ET HEURE D'ETABLISSEMENT DE LA FICHE
15. DIAGNOSIS (including cause) / DIAGNOSTIC (Cause comprise)		NATURE OF CASUALTY OR ILLNESS / NATURE DE LA BLESSURE OU MALADIE		17. DATE & HOUR INJURED / DATE ET HEURE DE LA BLESSURE
		DISABILITY / INCAPACITE	ENEMY ACTION / DU FAIT DE L'ENNEMI	
16. LINE OF DUTY / EN RELATION AVEC LE SERVICE		18. INJURY / BLESSURE	<input type="checkbox"/> YES / OUI <input type="checkbox"/> NO / NON	19. WHAT WAS HE DOING WHEN INJURED / QUE FAISAIT-IL LORSQU'IL FUT BLESSE
		17. SICK / MALADIE	<input type="checkbox"/> YES / OUI <input type="checkbox"/> NO / NON	
19. TREATMENT GIVEN (For antibiotics specify which and give dose, hour and date) / TRAITEMENT EFFECTUE (Si des antibiotiques ont été donnés, précisez leur nature, la dose, l'heure et la date) <i>Fid dressing &amp; pressure dressing applied to left thigh.</i>		TREATMENT / TRAITEMENT EFFECTUE		20. DOSE / DOSE
21. TOURNIQUET (Yes or No; Time & date applied) / MISE EN PLACE D'UN GARROT (Oui ou Non; heure et date) <i>No</i>		21. MORPHINE - 1st / MORPHINE - 1ère		22. HOUR AND DATE / HEURE - DATE
27. DISPOSITION-DISPOSAL / DESTINATION DONNEE AU BLESSE		22. MORPHINE - 2nd / MORPHINE - 2ème		
		23. MORPHINE - 3rd / MORPHINE - 3ème		
		24. MORPHINE - 4th / MORPHINE - 4ème		
		25. TETANUS TOXOID / VACCIN ANTITETANIQUE		
		26. A. T. SERUM / SERUM ANTITETANIQUE		
		28. MEDICAL OFFICER (Signature & Grade) / SIGNATURE ET GRADE DU MEDECIN <i>TJF</i>		

DU FORM 1380, 1 JUN 58 U. S. FIELD MEDICAL CARD / FICHE MEDICALE DE L'AVANT ETATS-UNIS

REVERSE

a. ABSOLUTION / CONFESSION		b. HOLY COMMUNION / SAINTS COMMUNION		c. EXTREME UNCTION / EXTREME ONCTION	
29. d. OTHER MINISTRATIONS / AUTRES MINISTERES			e. CHAPLAIN (Signature) / SIGNATURE DE L'AUMONIER		
30. DIET / REGIME ALIMENTAIRE					
<input type="checkbox"/> REGULAR / NORMAL <input type="checkbox"/> LIQUID / LIQUIDE <input type="checkbox"/> NOTHING BY MOUTH / RIEN PAR VOIE ORALE					
31. REMARKS / REMARQUES					

★ U. S. GOVERNMENT PRINTING OFFICE: 1967-265-369

Figure 4-1. DD Form 1380, US Field Medical Card.

b. Enter the casualty's identification information in Blocks 1, 2, and 3. Information may be secured from the patient or from such things as identification tags and the casualty's uniform.

(1) Block 1. Enter the casualty's name in last name, first name, middle initial format.

(2) Block 2. Enter the casualty's SSN if the casualty is a member of the US Armed Forces. If the casualty is a member of a foreign military, including a prisoner of war, enter the casualty's military service number. If the casualty is not military, leave the block blank.

(3) Block 3. Enter the abbreviation of the casualty's grade (SGT, CPT, and so forth). Approved abbreviations are listed in AR 310-50.

c. Enter a description of medical care given in Blocks 20 through 26. If additional space is needed, use Block 32 on the back of the form. If Block 32 is used, reference the block being continued.

**NOTE:** To record information on the back of the form, remove the card and the carbon paper from the book, turn the duplicate copy so the reverse side is up, place the carbon paper on top of the duplicate copy with the carbon side facing the duplicate copy, and place the card on top of the carbon paper with the reverse side of the card facing up.

(1) Block 20. Enter a brief description of the medical care rendered other than the application of a tourniquet and administration of medication listed in Blocks 22 through 26. If any drugs, antibiotics, or blood plasma was administered, record the name of the item administered, the dosage administered, and the time and date it was administered. Enter the time using the military 24-hour system, such as 1550.

(2) Block 21. Enter "yes" if a tourniquet was applied or "no" if a tourniquet was not applied. If "yes" is entered, also enter the time and date that the tourniquet was applied.

(3) Blocks 22 through 26. If the indicated drug [morphine, tetanus toxiod, or antitetanic serum (tetanus antitoxin)] was administered, enter the required information. Note that there is room to record up to three administrations of morphine (blocks 22, 23, and 24).

(a) Record the dosage in column "a" across from the appropriate drug.

(b) Record the time and date the drug was administered in column "b" across from the appropriate drug.

d. Enter your initials in the far right of Block 29. This will let the medical officer at the medical treatment facility (usually the battalion aid station) know who initially treated the casualty and still leave room for the medical officer to sign the card.

#### **4-4. ENTERING ADDITIONAL INFORMATION ON A FIELD MEDICAL CARD**

Enter the following information if you have time and the situation permits.

a. **Block 4.** Enter the name of the country of whose armed forces the casualty is a member. If the casualty is a member of the US Armed Forces, for example, enter "USA."

b. **Block 5.** Enter the name of the Armed Service of which the casualty is a member, such as "US Army," "US Navy," or "US Air Force (USAF)."

c. **Block 6.** If the casualty is an officer of the US Armed Forces, enter the name of the casualty's branch or corps. Enter the casualty's area of concentration (AOC) code or military occupation specialty (MOS) code. If the AOC or MOS is not known or if the casualty is a member of a foreign military, enter a brief description, such as "light weapons infantryman."

d. **Block 7.** If the casualty is in the military (US or foreign), enter the name of his duty unit. If the casualty is a civilian, enter identifying information, such as "Stars and Strips reporter."

e. **Block 8.** If the casualty is in the military, enter the total amount of active military service. Use the rules given below instead of the example shown on the form.

(1) Service of less than 1 month is shown in days (for example, service of 23 days is entered as "23/365").

(2) Service of more than one month but less than 2 years is shown in completed months (for example, service of 15 months is entered as "15/24").

(3) Service of more than 2 years is shown in completed years (for example, service of 2 years and 9 months is entered as "2 YRS").

f. **Block 9.** Enter the casualty's age.

g. **Block 11.** Enter the casualty's religious preference. If the casualty does not have a religious preference, enter "None."

h. **Block 13.** Enter the date and hour (using 2400-hour system) when the casualty first received any type of medical care by a member of any of the military medical services.



(1) If you are initiating the card on the battlefield and you were the first medical person to render care, enter the time you began your examination and treatment of the casualty.

(2) If another medic began treating the casualty but did not initiate a field medical card, enter the time the first medic began his examination and treatment.

(3) If a combat lifesaver, another nonmedical soldier, or the casualty himself initiated care before you arrived, enter the time that you examined the casualty. Care given by a nonmedical soldier does not constitute medical treatment.

i. **Block 18.** Enter the date and hour (using 2400-hour system) when the casualty was injured. Be as accurate as possible when completing Blocks 13 and 18. Blocks 13 and 18 will tell medical personnel at the MTF approximately how much time elapsed between the injury and the start of medical treatment.

j. **Block 19.** Enter a brief description of the circumstances leading to the injury.

k. **Block 27.** If the casualty is to returned to duty (RTD) without further medical treatment, enter "CRO-duty,"

#### **4-5. INITIAL DISPOSITION OF THE FIELD MEDICAL CARD**

Retain the carbon copy of the form in your book. Follow standing operating procedures (SOP) for initial disposition of the carbon copies in the book.

a. **Return to Duty.** If the soldier is to RTD without inpatient treatment at a MTF (CRO-duty), leave the original card in the book and return the soldier to duty. Follow SOP for sending the card to higher headquarters within the command for coding.

b. **Evacuation.** If the casualty is to be evacuated to a MTF, remove the card from the book and use the wire to attach the card to the casualty's clothing. The information on the card will provide valuable information to other medical personnel who treat the casualty.

#### **4-6. RECORDING INFORMATION DURING EVACUATION**

If you are a medical specialist assigned to an evacuation vehicle, record additional information as needed on the casualties' FMC.

a. **Treatment.** If additional treatment is given to the casualty in route to the MTF, enter the nature of the treatment, where it was given, and the date and hour it was given in Block 32 of the FMC.

b. **Death.** If the casualty dies in route to the MTF, enter the date and hour of death, the cause of death, and the approximate location where the casualty died in Block 32 of the field medical card.

#### 4-7. COMPLETING A FIELD MEDICAL CARD

A medical officer at the battalion aid station or other MTF will complete the field medical card or supervise its completion. The physician or physician assistant may direct you to enter information on the patient's FMC. If any of the blocks discussed in paragraphs 4-3 and 4-4 have not been completed, enter any needed information in these blocks. The directions for completing the remaining blocks are given in the following paragraphs.

a. **Block 10.** Enter the patient's race.

- (1) Enter "Cau" for Caucasian.
- (2) Enter "Neg" for Black (Negroid or African).
- (3) Enter "Oth" for other races.
- (4) Enter "Unk" if the patient's race is unknown.

b. **Block 12.** Enter identification of the MTF and its location in geographic terms (for example, "Aid Sta, 2/79 Inf, 199 Inf Div, near Song Won, ROK").

c. **Block 14.** This block should be completed by the physician or physician assistant. If you are told to record information in the block, enter the information as given to you by the medical officer. Enter only the condition, not treatment, and use standard terms. If additional space is needed, continue the remarks in Block 32 (be sure to reference Block 14) or on a supplemental card (paragraph 4-8).

(1) Puncture, penetrating, or missile wounds. Record the point of entry and the name of the organs, arteries, and/or nerves involved.

(2) Injuries not incurred in combat. State the nature of the injury; the causative agent; the body parts affected; the circumstances leading to the injury; whether the injury was accidentally incurred, deliberately self-inflicted, or deliberately inflicted by another, and the place and date.

(3) Injuries incurred in combat. In addition, indicate that the injury was a result of enemy action, state the kind of missile causing the injury, and the general geographical location.

(4) Injuries or diseases caused by chemical or bacteriological agents or by ionizing radiation. Enter the information required in paragraph (2) above. In addition, state the name of the agent or type of ionizing radiation if known. If not known, give anything that is known about the physical, chemical, or physiological properties of the agent such as odor, color, or physical state. Also state the date, time, and place where contamination took place, the time interval between contamination and treatment, and the nature of the treatment. If the casualty was affected by ionizing radiation, record the following information.

(a) The approximate distance from the source.

(b) If the exposure was to external gamma radiation.

(c) The actual or estimated dosage (for example, "est 150 rad" or "measured 200 rad").

(d) If exposure was caused by an airburst, ground burst, water surface burst, or underwater burst.

d. **Block 15.** Enter either "yes" or "no" based upon instructions given by the physician or physician assistant.

e. **Blocks 16 and 17.** Mark the appropriate box to indicate whether the patient was injured caused by enemy action, injured not caused by enemy action, sick caused by enemy action, or sick not caused by enemy action. The term "sick" refers to any disease.

f. **Blocks 20 and 22 through 26.** Enter treatment given at the facility. Block 32 or a supplemental FMC (paragraph 4-8) can be used as needed.

g. **Block 27.** Enter the disposition of the patient.

(1) If the patient is transferred to another MTF, enter "Transfer to (name of MTF)." If the facility is not known, enter the general destination and the means of transportation.

(2) If the patient is RTD following treatment, enter "Duty."

(3) If the patient died at the facility, enter "Died."

(4) If the casualty was CRO (treated as an outpatient) and RTD, enter "CRO-duty."

(5) If the casualty was dead upon arrival, enter "CRO-death."

h. **Block 28.** Enter the time and date the patient was dispositioned (transferred, died, or RTD).

i. **Block 30.** Make no entries in the block. The block, when used, is completed by a chaplain. If entries are made, the chaplain making the entries must sign the form in the space provided.

j. **Block 31.** Mark the appropriate diet box, if applicable.

k. **Block 29.** Make sure the FMC is signed by the medical officer in charge of the MTF, by an AMEDD officer, or by an enlisted person designated by an AMEDD officer. The person signing should review all entries on the form, enter his signature, grade, and organization in the block.

#### **4-8. SUPPLEMENTAL FIELD MEDICAL CARD**

If additional space is required to record information (for example, additional treatment needs to be recorded and Block 32 has been filled), initiate a supplemental FMC.

- a. Write "FMC number two" in the upper right corner of the supplemental card.
- b. Complete Blocks 1, 2, and 3 of the supplemental card. Use the information on the first card to complete these blocks.
- c. Enter the additional information.
- d. Attach the supplemental card to the original card.
- e. If additional supplemental cards are needed, repeat the procedures given above. In step a, enter the appropriate card number.

#### **4-9. FINAL DISPOSITION OF THE FIELD MEDICAL CARD**

- a. If the casualty is treated as an inpatient at a MTF, the original FMC becomes part of the casualty's ITR.
- b. If the casualty is treated as an outpatient, the original FMC will eventually be filed in the casualty's HREC or OTR.
- c. If the casualty is CRO, the original FMC is dispositioned IAW AR 40-66.
- d. The duplicate (carbon) copies of the form are dispositioned IAW AR 340-18.

**Continue with Exercises**

## EXERCISES: LESSON 4

**INSTRUCTIONS:** For each question or incomplete statement followed by a group of lettered responses, circle the letter of the response that BEST answers the question or BEST completes the statement.

1. When is a DD Form 1380, US Field Medical Card, used to record medical treatment?
  - a. When the combat medic treats a wounded soldier on the battlefield.
  - b. When the combat medic treats a sick soldier in a combat situation.
  - c. When medical personnel at an aid station, treatment station, or clearing station treat a soldier in a combat situation.
  - d. All of the above.
  
2. Of the following, which block would not be used by a combat medic treating an injured soldier on the battlefield prior to evacuation to an aid station?
  - a. Block 2, Service Number.
  - b. Block 11, Religion.
  - c. Block 14, Diagnosis.
  - d. Block 22, Morphine.
  
3. You are entering information of a DD Form 1380 concerning the care you have given a combat casualty. You have filled the Treatment Given block, but still have not recorded all of the information you wish to document. You should:
  - a. Not record the additional information.
  - b. Record the rest of the information in Block 30d, Other Ministrations.
  - c. Record the rest of the information in Block 32, Remarks.
  - d. Record the rest of the information on a separate DD Form 1380.

4. You are going to make an entry on the back (reverse side) of a field medical card. What must you do before recording the information?
  - a. Remove the card and the carbon paper from the book, turn the duplicate copy so the reverse side is up, place the carbon paper on top of the duplicate copy with the carbon side facing the duplicate copy, and place the card on top of the carbon paper with the reverse side of the card facing up.
  - b. Remove the duplicate copy and the carbon paper from the book, turn the card so the reverse side is up, place the carbon paper on top of the card with the carbon side facing the card, and place the duplicate copy on top of the carbon paper with the reverse side of the duplicate copy facing up.
  - c. Remove and discard the carbon paper.
  - d. None of the above. Simply turn the card over and enter the information.
  
5. You are entering information on a casualty's field medical card. The soldier has been in the Army for 1 year, 8 months, and 17 days. What is entered in Block 8, Service?
  - a. 1 YR.
  - b. 2 YRS.
  - c. 1/8.
  - d. 20/24.
  - e. 1/8/17.
  - f. 622/365.
  - g. 1-8/12-17/30.

6. You are working at a medical treatment facility. An unconscious casualty with a field medical card reaches your facility. The medical officer asks you how much time elapsed from the time the soldier was shot until he first received medical treatment. How can you determine this information?
  - a. Wait until the casualty regains consciousness and question him about the injury and his treatment.
  - b. Determine the time difference between Block 13 and Block 18 of the FMC.
  - c. Obtain the information from Block 19 of the FMC.
  - d. Obtain the information from Block 20 of the FMC.
  
7. You are assigned to an aid station. A soldier with a minor wound is treated and returned to duty (outpatient, CRO). You initiated a field medical card on the casualty. What do you do with the form?
  - a. Destroy the form since the casualty is not to be evacuated.
  - b. Forward the form to higher headquarters.
  - c. Use the wire on the original form to attach the form to the casualty's clothing.
  - d. Have the casualty carry the duplicate copy back to the combat medic assigned to his unit.
  
8. You are treating a casualty while the casualty is being evacuated. You have used up the space in Block 32, but still need to record additional information. You should:
  - a. Continue your entries in Block 20 of the card.
  - b. Continue your entries in Block 30d of the card.
  - c. Continue your entries in Block 32 of the duplicate copy of the card.
  - d. Enter the casualty's identification on another field medical card, write "FMC number two" in the upper right hand corner of the card, and continue your entries.

9. A casualty with a field medical card is received at a military hospital. What happens to the card when an Inpatient Treatment Record is initiated on the patient?
- a. The card is filed in the patient's ITR.
  - b. The information on the card is transferred to the ITR and the card is filed in the patient's Health Record.
  - c. The card becomes a permanent part of the patient's chart that is maintained on the ward.
  - d. The information on the card is transferred to the ITR and the card is destroyed.

**Check Your Answers on Next Page**



## **SOLUTIONS TO EXERCISES: LESSON 4**

1. d (para 4-1a)
2. c (paras 4-7c; 4-3b(3), c(3); 4-4g)
3. c (para 4-3c)
4. a (para 4-3c Note)
5. d (para 4-4e(2))
6. b (para 4-5i)
7. b (para 4-5b)
8. d (para 4-8)
9. a (para 4-9a)

**End of Lesson 4**

## LESSON ASSIGNMENT

### LESSON 5

Sick Call Procedures.

### TEXT ASSIGNMENT

Paragraphs 5-1 through 5-9.

### LESSON OBJECTIVES

When you have completed this lesson, you should be able to:

- 5-1. Identify the purpose of sick call.
- 5-2. Identify the purpose of DD Form 689.
- 5-3. Identify the purpose of the Algorithm-Directed Troop Medical Care (ADTMC) system.
- 5-4. Triage a patient using an algorithm.
- 5-5. Identify proper sick call and emergency procedures.

### SUGGESTION

Work the lesson exercises at the end of this lesson before beginning the examination. These exercises will help you to accomplish the lesson objectives.

## LESSON 5

### SICK CALL PROCEDURES

#### 5-1. SICK CALL

Sick call is an assembly of sick and injured military active duty personnel held each day at a designated time and place (usually at the troop medical clinic or battalion aid station) for the purpose of providing routine medical examination and treatment. After the examination, soldiers who are medically unfit for duty are admitted to a hospital, confined to quarters, or authorized to occupy a bed in a dispensary or Army health clinic. Other patients receive necessary treatment and are then returned to full duty or to duty with specific limitations.

a. Military personnel who do not report for medical treatment at sick call may be seen on an appointment basis.

b. In an emergency, a patient may be seen any time the facility is open. Sometimes a specific area or facility other than the area or facility used for sick call is designated for treating emergency patients.

#### 5-2. THE INDIVIDUAL SICK SLIP

Each person who comes to sick call should have an Individual Sick Slip (DD FORM 689) (figure 5-1). DD FORM 689 is usually prepared by the unit orderly room. After the person has been examined, the physician or other authorized person indicates the disposition of the patient on the Individual Sick Slip, which is then returned to the unit commander. In certain cases, such as an emergency in which the individual reports directly to the clinic for treatment, the Individual Sick Slip can be initiated by clinic personnel.

#### 5-3. HOLDING SICK CALL

The following is an example of typical sick call procedures.

a. Upon arriving at the clinic, the soldier gives the clerk his Individual Sick Slip.

b. The clerk removes the soldier's Health Record (HREC) from the file and enters the date and the facility identification (if needed) on the current Chronological Record of Medical Care. He then gives the HREC and the Individual Sick Slip to you (the medical specialist).

c. If the Algorithm-Directed Troop Medical Care (ADTMC) system is utilized, interview the patient and follow the instructions in the manual. (The ADTMC process is discussed in paragraphs 5-5 through 5-7.) If the ADTMC system is not used, you will normally proceed as follows.

INDIVIDUAL SICK SLIP		DATE
<input type="checkbox"/> ILLNESS <input checked="" type="checkbox"/> INJURY		20 May 199X
LAST NAME - FIRST NAME - MIDDLE INITIAL OF PATIENT <i>ADAMS Joseph K</i>		ORGANIZATION AND STATION <i>Co A 128th Engr Bn Ft Blank, TX</i>
SERVICE NUMBER/SSN <i>99337 20 78</i>	GRADE/RATE <i>PFC</i>	
UNIT COMMANDER'S SECTION		MEDICAL OFFICER'S SECTION
IN LINE OF DUTY <i>Yes</i>		IN LINE OF DUTY
REMARKS <i>SM injured leg while playing basketball in post gym @ 2100 19 May 9X</i>		DISPOSITION OF PATIENT <input type="checkbox"/> BICK BAY <input type="checkbox"/> DUTY <input type="checkbox"/> QUARTERS <input type="checkbox"/> HOSPITAL <input type="checkbox"/> NOT EXAMINED <input type="checkbox"/> OTHER (Specify)
SIGNATURE OF UNIT COMMANDER <i>for Alan Sanders 1SG</i> HARRISON R. HAYES, CPT, CF		SIGNATURE OF MEDICAL OFFICER
DD FORM 689 1 MAR 83		PREVIOUS EDITIONS ARE OBSOLETE.

Figure 5-1. DD Form 689, Individual Sick Slip.

(1) Take the patient's TPR and blood pressure. Observe the patient and question him about his complaint. Some of the signs and symptoms that you should try to observe are listed in paragraph 5-4. The significance of almost any symptom will change, if it is accompanied by an elevated temperature.

(2) If the patient appears to be acutely ill, notify the physician, physician assistant (PA), or other designated person immediately.

(3) If you believe the patient has a communicable disease (the patient has an obvious rash, an elevated temperature, a sore throat, and so forth.), move the patient to a segregated waiting area rather than allowing him to remain in close proximity to other patients in the common waiting room.

d. If the patient is to see the medical officer (physician, PA, or nurse practitioner), give the patient's HRED and Individual Sick Slip to the medical officer. The medical officer calls each patient in individually, questions and examines him, and determines what treatment he is to receive. He may treat a patient himself, direct an assistant to treat the patient, or refer the patient to another MTF.

e. The medical officer enters his comments, including his determination of the patient's duty status (returned to full duty, RTD with limitations, relieved of duty for "sick in quarters," or relieved of duties for hospitalization) on the patient's Chronological Record of Medical Care and the Individual Sick Slip.

f. Before the patient is dismissed from the clinic, you should review the medical officer's orders on the Chronological Record of Medical Care and make sure the patient understands what he is to do. If the patient requires additional instruction, check with the medical officer to make sure the additional instructions you give are in accordance with his instructions.

g. If the patient was administered medications that may cause drowsiness, loss of coordination, or similar problems, you may wish to detain the patient for observation (usually about 15 to 20 minutes). A cot or recovery bed is often provided near the treatment room for this purpose. An escort may also be provided to ensure the patient reaches his destination safely.

#### **5-4. THE SICK CALL INTERVIEW**

When you are interviewing a patient during sick call and are not using ADTMC, you should talk to the patient, listen to his complaints, and look for signs and symptoms of discomfort or distress. Some of the signs and symptoms you should look for during the initial contact are indicated below.

**a. Skin.**

- (1) Is the skin hot to the touch? Cold to the touch?
- (2) Does it look flushed? Pale?
- (3) Is a rash present? If so, where is it located?
- (4) Are the lips or nail beds bluish?

**b. Wounds.**

- (1) Where is the wound located?
- (2) Has a dressing been applied to the wound? If so, what is the condition of the dressing?

**c. Eyes and Eyelids.**

- (1) Are the pupils enlarged? Pinpoint?
- (2) Is the "white" of the eye yellow? Red?
- (3) Are the eyelids swollen? Are they encrusted at the margins?

**d. Complaint of Pain.**

- (1) Where is the pain located?
- (2) How did the pain start? When?
- (3) Is the pain sharp or dull? Mild or severe? Constant or intermittent?

**e. State of Consciousness.**

- (1) Is the patient alert or drowsy?
- (2) Is the patient oriented to his surroundings (Does he know where he is, or does he seem confused)?

**f. Nausea and Vomiting.**

- (1) When did the nausea begin?
- (2) Did vomiting occur? If so, when? Was blood present in the vomitus?
- (3) At what time did the patient last eat? What did he eat?

**g. Temperature, Pulse, and Respiration.**

- (1) Is there any marked deviation from normal TPR? (An oral temperature in the 97.6°F to 99.6°F range is considered to be normal. Normal pulse rate is between 60 and 80 beats per minute. Normal respiration rate is between 14 and 20 breaths per minute.)
- (2) Are there any abnormalities in the pulse rate rhythm?
- (3) Is the patient experiencing difficulty in breathing?

**h. General Posture and Gait.**

- (1) Does the patient experience difficulty in sitting?
- (2) Does the patient experience difficulty in standing? Walking?

**5-5. THE ALGORITHM-DIRECTED TROOP MEDICAL CARE SYSTEM**

In some medical facilities, the algorithm-directed troop medical care (ADTMC) system is utilized. The algorithm system was developed to assist the medical specialist and others in routing the patient being interviewed directly to the appropriate level of health care provider based upon the type and severity of his signs and symptoms.

Algorithms, which are sets of rules for solving a problem in a limited number of steps, allow individuals to use advanced medical logic to deal with patient problems within the limits of their training. This system allows you to rapidly determine the degree of urgency each soldier's complaint demands, quickly identify the health care provider who should evaluate that complaint, and speed the soldier's return to duty. Algorithms may vary from facility to facility. The algorithms shown in this subcourse are taken from HSC Pamphlet 40-7-21, Ambulatory Patient Care: Algorithm-Directed Troop Medical Care. The manual is designed to allow personnel, such as the medical specialist, to conduct initial patient screening and triage (sort or categorize) patients based upon specific common medical conditions. The steps of the procedure are documented on a DA Form 5181-R, Screening Note of Acute Medical Care (figure 3-2), as the screening process takes place.

## **5-6. LEVELS OF CARE IN THE ALGORITHM-DIRECTED TROOP MEDICAL CARE SYSTEM**

The decision trees in the Ambulatory Patient Care (APC) manual end in one of five courses of action being selected for the patient.

**CAUTION:** Many algorithm endpoints contained within the triage (sorting) manual recommend that the medical specialist prescribe self-care protocols. If this type of screening is done, the patient must be allowed to see a medical officer (physician, physician assistant, or nurse practitioner) if he requests. Also, any patient who does not accept Level IV protocol must be referred to the PA (Level III).

a. **Level I: See Physician Immediately.** Physician stat. (MD stat.) indicates that a medical problem exists which may be life threatening (an emergency) and requires the immediate attention of a physician. If a physician is not immediately available, emergency care should be initiated and ambulance transportation called. The facilities at a troop medical clinic or battalion aid station are usually not adequate to care for these patients. These patients should be transferred to a facility capable of providing advanced cardiac and trauma life support, usually an emergency room in a hospital, as soon as possible.

b. **Level II: See Physician Assistant Immediately.** Physician assistant stat. (PA stat.) indicates that a medical problem exists which may develop into a life-threatening emergency if not evaluated and treated by a medical officer quickly.

M	TAB	TAB	TAB
<b>SCREENING NOTE OF ACUTE MEDICAL CARE</b>			
<small>For use of this form, see AR 40-66. the proponent agency is the TSG</small>			
<small>TIME PATIENT DEPARTS UNIT (From DD Form 689)</small>	<small>SCREENER LOCATION</small>		
	<small>TIME PATIENT ARRIVES</small>	<small>TIME ENCOUNTER BEGINS</small>	<small>TIME PATIENT LEAVES</small>
<small>DATE</small>	<small>SCREENER LOCATION</small>	<small>CHIEF COMPLAINT</small>	<small>DURATION</small>
<small>PATIENT RESIDENCE ( ) BARRACKS                      ( ) POST HOUSING ( ) OFF POST                      ( ) TRANSIENT</small>		<small>VITAL SIGNS TEMPERATURE _____ ALLERGIES _____ PULSE _____ BP _____ RESP _____</small>	
<small>FIRST VISIT FOR THIS COMPLAINT ( ) YES ( ) NO. IF NO, WAS RETURN SCHEDULED/REQUESTED BY CARE PROVIDER? ( ) YES ( ) NO</small>			
<small>ALGORITHM/CODE</small>		<small>ALGORITHM/CODE</small>	
<small>ALGORITHM SUMMARY</small>		<small>ALGORITHM SUMMARY</small>	
<small>COMMENTS (Reasons for referral, method of referral, hospital appointments, self-care protocols, and patient instructions/precautions)</small>			
<small>PATIENT'S IDENTIFICATION (Use mechanical imprint if available; for typed or written entries give: Name, SSN, Unit, Sex, Birthdate and Duty Phone)</small>		<small>FINAL DISPOSITION</small>	
		<small>( ) I—PHYSICIAN STAT    ( ) IV—SELF CARE PROTOCOL  ( ) II—PA STAT            ( ) V—HOSP CLINIC REFERRAL  ( ) III—PA</small>	
		<small>AIDMAN'S SIGNATURE AND CODE</small>	<small>AUDITOR'S INITIALS AND DATE</small>
<b>DA FORM 5181-R, OCT 86</b>			
<small>EDITION OF DEC 84 IS OBSOLETE</small>			

Figure 5-2. DA Form 5181-R, Screening Note of Acute Medical Care.



c. **Level III: See Physician Assistant Today.** Physician assistant today (PA today) indicates that a medical condition exists which requires a physician assistant's evaluation. The PA or other medical officer will make the decision as to the disposition of the patient.

d. **Level IV: Self-Care Protocol.** Self-care protocol (SCP) indicates that a health condition exists for which the patient can administer adequate care to himself (self-care). The instructions and medications to be offered the patient are contained within the body of the protocol. Either the patient or the screener may overrule this recommendation of self-care. If a patient refuses the SCP, refer him to the PA for further screening.

e. **Level V: Hospital Clinic Referral.** Hospital clinic referral indicates that a medical condition exists which should be evaluated in a specialty or subspecialty clinic of a hospital.

**NOTE:** These "clinics" are part of the MEDCEN or USACH hospital and are not to be confused with the medical and dental clinics discussed in Lesson 2.

Consultation with either a PA or supervising physician is required. When an appointment is not available within the time frame specified by the algorithm, the patient will be referred to Level III (PA today).

## **5-7. USING THE ALGORITHM-DIRECTED TROOP MEDICAL CARE SYSTEM (AMBULATORY PATIENT CARE MANUAL)**

The following steps provide general guidance for using the APC manual in an ADTMC.

a. **Initiate DA Form 5181-R.** Enter the patient identification information and heading information on a DA Form 5181-R, Screening Note of Acute Medical Care. Continue to enter information, to include physical findings and results of the algorithm, as the screening process takes place. Once the form is completed, it is filed with the patient's SF 600.

b. **Select Appropriate Section.** Determine the reason the patient is visiting the facility (chief complaint). Classify the patient's main (chief) complaint and turn to the appropriate section of the APC manual.

- (1) Constitutional complaint (fatigue, fever, chills, heat injury)--TA section.
- (2) Neuro-psychiatric complaint (drowsiness, depression, nervousness, anxiety, weakness, numbness, dizziness, fainting, headache, and so forth)--TB section.
- (3) Eye complaint (pain, redness, vision problem, and so forth)--TC section.

(4) Ear, nose, and throat (ENT) complaint (hearing problem, injuries, allergy, sore throat, cough, cold, and so forth)--TD section.

(5) Cardiorespiratory complaint (shortness of breath, chest pain, wheezing)-TE section.

(6) Gastrointestinal complaint (nausea, vomiting, diarrhea, constipation, abdominal or rectal pain, difficulty in swallowing, and so forth)--TF section.

(7) Genitourinary complaint (painful urination, blood in urine, testicular pain, and so forth)--TG section.

(8) Gynecology (GYN) complaint (breast problems, vaginal discharge, menstrual problems, possible pregnancy, and so forth)--TH section.

(9) Musculoskeletal complaint (back or neck pain, pain in arm or leg, muscle ache, and so forth)--TI section.

(10) Dermatology complaint (skin rash, fever blisters, sexually-transmitted diseases, corns on feet, frostbite, and so forth)--TJ section.

(11) Miscellaneous complaint (prescription refill, immunization shots, request for nonprescription medication, prescription refill, and so forth)--TK section.

(12) Miscellaneous reason for return (not getting better, return requested by health care provider)--TL section.

c. **Select Appropriate Algorithm.** Once the appropriate section has been selected, determine which algorithm within the section should be used based upon the patient's condition and complaints.

d. **Follow Instructions Given in Algorithm.**

(1) Each algorithm indicates which vital signs (TPR and blood pressure) are to be taken. In order to save time, take only those vital signs indicated.

(2) Sometimes, a list of associated complaints is also given. If any associated complaint is in **boldface** or has an asterisk (\*) by the complaint, ask the patient if he has any of the associated complaints. If the patient has an associated complaint that is in boldface or has an asterisk, screen the patient using the algorithm for the associated complaint. The boldfaced or asterisked complaint is more significant than the patient's original complaint.

(3) Each algorithm has a flow chart giving yes/no type questions. Answer the question and follow the appropriate arrow to the next step in the decision path.

(4) Each algorithm has a text section which explains the decision blocks in the flow chart, describes any Level IV (self-care) protocols indicated in the diagram, and provides any additional information. Refer to this information as needed.

(5) Once the appropriate Levels (I through V) is reached, take the appropriate steps (refer patient to physician or physician assistant, instruct patient in self-care protocol, or consult physician or physician assistant regarding referral to another medical treatment facility.)

**NOTE:** Consult local SOP as required, especially if the patient is a basic trainee with a fever and a possible acute respiratory disease.

(6) Complete the DA Form 5181-R and file.

### **5-8. EXAMPLE OF A PATIENT INTERVIEW USING ALGORITHM-DIRECTED TROOP MEDICAL CARE SYSTEM**

Suppose a patient comes in with a primary complaint of having a common cold. He could be screened as follows.

- a. A "cold" is an ear, nose, and throat complaint. Go to the TD section.
- b. One of the algorithms in the ENT section is "cold" (TD-21). Select this algorithm as a starting point.
- c. Check for associated complaints. Upon checking the cold algorithm (figures 5-3 and 5-4), you find a list of associated complaints. Upon questioning the patient, he says he also has a sore throat, but does not have a sinus problem, ear pain, or shortness of breath. Since "sore throat" has an asterisk and is in boldface, you must use the sore throat algorithm instead of the cold algorithm. The "sore throat" (TD-15) is a more important complaint than the "cold" (TD-21).
- d. Go to the "sore throat" algorithm and check for associated complaints. Upon checking the sore throat algorithm (figures 5-5 and 5-6), you see that the associated complaint "sinus problems" has an asterisk and is in boldface. Since the patient has already denied having this complaint and no other complaint has an asterisk or appears in boldface, the sore throat algorithm is the appropriate algorithm for the patient.
- e. Check the vital signs portion of the chart (upper left corner). The instructions tell you to take the patient's temperature. Take the patient's oral temperature.

**NOTE:** Temperatures should be taken orally unless otherwise indicated.

COLD

People mean different things when they say, "I have a cold." Most people who complain of having a cold have just that and will get better even if they receive no medication. However, some people who think they have a cold may actually have strep throat, pneumonia, or even meningitis. Do not assume that everyone complaining of a cold is correct. Following the screening manual significantly decreases the chances of missing someone with a severe underlying illness, mistakenly called a cold.

You can best determine the patient's specific complaint by asking "What do you mean by a cold?" If his complaint can be screened by another algorithm, use that algorithm, especially if it is one of the associated complaints indicated by the asterisk (\*) and bold type.

If the patient's complaint remains vague or general, use the cold (TD-21) algorithm. This algorithm is a combination of algorithms used to evaluate the most common symptomatic complaints associated with colds.

## Rx Protocol TD-20

1. Provide the patient with the appropriate medication that will make him feel more comfortable; e.g., an antihistamine or decongestant for congestion, aspirin or Tylenol for minor aches and pains, etc.
2. Instruct the patient to return if he develops a temperature greater than 101°F, a productive cough, or if his symptoms do not improve within the next several days.

Figure 5-3. Algorithm TD-21: Cold (text).

COLD (TD-21)

Vital signs - Temperature

- Associated Complaints:
- Fever
  - Runny/Stuffy Nose
  - \*Sinus Problem
  - Allergy/Hay Fever
  - \*Shortness of Breath
  - Muscle Aches
  - \*Ear Pain
  - Cough
  - \*Sore Throat

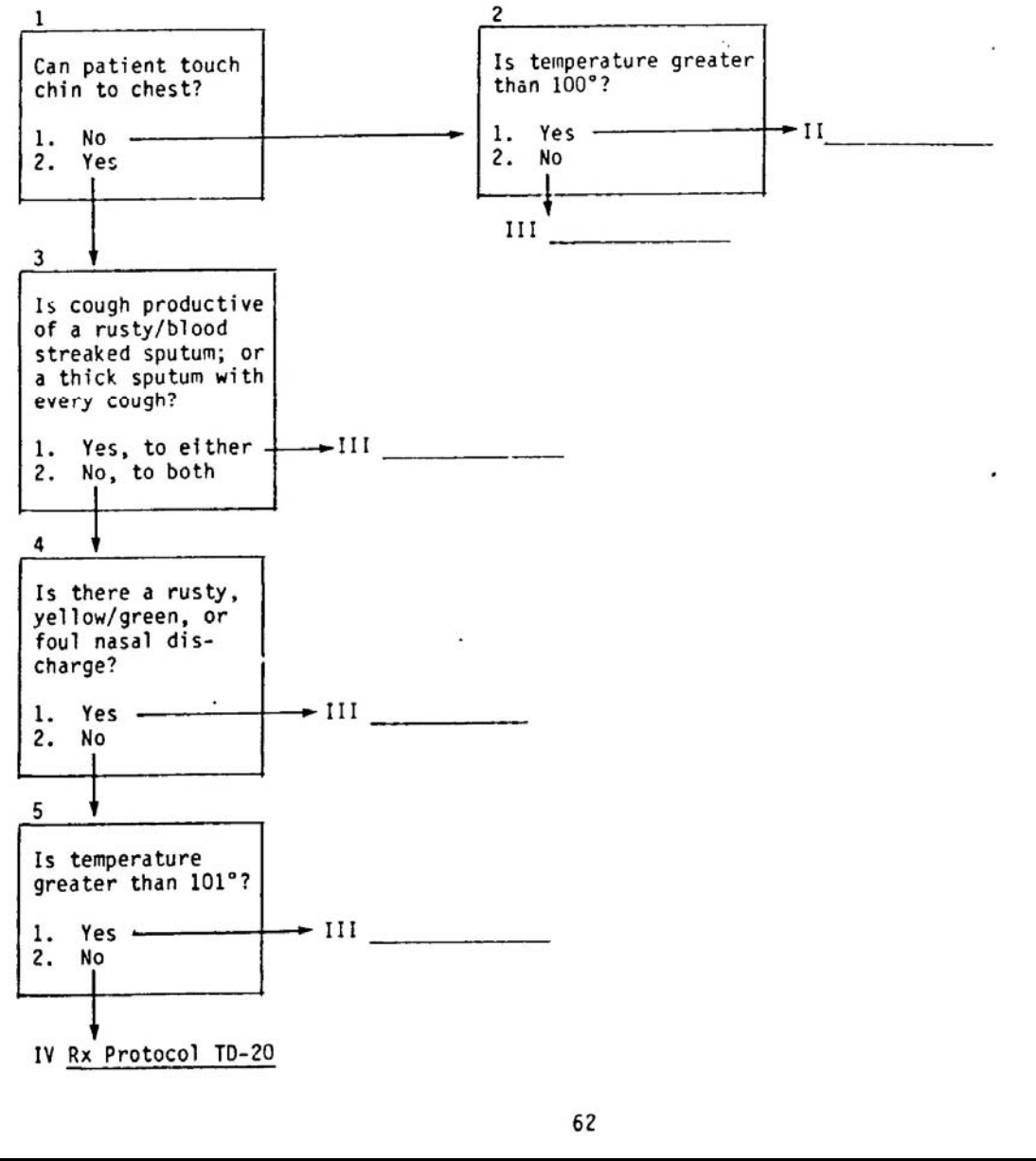


Figure 5-4. Algorithm TD-21: Cold (flow chart).

SORE THROAT

1-2. Inability to touch the chin to the chest plus an elevated temperature greater than 100° indicates possible meningitis and should be evaluated by the PA stat.

3. In the absence of a temperature of 101°, pus on the tonsils and swollen tonsils, the patient probably does not have a strep throat requiring treatment. If any one of these three symptoms is present, the patient should be sent to the PA. An inability to swallow should not be confused with difficulty in swallowing. Inability to swallow is manifested by drooling. If the patient cannot swallow his own saliva, a life-threatening illness may be present. Immediate PA evaluation is necessary. Difficulty swallowing due to pain is common with a sore throat and is not a cause for immediate concern.

4. An inability to clear the ears may be an indication of inflammation of the eustachian tubes thus making the patient susceptible to inner ear infection. In this instance, the individual needs further evaluation and not self-care.

## Rx Protocol TD-14

1. Aspirin and Chloraseptic gargles or Cepacol lozenges may be provided to relieve the pain. Make sure patient understands directions for use. Also, gargling with salt water (1/2 teaspoon of salt in 1 cup warm water) may help.

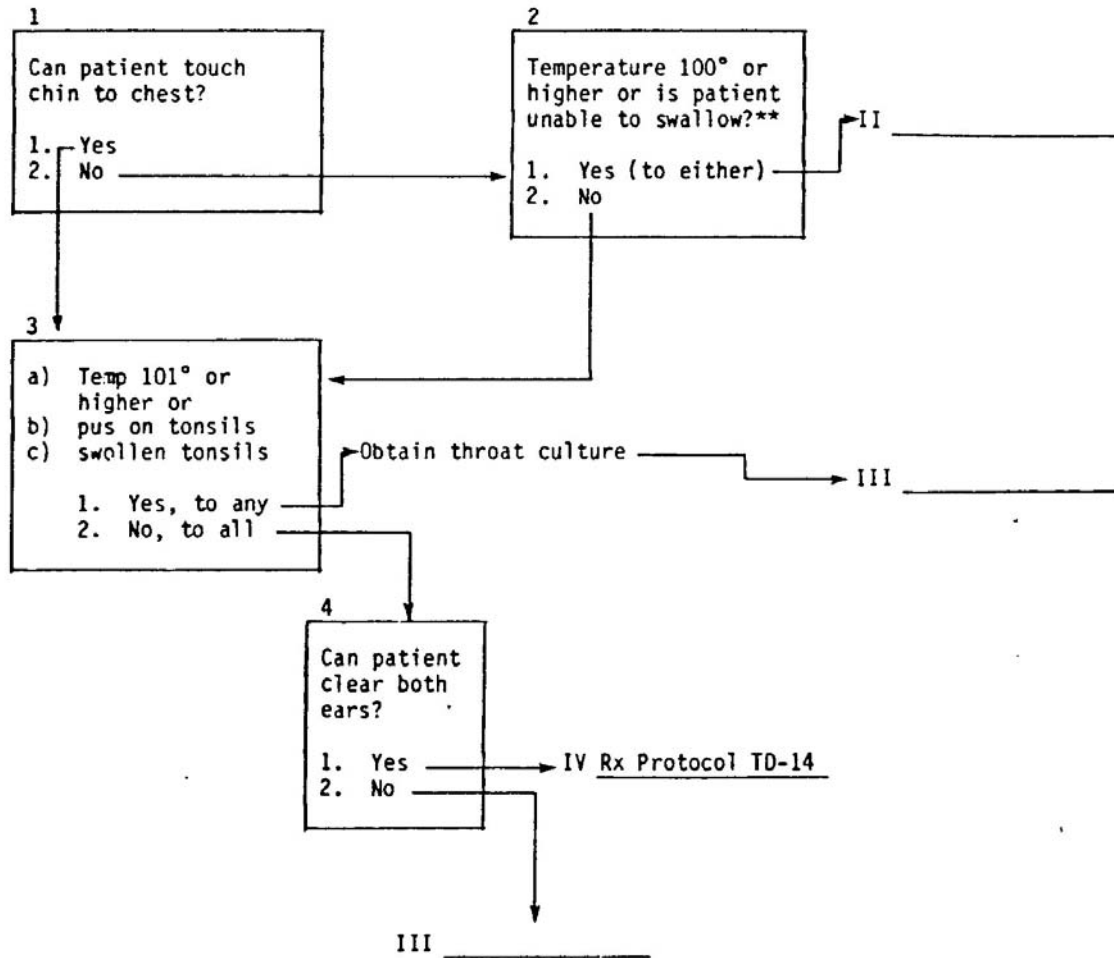
2. Instruct the patient to return for medical assistance if the sore throat has shown no signs of improvement after three days of the above treatment or temperature becomes greater than 101°F.

Figure 5-5. Algorithm TD-15: Sore throat (text).

SORE THROAT (TD-15)

Vital signs - Temperature

Associated Complaints: \*Sinus Problem  
Allergy/Hay Fever  
Runny/Stuffy Nose  
Fever  
Headache  
Muscle Aches  
Hoarseness



\*\*Answer determined by observing patient.

If patient has already tried or will not accept protocol, enter "III" as the disposition.

Figure 5-6. Algorithm TD-15: Sore throat (flow chart).

f. Block TD-15-1 (block number 1 of algorithm number 15 of the TD section.) asks if the patient can touch his chin to his chest. Tell the patient to try to touch his chin to his chest.

(1) If he cannot perform this maneuver, proceed to block TD-15-2.

(2) If he can perform this maneuver, proceed to block TD-15-3 instead.

g. Assume the patient can touch his chin to his neck. Upon reading block TD-15-3, you see that you are to check the patient's throat for swollen tonsils and pus on the tonsils. Check his throat.

(1) If his tonsils are swollen or if you observe pus or if his oral temperature is 101°F or higher, take a throat culture and have the patient see the PA today (Level III).

(2) If his tonsils are not swollen and no pus is observed on his tonsils and his oral temperature is below 101°F, proceed to block TD-15-4.

h. Assume the patient's tonsils appear normal (or have been removed) and his oral temperature is 99.8°F. You would then proceed to block TD-15-4. Block TD-15-4 requires you to determine if the patient can clear both ears. Ask the patient to clear his ears.

(1) If the patient cannot clear one or both ears when he swallows, the eustachian tubes (channels leading from middle ears to the nasopharynx which serve to adjust the air pressure in the middle ear to the external air pressure) may be inflamed. Refer the patient to the PA today (Level III).

(2) If the patient clears both ears when he swallows, proceed to self-care protocol TD-14. Tell the patient to take the appropriate self care measures. Provide aspirin and gargles or lozenges as needed. Instruct the patient to return if there is no improvement in three days or if his oral temperature rises above 101°F).

i. Upgrade the Level IV evaluation to Level III if the patient rejects the protocol or if you believe that Level III is more appropriate (for example, the patient had temperature of 100.8°F and significant pain upon swallowing).

## **5-9. EMERGENCY TREATMENT**

Although most of the work in a clinic can be described as routine, emergencies do occur. You should be prepared for emergencies and know the appropriate procedures to follow.



**a. Prepare for Emergencies.**

(1) Maintain proficiency in applying basic medical measures such as clearing an airway, restoring breathing and heartbeat (cardiopulmonary resuscitation), stopping severe bleeding, controlling shock, and applying dressings.

(2) Have emergency equipment ready for use and immediately available.

(3) Be familiar with the operation of all emergency apparatus and the use of all items on an emergency tray without having to refer to a manual or instruction booklet.

**b. Initiate Patient Care Measures.** In an emergency, you should:

(1) Take the patient to an examining or treatment room and, if his condition allows, have him lie down.

(2) Find out what is wrong. This can be done by observing the patient and asking the patient if he is in pain. If the patient is in pain, ask him where he hurts.

(3) Look for signs of breathing difficulty, bleeding, shock, and poison. Treatment of these conditions takes precedence over everything else since they are life-threatening.

(4) Notify the physician, PA, or other designated personnel immediately and give a brief description of the nature of the emergency and the patient's condition. An emergency or seriously ill patient should never be left unattended. If you must leave the patient, have someone remain with him until you return. Return to the patient as quickly as possible.

(5) Take and record the patient's vital signs.

(6) Obtain a chaperon, if needed.

(a) When a male performs a medical examination or procedure on a female patient (adult or child), a chaperon is needed. The chaperon is normally a female nurse or attendant. When female personnel are not assigned to the clinic or are not available, it is important to request that the husband, the parent, or a responsible female adult remain in the waiting room on call in case a chaperon is needed.

(b) The male medical specialist assisting with patient care must make certain that an appropriate chaperon is present before preparing the female patient for examination, before advising a male medical officer that the patient is ready for examination or treatment, or before performing any procedure himself.

(7) Loosen and remove enough of the patient's clothing to enable the physician (or other medical person) to examine the patient. If it is necessary to cut the patient's clothing, ask for his permission (or that of an accompanying relative) if possible. Clothing should be cut along seams, if practicable, so they can be repaired.

(8) Assist the physician, PA, or designated personnel as needed. Obtain any required equipment and carry out orders quickly and accurately.

c. **Perform Follow-up Measures.** After you are no longer needed in treating the emergency, you should:

(1) Assure the patient's relatives or concerned individuals who brought the patient that care is being given, ask them to remain in the waiting room until the physician (or other person) can see them, and make them as comfortable as possible.

(2) Briefly explain to the other patients who are waiting why their care is being delayed.

**Continue with Exercises**

## EXERCISES: LESSON 5

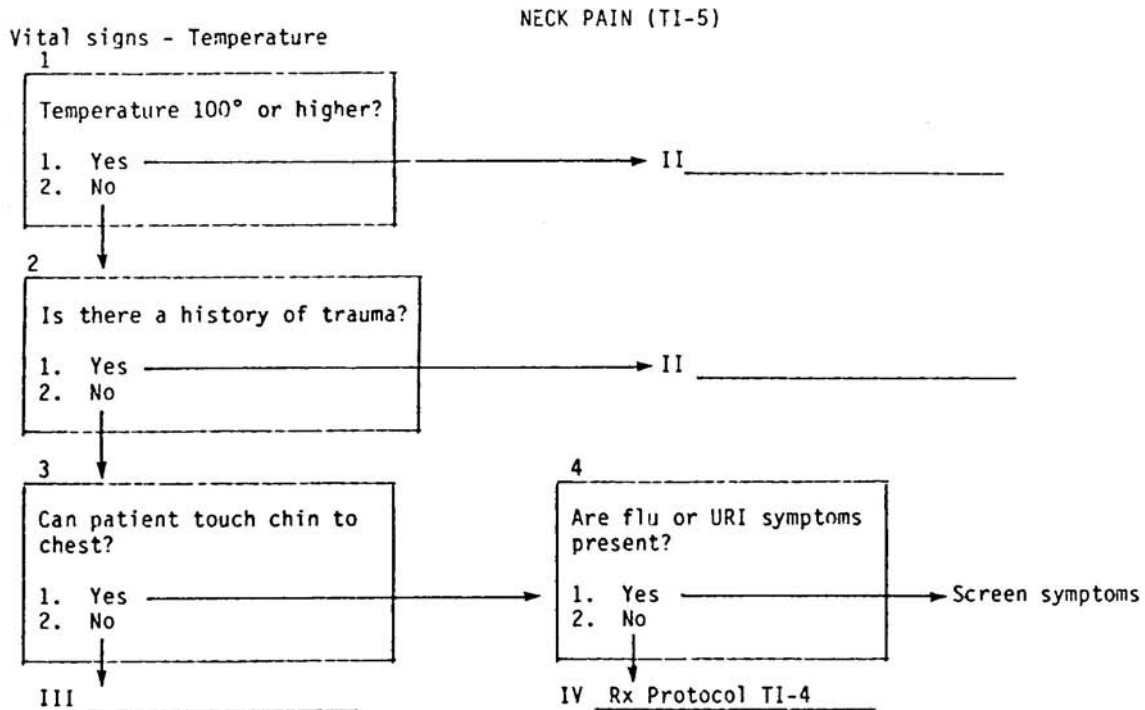
**INSTRUCTIONS:** For each question or incomplete statement followed by a group of lettered responses, circle the letter of the response that BEST answers the question or BEST completes the statement. After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers. For each exercise answered incorrectly, reread the material referenced after the solution.

1. A medical specialist working in a clinic should:
  - a. Have emergency equipment ready for immediate use.
  - b. Know how to apply the basic lifesaving steps.
  - c. Know the names and uses of the items on an emergency tray.
  - d. All of the above.
  
2. A clinic uses a screening process to determine which patients should see a medical officer and which patients can be treated by qualified paraprofessional personnel. A soldier with a minor abrasion reports to sick call. After the patient is told the injury will be treated without the patient seeing a medical officer, the patient requests to see the physician "just to be sure." The patient should be:
  - a. Permitted to see a medical officer.
  - b. Returned to his unit immediately since he refused treatment.
  - c. Treated and returned to his unit without seeing a medical officer.
  - d. Treated and returned to his unit as "sick in quarters."
  - e. Treated and told that he may see a medical officer if his injury does not heal properly.

3. A soldier reporting to sick call should bring an initiated:
  - a. SF 600.
  - b. DD Form 689.
  - c. DA Form 3444-series folder.
  - d. APC manual.
  
4. Sick call is normally conducted at a/an:
  - a. Army health clinic.
  - b. Brigade headquarters.
  - c. Hospital.
  - d. Troop medical clinic.
  
5. Before leaving sick call and returning to his quarters, a soldier says the medication that he took is making him feel dizzy. You should:
  - a. Advise him to go to his quarters as soon as possible.
  - b. Have him fill out the paperwork and retriage him when his turn comes.
  - c. Tell him to lie down for a few minutes and obtain an escort for the patient if needed.

6. A patient comes into the clinic with a complaint of a stiff, painful neck. His oral temperature is 100.4°F. According to the following algorithm, the patient should be:
- Seen by the physician immediately.
  - Seen by the physician assistant immediately.
  - Seen by the physician assistant today.
  - Told the appropriate self-care protocol.
  - Referred to another medical treatment facility immediately without any additional examination.

HSC Pam 40-7-21



If patient has already tried or will not accept protocol, enter "III" as the disposition.

7. If you are not using a screening algorithm, you should:
  - a. Take the patient's temperature, pulse, and respiration.
  - b. Ask the patient about any pains.
  - c. Observe the way the patient sits and walks.
  - d. Observe the patient's skin and eyes.
  - e. Do all of the above.
  
8. Algorithms are designed to:
  - a. Route patients to health care providers using random selection.
  - b. Take a complete patient history.
  - c. Route patients to the appropriate health care provider using proved medical logic.
  - d. Determine which patients are ill and which are malingering.
  
9. You are using HSC Pam 40-7-21 to screen patients. The algorithm results in a Level V. This means the patient:
  - a. Needs to see a medical officer immediately.
  - b. Needs to be seen by another medical facility.
  - c. Needs to see a medical officer sometime today.
  - d. Can care for himself.
  - e. Requires immediate hospitalization.

10. You are using HSC Pam 40-7-21 to screen patients. A patient complains of being "short of breath." You should go to the \_\_\_\_\_ section of the triage manual.
- a. TA.
  - b. TB.
  - c. TC.
  - d. TD.
  - e. TE.
  - f. TF.
  - g. TG.
  - h. TH.
  - i. TI.
  - j. TJ.
  - k. TK.
11. DA Form 5181-R, Screening Note of Acute Medical Care, is used to:
- a. Transfer patients to other medical treatment facilities.
  - b. Request prescribed medications.
  - c. Document the patient screening process when the ADTMC system is used.
  - d. Place soldiers on "sick in quarters" status.

**Check Your Answers on Next Page**

## **SOLUTIONS TO EXERCISES: LESSON 5**

1. d (paras 5-9a)
2. a (para 5-6)
3. b (para 5-2)
4. d (para 5-1)
5. c (para 5-3g)
6. b (paras 5-6, 5-7)
7. e (paras 5-3, 5-4)
8. c (para 5-5)
9. b (para 5-6e)
10. e (para 5-7b(5))
11. c (paras 5-5, 5-7a)

**End of Lesson 5**